Windsor Dental Centre

Combermere Barracks, Windsor, Berkshire, SL4 3DN

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 Windsor Dental Centre on 11 June 2025.

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

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

This inspection is one of a programme of inspections 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 Windsor Medical Centre, the dental centre is a newly refurbished 2 chair practice that includes a purpose built central sterile services department and laboratory. The practice provides a service to a personnel population of 1,101 including reservists and personnel based at Victoria Barracks located nearby. The practice provides general dentistry with an emphasis on preventative care. Patients can access a hygienist at Pirbright Dental Centre.

Opening times are from 07:45 to 16:30 hours Monday to Thursday (closed for lunch 12:45 to 13:30 hours) and 07:45 to 13:15 on a Friday. A duty Dental Officer is available outside of working hours, at weekends and on public holidays for emergency treatment only.

The staff team

Dentists	Military Senior Dental Officer (SDO) Locum civilian dentist (until the end of June 2025)
Dental nurses	Civilian nurse x 2 Locum civilian nurse (until the end of June 2025)
Practice management	Civilian practice manager

Our inspection team

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

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the SDO, practice manager and clinical staff. 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.
- A 2-year practice development plan was in place and the SDO was considering developing a staff charter.
- 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.
- Clinical waste was overseen by the building custodian based in the medical centre. Some of the clinical waste documentation was incomplete.
- Staffing levels were identified as a risk. Arrangements were in place to provide additional resources when the 2 locum staff leave at the end of June 2025. The SDO planned to monitor the status of staffing each month and report to Regional Headquarters.
- 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. Quality improvement activity (QIA) was key to the service development plan and it was evident QIA had already started to lead to improvements.
- 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:

- Due to inconsistencies for patients accessing OPGs (panoramic dental X-ray), an agreement with the local hospital was developed for OPGs. Putting this structure in place has resulted in the reduction of referral wait times for OPGs by approximately 8 weeks.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

- 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.

The Chief Inspector recommends to the practice:

- Review the process for managing transferred dental clinical waste with the building custodian so the practice is provided with assurance that waste documentation is completed in line with DPHC policy.

- Ensure the safety of the compressor is inspected as part of the 5-yearly fire risk assessment.

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 system (referred to as ASER), a DMS-wide process for the management of significant events. A register of events and incidents was maintained and all staff were registered to the use the system and received ASER training in January 2025.

Staff we spoke with appropriately described the types of incidents reported through ASER and described changes made as a result of ASERs. For example, an ASER was raised in August 2024 following extraction of the incorrect molar at a private clinic which a patient had been referred to. Since then clinicians have ensured referrals include additional information and patients receive an emailed copy of the referral so they are aware of the treatment to be undertaken.

Staff related accidents and incidents not involving the patient care pathway were reported through the ‘MySafety account’. The last reported staff incident was in November 2022. 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.

Staff were also notified of alerts through ‘direction and guidance’ from Regional Headquarters (RHQ). ASER, staff safety incidents and patient safety alerts were a standing agenda item at the practice meetings. Minutes of the meetings were sent to staff who were unable to attend and dates were recorded when staff read the minutes.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead and had completed level 3 training. In the absence of the SDO, staff had access to the level 3 trained safeguarding lead in the medical centre. 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.

Some of the contact details in the safeguarding children, adults and vulnerable people protocol differed to those in the safeguarding adults local policy. The practice manager confirmed promptly after the inspection that this had been rectified and the correct numbers were now in place.

Under 18s were offered a chaperone during consultations/treatment. At the time of the inspection, there was 1 registered patient under the age of 18.

We were given an example of how a safeguarding concern had been managed. The clinician discussed the concern with the SDO who then raised the matter with the

Regimental Medical Officer (RMO) at the medical centre. When the patient missed a dental appointment both the RMO and Chain of Command were promptly informed and a welfare check initiated.

Clinicians were familiar with 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 and staff we spoke with had a clear understanding of what was expected of them regarding the DoC principles. A DoC register was maintained. We noted a recent DoC incident was discussed at a practice meeting and was due for further discussion at the July 2025 practice meeting when the investigation was completed.

Dentists were always supported by a dental nurse when treating patients. Although a practice lone working risk assessment was in place, lone working did not take place as the dental centre was co-located with the medical centre. Each surgery had an alarm button and they were checked as part of 373 weekly/monthly routine checks.

