Stonehouse Dental Centre

Durnforth Street, Plymouth, Devon, PL1 3QS

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Are services safe?	**No action required**	✓
Are services effective?	**No action required**	✓
Are services caring?	**No action required**	✓
Are services responsive?	**No action required**	✓
Are services well led?	**No action required**	✓

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Stonehouse Dental Centre on 10 May 2022 and sought patient feedback about the service by telephone on 12 May 2022.

As a result of the inspection we found the practice was safe, effective, caring, responsive and well-led in accordance with CQC's inspection framework.

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

Background to this practice

Co-located with Stonehouse Medical Centre, the Dental Centre is a two-chair practice providing a routine, preventative and emergency dental service. Just one chair was in use at the time of the inspection. The patient population of 850 comprised service personnel from Stonehouse Barracks and the Royal Citadel Barracks. The dental centre has a dedicated central sterilisation department.

The practice is open from 08:00 hours to 16:30 hours Monday to Friday and from 08:00 hours to 12:30 hours on Friday. Out-of-hours emergency access is facilitated by the regional duty team.

The staff team

Dentist	Civilian Senior Dental Officer (30 hours a week)
Practice manager/leading dental nurse	Cover provided by a military dental nurse until January 2023
Dental nurse	Vacant

Our Inspection Team

This inspection was undertaken by a CQC inspector and a dentist specialist advisor.

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the acting practice manager/dental nurse and Senior Dental Officer. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the premises, equipment and facilities. We also reviewed patient feedback and interviewed patients by telephone on 12 May 2022.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Local systems were in place to support the management of risk, including clinical and non-clinical risk. Arrangements to ensure safe water temperatures for the building were in place and managed by an external stakeholder but the process was not effective.
- Arrangements for monitoring the environmental cleaning contract were not clear and we were unable to establish the deep cleaning arrangements.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults.
- Appraisals and required training for staff were up-to-date, and staff were supported with continuing professional development.
- Clinicians provided care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.
- Leadership at the practice was inclusive and effective. Despite staff vacancies, the team worked well together and managed the staff gaps to ensure patient care was not unduly impacted.

- Medicines and life-saving equipment were available in the event of a medical emergency. The monitoring of medicines requiring cold storage was not carried out in accordance with organisational policy.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Systems for assessing, monitoring and improving the quality of the service were in place.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

- That the team/department responsible for the management of water safety addresses the reason why water temperatures have not always been within the range to minimise the risk of Legionella in the water system. In addition, the DPHC should ensure water temperature checks are routinely shared with the practice so the practice is assured checks are being carried out and that temperatures are within the parameters as outlined in HTM 01-05 (chapter 19).
- Review staffing levels to ensure the practice has sufficient capacity to provide continuity of care for patients.

The Chief Inspector recommends to the practice:

- That the domestic fridge used to store medicines requiring cold storage is replaced by the recently procured pharmaceutical fridge without delay.
- Liaise with the team/department responsible for environmental cleaning to ensure the practice has access to the current cleaning contract and cleaning schedule and, to confirm the arrangements for deep cleaning of the premises.
- Follow up on the work request for improvements to the clinical areas. In particular, improvements should be made to surgery 2 before it is used to treat patients.

Dr John Milne MBE BChD, Senior National Dental Advisor

(on behalf of CQC's Chief Inspector of Primary Medical Services and Integrated Care)

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

Staff had a log-in to the Automated Significant Event Reporting (ASER) DMS-wide system to report a significant event (SE). They had completed ASER training in April 2022. Staff were clear in their understanding of the types of SEs that should be reported, including never events. A log of SEs was maintained and the regional Governance, Performance, Assurance and Quality (GPAQ) dashboard was used to monitor SEs. GPAQ showed that one SE had been raised since May 2021. The practice manager provided a detailed overview of how this SE was managed and changes made to minimise a reoccurrence. SEs were a standing agenda item at practice meetings.

Accidents were reported through the ASER system and to the camp health and safety advisor (referred to as SHEF) if the accident involved the infrastructure. Staff were aware of when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

National patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority and the Department of Health Central Alerting System were a standing agenda item at the practice meeting. Alerts were logged including the action taken. Staff provided examples of recent alerts discussed.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead for the practice. A safeguarding children and vulnerable adults policy was displayed, including safeguarding alerter guidance. Staff had completed child protection training. Although not fully clear on the personnel management system (PMS), an organisation-wide system used to monitor training, the practice provided evidence to demonstrate staff were current for level 1 and 2 adult safeguarding training. We determined the lack of clarity regarding adult safeguarding training was related to the PMS system and possibly impacted other defence dental practices rather than just Stonehouse Dental Centre. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. The SDO provided an example of a safeguarding concern identified; the action taken demonstrated appropriate engagement with the Chain of Command and the military police.

