Marham Dental Centre

Burnthouse Drive, Upper Marham, King's Lynn, Norfolk, PE33 9NP

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Marham Dental Centre on 20 May 2025.

As a result of the inspection we found action was required for safe. The practice was 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

Based in the Defence Primary Healthcare (DPHC) East Region, Marham Dental Centre is a 4-chair practice supporting a tri-service patient population of 2,238 at the time of the inspection. The population fluctuates as multiple squadrons often deploy at the same time. Patients from Swanton Morley Barracks are registered at the practice and travel to Marham for dental care.

The practice is open from 08:00 to 17:00 hours Monday to Thursday (closed for lunch 12:00 to 13:00 hours) and 08:00 to 13:30 hours Friday. The practice is closed Wednesday afternoons from 13.30 hours for meetings and mandatory staff training. An emergency clinic is held each morning between 10:30 and 11:30 hours.

The staff team

Dentists	Military Senior Dental Officer (SDO) Military unit dental officer
Hygienist	Position vacant
Dental nurses	Military nurse Civilian nurse x 2
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 recently 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. Staff provided examples of when the practice had gone ‘the extra mile’ to support patients.
- 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.
- The dental centre was not ideal as a healthcare environment and not suitable for patients with all patients who used mobility aids.
- Holes in the ceiling lining and ill-fitted fire doors increased the risk of fire.
- Systems were in place to support the governance and risk management of the practice.
- Staffing levels were identified as a risk. We were assured that the recent recruitment of a dental hygienist coupled with another dentist taking up post in the summer would reduce this risk.

- 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.
- 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 DPHC:

- Given that the plan for a new build at Marham has shifted to 2047, the infrastructure should be reviewed to ensure it is fit for purpose, including accessibility for people with mobility needs.
- Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste that reflects with the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.

The Chief Inspector recommends to the practice:

- The actions from the 2023 fire risk assessment should be reviewed and effectively addressed to minimise the risk of a fire spreading.
- Discuss and agree with other teams/departments based in the building who is responsible for the flushing of shared water outlets.

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. The staff team were registered to use the system and had received refresher ASER training in November 2024 with annual training scheduled for August 2025. ASERs were a standing agenda item at the practice meetings with more urgent ASERs discussed at the Monday morning briefing/huddle. Learning from incidents was recorded.

Staff we spoke with appropriately described the types of incidents reported through ASER and highlighted changes that had been made as a result of ASERs raised. For example, a patient's record did not save correctly so there was no record of their consultation. As a result, staff received training in how to ensure records were saved. Clinicians now aim to complete patient notes before seeing the next patient. No further similar incidents have since been reported.

Staff related accidents and incidents not involving the patient care pathway were reported through the 'MySafety account' or the local unit accident report system (referred to as NSOR) for staff related injuries

The practice manager 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 as a sentinel event.

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 (RHQ). Safety alerts were a standing agenda item at the practice meetings.

Reliable safety systems and processes (including safeguarding)

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

In relation to the management and support for vulnerable patients, the SDO had close links with both the executive team and medical centre team. At the time of the inspection, there were no registered patients under the age of 18. Vulnerable patients were discussed at the Commanders Executive Meeting attended by the SDO. Safeguarding information

was displayed including the practice policy and contact details for making referrals to the local safeguarding team.

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. DoC information was displayed in communal areas and staff we spoke with had a clear understanding of what was expected of them regarding the DoC principles..

A practice lone working risk assessment (November 2024) and policy (May 2025) was in place. Each surgery had an alarm buzzer that was linked to a display panel adjacent to reception with the display indicating the surgery number. This was tested during the inspection and the alarm system was fully functioning. The alarm system was tested regularly to ensure it was in working order. Dentists were supported by a dental nurse when treating patients.

The availability of a chaperone was displayed. The SDO advised that no patients had requested a chaperone. Patients could be observed in the waiting area from reception.

A dental dam was used routinely for endodontics (root canal treatment) and restorative treatment. Our review of patient records confirmed the use of a dental dam was recorded.

The business continuity plan (BCP) was reviewed in January 2025, this was discussed with staff in April 2025 and a table top exercise was scheduled for July 2025. The BCP was activated in February 2025 due to a power and water failure.

Medical emergencies

All staff were up-to-date with the required medical emergency training, including Basic Life Support, use of the automated external defibrillator and anaphylaxis. The training in April 2025 also included simulation or scenario-based training. Staff advised us of an actual medical emergency that had been effectively managed.

