Larkhill Dental Centre

Willoughby Road, Larkhill, Wiltshire, SP4 8QY

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 Larkhill Dental Centre on 11 March 2025. We gathered evidence remotely and undertook a visit to the practice.

As a result of the inspection we found the practice was safe, effective, caring, responsive and well-led in accordance with 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 one of a programme of inspections that CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

Background to this practice

Located in Wiltshire and part of the Defence Primary Healthcare (DPHC) Dental Central and Wessex region, Larkhill Dental Centre is a 12-chair practice providing a routine, preventative and emergency dental service to a military patient population of approximately 3,500. Larkhill is the biggest military dental centre and is home to the Royal Artillery and The School of Artillery. Dental Care is provided to Phase 2 soldiers, nearby artillery regiments, Middle Wallop and to Headquarters Andover. The dental centre is a new build, co-located with the medical centre and is situated on the first floor of the building.

The dental centre is open Monday to Thursday from 07:45-16:45 and 07:45-13:15 on a Friday. Daily emergency treatment appointments are available. There is a hygiene hub in situ that looks after the Salisbury Plain Area with patients from Tidworth, Bulford and Warminster. A regional emergency rota provides access to a dentist when the practice is closed. A number is provided for patients to call a dentist; following triage, the patient can be seen at a military dental centre. Minor oral surgery referrals are made to an Intermediate Minor Oral Surgery Service that can be provided at Lyneham Dental Centre. Secondary care support is available from the local NHS hospital trust (Salisbury Hospital) for oral surgery and oral medicine. DPHC's Defence Centre for Rehabilitative Dentistry can also be used for other referrals.

The staff team at the time of the inspection

Senior Dental Officer (SDO) (military)	1
Dentist (civilian)	4 (full-time and part time equivalent to 3 whole time equivalent)
Dental hygienist (civilian)	3 (part-time and full-time. Part of the hygiene hub and includes patients for Tidworth, Warminster and Bulford Dental Centres)
Dental nurses (civilian)	9 (full-time and part time) 1 dental nurse locum
Practice manager (military)	1
Practice manager (civilian)	1
Receptionists (civilian)	2 (part time equivalent to 1 whole time equivalent)

Our Inspection Team

This inspection was undertaken by a CQC inspector supported by a dentist and a practice manager/dental nurse specialist advisor. Two new specialist advisors attended as observers.

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, a hygienist, dental nurses, practice manager 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.

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 treated patients with dignity and respect and 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:

There was a recurring theme of staff tailoring the services to meet the specific needs of the patients, of note with health promotion, management of the appointment times and referrals to the medical centre for further treatment.

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.

We recommend to Defence Primary Healthcare:

- The dental team should have access to training around supporting patients with a learning disability / autistic spectrum disorder (ASD) in line with the national requirement for all healthcare providers.
- Issue clear guidance to dental teams with regard to the key changes to Health Technical Memorandum 07-01 and what this means in practice.

We recommend to the practice:

- Strengthen arrangements for legionella management and monitoring.
- Ensure clinical waste management processes are fully effective in providing a traceable record of waste removal and disposal.

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

(on behalf of CQC's Chief Inspector of Primary Medical Services and Integrated Care)

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. The staff team completed external ASER training 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 6 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, oral surgery retractors (a tool used to hold back soft tissue during dental procedures) were now used following an ASER where a patient had accidentally suffered a cut to their tongue. Significant events were a standing agenda item at the monthly practice team meeting. Staff unable to attend could review records of discussion, minutes of these meetings were held in a shared electronic folder (known as SharePoint).

Staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff we spoke with were not sure of their responsibilities for reporting incidents but stated that any accident or injury would be reported to the practice management.

Alerts were included on the ‘direction and guidance’ email so that the Senior Dental Officer (SDO) and practice managers were informed by regional headquarters (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). Alerts were acknowledged as read and the practice had to input receipt and action into a regional register. Copies were shared with staff using a hard copy form. This was done at practice meetings where attendees were listed but there was no signature to say that staff had read and understood the alert. The practice planned to share alerts electronically so electronic signatures of receipt could be requested. The SDO and practice managers deconflicted annual leave so that a buddy system for the receipt of alerts was in place.