Clinical staff understood the duty of candour principles, a set of specific legal requirements that services must follow when things go wrong with care and treatment. From examples provided, it was clear that duty of candour principles had been applied, including informing the patient and offering an apology.

A lone working protocol was in place and was reviewed in January 2022. It took account of actual and potential lone working circumstances and clearly indicated patients were not seen if chairside support was unavailable. Given the low staffing levels currently

experienced and to ensure chairside support for the SDO, the practice sought dental nurse support from other local defence dental practices.

Staff were aware of how to raise concerns through whistleblowing processes. Information was displayed in the staff room about whistleblowing and 'Freedom to Speak Up (FTSU), including a FTSU flowchart.

Dentists routinely used rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment and also for some composite fillings.

The business continuity plan was revised in September 2021 and outlined how the service would be provided if an event occurred that impacted its operation. The plan referenced loss of power, loss of temperature control of fridges, adverse weather conditions and loss of compressed air.

Medical emergencies

The SDO was the lead for the management of medical emergencies. The resuscitation trolley was the standard type used across Defence Primary Healthcare (DPHC) medical centres and was tamper-tagged. Appropriate laminated guides were displayed with the trolley. The trolley was secured in a locked storeroom when the practice was closed. The automated external defibrillator (AED) was held in the medical centre on the floor above the dental centre. The dental centre was rarely open at times when the medical centre was closed. In the event this happened then the dental centre had access to the AED in the guardroom located nearby. The medical emergency kit and medicines were regularly checked and a log maintained of the checks. Appropriate oxygen signage was in place.

Records identified staff were up-to-date with training in managing medical emergencies, including annual basic life support and the use of the AED. During COVID-19 interactive-based cardiopulmonary resuscitation and AED training was cancelled so staff undertook online training to mitigate the risk. The SDO provided the team with training in the use of the medical emergency kit, snapping ampoules and drawing up syringes in October 2021 and again in April 2022. As part of the April training, the intermediate life support trainer from the medical centre facilitated scenario-based training for the dental team.

First aid, bodily fluids and mercury spillage kits were available and all were in-date. The DPHC protocol for managing spillages was displayed at the practice. Training records confirmed staff were up-to-date with first aid training. Staff were aware of the signs of sepsis. It was planned to include the sepsis toolkit in the next medical emergency training session.

A portable emergency alarm system was used across the practice and regularly checked to ensure each alarm was working. We activated the alarm in the furthest surgery and it could be heard at reception.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The practice manager had access to the PMS system so could demonstrate that relevant safety checks had taken place at the point of recruitment, including an enhanced Disclosure and Barring

Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in line with DPHC policy. The registration of staff with the General Dental Council was up-to-date and staff had the relevant vaccinations staff required for their role.

Monitoring health & safety and responding to risks

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained that took account of the 'four T's' (transfer, tolerate, treat, terminate) to clearly indicate where and how risks were being managed. It included risks staff made us aware of, such as chipped cabinetry in surgeries, access to the AED and recruitment. The stem of the male toilet used by staff and patients was cracked and we highlighted that this was an accident risk. Staff closed the toilet to use, placed a notice on the door advising patients to use the toilet in the medical centre and added the issue to the risk register. The toilet was replaced a week after the inspection.

Reviewed in September 2021, a practice risk assessment referenced: the work environment; infection prevention and control (IPC); water safety; latex allergy; Control of Substances Hazardous to Health (COSHH); radiation; air safety and accidents. A range of weekly and monthly environment checks were undertaken.

The five-yearly fire risk assessment was undertaken in May 2021. A member of staff in the medical centre was the building manager so organised fire evacuation drills; the most recent took place in November 2021. The practice manager carried out weekly checks of the fire system. We checked the firefighting equipment and it was in-date. The staff team were up-to-date with fire training. Regular building management meetings were held for the camp and the building manager attended.

COSHH risk assessments and data sheets were in place. The risk assessments were reviewed annually or if there was a change of product. They were last reviewed in September 2021. COSHH products were stored securely.

