Cosford Dental Centre

RAF Cosford, Albrighton, Wolverhampton. West Midlands, WV7 3EX

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 Cosford Dental Centre on 29 July 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

Cosford Dental Centre supports a patient population of 1,670 that includes Phase 2 trainees attending courses and the Parsons Barracks, a local British Army Base.

It is a 5-chair practice providing general dentistry with an emphasis on preventative care. Patients can be referred to Queen Elizabeth Hospital, Birmingham, for minor oral surgery and internal referrals are made via the Restorative Managed Clinical Network. In addition, an enhanced practitioner visits the practice once a week to provide restorative and endodontic treatment (root canal treatment).

The dental centre is open from 08:00 hours to 17:00 hours Monday to Thursday and from 08:00 hours to 13:30 hours on Friday (closed for lunch 12:00 to 13:00 hours and Friday afternoons). Wednesday afternoon is dedicated time for staff training and operational meetings. A regional service provides cover for emergencies out-of-hours, including weekends and public holidays.

The staff team

Dentists	Military Senior Dental Officer (SDO) MOD dentist Military enhanced dental practitioner (once a week)
Dental nurses	Civilian nurse x 2 Military nurse x 1 Student dental nurse
Practice management	Military practice manager
Hygienist	Civilian Hygienist x 1

Our inspection team

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

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the 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.
- Leadership at the practice was inclusive, collaborative and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Effective systems were in place to support the governance and risk management of the practice.
- 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.

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

- The SDO introduced a leaflet on periodontal staging to facilitate patient understanding of the periodontal care pathway, especially the importance of seeing the oral health dental nurse initially. The team reported this had been a very successful introduction leading to a reduction in a recent theme of patient grumbles because they expected to have access to a hygienist appointment in the first instance.
- Although the practice did not treat children, the dental nurse facilitated a session on oral health for the children at the station nursery last year. This included an age-appropriate story telling session about oral hygiene and providing samples of toothbrushes and other resources for the children. Information leaflets were also sent home with the children for their parents to read. In addition, free sample packs of children's toothbrushes and toothpaste were available in reception. The nurse planned to provide a further session this year.

The Chief Inspector recommends to 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:

- Consider replacing the carpet in the clinical area corridor with clinical flooring.
- Consider developing a local process for the regular auditing of clinicians' record keeping so the quality and safety of dental care provided can be consistently assured.

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 records confirmed all staff had received ASER training and were registered to use the system.

Staff we spoke with appropriately described the types of incidents reported through ASER. ASER was a standing agenda item at the practice meetings. No ASERs had been raised in the last 12 months.

Staff related accidents and incidents not involving the patient care pathway were reported through the 'MySafety' system. Such incidents were escalated to the practice manager or Senior Dental Officer (SDO). 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.

The practice manager was notified of Central Alerting System (CAS) medical alerts through 'direction and guidance' from Regional Headquarters. Action taken by the practice was recorded on the regional CAS register. CAS alerts were a standing agenda item at practice meetings.

Reliable safety systems and processes (including safeguarding)

The SDO was the designated safeguarding lead. The local safeguarding policy was available in reception for staff to access. All staff were up-to-date with safeguarding training at a level appropriate to their role, including the SDO who was trained to Level 3 safeguarding for adults and children.

Staff we spoke with were aware of their responsibilities if they were worried about the safety of patients who were vulnerable due to their circumstances. They provided examples of how potential safeguarding concerns had been raised and managed. Unit safeguarding meetings were held at which concerns could be raised.

The practice manager carried out DMICP (patient electronic record system) searches each month to identify patients under the age of 18. At the time of the inspection, there were 82 registered patients under 18. A local unit policy was in place regarding the care of under 18s.

Duty of candour (DoC) guidance was displayed and the staff had completed relevant training. The DoC principles is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. DoC breaches were reported through the ASER system. Staff we spoke with understood what was expected of them regarding the DoC principles. We were given an example of a DoC incident involving

an ultrasonic scaler tip fracture. The patient was informed of the incident and an ASER was raised.

