# Harrogate Dental Centre

Uniacke Barracks, Pennypot Lane, Killinghall, North Yorkshire, HG3 2RU

## 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 previously carried out an announced comprehensive inspection of Harrogate Dental Centre in April 2019. There were no actions required for the safe, caring and responsive key questions. However, improvement was required for the effective and well led key questions.

A copy of the report from the previous inspection can be found at:

Harrogate Dental Inspection Report April 2019

An announced follow up comprehensive inspection was undertaken across 16 and 17 June 2021. We re-inspected all of the key questions and checked to see that our recommendations had been acted upon.

**As a result of this inspection we found that this 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 Defence Medical Services.

## Background to this practice

Located in Uniacke Barracks, Dental Centre Harrogate serves the Army Foundation College (the only Phase 1 Junior Entry training establishment in the British Army). The three-chair practice provides a routine dental service to new army recruits aged 16 - 18 years, as well as to permanent staff members of the armed forces based at the College. The practice confirmed to us that many young recruits and soldiers had greater than average dental care needs. This relates to oral health demographics with an above average percentage of the dental centre patient base recruited from areas of deprivation and poor oral health. At the time of inspection, the practice patient register numbered approximately 1,300 patients, with approximately 960 of these being 16-18 year old recruits to the Army.

The mission statement for the practice aligns with that of DPHC (Defence Primary Health Care) and is to "deliver a unified, safe, efficient and accountable primary healthcare and

dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations."

The Centre has a mix of military, civil service and temporary health workers (locums). There are eight posts and the current establishment and staffing gaps are outlined in the table below:

| Position | Incumbent April 2019 | Incumbent June 2021 |
|---|---|---|
| **Military Senior Dental Officer** | Military staff in post | Military staff in post |
| **Military Practice Manager** | Not in post | Military staff in post |
| **Military Dental Nurse** | Not in post | Military staff in post |
| **Civilian Dental Practitioner** | Civilian dentist in post | Civilian dentist in post |
| **Civilian Dental Nurse Band 4** | Not in post | Civilian nurse in post |
| **Civilian Dental Nurse Band 3** | Civilian nurse in post | Civilian nurse in post |
| **Civilian Dental Nurse Band 3** | Part time civilian nurse in post | Two part time civilian nurses in post |
| **Therapist / Hygienist** | Post removed | Hygienist in post |

At our inspection in 2019, four of these posts were vacant. In June 2021 we saw that additional staff had come into post, including a full time practice manager, a Band 4 nurse and a hygienist. The dental centre is open Monday to Thursday 07.45 to 12:30 and 13:30 to 16:30 and on Fridays from 07:45 to 13.00. The practice provides an emergency service during working hours and when the practice is closed. Patients can be referred internally and to the local NHS Trust for treatment not provided at the dental centre.

## Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and a dental nurse/manager.

## 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 practice manager, the senior dental officer, the civilian dentist, the dental nurses and the hygienist. We looked at practice systems, policies, standard operating procedures and other records in relation to how the service was managed. We also checked the building, equipment and facilities.

We also spoke with 9 patients who were currently registered at the dental centre. All the feedback from patients was positive.

**At this inspection we found:**

- The practice used a DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the management of risks.
- Suitable safeguarding processes were established and staff knew their responsibilities for safeguarding adults and young people.
- The clinical staff provided care and treatment in line with current guidelines. Clinical notes were detailed and accurate.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- The practice asked patients for feedback about the services they provided.
- There was a system in place for managing complaints.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- Infection control guidelines were being followed and standards met.
- Systems for assessing, monitoring and improving the quality of the service were in place.
- Staff appreciated and responded to the leadership of the Senior Dental Officer who they saw as a hardworking and approachable leader.
- Staff were appropriately recruited and received a comprehensive induction when they started work at the practice. Training requirements for staff had been met, including infection control training for the lead nurse.

- Staffing gaps had been addressed in support of DPHC's commitment to deliver Project MOLAR: a treatment strategy to improve the dental health of personnel entering the military.

**There was one area for improvement:**

- The dental centre should extend the radiology audit to include radiographs undertaken by all staff.

