Honington Dental Centre

Bury St Edmunds, Bury St Edmunds, Suffolk, IP31 1EE

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?	**Actions required**	X
Are services effective	**No action required**	✓
Are service caring?	**No action required**	✓
Are services responsive to people's needs?	**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 Honington Dental Centre on 3 February 2026.

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. Action was required within the safe domain due to low staffing numbers.

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

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, collaborative and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Effective systems were in place to support the governance and risk management of the practice.
- Staffing levels were identified as a risk with key members of staff due to leave the practice.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, training and continuing professional development.
- The dental centre was visibly clean throughout. However, ongoing issues with the cleaning contract required action to ensure ongoing compliance.
- Clinicians provided care and treatment in line with current guidelines.

- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- 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.

The Chief Inspector recommends to the practice

- Ensure the fire drills are undertaken in a timely manner.
- Direct reference to the management of risk around the dental centre compressor should be made within the fire safety risk assessment.

The Chief Inspector recommends to the station/unit:

- The cleaning contract and arrangements should be reviewed as a matter of urgency and improvements made to ensure effective cleaning is sustained in line with nationally recognised standards.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC)

- Review staffing levels so they are sufficient to meet patient need and safeguard the health and wellbeing of staff.

Mr Robert Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Background to Honington Dental Centre

Located in Bury St Edmunds, Honington Dental Centre is a multi-chair practice providing a routine, preventative and emergency dental service to a military population of approximately 900 service personnel. Honington also provides emergency care for 1,000 recruits and their training teams including service personnel from other nations.

The dental centre is open Monday to Thursday from 08:00-17:00 and on Fridays from 08:00-14:00 hours.

Out-of-hours (OOH) arrangements are in place through a duty dental officer who is contactable 24 hours a day and 7 days a week. This duty rotates around the East region Dental Officers and nurses. Emergency OOH is provided by the duty Dental Officer.

The staff team

Senior Dental Officer (SDO)	1
Nurse	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 part time civilian dentist who was acting SDO, practice manager and the 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.

Are services safe?

We found that this practice was not safe in accordance with CQC's inspection framework

Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting (referred to as ASER), the 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 Defence Unified Reporting and Lessons System (referred to as DURAL) system for staff incidents.

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).

ASERS were a standing agenda at the practice meeting. Organisational learning was also discussed and recorded.

Patient safety alerts were a standing agenda item for discussion at practice meetings. Staff were also notified of alerts through ‘direction and guidance’ from Regional Headquarters. Safety alerts were also a standing agenda item at the practice meetings.

Reliable safety systems and processes (including safeguarding)

The Senior Medical Officer (SMO) based in the medical centre was the safeguarding lead and both the acting Senior Dental Officer (SDO) and the SMO were trained to level 3. All other members of the staff team had completed level 2 safeguarding training. 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 case discussion meetings with the SMO when required. Safeguarding information was displayed and was a standing agenda item at the practice meeting.

Staff had a good understanding 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. We discussed a recent incident that had duty of candour applied. There was a register in place with all incidents recorded.

The chaperone policy was displayed in the waiting area and was reviewed regularly. Patients could access a chaperone if they wished. Patients could be observed in the waiting area from the reception desk.

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. There were alarms in all surgeries and these were tested monthly. The alarm also sounded in the medical centre; a drill was undertaken last year and medical staff responded within 2 minutes.

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.

A business resilience plan was in place and was last reviewed in December 2025, which covered all required work arounds from loss of IT, power, water, compressors to staff illness and radiation faults. It outlined critical business activities and provided up-to-date contact details.

Medical emergencies

The acting 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 with the last being last week with all staff attending.

The medical emergency kit was contained in a trolley bag and accessible only to staff. We checked the full emergency medical kit and all required items were in place and in-date.

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.

Sepsis/deteriorating patient information was displayed. Although not mandated training, all staff had received in-house training in sepsis.