Dentists were always supported by a dental nurse when treating patients. In accordance with Defence Primary Healthcare Policy (DPHC), the dental hygienist did not work with a nurse except on occasions when a nurse provided assistance with charting and aspiration. If the patient felt uncomfortable with the hygienist working alone then the support of a nurse would be requested. All surgeries were fitted with a panic button that alerted the reception when activated; reception was always staffed.

A lone working policy was in place along with a risk assessment that was reviewed in January 2025. It was only cleaning staff who worked alone in the building and they operated a clocking in and out system as well as a 'buddy' process to ensure they had access to another member of the cleaning team.

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

A dental dam was used for all endodontic procedures. If of benefit, the SDO used a dam for restorative procedures. The SDO advised that they would not undertake endodontic treatment if the patient refused the use of a dam as the risk increased without a dam in place.

A business continuity plan (BCP) was in place and last reviewed in November 2024. The practice buddied with Shawbury Dental Centre so each had access to each other's DMICP and could contact patients to cancel their appointment in the event of power outage/IT loss.

Medical emergencies

The practice manager was the lead for resuscitation and one of the dental nurses was the nominated first aider. All staff were up-to-date with annual medical emergency training, including Basic Life Support, use of the automated external defibrillator (AED) and anaphylaxis. Both the medical emergency protocol for within and outside of working hours was displayed. The medical centre was located nearby for support in the event of an emergency next door and contact numbers were displayed. A medical emergency training exercise was carried out whereby the drill for incidents and emergencies was tested.

Staff participated in regular scenario-based training with areas of good performance and areas for development identified. These included impromptu scenario-based training sessions involving the practice manager activating the alarm and 1 of the staff presenting with a medical emergency. Conditions covered recently included chest pain and a seizure. Staff told us they valued this type of training as it was a very useful learning approach involving the whole team. Local medical emergency protocols were displayed in each surgery.

We were given an example of when staff responded promptly to a patient with a high temperature who was feeling generally unwell. They were sent to the medical centre and anaphylactic shock was diagnosed.

The medical emergency kit was stored in the central sterile services department (CSSD) which was easily accessible to all staff. Controlled drugs (medicines with a potential for misuse) were securely held in a safe in the CSSD. The safe was left open for clinical staff during clinical sessions and was locked at lunchtimes and in the evening. Patients had no access to the clinical areas without supervision. Glucagon (medicine used to treat low blood sugar levels) was stored in the pharmaceutical fridge in in the dental laboratory.

Records showed the AED, emergency medicines and oxygen were checked daily. Weekly checks were carried out for all other equipment. We reviewed the full medical emergency kit and emergency medicines; all required items were available and in-date. The biohazard spill kit, eye care and mercury spillage kits were checked regularly to ensure they were in-date. Medicines were disposed of through the medical centre. Safe arrangements were in place for the disposal of controlled drugs.

Measures were in place to ensure patients understood what to do if they experienced pain or their condition deteriorated following treatment. The dentists discussed potential risks with patients and they were advised to contact the practice during working hours and the dentist on-call or NHS 111 out-of-hours (OOH). Opening times and OOH arrangements were displayed on the front door, in the practice information leaflet and explained individually to patients during a consultation if needed.

The staff had completed sepsis/deteriorating patient training both on-line and as an in-service training session. The success of this training was evident when a dental nurse identified a patient was displaying symptoms of sepsis following treatment at an external facility. The patient was admitted to hospital and a diagnosis of sepsis was confirmed.

Staff recruitment

The practice manager had oversight of the recruitment for permanent and locum staff. Although the full range of recruitment records for permanent staff was held centrally, staff packs were sent to the practice manager for checking and review ahead of employment. Evidence was in place to confirm that recruitment checks had been completed for staff new to the practice. This 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 required for their role were also monitored.

A member of staff who recently joined the practice described a thorough induction involving shadowing/observation, time to become familiar with policies and time to complete the required training.

Monitoring health & safety and responding to risks

The SDO was the risk manager and the practice manager was the building custodian and lead for safety, health, environment and fire (SHEF). The risk register was regularly reviewed and updated. Regional Headquarters also carried out reviews of the risk register each month. At the time of the inspection, carpet in the clinical corridor was the only risk on the register. Reviewed in January 2025, a range of risk assessments were in place including assessments relevant to the premises, staff and clinical care. SHEF was a standing agenda items at the practice meetings.

