Thorney Island Dental Centre

Baker Barracks, Thorney Island, Emsworth, West Sussex, PO10 8DH

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Are services safe?	**No action required**	✓
Are services effective?	**No action required**	✓
Are services caring?	**No action required**	✓
Are services responsive?	**No action required**	✓
Are services well led?	**No action required**	✓

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Thorney Island Dental Centre on 20 September 2023. We gathered evidence remotely and undertook a visit to the practice.

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

The Care Quality Commission (CQC) does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of CQC's observations and recommendations.

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

Background to this practice

Located in Baker Barracks, Thorney Island, Emsworth and part of the Defence Primary Healthcare (DPHC) Dental, London & South Region, Thorney Island Dental Centre is a 2-chair practice providing a routine, preventative and emergency dental service to a military patient population of 1,200. Patients from two nearby external units also receive treatment and care at Thorney Island Dental Centre. They are within a 30-minute drive and are army personnel from the Armed Forces Careers Office in Portsmouth and full time reservists based in Hilsea. Families are signposted to nearby dental practices. The Dental Centre is co-located with the Medical Centre within a purpose-built ground level building.

Dental clinics are held 5 days a week Monday, Wednesday and Thursday 08:00-12:30 and 13:30-17:00, Tuesday 08:00-12:30 and Friday 08:00-13:00. Daily emergency treatment appointments are available. Hygiene support was carried out by a part-time hygienist on a Tuesday and Wednesday 08:00-17:00. A regional emergency duty dentist rota provides access to dental treatment when the practice is closed. A contact number is provided for patients to call. Intermediate minor oral surgery referrals can be sent externally to Practice in the Park, Havant or internally to Dental Centre Northwood. Secondary care support for oral surgery and oral medicine is available from the local NHS Portsmouth Hospital Trust, Queen Alexandra Hospital, Cosham and for rehabilitative dentistry, patients are referred to DPHC's Defence Centre for Restorative Dentistry in Aldershot.

The staff team at the time of the inspection

Senior Dental Officer (SDO) (military)	1
Dental hygienist (military) Dental nurses (civilian)	1 part-time 1
Practice manager (civilian)	1

Our Inspection Team

This inspection was undertaken by a CQC inspector supported by a dentist and a practice manager/dental nurse specialist advisors.

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, the hygienist, the dental nurse and practice manager. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We also checked the building, equipment and facilities. We also reviewed feedback from 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. Of note, the responses from patients evidenced a high level of patient satisfaction with the care provided.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the management of risk, including clinical and non-clinical risk. Some risks were held by other dental centres in the region.
- Suitable safeguarding processes were established, and staff understood their responsibilities for safeguarding adults.
- The required training for staff was up-to-date and they were supported with continuing professional development.
- The clinical team provided care and treatment in line with current guidelines. Record keeping was of a high standard.
- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.

- The appointment and recall system met both patient needs and the requirements of the Chain of Command. However, at the time of inspection, the wait time to see a hygienist resulted in required treatment being delayed.
- Leadership at the practice was inclusive and effective. Staff worked well as a team and their views about how to develop the service were considered.
- An effective system was in place for managing complaints.
- Medicines and life-saving equipment were available in the event of a medical emergency.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Systems for assessing, monitoring and improving the quality of the service were in place. Staff made changes based on lessons learnt.

Mr Robert Middlefell BDS

National Professional Advisor for Dentistry and Oral Health

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events and incidents. All staff had access to the system to report a significant event. The staff team completed initial training followed by 6 monthly informal ASER training with the practice manager. Staff we spoke with were clear in their understanding of the types of significant events that should be reported, including near misses. A record was maintained of all ASERs, this was categorised to support identification of any trends. The most recent ASER had been raised in June 2023. Staff could demonstrate the knowledge on how to manage any event including keeping a record of any lessons learnt and actions taken. Discussion at practice team meetings did include learning from ASERs raised at other military dental centres. For example, an ASER from another dental centre reporting a perforation to a Sharps box. This had been discussed and a check done of their own supplies. Staff unable to attend could review records of discussion, minutes of these meetings were held in a shared electronic folder (known as SharePoint). In addition, staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff we spoke with had a good understanding of their responsibilities and reporting requirements.

Alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and Central Alerting System (CAS) were received into both the group email account and the practice manager's account. These would be discussed and actioned on the day when urgent. In addition, the Senior Dental Officer (SDO) and practice manager were informed by regional headquarters (RHQ) about national patient safety and medicines alerts. Alerts were entered onto the regional spreadsheet and an update on actions discussed at practice meetings and filed with a note of actions taken.

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead and had level 2 training. Access to a level 3 trained member of staff was through the Senior Medical Officer in the medical centre. The safeguarding policy together with personnel in key roles were displayed on a noticeboard. All other members of the staff team had completed level 2 safeguarding training. Although no safeguarding concerns had been raised, staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. Patients under the age of 18 and those considered vulnerable were identified on the electronic clinical operating system (known as DMICP) and would always be offered a chaperone. The chaperone policy was displayed at the reception counter.

Clinical staff understood the duty of candour principles and this was evident in patient records when treatment provided was not in accordance with the original agreed treatment plan. There was a duty of candour protocol displayed in the reception area and a copy was

on the staff noticeboard in the administration office. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

The dentists were always supported by a dental nurse when assessing and treating patients. Although lone working was normal for the hygienist, there was always another member of staff in the dental centre (as stated in the lone working protocol). This had been highlighted in the lone worker's risk assessment carried out in November 2022. Each surgery room had a panic alarm button that allowed staff to call for assistance.

A whistleblowing policy was in place and displayed on the staff noticeboard. Staff had whistleblowing training delivered annually and said they would feel comfortable raising any concerns. Staff also had the option to approach the regional 'Freedom to Speak Up Champion'. The policy and contact details were displayed in the reception area and staff told us they had held discussions at practice meetings around the freedom to speak up.

We looked at the practice's arrangements for the provision of a safe service. The practice manager was the designated health and safety lead and was supported by the SHEF (safety, health, environment and fire) team for the camp. The practice manager was a trained risk assessor and had completed role specific training in relation to risk and safety. A risk register was maintained, this was reviewed annually as a minimum for higher risk activities and every 2 years for those classified as low risk, the last review was carried out in November 2022. A range of risk assessments were in place, including for the premises, staff stress, surgery clinical procedures and legionella. The COVID-19 risk assessment had been reviewed and revised frequently as the restrictions had reduced. The practice was following relevant safety legislation when using needles and other sharp dental items. Needle stick injury guidance was available in the surgery in the form of a written 'sharps protocol'.

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

A comprehensive business continuity plan (BCP) was in place and had last been reviewed in June 2023. The BCP set out how the service would be provided if an event occurred that impacted its operation. Testing of the BCP took place every 6 months and this was split into separate areas of the plan. For example, compressor failure was tested in February 2023 and loss of power to the dental centre in September 2023. The BCP could be accessed remotely should access to the building be restricted.

Medical emergencies

The medical emergency standard operating procedure from Defence Primary Healthcare (DPHC) was followed. The automated external defibrillator (AED) and emergency trolley were well maintained and securely stored as were the emergency medicines. The temperature of the room where the emergency trolley was monitored. If high temperatures were expected, the trolley would be moved into a temperature controlled area. Daily

checks of the medical emergency kit were undertaken and recorded by the dental nurses who had been given specific training to undertake the role. A review of the records and the emergency trolley demonstrated that all items were present and in-date. Reviews of the emergency medicines were done at headquarter level. All staff were aware of medical emergency procedure and knew where to find medical oxygen, emergency drugs and equipment. Records identified that staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED. The team completed basic life support, cardiopulmonary resuscitation and AED training annually. Training that used simulated emergency scenarios was undertaken annually with medical centre staff involvement. This was supplemented by the dental centre undertaking walk through scenarios and review of medical emergency protocols. We discussed the addition of a lessons learnt notes to enhance the record.