**We found areas where practice was notable:**

- The SDO (Senior Dental Officer) worked collaboratively with staff from the AFC (Army Foundation College) to undertake a Group Action Project (GAP). The GAP was a compulsory element of a part-time MSc in Programme and Project Management that two training staff (non-dental) from AFC were undertaking. The project selected looked at dental failure to attend (FTA) rates and how to potentially reduce them. A significant reduction was achieved in 2019 and in pre-pandemic 2020 through improvements to dental centre processes and AFC asking a single soldier to make individuals in their platoon aware of their dental appointments. COVID-19 has understandably impacted FTA rates as patients have been required to isolate at short notice.
- Every junior soldier is given a tailored dental intake brief when they arrive. This has been built into the college programme at the request of the SDO. It gives the practice the opportunity to introduce all staff and deliver a bespoke dental prevention presentation aimed at junior soldiers. At least three members of the dental staff team take part in delivering different parts of the presentation. The nature of the presentation requires involvement from the junior soldiers and staff have received positive feedback from junior soldiers who attend.

**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

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events and incidents. Both permanent and locum staff had access to the system to report a significant event. Staff were clear in their understanding of the types of significant events that should be reported and understood how to report an incident, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was scope to maintain a log of significant events as a comprehensive record of all ASERs, to provide trends analysis and so prompt optimal learning. Significant events had been discussed at practice team meetings and staff we spoke with confirmed what they had learned.

The Senior Dental Officer (SDO) and Practice Manager were informed by Regional Headquarters (RHQ) about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). There was scope to ensure that MHRA and CAS alerts received were systematically logged and that required action was recorded as undertaken. As a standard agenda item, they were discussed at practice meetings and minutes maintained.

### Reliable safety systems and processes (including safeguarding)

The senior dental officer (SDO) was the safeguarding lead for the practice and had completed level three safeguarding training. All other members of the staff team had completed level two safeguarding training which was appropriate to their roles. Staff we spoke with were aware of their responsibilities if they had concerns about the safety of young people and adults who were vulnerable due to their circumstances. A bespoke Army Foundation College (AFC) safeguarding policy and procedure was in place and contained the local contact details needed to appropriately signpost staff who needed to raise a concern.  Staff told us that they could approach the SDO or the AFC safeguarding lead if they identified and needed to report suspected abuse. Practice staff understood the importance of working closely with welfare teams and chain of command and recognised the unique vulnerabilities of young service personnel in their care. Staff told us about occasions where they had been able to act to support and assist vulnerable junior soldiers by addressing their holistic needs and seeking additional support for them through their unit or welfare services.

Staff understood their duty of candour and were able to recall an occasion where a patient had been contacted following an error in their patient record.

The dentists were always supported by a dental nurse when assessing and treating patients. Nurse were sometimes able to work as chaperones for the dental hygienist and always when aerosol generating procedures were required. Where staff worked alone at the practice, there was a lone working policy in place to guide staff.

A whistleblowing policy was in place and available to staff in the staff room and online. Staff described what they would do if they wished to report in accordance with DPHC policy.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments. The practice was following relevant safety legislation when using needles and other sharp dental items. A needle stick injury policy was available in all surgeries.

The dentists routinely used rubber dams when providing root canal treatment in line with guidance from the British Endodontic Society. They also used a rubber dam for some other complex treatments, such as restorative procedures.

A comprehensive business resilience policy and disaster recovery plan was in place, which set out how the service would be provided if an incident occurred that impacted on its operation.

### Medical emergencies

A dentist maintained oversight of the defibrillator and emergency drugs kit. All staff were aware of medical emergency procedure and knew where to find medical oxygen, emergency drugs and equipment. Records identified that staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED (automated external defibrillator). Interactive simulated emergency scenarios were used to provide practical learning and thought had been given to using innovative methods to suit all learning styles. An AED was available in the medical centre which is in the same building. Daily checks of the medical emergency kits were recorded and demonstrated that all items were present and in-date.

The medical emergency kit was located in the corridor outside the surgeries during working hours and then secured in the CSSD when the practice was closed, including during the lunch hour. Signage was in place to identify the location of the medical oxygen.

A first aid kit, bodily fluids and mercury spillage kits were available. Training records confirmed staff were up-to-date with first aid training.

### Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The practice manager had access to the DMS-wide electronic 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 requirements.

The regional clinical operations team monitored each member of staff's registration status with the General Dental Council (GDC). The SDO confirmed all staff had professional Crown indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

## Monitoring health & safety and responding to risks

A number of local health and safety policy and protocols were in place to support with managing potential risk. The fire risk assessment was comprehensive and included risks and contingencies. Staff received annual fire training and evacuation drills were scheduled. Fire alarms were tested weekly. Portable appliance testing had been carried out in line with policy. A COSHH (Control of Substances Hazardous to Health) risk assessment had been undertaken, along with routine environmental checks to ensure that the building was safe for patients and staff.

