Hereford Dental Centre

Hereford

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 Hereford Dental Centre on 14 February 2023. We gathered evidence remotely and undertook a visit to the practice.

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 Care Quality Commission (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 CQC's observations and recommendations.

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

Background to this practice

Located in Herefordshire and part of the Defence Primary Healthcare (DPHC) Dental Northern Ireland, Wales and West Region, Hereford Dental Centre is a 2-chair practice providing a routine, preventative and emergency dental service to a military patient population. A third surgery was being built with a completion date of March 2023. Treatment and care was also provided to entitled reservists. Families are signposted to nearby dental practices. The dental centre is located within a shared 2 storey building that also houses the medical centre. All rooms are situated on the first floor of the building.

Clinics are held 5 days a week Monday to Thursday 08:00-12:30 hours and 13:30-16:45 hours and Friday 08:00-12:45 hours. Daily emergency treatment appointments are available. Hygiene support is currently carried out by a part-time hygienist. A regional emergency rota provides access to a dentist when the practice is closed. A number is provided for patients to call a dentist and, following triage, the patient can be seen at a military dental centre. Minor oral surgery referrals are made to an Intermediate Minor Oral Surgery service. Secondary care support is available from the local NHS hospital trust (Hereford County Hospital or Worcester Royal Hospital) for oral surgery and oral medicine and through the DPHC's Defence Centre for Rehabilitative Dentistry and its Managed Clinical Network for other referrals.

The staff team at the time of the inspection

Senior Dental Officer (SDO) (military)	1
Dentist (civilian)	1 (full-time, post vacant, recruitment process underway and DPHC dentists being provided to cover)
Dental hygienist (civilian) Dental nurses (civilian) Dental nurses (military)	1 (0.5 whole time equivalent) 2 1
Practice manager (military)	1

Our Inspection Team

This inspection was undertaken by a CQC inspector supported by 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 SDO, dental nurses and practice manager. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We also checked the building, equipment and facilities. We reviewed feedback and spoke with 6 patients who were registered at the dental centre.

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.
- Systems were in place to support the management of risk, including clinical and non-clinical risk.
- Suitable safeguarding processes were established, and staff understood their responsibilities for safeguarding adults.
- The required training for staff was up-to-date and they were supported with continuing professional development.
- The clinical team provided care and treatment in line with current guidelines. Record keeping was of a high standard.

- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.
- The appointment and recall system met both patient needs and the requirements of the Chain of Command.
- Leadership at the practice was inclusive and effective. Staff worked well as a team and their views about how to develop the service were considered.
- An effective system was in place for managing complaints.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- 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. Staff made changes based on lessons learnt.

We identified the following area of notable practice:

- The utilisation of technology to inform both staff and patients of information pertaining to the practice. In particular, the development of a document to enhance the induction process.

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. All staff had access to the system to report a significant event. The staff team had all completed formal training (refreshed annually) and had links to the ASER system via a shared electronic folder (SharePoint). Staff we spoke with were clear in their understanding of the types of significant events that should be reported, including near misses. A record was maintained of all ASERs, this was categorised to support identification of any trends. Two ASERs had been recorded in 2022. A review of these and discussion with staff showed they had been effectively managed and the team understood how to use the system effectively. Significant events were discussed at practice team meetings or sooner if required. Staff unable to attend could review records of discussion, minutes of these meetings were held in SharePoint. In addition, staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff we spoke with had a good understanding of their responsibilities and reporting requirements.

The Senior Dental Officer (SDO) and practice manager were informed by regional headquarters about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority and the Department of Health Central Alerting System. Alerts were acknowledged as read by staff completing a form on SharePoint that is returned to regional headquarters. The form included a record of actions taken and completion was required within set timeframes. They were then discussed at practice meetings and filed with a note of actions taken. Arrangements were in place for region to act during periods of block leave. Any relevant alert received was discussed at the following practice meeting.