The medical emergency kit was contained in a trolley bag close to a used surgery, which was locked when the practice was closed. 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 (medicines with a potential for misuse). We noted that 1 of the Buccolam syringes (schedule 3 controlled drug used to manage seizures) was not labelled and staff were unaware of this as it was contained in a tube. Promptly after the inspection, the practice manager raised an ASER and contacted the pharmacist who advised labelling it as ‘do not use’ and to await further advice from Regional Headquarters (RHQ). Furthermore, we identified that unlabelled Buccolam syringes was an issue at other dental centre sites and RHQ planned to contact all practices regarding the action to take.

The practice manager and a dental nurse were the first aiders for the practice. Signage was displayed indicating where the first aid kit was held. 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 (OOH) or NHS 111. OOH support was displayed on the front door, in the practice information leaflet and explained individually to patients during a consultation if needed.

Sepsis/deteriorating patient information was displayed in reception and the surgeries. Staff we spoke with said they had received training so were familiar with what to do if they were concerned a patient may be displaying the signs of 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.

Monitoring health & safety and responding to risks

The SDO was responsible for risk management. The practice manager was the lead for safety, health, environment and fire (referred to as SHEF) and a dental nurse deputised. The role involved undertaking risk assessments and managing the risks with sign-off from the SDO. Two-yearly station-led SHEF audits were undertaken and the practice carried out 6-montly workplace inspection self-audits; the most recent in January 2025. The practice manager was the building custodian and the OC (lead) physiotherapist based in the co-located Primary Care Rehabilitation Facility deputised. SHEF was a standing agenda item at the practice meetings.

Risks for the practice were recorded on the regional risk register, which was regularly monitored and updated accordingly. A range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The building was old (circa 1947) and not ideally suited as a healthcare environment. This was well recognised as a new build had been planned but had since been re-scheduled to take place in 2047. Through feedback, some patients commented that the building needed to be improved. Practice staff indicated that ideally they would prefer to be co-located with the medical centre for relationship/communication purposes and access to additional support in the event of a medical emergency.

The practice manager was the fire warden. The fire alarm was checked weekly and firefighting equipment and evacuation measures were checked each month. Staff confirmed they had participated in a fire evacuation drill in May 2025 and another was due in November 2025. The practice manager planned to coordinate a drill sooner to address the previous learning points.

The 5-yearly fire risk assessment was undertaken by the fire safety officer in July 2023 and it identified the building as a tolerable risk. A range of actions were made and directed to the building custodian. Although some had been addressed, many were outstanding. For example, the external fire door was not compliant and some internal fire doors required adjusting. There was evidence in place to show statements of need had been submitted for improvements to be made.

A key action that had not been effectively addressed was the risk of fire spreading from one compartment or area to another through holes and gaps in ceiling linings. We observed many holes in the ceilings of various rooms, some of which had not been sealed and others that had been sealed with what appeared to be masking tape. This type of sealant was not appropriate to prevent the spread of fire due to its flammability. Furthermore, not all emergency exits were suitable for wheelchair users. Promptly after the inspection, the practice manager added the risk of fire to the risk register and made contact with the fire safety officer to review the risk assessment.

All Control of Substances Hazardous to Health (COSHH) were reviewed in December 2023 and were stored securely. Data sheets were available and the practice manager cross-reference them with the on-line versions to ensure they were current. Risk assessments were available electronically. We discussed ensuring these were readily accessible in the event of an incident involving a COSHH product. The contracted cleaner kept cleaning products in a lockable container and had a copy of the company's COSHH risk assessments.

The safety of water was monitored and the legionella risk assessment was reviewed by the contractor in January 2024. There were a number of items incomplete from the assessment. The practice manager was unaware if the actions had been completed and advised they would check with the contractor. Although records were not shared with the practice, the practice manager confirmed the contractor carried out monthly annual water checks. Whilst water outlets were flushed and recorded for the dental surgeries, there was no record of this for the toilets/changing areas which were shared with environmental health and the health and safety teams based in the same building.

A range of tests were undertaken of the dental unit waterlines (DUW) including daily flushing of DUWs and flushing between patients. Water quality checks and monthly dip slide testing for monitoring microbial contamination were undertaken. Quarterly flushing and tests of the water purification process were carried out. Instead, waterline treatment tablets were used and left in the surgery chair water. The last water quality report was received in December 2024 and no actions were identified. Bacteria readings (referred to as CFU) were slightly high in some areas. However, this was monitored through the daily quality water checks. An amalgam separator was used to reduce the amount of amalgam in dental wastewater.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available, safety posters were displayed in surgeries and sharps boxes 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. 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 nurses were the leads for infection prevention and control (IPC) and had completed either Level 2 or 3 training. All staff completed IPC training in October 2024 and further training was scheduled for June 2025. IPC was a standing agenda item at practice meetings.