Patients had access to a chaperone and the DPHC chaperone policy was displayed in the waiting area. Patients could be observed in the waiting area from both the dental and medical receptions.

A dental dam was used routinely for endodontics (root canal treatment) and sometimes for other treatments. We were advised that no patients had refused the use of a dam therefore a risk assessment had not been required. Our review of patient records confirmed the use of a dental dam was recorded.

The business resilience plan (BRP) was reviewed in September 2024. Involving all staff, a BRP exercise was held in May 2025. The BRP was initiated in 2024 when a building on the camp was demolished and a fuel tank was discovered. Both the dental and medical centre were shut and patients were seen at Pirbright Medical Centre. Clinical staff relocated to Northolt Dental Centre to help out and the practice manager worked from home or Pirbright Dental Centre.

Medical emergencies

The SDO was the lead for resuscitation and the locum dentist was also qualified as a resuscitation lead. Staff were up-to-date with the required medical emergency training, including Basic Life Support, use of the automated external defibrillator (AED) and anaphylaxis. Besides a patient briefly fainting, the practice had not experienced a medical emergency.

Scenario-based training was held 6-monthly. An asthma and anaphylaxis scenario was facilitated in March 2025 and included how to use the ‘what3words’ app as a location finder was used in the event an ambulance needed to attend the practice. As the ‘what3words’ location was considered more reliable than a postcode, it was included on all the medical emergency cards.

The medical emergency kit and emergency medicines were kept in the laboratory which was unlocked during working hours. It was secured safely when the practice was closed.

The AED and oxygen were checked daily and the emergency medicines were checked weekly. The key for the emergency medicines was stored in a key safe and a key was held by the medical centre and at the guard room. A signature list was maintained for signing out the key from the guard room. We checked the full medical emergency kit and all required items were in place and in-date. As the current contract did not accommodate a spare oxygen cylinder, a local agreement was in place for the practice to use spare oxygen held at the medical centre if needed.

Safe arrangements were in place for the disposal of controlled drugs (medicines with a potential for misuse). Quarterly Buccolam (schedule 3 controlled drug used to manage seizures) checks were undertaken.

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 or NHS 111 out-of-hours (OOH). Opening times and OOH arrangements was displayed on the front door, in the practice information leaflet and explained individually to patients during a consultation if needed.

A recently reviewed sepsis protocol was in place for the practice. Sepsis/deteriorating patient information was displayed in reception and the surgeries. The locum dentist facilitated in-service sepsis training for the team this year. Staff we spoke with 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 for 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. Although some signatures were missing from induction documentation, staff who recently joined the practice described a thorough induction involving shadowing/observation, time to become familiar with policies and complete required training.

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 had completed the Institution of Occupational Safety and Health training and the Health and Safety Risk Assessor course. The SHEF lead role involved ensuring safety of the infrastructure and undertaking risk assessments and managing the risks with sign off from the SDO.

Workplace inspections were undertaken 6-monthly; the most recent was completed in February 2025. A unit SHEF inspection had not been undertaken and this had been added to risk register, including the action taken by the practice to follow this up. The practice manager attended the site infrastructure management meetings. The practice manager for the co-located medical centre was the building custodian.

Risks for the practice were recorded on the regional risk register, which was reviewed by the SDO and RHQ every month. A range of recently reviewed risk assessments were in place including assessments relevant to the premises, staff and clinical care. SHEF and the risk register were standing agenda items at the practice meetings.

The building was refurbished in 2020. Since then, there had been issues with the boiler in that either heating or hot water had to be prioritised for use; the main impact was in the winter. In addition, when the air conditioning unit was in use it needed to be on the same setting (hot or cool) in every room otherwise it would not work. These issues were identified on the risk register and had been reported. As there was no easy or cost effect solution, the practice had a workaround to managing the situation. Infrastructure and faults was a standing agenda item at practice meetings.

The 5-yearly fire risk assessment was undertaken by the fire safety officer in December 2020 and it identified the building as a tolerable risk. The building custodian at the medical centre coordinated the routine fire checks. The fire alarm was checked weekly and firefighting equipment and evacuation measures were checked each month. Staff confirmed they participated in fire evacuation drills every 6 months.

