Neptune Dental Centre

HMS Neptune, His Majesty's Naval Base Clyde, Helensburgh, Argyll & Bute, G84 8HL

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 Neptune Dental Centre on 16 September 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 (CQC's) 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 the observations and recommendations within this report.

This inspection is 1 of a programme of inspections that 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:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- 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 management of risk, including clinical and non-clinical risk.
- Suitable safeguarding processes were established, and staff understood their responsibilities for safeguarding adults.
- The required training for staff was up-to-date and they were supported with continuing professional development.
- The clinical team provided care and treatment in line with current guidelines. Record keeping was of a high standard.
- Staff took care to protect patient privacy and personal information.
- The appointment and recall system met both patient needs and the requirements of the Chain of Command.
- Leadership at the practice was inclusive and effective. Staff worked well as a team and their views about how to develop the service were considered.
- An effective system was in place for managing complaints.

- Medicines and life-saving equipment were available in the event of a medical emergency.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Systems for assessing, monitoring and improving the quality of the service were in place. Staff made changes based on lessons learnt and patient feedback.

We identified the following area of notable practice:

- In response to feedback on the 5 hour travel time for a check-up, a team was deployed to provide outreach clinics held at the medical centre in Barrow. A total of 90 patients were seen at Barrow across the 6 days on which clinics were hosted there.
- A template form had been developed to capture information on failed to attend appointments to collate information that could be used to improve patient access.

We recommend to the unit:

- Direct reference to the management of risk around the dental centre compressor should be made within the fire safety risk assessment. Staff from the dental team should be able to access this area as required.
- Urgently address the water system issues to minimise the risk of further legionella outbreaks.

We recommend to Defence Primary Healthcare:

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

Mr Rob Middlefell BDS, CQC's National Professional Advisor for Dentistry and Oral Health

Background to this practice

Located in Argyll and Bute, Neptune Dental Centre is part of Defence Primary Healthcare (DPHC) Dental Scotland and North Region. It is a 7-chair practice providing routine, preventative, and emergency dental services to a military patient population.

HMS Neptune is the shore establishment at HM Naval Base Clyde, the Royal Navy's (RN) principal submarine base and headquarters of the Submarine Service. It supports a wide range of operational units and provides essential support to the wider fleet of submariners across the RN.

Phase 2 and specialist submarine training is delivered on-site, contributing to a dynamic personnel turnover. The current patient population sits just under 4,000, with plans to increase by approximately 700 personnel. Neptune also provides dental support to ships' companies of vessels currently under construction in Glasgow, ensuring continuity of care from build to deployment.

Medical and dental services are co-located within a purpose-built facility on the eastern shore of Gare Loch. Patients also come from nearby units including RN Armaments Depot Coulport, the Northern Diving Group, and RN Police. Families are directed to local NHS dental practices in Helensburgh and surrounding areas.

The dental centre is open Monday to Thursday from 08:00-12:00 and 13:00-16:30. On a Friday, the opening hours are 08:00-12:00. Daily emergency treatment appointments are available. Hygiene services are currently provided by dentists pending security clearance for 2 locum hygienists. Out-of-hours emergency treatment is accessed through calling NHS 111. Minor oral surgery is conducted in-house by 1 of the military dentists. Secondary care support is available through Glasgow Dental Hospital for oral surgery and oral medicine. DPHC's Defence Centre for Rehabilitative Dentistry can also be used for other referrals.

Our Inspection Team

This inspection was undertaken by a CQC inspector supported by a dentist and a 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, dentists, dental nurses, practice managers and administration staff. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We also checked the building, equipment and facilities. We also reviewed feedback from patients who were registered at the dental centre.

The staff team

Senior Dental Officer (SDO) (military) Deputy SDO (military)	1 1
Dentist (civilian)	3 (2 full-time and 1 part-time locum)
Dental hygienist (civilian) Dental hygienist (military) Dental nurses (civilian)	1 (part-time. Post vacant) 1 (part-time. Post vacant) 2 (full-time locums)
Practice manager (military) Deputy practice managers (military) Receptionists (civilian)	1 2 1 (full-time. Post vacant) 1 (part time)

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events and incidents. All staff had access to the system to report a significant event and if required, were supported by the management team to raise an event. The staff team last completed in-house ASER training in July 2025 and this was recorded on the training log. Staff we spoke with were clear in their understanding of the types of significant events that should be reported, including good practice and near misses. A record was maintained of all ASERs, this was categorised to support identification of any trends and displayed on a dedicated notice board.

