# Cottesmore Dental Centre

Kendrew Barracks, Leicestershire, LE15 7BL

## 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.

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| 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 Cottesmore Dental Centre on 6 August 2024.

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

CQC does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare 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 Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against CQC's observations and recommendations.

This inspection is one of a programme of inspections CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

## Background to the practice

Cottesmore Dental Centre is a 3-chair practice supporting a patient population of 1,800. It is a networked dental practice with Wittering Dental Centre (population 1,000), referred to as 'Witmore Integrated Group Practice'. The practice manager and Senior Dental Officer (SDO) manage the networked dental practice. Although all staff have a primary dental centre from which they work, they work flexibly between the 2 services to support staffing as needed.

The full range of primary dental care is provided, including urgent same day appointments and an out-of-hours on-call service. The patient population for both dental centres are not formally integrated although patients can attend either dental centre to support timely access to care and for patient convenience. Cottesmore and Wittering dental centres are 11 miles apart and patients are supported to travel between the 2 services.

Opening times at Cottesmore Dental Centre are 08:00 – 17:00 hours Monday to Thursday (closed for lunch 12:30 to 13:30 hours), 08:00 to 12:30 hours on Wednesday and 08:00 to 13:30 hours Friday.

### The staff team

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|---|---|
| Dentists | SDO<br>Civilian dentist (locum) |
| Hygienist | Civilian hygienist |
| Dental nurses | Military nurse<br>Civilian nurse x 2 (1 locum) |
| Practice management | Military practice manager |
| Administration | Civilian receptionist (part time) |

## Our inspection team

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

## How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the SDO, practice manager and staff who were working that day. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the building, equipment and facilities and reviewed patient feedback.

**At this inspection we found:**

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Leadership at the practice was inclusive and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Systems were in place to support the governance and risk management of the practice.
- There was limited resilience within the system in terms of staffing levels.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, required training and continuing professional development.
- Clinicians provided care and treatment in line with current guidelines.

- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Processes for assessing, monitoring and improving the quality of the service were in place.
- Arrangements were in place to support the safe use of X-ray equipment.

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

- An educational 'question of the month' had been introduced with a token system for patients to indicate whether they knew the answer. At the time of the inspection, the question was, 'Did you know you should not use mouthwash after tooth brushing?' A written rationale for when mouthwash should be used was displayed. The questions were decided at the practice meeting and were targeted to gain an understanding of the patients' knowledge of a variety of issues, including oral health matters. Patient responses to these questions supported the practice with modifying patient information resources.

- Given the diverse patient population and high levels of neurodiversity, the practice developed a simplified patient triage process to promote inclusivity. The triage form was completed by patients with an urgent need (usually dental pain). The questions were targeted requiring yes/no responses. A picture of the mouth was included so patients could circle the area causing the problem. The Senior Dental Officer highlighted that this process supported with understanding the dental problem from the patient's perspective. The initiative was raised as a quality improvement project.

- Staff took a pro-active approach to oral health education beyond what was expected of them. For example, the 'Smiles at School' involved staff providing children at the station school with a session on how to brush their teeth correctly and how to limit their sugar intake. This initiative was undertaken despite Defence UK-based dental centres not treating families of service personnel.

**The Chief Inspector recommends to Defence Primary Healthcare:**

- Ensure staffing levels are kept under review so they are sufficient at all times to meet patient need and safeguard the health and wellbeing of staff.

**The Chief Inspector recommends to the practice:**

- Review the induction process to ensure it is sufficient for civilian staff joining the practice.
- Seek the views of staff as part of the broader change programme for the 'networked dental practice'.

**Mr Robert Middlefell BDS**

**CQC's National Professional Advisor for Dentistry and Oral Health**

# Our Findings

# Are Services Safe?

### Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting (referred to as ASER) DMS-wide system. A register of events and incidents reported through ASER was maintained. All staff were registered to the use the system and the team had received ASER training in February 2024.

ASERs were a standing agenda item at the weekly practice meeting. For example, an ASER was raised when an unexpected IT outage occurred a few weeks ago due to building works; this was discussed at the practice meeting. Staff related accidents and incidents were reported via the Defence Unified Reporting and Lessons System (referred to as MySafety).