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding point of contact for the dental centre and had level 2 training. Access to a level 3 trained lead was available through a nurse in the medical centre. All other staff were trained to level 2. The safeguarding policy and personnel in key roles were displayed on a dedicated noticeboard in the staff room and on SharePoint. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. The electronic system had the facility to highlight any patient where there was a safeguarding concern.

All staff had completed training and understood the duty of candour principles. This was evident in patient records when treatment provided was not in accordance with the original agreed treatment plan. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

The dentists were always supported by a dental nurse when assessing and treating patients. Although lone working was normal for the hygienist, there was always another member of staff in the dental centre. Each surgery room had a panic alarm button that allowed staff to call for assistance.

A whistleblowing policy was in place and displayed on the staff noticeboard and in SharePoint. Staff had completed whistleblowing training, discussed informally and said they would feel comfortable raising any concerns. Staff also had the option to approach the regional 'Freedom to Speak Up Champion'. Contact details were displayed in the staff room. These included a confidential helpline number and the Defence Consultant Advisors.

We looked at the practice's arrangements for the provision of a safe service. The practice manager was the appointed health and safety lead but had not completed role specific training in relation to risk and safety. However, links had been developed with the safety, health, environment and fire (known as SHEF) lead for the camp who supported and provided information as well as a dedicated section on SharePoint. A risk register was maintained, and this was reviewed annually as a minimum, the dates were staggered and reviews were carried out by the practice manager and SDO. A range of risk assessments were in place, including for the premises, clinical procedures and legionella. The COVID-19 risk assessment had been reviewed and revised frequently as the restrictions had reduced. The practice was following relevant safety legislation when using needles and other sharp dental items. Needle stick injury guidance was available in the surgery in the form of a written 'sharps protocol'.

The dentists routinely used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment and for Aerosol Generating Procedures (AGPs) due to COVID-19. Floss ligatures (to secure the dam) were used with the support of the dental nurse. A split dam was used if required. Rubber dam usage was mandated for endodontics (root canal treatment) and used for all restorations where it could be placed.

A comprehensive business continuity plan (BCP) was in place and had last been reviewed in January 2023. The BCP set out how the service would be provided if an event occurred that impacted its operation. The plan included staff shortages, loss of water, radiography failure, adverse weather conditions and loss of compressed air. A list of key contacts listed on the plan included senior members of the regional team, nearby dental centres and staff members. We highlighted that this could be extended to include the Radiation Safety Officer, the Radiation Protection Advisor and the compressed air authorised person. The BCP could be accessed remotely should access to the building be restricted. Quarterly training included scenario based exercises. The BCP included relocation and reopening protocols.

Medical emergencies

The medical emergency standard operating procedure from Defence Primary Healthcare (DPHC) was followed. The automated external defibrillator (AED) and emergency trolley were well maintained and securely stored, as were the emergency medicines. Daily and weekly checks of the medical emergency kit were undertaken and recorded by the SDO. In their absence, this was undertaken by another registered clinician who had been given

specific training to undertake the role. A review of the records and the emergency trolley demonstrated that all items were present and in-date. Reviews of the emergency medicines were done at headquarter level. 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. The team completed basic life support, cardiopulmonary resuscitation and AED training annually. Training that used simulated emergency scenarios had recently commenced and was scheduled to be undertaken quarterly.

First aid kit, bodily fluids and mercury spillage kits were available. The practice used the duty medic for any first aid requirements but also planned to send one of the dental nurses for first aid training. Staff were aware of the signs of sepsis and sepsis information was displayed in the surgeries. Panic alarms to attract attention in the event of an emergency was audible both in the medical centre and at reception.

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. The DBS check was managed by station and civilian personnel were checked every 3 years, military personnel every 5 years.

Monitored by the practice manager, a register was maintained of the registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role.