A total of 2 ASERs had been recorded in the previous 12 months. A review of these showed that each had been managed effectively and included changes made as a result. For example, an X-ray was taken without the prior test being done. Although the radiograph was captured successfully, the incident was discussed and staff encouraged to speak up if they realised a step in the process had been missed. The second ASER was raised when labwork had been incorrectly labelled; this was identified and rectified.

Significant events were a standing agenda item at the weekly practice team meeting. Staff unable to attend could review records of discussion, minutes of these meetings were held in a shared electronic folder in addition to a hard copy made available. Regional headquarters (RHQ) were also made aware of any ASERs raised.

Staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Not all staff we spoke with were sure of their responsibilities for reporting incidents but stated that any accident or injury would be reported to the practice management. Staff provided us with an example of a scenario where a patient had fallen. The incident was reported to the management team and an ASER raised via the ‘MySafety’ app.

Alerts were included on the ‘direction and guidance’ email so that the Senior Dental Officer (SDO) and practice managers were informed by RHQ about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). Hard copies were shared with staff at practice meetings (or sooner if required) where attendees signed a copy of the minutes. In addition, alerts were acknowledged as read electronically by staff ticking a box in ‘OneNote’. An electronic copy of each alert was displayed on the dental centre’s Microsoft Teams page. A buddy system was in place to ensure the receipt of alerts was not delayed due to staff not being in work.

Reliable safety systems and processes (including safeguarding)

The Deputy Principal Medical Officer was the safeguarding lead and had completed level 3 training. The SDO was the deputy safeguarding lead and had level 2 training. All other

members of the staff team had completed level 2 safeguarding training with the exception of 1 member of the administration team who was to be enrolled should their status become more than a temporary posting. A basic introduction to safeguarding, including training on the local policy, was included as part of the induction for all staff. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. We highlighted a recent Defence Primary Healthcare (DPHC) policy that required safeguarding leads to complete tier 1 training on learning disability and autism.

The safeguarding policy and personnel in key roles were displayed on a dedicated noticeboard. Also displayed were links to external teams (including the out-of-hours telephone number) and the DPHC safeguarding page. There were standard operating procedures (SOP) for safeguarding and for vulnerable patients. No recent safeguarding concerns had been raised within the practice. Vulnerable person information was held at unit level and discussed at a monthly meeting (dental centre staff were not involved in this meeting as no incidence had been raised. They would attend in the event of concerns being raised by dental centre staff).

The ‘Submarine Training School’ was due to be relocated to Neptune and this would result in an increase in patients aged under 18. The joining routine for new patients identified any patient aged under 18 and an alert was added to their DMICP medical record.

Although no formal training had been provided, clinical staff understood the duty of candour principles and this was evident in patient records when treatment provided was not in accordance with the original agreed treatment plan. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A duty of candour log was in place.

The dentists were always supported by a dental nurse when assessing and treating patients. A chaperone policy was held in reception and referenced in the patient information leaflet. If a dental nurse had to leave the room, this was first agreed by the dentist and the door would be left open for the short time that they were away. Although lone working was not normal practice, there was a lone working risk assessment and always another member of staff in the building. Each surgery and office room had a handheld panic alarm to call for assistance and there was a fixed alarm system at reception that notified colleagues in the medical centre, co-located in the same building. The panic alarms had been tested in the last week and during scenario based training.

Rubber dams were routinely used for nearly all restorative and endodontic treatments (to improve isolation and access) in line with guidance from the British Endodontic Society. This was recorded in patient notes and seen as part of the record review audit.

A comprehensive business continuity (BCP) and resilience plan was in place and had last been reviewed in December 2024.The BCP set out how the service would be provided if an event occurred that impacted its operation. The plan included staff shortages, loss of power, temperature control, loss of refrigeration and loss of compressed air. A list of key contacts listed on the plan included RHQ, nearby dental centres, the contractor responsible for infrastructure on site and a single point of contact number for the site. The BCP could be accessed remotely via staff laptop devices should access to the building be restricted. The BCP was being actively tested due to ongoing issues with legionella.