A staff protocol was in place to minimise the spread of infectious diseases, including hand washing guidance, the availability of hand sanitiser and access to a sufficient stock of personal protective equipment. Aerosol generating procedures were used if a patient with an infectious disease needed emergency treatment. Furthermore, the patient would be seen at the end of the working day to maximise additional IPC procedures.

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 March 2025; no recommendations were made. The next audit was next in September 2025. The regional IPC lead reviewed the IPC audits.

Cleaning was undertaken twice a day; prior to the morning and afternoon clinics. 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 inverted. Colour coded mop buckets corresponded to colour coded door stickers to remind staff of the risk in each room.

The cleaning contract was overseen by the station estates management team and the practice manager raised any concerns via the cleaning manager. The cleaning contract provided for a deep clean every 6 months.

Overseen by the dental nurses, 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 and was collected weekly by the contractor. A waste log, waste transfer notes and consignment notes were in place and up-to-date. The pre-acceptance clinical waste audit was completed in December 2024.

Staff were aware of the December 2024 revision to HTM 07-01 regarding the classification of clinical waste. As directed by Defence Primary Healthcare (DPHC), changes had not yet been made to clinical waste processes until DPHC-wide policies were updated.

Equipment and medicines

One of the dental nurses was the lead for equipment care. An equipment spreadsheet was in place detailing all equipment held and date of last/next servicing. A faults log was included with the equipment spreadsheet. Equipment care was a standing agenda item at practice meetings.

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. Electrical Equipment Testing was up-to-date.

Evidence was in place to demonstrate the compressor was checked by a specialist engineer quarterly and maintained annually for air quality control. Maintenance of the compressor was next due in July 2025.The compressor was identified on the risk register due to a history of failure in adverse weather conditions (3 times in 18 months). A statement of need had been submitted for a new compressor storage compartment and consideration for the compressor to be relocated within the building.

One of the dental nurses was the lead for stock control and carried out monthly checks to ensure materials were in-date in all surgeries. A check form in each surgery included the expiry dates of stock and was countersigned weekly. Dental materials requiring temperature control were stored in the air conditioned surgeries. We checked the surgeries and they were clean and tidy. All equipment was latex free.

Prescriptions forms were held securely and a log maintained of prescriptions issued, which were also recorded on DMICP. Pharmaceutical fridge temperatures were monitored and recorded daily; temperatures were within the expected range. The SDO used the log to monitor prescribing patterns.

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. It was reviewed as part of the Health Assessment Framework, an internal quality assurance system used to monitor safety and performance. 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. To minimise radiation exposure, staff stood outside of the scatter zone when a patient was being X-rayed. 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 image quality checks were undertaken daily and weekly. Staff requiring IR(ME)R training had received relevant updates. A radiology audit was undertaken in April 2025.

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, Scottish Intercollegiate Network guidance and the Faculty of General Dental Practice 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 detailed 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.

Our review of patient records showed the appropriate pathway for Basic Periodontal Examination (BPE) was followed and treatment provided recorded. A BPE was carried out at each dental inspection. The Senior Dental Officer (SDO) acknowledged that hygiene treatment to prevent and treat gum disease was currently limited due to staff vacancies.

Furthermore, occupational preparation of service personnel (SP) for Operation Highmast (deterrence and readiness) had been the focus with all SP receiving a dental review even though it was outside of the recall period for some. Regarding Operation Highmast deployment, records showed patients received an appropriate risk assessment of their dental health, including consideration of each individual's role and tasking.

The military dental fitness targets were closely monitored by the (SDO) and were also a standing agenda item at the practice meetings. At the time of the inspection, the practice was not meeting the targets due to the focus on dental preparation for Operation Highmast deployments.

Health promotion and prevention

One of the dental nurses was the lead for oral health education (OHE). A range of measures were in place to ensure the practice was providing information and care in accordance with nationally recognised guidance - Delivering Better Oral Health toolkit: an evidence-based toolkit for prevention. The OHE lead held weekly (sometimes twice a week) clinics whereby preventative measures were discussed with individual patients. The nurse carried out a soft tissue check and referred the patient to a dentist if there were any concerns.

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 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.

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 and we were given examples of referrals that had been made.

The patient-orientated OHE displays in reception/patient waiting area were refreshed each month to reflect the national strategy. A 'National Smile Month' display was in place at the time of the inspection. Information was also displayed about alcohol limits and a range of leaflets related to dental conditions were available. 'Top tips' for oral health was outlined in in the patient information leaflet.