Reliable safety systems and processes (including safeguarding)

One of the civilian dentists was the safeguarding lead and had level 3 training. One of the other civilian dentists was also trained to level 3 so could provide cover. The safeguarding policy and personnel in key roles were displayed on a dedicated noticeboard. All other members of the staff team had completed level 2 safeguarding training with the exception of 1 dentist whose training had expired and was being enrolled onto the next available course. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances. Training on the local policy had

been delivered in March 2025. We highlighted a recent DPHC policy that required safeguarding leads to complete tier 1 training on learning disability and autism.

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.

The dentists were always supported by a dental nurse when assessing and treating patients. A chaperone policy was held in reception and it was being planned to include this in the new patient induction. Although lone working was normal for the hygienist, there was always another member of staff in the dental centre. On call staff entered and exited the building together when on duty. Each surgery room had a panic alarm button that allowed staff to call for assistance. The panic alarms were tested weekly and connected to all surgeries as well as reception so a sounding of the alarm would be heard in those areas.

A ‘raising concerns’ policy was in place and displayed in reception. Staff had received training delivered in November 2024 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.

Rubber dams were routinely used for nearly all restorative and endodontic treatments in line with guidance from the British Endodontic Society.

A comprehensive business continuity/resilience plan (BCP) was in place and had last been reviewed in July 2024 and was last amended in February 2025. 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, terrorist attack/mass casualty event, adverse weather conditions and contagious outbreaks. A list of key contacts listed on the plan included staff members, senior members of the regional team, nearby dental centres, the cleaning contractor, the Radiation Protection Advisor and the main guardroom. The BCP could be accessed remotely should access to the building be restricted. The BCP had been tested in January 2025 using a simulated exercise which included an overview, summary and improvements identified.

Medical emergencies

The medical emergency standard operating procedure from Defence Primary Healthcare (DPHC) was followed. The automated external defibrillator (AED) and emergency trolley were well maintained and securely stored, as were the emergency medicines. Daily 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 (some were rectified on the day). 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. One of the dental nurses was the appointed first aider and there were first aid stations in the central sterilisation services department (CSSD) and at reception. 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 in the surgeries.

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 an enhanced Disclosure and Barring Service (DBS) 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 3 years, military personnel 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 corridor and there was an H&S notice board furnished with the latest information. The safety, health, environment and fire team carried out an annual workplace health and safety inspection and completed monthly checks. In addition, the civilian practice manager was the named health and safety lead and this was reflected in their terms of reference. The military practice manager was a trained risk assessor and there was a set of risk assessments that included access/egress, movement around the practice and lone working. The unit carried out a fire risk assessment of the premises every 5 years with the most recent assessment undertaken in February 2023. The medical centre practice manager was the fire warden for the premises and the duty medic checked the fire system weekly with a record made in the fire logbook. Staff received annual fire training provided by the unit and an evacuation drill of the building was conducted in February 2025. There was a fire safety noticeboard displayed in the reception corridor. Portable appliance testing had been carried out in line with policy. A Control of Substances Hazardous to Health (COSHH) risk assessment was in place and had been reviewed in August 2024. COSHH data sheets were in place and had been reviewed in August 2024. A log sheet was maintained of each hazardous product with links to the safety data sheets. All staff had signed this log sheet. Internal audits of safety processes were carried out annually in conjunction with the medical centre.

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

SDO and practice managers, an electronic alert was in place to serve as a reminder. The main issues identified were poor soil piping for the toilet and lengthy wait times for secondary care. These had been escalated to regional headquarters.

Infection control

One of the dental nurses had 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 twice a year and the most recent was undertaken in January 2025. A dedicated IPC spreadsheet plotted and recorded checks to be carried out. These included a 6 monthly fridge defrost, quarterly ultrasonic testing and monthly dipslides (used to test water lines for microbial growth).

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 were satisfied that the current contract was sufficient for the practice needs and deep cleaning arrangements were in place. 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 air conditioning units in each surgery.

