Bickleigh Dental Centre

Shaugh Prior, Plymouth, Devon PL67AJ.

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**	✓

Published: 22 July 2025

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Bickleigh Dental Centre on 17 June 2025.

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

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 observations and recommendations within this report.

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

Background to the practice

Located in Devon, Bickleigh Dental Centre is a 2 -chair practice providing a routine, preventative, and emergency dental service to a military population of approximately 650 service personnel.

The dental centre is open Monday to Thursday from 08:00 -16:30 and on Fridays from 08:00 -12:30.

Out-of-hours (OOH) arrangements are in place through a duty dental officer located within the South Region, patients call the OOH mobile number and are triaged, they then are directed to which establishment to attend if needed to be seen.

The staff team

Senior Dental Officer (SDO)	1
Nurses	1
Practice manager	1

Our inspection team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and practice manager/dental nurse 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, practice manager, a representative for the maintenance team and the dental nurse. 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 and reviewed patient feedback.

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.
- 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.
- Systems for assessing, monitoring and improving the quality of the service were in place. Staff made changes based on lessons learnt.
- Systems were in place to support the governance and risk management of the practice.
- Staffing levels were low but the needs of patients and occupational demands of the regiments/units were met.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- Staff were up-to-date with appraisals, required training and continuing professional development.
- Clinicians provided care and treatment in line with current guidelines.
- The appointment and recall system met both patient needs and the requirements of the Chain of Command.
- Infection control procedures in place were effective.
- Processes 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.

We identified the following area of notable practice:

Staff were committed to improving the service for patients. A monthly focussed educational feedback token system was used to ask specific questions to determine patients'

knowledge and understanding of dental related issues. For example, patients were asked if they were aware of the complaints process. Although the response was mostly favourable, in response the practice made information more visible in the waiting room.

We recommend to the practice

Undertake a further review and test of the business continuity plan (BCP).

Complete the review of the infection prevention and control audit.

CQC recommends to Defence Primary Healthcare (DPHC) and the Unit:

Direct reference to the management of risk around the dental centre compressor should be made within the fire safety risk assessment. Staff from the dental team should be able to access this area as required.

Issue clear guidance to dental teams with regard to the key changes to Health Technical Memorandum 07-01 and what this means in practice.

Mr Robert Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting (referred to as ASER), a DMS-wide system for the management of significant events.

The staff team had received ASER training and were registered to the use the system. Staff appropriately described the types of incidents reported through ASER system. Staff confirmed they would use the DURRALs system for staff incidents.

Staff related accidents and incidents were reported via the Defence Unified Reporting and Lessons System (referred to as MySafety).

Staff had a good understanding of the types of incidents that met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (referred to as RIDDOR).

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead and had completed the required level of safeguarding training for dental services. All staff were up-to-date with safeguarding training at a level appropriate to their role. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances.

Vulnerable patients were discussed at the Commanders Monthly Case Review meetings, at which the practice was represented. Safeguarding information was displayed and was a standing agenda item at the practice meeting

Staff had a good understanding of the duty of candour (DoC) principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

A lone working risk assessment and policy was in place for the practice, it clearly laid out the procedure to follow should any member of staff be alone in the department. This was reviewed in May 2025. This is also supported by a risk assessment that was reviewed in January 2025.

The practice was small and a vocal alarm made by staff could be easily heard, there was also an alarm linked to the medical centre and the guard room. This was last tested by the practice manager in March 2025.

A dental dam was used routinely for adhesive restorations and endodontics (root canal treatment). It was also used with restorative treatment when required. This was recorded in patient notes and was seen as part of the record review audit.

The business continuity plan (BCP) was reviewed in March 2025 and covered all required work arounds from loss of power, water, compressors to staff illness and radiation faults. It outlined critical business activities and up-to-date contact details. It also stated that it should be tested annually, we noted that this was overdue. It included the loss of the compressor and the practice had developed a flow chart that was displayed in the reception. Throughout the document we noted some outdated terminology, the SDO agreed to review this.

Medical emergencies

The SDO was the lead for medical emergencies and resuscitation. All staff were up-to-date with the required medical emergency training, including Basic Life Support, use of the automated external defibrillator and anaphylaxis. Scenario-based training in managing medical emergencies was held regularly.

The medical emergency kit was contained in a trolley bag close to the surgeries in reception and accessible only to staff. We checked the full emergency medical kit and all required items were in place and in-date. Safe arrangements were in place for the disposal of controlled drugs.

