Care Quality Commission

Weeton Dental Centre

Weeton Camp, Kirkham, Preston , PR4 3JQ

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?	**Action required**	X
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**	✓

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Summary

About this inspection

We carried out an announced comprehensive inspection of Weeton Dental Centre on 13 April 2023.

As a result of the inspection we found the practice was effective, caring, responsive and well-led in accordance with the Care Quality Commission's (CQC) inspection framework. However improvement is required in order to meet standards around safety.

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 the practice

Co-located with Weeton Medical Centre, the dental centre is a one chair practice providing a routine, preventative and emergency dental service to a military patient population of around 500. Facilities include a laboratory and central sterilisation department, although these did not meet with safety requirements.

The practice is open Monday to Wednesday from 08:00 to 16:30 hours (closed 12:30 - 13:30). On Thursdays the practice is closed to patients. On Fridays the practice is open 08:00 – 12:30. Urgent appointments are routinely available Mondays to Wednesdays at 13:30 and patients can also be seen at other military practices nearby. Out-of-hours emergency care can be accessed via the regional on-call roster.

The staff team

Dentist	Senior Dental Officer (military)
Dental nurses	two (one locum civilian and one post vacant)
Practice manager	One (military)

Our Inspection Team

This inspection was undertaken by a CQC inspection manager, a dentist specialist advisor and dental nurse/practice manager 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 Senior Dental Officer (SDO), the dental nurse, the practice manager, a member of the cleaning team and the co-located medical centre practice manager. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the building, equipment and facilities. We also interviewed 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. Several told us they had received 'exceptional' care from knowledgeable and trustworthy staff.
- Staffing establishment was sufficient for the size of the patient population. However the vacant nurse post meant that the team had to work in a smart way to ensure patient care was not unduly impacted.
- The practice used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the governance and risk management of the practice. The dental team had not been able to secure key documentation from the contractor and the station to support their governance processes.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, required training and continuing professional development.
- The Senior Dental Officer provided care and treatment in line with current guidelines.
- Staff were unable to work in line with national practice guidelines for the decontamination of dental instruments due to the unsuitability of the central sterile services department (CSSD) and laboratory space.
- The infrastructure at Weeton Dental Centre was not appropriate for the provision of a dental service, although a statement of need for a new 3-4 chair dental centre had been submitted.
- Systems for assessing, monitoring and improving the quality of the service were in place.
- Arrangements were in place to support the safe use of X-ray equipment.

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

- Ensure that the building is appropriate and safe for the provision of dental care and follows the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'. This should include the provision of a CSSD and laboratory space which is fit for purpose.

- Ensure that the contractor provides both the full legionella testing report and an up-to-date cleaning contract to the dental centre. Ensure that cleaning timings meet the requirements of the service.

The Chief Inspector does not have recommendations to the Dental Centre

Mr Robert Middlefell BDS

National Professional Advisor for Dentistry and Oral Health

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

With the exception of the locum nurse who had recently come into post, staff had a log-in to the Automated Significant Event Reporting (ASER) DMS-wide system to report a significant event. They were clear in their understanding of the types of events that should be reported through the ASER system, including accidents, near misses and never events. An ASER register was maintained and significant events were discussed at staff meetings. ASER training took place in March 2023 for all staff.

Incidents that met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (referred to as RIDDOR) were reported through the regional headquarters team and also reported to the station health and safety team. Work accidents involving military personnel were reported via the Defence Unified Reporting and Lessons System (DURALS).

A process was in place to monitor and share with the staff team national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority and the Department of Health Central Alerting System. Alerts were received via daily 'direction and guidance' notifications from the regional headquarters. All staff had access but the SDO and PM actioned each alert or update. They also completed an online spreadsheet (the regional safety alerts register) to identify whether the alert was relevant to the dental centre, how it had been shared with the team and what action had been taken.

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead for the practice and had undertaken level two training. Staff in the adjoining medical centre were level three trained and were on hand if needed. All members of the staff team were up-to-date with safeguarding training at a level appropriate to their role. Staff we spoke with were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. A safeguarding flow chart and information was displayed on the notice board in reception.