Prior to the inspection, the practice manager attempted to secure the building legionella risk assessment and email evidence was in place to support this. Although the SHEF advisor confirmed a legionella risk assessment had been completed, it was held by the contractor. We were advised that the recent change of contractor meant information in relation to water safety was not available. We later secured the legionella risk assessment (carried out in March 2020) from the medical centre.

We were advised the contractor for the camp carried out monthly water temperature checks but did not routinely share this information with the practice. After the inspection, the practice manager secured the building water temperature checks for 2022. We noted the temperatures for January 2022 for two hot water outlets (one in the medical centre and one in the dental centre) were not within the range as outlined in HTM 01-05 (chapter 19). The practice had not been made aware temperatures were outside of the required parameters to minimise the risk of Legionella in the water system and records indicated these two outlets had not been checked since.

Dip slides (to check for bacteria) were undertaken by practice staff each month for qualitative testing. In accordance with policy, samples were sent to a dental IPC company every three months for quantitative testing.

In response to COVID-19, the practice worked to the Defence Primary Healthcare (DPHC) SOP, 'Infection Prevention and Control for Respiratory Infections (including SARS-CoV-2) in DPHC dental settings (February 2022)'. Patients were triaged by telephone before their appointment and were assigned either the non-respiratory pathway or respiratory pathway. For the latter pathway, full personal protective equipment (PPE) was used along with the measures outlined in the guidance. Clinical staff were aware of which AGP presented a low or high risk depending on whether high volume suction and/or a rubber dam was used. Fallow periods between patients were built into the appointments schedule if required. Information about the virus was displayed around the dental centre. Hand sanitiser was provided throughout the building and the practice had procured a large stock of PPE for use by both staff and patients. The general COVID-19 risk assessment was reviewed in September 2021. Individual staff COVID-19 risk assessments had also been completed.

The practice followed relevant safety laws when using needles and other sharp dental items. The local risk assessment and protocol for the management of sharps and needle stick injuries was displayed in clinical areas. The sharps boxes were labelled, dated and used appropriately. The SDO confirmed there had been no sharps injuries in recent years.

Infection control

The practice manager on extended leave was the lead for IPC and had the appropriate training for the role. The acting practice manager had taken over the lead role and was awaiting a date for the IPC practitioner training. In the interim, they were supported by the IPC lead for the medical centre and the regional team. Reviewed regularly throughout the COVID-19 pandemic, the local IPC policy took account of the Department of Health's 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. The IPC policy was displayed in the practice. The staff team were up-to-date with IPC training. IPC audits were undertaken twice a year. The last audit identified an overall compliance score of 86%. Shortfalls mainly related to the current IPC lead waiting to complete the training and infrastructure issues.

We checked the two surgeries. Overall, they were clean and clutter free. We did observe dust and dirt in the narrow gap between the chair base and electrical unit in each surgery. Shortly after the inspection we received photographic evidence demonstrating this had been addressed and confirmation that these areas would be included in the daily cleaning schedule. There was minor damage to the work surfaces, high paintwork and door handles in surgery 1. Although currently not in use, we noted similar damage in surgery 2, particularly to the flooring. Surgery 2 would need to be improved in light of plans to appoint a part-time hygienist who would use this surgery. These infrastructure issues were identified on the risk register. We were advised a statement of need (works request) had been submitted some time ago (possibly two years ago). Despite their best efforts, practice staff were unable to determine how this request was progressing. We noted damage to the paintwork in the male toilet used by patients and staff. This had been assessed and improvement work was scheduled to take place.

Decontamination took place in a small central sterilisation services department (CSSD), which was also used as the dental laboratory. The room was small and include two sinks. Staff followed the DPHC ultrasonic cleaning protocol that supported the use of one sink and two removable bowls for the cleaning instruments. The other sink was used for handwashing. We noted damp damage to the cupboard below the sink. The absence of a dedicated handwashing sink and damp damage had been added to the risk register and had been reported as part of a works request for improvements to clinical areas. The practice had been advised that the infrastructure did not support the installation of a third sink. A clean and dirty flow was clearly identified in the CSSD. External ventilation was through an extractor fan which we tested. We suggested it would be useful to explore the air-exchange rate within the room.

An efficient process was in place for the sterilisation of dental instruments. Autoclave records were retained, which could be cross-matched with the expiry dates on packaged instruments. Records of routine checks were maintained to demonstrate the ultrasonic baths and autoclave were monitored to ensure they were working correctly. Equally, records of temperature checks and solution changes were in place. Instruments and materials were regularly checked with arrangements in place to ensure materials were in-date.