RAF Marham has not held a health fair since Covid-19. RAF Swanton Morley last held a health fair in September 2023.

Staffing

From our discussions with staff and hearing about the increased workload due to pressures of Operation Highmast, we determined that staffing levels had not been adequate to meet the needs of the patient population and ensure the wellbeing of staff. Visiting dentists had supported the practice with the workload. Both a dentist and dental nurse had been appointed shortly before the inspection and were going through induction. The SDO advised that another dentist was due to take up post in June 2025 and a hygienist had been recruited and would be starting work at the practice soon.

New staff completed the Defence Primary Healthcare (DPHC) induction programme, including locum staff, and we saw some examples of completed inductions during the inspection. The practice manager reviewed staff inductions annually at the point of completing the annual report. Staff described a thorough induction when they joined the practice.

The practice manager monitored the status of mandatory training, which was also reviewed at the practice meetings. Training was recorded on the DPHC Dental Personnel Management System. Staff were given time to complete training. At the time of the inspection, staff were up-to-date with mandated training with the exception of infection prevention and control (IPC). Some staff were slightly out-of-date and training was scheduled. An annual plan was in place for in-service training.

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 to ensure patients were offered treatment in a timely manner with the SDO attending the Command Executive Meetings.

One of the dental nurses was the lead for the Swanton Morley cohort of patients and attended the unit meetings.

A detailed process was in place to monitor referrals, including the use of the DPHC centralised process for the management of all referrals. There was an approximate 12-week wait for routine referrals, such as extractions of wisdom teeth. Two-week-wait (2WW) referrals for patients with a suspicious lesions were highlighted in orange on the referrals register. A letter was sent to the medical centre providing the details of patients referred as a 2WW. One of the dental nurses was the lead for referrals and checked the status of referrals each week.

Routine referrals could be treated as urgent if the patient was due to deploy. In instances like this, the hospital had the option refer to a local civilian dentist that had a visiting oral surgeon. In addition, referrals could be made to an oral surgery specialist at Wyton Dental Centre or to the enhanced practitioner at Colchester Dental Centre if treatment was within their scope of practice.

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 and recorded for routine procedures. Written consent was secured for extractions. Our review of clinical records demonstrated discussions were held with patients undergoing any operative treatment.

Records showed staff had completed online Mental Capacity Act (2005) as part of their induction. 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 61 patients via our pre-inspection feedback cards. All patients indicating staff were kind, professional and respectful. We were given numerous examples of when the practice had gone ‘over and above’ to support the needs of patients, including referring a patient to the Padre.

The needs of patients with a known dental anxiety were given additional time to discuss their concerns and their wishes were respected. For example, an anxious patient requested a friend to attend with them during treatment and the dental team were able to facilitate this so that the patient was as relaxed as possible during the treatment.

The practice had access to the ‘Big Word’, a translation service for patients who did not have English as their first language. A recent check was undertaken to ensure the translation service was functional and further training in its use was scheduled to take place.

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. A full range of techniques were used to illustrate the treatment needed discussed using all available resources and patients’ records confirmed this. 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 and Defence Primary Healthcare guidelines to determine recall intervals between oral health reviews. All risk markers were considered, including operational demands. The majority of patients were recalled every 12 months with some on a 6 or 18 month recall.

Patients could make appointments between recall intervals depending on the requirement or request. Those reporting pain were usually seen on the same day and patients with an issue not deemed to be urgent were given the next routine appointment.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in March 2025. The premises was not ideal for a person with mobility needs, including those who used mobility aids. A hearing loop was not available based on the needs of people who currently accessed the building.

Accessibility of the dental centre was highlighted on risk register as the dental centre was limited for people with mobility needs. The front entrance had a step and some of the internal non-automatic doorways were narrow. If needed, staff would escort a patient through and ensure doors were opened for them. An access and egress risk assessment was completed in November 2024. There was a ramp access through double doors in another part of the building (not part of the dental centre) providing access to people who used mobility aids and an accessible toilet was available in this area also. An agreement was in place with the Dental Centre at Honington to treat any patients who are unable to access the building.

Staff considered the needs of patients in terms of disability, gender, gender identity, race, religion or belief and sexual orientation. The team had completed the mandated training in equality and diversity and Station-wide training had also been held. Staff completed training in May 2025 about in how to interact appropriately with neurodiverse people including those with a learning disability and/or autism.