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 safety, health, environment and fire team carried out an annual workplace health and safety inspection and completed monthly checks. The most recent assessment in January 2023 made a small number of recommendations that had been actioned. The practice manager was the named health and safety lead and had a comprehensive tracker that detailed checks and deadlines. For example, a monthly rolling programme included checks on the fire extinguishers and fire escapes. The unit carried out a fire risk assessment of the premises every 5 years with the most recent assessment undertaken in January 2021. The practice manager was the fire deputy for the dental centre and ensured that all of the relevant checks were conducted. The building had a fire warden who was responsible for conducting evacuation drills and took a nominal role in the event of a drill or fire. Staff received annual fire training provided by the unit and an evacuation drill of the building was conducted in November 2022. Portable appliance testing had been carried out in line with policy. A Control of Substances Hazardous to Health (COSHH) risk assessment was in place and had been reviewed in February 2023 with the change of practice manager. COSHH data sheets were in place and had been reviewed in February 2023. A log sheet was maintained of each hazardous product with links to the safety data sheets. All staff had signed this log sheet. SDO applied to do risk

management training and SDO had requested role specific training for the practice manager (IOSH).

DPHC had produced a standard operating procedure for the resumption of routine dentistry during the COVID-19 pandemic. The dental team demonstrated that they were adhering to the guidance in order to minimise the risk of the spread of COVID-19. Testing for COVID-19 was undertaken regularly by all staff. Patients were screened on arrival. 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 personal protective equipment for use by both staff and patients. Clinical staff knew which aerosol generating procedures presented a low or high risk depending on whether high volume suction and/or a rubber dam was used. These patients were identified by a screening questionnaire in advance of the appointment.

The practice followed relevant safety laws when using needles and other sharp dental items. The sharps boxes in clinical areas were labelled, dated and used appropriately.

Infection control

The practice manager had the lead for infection prevention and control (IPC) and had booked onto the required training. The IPC policy and supporting protocols 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. All the staff team were up-to-date with mandated IPC training and records confirmed they completed refresher IPC training every 6 months. IPC audits were undertaken twice a year with the most recent carried out in January 2023. Documents were uploaded to allow a check to be completed by regional headquarters.

We checked the surgeries. They were clean, clutter free and met IPC standards, including the fixtures and fittings. Environmental cleaning was carried out by a contracted company twice a day and this included cleaning in between morning and afternoon clinics. The cleaning contract was monitored by the unit and the practice manager reported any inconsistencies or issues to the cleaning manager. The practice manager had sight of the cleaning contract and was satisfied that the current contract was sufficient for the practice needs and deep cleaning arrangements were in place. The cleaning cupboard was tidy and well organised and staff could access it if needed in between the routine daily cleaning.

Decontamination took place in a central sterilisation services department, accessible from the surgeries. Sterilisation of dental instruments was undertaken in accordance with HTM 01-05. Records of validation checks were in place to monitor that the ultrasonic bath and autoclave were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were regularly cleaned with arrangements in place to check materials to ensure they were in-date.

A legionella risk assessment had been carried out by the practice in January 2021 and this supplemented the more detailed unit legionella management plan from March 2021 that covered all the required areas. Water was sent away for quality testing monthly. A protocol for the prevention and management of legionella was in place. This protocol detailed the process for flushing taps and disinfecting water lines. A log sheet was maintained to

evidence daily flushing of all taps for two minutes. Faults and recommendations identified in March 2021 had been actioned.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. The clinical waste bin, external of the building, was locked, secured and away from public view. Clinical waste was collected weekly and consignment notes were provided by the contractor. Waste transfer notes were retained by the IPC lead and were audited annually, the most recent was carried out in November 2022 and found all notes were returned. Disposal certificates were retained to ensure there was an audit trail from once waste had been removed.

Equipment and medicines

An equipment log was maintained to keep a track of when equipment was due to be serviced. The autoclave was last serviced in April 2022, and the ultrasonic bath had been serviced in June 2022. The servicing of all other routine equipment, including clinical equipment, was in-date in accordance with the manufacturer's recommendations. A Land Equipment Audit was scheduled for March 2023 and recommendations from the 2022 audit had been actioned. Portable appliance testing was undertaken annually by the station's electrical team.