First aid kit, bodily fluids and mercury spillage kits were available. The practice used the duty medic for any first aid requirements. Staff were aware of the signs of sepsis and sepsis information was displayed in the surgeries. Panic alarms to attract attention in the event of an emergency could be heard throughout the building including at reception and in the medical centre. In addition, there was an ‘InterCall’ system that displayed where the alarm had been activated from.

Staff recruitment

The practice manager had access to the DMS-wide electronic system so could demonstrate that relevant safety checks had taken place at the on the first day for any new employee, including an enhanced Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. The DBS check was managed by station and civilian personnel were checked every 3 years, military personnel every 5 years. A register was held on the practice’s SharePoint site, the practice manager maintained oversight and informed staff 3 months prior to expiry of their DBS for a renewal application.

Monitored by the practice manager, a register was maintained of the registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role. A 6 monthly automated reminder was used to carry out regular checks on the registration status of staff. In addition, checks are included as part of the annual assurance check on the DPHC Healthcare Governance team site.

Monitoring health & safety and responding to risks

A number of local health and safety policy and protocols were in place to support with managing potential risk. The SHEF team carried out an annual workplace health and safety inspection and completed monthly checks. In addition, the practice manager was the named health and safety lead and conducted risk and Control of Substances Hazardous to Health (COSHH) assessments which were then signed off by the SDO.

A monthly rolling programme included checks on the fire extinguishers and fire escapes. The unit carried out a fire risk assessment of the premises every 5 years with the most recent assessment undertaken in May 2021. There was no appointed fire warden for the premises but the practice managed and SHEF team regularly checked the fire system including the extinguishers and emergency lighting. Staff received annual fire training

provided by the unit and an evacuation drill of the building was conducted in July 2023. The practice manager had also conducted an evacuation drill in 2023 for only the dental centre staff. Both fire evacuation drills were evaluated and any lessons learnt emailed out to staff. Portable appliance testing had been carried out in line with policy. A (COSHH) risk assessment was in place and had been reviewed in August 2023. COSHH data sheets were in place and had been reviewed in August 2023. A log sheet was in place for each hazardous product with links to the safety data sheets. These were available to all staff on SharePoint.

DPHC had produced a standard operating procedure for the resumption of routine dentistry during the COVID-19 pandemic. The dental team demonstrated that they were adhering to the guidance in order to minimise the risk of the spread of COVID-19. A risk assessment had been last updated in July 2023. Staff who tested positive or displayed symptoms were told not to attend work. Staff identified as vulnerable would not be involved in the treatment of high-risk patients. Patients with COVID or suspected COVID had their appointment deferred if deemed appropriate by a dentist. Hand sanitiser was provided throughout the building and the practice provided the option for staff, patients and visitors to wear personal protective equipment. Clinical staff knew which aerosol generating procedures presented a low or high risk depending on whether high volume suction and/or a rubber dam was used. These patients were identified by a screening questionnaire in advance of the appointment. Ventilation was used within the building, cleaning routines and IPC procedures were adhered to.

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

Infection control

The dental nurse had the lead for infection prevention and control (IPC) and had the experience and knowledge to carry out the role. Although the one day IPC lead course had been completed, we recommended that the level 2 IPC lead course was completed in line with DPHC policy. The IPC policy and supporting protocols took account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. All the staff team were up-to-date with IPC training , records confirmed they completed refresher IPC training every 6 months. IPC audits were undertaken twice a year and the most recent was undertaken in July 2023 (90% compliance achieved. The audit followed a standardised process and the 10% non-compliance was due to there not being a washer disinfector despite there not being a need). A document check was carried out quarterly by regional headquarters.