Decontamination took place in a CSSD, 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 an external contractor in December 2022 and covered all the required areas. The review date required an updated risk assessment to be conducted every 3 years. A protocol for the prevention and management of legionella was in place. This protocol detailed the process for flushing taps and disinfecting water lines. A log sheet was maintained to evidence of the flushing programme. Water testing was carried out quarterly and results provided. Dead legs (sections of water pipe seldom used) were flushed by the contractor monthly. Although the team was satisfied with the processes around managing legionella, there was scope to further strengthen by having an agreed formal notification should the water temperature fall outside of the temperature parameters and for individuals carrying out the flushing of taps to sign on completion.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. The clinical waste bin, external of the building, was locked, secured and away from public view. Clinical waste was collected weekly and consignment notes were provided by the contractor. Waste transfer notes

were retained and audited annually. We highlighted that arrangements should be strengthened with clarity on which waste was from the dental centre and which was from the medical centre. Destruction certificates should be obtained for best practice despite the waste removal being carried out by a licensed contractor. 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 and a 'non-task worthy' sign placed on it. The autoclave and ultrasonic bath had been serviced in February 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. Pharmaceutical fridges were defrosted and cleaned quarterly. A Land Equipment Audit (LEA) was completed in February 2025 and the report was yet to be completed. Recommendations made in the 2024 LEA audit had been actioned. Portable appliance 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.

A manual log of prescriptions was maintained 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 hormone used to treat low blood sugar levels) was stored in the fridge in easy reach of the emergency trolley. The practice had carried out a recent audit of prescribing in February 2025. Although this is not a requirement, it is good practice and improves clinical oversight. Prescribing audits were on the practice audit plan but had not been prioritised due to the low numbers of items prescribed.

Compressor checks were not included in the fire risk assessment where there was no mention of the risks associated with compressed air. The next fire risk assessment was planned for June 2025 and the practice assured us that they would request 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 January 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 January 2023.

Evidence was in place to show equipment was maintained annually, last done in February 2025. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

The dental care records for patients showed the dentists justified, graded and reported on the X-rays taken. The SDO carried out an intra-oral radiology audit every 6 months, the most recent was underway awaiting for the full 100 exposures per surgery before analysis.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients were assessed by the dentists in line with recognised guidance, such as National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network guidelines. 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.

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. The dentists followed the guidance from the British Periodontal Society around periodontal staging and grading. Records confirmed patients were recalled in a safe and timely way. We discussed how the use of standardised recording of the risk profile would support decision making on the frequency of recalls for patients.

The Senior Dental Officer (SDO) 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 SDO and practice management. We noted that performance of key performance indicators were below target levels but had been targeted for improvement in 2025. For example, 69% of patients were category 1 (had all operative treatment completed) and category 2 (treatment needed but not urgent and patient deployable). A locum dentist had started in February 2025 and a new military dentist was scheduled to start in April 2025. The plan was to catch up now that workforce gaps had been filled.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. Four of the dental nurses were qualified as oral health educators (OHE) and one took the lead on health education campaigns supported by colleagues who included the regional OHE lead. They 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). A yellow card was used to promote a proactive approach. The card was used to communicate information to the medical centre staff when a patient was referred.

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 coordinator maintained a health promotion area in the patient waiting area. Displays were clearly visible and at the time of inspection included a campaign to support patients to stop smoking.

MOLAR statistics were provided as Larkhill Dental Centre is a training establishment and targets were being achieved. Project MOLAR is a treatment strategy to improve the dental health of personnel entering the military.

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. However, this was not evident from the 6 records reviewed.

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 civilian practice manager monitored the training plan and ensured it covers all the mandated requirements at the right times. The in-house training programme was detailed on a training register and discussed at practice meetings. The receptionist had completed a course on reception duties. This had led to the introduction of a welcome letter and leaflet for new patients that was followed up with an introductory visit to the dental centre.

All dental nurses that were asked were aware of the General Dental Council 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 General Dental Council'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 the practice managers attended the regional practice managers' meetings.

The staff members we spoke with confirmed that the staffing establishment and skill mix was 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 Salisbury District Hospital for secondary care. 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.

The practice worked closely with the medical centre in relation to patients with long-term conditions impacting dental care. In addition, doctors have 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 SDO and practice manager attended the unit health committee 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.

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 Larkhill Dental Centre. The practice had conducted their own patient survey in using the General Practice Assessment Questionnaire (GPAQ) feedback tool. A total of 102 responses had been captured between January and March 2024. A total of 98% of respondents said they were generally happy with their healthcare provided. A total of 30 patients provided written or verbal feedback to us as part of this inspection. All of 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 informative.