The practice manager was the designated lead for Control of Substances Hazardous to Health (COSHH). Reviewed annually and with oversight from the station environmental team, a range of COSHH risk assessments were in place. COSHH data sheets and risk assessments were held electronically and in paper format so were readily accessible to staff. The contracted cleaner kept cleaning products securely in the medical centre and had access to a copy of the company's COSHH risk assessments and data sheets. These were also held at the practice.

The 5-yearly fire risk assessment (FRA) was undertaken by the fire safety officer in June 2024 and it identified the building as a tolerable risk. Although the compressor was not specifically referred to in the FRA, a sample of electrical equipment was inspected as part of the assessment. The practice manager confirmed the fire inspector had scheduled to complete a specific FRA of the compressor on 27 August 2025. The fire action plan was displayed and staff confirmed they participated in fire evacuation drills with the last taking place in March 2025.

The station fire unit monitored the practice's firefighting equipment with the most recent checks completed in June 2025. Records were maintained on the unit spreadsheet and the Station Commander had oversight. In addition, records showed the practice manager also conducted building and fire safety checks each month.

The practice legionella risk assessment was reviewed in November 2024 and included a link to the station legionella risk assessment and action plan. The unit completed water safety checks, including temperature checks, and forwarded the results to the practice manager.

Staff adhered to relevant safety laws when using needles and other sharp dental items. The sharps exposure/injury procedure was displayed in the surgery 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 and the snapping of ampoules. Sharps injuries were managed in line with DPHC policy and incidents involving sharps were reported using the 'MySafety' and ASER systems. Details of how to access occupational health for advice and support was available. The practice had experienced no sharps injuries in the last 3 years.

Infection control

One of the dental nurses was the lead for infection prevention and control (IPC) and had completed level 3 IPC lead training. All staff were in-date for IPC training.

We found that IPC measures at the practice were of a high standard, which supported with minimising the spread of infectious diseases. Hand washing guidance was displayed in clinical areas and toilets. Hand sanitiser was available and there was access to a sufficient stock of personal protective equipment. Audits by the IPC lead were routinely undertaken to monitor IPC standards. No major concerns were identified from the audits.

Cleaning of the premises was completed daily 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. We noted that the premises was extremely clean and tidy confirming cleaning was carried out to a high standard. Arrangements were in

place for an annual deep clean of the premises and additional deep cleans could be requested via the cleaning manager.

The cleaning contract was overseen by the practice manager who had good relationship with the cleaning manager. The cleaning manager conducted 'spot checks' regularly to ensure the contract was being adhered and standards maintained. We were advised that the practice manager could request additions or changes to contract should it be required, and requests had previously been made with no issues.

The corridor in the clinical area was carpeted and staff had submitted a statement of need for it to be replaced with clinical flooring.

Water quality checks of dental unit waterlines were routinely undertaken by the IPC lead. We had access to the results, which were held electronically. Copies of result letter from external testing of water quality was retained. Amalgam (material used for fillings) separators (to reduce the amount of amalgam in dental wastewater) were integral to the dental chairs.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) on the practice's SharePoint site. A comprehensive process was established for the decontamination of dental instruments, which aligned with HTM 01-05 and DPHC standards. Used dental instruments were pre-soaked in the surgery, which we checked and confirmed met requirements. They were then transported in lidded boxes to the CSSD. The CSSD was new and was well-organised with a clearly defined flow from dirty to clean areas to ensure the safe and efficient handling of instruments to minimise the risk of cross-contamination.

Clinical waste was safely managed including extracted teeth, gypsum (for taking dental impressions) and amalgam. A waste log and consignment notes were in place and up-to-date. The annual pre-acceptance clinical waste audit was carried out in March 2025. The clinical waste bin was locked and stored outside. The area it was located in did not have a structure nearby to secure the bin to. To address this, the practice completed a risk assessment. Given the level of security on the station, theft of the clinical waste bin was a low risk.

Staff were aware of the 2023 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 equipment care manager. Records showed equipment was appropriately checked, including the annual servicing of clinical equipment by the medical and dental servicing section (a military capability referred to as MDSS). Electrical Equipment Testing was undertaken in July 2025. A faults log was maintained to ensure all issues were accurately recorded and tracked for timely resolution. Out-of-date or broken equipment was labelled and segregated into the store to await repair or disposal via the regional equipment manager.