The surgeries were clean, clutter free and met IPC standards, including the fixtures and fittings. Environmental cleaning was carried out by a contracted company twice daily and this included cleaning in between morning and afternoon clinics. The cleaning contract was monitored by the practice manager and any issues reported to the cleaning supervisor or cleaning manager. Deep cleaning was conducted twice each year with the most recent having been done in August 2023. The cleaning cupboard was tidy and well organised and staff could access it if needed in between the routine daily cleaning.

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

A detailed legionella risk assessment had been carried out on the building by an external contractor in February 2021 and monthly checks on the water temperatures were conducted. A protocol for the prevention and management of legionella was in place. This protocol detailed the process for flushing taps and disinfecting water lines.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. The clinical waste bin, external of the building, was locked, secured and away from public view. Clinical waste was collected weekly and consignment notes were provided by the contractor. Waste transfer notes were retained by the IPC lead and were audited annually. However, there was no evidence of cross referencing waste disposal once removed from the site (disposal certificates were required from the contractor who removed the waste).

Equipment and medicines

An equipment log was maintained to keep a track of when equipment was due to be serviced. The autoclave and ultrasonic bath had been serviced in January 2023. The servicing of all other routine equipment, including clinical equipment, was in-date in accordance with the manufacturer's recommendations. A Land Equipment Audit was completed in August 2023 and there was a single recommendation that had been actioned. Portable appliance testing was undertaken annually by the station's electrical team.

A manual log of prescriptions was maintained and prescriptions were sequentially numbered and stored securely. The practice manager conducted regular checks of sequential serialised number sheets to maintain traceability and accountability for any missing prescriptions. Void prescriptions were being shredded and we highlighted that these should be retained for audit purposes. Minimal medicines were held in the practice, patients obtained medicines through a local pharmacy. Medicines that required cold storage were kept in a fridge, cold chain audit requirements were in place and recorded. Glucagon was stored in the fridge in easy reach of the emergency trolley. The SDO carried out annual audits of antimicrobial prescribing. Although this was not a requirement, it was good practice and improved clinical oversight. The process would benefit from external input as the SDO was mainly reviewing their own prescribing. Adding the dosages and quantity of medication issued onto the prescription log would also aid monitoring (only the name of the medication was displayed on the audits we viewed). Prescribing audits were on the practice audit plan but had not been prioritised due to the low numbers of items prescribed.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A

Radiation Protection Advisor and Radiation Protection Supervisor (RPS) were identified for the practice. Signed and dated Local Rules were available in each surgery along with safety procedures for radiography. The Local Rules were updated in December 2022 and reviewed annually or sooner if any change in the policy were made, any change in equipment took place or if there was a change in the RPS. A copy of the Health and Safety Executive notification was retained and the most recent radiation protection advisory visit was in April 2021.

Evidence was in place to show equipment was maintained annually, last done in January 2023. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

The dental care records for patients showed the dentists justified, graded and reported on the X-rays taken. The SDO carried out a continuous audit of each X-ray taken. In addition, a quality assurance audit was undertaken annually, the most recent was carried out in July 2023.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients was assessed by the dentists in line with recognised guidance, such as National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network guidelines. Treatment was planned and delivered in line with the basic periodontal examination - assessment of the gums and caries (tooth decay) risk assessment. The dentists referenced appropriate guidance in relation to the management of wisdom teeth, taking into account operational need.

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

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

The Senior Dental Officer (SDO) discussed the downgrading of personnel in conjunction with the patient's doctor to facilitate completion of treatment. The military dental fitness targets were closely monitored by the SDO. We noted that all met or exceeded key performance indicators; for example, 78% of patients were category 1 (had completed a dental check-up and cleaning within the past year).