DPHC had produced a standard operating procedure (SOP) for the resumption of routine dentistry during the COVID-19 pandemic. The Harrogate dental team demonstrated that they were following this guidance closely in order to protect both staff and patients from potential COVID infection. Risk assessments were in place for individual staff members, COVID-19 testing was undertaken regularly by all staff and symptoms to look out for were displayed around the dental centre. The waiting room had been reconfigured to enable social distancing, hand sanitiser was provided throughout the building and the centre had procured a large stock of personal protective equipment for use by both staff and patients. Dental staff knew which aerosol generating procedures presented a low or high risk and, depending on whether high volume suction and/or a rubber dam was used, fallow periods of varying lengths between patients were built into the appointments schedule.

## Infection control

An Infection prevention and control (IPC) policy was displayed on the staff room and CSSD (Central Sterile Services Department) notice board. It included supporting protocols, which took account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. It was also available electronically. A dental nurse took the IPC lead at the practice, supported and overseen by the Senior Dental Officer. They had received appropriate training. All practice staff were up-to-date with IPC training and records confirmed they completed refresher IPC training every six months. IPC audits were undertaken twice a year by the IPC lead and we saw that any issues had been swiftly resolved.

The surgeries, including fixtures and fittings, were tidy, clean and clutter free. Environmental cleaning was carried out by a contracted company twice daily. Clean and dirty areas were clearly labelled and were used correctly by staff.

Decontamination of dental instruments took place in the purpose built CSSD. Sterilisation was undertaken in accordance with HTM 01-05. Routine checks were in place to monitor that the ultrasonic baths and autoclaves were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were routinely checked by staff: we saw that the sterilisation use-by-date was in place and we did not

note any out of date items. An additional magnifying glass and clinical waste bin had been purchased since our last inspection, further reducing the risk of cross contamination.

The legionella risk assessment for the practice had been undertaken by the station and it was specific to the requirements within a health centre.

### Equipment and medicines

Equipment logs were maintained to keep a track of when equipment was due to be serviced. Autoclaves had been serviced and replaced as necessary. All other routine equipment checks, including clinical equipment, were in-date and in accordance with the manufacturer's recommendations. An equipment service audit was undertaken annually. A safety test of portable electrical appliances had been completed.

Prescription sheets were numbered and stored securely. Antibiotics were held at the practice and monthly checks undertaken by the SDO. Protocols were in place for the safe management of antibiotics and correct labelling techniques were in place. There was scope to undertake an audit of antibiotic prescribing practice in order to promote judicious use of antimicrobials and so preserve their future effectiveness. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded.

Checks of medicines, including controlled drugs, were routinely undertaken by the practice staff with periodic checks by the SDO and the regional dental team.

### 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 located in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were displayed in each surgery, along with safety procedures for radiography. Evidence was in place to show equipment was maintained every three years. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training, had received relevant updates.

To corroborate our findings, we looked at range of patient's dental care records. They showed the dentists justified, graded and reported on the X-rays they took. The Senior Dental Officer carried out an annual radiology audit of their own radiographs, but there was scope to audit all the radiographic work undertaken by the dental centre.

# Are Services Effective?

## Monitoring and improving outcomes for patients

Patients' treatment needs were assessed by the dentist in line with recognised guidance. For example, wisdom teeth management was conducted in line with NICE and SIGN guidelines. Treatment was planned in accordance with the BPE (basic periodontal examination - assessment of the gums) and caries (tooth decay) risk assessment. The dentists also followed appropriate guidance in relation to recall intervals between oral health reviews. Feedback from patients indicated that the assessment and treatment they received was comprehensive and effective.

We looked at patients' dental records to corroborate our findings. The records were detailed; containing comprehensive 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 that treatment options were discussed with the patient. Patients completed a detailed medical and dental history form at their initial consultation and this was verbally checked for any changes at each subsequent appointment.

## Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure better oral health. Dental nurses delivered oral health education including smoking cessation and alcohol intake management. Dental records showed that lifestyle habits of patients, such as smoking and drinking, were included in the dental assessment process. An alcohol consumption audit was completed with all patients. Oral hygiene advice was given to patients on an individual basis, including discussions about lifestyle habits. The application of fluoride varnish and the use of fissure sealants were options the clinicians considered if necessary. Equally, high concentration fluoride toothpaste was recommended to some patients. Referrals could be made to other health professionals, such as referrals to the medical centre for advice about smoking, diet and alcohol use. A hygienist had been recruited since our last inspection and they were working around the challenges posed by COVID-19 to ensure that the needs of the population at risk were met.