Medical emergencies

The medical emergency SOP from DPHC was followed. The automated external defibrillator (AED) and emergency trolley were well maintained and securely stored, as were the emergency medicines. Daily and monthly checks of the medical emergency kit were undertaken and recorded by the dental nurses who had been given specific training to undertake the role. A review of the records and the emergency trolley demonstrated that all items were present and in-date. Reviews of the emergency medicines were completed at headquarter level.

All staff had received anaphylaxis and sepsis training, were aware of medical emergency procedure. and knew where to find medical oxygen, emergency drugs and equipment. Records identified that staff were up-to-date with training in managing medical emergencies, including emergency resuscitation and the use of the AED. The team completed basic life support, cardiopulmonary resuscitation and AED training annually. Training that used simulated emergency scenarios was undertaken 6 monthly.

First aid, bodily fluids and mercury spillage kits were available. Two of the staff were booked onto first aid training and there was a first aid kit kept in the consumable store (although there was no check in place to record when it was used). The medical practice was co-located (downstairs) so could easily be used to support with any first aid requirements. Staff were aware of the signs of sepsis and sepsis information was displayed around the practice. Staff had received training in recognising the signs of sepsis and of a deteriorating patient.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The practice manager had access to the DMS-wide electronic system so could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Protecting Vulnerable Groups (PVG/Disclosure Scotland) check to ensure staff were suitable to work with vulnerable adults and young people. The DBS check was managed by station and civilian personnel were checked every 5 years.

Monitored by the practice managers, a register was maintained of the registration status of staff with the General Dental Council, indemnity cover and the relevant vaccinations staff required for their role.

Monitoring health & safety and responding to risks

A number of local health and safety (H&S) policy and protocols were in place to support with managing potential risk. The H&S policy statement was current and displayed in the reception area and there was an H&S notice board furnished with the latest information. The safety, health, environment and fire (SHEF) team carried out 6 monthly workplace health and safety inspections. In addition, the practice manager was the named health and safety lead and this was reflected in their terms of reference. The practice manager had completed the Institution of Occupational Safety and Health training.

There was a set of risk assessments that included access/egress from the building, portable heaters and lone working. The unit carried out a fire risk assessment of the premises every 5 years with the most recent assessment undertaken in May 2021. There was no appointed fire warden or building custodian but the practice manager acted as the departmental safety manager supported by the SHEF team. A SHEF audit completed in December 2024 scored 100% compliance. This audit included a section on fire safety management that included checks on the maintenance of equipment, fire alarms, evacuation (that included an evaluation post event), fire doors and fire awareness training for all staff. There was fire safety information displayed on the SHEF noticeboard.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place and had been reviewed in August 2025. COSHH data sheets were in place and had also been reviewed in August 2025. A log sheet was maintained of each hazardous product with links to the safety data sheets. All staff had access to both electronic and hard copies although some staff were not familiar with the documentation.

The practice followed relevant safety laws when using needles and other sharp dental items. The sharps boxes in clinical areas were labelled, dated and used appropriately.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained and risks were up-to-date. The risk register was reviewed monthly by the practice manager (as risk manager) or deputy practice manager in their absence. The main issues identified were ongoing infrastructure issues that made decontamination challenging, having no hygienist and the recruitment of civilian staff and temporary healthcare workers. The infrastructure risk had been escalated to regional headquarters. We found that staff vacancies had been an issue in the last 12 months and a resource prioritisation was in place for a hygienist.

Infection control

One of the dental nurses was the lead for infection prevention and control (IPC) and had completed the required training. The IPC policy and supporting protocols took account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. All the staff team were up-to-date with IPC training, and records confirmed they completed refresher IPC training every 6 months. IPC audits were undertaken annually and the most recent was undertaken in August 2025.

We checked the surgeries. They were clean, clutter free and met IPC standards, including the fixtures and fittings. Environmental cleaning was carried out by a contracted company twice a day and this included cleaning in between morning and afternoon clinics. The cleaning contract was monitored monthly by the contractor and spot checks by the practice manager. Any inconsistencies or issues were reported to the cleaning manager. The contractor provided a cleaning schedule but not the contract. However, the practice management was satisfied that the current contract was sufficient for the practice needs and deep cleaning arrangements were in place (completed quarterly by dental centre staff). The cleaning cupboard was tidy and well organised and staff could access it if needed in between the routine daily cleaning. Suitable ventilation was provided by having windows in each surgery. Air conditioning units were planned for 2026/2027.