Clinical areas were cleaned by practice staff at the end of each day. Environmental cleaning of non-clinical areas was carried out by a contracted company twice a day and the practice staff said they were satisfied with the standard of cleaning. The cleaning contract we were provided with lacked clear detail, such as a cleaning schedule and arrangements for deep cleaning. We asked medical centre staff as we understood it was one contract for both areas. The medical centre had received the cleaning schedule and shared this with the SDO. The IPC lead for the medical centre was currently seeking confirmation from the contractor about the deep clean arrangements.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth and gypsum. Clinical waste bins were stored securely outside the building. The practice received copies of the consignment notes from the medical centre. A pre-acceptance waste audit was undertaken in October 2021.

Equipment and medicines

How equipment was managed, including faulty equipment was displayed on the equipment care board. An equipment log was maintained to keep a track of when equipment was due to be serviced. Maintenance records confirmed the autoclave and ultrasonic baths were in-date for servicing. Although the equipment log indicated the compressor was in-date for servicing, the service report was not available. The practice manager confirmed that the new contractor was unable to access this on the previous contractor's system. All other routine equipment, including clinical equipment, had been serviced in accordance with the manufacturer's recommendations. A Land Equipment Assessment visit was undertaken in January 2022 and there were no actions outstanding. Routine portable appliance testing was undertaken every three years and was next due in November 2022. A faults log was in place to track the reporting and management of faulty equipment. A 'snap' inspection of two pieces of equipment was conducted each week. All equipment held at the practice

was latex free. A system was in place for the management of stock to ensure there was adequate stock in place.

Serialised prescription sheets were stored in a locked cupboard below the printer in the office. The prescription log demonstrated each prescription sheet was used in sequential order. The log showed minimal antibiotic prescribing at the practice indicating adherence to the Faculty of General Dental Practice good practice guidelines on antibiotic prescribing. Prescriptions were dispensed via the medical centre dispensary by means of an arrangement with a local pharmacy.

We looked at the last three months of temperature checks for medicines requiring cold storage. The temperatures varied considerably within the 2-8 degree Celsius parameter suggesting either an inefficient fridge or the door was being opened too frequently. On two occasions the recorded temperature fell outside the parameter and no action was taken. Staff confirmed the fridge temperatures would be checked twice a day following this feedback. These medicines were kept in a domestic fridge. Although not appropriate, the fridge was clean, contained minimal medicines and all items were within their expiry date. A pharmaceutical fridge had arrived and was awaiting sign-off by the contractor. There was a delay with this; DPHC were aware and had issued interim direction.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was held in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were available in surgery 1 along with safety procedures for radiography and the Health and Safety Executive (HSE) notification. Evidence was in place to show equipment was maintained in accordance with the manufacturer's instructions. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

Radiology audits are required to be completed every six months. An audit was ongoing since April 2022 and we noted others were completed in September 2020, October 2021 and March 2021.

The SDO also audited each digital image and provided justification, quality assurance grading and an outcome in the patient's clinical records.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients were assessed in line with recognised guidance, such as the National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. The Senior Dental Officer (SDO) followed guidance from the British Periodontal Society regarding periodontal staging and grading; basic periodontal examination (BPE) - assessment of the gums and caries (tooth decay). Taking into account operational need, the SDO referenced SIGN and Faculty of General Dental Practice guidance in relation to the management of wisdom teeth.

We looked at the dental records for 20 patients to corroborate our findings. They included information about the patient's current dental needs, past treatment, medical history and treatment options. The diagnosis and treatment plan for each patient was clearly recorded and showed treatment options were discussed with the patient. Patients completed a medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment. Although patients were recalled in a timely way, we noted from records the recall interval was not always re-assessed at each consultation in accordance with Defence Primary Healthcare guidance (DPHC). Although the maximum recall period was 24 months, most recalls were in the range of nine to 15 months depending on perceived risk. We discussed with the SDO the potential to give patients a longer recall interval while remaining within NICE guidance, as this would free up more time for preventative work.

Defence dental fitness targets for the patient population was closely monitored by the SDO and presented at the weekly practice team meeting.

Health promotion and prevention

In line with the Delivering Better Oral Health toolkit, the practice was pro-active in supporting patients to maintain optimal oral health. The previous locum nurse provided oral health education (OHE) at periodontal inspections (PDI) whilst the SDO recorded in the patient's notes. No OHE, fluoride varnish or smoking cessation clinics had been held since their departure in March 2022.