Control of Substances Hazardous to Health (COSHH) risk assessments were in the process of being reviewed given the recent change of SDO. Hard copy and electronic copies of the risk assessments were available to staff. Data sheets were in place and a quick reference guide was displayed for action to take in the event of an incident involving a COSHH product. The contracted cleaner kept cleaning products in a lockable cupboard and held a copy of the company’s COSHH risk assessments.

The safety of water was monitored and the practice had access to the legionella management and control risk assessment report completed in April 2025. We confirmed the contractor carried out monthly, quarterly, six-monthly and annual water checks. The practice manager was following up with the contractor on temperatures identified as outside of parameters. In addition, they were following up on the descaling of showers and taps as it was identified in the legionella risk assessment as incomplete.

A range of tests were undertaken of dental unit waterlines including flushing for 2 minutes twice a week, water quality checks and monthly dip slide testing for monitoring microbial contamination. Quarterly water quality check certificates were in place for the surgeries and reverse osmosis (water purification process). Amalgam separators (to reduce the amount of amalgam in dental wastewater) were integral to the dental chairs. Amalgam waste pots were also available in the central sterile services department (CSSD).

The practice adhered to relevant safety laws when using needles and other sharp dental items. The sharps procedure was displayed in the 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. The May 2025 scheduled training in snapping ampoules was cancelled due to a shortage of staff and had been re-arranged to take place in June 2025. Sharps incidents were reported using the MySafety and/or ASER systems. Arrangements were in place for blood tests to be taken at the medical centre in the event of a staff member sustaining a sharps injury. DoC principles were followed if the sharps injury involved a patient. There had been no sharps injuries in the last 12 months.

Infection control

One of the dental nurses was the lead for infection prevention and control (IPC) and had completed the required training for the role. All staff were in-date for IPC training. IPC was a standing agenda item at the practice meetings.

Arrangements were 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. The business continuity plan included a section about the action to take if there was an outbreak. IPC audits were completed between March and February 2025.

Cleaning of the premises was undertaken twice a day with a schedule in place outlining the cleaning arrangements for each area and frequency. A log was maintained by cleaning staff to confirm cleaning had taken place. A decline in environmental cleaning standards was identified from the IPC audit and added to the risk register. These concerns had been raised with the cleaning contractor and the Quarter Master (QM). The practice manager was monitoring the quality of cleaning through spot checks and reported monthly to the QM. Arrangements for deep cleaning was in place and the last deep clean took place in April 2025.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) online. The CSSD clearly identified clean and dirty areas. A decontamination risk assessment had been undertaken. Although we identified some recording gaps in the paperwork, our overall review of the decontamination process showed a safe process was in place.

A recently reviewed clinical waste protocol was in place for the practice. With the building custodian taking the lead, clinical waste from the dental centre was transferred to the medical centre. We identified inconsistencies with consignment notes in comparison to the waste recorded on the clinical waste log. The practice did not undertake their own checks to cross-reference consignment notes with the waste log. In addition, there were gaps in the log, such as waste collection dates. Transfer notes were not available to confirm how chemicals were disposed of. The pre-acceptance clinical waste audit was completed in March 2025. Secure storage for clinical waste was located outside the building.

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

Equipment and medicines

The practice manager was the lead for equipment care and a list of all equipment held at the practice was maintained, including equipment disposed of and transferred out. The equipment care policy and fault reporting process was displayed for staff to access. 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, reverse osmosis and autoclave. Electrical Equipment Testing was carried out in May 2025 except for 1 item that was missed during the testing; the practice manager was following this up. An equipment audit (referred to as a LEA) was due in June 2025. The practice manager carried out snap equipment checks monthly and equipment care was a standing agenda item at practice meetings.

Although not specifically referenced in the fire risk assessment, equipment was considered as part of the assessment. Recent organisational changes now require that safety of the compressor is specifically referenced in the fire risk assessment. Evidence was in place to demonstrate the compressor was maintained by a specialist engineer quarterly and checked bi-annually for air quality control. In addition, we were provided with evidence to confirm a visual safety check of the compressor was carried out each week by the unit.

One of the dental nurses was the lead for stock control and other members of staff could order if the lead was absent from the service. An order list was held at reception which staff could add to. Climate control was available in the stock room. Regular checks of the surgeries were undertaken to ensure materials were in-date. We checked the surgeries and they were clean and tidy. All equipment was latex free.