Decontamination took place in a central sterile services department, accessible from the surgeries. Sterilisation of dental instruments was undertaken in accordance with HTM 01-05. Records of validation checks were in place to monitor that the ultrasonic bath and autoclave were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were regularly cleaned with arrangements in place to check materials to ensure they were in-date.

A detailed legionella risk assessment had been carried out (by the external contractor responsible for the site) in July 2022 and covered all the required areas. A legionella management plan was in place and had been renewed in early September 2025. There was a protocol that detailed the process for flushing taps (2 minutes at the beginning of each day and in between patients) and disinfecting water lines. A log sheet was maintained to evidence of the flushing programme. However, legionella was a continuing issue despite different chemicals having been used to clean the water tank, dead legs had been removed and flexible pipes had been replaced. Issues had been raised with the unit and escalated as a risk to RHQ.

A funding request had been submitted for chlorine dioxide equipment and dead legs (unused or infrequently used piping in the water system) had been removed to reduce the risk of legionella and the practice manager chased information and was now notified when temperatures fell outside of parameter. Regular meetings had been held with the unit but limited communication from the external contractor was impacting the effective management of legionella. Showers at the time of inspection were not working. The water pressure was not high enough for power filters, these were scheduled to be changed later in the month as they were not fit for purpose (due to the tanks not being far enough for the gravity to pull the water down to give pressure). The water temperatures were being continuously tested as the dental centre had experienced legionella outbreaks. Signage was displayed on certain sinks that were considered higher risk (those without filters). Portable hand wash stations were being used.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps and extracted teeth. An individual contract was in place for the dental centre. The clinical waste bin, located outside the building, was locked and secured. The dental centre bin was labelled to try and prevent it from being used by the boats or medical centre for disposing of their clinical waste. An amalgam (filling material) separator was used (in accordance with legal requirements from the Environmental Protection Agency) to prevent the mercury contained from entering the air, water or land. Clinical waste was collected weekly and consignment notes were provided by the contractor. Waste transfer notes were retained and audited annually.

However, some issues had been identified by the practice manager and added to the risk register. It was reported that the medical centre had been signing for clinical waste without knowing what had been logged and without the dental centre’s knowledge. The practice manager had requested that dental staff need to be present to cross reference with the clinical waste log. Some clinical waste drivers would not come to the dental centre; this had been raised with the contractor as some waste had been collected without the dental centre being informed. The dental centre did not hold a copy of the waste management plan as the contractor had not provided a copy of the licence when requested.

Following some key changes to the HTM 07-01 in December 2024, DPHC practices await guidance from DPHC around the treatment of clinical waste (the use of tiger bags versus orange bags and single use versus reusable aspirator tips).

Equipment and medicines

An equipment log was maintained to keep a track of when equipment was due to be serviced. Any fault was recorded and pieces of equipment that could not be used were separated (a dedicated area was designated) and a 'non-task worthy' sign placed on it. The autoclave and ultrasonic bath had been serviced in September 2024 and the annual service was booked in for September 2025. The servicing of all other routine equipment, including clinical equipment, was in-date in accordance with the manufacturer's recommendations. A separate log was maintained to record internal checks carried out a daily, weekly, monthly and quarterly intervals in-line with the individual schedule for each piece of equipment.

Pharmaceutical fridges were defrosted and cleaned prior to each leave period and included in the department deep clean. We found a number of out-of-date items in the fridge which were removed on the day. A Land Equipment Audit (LEA) was completed in November 2024 and the 6 items of non-conformance identified in the report had been actioned. Recommendations made in the 2024 LEA audit had been actioned. Electrical equipment testing was undertaken annually by the station's electrical team. A register of equipment was maintained and the most recent testing took place in January 2025. However, we highlighted that a number of portable heaters had not been tested and some items were on a 5 year cycle (although there are no specific regulations that mandate fixed intervals for testing, the policy was for each item to be tested annually).

An electronic log of prescriptions was maintained (using a templated form) and prescriptions were sequentially numbered and stored securely. Staff conducted monthly checks of sequential serialised number sheets to maintain traceability and accountability for any missing prescriptions. Minimal medicines were held in the practice. Patients obtained medicines either through the dispensary in the medical centre or through a local pharmacy. Medicines that required cold storage were kept in a fridge, and cold chain audit requirements were in place and recorded. Glucagon (a medicine used to treat low blood sugar levels) was stored out of the fridge and the expiry date had been amended accordingly.