There were no vulnerable patients and no minors known to the dental centre at the time of this inspection. There was no formal policy in place with the medical centre around sharing information about vulnerable patients.

Staff we spoke with were aware of the duty of candour principles, a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. Staff confirmed that they had received duty of candour training and were able to tell us how they had applied the principles following a breach of confidential information.

The SDO was supported by a dental nurse when treating patients. Information regarding access to a chaperone was displayed on the patient information board in the waiting room.

The lone working risk assessment for the practice was reviewed in February 2023 and an agreed system was in place for staff to summons assistance if they needed it.

Staff had completed whistleblowing training and were aware of how to raise concerns through whistleblowing processes. Whistleblowing information was displayed on the notice board. Staff were aware that they could approach 'Freedom to speak up champions' if they needed to.

The SDO used a rubber dam routinely for endodontics and most restorative treatments. A dynamic risk assessment method was used to identify patients. All clamps were pre-flossed.

The business continuity plan (BCP) was reviewed in February 2023 and outlined how the service would be provided if an event occurred that impacted its operation.

Medical emergencies

The SDO was the lead for the management of medical emergencies. The automated external defibrillator (AED) and medical emergency kit were well maintained. The AED and oxygen were checked daily. All staff were aware of the medical emergency procedure and knew where the medical emergency kit was located. Emergency drugs were stored in a cupboard in the treatment room and oxygen was stored separately. The AED was stored in the waiting room and glucagon in the fridge in the CSSD. These storage arrangements were not ideal due to spread of equipment but due to small size of the dental centre, staff did not have to go far to locate each item.

he AED was stored in the waiting room and glucagon in the fridge in the staff room. These storage arrangements were not ideal due to spread of equipment but due to small size of the dental centre staff did not have to go far to locate each item. Appropriate signage was in place to identify the room containing emergency drugs and oxygen.

Records identified staff were up-to-date with training in managing medical emergencies, including annual basic life support and the use of the AED.

First Aid boxes and spillage kits were held in the dental centre and staff were able to name the location of each item. Training records confirmed staff were up-to-date with first aid training. Clinical staff were aware of the signs of sepsis and had completed on-line training in recognising the deteriorating patient. The UK Sepsis Trust 'Sepsis Decision Support Tool for Primary Dental Care' was displayed.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The practice manager monitored that recruitment checks had been completed for staff new to the practice. These included an enhanced Disclosure and Barring Service (DBS) check to ensure they were suitable to work with vulnerable adults and young people. The registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role were also monitored. DBS checks were renewed in line with organisational policy.

Monitoring health & safety and responding to risks

Having completed relevant training for the role, the practice manager was the lead for safety, health, environment and fire (referred to as SHEF). A local SHEF SOP was in place, underpinned by Defence Primary Healthcare policy (DPHC). Health and safety information was displayed at the practice, including the named health and safety representative for the station.

The risk register was maintained by both the SDO and practice manager. Risk was a standing agenda item at the practice meetings. The register showed risks were managed in accordance with the '4 Ts' (transfer, tolerate, treat, terminate). A range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The most recent fire risk assessment was undertaken in August 2019. Actions had been implemented. Fire extinguishers were checked monthly and service checks annually by dental centre staff and the fire warden. Fire evacuation tests were run annually and were last done in January 2023.

The practice manager was the lead for the Control of Substances Hazardous to Health (COSHH). COSHH risk assessments were undertaken annually and most recently in January 2023. COSHH products were stored securely. Risk assessments and data sheets were held on SharePoint.

The dental team had requested that the SHEF advisor provide a copy of the most recent unit legionella risk assessment and the management plan for water lines within the dental centre but this had not been sent. The dental team were therefore not assured that the water supply was safe for staff and patients.

Information about COVID-19 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.

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

The building was not fit for its intended use. It was an old building and we noted flaking paint, mould on window frames (including in the CSSD), unsafe flooring which did not comply with IPC guidelines, broken cabinetry and shelving, unstable tables and surfaces and sinks and taps that did not comply with IPC guidelines. There was no air extraction facility in the CSSD/laboratory space. The store cupboard was cramped without ventilation and there were black stains on the walls and ceilings which suggested an issue with mould. The staff room coupled as an office for the SDO and was cramped and meant that staff did not have an appropriate area to change in. An old table was being used to support a large printer and this posed a risk to staff due to instability.

