Lyneham Dental Centre

Calne Road, Chippenham, Wiltshire, SN15 4XX

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**	✓

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Summary

About this inspection

We carried out an announced comprehensive inspection of Lyneham Dental Centre on 6 May 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 CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

Background to the practice

Co-located with the medical centre, Lyneham Dental Centre was established in 2016. It is a 5-chair practice providing general dentistry, urgent same day appointments, Tier 2 oral surgery and oral health advice. The patient population of 2,700 includes Phase 2 trainees and reservists. Facilities include an oral health education (OHE) suite and central sterilisation services department.

The practice is open from 07:45 to17:00 hours Monday to Wednesday (closed for lunch 12:30 to 13:30 hours), 07:45 to 16:30 hours on Thursday and 08:00 to 12:45 hours Friday.

The staff team

Dentists	Military Senior Dental Officer (SDO) Civilian MOD dentist x 3
Hygienist	Civilian hygienist (locum part time)
Dental nurses	Military nurse Civilian nurse x 5 Trainee dental nurse
Practice management	Military practice manager
Administration	Civilian receptionist

Our inspection team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and practice manager/dental nurse specialist advisor. A newly recruited specialist advisor shadowed the inspection as part of their induction.

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 and staff who were working that day. 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 the team worked well together.
- 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 governance and risk management of the practice.
- Staffing levels were sufficient to meet the needs of patients and occupational demands of the regiments/units.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.

- Staff were up-to-date with appraisals, required training and continuing professional development.
- 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.

We identified the following notable practice, which had a positive impact on the patient experience:

- The staff team were pro-active with OHE and this was a positive emerging theme from the patient feedback, who commented on the availability and high quality of OHE provision. There was a dedicated training room to facilitate group OHE, mainly for Phase 2 trainees. It was equipped with a range of learning resources including displays, equipment and props to support with training.
- The practice manager developed a bespoke electronic approach to induction that included specific tabs and links to processes/practice information, such as terms of reference, health and safety and risk assessments. The structure meant all areas of induction were captured in 1 document, which was easy to navigate to locate specific information. It also was an environmentally-friendly approach as paper documents did not require printing.

The Chief Inspector recommends to Defence Primary Healthcare:

- Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste that reflects the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.

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. A register of events and incidents was maintained, which showed 5 ASERs were raised since July 2024. The staff team had received ASER training and were registered to the use the system. Staff, including locum staff, appropriately described the types of incidents reported through ASER. They were also aware the system could also be used to report good practice. ASERs were a standing agenda item at the weekly practice meeting.

Staff related accidents and incidents were reported through the 'MySafety account'. 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). Such incidents were reported through the ASER system.

Patient safety alerts were a standing agenda item for discussion at practice meetings and/or in the weekly staff briefings. Staff were also notified of alerts through 'Direction and Guidance' from Region Headquarters (RHQ).

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead and had completed the required level safeguarding training for dental services. As there were registered patients under the age of 18, the practice had access to the Senior Medical Officer in the medical centre who was Level 3 trained in child and adult safeguarding. All staff were up-to-date with safeguarding training at a level appropriate to their role. There had been a recent move for all to complete Level 3 safeguarding training. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. Reviewed in February 2025, a dental treatment risk assessment for under 18s was in place.

There were 72 patients under the age of 18. They had an alert on their record so reception staff were aware of their age when they contacted the practice. Vulnerable patients were discussed at the Commanders Monthly Case Review meetings, at which the practice was represented. Safeguarding information was displayed including contact details for the Wiltshire Multi-Agency Safeguarding Hub. Safeguarding was a standing agenda item at the practice meeting

Staff had completed training in 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 DoC register was maintained and included detail of lessons and actions identified. DoC information was displayed.

A lone working risk assessment and policy was in place for the practice, which detailed that there should always be 2 members of staff on the premises. Dentists were always supported by a dental nurse when treating patients. In accordance with Defence Primary Healthcare (DPHC) policy, the dental hygienist did not have chairside support but had access to an alarm in the surgery. Each surgery had an emergency alarm button which was audible throughout the premises. The alarm system was tested regularly to ensure it was in working order. Patients could be observed in the waiting area from reception.

The availability of a chaperone was displayed. We were advised that all patients under the age of 18 were offered a chaperone.

A dental dam was used routinely for adhesive restorations and endodontics (root canal treatment). If patients were unable to tolerate a dam then endodontic treatment could not be completed for safety reasons.