A manual log of prescriptions was maintained and prescriptions were sequentially numbered and stored securely. The SDO conducted monthly checks of sequential serialised number sheets to maintain traceability and accountability for any missing prescriptions. Minimal medicines were held in the practice. Patients obtained medicines either through the dispensary in the medical centre or through a local pharmacy. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded. Glucagon was stored in the fridge in easy reach of the emergency trolley. The practice carried out regular audits of prescribing. Although this is not a requirement, it is good practice and improves clinical oversight. Prescribing audits were on the practice audit plan but had not been prioritised due to the low numbers of items prescribed.

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 (RPS) were identified for the practice. Signed and dated Local Rules were available in each surgery along with safety procedures for radiography. The Local Rules were updated in January 2023 and reviewed annually or sooner if any change in the policy was made, any change in equipment took place or if there was a change in the RPS. A copy of the Health and Safety Executive notification was retained and the most recent radiation protection advisory visit was in January 2023.

Evidence was in place to show equipment was maintained annually, last done in June 2022. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

The dental care records for patients showed the dentists justified, graded and reported on the X-rays taken. The SDO carried out an intra-oral radiology audit every 6 months, the most recent was carried out in January 2023.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients was assessed by the dentists in line with recognised guidance, such as NICE, Faculty of General Dental Practice (UK) and Scottish Dental Clinical Effectiveness Programme guidelines. Link were available on SharePoint and printed copies displayed on the wall in the surgeries. Treatment was planned and delivered in line with the basic periodontal examination - assessment of the gums and caries (tooth decay) risk assessment. The dentists referenced appropriate guidance in relation to the management of wisdom teeth, taking into account operational need.

The dentists followed appropriate guidance in relation to recall intervals between oral health reviews, which were between 6 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. In addition, recall was influenced by an operational focus, including prioritising patients in readiness for rapid deployment.

We looked at patients' dental care records to corroborate our findings. The records included information about the patient's current dental needs, past treatment and medical history. The diagnosis and treatment plan for each patient was clearly recorded together with a note of treatment options discussed with the patient. Patients completed a detailed medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment. The dentists followed the guidance from the British Periodontal Society around periodontal staging and grading. Records confirmed patients were recalled in a safe and timely way.

The Senior Dental Officer (SDO) discussed the downgrading of personnel in conjunction with the patient's doctor to facilitate completion of treatment. The military dental fitness targets were closely monitored by the SDO. We noted that performance was in line with Defence Primary Healthcare (DPHC) averages despite challenges with high levels of deployment and manning. For example, 63% of patients were dentally fit (category 4). Although the DPHC target was 75%, COVID-19 has resulted in the DPHC average dropping to 69% (at the time of inspection).

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. One of the dental nurses was qualified as an oral health educator and took the lead on health education campaigns. They were not trained in smoking cessation beyond 'Very Brief Advice on Smoking' (VBA) so patients were referred to the medical centre for this service (VBA is an evidence-based intervention designed to increase quit attempts among patients who smoke). Dental care records showed that lifestyle habits of patients were included in the dental assessment process. The dentists and hygienist provided oral hygiene advice to patients on an individual basis, including discussions about lifestyle habits, such as smoking and alcohol use. Oral health promotion leaflets were given to patients and the oral health coordinator maintained a health promotion area in the patient waiting area. Displays were clearly visible and at the time of inspection and the dental nurses were about to start an oral health education course. Once completed, health promotion clinics were planned to commence. In the absence of unit

health fairs, the staff had started a monthly stand in the social hub on camp where patients could ask questions, receive information and a DMICP enabled laptop enabled patients to book in for an appointment.

The application of fluoride varnish and the use of fissure sealants were options the dentists considered if necessary. Equally, high concentration fluoride toothpaste was recommended to some patients.

The dentists described the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Staffing

The induction programme included a generic programme and induction tailored to the dental centre.