Organised via the station and carried out by qualified engineers, the compressor was routinely checked and serviced. The practice had a copy of the service certificate from June 2025. The compressor was due for a further check in August 2025. The practice had

been provided with a key to the compressor storage unit so had started to undertake monthly checks. The practice manager liaised with the station compressor manager regarding the contract, particularly if they had any concerns. The BCP included a section on the action to take in the event of compressor failure.

Dental stock was effectively managed. Regular checks of the stock were undertaken to monitor materials were available and in-date. We checked the surgeries and they were clean and tidy. All equipment was latex free. Ambient temperatures were monitored through the use of thermometers in key areas; temperatures were checked and logged twice a day. The pharmaceutical fridge temperatures were monitored and recorded twice a day; temperatures were within the expected range.

Prescription forms were held in reception in a locked cabinet. All prescriptions issued were recorded on a paper prescription log held at reception and later transferred onto an electronic log by the MOD dentist. The use of antibiotics was audited quarterly and assessed against professional guidelines.

Radiography (X-rays)

Suitable arrangements were in place to ensure the safety of the X-ray equipment, including a radiation protection file that contained the required documentation. A Radiation Protection Advisor for the practice was identified. The SDO at Shawbury Dental Centre was the Radiation Protection Supervisor (RPS) until the SDO at Cosford Dental Centre had completed the required training.

Appropriate signage was displayed on the door of the surgery to indicate X-rays took place. 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. A rectangular collimator to reduce unnecessary radiation exposure was used. All staff wore dosimeters (to monitor radiation exposure) and these were changed monthly. The SDO reviewed the data monthly to ensure staff had not been exposed to excessive radiation.

X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R) and was regularly serviced by MDSS. Clinicians had received IR(ME)R training updates.

The SDO continually quality assured the X-rays they took and captured the results on a personal spreadsheet. We discussed with the SDO the option of a centralised record of radiographic quality assurance for all clinicians which was held on the dental centre Sharepoint for overview of acceptable/unacceptable scores. Radiology and intraoral radiology audits were completed in October 2024 and an imaging audit in January 2025.

Are Services Effective?

Monitoring and improving outcomes for patients

From discussions with clinicians and a review of patient records, we confirmed the treatment needs of patients were assessed in line with organisational policy and recognised national guidance, including National Institute for Health and Care Excellence (NICE) and College of General Dentistry guidance. NICE guidelines were followed for the management of wisdom teeth or third molars and dental recall.

Guidance from the British Society of Periodontology (BSP) was adhered to in relation to periodontal disease (inflammation of tissues supporting the teeth), including staging and grading, confirmed through our review of clinical records. The hygienist had the BSP guidance displayed in surgery and referred to it regularly.

The Senior Dental Officer (SDO) considered occupational requirements when planning treatment for patients, such as the prioritisation of deploying personnel. Furthermore, each individual's occupational role and tasking was taking into account. For example, treatment was coordinated to ensure aircrew were not flying 12 hours after a local anaesthetic. Patients were downgraded if they were assessed as systemically unwell.

Our review of a range of dental records confirmed an assessment, including information about the patient's current dental needs, past treatment, medical history and treatment options were routinely undertaken. The diagnosis and treatment plan for each patient was 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. 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.

We noted some deficits with the record keeping for one of the clinicians, mainly in relation to recording sufficient detail and how DMICP was used. This had been identified as an area for improvement on the clinician's Clinical Quality Assurance and Appraisal (commonly known as CQAA), an internal process to ensure the quality and safety of dental care provided to service personnel. We discussed this with both the clinician and the SDO, including measures planned and further options that could be taken to provide support with record keeping. We were assured action would be taken.

The military dental fitness target framework was closely monitored by the SDO and staff team. The targets for July 2025 were in a good place with Category 1 and 2 at 85%, Category 3 at 6% and Category 4 at 9%.