The business continuity plan (BCP) was reviewed in March 2025 and was displayed in the staff room. We asked various staff about BCP related topics and all could explain what to do if an event occurred.

Medical emergencies

The SDO was the lead for medical emergencies and resuscitation. The management of medical emergencies risk assessment was reviewed in February 2025. 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. Staff advised us of an actual medical emergency that had been effectively managed. The practice was planning for future scenario-based sessions to be held jointly with the medical centre.

The medical emergency kit was contained in a trolley bag close to the surgeries in an area accessible only to staff. Emergency medicines including controlled drugs (medicines with a potential for misuse) were easily accessible with a pin code. 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. All other out-of-date medicines were returned to the dispensary in the medical centre and replacements ordered.

The practice manager for the medical centre was the first aider for the building. 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.

We discussed with the SDO if patients understood what to do if they experienced pain or their condition deteriorated. Patients were advised to contact the dental centre during working hours and the dentist on-call out-of-hours or NHS 111. Out-of-hours support was displayed on the front door, at reception and explained individually to patients during a consultation if needed.

Sepsis/deteriorating patient information was displayed and staff we spoke with, including the receptionist, were familiar with what to do if they were concerned a patient may be displaying the signs of sepsis. Heat illness information was also 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. The regional recruiting lead was notified if permanent or locum staff were required.

Monitoring health & safety and responding to risks

The practice manager was the lead for safety, health, environment and fire (referred to as SHEF) and the military dental nurse deputised. The role involved developing and monitoring risk assessments and environmental safety. The practice manager liaised regularly with the building custodian based in the medical centre. In addition, the practice had an effective working relationship with the unit SHEF manager. A SHEF inspection was undertaken in November 2024 and the recommendations had been actioned. A workplace inspection self-audit was completed in February 2025. SHEF and risk were a standing agenda item at the practice meetings.

Risks for the practice were recorded on the regional risk register held, which the SDO regularly monitored and updated accordingly. Reviewed in February 2025, a range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The 5-yearly fire risk assessment was undertaken in March 2021 and it identified the building as a tolerable risk; no action points were identified. The building fire warden was based in the medical centre and they carried out the routine fire checks. The military dental nurse deputised in their absence. The fire alarm was checked weekly and firefighting equipment and evacuation measures were checked each month. A fire evacuation drill was carried out quarterly in conjunction with the medical centre. It was last undertaken in April 2025.

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 March 2025. Risk assessments/data sheets were reviewed if there was a change of products or a change of SDO or practice manager. The contracted cleaner kept cleaning products in a cupboard and had a copy of the company's COSHH risk assessments.

The safety of water was monitored with the last full legionella risk assessment carried out by the contractor in January 2021. In addition, the contractor carried out monthly,

quarterly, six-monthly and annual water checks. The legionella risk assessment for the practice was reviewed in April 2025.

Waterlines were flushed for 2 minutes before each clinical session and for 20-30 seconds after each patient was treated. The ultrasonic was tested weekly, logged manually and transferred to the electronic spreadsheet held on SharePoint. The infection prevention and control (IPC) lead tested the water each month for the presence of bacteria. If the dip slide test failed then the surgery was closed and the water treated. After 24 hours the dip slide test was repeated. Dental unit waterline samples were quarterly tested 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 dentists 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 using out-of-date ampules. 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.

Infection control

The dental nurse with the lead for IPC and had completed Level 2 training via the Dental Nurse Network. 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. If staff were ill then they were advised to stay off work.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). Updates were received from RHQ, including any new information circulated by the GDC. 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 IPC lead provided training in January 2025 for all 9 IPC topics and staff were issued with attendance certificates. In addition, the lead provided webinar workshops for the region and staff had access to the webinar link, including staff who were unable to attend.

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. Dental nurses supported the hygienist with the decontamination of their instruments.

The last IPC audit was completed in January 2025. The decontamination audit was undertaken every 6 months and was next due in July 2025. The regional IPC lead reviewed the audits.

Environmental cleaning was carried out by a contractor and a schedule was in place outlining the cleaning arrangements for each area and frequency. Cleaning was undertaken twice a day, prior to the morning and afternoon clinics. A log was maintained by cleaning staff to confirm cleaning had taken place. Together, both the practice manager and cleaning supervisor checked the standard of cleaning each week. In addition, the practice manager carried out weekly spot checks of the surgeries The cleaning contract provided for a deep clean every 6 months.

