High Wycombe Dental Centre

Walters Ash, High Wycombe, HP14 4UF

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.

Overall rating for this service	**No action required**	✓
Are services safe?	**No action required**	✓
Are services effective	**No action required**	✓
Are service caring?	**No action required**	✓
Are services responsive to people's needs?	**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 High Wycombe Dental Centre on 1 October 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 1 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.

At this inspection we found:

- Leadership at the practice was inclusive and the team worked well together.
- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Systems were in place to support the governance and risk management of the practice.
- 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.

CQC recommends to Defence Primary Healthcare (DPHC) and the Unit:

- Issue clear guidance to dental teams with regard to the key changes to the Health Technical Memorandum 07-01 and what this means in practice.

Mr Robert Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Background to High Wycombe Dental Centre

High Wycombe Dental Centre is a primary healthcare dental care service providing dental care to Headquarters Air Command and is networked with Halton Dental Centre. It is a 3-chair practice providing a routine, preventative, and emergency dental service to a military population of between 1,450-1,600 service personnel. The dental centre is open Monday to Thursday from 08:00 -17:00 hours and on Fridays from 08:00 -13:30 hours.

Out-of-hours (OOH) arrangements are in place through a duty dental officer located within the Central Wessex Region. Patients call the OOH mobile number, are triaged then directed to which establishment to attend if they need to be seen.

The staff team

Senior Dental Officer (SDO)	1 (civilian)
Civilian dentists	1 (part time)
Nurses	1 full time civilian nurse 1 military trainee 1 post vacant
Hygienist	I part time locum
Administrators	2 part time
Practice manager	1 military practice manager temporarily in post whilst recruitment for a civilian takes place.

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.

Are services safe?

We found that this practice was safe in accordance with CQC's inspection framework

Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting (referred to as ASER), a DMS-wide system for the management of significant events.

The staff team had received ASER training and were registered to the use the system. Staff appropriately described the types of incidents reported through ASER system. Staff confirmed they would use the DURALs system for staff incidents.

Staff had a good understanding of the types of incidents that met the criteria for Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (referred to as RIDDOR).

ASERS were a standing agenda at the practice meeting, we discussed a previous incident that had been reported, this was discussed in practice meeting and shared learning was shared with the wider team at the network practice meetings. More urgent incidents were discussed at a huddle and were then followed up by email. Organisational learning was also discussed and recorded.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead and was trained to level 3. 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. Safeguarding information was displayed and was a standing agenda item at the practice meeting

Staff had a good understanding of the duty of candour (DoC) principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A DoC policy was displayed in reception. We discussed a recent incident that had duty of candour applied. There was a register in place with all incidents recorded.

The chaperone policy was displayed in the waiting area; this was last reviewed in September 2025. Patients could access a chaperone if they wished. Patients could be observed in the waiting area from the reception desk.

A lone working risk assessment and policy was in place for the practice; it clearly laid out the procedure to follow should any member of staff be alone in the department. This was reviewed in August 2025 and was supported by a risk assessment that was reviewed in September 2025.

There was an emergency alarm in each surgery which alerted reception to an incident. This was tested monthly and was installed in September 2025. A simulation of medical emergencies was carried out 6 monthly and these were recorded.

A dental dam was used routinely for adhesive restorations and endodontics (root canal treatment). It was also used with restorative treatment when required. This was recorded in patient notes.

The business continuity plan was reviewed in February 2025 and covered all required work arounds from loss of power, water, compressors to staff illness and radiation faults. It outlined critical business activities and up-to-date contact details. There was an exercise carried out in September 2025, related to the loss of the internet, this was based on a real incident which happened earlier in the year.

Medical emergencies

The SDO was the lead for medical emergencies and resuscitation. All staff were up to date with the required medical emergency training, including Basic Life Support, use of the automated external defibrillator and anaphylaxis. Scenario-based training in managing medical emergencies was held regularly with the last being in September 2025 using the scenario of a patient having an asthma attack with a staff member acting as the medical emergency.

The medical emergency kit was contained in a trolley bag close to the surgeries in reception and accessible only to staff. We checked the full emergency medical kit and all required items were in place and in-date. Safe arrangements were in place for the disposal of controlled drugs.