Health promotion and prevention

The hygienist was the lead for oral health education (OHE) and a dental nurse was the oral health educator. The way in which OHE was delivered aligned with nationally recognised guidance - Delivering Better Oral Health toolkit: a Public Health England evidence-based toolkit on prevention of oral diseases, such as caries (tooth decay).

The SDO introduced a leaflet on periodontal staging to facilitate patient understanding of the periodontal care pathway, especially the importance of seeing the oral health dental nurse initially. The team reported this had been a very successful introduction leading to a

reduction in a previous theme of patient grumbles because they expected to have access to a hygienist appointment in the first instance.

Patients were initially referred to the nurse for plaque indices and OHE. Education with the nurse involved a lifestyle assessment, teeth brushing patterns and the use of interdental brushes. Disclosing tablets (harmless dye to highlight dental plaque) were given to patients to map if their oral hygiene was improving. Once OHE was at an acceptable standard, patients were booked to see the hygienist for treatment.

An Audit-C assessment to screen for alcohol use was carried out if excessive alcohol was determined or suspected. Although the hygienist was a qualified smoking cessation advisor, patients were mostly referred to the medical centre. The hygienist provided dietary advice to patients who were at an increased risk of caries; these patients were identified using an additional risk assessment questionnaire prior to a hygiene appointment.

The hygienist referred to the dentist for prescriptions of high fluoride toothpaste. Dentists usually prescribed topical fluoride varnish; if it was not prescribed, the hygienist requested this be added to the patient's treatment plan. Fissure sealants were usually carried out by dentists because, without a nurse present, the hygienist found this a challenging procedure to undertake on their own.

Periodontal multi-disciplinary team (MDT) discussions were held between the dentists and hygienist to ensure adequate management of patients. To ensure holistic management, the MDTs included the management of patients with severe disease or those who were not responding to treatment.

Patient-orientated OHE information in the patient waiting area was regularly refreshed to reflect national and organisational strategy. In response to the Defence Primary Healthcare's (DPHC) guidance on 'dental tourism' ('Turkey Teeth') for cosmetic procedures was displayed; the hygienist reported this was a significant issue amongst the patient population. In addition, a leaflet had been introduced by the hygienist on the use of smokeless tobacco because this was identified as an increasing habit for patients. Leaflets were also available for a range of oral health conditions. The 'Top Ten Tips for Teeth' was outlined in the practice's patient information leaflet.

The practice was represented at the annual unit health fair in April 2025. A large focus was on the use of dental shields for contact sports.

Although the practice did not treat children, the dental nurse facilitated a session on oral health for the children at the station nursery last year. This included an age-appropriate story telling session about oral hygiene and providing samples of toothbrushes and other resources for the children. Information leaflets were also sent home with the children for their parents to read. In addition, free sample packs of children's toothbrushes and toothpaste were available in reception. The nurse planned to provide a further session this year.

Staffing

At the time of the inspection, the practice was fully staffed and included a supernumerary student dental nurse. Ideally, the team reported they would benefit from a dedicated receptionist but no funding was available for this role.

Staff new to the practice described a thorough induction and induction paperwork was fully completed. Mandatory training for staff was up-to-date. It was recorded on the DPHC dental Personnel Management System and the practice manager also maintained their own training register. Training was a standing agenda item at practice meetings. At the time of the inspection, all 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. To support with CPD, staff could attend regional training events, dental conferences and weekly in-service training. DPHC webinars were available for staff via the 'Agilio' online training platform.

The Regional Training Lead (SDO at Shawbury Dental Centre) was arranging a Regional Training Day to take place in March 2026. Regional Headquarters were also exploring the option of reinvigorating regional peer reviews.

The student nurse described how they were very well supported and supervised by their dedicated dental nurse mentor, which included regular training/information sessions.

Working with other services

Practice staff worked closely with the units who were pro-active with monitoring dental fitness for deployment. The SDO attended the executive meeting each week and also the monthly unit meetings. The Station Commander was new and we were advised that they were keen to engage with the dental centre.

The MOD dentist was the lead for referrals. The hospital's referral system was used to monitor and track all referrals. As this was held centrally for all Defence referrals, clinicians in all dental centres could review the referrals, follow-up on patients and identify when patients had been waiting too long to be seen. Each clinician reviewed the referrals they made a minimum of 2 weekly, including monitoring 2-week-wait referrals for patients with suspicious lesions.