The practice used an in-house template to carry out a review of any antibiotic prescribed (normally completed on the day). Although this was not a requirement, it is good practice and improves clinical oversight. A sample review of the forms evidenced that a comprehensive evaluation took place, any recommendations were discussed and any issued identified followed up.

Compressor checks were not included in the fire risk assessment. The next fire risk assessment was planned for May 2026 and the practice had requested for it to be included.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor (RPS) were identified for the practice. Signed and dated Local Rules were available in each surgery along with safety procedures for radiography. The Local Rules were updated in May 2025 and reviewed annually or sooner if any change in the policy was made, any change in equipment took place or if there was a change in the RPS. A copy of the Health and Safety Executive notification was retained and the most recent radiation protection advisory visit was in July 2024 (the dental centre was graded as ‘very good’).

Evidence was in place to show equipment was maintained annually, last done in July 2024. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had completed online training within the 5-year General Dental Council cycle.

The dental care records for patients showed the dentists justified, graded and reported on the X-rays taken. Intra-oral radiology audits were carried out every 6 months using an electronic form that had been developed in-house. All patients X-rayed were reviewed as part of the audit and findings discussed with the SDO and dental officers. A note review was added to the clinical system to confirm the points discussed.

Test X-rays were taken daily and printed weekly. Print outs were stored electronically on SharePoint. Non-used surgery data sheets were checked and sensors not regularly used checked weekly. In-use sensors were checked daily.

Are Services Effective?

Monitoring and improving outcomes for patients

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 Dentistry guidance. NICE guidelines were followed for the management of wisdom teeth or third molars and dental recall. Treatment was planned and delivered in line with the basic periodontal examination - assessment of the gums and caries (tooth decay) risk assessment. The dentists referenced appropriate guidance in relation to the management of wisdom teeth, considering operational need. Information was displayed on desks in the surgeries to act as an aide memoire.

The dentists followed appropriate guidance in relation to recall intervals between oral health reviews, which were between 3 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. In addition, recall was influenced by an operational focus, including prioritising patients in readiness for rapid deployment.

We looked at patients' dental care records to corroborate our findings. The records included information about the patient's current dental needs, past treatment and medical history. The diagnosis and treatment plan for each patient was clearly recorded together with a note of treatment options discussed with the patient. Patients completed a detailed medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment.

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 dentists discussed the downgrading of personnel in conjunction with the patient's doctor to facilitate completion of treatment. The military dental fitness targets were closely monitored by the Senior Dental Officer (SDO) and practice management. We noted that performance of key performance indicators were below target levels but statistics were maintained and displayed for each boat and used to tailor a plan for each. For example, 69% of patients were category 1 (had all operative treatment completed) and category 2 (treatment needed but not urgent and patient deployable). The target was 80% and the practice found it difficult to achieve with not having a hygienist and with having a patient group that was frequently deployed for sustained periods of time. Two locum hygienists (1 full-time, 1 part-time 2 days a week) were due to start once security clearance had been completed.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. Two of the dental nurses were qualified as oral health educators (OHE) and another dental nurse took the lead on health education campaigns supported by colleagues including the regional OHE lead who provided topics to promote and promotional material. There was a monthly topic but dental centres had the autonomy to develop their own promotional calendar tailored to their population. At the time of

inspection there was a prominent, colourful display detailing oral diseases. This included pictorial aids supported by concise information text bubbles. Previous promotions included an educational display that showed how much sugar was contained in certain drinks and foods.

Dental nurses were not trained in smoking cessation beyond 'Very Brief Advice on Smoking' (VBA) so patients were referred to the medical centre for this service (VBA is an evidence-based intervention designed to increase quit attempts among patients who smoke).

Dental care records showed that lifestyle habits of patients were included in the dental assessment process. The dentists and hygienist provided oral hygiene advice to patients on an individual basis, including discussions about lifestyle habits, such as smoking and alcohol use. Oral health promotion leaflets were given to patients and the oral health lead maintained a health promotion area in the patient waiting area.