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. One of the dental nurses was qualified as an oral health educator and took the lead on health education campaigns. However, the lead was unable to provide dedicated clinics due to being the only dental nurse at the location. Clinical staff were not trained in smoking cessation beyond 'Very Brief Advice on Smoking' (VBA) so patients were signposted to the medical centre for this service (VBA is an evidence-based intervention designed to increase quit attempts among patients who smoke). Dental care records showed that lifestyle habits of patients were included in the dental assessment process. The dentists and hygienist provided oral hygiene advice to patients on an individual basis, including discussions about lifestyle habits, such as smoking and alcohol use. The SDO understood the process of consented referral to the medical centre when patients scored 10-12 on AUDIIT-C (an alcohol screening questionnaire). All high risk patients were offered fluoride and high concentration fluoride toothpaste was occasionally prescribed and fluoride varnish applied to high caries (tooth decay) risk patients. Oral health promotion leaflets were given to patients and the oral health coordinator maintained a health promotion area in the patient waiting area. The television in the patient waiting

area had rolling advertisements that promoted oral health. There was a display on dental erosion at the time of inspection but with the display space shared with the medical centre, we fed back that the dental health promotion displays would benefit from having more space and be more prominent. The oral health education lead attended the annual health fayre on the camp.

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

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

Staffing

The induction programme included parts for both temporary and permanent staff. All staff had individual terms of reference which included roles and responsibilities which were used to establish specific training requirements.

We looked at the organisational-wide electronic system used to record and monitor staff training and confirmed staff had undertaken the mandated training. The practice manager monitored the training plan and ensured it covered all the mandated requirements at the right times. The in-house training programme was delivered weekly and planned for annually. The practice manager reviewed the status of training for each practice meeting. All staff were used to deliver training to help them learn in multiple ways and to utilise the skills within the team.

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. All staff managed their own CPD requirements and had no issues accessing or completing the required work. Staff completed CPD work in their protected time each Tuesday afternoon, attended regional CPD peer review events and DPHC personnel had an annual allowance for CPD funded activity.

The staff members we spoke with confirmed that the staffing establishment and skill mix was lower than expected to meet the dental needs of the patient population and to maximise oral health opportunities. Although ad hoc support was provided from dental centres in the same region, the number of registered patients was higher than that for a single handed dentist. The dental team were working to deliver the best level of care possible whilst operating within the restrictions from staffing levels and responding to short notice rapid deployment pressures. The practice manager covered reception duties on top of their managerial duties so had to schedule protected time to complete governance work and assurance checks. When the SDO had an unplanned absence, all booked appointments were cancelled or rescheduled and pain case patients would be covered by HMS Nelson or HMS Excellent. Cover would be provided for the dental nurse by 10am so in the event of an unplanned absence, the first appointments of the day would be rescheduled. If the practice manager had any unplanned absence, there was no cover, the SDO and dental nurse would work with emergency support covered by the medical centre. The dental hygienist was leaving on the day of the inspection, there was a 10 week waiting

time for a hygienist appointment and no replacement had been found. The SDO had planned to use a locum hygienist and provide the periodontal (cleaning of teeth and gums normally done by a hygienist) treatment in the interim.

Working with other services

The SDO confirmed patients were referred to a range of specialists in primary and secondary care for treatment the practice did not provide. The dentists followed NHS guidelines, the Index of Orthodontic Treatment Need and Managed Clinical Network parameters for referral to other services. Patients could be referred to the Queen Alexandra Hospital, Portsmouth for secondary care where tri-service military consultants and clinicians worked alongside civilian staff. A spreadsheet was maintained of referrals and checked weekly. Each referral was actioned by the referring clinician once the referral letter was returned or the REGO (online referral platform) system was completed. Urgent referrals followed the 2-week cancer referral pathway.

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

The practice manager attended the unit health committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the practice manager provided an update on the dental targets. A slide pack was updated in advance by the dental centre and formed part of the agenda at the meetings. The SDO attended the wider camp meetings. For any vulnerable or downgraded patients (dentally related) the Battery Sergeant Majors liaised directly with the SDO.

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. A summary of the principles was displayed in the reception area, supported by a protocol and online training was mandated

Are Services Caring?