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, 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 range of local health and safety policies and protocols were in place to support with managing potential risk. A fire risk assessment had been undertaken; the fire alarm was checked weekly and firefighting equipment was checked each month. A fire evacuation drill was carried out every 6 months and was last was undertaken in July 2025. This most recent drill was overdue; it had not been yet completed because of the shortage of staff.

The dental centre was experiencing significant workforce challenges and had been operating on critical staffing levels since November 2025. There were 2 staff that were currently deployed (military full time SDO and a military full time dental nurse). A part time civilian dentist was acting up as SDO until May when the permanent SDO returned from deployment. The military dental nurse was anticipated to return to work in May. Clinical capacity had been maintained through a civilian dentist working 2 days per week (Wednesday and Thursday) and temporary support from another unit for a further 2 days (Monday and Tuesday). A new dentist was due to start in March and would provide 2 days of permanent staffing (Monday and Tuesday). As a result, the external support would cease. Operational capacity was further constrained by the absence of a dedicated receptionist. This has created an additional administrative burden for clinical staff and no dedicated member of staff to oversee the waiting room area.

The current dental workforce was insufficient to meet existing patient demand. With approximately an additional 1,000 patients linked to Operation Interflex (the UK-led multinational training programme supporting overseas recruits and training staff). The dental centre provided routine and urgent care for these patients. Service delivery times were already being affected, with delays noted in routine care and appointment availability. Within the next 6 to 9 months, the current SDO was expected to change, and it was anticipated that the practice manager would also move on.

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.

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 October 2025. Items were held inside a lockable cupboard. COSHH items were only accessible to staff.

The safety of water was monitored and the legionella risk assessment was reviewed by the contractor in December 2025. There were no issues raised and the records were shared with the practice manager.

Processes were in place for the regular monitoring of utilities and equipment. Gas and electrical safety checks were up-to-date. Regular checks of equipment (referred to as LEA) were up-to-date.

The practice manager-maintained records of the servicing contract for the compressor, ensuring that the contract was monitored effectively, and that the compressor was serviced and air-tested by qualified personnel. The dental centre had conducted a visual

inspection of the compressor in January 2026. The fire risk assessment did not include fire risks associated with the compressor. However, there was a local risk assessment in place.

Infection control

The practice manager was the lead for infection prevention and control (IPC) and had completed the required training for the role. A staff protocol was in place to minimise the spread of infectious diseases, along with hand washing guidance. Hand sanitiser was available and there was a sufficient stock of personal protective equipment. Additional precautions were used when undertaking aerosol generating procedures if a patient with an infectious disease needed emergency treatment.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) online to ensure it was the latest version. The practice had a central sterile services department (CSSD) with clearly identifiable clean and dirty areas. Our review of the decontamination process showed 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. The last IPC audit was completed in January 2026; with all action points now rectified.

A range of tests were undertaken of dental unit waterlines including water quality checks and monthly dip slide testing for monitoring microbial contamination. Quarterly water quality check certificates were in place for the surgeries and reverse osmosis (water purification process).

Cleaning was undertaken twice a day. A schedule was in place outlining the cleaning arrangements for each area and frequency. A log was maintained by cleaning staff to confirm cleaning had taken place. Mops and materials were colour coded and stored correctly. The practice manager performed weekly spot checks on the cleaning quality and reported any issues with the cleaning service to the contracted cleaning manager. It had been identified by the practice that the standard of cleaning provided by the cleaning contractor required improvement. This issue has been highlighted to the cleaning manager by the dental centre practice manager and a nurse from the medical centre. This issue was still ongoing. Deep cleaning was undertaken twice a year.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. Clinical waste was collected weekly and consignment notes were provided by the contractor. Waste transfer notes were retained and audited annually.

Staff were aware of the 2023 revision to HTM 07-01: Safe and sustainable management of healthcare waste. The team had completed regional training regarding the changes and had received a supply of ‘tiger bags’ (used for offensive non-infectious waste). They were still awaiting the correct clinical waste bins to be delivered.