The SDO routinely assessed alcohol and smoking habits at each BPE. Sugar intake was also estimated through a series of questions about diet and fluid intake. Patients were referred to the medical centre for smoking cessation and a clinical code added to the patient's record. Both high concentration sodium fluoride toothpaste and fluoride varnish were prescribed by the SDO when a patient demonstrated an increased caries risk assessment. There was clear evidence in the prescription log of these both being prescribed. Bespoke brief interventions were recorded in the 20 dental records we reviewed. A range of oral health promotion leaflets and displays were available for patients in the waiting room.

Staffing

An induction programme that included a generic programme and induction tailored to the dental centre was in place for new staff joining the team. Staff were current with mandatory

training. We confirmed staff were up-to-date with their continuing professional development required for maintaining registration with the General Dental Council.

The SDO described how 12 months ago the staffing level was stable. Since then, the practice manager/leading dental nurse has been on extended leave. A junior military dental nurse was recruited as acting practice manager until January 2023. The civilian locum dental nurse who had worked at the practice for nine months left in March 2022. Dental nurse cover was provided from neighbouring defence dental centres whilst recruitment for another locum nurse was in progress. At the time of the inspection, a locum nurse had not been confirmed. Provision of a military dental hygienist two or three days a month from Drake Dental Centre was under discussion. In addition, it was anticipated that a trainee military dental nurse would be allocated to the practice in July 2022.

If dental nurse cover could not be secured then the practice manager supported the SDO in surgery, which meant there was no cover for reception. This was mitigated by an answer phone message and a notice advising patients who arrived without an appointment of the situation. Often those who called to practice were new arrivals wishing to register. A joiners and leavers desk was positioned near the front door with the relevant forms available to complete. Patient feedback, including patients we spoke with, raised no concern that reception was not staffed on some occasions.

Working with other services

The SDO referred patients to Derriford Hospital for oral surgery and extra-oral radiography. There were named contacts at the hospital with whom the SDO could liaise with for urgent or priority referrals. The referral letters we reviewed included sufficient information and a clear reason for the referral. A log was in place to monitor the progress of referrals. The SDO had not had to refer any patients for suspicious lesions.

Consent to care and treatment

Patients we spoke with confirmed they were given information about treatment options and the risks and benefits of these so they could make informed decisions. The patient records we reviewed showed implied consent was recorded for each periodontal inspection. Verbal consent was taken from patients for routine treatment. Scanned consent letters and pre-surgical checklists for treatment and oral surgery were evident in records.

Clinical staff had received training and had a good awareness of the Mental Capacity Act (2005) and how it applied to their patient population. If needed, the SDO said they would discuss any concerns regarding capacity for individual patients with the Senior Medical Officer in the medical centre.

Are Services Caring?

Respect, dignity, compassion and empathy

We reviewed patient feedback which was obtained using a variety of methods. These included direct interviews with 12 patients, the Governance, Performance, Assurance and Quality (GPAQ) analysis of patient feedback (40 respondents) and the Defence Medical Services Regulator (DMSR) patient satisfaction survey (26 respondents) which complemented this inspection. All sources of feedback indicated staff treated patients with kindness, respect and compassion.

The GPAQ analysis, DMSR survey and the patients we spoke with indicated adequate time was allocated for patient appointments, so they did not feel rushed. The Senior Dental Officer (SDO) confirmed appointment times could be extended for discussions and explanations, particularly for anxious patients. If needed, the SDO used an alternative room to the surgery for discussions with patients. Information displayed on the ceiling above the dental chair aimed to distract patients. It included a movie quiz, famous quotes and a photography gallery.

Access to a translation service was available for patients who did not have English as their first language.

Involvement in decisions about care and treatment

All sources of patient feedback suggested the SDO provided clear information to support patients with making informed decisions about treatment choices. This included verbal explanations and printed information. The dental records we looked at indicated patients were involved in the decision making about the treatment choices available.

A broad range of visual aids was available in the surgery, including a chair-mounted screen which supported patients to view charts, X-rays and other information. Occupational needs were discussed to assist patients with choosing a suitable treatment plan.

Are Services Responsive?

Responding to and meeting patients' needs

Patients could make routine appointments between their recall periods if they had any concerns about their oral health. A daily urgent appointment slot was in the afternoon as this time best met the needs of the patient population.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in March 2022. Although the practice was on the ground floor, there was step access from the footpath. Because the building was Grade 1 listed which meant there were limitations with making adaptations, a notice outside the building advised patients there was no disabled access. As an alternative, patients could be referred to neighbouring Bickleigh Dental Centre which was accessible.