First aid kits were easily accessible. The biohazard spill kit, eye care and mercury spillage kits were checked regularly to ensure they were in-date.

In-house training in sepsis/deteriorating patient was completed and information was displayed.

Staff recruitment

The practice manager had oversight of the recruitment of permanent and locum staff. The full range of recruitment records for permanent staff was held centrally. Evidence was in place to confirm that recruitment checks had been completed for staff new to the practice. These included a Disclosure and Barring Service check to ensure staff were suitable to work with vulnerable adults and young people. The registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff require for their role were also monitored. Copies of induction paperwork and all certificates were retained by the practice manager.

Monitoring health & safety and responding to risks

A number of local health and safety policies and protocols were in place to support with managing potential risk. The practice manager was the named safety, health, environment and fire (SHEF) lead and had completed the Institution of Occupational Safety and Health qualification, they were also currently part way through the National Examination Board in Occupational Safety and Health. A fire risk assessment had been undertaken and the fire alarm was checked weekly, firefighting equipment was checked each month. A fire evacuation drill was carried out every 6 months and was last undertaken in August 2025.

Risks for the practice were recorded on the regional risk register which the team reviewed monthly. A range of risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The practice manager was the lead for Control of Substances Hazardous to Health (COSHH) and the SDO reviewed the COSHH risk assessments when they were completed. A COSHH register was in place with links to the risk assessments updated in April 2025. Items were held inside a lockable cupboard. COSHH items were only accessible by staff. We noted there were no hard copies of the COSHH risk assessments available instead they were kept electronically. We discussed the benefits of keeping these also in paper form so they were readily available for all staff.

There was a legionella risk assessment in place and this was reviewed in May 2024, the practice had their own risk assessment that had been completed in September 2025. There had been a previous issue with legionella found in the building, all works had been completed and no further issues had been reported. We saw documentation that evidenced this.

A range of tests were undertaken of dental unit waterlines including 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.

The practice had a risk assessment in place for the compressor, this had last been reviewed in September 2025. Only the contractor had access to the compressor but the practice could request access if required. Routine checks were conducted and the practice manager checked these records, they were carried out 3 monthly, 6 monthly and annually.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. The Insafe system was used to reduce the risk of sharps injuries and clinicians disposed of the sharps they used. Staff had completed training on sharps injuries, which included how to manage injuries and the action to take post-incident. In addition, staff had received training in snapping ampoules and using out-of-date ampoules. Sharps incidents were reported using the MySafety and/or ASER systems. There had been no sharps injuries in the last 12 months.

Infection control

The civilian dental nurse was the lead for infection prevention and control (IPC) and the military dental nurse was the deputy. Both nurses were trained to level 2. An IPC policy supported by training for all staff was in place; records showed staff were up to date with IPC training.

Measures were established to minimise the spread of infectious diseases. Hand washing guidance was displayed; hand sanitiser was available throughout the building and staff had access to a sufficient stock of personal protective equipment. IPC audits were undertaken every 6 months.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). Updates were received from Regional Headquarters including any new information circulated by the General Dental Council. These were discussed at the practice meetings.

The practice had a central sterile services department (CSSD) with clearly identifiable clean and dirty areas. Our review of the decontamination process showed that a robust process was in place and the dental nurse with the lead for decontamination had an in-depth understanding of the process and monitored that it was being adhered to.

Environmental cleaning was carried out by a contracted company twice a day and the dental nurses cleaned surgeries in between patients. The cleaning contract was monitored by the practice manager who reported any inconsistencies or issues to the cleaning manager. The dental team was satisfied that the current contract was sufficient for the practice needs. Deep cleaning was provided annually.

Clinical waste was safely managed, including extracted teeth, gypsum (for taking dental impressions) and amalgam (used for fillings). Secure storage for clinical waste was located outside of the building in a locked cage. Waste transfer notes and consignments notes were in pace but no destruction certificates were held. We discussed this with the practice manager and they were going to obtain these as a matter of urgency. The annual clinical waste audit had been completed.

Following some key changes to the HTM 07-01 in December 2024, Defence Primary Healthcare (DPHC) practices await guidance around the treatment of clinical waste (the use of tiger bags versus orange bags and single use versus reusable aspirator tips). The practice were aware of this and had discussed it as a team.