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

Both the Senior Dental Officer (SDO) and practice manager were registered for the Central Alerting System. Patient safety alerts were a standing agenda item for discussion at practice meetings. Urgent alerts were discussed during the ‘morning staff huddle’ and emailed immediately to staff also.

### Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead and the practice manager was the deputy lead. All staff were up-to-date with safeguarding training at a level appropriate to their role. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances.

The practice manager and receptionist conducted a monthly DMICP (patient electronic record) search to identify patients under the age of 18. The SDO ensured these patients were aware of welfare support when they attended for an appointment. All patients were informally assessed during appointments for vulnerabilities taking into account the impact deployment tempo can have on wellbeing. In addition, reception staff were aware of possible vulnerable patients and booked them in earlier than needed if there were any concerns about their welfare.

All staff had completed training in the duty of candour (DoC) principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A DoC register was maintained and was a standing agenda item at the practice meetings. A DoC notice was displayed in the patient waiting area.

Dentists were always supported by a dental nurse when treating patients. In accordance with Defence Primary Healthcare (DPHC) policy, the dental hygienist did not have

chairside support but their surgery was located close to reception and the practice manager's office if support was required, and in case of a medical emergency.

The chaperone policy was displayed in the waiting room so was accessible for patients to view. Patients were also reminded that they could have a chaperone during appointments if needed.

The practice had a good relationship with the co-located medical centre staff team whom they could call on for additional support if needed. Although staff rarely worked in the building alone, a lone working risk assessment was in place. Arrangements for lone working included informing the medical centre or the guard room.

Each surgery had an emergency alarm button and there was also an alarm at reception. The alarm could be heard throughout the dental centre so staff could immediately respond to a medical emergency or other incident. All alarms were tested weekly. Patients could be observed in the waiting area from reception.

A dental dam was used routinely for adhesive restorations and endodontics (root canal treatment). If patients were unable to tolerate a dam then endodontic treatment could not be completed for safety reasons.

The business continuity plan was available on SharePoint and was last reviewed in May 2024. The plan had been actioned during an IT outage a few weeks before the inspection.

### Medical emergencies

The SDO was the lead for medical emergencies. All staff were up-to-date for medical emergency training. Training was last delivered in January 2024. Simulation training with using the medical emergency kit was routine and all new joiners were taken through the process as part of their induction. Although easily available and visible during working hours, the kit was securely stored when the practice was closed.

All components of the medical emergency kit were stored together in a grab bag. Controlled drugs (medicines with a potential for misuse) used for medical emergencies were easily accessible during working hours but were locked away during lunchtimes and out-of-hours. The glucagon (medicine used to treat low blood sugar levels) was stored in the pharmaceutical fridge so was not included in the grab bag. This meant there was a possible risk with quick access to the glucagon during a medical emergency. The SDO said they would hold a dose of glucagon in the bag for easy access. We checked the full emergency medical kit and all required items were in place and in-date. A local protocol was in place for the disposal of medicines via the medical centre dispensary.

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

The temperature log for the medical emergency kit showed a daily maximum temperature check of 39.3 degrees had been recorded but no action had been taken. The SDO investigated this further following the inspection. Action taken included a re-setting of the thermometers daily to capture all daily readings (as part of the daily kit checks process). Staff have continued to review the temperatures in the stock room used to secure the

medicines overnight where both ambient temperature, fridge temperature and the drug kit temperature were recorded daily. Blinds in the room were kept closed to block sunlight and the door was kept open during working hours when staff were present. The SDO confirmed in-service training was provided for staff regarding temperature checking. To proactively manage any future risk with peaks in temperature, a statement of need has since been raised requesting that air conditioning be installed in the stock room to ensure the room remains at a steady temperature.

Scenario-based training in managing medical emergencies was held every 6 months with the last taking place in February 2024. The practice experienced 2 medical emergencies in the previous 6 months; both due to patients fainting after extractions. Both situations were managed well and the patients recovered quickly. Learning took place as a result of these incidents with all patients given glucose tablets before an extraction; their medical history permitting.