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.

Staff were aware of recent developments to HTM 07-01 regarding the classification of clinical waste. As directed by Headquarters DPHC, changes had not yet been made to clinical waste processes until pan-DPHC policies were updated.

Equipment and medicines

One of the dental nurses was the lead for equipment care. 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. Equipment care was a standing agenda item at practice meetings.

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, washer disinfector and autoclave. Evidence was in place to demonstrate the compressor was checked quarterly (January, April, July and December) maintained/checked for air quality control by an external contractor. An equipment audit (referred to as a LEA) was carried out in January 2025. 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. Stock checks were completed for all surgeries. All stock requiring temperature control were 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. Pharmaceutical fridge temperatures were monitored and recorded twice a day.

Prescriptions forms were held securely and a log maintained of prescriptions issued, which were also recorded on DMICP. A ‘doctor’s bag’ of analgesia/antibiotics was available for out-of-hours prescribing. The SDO had recently completed the annual antibiotic prescribing audit. It identified that not prescriptions used were recorded correctly. The audit was presented at the practice meeting and actions agreed.

Expired medicines were returned to the dispensary in the medical centre and replacements ordered. Two members of staff witnessed the destruction of controlled drugs (medicines with a potential for misuse).

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. A Radiation Protection Advisor for the practice was identified. 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. A rectangular collimator (used to reduce unnecessary radiation exposure) was available on the intra oral units.

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 dentists prior to use.

Staff requiring IR(ME)R training had received relevant updates. RHQ booked the training and carried out checks to ensure it was completed.

A radiography audit was undertaken with quarterly quality assurance of image processing.

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 Periodontal Society (BPS) in relation to periodontal (gum disease) staging and grading was followed. Each surgery had a laminated copy of the BPS guidance and referrals were made to the hygienist as needed. Clinicians used the 'Healthy Gums Do Matter' Toolkit, developed by the Greater Manchester Local Dental Network. Patients with significant periodontal disease were referred to the medical centre for blood tests.

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. Dental downgrades were discussed with the patients' primary care doctor and a referral made via a FMed (referral letter).

The military dental fitness targets were closely monitored by the Senior Dental Officer (SDO) and were also a standing agenda item at the practice meetings. To improve compliance with the targets a range of measures had been employed. These included Tier 2 practitioners taking on external referrals and working with the Chain of Command to reduce non-attendance at appointments.

Health promotion and prevention

One of the dental nurses was the lead for oral health education (OHE) and had completed the relevant training for the role. Where applicable, the patient records we reviewed showed proposed treatment pathways and information given to individual patients was in accordance with the Delivering Better Oral Health toolkit.

Project MOLAR is a treatment strategy used by Defence to improve the dental health of personnel entering the military. All dental treatment along with the delivery of OHE is carried out at the start of a service personnel's career. The practice had a dedicated training room to facilitate group OHE for Phase 2 trainees, which they received within their

first week of registering at the practice. The room was equipped with a range of displays, equipment and props to support with training. OHE was also provided to patients on an individual basis. The OHE lead participated in the unit health fairs. The last event was held in November 2024 and another was planned to take place in May 2025.

The patient-orientated OHE displays in reception/patient waiting area were refreshed each month to reflect regional requirements. At the time of the inspection information was displayed either in the training room or waiting area regarding healthy snacks, sugar consumption, alcohol, smoking/vaping and gum problems. In addition, patients had access to a wide-range of oral health information leaflets and 'Top teeth tips' was outlined in the patient information leaflet.

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. Patients were provided with information and advice about lifestyle choices and habits that could have an adverse impact on their dental health. 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.

High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available.

Staffing

Despite a long term gap for a dental hygienist, the majority of staff we spoke with said staffing levels were sufficient to meet the needs of the patient population and fulfil governance requirements for the practice. Staff did highlight that the protracted recruitment process meant there were delays with new staff taking up post. Staff vacancies were covered by locums. The receptionist was employed by the contractor Mitie. They advised that cover was provided by Mitie when they were not in work.

New staff completed the Defence Primary Healthcare (DPHC) induction programme, including locum staff. The practice manager had developed a bespoke electronic approach to induction that included specific tabs and links to processes/practice information, such as terms of reference, health and safety and risk assessments. The structure meant all areas of induction were captured in 1 document and it was easy to navigate and locate specific information. We highlighted the benefits of raising this work as a quality improvement project. Staff described a thorough induction when they joined the practice.