Infection control

The practice manager was the lead for infection prevention and control (IPC) and had the appropriate training and experience for the role. The local IPC policy took account of the

Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. The staff team were up-to-date with IPC training. IPC audits were undertaken twice a year with the most recent completed in March 2023. An implementation and improvement plan was in place and took full account of the non-compliance of the CSSD, laboratory and staff changing area. A statement of need had been submitted to implement the improvements required to bring the facility in line with national IPC standards. Funding was as yet unapproved.

Decontamination took place in the CSSD. The layout and facilities of the CSSD did not meet the requirements of HTM 01-05 best practice guidance. Staff were doing the best they could with the building and layout available to them in order to sterilise dental instruments. Records of routine checks were maintained to demonstrate the ultrasonic baths and autoclaves 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.

The dentist's treatment room met the requirements of HTM 01-05 best practice guidance.

The reception area and waiting room were carpeted and cleaning staff told us that they hoovered daily, but that no deep clean had taken place.

Cleaning was undertaken by contract staff via the quarter master department. Cleaning took place at 10:00 and 12:00 on working days. However these hours did not meet the service's requirements due to the first patient being seen at 08:00 and the last at 15:30. This meant that dental staff were conducting cleaning at the end of the day to ensure a clean and safe environment for the first patient the next day. The dental team did not have a copy of the cleaning contract. There were adequate cleaning materials and these were stored appropriately and safely. There were no arrangements in place for deep cleaning of the premises. We spoke with a member of the cleaning team who told us that she was well supported to undertake her role.

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 and staff confirmed that these were emptied regularly.

Equipment and medicines

An equipment management register was held on SharePoint and maintained by the practice manager. The compressor, autoclaves, sterilisers and ultrasonic baths were in-date for servicing. Evidence of testing information for sterilisation equipment was in place.

All other clinical equipment passed validation and was in date for service testing. Evidence was in place to confirm portable appliances were regularly tested. A faults log was in place to track the reporting and management of faulty equipment. Packaged instruments were stamped with an expiry date. All equipment held at the practice was latex free.

A system was in place for the management of stock and one of the nurses took the lead with ensuring there was adequate stock. A register was in place to show the expiry dates

of materials was checked each month. The ambient temperatures of the stock room were checked and recorded daily. The stock room was small, paint on the pipes was peeling, flooring was stained and shelving required updating.

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 (RPA) and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were available in the surgery as well as Health and Safety Executive notifications. Quality assurance audits were carried out by clinical staff on a 6 monthly basis, most recently carried out in December 2022. An annual audit of radiography procedures was completed in July 2022.

Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

Are Services Effective?

Monitoring and improving outcomes for patients

Our review of patient records demonstrated the treatment needs of patients was assessed in line with recognised national guidance, such as The National Institute for Health and Care Excellence. Equally, records showed 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). A BPE was carried out at each periodontal inspection (PDI). Appropriate guidance was referenced in relation to the management of wisdom teeth taking into account operational need.

The records we reviewed 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 that treatment options were discussed with the patient. A medical and dental history assessment was completed at the patient's initial consultation and was checked for any changes at each subsequent appointment.

Performance against military dental fitness targets was currently 61% which sat below the goal performance of 75%. However post covid the DPHC average was 69% at the time of this inspection. Measures to improve performance were in place, including cover by the regimental dentist whenever the SDO was working elsewhere. Recent changes to KPI recording also presented challenges in consistent performance management due to changing NATO categorisation.

Health promotion and prevention

The practice manager was the lead for oral health promotion/education. In line with the Delivering Better Oral Health toolkit, the SDO provided preventive advice to patients at PDIs.

Patients were asked at their appointment about dietary habits, smoking and alcohol use. Where applicable, brief interventions were provided for smoking and alcohol. In addition, patients could be referred to the medical centre for smoking cessation support and if the alcohol screen tool (referred to as AUDIT-C) raised concerns. In addition, a referral could be made for diabetes testing and sleep apnoea testing. Fluoride application and fluoride toothpaste was prescribed where appropriate.