We looked at the organisational-wide electronic system used to record and monitor staff training and confirmed staff had undertaken the mandated training. The practice manager monitored the training plan and ensured it covered all the mandated requirements at the right times. The in-house training programme ran on a monthly rolling plan, all staff had completed training or had it scheduled. Laminated sheets and SharePoint were used to log training dates and monitor when training was due. Staff were used to delivering training to help them learn in multiple ways and increase their confidence. Staff we spoke with felt empowered by their involvement in delivering training and commented that it resulted in a better understanding throughout the team.

Dental nurses were asked were aware of the General Dental Council (GDC) requirements to complete continued professional development (CPD) over a 5-year cycle and to log this training. Most staff had subscribed to a specialist online training provider for mandatory training that had been designed by the GDC so that dental professionals could maximise CPD activities they chose to complete. All staff managed their own CPD requirements and had no issues accessing or completing the required work. Staff attended CPD events and attended regional training events.

The staff members we spoke with confirmed that the staffing establishment and skill mix was appropriate to meet the dental needs of the patient population and to maximise oral health opportunities. The dental team were working to deliver the best level of care possible whilst responding to short notice rapid deployment pressures. However, the patient list was twice that for a full-time dentist. Recruitment of a second dentist was ongoing in order to fill the gap in an established position. Support had been provided by temporary dentists from within DPHC and two days a week from a medical regiment dentist. With the increasing patient list size, the dental centre planned to submit a case for administration support that would maximise clinical time for the dental nurses and practice manager.

The dental centre had developed a bespoke electronic document for all new starters including temporary staff. This was sent to staff members prior to their arrival or shared with them on day one. It was separate to their induction and gave them a comprehensive overview which included:

- The dental centre infrastructure, statistics and garrison points of contact.
- The team and leads for all areas, infection prevention and control, complaints.
- The camp, the gymnasium and security.
- Forecast and schedule of future events.
- Features and procedures specific to the dental centre.
- Links to SharePoint, the referral log and the prescription log.
- Information on the communications we have with the units

This had been shared with 12 members of staff to aid them to settle in. Staff feedback had been very positive. Following discussion with region, the SDO aimed to further develop this document before sharing with other practices to implement in the future.

Working with other services

The SDO confirmed patients were referred to a range of specialists in primary and secondary care for treatment the practice did not provide. The dentists followed NHS guidelines, the Index of Orthodontic Treatment Need and Managed Clinical Network parameters for referral to other services. Patients could be referred to Hereford County Hospital or Worcestershire Royal Hospital for secondary care. Two week wait referrals could be referred to Birmingham as Hereford was not offering maxillofacial consultancy. A spreadsheet was maintained of referrals and checked monthly or more frequently if 2-week wait referrals were on the list (checked on the 2 week point). Each referral was actioned by the referring clinician once the referral letter was returned. Urgent referrals followed the 2-week cancer referral pathway. Maxillofacial surgery (reconstruction of the face) was gapped at Hereford County Hospital so patients were being referred to Birmingham Dental Hospital.

The practice worked closely with the medical centre in relation to patients with long-term conditions impacting dental care. In addition, the doctor reminded the patient to make a dental appointment if it was noted on their record during a consultation that a dental recall was due. The Chain of Command was informed if patients failed to attend their appointment.

The SDO and practice manager attended the unit health committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the SDO provided an update on the dental targets. These were attended in person or remotely as required. Oral health promotion was discussed with unit.

Consent to care and treatment

Clinical staff understood the importance of obtaining and recording patient's consent to treatment. Patients were given 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 from patients confirmed they received clear information about their treatment options.

Clinical staff had a good awareness of the Mental Capacity Act (2005) and how it applied to their patient population.

Are Services Caring?