For patients who were particularly anxious, the practice had an 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 could also be referred for hypnosis or treatment under sedation as a final option, done by referral to Salisbury District Hospital.

The waiting area for the dental centre was well laid out to promote confidentiality.

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. Some forms had been translated into foreign languages. 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. Some of the clinical team maximised appointment times by completing as many treatments as possible for the patient during the 1 visit. Staff informed us that this was normally the case with military dentists. 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. Feedback from patients suggested they had been able to get an appointment with ease and at a time that suited them.

Any cancelled or missed appointments would try and be filled using waiting lists of urgent and routine patients who were able to attend at short notice. The text messaging service had been introduced to provide short notice communications. Internet connection at Larkhill was an ongoing issue so email and voicemail communications had not been effective. Patients travelling from Andover were not given the early appointments to allow time to notify patients of any cancellation. Prior to this, patients were travelling to be told that their appointment was cancelled, normally when a clinician was absent and clinics had to be cancelled.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in January 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. However, there was a device kept behind reception should it be required. The facilities included automatic doors at the entrance, visible and audible fire alarms, car parking spaces close to the entrance for disabled patients and wheelchairs were available. All rooms were situated on the first floor of the building and there was a lift for patients if unable to use the stairs.

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. Through the My Healthcare Hub, a Defence Primary Healthcare (DPHC) application used to advise patients on services available, patients could also access the information.

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 September 2024. Two written and 1 verbal complaint had been recorded in the last 12 months. These were investigated and responded to appropriately and in a timely manner. We reviewed the complaint from September 2024 in detail and found that it had been appropriately managed and as a result signage was introduced to advise patients to inform reception if waiting for more than 15 minutes. Staff advised that any complaint would be discussed in a practice meeting and complaints was included as a standing agenda item. However, minutes recorded in the following practice meeting did not include any note of discussion or any lessons learnt.

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. Quick review codes were added to the contact cards displayed on reception and given to all patients booked for a future appointment when at the desk. 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 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, including the hygienist, 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 standard operating procedures and any new materials.

An Internal Assurance Review visit took place in May 2024. The practice was given a grading of ‘substantial assurance.’ A management action plan (MAP) was developed as a result; actions identified had been completed or were in progress. Of note, the SDO had added impetus since joining in January 2025. 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 the monthly practice meetings. 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. Of note, we received positive comments on the practice managers and how they managed the combined role effectively. 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 every month, these had an agenda and were minuted. All staff felt they had input and could speak freely as well as being listened to. Minutes were sighted at

the visit and confirmed to include all the required standing agenda items. A ‘go to’ wipe board was maintained to inform staff of current information and this was supported by a weekly huddle on a Friday to discuss current issues and requirements for the week ahead.

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 the Defence Information Management Passport training, data protection training and training in the Caldicott principles. Of note, we observed receptionists keeping any documents that included patient information face down to maintain confidentiality. Patients were asked to confirm their surname when on the telephone to prevent the patients’ names being audible to those in the waiting area. Plastic cards were used for patients to re-book and these were wiped clean once the appointment was put onto the system.

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. Staff spoke of the practice being an enjoyable place to work, of note, the benefits of having both a military and civilian practice manager. This combination allowed for a greater understanding of military requirements for patients and for the nuances of being a civilian employed by DPHC. Staff from the dental centre held roles within the regional team. For example, one of the dental nurses was the oral health education lead for the region.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were effective.

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 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. The feedback had been positive and there were no examples of changes or negative experiences from patients. A ‘you said, we did’ display in reception informed patients of action taken as a result of feedback. For example, out-of-hours duty dental instructions had been placed on the reception desk after a questionnaire revealed that 80% of patients did not know how to access out-of-hours care (it was the responsibility of the unit to inform patients through standing orders). In 2024, a text messaging service was introduced to provide patients with a reminder of their appointment and to inform if an appointment needed to be rebooked. Staff reported that this system led to significant improvement in failures to attend.

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. All staff had been invited to complete a climate assessment survey in December 2024. Anonymous feedback was sent to the Principal Dental Officer. Results were collated and any outcomes would be discussed at the next regional training day (held every 6 months). Whitespace events had been held although some staff fed back that these had not always been effective.