There had been no unit health fairs in the last 12 months but the lead had attended a health promotion day in Glasgow where there was dedicated sections around health promotion. 'Lunch and learn' sessions were held where external companies provided information on their products. For example, a recent example was for a presentation on electric toothbrushes.

The dentists described the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Staffing

The induction programme included a generic, organisation-level programme and induction tailored to the dental centre.

We looked at the organisational-wide electronic system used to record and monitor staff training and confirmed staff had undertaken the mandated training. The military practice manager monitored the training plan and ensured it covered all the mandated requirements at the right times. The in-house training programme was detailed on a training register and discussed at practice meetings.

All dental nurses that were asked were aware of the General Dental Council (GDC) requirements to complete continued professional development (CPD) over a 5-year cycle and to log this training. Staff had subscribed to a specialist online training provider for mandatory training that had been designed with the GDC's requirements in mind so that dental professionals could maximise CPD activities they chose to complete. All staff managed their own CPD requirements and had no issues accessing or completing the required work. Staff attended CPD events (included the Defence Primary Healthcare webinar series) as required and staff attended regional training days and a regional meeting was held annually.

The staff members we spoke with confirmed that although there had been challenges with staffing levels in the last 2 years, the staffing establishment and skill mix had recently improved and with the imminent arrival of a hygienist, was now appropriate to meet the

dental needs of the patient population and to maximise oral health opportunities. The dental team were working to deliver the best level of care possible whilst responding to short notice rapid deployment pressures.

Working with other services

The SDO confirmed patients were referred to a range of specialists in primary and secondary care for treatment the practice did not provide. The dentists followed NHS guidelines, the Index of Orthodontic Treatment Need and Managed Clinical Network parameters for referral to other services. Patients could be referred to Glasgow Dental Hospital for secondary care. The practice had a direct referral line into the hospital. A spreadsheet was maintained of referrals and checked weekly. Each referral was actioned by the referring clinician once the referral letter was returned. Urgent referrals followed the 2-week cancer referral pathway and were coded in red. The current wait time for a routine appointment was 12 weeks and each referral was logged and the record reviewed weekly.

The practice worked closely with the medical centre in relation to patients with long-term conditions impacting dental care. In addition, doctors had been instructed to remind the patient to make a dental appointment if it was noted on their record during a consultation that a dental recall was due. The Chain of Command was informed if patients failed to attend their appointment.

The practice manager attended the Commander Case Review meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the unit were provided an update on the dental targets.

Consent to care and treatment

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. An online course was part of the annual mandated training programme for all staff.

Are Services Caring?

Respect, dignity, compassion and empathy

We took into account a variety of methods to determine patients' views of the service offered at Neptune Dental Centre. The practice had conducted their own patient survey through the General Practice Assessment Questionnaire (GPAQ) feedback tool. A text was sent to all patients who had attended, inviting them to provide feedback anonymously. This was reviewed monthly. A total of 57 responses had been captured between April and August 2025. A total of 91% (52 of the 57) of respondents said they were generally happy with their healthcare provided. Thirty-five patients provided written or verbal feedback to us as part of this inspection. The comments were positive and praised the staff for the level of care and service provided. The main themes were that staff were both friendly and professional.

For patients who were particularly anxious, the practice had an individualised approach to understand the reason for anxiety, provided longer appointments and time to discuss treatment and invite any questions. Continuity of seeing their preferred clinician was facilitated by the addition of a patient alert on their record. Patients had been invited to bring headphones to shut out the noise, others had been given time to explain how the treatment would be administered so they understood each stage. Patients could also be referred for treatment under sedation as a final option, undertaken by referral to Glasgow Dental Hospital.

The waiting area for the dental centre was well laid out to promote confidentiality. Seating was set back from the reception desk; a television was well-positioned to provide background noise and prevent conversations at the desk from being overheard.

Access to a translation service was available for patients who did not have English as their first language. Information on telephone interpretation was displayed on the patient information board and a test call had been made to familiarise the process to be followed. In addition, there was a protocol for staff to follow included on the poster. Foreign ships arriving at Neptune were rare and, in the 1 instance staff could recall, they had their own translator. Patients were able to request a clinician of the same gender as there was a mix of male and female dentists.

Involvement in decisions about care and treatment

Patient feedback suggested staff provided clear information to support patients with making informed decisions about treatment choices. The dental records we looked at indicated patients were involved in the decision making and recording of discussion about the treatment choices available.