Equipment and medicine

An equipment spreadsheet was in place that included the status of each piece of equipment, such as fault reporting (date of completion/repair), disposal and transfer of equipment between dental centres.

Staff undertook daily checks of equipment in the surgeries, laboratory and CSSD. Clinical equipment was serviced annually by the medical and dental servicing section (a military

capability referred to as MDSS). All equipment was in-date for servicing and testing including the ultrasonic bath and autoclave. Electrical Equipment Testing was up to date.

A system was in place to ensure adequate stock and that it was efficiently managed. All stock requiring temperature control was stored in a room with air conditioning. Stock was checked each month and logged and it was ensured items with closer expiry dates were located at the front of the shelf/drawers. All equipment was latex free.

An online register was used to keep track of issued prescriptions. This was checked monthly by the SDO. Pharmaceutical fridge temperatures were monitored and recorded daily; temperatures were within the expected range. The SDO completed an antibiotic prescribing audit annually. The practice followed Faculty of General Dental Practice UK (FGDP) and the British National Formulary (BNF) guidance for antimicrobial prescribing.

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. The SDO was the Radiation Protection Supervisor (RPS) and had completed the required RPS training for the role. Signed and dated Local Rules were displayed in each surgery.

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

A radiography audit was undertaken with quarterly quality assurance of image processing. The last audit was completed in August 2025.

Are services effective?

We found that this practice was effective in accordance with CQC's inspection framework

Monitoring and improving outcomes for patients

Through discussion with clinicians and a review of patient records, we confirmed the treatment needs of patients was assessed in line with organisational policy and recognised national guidance, including National Institute for Health and Care Excellence, information from NATO Cat webinar and the College of General Dentistry guidance. Guidelines were followed for the management of wisdom teeth or third molars, antibiotic prescribing, occupational focus and caries (tooth decay) risk.

Our review of a range of dental records confirmed a thorough assessment, including information about the patient's current dental needs, past treatment, medical history and treatment options. The diagnosis and treatment plan for each patient was clearly recorded. A medical and dental history assessment was completed at the patient's initial consultation and was checked for any changes at each subsequent appointment.

In addition, records demonstrated that guidance from the British Society of Periodontology (BSP) in relation to periodontal (gum disease) staging and grading was followed.

A Basic Periodontal Examination was carried out at each periodic dental inspection or recall. Occupational requirements were taken into consideration when planning treatment for individual patients and to determine recall periods. Patients were asked at consultation about upcoming deployments, taskings and assignments.

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 struggled to meet targets during the year 2024-2025 due to a refurbishment of the practice and staff shortages during the networking process with Halton Dental centre. The team had worked hard to improve dental outputs and gradual improvements had been seen. The key performance indicators were

- Cat 1 (fully dentally fit) 55%,
- Cat 2 (dental treatment required but not expected to cause problems within a year) 17%
- Cat 3 (treatment required and expected to cause problems within a year) 10%
- Cat 4 (missing or incomplete dental records or the need for a periodic examination)18%

The dental centre had introduced a cancellation list which had resulted in an improvement of CAT 3s and people waiting less time for an appointment.

Health promotion and prevention

The military dental nurse was the lead for oral health education (OHE) and had completed the relevant training for the role. The patient records we reviewed showed proposed treatment pathways and information given to individual patients. The practice utilised the Delivering Better Oral Health toolkit: a Public Health England evidence-based toolkit on prevention of oral diseases, such as caries.

Patients had access to information from the practice SharePoint page, oral health display boards, leaflets, oral health fairs, and the practice leaflet.

From our discussions with clinicians and a review of patient records, we confirmed that patients were routinely asked about their oral hygiene routine, dietary habits, alcohol intake and smoking, including vaping. Dietary, oral hygiene and lifestyle habits were captured on initial consultation and followed up at subsequent appointments. High concentration sodium fluoride toothpaste, fissure sealants and fluoride varnish treatment options were available. Clinicians could refer patients to the medical centre if there were concerns about a patient's general health.