Medical emergencies scenario training was organised by the practice manager with the medics from the medical centre, this involved the whole team with a walk through of the process including alerting of staff and use of the emergency medical kit.

First aid kits were easily accessible. The biohazard spill kit, eye care and mercury spillage kits were checked regularly to ensure they were in-date.

In house training in sepsis/deteriorating patient was completed and information was displayed.

Staff recruitment

The practice manager had oversight of the recruitment of permanent and locum staff. The full range of recruitment records for permanent staff was held centrally. Evidence was in place to confirm that recruitment checks had been completed for staff new to the practice. These included a Disclosure and Barring Service check to ensure staff were suitable to work with vulnerable adults and young people. The registration status of staff with the General Dental Council (GDC), indemnity cover and the relevant vaccinations staff require for their role were also monitored. Copies of induction paperwork and all certificates were retained by the practice manager.

Monitoring health & safety and responding to risks

A number of local health and safety (H&S) policy and protocols were in place to support with managing potential risk. The practice manager was the named safety, health, environment and fire (SHEF) lead and had completed the Institute of Occupational Health

qualification. A fire risk assessment had been undertaken and the fire alarm was checked weekly, firefighting equipment was checked each month. A fire evacuation drill was carried out every 6 months. It was last undertaken in April 2025.

Risks for the practice were recorded on the regional risk register which the team reviewed monthly. A range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The practice manager was the lead for Control of Substances Hazardous to Health (COSHH) and the SDO reviewed the COSHH risk assessments when they were completed. A COSHH register was in place with links to the risk assessments updated in January 2025. The contracted cleaner kept cleaning products in a cupboard and had a copy of the company's COSHH risk assessments.

There was a legionella management plan in place and this was reviewed in February 2024, the legionella risk assessment was embedded within it. A protocol for the prevention and management of legionella was in place. This protocol detailed the process for flushing taps and disinfecting water lines. Waterlines were flushed for a minimum of 2 minutes in the morning and for 30 seconds between patients. The ultrasonic bath/cleaner was tested weekly. The infection prevention and control (IPC) lead tested the water each month for the presence of bacteria. If the dip slide test failed, a shock treatment was used and the test was repeated. Dental unit waterline samples were tested quarterly at a laboratory.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. The Insafe system was used to reduce the risk of sharps injuries and clinicians disposed of the sharps they used. Staff had completed training on sharps injuries, which included how to manage injuries and the action to take post-incident. In addition, staff had received training in snapping ampoules and using out-of-date ampoules. Sharps incidents were reported using the MySafety and/or ASER systems. DoC principles were followed if the sharps injury involved a patient. There had been no sharps injuries in the last 12 months.

Compressor checks were not included in the fire risk assessment and there was no mention of the risks associated with compressed air. The next fire risk assessment was planned for 2027 and the practice assured us that they would request for it to be included. In the meantime, the practice assured us they would implement their own fire risk assessment. Following the inspection, we received the individual risk assessment completed for the practice by the practice manager and it also included risks associated with the compressor.

Practice staff had access to the compressor should they need to check it; this was arranged through the quartermasters office and the maintenance company. Access was granted during this visit; we saw the space was well ventilated and clean with evidence of service records in place.

Infection control

The practice manager was the lead for IPC and had completed the appropriate training. Measures were established to minimise the spread of infectious diseases. Hand washing guidance was displayed; hand sanitiser was available throughout the building and staff had access to a sufficient stock of personal protective equipment. To minimise the risk of a spread of infection, patients presenting with an infectious illness had their appointment rebooked. Should there be urgent care requirements for the treatment of patients with an infectious disease, staff confirmed that aerosol-generating procedures would be followed and that care would be given at the end of the day.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). Updates were received from Regional Headquarters including any new information circulated by the General Dental Council. These were discussed at the practice meetings.

An IPC policy supported by training for all staff was in place; records showed staff were up-to-date with IPC training. The last IPC audit was completed in July 2024; we noted the regional IPC lead had not signed this off to date. The 6 monthly review had not been completed.

The practice had a central sterile services department (CSSD) with clearly identifiable clean and dirty areas. Our review of the decontamination process showed that a robust process was in place and the dental nurse with the lead for decontamination had an in-depth understanding of the process and monitored that it was being adhered to.