Respect, dignity, compassion and empathy

We took into account a variety of methods to determine patients' views of the service offered at Thorney Island Dental Centre. The practice had conducted their own patient survey in using the General Practice Assessment Questionnaire (GPAQ) feedback tool. A total of 51 responses had been captured between July 2022 and July 20232. A total of 100% of respondents said they were happy with their healthcare and 100% said they would recommend the dental practice to family and friends. Patients were invited to complete comment cards sent out in advance of this inspection. We received 40 completed cards which were all positive about the service and treatment received. Of note, 13 patients had complemented the staff on being supportive, with a number of these making specific reference to the time taken to explain treatments and alleviate any anxiety

For patients who were particularly anxious, the practice had an approach to understand the reason for anxiety, provided longer appointments and time to discuss treatment and invite any questions. Patients could also be referred for hypnosis or treatment under sedation as a final option, done by referral to Practice in the Park, an NHS dental practice in Havant where 2 consultants from the Queen Alexandra Hospital (QAH) visited to see patients, direct to the QAH, or to an alternative hospital via the online 'REGO' referral system. We were shown a good example where the team used positive behavioural techniques on an anxious patient to manage the care and deliver all of the planned treatment. This resulted in a positive feedback submission and a request to retain the dental team for the ongoing management.

The waiting area for the dental centre was well laid out to promote confidentiality . Practice staff advised us that all necessary questions were asked in advance of the patient arriving (by telephone) so that conversations at the reception desk were minimised.

Access to a translation service was available for patients who did not have English as their first language. Information on telephone interpretation was displayed on the patient information board and there was a protocol for staff to follow. Patients were able to request a clinician of the same gender. The SDO was male and although staff told us that they had never been asked by a female patient to see a female dentist, any such request could be accommodated at HMS Excellent Dental Centre.

Involvement in decisions about care and treatment

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

Are Services Responsive?

Responding to and meeting patients' needs

The practice took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 6 to 24 months depending on a dental risk assessment and rating for each patient. Patients could make routine appointments between their recall periods if they had any concerns about their oral health. The clinical team maximised appointment times by completing as many treatments as possible for the patient during the first visit. Any urgent appointment requests would be accommodated on the same day, emergency appointments were protected at the end of morning surgery. An additional emergency appointment was added following periods of leave. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in December 2022. The audit found the building met the needs of the patient population, staff and people who used the building. Staff we spoke with told us that had never encountered the need for a hearing loop at the reception desk and the audit confirmed that there were no patients with a hearing impairment. The facilities included automatic doors at the entrance, visible and audible fire alarms, car parking spaces close to the entrance for disabled patients and wheelchairs were available. Patients could request a printed copy of the practice leaflet in a larger font (available to staff through the SharePoint site).

Access to the service

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

Routine appointments to see a dentist were available within 4 weeks and 1 hour of emergency appointment slots were protected daily. The hygienist was fully booked 6 weeks ahead with 96 patients requiring initial treatment and 46 requiring recall to see the hygienist. The hygienist was due to leave the practice on the day of inspection. However, the liability was held by HMS Excellent, therefore the recruitment of a replacement was being undertaken by that dental centre. Thorney Island Dental Centre had applied for a locum hygienist to fill the temporary gap.

Concerns and complaints

The Senior Dental Officer (SDO) was the lead for clinical complaints and the practice manager was the named contact for compliments and suggestions. Complaints were managed in accordance with the DPHC complaints policy. The team had all completed complaints training that included the DPHC complaints' policy. A process was in place for managing complaints, including a complaints register for written and verbal complaints.

One written and no verbal complaints had been recorded in the last 12 months. The complaints were investigated and responded to appropriately and in a timely manner. The complaint was about staff attitude and as a result training in customer service was delivered to the whole team.

Patients were made aware of the complaints process through the practice information leaflet and a display in the practice. The practice had a box in the waiting area and could scan a quick response code from one of a number of posters discreetly positioned on walls at reception and in the patient waiting area. Appointment cards were not used as the practice sent out a weekly appointment list to the units, a text was automatically sent to the patient 3 days before and 1 day before their appointment. In this way, patients were able to give feedback out of sight from the reception area to promote confidentiality of any comments.