Are Services Responsive?

Responding to and meeting patients' needs

The practice took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 3 to 24 months depending on a dental risk assessment and rating for each patient. Patients could make routine appointments between their recall periods if they had any concerns about their oral health. The clinical team maximised appointment times by completing as many treatments as possible for the patient during the 1 visit. Any urgent appointment requests would be accommodated on the same day, emergency appointments were protected in the morning and staff reported that urgent requests for pain or trauma would be accommodated in the afternoon clinics or sooner if required. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them.

The deputy practice manger delivered an introductory brief to new joiners as part of the wider induction process onto the base. This was held in the conference room of the amenities hall, the main hub for new joiners. Block bookings had been used to accommodate urgent treatment prior to deployment. The uptake had been low so the approach had been tailored by boat to try and match clinical time to demand. For example, with 1 boat, Tuesday and Thursday afternoons were blocked, communicated to the crew by the medic on board and reopened to other patients if not used a week before. Another boat was only back for a week between deployments so appointments were made on behalf of the crew via the medical staff thus creating capacity in anticipation of demand.

With cancelled or missed appointments, the practice would try and fill these by using their knowledge of patients awaiting treatment and communicating with the units prioritising patients due to deploy. Waiting lists were kept for urgent and routine patients who were able to attend at short notice. The practice telephone out to mobiles and offices around the base (as the use of mobiles was prohibited in many areas). The text messaging service was utilised, primarily to cancel appointments and to send an automated reminder 5 days, 2 days and 1 day in advance of their appointment. Failure to attend appointments was communicated to the Chain of Command on the boat, a contact was held for each boat, whether on board or based in the firm base.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in May 2025. The audit found the building met the needs of the patient population, staff and people who used the building. Staff we spoke with told us that had never encountered the need for a hearing loop at the reception desk but were aware that patients could be signposted to the medical centre where a device was installed. The facilities included automatic doors at the external entrance to the building, visible and audible fire alarms, car parking spaces close to the entrance for disabled patients. Wheelchairs were available from the medical centre and the corridors in the building wide enough to accommodate them. All rooms were situated on the fourth floor of the building and there was a lift for patients if unable to use the stairs. An accessible toilet was available on the same floor in the Department of Community Mental Health area, adjacent to the dental centre.

Access to the service

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed on the front door, in the practice leaflet, on the practice SharePoint site and was included as part of the recorded message relayed by telephone when the practice was closed. An informative poster was displayed at the main internal entrance to the dental centre informing patients of what constituted urgent treatment (included when to go straight to the accident and emergency department) and what could wait for non-urgent treatment (e.g. broken or loose fillings, bleeding gums and broken crowns). The poster included information on how to access out-of-hours care. Through the My Healthcare Hub, a Defence Primary Healthcare (DPHC) application used to advise patients on services available, patients could also access the information.

Any patients presenting with pain would be seen on the same day. A pain proforma was used by non-clinical reception staff to ascertain whether the patient required and emergency or routine appointment. Patient feedback on access was positive; 88% said they had been able to access care easily in the last 6 months.

Concerns and complaints

The Senior Dental Officer was the lead for clinical complaints and the practice managers were the named contact for compliments and suggestions. Complaints were managed in accordance with the DPHC policy. The team had all completed training that included the DPHC complaints' policy. A process was in place for managing complaints, including a register for written and verbal feedback.

The last recorded complaint was from August 2025. One written and 1 verbal complaint had been recorded in 2025. These were investigated and responded to appropriately and in a timely manner. We reviewed both complaints in detail and found that they had been appropriately managed and had been logged as informal complaints to identify trends. Both complaints were about not having access to a hygienist and this had been discussed at the practice meeting and staff reminded that oral health education clinics were clearly explained and patients were emailed to advise that oral health education clinics was the pathway into treatment. Staff advised that complaints were discussed in a practice meeting and complaints was included as a standing agenda item.