Respect, dignity, compassion and empathy

We took into account a variety of methods to determine patients' views of the service offered at Hereford Dental Centre. The practice had conducted their own patient survey through the Governance, Performance, Assurance and Quality feedback tool. A total of 39 responses had been captured between January 2022 and February 2023. A total of 95% of respondents said they were generally happy with their healthcare and 93% said they would recommend the dental practice to family and friends. A patient survey was arranged by the Defence Medical Services Regulator to complement this inspection. No responses were received. Paper forms, QR codes (in surgery, waiting area and on the bottom of each email to all patients sent out monthly (includes stats, fun fact, next appointment availability and health promotion), link on SharePoint,

For patients who were particularly anxious, the practice had an approach to understand the reason for anxiety, provided longer appointments (booked at the end of the clinic) and acclimatisation visits to discuss treatment and invite any questions. In addition, patients who were anxious during treatment were offered headphones to listen to music. Continuity of seeing their preferred clinician was facilitated by the addition of a patient alert on their record. Patients could also be referred for hypnosis or treatment under sedation as a final option, done by referral to Birmingham Dental Hospital or Cardiff Hospital.

The waiting area for the dental centre was well laid out to promote confidentiality . Practice staff advised us that all necessary questions were asked in advance of the patient arriving (by telephone) so that conversations at the reception desk were minimised. Patients were asked to continue wearing face masks and instructed patients to not attend with COVID-19 symptoms. Each patient attending was required to complete a screening questionnaire to identify potential COVID-19 patients.

Access to a translation service was available for patients who did not have English as their first language. Information on telephone interpretation was displayed on the patient information board and there was a protocol for staff to follow. Patients were able to request a clinician of the same gender as there was a mix of male and female dentists.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support patients with making informed decisions about treatment choices. The dental records we looked at indicated patients were involved in the decision making and recording of discussion about the treatment choices available.

Are Services Responsive?

Responding to and meeting patients' needs

The practice took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 6 to 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 concerns about their oral health. The clinical team maximised appointment times by completing as many treatments as possible for the patient during each visit. Treatment of pain was prioritised, if complex treatment was required, patients would be asked to come back to allow more time. Any urgent appointment requests would be accommodated on the same day, emergency appointments were protected in the morning and afternoon. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them. All patients received a text reminder the day before their appointment. A routine appointment for treatment was available within 3 weeks, check-up appointments were available within 2 weeks, and the wait time to see the hygienist was 4 weeks.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in February 2023. The audit found the building met the needs of the patient population, staff and people who used the building. Staff we spoke with told us that had never encountered the need for a hearing loop at the reception desk but one was available and staff had been trained to use it. The facilities included automatic doors at the main entrance. There was a plan to install a doorbell at an internal door that was not automated. The building had visible and audible fire alarms and car parking spaces close to the entrance for disabled patients. Wheelchairs were available if required. The noticeboards included the Equality, Diversity and Inclusion Statement and contact details for a specialist advisor and practitioner.

Access to the service

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed on the front door, in the practice leaflet, on the practice SharePoint site and was included as part of the recorded message relayed by telephone when the practice was closed. Through the My Healthcare Hub, a Defence Primary Healthcare (DPHC) application used to advise patients on services available, patients could also access the information. SharePoint was utilised to provide patient information with patients and visitors having their own section separate to staff.

Concerns and complaints

The Senior Dental Officer (SDO) was the manager for complaints and the practice manager was the named lead contact for complaints, compliments and suggestions. Complaints were managed in accordance with the DPHC complaints policy. The team had all completed complaints training that included the DPHC complaints' policy. A process was in place for managing complaints, including a complaints register for written and verbal complaints. No complaints had been recorded in the last 12 months. Any complaint would be discussed in a practice meeting and minutes recorded included a summary of

any lessons learnt. The most recent survey showed 98% of patients felt that they would be listened to if they had a comment, complaint or compliment.

Patients were made aware of the complaints process through the practice information leaflet and a display in the practice. The practice had a box in the waiting area and could scan a quick review code from one of a number of posters discreetly positioned on walls throughout the building and also in the surgeries and at the bottom of the monthly email sent to all patients. In this way, patients were able to give feedback out of sight from the reception area to promote confidentiality of any comments.