Patients referred for minor surgery were seen at the Queen Elizabeth Hospital, Birmingham; referrals for service personnel were fast tracked as there was a military maxillofacial surgeon based at the hospital. Referrals made through the Managed Clinical Network were sent to the Defence Centre for Restorative Dentistry and then allocated to the visiting Enhanced Practitioner.

Consent to care and treatment

Feedback from patients confirmed they were given information about treatment options and the risks and benefits of these so they could make informed decisions. Depending on the type of examination or treatment, implied or verbal consent was taken. Written consent was secured for extractions.

The staff team had completed Mental Capacity Act (2005). Clinicians we spoke with had a good awareness of mental capacity and how it could apply to their patient population, including if the patient was intoxicated.

Are Services Caring?

Respect, dignity, compassion and empathy

We received feedback from 65 patients via our pre-inspection feedback cards. All patients spoke highly of the staff with references to staff being kind, caring, professional and respectful.

Staff provided examples of when the practice had gone ‘the extra mile’ to support patients, particularly for visiting overseas military personnel based at the station for training. Only overseas pilots were entitled to dental care at the practice as they had to be dentally fit to fly. The practice was informed when an overseas air force unit was due to arrive. All other overseas personnel were non-entitled and registered with local civilian dental practices. However, the practice treated all overseas patients presenting with acute dental pain. Usually the patient was supported by their English speaking trainer. Alternatively, the ‘Big Word’ translation service or Google Translate were used. The practice had translated the medical history assessment for overseas personnel.

The ’Big Word’ did not provide a Fijian translation service. Along with the practice manager at Ternhill Dental Centre, a Fijian speaking dental nurse at Cosford Dental Centre were working together on translating oral health education leaflets so information was available in Fujian for patients. Once the leaflets have been approved they will be circulated to the region for other dental centres to use. When completed, the intention is to capture this work as a quality improvement project.

Measures were in place to support patients who experienced dental anxiety including working at a pace the patient felt comfortable with, longer appointments and general conversation to relax/distract the patient. The Senior Dental Officer (SDO) advised that if a patient was particularly anxious an alert would be placed on their DMICP record so an extended appointment could be allocated, preferably with the same clinician for continuity.

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 discussions with clinicians and a review of clinical records, we confirmed treatment options were discussed with patients, including material choice for restorative procedures.

The option of no treatment was offered but the consequences of not having any treatment would also be explained. The MOD dentist described a recent complex treatment plan so they asked the laboratory to create some mock-ups samples to illustrate the potential options to the patient as they were concerned the patient had not fully understood the nature of the treatment.

Patients were given explanatory leaflets prior to endodontic treatment. Leaflets were also provided for crowns and pre-operative instructions for extractions. In addition, clinicians used visual aids and models to supplement explanations about periodontitis. The SDO reported that they did not proceed with treatment until they were satisfied the patient fully understood the treatment plan.

Are Services Responsive?

Responding to and meeting patients' needs

Alongside clinical judgement, dentists referenced the National Institute for Health and Care Excellence and Defence Primary Healthcare (DPHC) guidelines to determine recall intervals between oral health reviews. Based on risk, patients over the age of 18 were recalled between 3 and 24 months.

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 November 2024. A hearing loop was not required based on the needs of people who currently accessed the building.

Staff considered the needs of patients in terms of disability, gender, gender identity, race, religion or belief and sexual orientation. Patients' personal preferences were respected. For example, those fasting during Ramadan could defer routine treatment if they felt more comfortable. The Senior Dental Officer (SDO) said that transgender patients were addressed in the manner they preferred and their gender identity respected.

The staff team had completed the mandated training in equality and diversity. In addition, they had completed the training about how to interact appropriately with neurodiverse people, including those with a learning disability and/or autism.

Access to the service

There was a 1 week wait to see a dentist and a wait of 2 weeks for the hygienist. Patients requiring an urgent appointment during working hours could be seen on the same day as dedicated appointments were available each afternoon to accommodate patients with an emergency need. The afternoon was chosen to fit with training programmes. If the emergency appointments were unfilled then they were offered to patients due a routine appointment.