Equipment and medicine

An equipment spreadsheet was in place that included the status of each piece of equipment, such as fault reporting (date of completion/repair). 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 delivered by the MODs Medical and Dental Servicing Section). All equipment was in-date for servicing and testing including the ultrasonic bath, and autoclave. Electrical equipment testing (previously PAT testing) was completed.

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 made obvious. All equipment was latex free.

A register was used to keep track of issued prescriptions. This was checked monthly by the SDO. Pharmaceutical fridge temperatures were monitored and recorded daily; temperatures were within the expected range. The SDO completed an antibiotic prescribing audit annually with the last cycle having been completed in September 2025. Follow-up of patient outcomes following antibiotic prescribing was incomplete in some cases, with the transient nature of the exercising troops visiting the dental centre for emergency care being a factor in this. The practice followed Faculty of General Dental Practice UK (now College of General Dentistry) and the British National Formulary guidance for antimicrobial prescribing.

Radiography (x-rays)

Suitable arrangements were in place to ensure the safety of the X-ray equipment. Although all the relevant radiation protection information was available, it was not collated into a dental radiation protection file. We discussed this with the practice manager and they agreed to action this straight away.

A Radiation Protection Advisor for the practice was identified. The SDO was the Radiation Protection Supervisor (RPS) and had completed the required training for the role. During the SDO’s deployment this position was managed by a suitable, qualified member of the Health and Safety team on station. Signed and dated Local Rules were displayed.

X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). It was regularly serviced by MDSS. Staff requiring IR(ME)R training had received relevant updates. A radiography audit was undertaken every 6 months.

Are services effective?

We found that this practice was effective in accordance with CQC's inspection framework

Monitoring and improving outcomes for patients

Through discussion with the clinician 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 College of General Dentistry 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 Periodontology (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.

The military dental fitness targets were closely monitored and were a standing agenda item at the practice meetings. The key performance indicators were:

- Cat 1 (fully dentally fit) 59%
- Cat 2 (dental treatment required but not expected to cause problems within a year) 8%
- Cat 3 (treatment required and expected to cause problems within a year) 12%
- Cat 4 (missing or incomplete dental records or the need for a periodic examination) 21%

We discussed this with the SDO. Dental targets were lower than expected due to inadequate staffing. Despite this the staff had worked hard and had improved Cat 4 statistics by 2% in the past year despite low staffing. Regional Headquarters were aware.

Health promotion and prevention

If patients were diagnosed with either gingivitis (mild form of gum disease) or periodontal disease they were usually referred to the oral health nurse. During this appointment oral health guidance was given. Once plaque (film of bacteria on the teeth) levels had

improved then patients were referred back to the dentist for further treatment. However, due to low staffing levels oral health appointments with the nurse had temporarily ceased.

The dental nurse took the lead on health education campaigns. There was a Defence Primary Healthcare (DPHC) monthly topic, at the time of the inspection there was a large display on the effect of alcohol and cancer awareness. Other oral health information and leaflets were available for patients to read and/or take away. There had been a unit health fair in February 2025 and the dental centre had attended and received positive feedback following the event.

The patient records we reviewed showed proposed treatment pathways and information given to individual patients. The practice utilised the Delivering Better Oral Health toolkit: a Public Health England evidence-based toolkit on prevention of oral diseases, such as caries.

Patients were routinely asked about their oral hygiene routine, dietary habits, alcohol intake and smoking, including vaping. Dietary, oral hygiene and lifestyle habits were captured on initial consultation and followed up at subsequent appointments. High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available. Clinicians could refer patients to the medical centre if there were concerns about a patient's general health.

Staffing

The induction programme included a generic programme and induction tailored to the practice. The practice manager monitored the status of mandatory training and training was recorded on the Defence Primary Healthcare (DPHC) Dental Personnel Management System. A regional spreadsheet was supplied to ensure all topics were covered at the correct time. This was shared to all dental centres in the region so topics were covered concurrently. Staff were given protected time to complete training. At the time of the inspection, staff were up-to-date with all mandated training. The dental team had also completed training around supporting patients with a learning disability/autistic spectrum disorder in line with the national requirement for all healthcare providers.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. They had access to the 'Agilio Training' platform for access to CPD courses. Clinical staff attended the regional training days and conferences.