We discussed with the SDO if patients understood what to do if they experienced pain or their condition deteriorated. How to manage pain and what to do if symptoms worsened was discussed with patients. Out-of-hours support was displayed on the front door, at reception and explained individually to patients during a consultation.

Training regarding recognition of the signs of sepsis had been provided as an in-service training and via presentation from Regional Headquarters (RHQ). This was included in all medical emergency training too. Sepsis aide-memoires were displayed in the staff room and at reception. All staff we spoke with were fully familiar with what to do if they were concerned a patient may be displaying the signs of sepsis.

### Staff recruitment

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

### Monitoring health & safety and responding to risks

The practice manager was the lead for safety, health, environment and fire (referred to as SHEF) and had completed appropriate training for the role (referred to as IOSH).

A risk register specific to the practice was in place with risks managed in accordance with the ‘4 Ts’ (transfer, tolerate, treat, terminate). A range of regularly reviewed risk assessments were in place including assessments relevant to the premises, staff and clinical care.

The 5-yearly fire risk assessment was undertaken in June 2024 and it identified the building as a green or tolerable risk. The building fire warden was based in the medical centre. The fire alarm was checked weekly and firefighting equipment and evacuation

measures were checked each month. A fire evacuation drill was undertaken in January 2024 with a further drill planned for July 2024 to capture new staff.

The practice manager was the lead for Control of Substances Hazardous to Health (COSHH). COSHH products were stored securely and risk assessments/data sheets were reviewed annually with the last review taking place in February 2024. Staff had access to the COSHH risk assessments on SharePoint. The contracted cleaner kept cleaning products in a locked cupboard and had access to the company's COSHH risk assessments.

The unit was responsible for water safety and provided the practice with the legionella risk assessment which was carried out in July 2023. Although the unit tested the water temperatures each month, the practice was not given the results of the tests.

Dipslide testing used to check for bacteria in water was completed monthly. Dental unit waterlines were managed in accordance with DPHC's dental standard operating procedure. Water lines were flushed for 3-5 minutes each Monday.

The practice adhered to relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. Sharps containers were closed when the indicated levels were reached. The Insafe system was used to reduce the risk of sharps injuries and disposable matrix bands were used. The dentists disposed of their own sharps, and the SDO described removing handpieces and ultrasonic scalers from their couplings on the bracket table to reduce the risk to the dental nurse when cleaning down. Staff had completed training on sharps injuries, which included how to manage injuries and the action to take post-incident. Although staff had received training in snapping ampoules, an ampoule breaker was held as part of the medical emergency kit. Sharps incidents were reported using the MySafety and/or ASER systems.

### Infection control

One of the dental nurses was the lead for infection prevention and control (IPC) and had completed the required training for the role. Measures were established to minimise the spread of infectious diseases. Hand washing guidance was displayed, hand sanitiser was available throughout the building and staff had access to a sufficient stock of personal protective equipment. An IPC policy supported by training for all staff was in place; records showed staff were up-to-date with IPC training. IPC training was recently facilitated following an internal audit of dental instruments. Staff were encouraged to wipe used instruments and soak them as soon as possible to reduce the chance of used materials or blood binding to the stainless steel.

The practice had a central sterile services department (CSSD) with clearly identifiable clean and dirty areas. Staff had a full understanding of the complete process and provided a full talk through of the decontamination process. Dental nurses supported the hygienist with the decontamination of their instruments.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). Updates were received from Regional Headquarters,

including any new information shared by the GDC. These were discussed at the practice meetings.

The last IPC audit was completed in February 2024. All pending actions had been recorded separately due to a newly updated organisational IPC audit, which did not include an improvement and implementation plan.

Environmental cleaning was carried out by a contractor and a schedule was in place outlining the cleaning arrangements for each area and frequency. Cleaning was undertaken twice a day and the contract included a deep clean twice a year. Cleaning products and equipment were stored securely. The practice manager monitored the cleaning and any concerns were reported through the Quarter Master's department. The surgeries were cleaned by the nurses each day.

Clinical waste was safely managed, including extracted teeth, gypsum (for taking dental impressions) and amalgam (used for fillings). An amalgam separator was attached to each dental operating unit and staff were aware of how to manage amalgam waste. Secure storage for clinical waste was located in a compound outside of the building. A waste log was maintained and consignment notes were in place and up-to-date. The last annual clinical waste audit was undertaken in February 2024.