Patients were made aware of the complaints process through the practice information leaflet and a display in the practice. The practice had a box in the waiting area together with a form complaints, compliments or suggestions. Quick response codes were also displayed around the dental centre and a text was sent to all patients following an appointment. This had been introduced in June 2025 and uptake on giving feedback had increased. In this way, patients were able to give feedback out of sight from the reception area to promote confidentiality of any comments.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The practice managers had the delegated responsibility for the day-to day administration of the service. Staff were clear about current lines of accountability and secondary roles. They 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 the regional headquarters to Defence Primary Healthcare (DPHC) headquarters. The risk register as well as the business continuity plan were seen at the visit and confirmed to be thorough. They were monitored on a regular basis for updates/compliance and changes.

A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were dental specific protocols and standard operating procedures (SOP) that took account of current legislation and national guidance. Staff were familiar with these and they referred to them throughout the inspection. Effective risk management processes were in place and checks and audits were in place to monitor the quality of service provision. The clinicians carried out peer case discussions each week. The periodontal and referral logs were reviewed together with any cases clinicians wished to discuss. This forum was used to review any clinical specific policy changes, new SOPs and any new materials.

An Internal Assurance Review visit took place in April 2025. The practice was given an overall grading of ‘limited assurance.’ The practice carried out their own self-assessment in March 2025 and graded themselves substantial assurance overall. A management action plan (MAP) was developed as a result; actions identified had been completed or were in progress. Of note, the gaps in the established workforce had been filled and this had facilitated the impetus to address the known issues.

Performance against military dental targets, complaints, staffing levels, staff training, audit activity, the risk register and significant events were all uploaded onto SharePoint and could be viewed by region, DPHC headquarters and anyone granted access. The Health Assurance Framework (HAF) was used as part of the practice manager handover, it was a live document, updated regularly by the practice. The SDO and the practice managers regularly monitored the HAF for changes and updates were provided at a monthly meeting. This was also discussed at practice meetings so all staff had an awareness of the document and its contents. The MAP was reviewed regularly and updated as actions were completed. The MAP was also monitored regularly by the regional headquarters and DPHC headquarters.

Staff felt well supported and valued. Staff told us that there were clear lines of communication within the practice and gave positive comments on the teamwork. Although the SDO and practice manager were responsible for the leadership and management of the practice, duties were distributed throughout the staff to ensure the correct subject matter expert had the correct role. All staff were encouraged to have input into the governance and assurance frameworks. Terms of reference were in place to clarify the responsibilities of those with lead roles. Practice meetings were held weekly; these had an

agenda and were minuted. Staff felt they had input and could speak freely as well as being listened to. Minutes were sighted during the inspection and confirmed to include all the required standing agenda items.

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. Discussions with patients were held away from reception if requested. A reporting system was in place should a confidentiality breach occur (on the ASER system via the SDO). Staff had completed training in protecting personal data, information awareness and data security awareness.

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. Throughout the inspection, it was evident that there was a strong team ethos and a team that were cohesive in their approach. Staff described leaders as supportive and considerate of the views of all staff. There was a large area where staff could meet, socialise at break times (included a monthly ‘bacon butty stand’) and hold training events. Staff spoke of the practice being an enjoyable place to work, of note. Staff from the dental centre held roles within the wider DPHC. For example, one of the dental nurses was the local health education coordinator.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective. To develop their managerial skills, the practice manager had provided the deputy practice manager and fleet practice manager delegated areas of responsibility such as infrastructure, equipment and liaison with the unit on dental performance statistics.

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 in line with General Dental Council requirements. Staff were encouraged to set goals and areas for improvement and development.

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

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; the deputy practice manager used the filter functions to dig deeper into the results and look for trends that appear. As the GPAQ is a live system, it means the information can also be accessed by the regional headquarters and DPHC headquarters who can then conduct trends analysis for wider regional trends. Updates were then fed to the staff at practice meetings. There were no examples of changes made

following feedback from patients. A ‘you said, we did’ display in reception informed patients of action taken as a result of feedback. For example, following comments made about the 5 hour travel time from Barrow for a check-up (from patients and the Chain of Command), a team was deployed to work from the medical centre at Barrow and provide outreach clinics. A total of 90 patients were seen at Barrow across the 6 days on which clinics were hosted there.

The SDO listened to staff views and feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. A staff suggestion box was positioned discreetly so that anonymous feedback could be given.

A ‘raising concerns’ policy was in place and displayed in reception. Staff had received training and said they would feel comfortable raising any concerns. Staff also had the option to approach the regional ‘Freedom to Speak Up Champion.’ Contact details were displayed on a poster displayed in reception.