The medicines management protocol for the practice had recently been reviewed. Prescriptions forms were held securely and an electronic log maintained of prescriptions issued. The log was checked by the practice manager to ensure no prescription numbers had been missed. Pharmaceutical fridge temperatures were monitored and recorded daily; temperatures were within the expected range. The practice manager was arranging for the installation of a controlled drugs key press.

Evidence was in place of regular prescription tracking and review of prescribing patterns. The Scottish Dental Clinical Effectiveness Programme guidance was followed, including a formula log for diagnosis and reason for prescribing. Patterns indicated prescribing was mostly for fluoride toothpaste. The SDO was new to practice and planned to complete an antibiotic prescribing audit.

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. 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 the 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) and was regularly serviced by MDSS. In-service image quality checks were undertaken daily. Staff requiring IR(ME)R training had received relevant updates. A radiology audit was in progress for June 2025.

Are Services Effective?

Monitoring and improving outcomes for patients

Through discussion with clinicians, review of patient records and a recent records audit, 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, pericoronitis (gum inflammation) and caries (tooth decay).

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.

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.

Service personnel were at high readiness to deploy so occupational preparation was a key focus for the practice, particularly in relation to wisdom teeth and the dental target categories for deploying personnel. Clinical records indicated patients received an appropriate risk assessment of their dental health, including consideration of each individual's occupational role and tasking.

The military dental fitness targets were closely monitored by the Senior Dental Officer (SDO) and were a standing agenda item at the practice meetings. The SDO reported that the practice had not met the targets in the last 6 years. Coupled with high readiness, the patient population had high treatment needs so the practice's focus was on prevention more so than targets to ensure readiness for deployment. The SDO had developed a tracker to monitor the status of dental targets, which showed a gradual improvement in meeting the targets. For example, the percentage of service personnel fit to deploy (categories 1/2) had increased from 70% to 81% since March 2025. This upward trend may likely drop once the locum dentist leaves at the end of June 2025.

Health promotion and prevention

One of the dental nurses was the lead for oral health education (OHE) and had applied for the OHE training course in July 2025. 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.

Patient-orientated OHE information in the patient waiting area was refreshed each month to reflect national and organisational strategy. A 'National Smile Month' display was in place at the time of the inspection.

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. Smoking cessation leaflets were given to patients and alcohol advice leaflets depending on the AUDIT-C score (assessment to identify at-risk drinkers).

During the refurbishment, wiring to the screen for the SDO's surgery to show X-rays and OHE information to patients was damaged and we were advised it was too complex to fix. Instead, the SDO displayed OHE information on the ceiling above the dental chair. In addition, dentists advised patients about lifestyle choices and habits that could have an adverse impact on their dental health. Patients were asked to bring their own toothpaste and toothbrush so the quality of the materials they used for cleaning teeth could be assessed, including how they used their toothbrush.

High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available. There was a high use of fluoride varnish at BPEs confirmed by the prescribing audit, and fissure sealants were used as a preventative measure. Because of the high prevention needs of the patient population, the SDO planned to carry out a caries audit. Patients could be referred for alcohol and smoking cessation at the medical centre. This was mainly self-referral on advice from the dentist rather than a formal pathway.

Staffing

As the practice team was small there was limited resilience to cover any staff absence or vacancy. The practice had had a temporary uplift in the workforce with a locum dentist and dental nurse joining the team. Both locums were due to finish at the end of June 2025 as further funding was unavailable. This issue was identified on the risk register. The plan was to backfill the positions with temporary military staff. For example, the SDO from Northolt Dental Centre will be working for a few months from Windsor Dental Centre while Northolt Dental Centre is being refurbished. The SDO planned to risk assess the situation each month and report to the subregion/Regional Headquarters a request for locum staff if needed.

The practice manager monitored the status of mandatory training, which was also reviewed at the practice meetings. Training was recorded on the Defence Primary Healthcare Dental Personnel Management System. Staff told us were given time to complete training. At the time of the inspection, staff were up-to-date with mandated training.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. The SDO was the regional training lead and organised virtual and face-to-face events. To support with CPD, all staff could attend regional training events, dental conferences and in-service training. Defence Primary Healthcare (DPHC) webinars were available for staff via the 'Agilio' online training platform. It was discussed at last practice meeting allocating dedicated CPD time for staff.