The dental team participated in the health and wellbeing promotion fairs held at the barracks, but these were currently restricted due to COVID-19. Oral care information was available to provide to young soldiers.

The SDO or practice manager attended unit health committee meetings with unit commanders to provide updates on the military dental targets and review the status of failed attendance at dental appointments (referred to as FTAs). Oral health promotion matters were also discussed, such as the uptake of smoking cessation.

## Staffing

Staff new to the practice had a period of induction that included a generic programme and induction tailored to the dental centre. Induction programmes had been completed, prior to clinical work being undertaken by new staff members.

We looked at the organisational-wide electronic system that recorded and monitored staff training and appraisal. Through this, we confirmed that all staff had undertaken training they were required to complete: since our last inspection, appropriate training had been provided for the IPC lead. Since our last inspection nursing staff had received fluoride varnish training.

The system showed clinical staff were undertaking the continuing professional development (CPD) required for their registration with the General Dental Council.

Since our previous inspection, additional nursing staff, a hygienist and a full time practice manager had come into post. The team confirmed that the staffing establishment and skills mix were appropriate to meet the dental needs of the patient population, to maximise oral health opportunities and to deliver Project MOLAR: a treatment strategy to improve the dental health of personnel entering the military. The dental team were working hard to deliver the best level of care possible whilst abiding by the current COVID-19 restrictions.

### Working with other services

The practice could refer patients to a range of services if the treatment required was not provided at the practice. For example, referrals to Harrogate Hospital for oral surgery and restorative specialties were seen at Aldershot. Orthodontic clinics were held at RAF Leeming on an ad hoc basis and most orthodontic patients were referred to and seen at the Defence Centre for Rehabilitative Dentistry in Aldershot. Staff were aware of the referral protocol in place for suspected oral cancer under the national two week wait arrangements. This was initiated in 2005 by The National Institute for Health and Care Excellence (NICE) to help make sure patients were seen quickly by a specialist. There was a practice referral log, which both dentists used to track referrals. This was checked regularly to ensure urgent referrals were dealt with promptly, and other referrals were progressing in a timely way.

### Consent to care and treatment

Staff understood the importance of obtaining and recording patient's consent to treatment. They said they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. The dental care records we looked at confirmed this. Verbal consent was taken from patients for routine treatment. For more complex procedures, full written consent was obtained. Feedback informed us that patients received clear information about their treatment and that treatment options were discussed with them.

Staff had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting and daily work.

# Are Services Caring?

## Respect, dignity, compassion and empathy

Staff were aware of their responsibility to respect people's diversity and human rights. We spoke with 9 patients on the day of the inspection and they all confirmed that the standard of dental care they received was good. Discussions suggested that staff listened to them and explained what they were going to do, staff ensured that discomfort was kept minimal and that they received comprehensive, accessible dental care.

Patient feedback also indicated staff put them at ease if they felt nervous about having dental treatment. Patients were offered the opportunity to make a longer appointment and talk through their anxiety if appropriate. If necessary other strategies for reducing anxiety could be considered, such as referral to the mental health team, medication pre-treatment or as a final option referral to an enhanced practice for conscious sedation. An alert could be placed on the patient's electronic record to identify if they were anxious.

The waiting area was close enough to the reception for conversations to be overheard. Staff told us that they therefore did not discuss treatment in this area. Patients could be brought through to a private area if required. The reception computer screens were not visible to patients and staff said that they did not leave personal information where other patients might see it. Staff password protected patient's electronic care records and backed these up to secure storage.

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed in the patient waiting area and available in the practice leaflet and online.

Staff could support patients who do not speak English as a first language through a translation service.

## Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support making treatment choices. The dental records clearly showed patients were informed about the treatment choices available and were involved in the decision making. A range of oral health posters were available for patients in the waiting area. Leaflets were kept in reception in accordance with COVID-19 guidelines and could be handed to patients as appropriate.

# Are Services Responsive?

## Responding to and meeting patients' needs

Patients we spoke with said that they felt confident they would be able to see a dentist if they needed an urgent appointment.