The practice had received 33 written and verbal compliments in the last 12 months. The main themes were around the supportive and inclusive approach to treatment care.

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 the day-to day administration of the service. Staff were clear about current lines of accountability and secondary roles. They knew who they should approach if they had an issue that needed resolving. The SDO had overall responsibility for the management of risks for the service. These risks were fed into the regional risk register and in turn then from the regional headquarters to Defence Primary Healthcare (DPHC) headquarters. The risk register as well as the business continuity plan were seen at the visit and were thorough. They were monitored on a regular basis for updates/compliance and changes. The practice also maintained their own risk register and staggered reviews to allow time for a proper review.

A framework of organisation-wide policies, procedures and protocols was 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 checks and audits were in place to monitor the quality of service provision. The clinicians, including the hygienist, carried out peer case discussions each week. The periodontal and referral logs were reviewed together with any cases clinicians wished to discuss. This forum was used to review any clinical specific policy changes, new standard operating procedures and any new materials. The SDO attended a quarterly regional peer review.

An internal Healthcare Governance Assurance Visit took place in December 2021. The practice was given a grading of ‘full assurance’. A management action plan (MAP) was developed as a result; actions identified had been completed or were in progress. Performance against military dental targets, complaints, staffing levels, staff training, audit activity, the risk register and significant events were all uploaded onto SharePoint and could be viewed by region, DPHC headquarters and anyone granted access. The Health Assurance Framework (HAF) was used as part of the practice manager handover, it was a live document, updated regularly by the practice, The SDO and the practice manager monitored the HAF monthly for changes and updates and set tasks for other staff. This was also discussed at practice meetings so all staff had an awareness of the document and its contents. The MAP was also monitored regularly by the regional headquarters and DPHC headquarters.

All staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice and gave positive comments on the teamwork. Although the SDO and practice manager were responsible for the leadership and management of the practice, duties were distributed throughout the staff to ensure the correct subject matter expert had the correct role. All staff were encouraged to have input into the governance and assurance frameworks. Terms of reference were in place to clarify the responsibilities of those with lead roles. Practice meetings were held every week on a Friday morning, these had an agenda and were minuted. All staff felt they had input and

could speak freely as well as being listened to. Minutes were sighted at the visit and confirmed to include all the required standing agenda items.

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. Discussions with patients were held away from reception if requested. A reporting system was in place should a confidentiality breach occur (on the ASER system via the SDO). Staff had completed the Defence Information Management Passport training, data protection training and training in the Caldicott principles.

Leadership, openness and transparency

Staff told us the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff described leaders as supportive and considerate of the views of all staff. Staff spoke of the practice being an enjoyable place to work, of note, the in-house training that supported policies and delivered by all staff members in turn.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. The dental centre had implemented guidance set out by DPHC around the safe return to dental care provision during the COVID-19 pandemic.

Staff received mid and end of year annual appraisal and these were up-to-date. These were supported by personal development plans tailored to individual staff members. Staff spoke positively about support given to complete their continued professional development in line with General Dental Council requirements. The regional SDO completed appraisals for the SDO.

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

Quick response codes were displayed in each surgery and at various points throughout the practice for patients to use to leave feedback, there was also paper methods available too and staff were always available should the patient want to give verbal feedback. The Governance, Performance, Assurance and Quality (GPAQ) questionnaire was used monthly to review feedback, the practice manager used the filter functions to dig deeper into the results and look for trends that appear. As the GPAQ is a live system, it means the information can also be accessed by the regional headquarters and DPHC headquarters who can then conduct trends analysis for wider regional trends. Updates are then fed to the staff and the unit at regular meetings. The feedback had been positive and there were no examples of changes or negative experiences from patients.

The SDO listened to staff views and feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. All staff completed the continuous attitude survey where results were fed up to DPHC headquarters.