Environmental cleaning was carried out by a contracted company twice a day and the dental nurse cleaned surgeries in between patients. The cleaning contract was monitored by the practice manager who reported any inconsistencies or issues to the cleaning contractor. The dental team was satisfied that the current contract was sufficient for the practice needs. Deep cleaning was provided twice a year.

Clinical waste was safely managed, including extracted teeth, gypsum (for taking dental impressions) and amalgam (used for fillings). Secure storage for clinical waste was located in a compound outside of the building. A waste log was maintained and consignment notes were in place and up-to-date. Waste transfer notes were saved and archived for 3 years. The annual clinical waste audit had been completed.

Following some key changes to the HTM 07-01 in December 2024, Defence Primary Healthcare (DPHC) practices await guidance around the treatment of clinical waste (the use of tiger bags versus orange bags and single use versus reusable aspirator tips). The practice were aware of this and had discussed it as a team.

Equipment and medicines

An equipment spreadsheet was in place that included the status of each piece of equipment, such as fault reporting (date of completion/repair), disposal and transfer of equipment between dental centres. We noted the door to the clinical waste in the CSSD had no handle, the practice manager had previously reported this but no action had been taken. The practice manager agreed to chase this up.

Staff undertook daily checks of equipment in the surgeries, laboratory and CSSD. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All equipment was in-date for servicing and testing including the ultrasonic bath, washer, disinfector and autoclave. Evidence was in place to demonstrate the compressor was checked for air quality and maintained by an external contractor. Electrical Equipment Testing (previously PAT testing) was up-to-date.

We checked the surgeries and they were clean and tidy. A system was in place to ensure adequate stock and that it was efficiently managed. All stock requiring temperature control was stored in a room with air conditioning. Stock was checked each month and logged and it was ensured items with closer expiry dates were located at the front of the shelf/drawers. All equipment was latex free.

A log of prescriptions was maintained and prescriptions were sequentially numbered and stored securely. We noted that the patient DMICP number was not recorded although it was possible to track through the date entered. The SDO agreed to include the DMICP numbers moving forward.

Minimal medicines were held in the practice. Patients obtained medicines through the dispensary at Drake Medical Centre. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded. We noted that the doctors bag, whilst kept in a temperature-controlled room, did not have any temperatures (highs and lows) recorded. It was agreed this would be completed.

The practice followed Faculty of General Dental Practice UK (FGDP) and the British National Formulary (BNF) guidance for antimicrobial prescribing.

Radiography (X-rays)

Suitable arrangements were in place to ensure the safety of the X-ray equipment, including a radiation protection file containing the required documentation. The SDO was the Radiation Protection Supervisor (RPS) and had completed the required RPS training for the role.

Signed and dated Local Rules were displayed in each surgery. When undertaking an X-ray, staff stood outside of the surgery and maintained sight of the patient throughout the exposure. Dosimeters (used to measure ionizing radiation exposure) were used in line with DPHC protocol.

X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). It was regularly serviced by MDSS. In-service daily checks, including test X-rays, were completed by the dental nurse and dentist prior to use.

Staff requiring IR(ME)R training had received relevant updates.

A radiography audit was undertaken with quarterly quality assurance of image processing. The last audit was completed in March 2025 and it showed 100% compliance.

Are Services Effective?

Monitoring and improving outcomes for patients

Through discussion with clinicians and a review of patient records, we confirmed the treatment needs of patients was assessed in line with organisational policy and recognised national guidance, including National Institute for Health and Care Excellence and the Scottish Intercollegiate Network guidance. Guidelines were followed for the management of wisdom teeth or third molars, antibiotic prescribing, occupational focus and caries (tooth decay) risk.

Our review of a range of dental records confirmed a thorough assessment, including 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. A medical and dental history assessment was completed at the patient's initial consultation and was checked for any changes at each subsequent appointment.

In addition, records demonstrated that guidance from the British Society of Periodontal (BSP) in relation to periodontal (gum disease) staging and grading was followed.

A Basic Periodontal Examination was carried out at each periodic dental inspection or recall. Occupational requirements were taken into consideration when planning treatment for individual patients and to determine recall periods. Patients were asked at consultation about upcoming deployments, taskings and assignments.

Appropriate guidance was followed in relation to recall intervals between oral health reviews, which were between 12 and 18 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. Further discussion was had with the Senior Dental Officer about recall and the effect on unit dental fitness, for example if patients become overdue for a review due to deployment, the individual patient risk markers and the ability to recall patients with a higher need more regularly.