The practice had received 27 written and verbal compliments in the previous 12 months. The main themes were around the quality of treatment, explanation of treatments and the care shown by staff.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for the day-to day administration of the service. Staff were clear about current lines of accountability and secondary roles. They knew who they should approach if they had an issue that needed resolving. The SDO had overall responsibility for the management of risks for the service. These risks were fed into the regional risk register and in turn then from the regional headquarters to Defence Primary Healthcare (DPHC) headquarters. The risk register as well as the business continuity plan were seen at the visit and confirmed to be thorough. They were monitored on a regular basis for updates/compliance and changes.

A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff were familiar with these and they referred to them throughout the inspection. Effective risk management processes were in place and checks and audits were in place to monitor the quality of service provision. The clinicians, including the hygienist, carried out peer case discussions . The periodontal and referral logs were reviewed together with any cases clinicians wished to discuss.

An internal Healthcare Governance Assurance Visit took place in July 2022. The practice was given a grading of ‘substantial assurance’. A management action plan (MAP) was developed as a result; actions identified had been completed. Performance against military dental targets, complaints, staffing levels, staff training, audit activity, the risk register and significant events were all uploaded onto SharePoint and could be viewed by region, DPHC headquarters and anyone granted access. The Health Assurance Framework (HAF) was used as part of the practice manager handover, it was a live document, updated regularly by the practice. The SDO and the practice manager monitored the HAF monthly for changes and updates. This was also discussed at practice meetings so all staff had an awareness of the document and its contents.

All staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice and gave positive comments on the teamwork. Although the SDO and practice manager were responsible for the leadership and management of the practice, duties were distributed throughout the staff to ensure the correct subject matter expert had the correct role. All staff were encouraged to have input into the governance and assurance frameworks. Terms of reference were in place to clarify the responsibilities of those with lead roles. Practice meetings were held monthly, these had an agenda and were minuted. All staff felt they had input and could speak freely as well as being listened to. Minutes were sighted at the visit and confirmed to include all the required standing agenda items.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Each member of staff had a login password to access the electronic systems and were not permitted to share their

passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. Discussions with patients were held away from reception if requested. A reporting system was in place should a confidentiality breach occur (on the ASER system via the SDO). Staff had completed the Defence Information Management Passport training, data protection training and training in the Caldicott principles.

Leadership, openness and transparency

Staff told us the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff described leaders as supportive and considerate of the views of all staff. Staff spoke of the practice being an enjoyable place to work, of note, the teamwork. Civil service reward schemes were used and the SDO used 'team' awards well as a 'thank you' scheme to reward individual staff members. A suggestions box was in place for staff to post (anonymously if preferred). At practice meetings, staff were encouraged to express their concerns and provide their ideas. This was backed up by a 'stop, start, continue' initiative which was used in practice meetings to discuss concerns, areas of success and reach a decision as a team as to the way forward. The initiative was recorded as a Quality Improvement Project (QIP). The results were discussed at a practice meeting and the QIP was recorded on the DPHC Healthcare Governance Assurance SharePoint site.

Learning and improvement

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

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

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

Quick response or 'QR' codes were displayed at reception and in the practice leaflet and at various points throughout the practice for patients to use to leave feedback, there was also paper methods available too and staff were always available should the patient want to give verbal feedback. The General Practice Assurance and Quality (GPAQ) questionnaire was used monthly to review feedback, the practice manager used the filter functions to dig deeper into the results and look for trends that appeared. As the GPAQ is a live system, it meant the information could also be accessed by the regional headquarters and DPHC headquarters who could then conduct trends analysis for wider regional trends. Updates were then fed to the staff and the unit at practice meetings. The feedback had been positive. However, following a complaint regarding staff attitude, targeted training on customer service had been delivered to the team.

The SDO listened to staff views and feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service

and said these were listened to and acted on. All staff were encouraged to complete the anonymous continuous attitude survey where results were fed up to DPHC headquarters.