Staff were sent reminders when mandatory training was due and training was also a standing agenda item at the practice meetings. Training was recorded on the DPHC Dental Personnel Management System. Staff were given time each week to complete training. All staff were up-to-date with mandated training at the time of the inspection.

An in-service training (IST) register was in place and included the training topic and which staff attended. Staff reported that they could contribute topics to add to the IST plan. IST certificates were signed off for staff attending training sessions.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. They had access to 'Apolline Training' for access to CPD courses. Funding was available and staff were encouraged to continually develop, such as attending the OHE training. Representatives from oral health companies had attended the practice and provided CPD sessions. Clinical staff attended the regional training days held 3 times a year.

Clinicians at the practice provided educational support to the wider region and DPHC community through clinical attachments, small group teaching and webinars. Furthermore, clinicians at the practice had been selected to present their studies and research at national meetings.

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.

The Defence Centre for Rehabilitative Dentistry was not accepting referrals at the time of the inspection. Two of the dentists based at the practice were Tier 2 dental practitioners so could undertake oral surgery. Patients requiring more complex treatment were referred to the Great Western Hospital.

A comprehensive process was in place to manage referrals, including the use of the DPHC centralised process for the management of all referrals. One of the dental nurses was the lead for referrals and checked the status of referrals each week. The SDO also monitored the referrals. There was a 9-week wait for urgent referrals, including 2-week-wait referrals for patients with a suspicious lesion. The SDO said would contact the hospital if they were concerned the patient needed to be seen sooner. There was a 9 to 12 month wait for routine referrals.

Consent to care and treatment

Feedback from patients confirmed that they were given information about treatment options and the risks and benefits of these so they could make informed decisions.

Verbal consent was taken for consultations with written consent secured for endodontic treatment, crowns and extraction under local anaesthetic. Tele-consultations were held with the patient and pre-operative consent taken for third molar extraction. In addition, information from the British Association of Oral Surgeons was given to patients referred for third molar treatment. Our review of clinical records demonstrated detailed discussions were held with patients undergoing any operative treatment.

Records showed staff had completed online Mental Capacity Act (2005) training. Clinicians we spoke with had a good awareness of mental capacity and how it could apply to their patient population.

Are Services Caring?

Respect, dignity, compassion and empathy

We received feedback from 73 patients via our pre-inspection feedback cards. 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. Staff had received training in April 2025 on using the Big Word and the access code had been tested.

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

Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support them with making informed decisions about treatment choices. From our discussion with clinicians, it was clear a range of options were used to ensure patients understood the problem and treatment options. Some of these measures included the use of a hand-mirror so the patient could see the issue, dental models, British Dental Association ‘pictures for patients’ and showing the patient their X-rays. Patients were given time to consider their 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 were also influenced by occupational needs particularly if patients were deploying overseas. Routine recalls were usually every 12 months and recalls of 24 months were rare.

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 worsens.

The practice used a focussed educational feedback token system at reception to ask specific questions in order to determine patients' knowledge and understanding of specific dental issues. Questions were refreshed each month. The outcome and action taken was then displayed. For example, patients where asked if they knew how to access out-of-hours (OOH) dental care and 30% said did not. The practice responded by displaying all areas of the Station the OOH details were available. A question about emergency care led to the practice increasing the number of emergency appointments, and in the afternoon as patients requested. Furthermore, oral health education clinics were increased in response to a question about preventative care. We highlighted the benefits of raising this initiative as a quality improvement project. The question of the month was decided at the practice meeting.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in March 2025 and no actions were identified. The premises was a new build so was fully accessible for patients with reduced mobility. There was a ramp and automatic opening front doors, lift access the dental centre on the first floor and an accessible toilet. A hearing loop was available.

Staff considered 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. They had also completed training in how to interact appropriately with neurodiverse people including those with a learning disability and/or autism. Requests for clinicians of a specific gender could be accommodated. Appointments could be organised to support patients who needed to fast for religious/cultural reasons. Patients were called into surgery by rank and surname thus avoiding reference to gender.

Access to the service

At the time of the inspection, the next available routine appointment with a dentist and the hygienist was within 5 weeks. Individuals or units deploying were prioritised. Often the practice 'block booked 'appointments for deploying units. The next available appointment

for oral surgery was the beginning of June 2025. If patients cancelled an oral surgery appointment then the staff offered the appointment to patients on the waiting list. Patients requiring an emergency appointment during working hours could be seen on the same day as a dentist had an afternoon dedicated each day dedicated to see patients with an emergency need. If the emergency appointments were unfulfilled by 10:00 hours they were offered to other patients, prioritising those due to deploy.