Working with other services

The practice worked closely with the Chain of Command and had a very good relationship with the station headquarters to ensure patients were offered treatment in a timely manner.

Patients requiring complex (Tier 2 or 3 complexity) restorative or orthodontic treatment were referred to Defence Primary Healthcare's (DPHC) Restorative Managed Clinical Network. Patients requiring complex oral surgery (Tier 2 or 3 complexity) were referred for

management within the NHS setting at either Cambridge or Peterborough Hospitals. The practice had previously made use of the recent Chief of Air Staff funding initiative, which allowed patients requiring oral surgery to have their treatment expedited by management in a private setting. However, this funding has since ceased.

A process was in place to manage referrals, including the use of the DPHC Hospital Referral System (HRS). However, the HRS has been offline since the beginning of the year meaning the dental centre has been unable to input or follow up and manage patient referrals. Fortunately, there has been no requirement during this period to process routine or priority referrals. Any new referrals would be manually logged, so they may be tracked until the system was back up and running. Urgent referrals (2 week waits) for oral surgery were made with minimal waiting times.

Consent to care and treatment

Clinical staff demonstrated a clear understanding of the importance of obtaining and documenting patient consent for treatment. Patients were provided with information about their treatment options, including associated risks and benefits, enabling them to make informed decisions. The dental care records reviewed confirmed that this process was followed. Verbal consent was obtained for routine treatments. Written consent was obtained for oral surgery. Patient feedback also indicated that they received clear and comprehensive information regarding their treatment choices.

Clinical staff showed good working knowledge of the Mental Capacity Act (2005) and its relevance to their patient group. Completion of an online course on The Act formed part of the annual mandatory training programme for all staff.

Are services caring?

We found that this practice was caring in accordance with CQC's inspection framework

Respect, dignity, compassion and empathy

We received feedback from 20 patients through pre-inspection feedback cards. All respondents were positive about the service, commenting that staff were kind, respectful, and supportive. Three of these responses although positive about staff commented on the lack of reception staff and the inconvenience it caused. The practice also carried out patient experience surveys during 2025, which received 344 responses. Nearly all, (99%) of respondents indicated they were satisfied with their care and were treated by friendly staff with care and kindness.

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 waiting area was generously sized, and the seating arrangement ensured that discussions at reception could not easily be overheard. There was a sign in place to inform patients they were able to have private room if they wished to discuss anything confidential to them. Although there was no receptionist, the practice manager could see the reception area from their office and could observe patients fully. There was a sign in reception directing patients what to do on arrival, to fill out a form and take a seat and wait to be called.

The practice had access to the ‘Big Word’, a translation service for patients who did not have English as their first language. Patients under ‘Operation Interflex’ brought their own interpreters with them.

Involvement in decisions about care and treatment

Patient feedback indicated that clinicians communicated information clearly, helping individuals make informed decisions about their treatment options. Our discussion with the acting Senior Dental Officer confirmed that a variety of methods were used to ensure patients fully understood their condition and the available treatments.

Are services responsive to people's needs?

We found that this practice was responsive in accordance with CQC's inspection framework

Responding to and meeting people's needs

Clinicians referenced National Institute for Health and Care Excellence guidelines and other national guidance regarding recall intervals between oral health reviews; between 6 and 24 months depending on the patient's assessed risk for caries, periodontal, oral cancer and tooth surface loss. We noted that there had been no routine recalls made since November 2025 due to staff shortages and lack of appointment availability. The practice had restarted them in early February and we were told this would improve further when the new part time civilian dentist took up post.