Oral health education boards were displayed in the waiting area and offered advice around diet, brushing and interdental cleaning. A range of information leaflets were available in the patient waiting area.

Staffing

The staff team indicated that current staffing levels were challenging but that the team of three worked hard to ensure that patient needs were met. The SDO was required to work at an additional site and the gapped military nurse post meant that staff needed to work flexibly to ensure that they delivered a good service. Resilience to cover staff shortage and

gaps included the use of locums and regimental dentists, but these were not easy to secure.

An induction programme that included generic detail coupled with an induction tailored to the dental centre was in place for new staff joining the team. The practice manager monitored the status of mandatory training through the mandated training platform. Monthly training expiry date updates were provided via software interrogation. An in-house training programme was scheduled to reflect planned monthly topics. All staff were up-to-date with the required training.

Regional peer review opportunities were held quarterly and helped to provide verifiable continuing professional development (CPD) for staff. Personal development plans were reviewed at annual reporting periods and learning needs identified. DPHC also ran verifiable CPD events and webinars. Staff maintained their own continuing professional development (CPD) records, required for maintaining registration with the General Dental Council.

The practice utilised the DPHC managed clinical network and had an enhanced practitioner working at the practice who also took referrals from local practices for endodontic, restorative and prosthodontic referrals. Oral surgery and oral medicine referrals were made using the local hospital system where waiting times (at the time of this inspection) were 3-6 months. Local referrals could also be made to a military oral surgeon in Catterick who's waiting times were currently 6-8 weeks.

Referrals were managed via a spreadsheet, where 2 week wait (urgent) referrals were also recorded (in a separate section which was audited weekly). All referrals were audited on a quarterly basis with comments added on how referrals have been chased up / how they are progressing.

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 indicated the SDO sought verbal consent for routine treatments. Signed written consent was taken for invasive procedures, such as dental extractions.

Mandatory training around the mental capacity act had been completed by all staff and was recorded. We spoke with staff about mental capacity: they were able to explain how they would assess capacity and what this might mean for the patient's ability to consent to treatment.

Are Services Caring?

Respect, dignity, compassion and empathy

We spoke with 4 patients who used the dental centre who all confirmed that the dental team treated them with appropriate dignity and empathy. We also received feedback from 12 patients who had completed CQC comments cards and all confirmed that they had been treated well.

The dental team encouraged patients to fill out patient experience surveys, which were then reviewed and discussed at practice meetings.

Staff are FTSU (Freedom to Speak Up) and diversity and inclusion trained and told us they would be proactive in speaking up if deficiencies were perceived within the team. Information available in the waiting area included ways to speak out.

Opportunities to ensure that patients were as comfortable as possible were taken. Where patients were nervous, they were offered longer appointments. If required, patients could be referred for assessment for sedation or general anaesthesia in secondary care.

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

A sign was displayed in reception stating that patients could request a chaperone if they wished. Privacy at the reception desk was limited as the waiting room is in the same room. Clinical rooms were therefore used to meet the needs of patients requiring privacy.

Involvement in decisions about care and treatment

The SDO provided clear information to support patients with making informed decisions about treatment choices. This included verbal explanations and printed information. The SDO talked through treatment options with patients and checked for their understanding. The dental records we looked at confirmed patients were involved in decision making about the treatment choices available. A patient we spoke with and 2 patients who completed comments cards confirmed that explanations provided by the SDO were particularly comprehensive.

Are Services Responsive?

Responding to and meeting patients' needs

The Senior Dental Officer (SDO) followed NICE guidelines in relation to recall intervals between oral health reviews; between 3 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. Appointment times took account of patients' work patterns. Patients could make routine appointments between their recall periods if they had any concerns about their oral health.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in March 2023. It was noted that the front desk would be too high for a wheelchair user, although the team could provide a work around if required. Where patients had hearing or sight impairments, the team liaised with the medical centre team to best deliver accessible care. A statement of need had been submitted to fit a hearing loop.

Patients were encouraged to inform the dental team of any specific needs they had. We noted that patients had confidently informed dental staff about their needs due to their beliefs (specifically Ramadan) and also their gender identity.