The practice was responsive to requests from other practices. For example, a patient out-of-area was seen at short notice for emergency dental treatment. Furthermore, the practice accommodated a patient in an emergency slot who had a failed extraction at another practice.

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. For acute dental emergencies, the ‘What3words’ app was used as a location marker for the ambulance service for acute emergencies. 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

The Senior Dental Officer was the lead for complaints, which 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. We discussed with the SDO a complaint received about a patient unable to access a prescription OOH. This had been effectively addressed and action taken to minimise the risk of the same issue happening again.

Patients were made aware of the complaints process through the practice information leaflet and information in the waiting area. Feedback from patients indicated they knew how to make a complaint.

Are Services Well Led?

Governance arrangements

The practice effectively worked to the Defence Primary Healthcare (DPHC) mission statement:

> "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental service for entitled personnel to maximise their health and to deliver personnel medically fit for operations."

The Senior Dental Officer (SDO) described effective communication with the various regiments/units and they attended the Commanders Monthly Case Review meetings on a regular basis. Effective communication pathways were in place with Regional Headquarters (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. Terms of reference were up-to-date for all staff.

In addition to the practice meetings, staff briefings were held twice a week to check how the week was progressing and to share any necessary information, such as medical alerts. The SDO attended meetings each month with RHQ and the practice manager attended the regional meeting for dental practice managers.

External and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the SDO with both RHQ and the Chain of Command had oversight. The practice used the Health Assessment Framework (HAF), an internal quality assurance system used to monitor safety and performance. Staff had received training in using the HAF.

The last Internal Assurance Review was completed in January 2023. The management action plan showed all actions had been completed.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Each member of staff had a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. A reporting system was in place should a confidentiality breach occur. Staff had completed the mandated Defence information management training, data protection training and training in the Caldicott principles to protect confidential patient information.

To address environmental sustainability, the practice aimed to reduce the use of paper through digitisation. An example of this was the introduction of an electronic induction programme that contained links to relevant information, which had reduced the printing of paper documents. The new waste legislation introduced this year was displayed and explained the 4 categories of waste segregation. Recycling bins were in use, including a box for the recycling of batteries. Stock was effectively managed to reduce wastage and any surplus was offered to other practices within the region.

Leadership, openness and transparency

All staff we spoke with were happy in their work environment and said the team was cohesive and worked well together. Staff spoke highly of the inclusive and supportive approach of the senior leadership team (SLT), indicating the SLT promoted a collaborative leadership culture to ensure all staff were able to raise issues at the earliest opportunity. They said they were involved in decision making about the service, including service developments.

From our conversations with staff, we identified here was an open and transparent culture. Staff said they were confident any concerns they raised would be addressed without judgement. They were familiar with whistleblowing arrangements, which were displayed on the notice board.

Learning and improvement

The SDO was the lead for clinical audit/quality improvement activity, which was a standing agenda item at the practice meetings. Examples of quality improvement initiatives included the monthly patient educational question, work with the Chain of Command to reduce non-attendance and the electronic induction pack. In addition, the team were highly pro-active with oral health educational (OHE) as demonstrated by the OHE sessions for trainees in a dedicated OHE suite.

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 and Basic Periodontal Examination (BPE) audits. An audit was recently undertaken to review prescribed toothpaste. All audits were discussed with staff at practice meetings.

Mid 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 keen to include the views of patients in how the service developed. To monitor how well the practice was performing, patients were encouraged to complete the Patient Experience Tool (referred to as the PET survey) via a QR code. This code was displayed on the premises and in the patient information leaflet. The monthly ‘yes’ or ‘no’ question using a token to respond was a good initiative to seek a targeted quick response from patients and had led to improvements as outlined earlier in the report.

Patient feedback was shared with the team during practice meetings. Minutes from the meeting in February 2025 highlighted that there had been a large number of compliments from patients. This mirrored the feedback from our patient survey that complemented this inspection. The emerging theme from the patient feedback we received was the availability and high quality of OHE provision.

Opportunities were available for staff to provide feedback, such as at the bi-weekly briefs, practice meetings and through a feedback survey. An anonymous questionnaire was developed to gain an insight into whether the team perceives they are meeting the needs of patients and the Chain of Command. A staff suggestion box was also in place.