Patients could make appointments between recall intervals depending on the requirement or request. Those presenting with pain were seen the same day and patients with an issue not deemed to be urgent were given into the next routine slot with advice to call back if the issue worsened.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in March 2025. The premises was accessible for patients with reduced mobility. The practice was on the first floor and there was a lift. The practice had an accessible toilet for patients and a practice leaflet in large font for anyone partially sighted.

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 and learning disability and autism.

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. 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 complaint

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 and all staff had competed complaints training.

Are services well-led?

We found that this practice was well-led in accordance with CQC's inspection framework

Governance arrangements

The practice worked to the Defence Primary Healthcare (DPHC) mission statement: "Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power".

A framework of organisational policies, standard operating procedures and protocols underpinned governance activity. Local protocols were held online and used during induction and staff training. Staff skillsets were effectively used, such as for lead roles. Terms of reference were up-to-date for all staff. External and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the Senior Dental Officer (SDO) with both Regional Headquarters (RHQ) and the Chain of Command having oversight.

The practice used the Health Assessment Framework (HAF), an internal quality assurance system used to monitor safety and performance, although this was not currently available due to the national system being offline. The practice manager had a workaround in place including a spreadsheet with all evidence required to work from.

The last internal assurance review was undertaken in July 2025. Most actions had been completed and a management action plan had been developed to complete the rest. The issues remaining were regarding secondary leads to roles which were unable to be filled with only one clinician. All issues were on the risk register.

A team communication structure was established, including a monthly practice meeting. Healthcare governance and assurance was a standing agenda item at the monthly practice meetings. Meeting minutes indicated that governance and risk management systems were routinely reviewed to ensure they were up-to-date and reflected the current operation of the practice.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Staff completed mandatory training in data protection 3 yearly. Training in the Caldicott principles to protect confidential patient information was undertaken. All 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 place. Stock was effectively managed to reduce wastage.

Leadership, openness and transparency

We found that leadership at the practice was collaborative and promoted inclusive decision-making. The staff team was cohesive and supportive and staff we spoke with expressed how much they enjoyed their work and said they could speak openly and were listened to. We heard that they felt valued and were empowered to maintain their skills and use their experience to benefit the service. 'White space' team building events were held on a regular basis. The dental centre had a good relationship with the medical centre and often shared training and social events with them. A 'thank you' scheme of staff rewards was in place.

Learning and improvement

There were informal quality improvement (QIP) processes in place, and this was a standing agenda at practice meetings.

Examples included:

- Processes were standardised within the central sterile services department and included instrument storage to support effective staff rotation, enabling staff to work confidently and consistently. The workflows were mapped and reviewed to identify duplication, gaps, and inefficiencies. As improvements were made, step-by-step guidance for each task was put in place and made accessible to all staff to follow.
- Dental centre protocols were constantly being developed and added to, keeping staff up-to-date. With current low staffing levels, this approach empowered team members to try tasks independently and reduced unnecessary reliance on others. These guides were stored on SharePoint so they could be accessed and referred to at any time.
- To maintain service continuity for patients during periods of staff shortage, a colour-coded slip system was introduced. The practice designed and implemented a range of colour-coded slips, each assigned to a specific purpose such as arrivals, clearances, and appointment-booking requests. These slips were kept on the reception desk with a sign to inform patients of how to complete them. Slips were then placed into a sealed box and staff actioned within 24 hours.

All required audits had been completed, including those for infection prevention and control, equality of access, clinical waste management, prescribing, and radiography. Mid-year and end-of-year staff appraisals were up-to-date.

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

The practice was committed to incorporating patient feedback into service development. To monitor performance, patients were encouraged to complete the Patient Experience Tool survey via a quick response or QR code, which was displayed in the premises, included in the patient information leaflet and on the patient form completed at the time of their appointment.

A ‘you said, we did’ display highlighted how the practice responded to feedback. For example, patients asked for text reminders for appointments; this was actioned and patients reminded to ensure their contact telephone number was up-to-date. Patients had requested a coat stand and this had been purchased.