Access to the service

We were advised that the appointment diary was regularly reviewed and routinely adapted. Due to increased number of deployments, individuals or units deploying were prioritised for appointments. Feedback suggested some patients raised concern about appointment wait times.

At the time of the inspection, the next available routine appointment with a dentist was within 2 weeks. Appointments for dental target Category 4 were only provided for patients deploying. There were 50 patients on the waiting list for treatments and a small number on the waiting list for the oral health education clinic. Block bookings had been scheduled for 300 service personnel from Swanton Morley who were deploying at the end of the year.

Patients requiring an emergency appointment during working hours could be seen on the same day as there was dedicated hour each morning to accommodate patients with an emergency need. Evening clinics were held if pilots or air traffic control personnel were unable to attend during the day. Text messages were sent to patients to remind them of their appointment.

Waiting times for oral surgery were 6 weeks if local anaesthesia was required and it was over 3 months if a general anaesthetic was needed. Advanced restorative treatment was triaged through the Managed Clinical Network.

Dental out-of-hours (OOH) care was provided all year round through the regional duty on-call rota. 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 and the practice manager deputised. Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. Staff completed complaints training in September 2024 and further training was scheduled June 2025. Complaints were a standing agenda item at the practice meetings. Two complaints concerning clinical care were received in recent months. The patients were interviewed and clinical care was continued at other dental practices due to lack of resources at the practice.

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 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."

With workforce turnover and requirements across the region, the staff team was new with the SDO taking up post in August 2024 and the practice manager in October 2024. The practice was supported by visiting dentists and locums until the very recent recruitment of a dentist and dental nurse. A dental hygienist and another dentist was due to start in the summer of 2025.

The Senior Dental Officer (SDO) described good communication with the Chain of Command and the practice was represented at the Commanders Executive meetings and unit meeting at Swanton Morley. The SDO also had good links with the Senior Medical Officer at the medical centre. Effective communication pathways were in place with Regional Headquarters (RHQ) and to address the workforce limitations with RHQ supportive of the need for the practice to focus on clinical operational delivery.

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 SDO with both 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. Staff had received training in using the HAF.

The last internal assurance review was undertaken 2 weeks before this inspection. We were advised that no significant concerns had been identified. A management action plan had been developed and all actions completed.

With the responsibility for risk management, the SDO shared the practice risks at the Command Executive Meetings. The infrastructure and workforce continuity were the main risks and were monitored at the practice meetings and through RHQ reviews.

A team communication structure was established, including a monthly practice meeting. In addition, staff briefings were held weekly to coordinate work for the week and to share any necessary information, such as ASERs and medical alerts.

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.

The SDO was the data protection lead and the practice manager deputised. 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 next due in June 2025.

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 use for food waste and mixed recycling. Stock was effectively managed to reduce wastage.

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 transparent 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. Staff were encouraged to promote their ideas in staff meetings and said they were empowered to speak up. They were involved in decision making about the service, including service developments. Given the infrastructure issues, the team worked hard to find workarounds and made the most of the current situation to deliver the best clinical care.

A ‘thank you’ scheme of staff rewards was in place. ‘White space’ days were usually held quarterly with Honington Dental Centre but had lapsed for Marham Dental Centre given the increased workload with Operation Highmast.

There was a sense of both pride and team satisfaction at ensuring force preparation for Operation Highmast. It was clear the team had worked diligently and effectively to ensure service personnel were prepared in a timely way. This was reflected in the low number of patients who failed to attend an appointment; 5 appointments were missed in April 2025, amounting to 2 hours of clinical time.

Staff said they were confident any concerns they raised would be addressed without judgement. They were familiar with organisational whistleblowing arrangements.

Learning and improvement

The SDO was the lead for clinical audit and quality improvement activity (QIA); a standing agenda item at the practice meetings. At the time of the inspection, QIA was limited due to the prioritisation of operational requirements within the context of limited staffing levels.

All the required audits had been completed, including infection prevention and control, equality access, clinical waste, radiography and the monitoring of prescribing. Audits were

a standing agenda item at the practice meetings. A periodontal audit was being considered when the new dental hygienist took up post and had completed their induction.

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

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

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. Results of the survey were disseminated by RHQ and analysed by the practice manager. The majority of the feedback was positive with less positive emerging trends related to appointment waiting times and access to hygienist treatment. This mirrored the feedback from our patient survey that complemented this inspection. The patient suggestion box was checked each Friday. Patient feedback was shared with the team during practice meetings.

Opportunities were available for staff to provide feedback, such as at the weekly briefings, practice meetings and through the organisation staff climate survey.