Access to the service

The wait to see the SDO was between four and six weeks. Patients with an emergency need could be seen on the same day as emergency appointments were available at 13:30. In addition, patients deploying, patients at high readiness to deploy or those with a high dental risk were prioritised. Reception staff alerted patients verbally on the phone, email or in person if the clinic was running late.

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 website. The OOH service was provided by a regional rotational duty dental team.

Concerns and complaints

The SDO was the lead for complaints and staff knew that complaints were to be managed in accordance with the DPHC complaints policy. Complaints training was provided to staff. A process was in place for managing complaints, including a register for written and verbal complaints. Complaints were a standing agenda item at practice meetings. No written complaints had been received recently although we noted that a verbal complaint had been recorded and processed appropriately. Any compliments or patient survey feedback had also been discussed at practice meetings.

Complaints and suggestions forms for patients were adequately visible in reception with a large red box to put them in. The complaints flow chart was displayed which detailed the process for making a complaint.

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. Leadership and management direction was also given by Regional Headquarters. Staff were clear about lines of accountability and communication. Staff with lead roles were allocated dedicated time to fulfil their secondary duties. Staff confirmed that communication across the team was effective. Governance and risk management systems were kept up-to-date.

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 took account of current legislation and national guidance. Staff were familiar with these and they referred to them throughout the inspection. The General Dental Council standards were displayed in the practice.

Internal and regional processes were established to monitor service performance. The practice manager lead on the Health Assessment Framework (eHAF). The eHAF is the internal quality assurance system used to monitor safety and performance.

Military dental targets, complaints, staffing levels, staff training, the risk register and significant events were monitored via regional headquarters utilising a centralised online system. Healthcare governance systems such as Governance Performance Assurance and Quality (GPAQ) have been utilised to identify issues and trends. A regional-led second party assurance visit (HGAV) took place in July 2021 and the dental centre was found not to be IPC compliant due to the CSSD.

The SDO assumed overall responsibility for risk in the dental centre and had a monthly diary reminder in place to review and update the regional risk register. Current risks included the pharmacy contract running out, reliance on Aquastat for reverse osmosis (RO) water, inability to recruit a full-time dental nurse and non-compliant infrastructure. Risks had been actioned locally where possible or appropriately escalated to RHQ if necessary. The requirement for a safe CSSD was acknowledged and a statement of need had been submitted but no decision or funding had been forthcoming.

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

Staff described a team that was cohesive and worked well together with the collective aim to provide patients with a good standard of care. They said there was an open and

transparent culture and were confident any concerns they raised would be addressed without judgement. The locum staff member confirmed that they had been welcomed appropriately and that they felt part of an inclusive and caring team.

Learning and improvement

DPHC mandatory audits such as disability access, IPC, waste management, radiography and complaints provided information as a basis for quality improvement. Audits were reviewed and where changes in practice have been implemented and created positive change these were then shared across the team and also across DPHC Dental utilising the DPHC audit spreadsheet. Audit of ASERs has resulted in significant improvements in Caldicott processes including removal of second screens from patient vision between appointments.

The SDO also conducted endodontic service evaluation (with research approval from the Surgeon General) to monitor outcomes from endodontic treatment provided by himself over the last 12 years. Changes to clinical practice have been made based on information gained from these.

Regional peer reviews were held quarterly. Audits and case presentations were discussed and information and learning shared. The SDO was also part of the managed clinical network (MCN - the process whereby primary care clinicians refer patients to the Department of Rehabilitative Dentistry for management of clinical needs with added complexity or requiring a multi-disciplinary response) and was involved in delivering DPHC Dental objectives and initiatives.

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 forms to complete in the waiting area, the PET survey and online email correspondence with dental centre staff. To date all feedback from patients had been received verbally or through the survey.

Some patients had provided verbal feedback that those travelling long distances were then frustrated when they had to make another appointment for small things; for example for hygienist treatment. The dental team made changes so that patients travelling long distances were given longer routine appointment slots so that treatment could be carried out at the same time.

Staff were able to recommend improvements through their audit work. They were also able to raise issues at practice meetings or during supervisions. The SDO operated an open door policy.