### Equipment and medicines

The SDO was the lead for equipment care and the practice manager was the deputy lead. Daily checks were undertaken of the equipment in the surgeries, laboratory and CSSD. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All equipment was in-date for servicing and testing. A fault log for equipment was held on SharePoint and a room was used to store quarantined equipment. The testing of electrical portable appliances was undertaken. We were advised the contractor was scheduled to visit in September 2024.

We checked the surgeries and they were clean and tidy. A system was in place to ensure adequate stock and that it was efficiently managed. Stock checks were completed for all surgeries. All equipment was latex free. Pharmaceutical fridge temperatures were monitored daily and recorded in a logbook. The practice manager and SDO carried out weekly spot checks of the logbook to ensure temperature checks were recorded. Similarly, they also spot checked the storeroom temperatures were recorded each day.

A prescription log was held on OneNote (digital note-taking app) with details of prescribing recorded, including the need for patient recall after antibiotic prescribing. The SDO undertook an antibiotic prescribing audit in preparation for this inspection and plans to repeat it in 6 months to monitor for improvements identified as a result of the audit.

### Radiography (X-rays)

Suitable arrangements were in place 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 for the practice was identified. The SDO was identified as the Radiation Protection Supervisor (RPS). The SDO had not yet undertaken the RPS course,

which was coordinated via RHQ. We discussed with the SDO applying for the next available course. The practice manager had completed the RPS course as they were trained in specialist radiology. This meant there were adequately trained staff at the practice.

Signed and dated Local Rules were displayed in each surgery. When undertaking an X-ray, staff stood outside of the surgery and maintained sight of the patient throughout the exposure. All staff wore dosimeters (used to measure ionizing radiation exposure) in line with DPHC protocol.

A rectangular collimator (used to reduce unnecessary radiation exposure) was available on the intra oral units. Staff were aware the new design had a tendency for the lead lining to peel slightly and create a white mark on the image; this rarely impacted diagnostic quality.

X-ray equipment was maintained in line with the Ionising Radiation Medical Exposure Regulations (IR(ME)R). It was regularly serviced by MDSS with the most recent service in March 2024. In-service daily checks, including test x-rays, were completed by the dental nurse and dentists prior to use.

Staff requiring IR(ME)R training had received relevant updates. All training was recorded in the radiography training log.

Ongoing audit of all X-rays was undertaken, with every image taken recorded on a radiography log, and results produced monthly. The SDO maintained a spreadsheet daily whereby every image taken was recorded at the time of exposure to allow for ongoing audit to be completed. At the end of the month, all images were reviewed to support quality assurance.

# Are Services Effective?

## Monitoring and improving outcomes for patients

Our review of patient records demonstrated the treatment needs of patients was assessed in line with recognised national guidance. The National Institute for Health and Care Excellence and the Scottish Intercollegiate Guidelines Network were referenced for recalls, the management of wisdom teeth or third molars, risk assessments, and X-ray intervals.

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

In addition, records demonstrated that guidance from the British Periodontal Society (BSP) in relation to periodontal (gum disease) staging and grading was followed. Each surgery had a laminated copy of the BSP guidance, with referrals made to the hygienist as needed. Patients were discussed on a monthly basis at a multi-disciplinary team meeting with the dental hygienist. Patients reluctant to engage with hygiene treatment were referred back to the dentist in accordance with BSP guidance.

Patient deployments were always determined at Periodic Dental Inspections (PDI), so that treatment needs were addressed prior to deployment, and shorter recalls given due to the higher risk posed from time spent deployed. Patients were downgraded if unfit to deploy and this was raised at Unit Health Committee meetings for unit commanders awareness. A pro-active management approach was taken for third molars of deployable patients.

A basic periodontal examination, assessment of the gums and for caries (tooth decay), was carried out at each PDI. The military dental fitness targets were closely monitored by the Senior Dental Officer (SDO). There had been a significant improvement in targets over the last few months.

## Health promotion and prevention

The dental hygienist was the lead for oral health education (OHE). Where applicable, the patient records we reviewed showed proposed treatment pathways and information given to individual patients was in accordance with the Delivering Better Oral Health toolkit.