Staffing

The induction programme included a generic programme and induction tailored to the dental centre. The practice manager monitored the status of mandatory training and training was recorded on the Defence Primary Healthcare (DPHC) Dental Personnel Management System. Staff were given time to complete training. At the time of the inspection, staff were up-to-date with all mandated training. The dental team had also completed training around supporting patients with a learning disability/autistic spectrum disorder in line with the national requirement for all healthcare providers.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. They had access to the 'Agilio Training' platform for access to CPD courses. Clinical staff attended the regional training days and conferences**.**

Consistent and adequate staffing levels were managed by using cover provided by other dental centres when required. The practice manager post was temporarily being filled by a dental nurse from RAF Benson, recruitment for a civilian practice manager was in progress. A dental nurse from RAF Halton provided cover when needed. The hygienist post was shared between RAF Halton and RAF High Wycombe and was covered by a temporary healthcare worker.

Working with other services

The practice worked closely with the Chain of Command to ensure patients were offered treatment in a timely manner. This work had been effective with reducing the number of appointments failed to attend.

Patients that required minor oral surgery were referred to the Tier 2 dental practitioners at Lyneham Dental Centre with minimal wait times. Patients requiring more complex treatment were referred to the Amersham hospital with wait times of up to 12 months.

A comprehensive process was in place to manage referrals, including the use of the DPHC centralised process for the management of all referrals. These were monitored weekly. Urgent referrals (two week waits) for oral surgery were made with minimal waiting times.

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.

Clinical staff understood the importance of obtaining and recording patient's consent to treatment. Patients were given information about treatment options and the risks and benefits of these so they could make informed decisions. The dental care records we looked at confirmed this. Verbal consent was taken from patients for routine treatment. For more complex procedures, full written consent was obtained. Feedback from patients confirmed they received clear information about their treatment options.

Clinical staff had a good awareness of the Mental Capacity Act (2005) and how it applied to their patient population, in-house training took place in August 2025.

Are services caring?

We found that this practice was caring in accordance with CQC's inspection framework

Respect, dignity, compassion and empathy

We received feedback from 49 patients via our pre-inspection feedback cards. All patients were happy with the service indicating staff were kind, respectful and supportive. Patients experience surveys were also undertaken by the practice, the results from the period July and August 2025 showed 60 responses and 100% of these said they were happy with the care provided.

Patients with a known dental anxiety were given extra time to discuss their concerns. One anxious patient described attending the dental centre for as filling as the" best filling of their life". Having described themselves as always being anxious, a patient described the dentist as very gentle and efficient, putting them at ease.

The waiting room was very small and directly opposite the reception window so patient privacy was hard to protect as conversations could be overheard. The practice had done all they could to mitigate this by the use of offering a private room should the patient wish to talk about a sensitive issue; a notice was clearly displayed explained this option.

The practice had access to the 'Big Word', a translation service for patients who did not have English as their first language. Staff had received training in April 2025 on using the Big Word and the access code had been tested.

As there were only female dentists, patients could not opt to see someone of the opposite gender, they could if they preferred to go to Halton Dental Centre for treatment. None of the patients responding to the survey or who we spoke with suggested that this caused them an issue.

Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support patients with making informed decisions about treatment choices. From our discussion with the Senior Dental Officer, it was clear a range of options were used to ensure patients understood the problem and treatment options.

Are services responsive to people's needs?

We found that this practice was responsive in accordance with CQC's inspection framework

Responding to and meeting people's needs

Clinicians referenced National Institute for Health and Care Excellence guidelines and other national guidance regarding recall intervals between oral health reviews; between 3 and 24 months depending on the patient's assessed risk for caries, periodontal, oral cancer and tooth surface loss.

Patients could make appointments between recall intervals depending on the requirement or request. Those presenting with pain were seen the same day and patients with an issue not deemed to be urgent were given into the next routine slot with advice to call back if the issue worsens.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in December 2024. The premises was accessible for patients with reduced mobility. The dental centre had level access but there was no automatic opening front door. The practice had a hearing loop installed at reception and accessible toilets for patients.

Staff considered the needs the needs of patients in terms of disability, gender, gender identity, race, religion or belief and sexual orientation. The team had completed training in equality and diversity.

Access to the service

At the time of the inspection, the next available routine appointment with a dentist was within 2 weeks. Individuals or units deploying were prioritised. If patients cancelled an appointment, then the staff offered the appointment to patients on a waiting list. Patients requiring an emergency appointment during working hours could be seen on the same day.