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 and the practice manager was the lead for compliments. Complaints were managed in accordance with the DPHC complaints policy and were recorded on the centralised DPHC complaints register. Staff we spoke with said they had completed in-service training on complaints in June 2025 and training records confirmed this. Complaints was a standing agenda item at the practice meetings.

There had been no recent complaints so we were given an example of a historic complaint and how it was managed. A patient was unhappy that they were not informed treatment could not be provided whilst they had a contagious oral lesion. Although this was dealt with at the lowest level and the patient was content with the outcome, it resulted in additional staff training and a review of how staff communicate with patients.

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

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."

The Senior Dental Officer (SDO) who joined the practice 4 weeks before this inspection was the clinical lead and lead for healthcare governance. The practice manager had the delegated responsibility for the day-to day administration of the service. A framework of up-to-date organisational and local policies, protocols, risk assessments and the risk register underpinned governance activity. These were available electronically and many were printed for ease of access. A protocols folder was held in each surgery.

Staff skillsets were effectively used, such as for lead roles. Terms of reference had been reviewed for all staff in June/July 2025.

Local and regional processes were established to monitor service performance, including the Health Assessment Framework (HAF); an internal quality assurance tool. The HAF self-assessment was retained as a live document so was continually updated. The practice manager kept a record of amendments made to the HAF so the practice could monitor progress made.

Clinical governance was a standing agenda item at the weekly practice meetings. Key performance indicators (KPI) and dental targets were monitored by the SDO. The practice submitted performance data to Regional Headquarters (RHQ) each month. KPIs were checked monthly by RHQ and discussed at weekly meetings with RHQ and the Regional SDO. The last internal assurance review (IAR) was undertaken in 2022 and all previous management action plan actions had been addressed. The next internal assurance review was scheduled for January 2026.

The SDO was the Caldicott Guardian to ensure the confidentiality of patient information was protected. Staff received training in the Caldicott principles in July 2025. Relevant Caldicott information was displayed. Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. 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, recycling bins were available, single-use items were used only when necessary and stock was effectively managed to reduce wastage. The station environmental health team also carried out regular sustainability audits.

Leadership, openness and transparency

We found that leadership at the practice was collaborative and promoted inclusive decision-making. The staff team was cohesive and supportive and all staff we spoke with

expressed how much they enjoyed their work and said they could speak openly and were listened to. We heard that they felt valued and were empowered to maintain their skills and use their experience to benefit the service. 'White space' team building events were held on a regular basis.

Staff told us they were confident any concerns they raised would be addressed without judgement as practice leaders were approachable. They were familiar with the organisational whistleblowing protocol for the practice and said they would approach the regional team if it was not appropriate to raise a concern at practice level. 'Thank you' schemes were used to acknowledge the contribution staff gave to the practice.

Learning and improvement

The SDO was the lead for clinical audit and quality improvement activity; a standing agenda item at the practice meetings. All mandated audits for dental services had been completed. In addition, the use of antibiotics was audited quarterly. Clinicians' record keeping was reviewed through the CQAA process 2 yearly. We considered that record keeping would benefit from more frequent review through a local audit. The MOD dentist planned to undertake an audit on waiting times for referrals.

Some good practice initiatives we identified would benefit from being raised as a 'purple' ASER or a quality improvement project, such as the leaflet for the oral health education (OHE) pathway and the OHE work with the nursery school children. Doing so, showcases the positive performance of the practice and also enables the sharing of good practice with other DPHC facilities.

Staff 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 quick response or QR code. This code was displayed in the surgeries. Paper copies of the feedback form were also available. Furthermore, patients had the option of leaving feedback in the suggestion box in the waiting area. Patient feedback was reviewed by the practice manager and shared with the staff team at practice meetings.

A fun interactive 'Thank you for your feedback' poster was displayed in the waiting area highlighting the feedback patients had provided. Improvements had been made based on this feedback, such as the installation of air conditioning as a number of patients commented about the building being too hot.

There was no suggestion box or feedback process for staff. This was due to the team ethos, 'whole team approach' and open-door policy which was working well. All staff we spoke with said they felt comfortable raising suggestions, improvements or feedback to the practice manager or SDO.