Staff had received training in equality and diversity, including training in conjunction with Drake Dental Centre.

Access to the service

At the time of the inspection, the next available routine was within two weeks. All sources of feedback indicated patients received a timely appoint that met their health and occupational needs. The Defence Primary Healthcare survey showed 77% of patients secured an appointment within a few days and 23% had to wait a week or longer.

An emergency appointment was available at 15:00 hours each day and access to this appointment was triaged based on risk. The practice aimed to include an extra slot at 11:40 each day in the event of a dental accident, such as a broken tooth.

Information about the service, including opening hours and access to an emergency out-of-hours (OOH) service, was displayed in the practice and on the practice leaflet. OOH emergency care was through South West regional duty team.

Concerns and complaints

The Senior Dental Officer was the lead for complaints which were managed in accordance with the Defence Primary Healthcare complaints policy. The team received training in managing complaints. Although a process was in place for managing complaints, the practice had not received any verbal or written complaints.

Patients were made aware of the complaints process through the practice information leaflet and a display in the waiting area. Feedback from patients indicated they knew how to make a complaint.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) was overall responsible for the management and clinical leadership of the practice with day-to day service administration delegated to the practice manager. In post for the last four months, the acting practice manager had received a two-week handover and induction from the practice manager who was on extended leave until December 2022. Lead roles were shared between the SDO and acting practice manager. The acting practice manager had not yet completed the required training for some lead roles so was supported by the regional team, medical centre infection prevention and control lead and the health and safety advisor for the camp.

Practice meetings were held each week and were clearly structured in line with Defence Primary Healthcare guidelines and took into account the broad range of governance activities at the practice.

A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were local dental specific protocols and standard operating procedures that referenced current legislation and national guidance. Staff were familiar with these and referred to them throughout the inspection. The General Dental Council standards were displayed in the practice.

The risks directly overseen by the practice were managed effectively. However, the management of risk by other stakeholders was not so effective, such as monitoring of safe water temperatures. In addition, it was unclear who was responsible for monitoring the cleaning contract.

Internal and regional processes were established to monitor service performance. The practice had moved from the internal quality assurance tool, the Common Assurance Framework (eCAF) used to monitor safety and performance, to the new ‘Health Assessment Framework’. A regional-led Health Governance Assurance Visit (HGAV) took place in December 2019. A management action plan (MAP) resulting from the HGAV was in place. The MAP and other governance updates were discussed at practice meetings. The regional team monitored the performance of the practice as they had access to the governance updates the practice uploaded to SharePoint. This information was used for Governance, Performance, Assurance and Quality (GPAQ) analysis undertaken at regional level.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Each member of staff had a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. A reporting system was in place should a confidentiality breach occur. Staff had completed the Defence Information Management Passport training, data protection training and training in the Caldicott principles to protect confidential patient information.

Leadership, openness and transparency

Although a small team, it was clear the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. The acting practice manager said the SDO had provided good support particularly as they were new to the role. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement.

Learning and improvement

Quality improvement activity (QIA) to encourage learning and continuous development was evident. The range of QIA included environmental, equipment and inventory checks. Regular audits including infection prevention and control and radiology. A handwashing audit was undertaken earlier in the COVID-19 pandemic.

A 'failure to attend' (FTA) appointments audit was undertaken twice 12 months ago and the findings shared with commanders at the unit health committee meetings. It led to the dental centre telephoning each patient a day prior to their scheduled appointment, which reduced the FTA rate significantly. However, continuing this was unsustainable with just two staff. A referral audit had been undertaken and identified the contact details for patients was limited. The action taken included adding two more lines to the referral letter (FMed7) so these details could be recorded manually. There was scope for further development of the medical and social history sheet to include the patient's mobile number and email address, and updating DMICP (electronic patient recording system) at each periodontal inspection

The practice manager participated in the bi-monthly regional practice manager meetings. Similarly, the SDO attended the bi-monthly regional clinical SDO meetings.

Staff received mid and end of year annual appraisal and these were up-to-date.

Practice seeks and acts on feedback from its patients, the public and staff

Options were in place for patients to leave feedback about the service including a suggestion box in the waiting room and a 'quick reference' or QR code to access the patient experience survey. The GPAQ dashboard was used by the regional team to analyse patient feedback.

Staff told us they had the option to provide feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for service and said these were listened to and acted on.