Dental out-of-hours (OOH) care was provided all year round through the regional duty on-call rota. Patients were seen at the practice where the duty dentist worked. 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

Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. A process was in place for managing complaints, including the recording of

complaints on the Regional Headquarters SharePoint. Complaints were a standing agenda item at the practice meetings and all staff had competed complaints training. Two complaints had been received between October 2024 and January 2025. Both were investigated fully and managed well.

Are services well-led?

We found that this practice was well-led in accordance with CQC's inspection framework

Governance arrangements

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

"DPHC is to provide and commission 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) described effective communication with the various units and they attended the station Executive Meetings every month. Effective communication pathways were in place with Regional Headquarters (RHQ) and the SDO also had good links with the Senior Medical Officer at the medical centre next door and at Halton Dental Centre.

Healthcare governance was a standing agenda item at the monthly practice meetings. The team routinely reviewed governance and risk management systems to ensure they were up-to-date and reflected the current operation of the practice. A framework of organisational policies, procedures and protocols underpinned governance activity. In addition, there were local dental specific protocols and standard operating procedures that took account of current legislation and national guidance. Staff skillsets were effectively used, such as for lead roles.

Terms of reference were up-to-date for all staff. In addition to the practice meetings, staff huddles were held several times a week to check how the week was progressing and to share any necessary information.

External and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the SDO and both RHQ and the Chain of Command had oversight. The practice used the Health Assessment Framework (HAF), an internal quality assurance system used to monitor safety and performance. RHQ set expectations to complete the Key Lines of Enquiry every month which helped plan activity completion. Separate HAF meetings were held with all staff and these were recorded and records kept on Sharepoint so that all staff could refer to them.

The last Internal Assurance Review was completed in January 2023; all actions had been completed. Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information.

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

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice, with support from the RHQ. The practice manager had the delegated responsibility for the day-to day administration of the service.

Staff were clear about current lines of accountability and they owned their terms of reference and any lead roles. Staff knew who they should approach if they had an issue that needed resolving. The SDO had overall responsibility for the management of risks for the service. These risks were fed into the regional risk register and in turn then from RHQ DPHC headquarters.

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To address environmental sustainability, the practice aimed to reduce the use of paper through digitisation. Recycling bins were in use, and stock was effectively managed to reduce wastage.

Leadership, openness and transparency

Staff told us the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff described leaders as supportive and considerate of the views of all staff. The SDO undertook individual face to face welfare checks every month with all staff, which included an opportunity for them to raise any concerns and ensure their wellbeing. White space' team building events were held including regular badminton matches.

The leadership team had an open-door policy; staff were encouraged to express any concerns. Regular practice meetings were held as an open forum. Staff were encouraged to promote their ideas in staff forums and felt empowered to speak up. A thank you scheme was used to give staff rewards. The practice manager held dental nurse meetings which empowered the team to take ownership and discuss any issues specific to their profession.

Learning and improvement

The SDO was the lead for clinical audit/quality improvement activity. All the required audits had been completed, including infection prevention and control, equality access, clinical waste, prescribing and radiography. Additional audits undertaken included clinical records, a CAT 3 waiting time audit to ensure patients were not lost on the system and had treatment completed in a timely manner and a waiting room audit. This was proactive as it was identified there was a need for increased privacy in waiting room.

Staff received mid and end of year annual appraisal and these were up to date. These were supported by personal development plans tailored to individual staff members. Staff spoke positively about support given to complete their continued professional development. The SDO had received outstanding feedback from the 360-degree Clinical Quality Assurance recently undertaken.

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

Staff were committed to improving the service for patients. A monthly focussed educational feedback token system was used to ask specific questions to determine patients' knowledge and understanding of dental related issues. For example, patients were asked if they were aware of the process for finding out their own dental fitness on the Joint Personnel Administration, the online system used by the MOD for personnel management. Although feedback was mostly favourable, the practice made sure they responded to this by displaying a clear process that described where patients could find the information themselves.

Quick response or 'QR' codes were displayed in each surgery and at various points throughout the practice for patients to use to leave feedback, there was also paper methods available too and staff were always available should the patient want to give verbal feedback. The General Practice Assurance and Quality (GPAQ) questionnaire was used monthly to review feedback.