The military dental fitness targets were closely monitored. We noted that key performance indicators were below the key performance indicators.

- Cat 1 (fully dentally fit) 65%,
- Cat 2 (dental treatment required but not expected to cause problems within a year) 12%
- Cat 3 (treatment required and expected to cause problems within a year) 11%
- Cat 4 (missing or incomplete dental records or the need for a periodic examination)12%

Regional Headquarters were aware of this and the team felt supported by them. It was acknowledged that there was no hygienist employed, one dental nurse was currently working at Stonehouse Medical Centre to cover staff shortages and the practice manager spent one day a week at Chivenor Dental Centre, this contributed to not being able to fully deliver on clinical outputs.

Health promotion and prevention

The dental nurse was the lead for oral health education (OHE) and had completed the relevant training for the role. The patient records we reviewed showed proposed treatment pathways and information given to individual patients. The practice utilised the Delivering Better Oral Health toolkit by ensuring patients had access to information from the practice SharePoint page, oral health display boards, leaflets, oral health fairs, and the practice leaflet. The displays were kept up to date based on trends, for example the use of nicotine pouches.

Oral health clinics focussed on different subjects depending on the patient need. For example, advice was given on toothbrushing and interdental cleaning using demonstrations, leaflets, and disclosing tablets. The practice held fluoride clinics regularly. High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available.

From our discussions with clinicians and a review of patient records, we confirmed that patients were routinely asked about their oral hygiene routine, dietary habits, alcohol intake and smoking, including smokeless tobacco (such as Snus) and vaping. Dietary, oral hygiene and lifestyle habits were captured on initial consultation and followed up at subsequent appointments. Clinicians could refer patients to the medical centre if there were concerns about a patient's general health and we were given examples of referrals that had been made.

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 covers all the mandated requirements at the right times. The dental team had also completed training around supporting patients with a learning disability / autistic spectrum disorder (ASD) in line with the national requirement for all healthcare providers.

The dental nurse was aware of the General Dental Council requirements to complete continued professional development (CPD) over a 5-year cycle and to log this training. Staff could access CPD courses and webinars through the joint education centre. Staff completed CPD in their non-clinical hours and time was blocked to allow for this. Regional Headquarters organised CPD peer review events and Defence Medical Services personnel used an annual allowance for CPD funded activity. Region held a peer review session in May 2025 which all staff attended.

Working with other services

The practice worked closely with the Chain of Command to ensure patients were offered treatment in a timely manner. This work had been effective with reducing the number of appointments failed to attend.

A comprehensive process was in place to manage referrals, including the use of the Defence Primary Healthcare centralised process for the management of all referrals. The status of referrals was checked each week.

Urgent referrals (two week waits) and also referrals for oral surgery were made with minimal waiting times. The Managed Clinical Network (through DPHC's Defence Centre for Rehabilitative Dentistry) was used for advanced treatment options. Referrals were managed on a central spreadsheet.

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 received feedback from 21 patients via our pre-inspection feedback cards. We saw many examples of very positive patient feedback via the compliment process and through the patient experience tool. All patients were happy with the service indicating staff were kind, respectful and compassionate.

Patients with a known dental anxiety were given extra time to discuss their concerns. Pain relief was used and they could be referred for extraction under general anaesthetic if needed.

The practice had access to the ‘Big Word’, a translation service for patients who did not have English as their first language.

The premises was a modern building so was conducive to supporting the privacy and confidentiality of patients. Patients could be observed in the waiting room at all times.

As there was only 1 dentist, patients could not opt to see someone of the opposite gender. None of the patients responding to the survey or who we spoke with suggested that this caused them an issue. If this was requested the patients could be seen at Drake or Stonehouse dental centre.

Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support patients with making informed decisions about treatment choices. From our discussion with the Senior Dental Officer it was clear a range of options were used to ensure patients understood the problem and treatment options.

Are Services Responsive?

Responding to and meeting patients' needs

Clinicians referenced National Institute for Health and Care Excellence guidelines and other national guidance regarding recall intervals between oral health reviews; between 3 and 18 months depending on the patient's assessed risk for caries, periodontal, and tooth surface loss. Recall intervals was also influenced by occupational needs particularly if patients were deploying overseas.