Working with other services

The SDO attended the quarterly Commanders Monthly Case Review meeting either in person or virtually, at which the dental targets were reviewed. Video conferencing was used for informal discussions to ensure local unit cohesion This level of engagement had supported with a decrease in the number of service personnel failing to attend appointments.

Clinicians had an effective relationship with medical centre staff and could discuss referrals and concerns about patients with the doctors. The SDO engaged with the regional team every 2 weeks and had one-to-one time with the regional SDO.

The SDO oversaw referrals and had recently reviewed the referrals protocol. The DPHC electronic referral system was used for hospital referrals and those to the Defence Centre for Restorative Dentistry. In addition, an OPG referral log and dental downgrade log was maintained. These were checked monthly by the SDO and comments added to show checks were completed. Two-week-wait referrals for patients with suspicious lesions were monitored by the referring clinician.

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.

Written consent was taken for all extractions and root canal treatment and the locum dentist also secured written consent for some crowns. Verbal consent was taken for all other treatments.

Staff completed Mental Capacity Act (2005) training early in 2025 and 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 26 patients via our pre-inspection feedback cards. We also reviewed feedback submitted by 48 patients through the Defence Primary Healthcare patient experience survey (March – April 2025). All patients spoke highly of staff with references to staff being kind, calm professional and respectful.

Measures were in place to support patients who experienced dental anxiety including acclimatisation, longer appointments, the use of music and general conversation to relax/distract the patient. Feedback from patients included the following, “I was really nervous but well looked after” and “amazing experience for what can be often daunting”.

Staff described occasions when the practice had gone ‘the extra mile’ to support patients. For example, a patient was downgraded for 2 years due to dental phobia and was unable to attend for treatment. The patient was given additional time for appointments and simple restoration work was undertaken initially until the patient was able to accept extractions. The patient provided positive feedback on their experience.

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

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 plan. Examples included showing patients dentures, bridges and crowns. Clinical flip charts were used to illustrate progression of periodontal disease. The Senior Dental Officer was keen to create quick response/QR codes for patient patients rather than long print outs.

Are Services Responsive?

Responding to and meeting patients' needs

Alongside clinical judgement, dentists referenced National Institute for Health and Care Excellence and Defence Primary Healthcare (DPHC) guidelines to determine recall intervals between oral health reviews. Patients with a high oral health need were recalled every 6-9 months, those with a medium need were recalled every 12 months and it was a recall of 15-24 months for patients who were a low risk.

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. There was ramp access and automatic doors to access the building and an accessible toilet. A hearing loop was not required based on the needs of people who currently accessed the building. The building custodian had made a request for an accessible parking space to be made 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 the mandated training in equality and diversity. In addition, they completed training in April 2025 about how to interact appropriately with neurodiverse people, including those with a learning disability and/or autism.

Access to the service

Routine dental appointments could be booked 2-3 weeks in advance. There was a 4 week wait for an appointment with the hygienist at Pirbright Dental Centre. Access to the hygienist was outlined in the patient information leaflet. Patients requiring an urgent appointment during working hours could be seen on the same day as there was a dedicated appointment slot at 10:00 hours to accommodate patients with an emergency need. Patients were requested to book the emergency slot before 08:00 hours on the day so the slot could be used for a routine appointment if unfilled. The Senior Dental Officer (SDO) planned to complete an audit of the emergency slot utilisation within the next few months.

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 SDO was the lead for complaints. Complaints were managed in accordance with the DPHC complaints policy. Staff we spoke with said they had completed complaints training.

Complaints were a standing agenda item at the practice meetings. Two complaints were received between January 2022 and October 2024.

Patients were made aware of the complaints process through the practice information leaflet and the complaints policy was displayed in the waiting area.

Are Services Well Led?

Governance arrangements

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

> "DPHC is to continue to provide safe and effective healthcare, which meets the needs of the patient and the chain of command in order to contribute to Fighting Power".

The Senior Dental Officer (SDO) was the lead for healthcare governance and since taking up post 3 months ago they had developed a service development plan for the next 2 years. Three stages were identified in the plan:

> Phase 1 – understand and build
>
> Phase 2 – deliver
>
> Phase 3 – sustain

Phase 1 was in progress and included the strengthening of relationships with units. The SDO attended the Commanders Monthly Care Review meetings and held informal meetings with unit commanders. This level of engagement had led to a reduction in the number of missed dental appointments. The SDO was exploring developing a team charter.