The practice also took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 6 - 24 months depending on a dental risk assessment and rating for each patient. Patients could make routine appointments between their recall periods if they had any changes to or concerns about their oral health.

Every junior soldier is given a tailored dental intake brief when they arrive. This has been built into the college programme at the request of the SDO. It gives the practice the opportunity to introduce all staff and deliver a bespoke dental prevention presentation aimed at junior soldiers. At least three members of the dental staff team take part in delivering different parts of the presentation. The nature of the presentation requires involvement from the junior soldiers and staff have received positive feedback from junior soldiers who attend.

## Promoting equality

A DDA (detailed disability access) audit had been completed. A list of wheelchair accessible dental centres was available to provide to patients with reduced mobility. A hearing loop was not available as this had not been identified as a need for the population at the station. Staff had access to a translation service should the need arise. Patient requests to see a dentist of a specific gender could be accommodated.

## Access to the service

The opening hours of the practice were displayed in the premises, recorded on the answer phone message and available in the practice leaflet. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. On-call arrangements were in place for access to a dentist outside of working hours and details of this were held at the guardroom should patients require this information when the practice was closed.

## Concerns and complaints

The senior dental officer had overall responsibility for complaints. The practice manager had the delegated responsibility for managing the complaints process. A process was in place for managing complaints, including a complaints register. Staff told us that verbal complaints were recorded and responded to. No complaints had been received in the last twelve months. The dental team recognised that junior soldiers may be reluctant to lodge a complaint and different ways had been provided for patients to give their feedback, including posters in reception, written forms and by QR code.

# Are Services Well Led?

## Governance arrangements

The senior dental officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for a large portion of the day to day running of the service. Staff we interviewed were clear about current lines of accountability and knew who they should approach is they had an issue that needed resolving.

A framework of organisation-wide policies, procedures and protocols were in place. In addition, there were dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff were familiar with these and they referred to them throughout the inspection. Effective risk management processes were in place and followed by staff and checks and audits were in place to monitor the quality of service provision.

A report was sent to regional headquarters (RHQ) each month that reported on a range of clinical and non-clinical statistics and activity at the practice. For example, the report included an update on the status of the practice's performance against the military dental targets, complaints received and significant events.

All staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice. Team meetings had not been held as regularly as usual in recent months and there was scope to ensure that minutes were sufficiently granular to provide a record of discussions, actions taken and to provide a comprehensive oversight to staff not in attendance.

Peer review meetings were also established. Dentists met to discuss cases, particularly complex cases and to discuss the progress of clinical audits.

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 their login password to access the electronic systems. They were not permitted to share their passwords with other staff. Paper dental care records were stored securely.

## Leadership, openness and transparency

Staff reported that they were happy working at Harrogate Dental Centre and that they were able to deliver a good standard of care to patients. All staff were confident that there was an open and transparent culture in place and that they knew how to address any concerns they might have. Staff spoke highly about the leadership of the SDO, the PDO (Principal Dental Officer) and the Regional SDO and they told us that where guidance or additional resource was required, this was forthcoming. The practice team were delivering good clinical care to patients and were able to demonstrate that junior soldiers arriving with poor dental fitness had benefited from intensive remedial treatment plans. Since our last inspection, the dental centre staff team had worked with the regional team to address key staffing gaps.

## Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. Infection control and health and safety management demonstrated that audit work in these areas had led to improvement. The dental centre had implemented guidance set out by DPHC around the safe return to dental care provision during the COVID-19 pandemic. Dental military targets, third molar referrals, recall intervals and the recording of consent were being routinely monitored. There was scope to ensure that radiology audits were undertaken by all clinicians to ensure that all radiographs were in line with IRMER requirements.

The staff team had opportunities to participate in clinical peer review. Staff received mid and end of year annual appraisal. We saw from the staff monitoring system that staff appraisals were up-to-date. Staff were encouraged to access websites providing dental CPD to further their professional development and clinical skillset.

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

Due to COVID-19 restrictions, the suggestion box previously located in the waiting area had been removed. However a poster was displayed in the waiting area, telling patients how they could give feedback or make a complaint. There was also a poster with a QR code that patients could use to provide feedback via their telephone. Staff told us that, when manning the reception area, patients sometimes asked them how long their appointment was delayed for. As a result, a system had been introduced requiring clinical staff to advise the staff member in reception if appointments were running more than five minutes late.

A system was in place for staff to provide anonymous feedback and to suggest improved ways of working by means of a staff comments box. Staff thought that this was an effective tool.