Patients could make appointments between recall intervals depending on the requirement or request. Feedback from patients suggested that they had been able to get an appointment with ease and at a time that suited them and confirmed that they had not had to wait whilst in pain.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in December 2024. The premises was accessible for patients with reduced mobility. On the ground floor there was an automatic opening front door, although this was not working on the day, a sign was in place advising patients to telephone if they required assistance. There was lift access to the dental centre on the first floor and an accessible toilet.

Staff considered the needs the needs of patients in terms of disability, gender, gender identity, race, religion or belief and sexual orientation. The team had completed training in equality and diversity.

Access to the service

At the time of the inspection, the next available routine appointment with a dentist was within 3 weeks. Individuals or units deploying were prioritised. If patients cancelled an appointment, then the staff offered the appointment to patients on a waiting list. Patients requiring an emergency appointment during working hours could be seen on the same day.

Dental out-of-hours (OOH) care was provided all year round through the regional duty on-call rota. Patients were seen at the practice where the duty dentist worked. Information about the service, including opening hours and access to an emergency OOH service was displayed on the front door of the practice and in the practice information leaflet.

Concerns and complaints

Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. A process was in place for managing complaints, including the recording of complaints on the Regional Headquarters SharePoint. Complaints were a standing agenda item at the practice meetings.

Staff were committed to improving the service for patients. A monthly focussed educational feedback token system was used to ask specific questions to determine patients' knowledge and understanding of dental related issues. For example, patients were asked if they were aware of the complaints process. Although the response was mostly

favourable, the practice made further improvements by updating information and making the complaints process more visible in the waiting room. The practice also took the feedback from the patient experience surveys regarding any complaints process to make improvements.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice, with support from the Regional Headquarters (RHQ). 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 they owned their terms of reference and any lead roles. Staff 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 RHQ to Defence Primary Healthcare (DPHC) headquarters.

The SDO described effective communication with the various units and they attended the Commanders Monthly Case Review meetings on a regular basis. Effective communication pathways were in place with RHQ and the SDO also had good links with the Senior Medical Officer at the medical centre.

Healthcare governance was a standing agenda item at the monthly practice meetings. The team routinely reviewed governance and risk management systems to ensure they were up-to-date and reflected the current operation of the practice. A framework of organisational policies, procedures and protocols underpinned governance activity. In addition, there were local dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff skillsets were effectively used, such as for lead roles.

The practice used the Health Assessment Framework (HAF), an internal quality assurance system used to monitor safety and performance. All staff had access to the HAF domain spreadsheet, with individual tabs for each key line of enquiry (KLOEs). These links led to staff knowing what and where the evidence and information was. This was colour coded to highlight open actions and areas to address. The KLOEs were divided between the individual staff who had their own subject matter expertise. These were discussed at the practice meetings and the daily morning huddles. The data was inputted during working groups by the practice manager.

The last internal assurance review was completed by RHQ in April 2025. The assurance team conducted the visit in person and reported on the evidence found in the HAF as well as interviewing staff. The practice was awarded a substantial level of assurance.

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.

To address environmental sustainability, the practice aimed to reduce the use of paper through digitisation. Recycling bins were in use, and stock was effectively managed to reduce wastage.

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. It was a small dental team with very experienced staff and there was a sense of both pride and satisfaction in the department and of their delivery of dental care. The team regularly had away days including paddle boarding, lunches out and walks.

Learning and improvement

The SDO was the lead for clinical audit/quality improvement activity. All the required audits had been completed, including infection prevention and control, equality access, clinical waste, prescribing and radiography. Additional audits undertaken included clinical records nicotine pouches, oral health education treatment and antibiotic prescribing. All audit findings were discussed with staff and any actions decided. For example, following the nicotine pouch audit a large visual information board on the use of pouches was made and put on display in the waiting room.

Mid and end of year staff appraisals were up-to-date.

Staff spoke positively about support given to complete their continued professional development in line with General Dental Council requirements. Staff were also encouraged to set goals and areas for improvement and development. For example, the SDO was undertaking a Master's of Science (MSc) in oral surgery, one of the dental nurses was undertaking an MSc in law and the practice manager was had achieved the certificate in practice management and was now studying for the diploma.

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

Quick response or 'QR' codes were displayed in the waiting room for patients to use to leave feedback. There were also paper methods available and staff were always available should the patient want to give verbal feedback.

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.