The SDO also had good links with the Senior Medical Officer at the medical centre and effective communication pathways were in place with Regional Headquarters (RHQ) and the Network Regional Dental Officer (NSDO).

A framework of up-to-date organisational policies, standard operating procedures and protocols underpinned governance activity. Local protocols were held online and were referenced during induction and staff training. Staff skillsets were effectively used, such as for lead roles. Terms of reference were in-date for all staff.

The practice used the Health Assessment Framework (HAF), the internal quality assurance tool, to monitor safety and performance. One Key Line of Enquiry was assessed each month by the SDO and practice manager.

External and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the SDO and a monthly report produced for the NSDO. RHQ monitored clinical performance and reviewed patient feedback.

The last internal assurance review was undertaken in April 2023. All but 3 actions on the management action plan had been completed. These were putting a 'you said, we did' board' in place, seeking clarity on the major incident plan and securing an accessible parking space.

The risk register was checked by the SDO and practice manager each month. Any changes were discussed with the staff team at the practice meetings who were invited to raise any other risks they had identified. The NSDO was kept informed of pressing risks during the fortnightly meetings with the SDO. The risk register was reviewed by RHQ each month. Workforce resilience was the key risk for the service. Constraints in relation to the boiler and climate control and the risk of clinical demand exceeding clinical capability were considered a threat or potential risk.

A team and wider communication structure was established, including a monthly practice meeting and 4 weekly Pirbright Network meeting. The SDO met with the NSDO for fortnightly briefs and with the regional SDO monthly. The monthly regional meeting (including training) was available to all staff.

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 Caldicott Guardian to ensure confidential patient information was protected. Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. All staff were in-date for data protection training and received in-service Caldicott training in February 2025. Following the inspection, Caldicott was added to the ASER tracking log as a Caldicott breach would be raised under this system.

A notice in reception advised patients of confidentiality arrangements. Measures taken to protect patient information included the use DMICP (patient electronic record system) numbers rather than names or service numbers for all laboratory work. Furthermore, recall lists were published on routine orders but no details about treatments required or the dental category were used on these.

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 available and stock was effectively managed to reduce wastage. Staff aimed to car share or use public transport when attending meetings and training events.

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 SDO and practice manager, indicating they promoted a collaborative leadership culture. Staff we spoke with confirmed they were empowered to share ideas and concerns and were involved in decision making about the service, including service developments.

The SDO was keen to introduce delegation and involve all staff with quality improvement activity and taking on additional secondary roles. 'White space' team building events were held with the most recent taking place in May 2025.

Staff said they were confident any concerns they raised would be addressed without judgement as practice leaders were approachable. They were familiar with organisational whistleblowing protocol for the practice and would approach the NSDO or regional team if it was not appropriate to raise a concern at practice level.

Learning and improvement

The SDO was the lead for clinical audit and quality improvement activity (QIA); a standing agenda item at the practice meetings. Even though required audits had been completed, the SDO identified QIA as an area for development. A schedule of quality improvement plans had been identified as part of the service development plan with projects allocated to individual staff. A spreadsheet of QIA, including ideas for audit, had been developed and progress was monitored at practice meetings. A periodontal pathway review and prescribing audit were scheduled for the next quarter. Discussions were taking place about formalising the hygiene pathway.

There was evidence in place of action taken and changes made as a result of audit. For example, a clinical record keeping audit carried out in May 2025 led to revisions made to how consent was recorded. In addition, the agreement developed for the acquisition of OPGs at the local hospital has resulted in a reduction referral wait times by approximately 8 weeks.

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 manager was the lead for patient engagement. 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. By placing the patient feedback QR code in the surgeries rather than just on the wall by reception, staff reported there was a significant increase in the response from patients. Patients also had the option of leaving feedback in the suggestion box in the waiting area. Patient feedback was reviewed by the SDO each month and shared with the staff team at practice meetings. The feedback we reviewed was exceptionally positive.

The practice acted on feedback. For example the practice responded to feedback about the phone not being answered in a timely way. This had happened when the practice was short of staff. As a result, the answerphone message was amended and a message sent to units to inform them it may take longer for the phone to be answered.

At the time of the inspection, the regional team were running a climate survey. The SDO planned to complete a local climate survey to seek staff feedback about the service.