The hygienist actively engaged with Phase 2 trainees by visiting the unit and providing oral health promotion sessions. In addition, a dental nurse and the hygienist recently visited the station school to facilitate an OHE session for children, titled 'Smiles at School'. The children were shown how to brush their teeth correctly and also how to limit their sugar intake. This demonstrated an advanced level of community engagement not usually seen in Defence UK-based dental centres as they do not treat families of service personnel.

The practice used a focussed educational feedback system to ask specific questions in order to determine patients' understanding of specific issues, including questions related to oral health.

Clinical records demonstrated that each patient was routinely asked about their oral hygiene routine, dietary habits and smoking, including smokeless tobacco and vaping. Dietary, oral hygiene and lifestyle habits were captured on the arrival form and followed up with a brief intervention. Checks were made at subsequent appointments. The alcohol screening tool (referred to as AUDIT-C) was used to capture the alcohol usage of patients. One of the dental nurses was the smoking cessation advisor but mostly patients were signposted for cessation support to the nurses in the medical centre.

High fluoride toothpaste was frequently prescribed for patients at a high risk of caries which was fully justified given the patient population was a high risk to caries. The hygienist applied fluoride varnish on prescription from the dentist. A spreadsheet was used to monitor the recall patients for further fluoride varnish application. In addition, the hygienist applied fissure sealants where moisture control was indicated. If placement of the sealant was a challenge, then the patient was referred back to the dentist to complete.

The patient-orientated oral health displays in reception/patient waiting area were refreshed each month. At the time of the inspection there was a display regarding wisdom teeth pain. In addition, patients had access to a wide-range of oral health information leaflets. Practice staff participated in the unit-led station health fairs. The last health fair was held in December 2023. The hygienist had been actively encouraging unit staff to hold another in the near future.

### Staffing

The minimum staffing policy for Cottesmore Dental Centre was 1 military SDO, 1 military practice manager, 1 civilian dental practitioner (CDP), 1 civilian dental hygienist, 2 civilian dental nurses and 1 military dental nurse.

The practice had been unable to recruit for a CDP and a dental nurse due to restrictions on the recruitment of civilians. A locum dentist was in post until the end of August 2024, which had taken the pressure off the SDO for a limited period. Although patients could access urgent and routine appointments in a timely way at the time of the inspection, 1 dentist was insufficient to meet the needs of the patient population. In addition, the added responsibility of managing 2 dental centres had impacted the clinical output of the SDO. If a CDP was to be recruited then we determined it was essential a dental nurse was recruited so the CDP has chairside support. Although locums could be sourced, this was not guaranteed especially as the location of the dental centre is isolated from major population centres.

Coordinated by the practice manager, the Defence Primary Healthcare (DPHC) induction programme was in place for all new and locum staff. We spoke to civilian staff who had been through the induction process. They found the 2 weeks shadowing valuable but indicated there was not enough induction time to familiarise themselves with Defence dental policy and governance framework. We heard this was mainly due to absence of key leaders at the time to respond to queries and explain issues.

Staff training was overseen by the practice manager and one of the dental nurses deputised. Training was recorded on the DPHC Dental Personnel Management System and also on the in-service training log. The practice manager reminded staff via email if

training was due to be refreshed. Training was also discussed at practice meetings. All staff were up-to-date with mandated training at the time of the inspection.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. Once a month staff had dedicated time for CPD and in-service training. In addition, East Region held monthly dentist peer review sessions (recently launched by new Regional SDO). In addition, 6-monthly regional training/team building sessions were held. Staff received ongoing direction and guidance updates from Regional Headquarters. Royal Army Dental Corps events and a dental care professional conference were held annually.

### Working with other services

Patients requiring oral surgery were referred to local Tier 2 services or the local hospital at Peterborough for more complex surgery. Usually treatment was completed within 2 months via the local Tier 2 oral surgery service. Referrals to the hospital have taken 6 months for treatment to be completed. OPTs (panoramic single image X-ray) taken at the local hospital were returned electronically to the practice within 2 weeks. Referrals were made to the Managed Clinical Network using the standard protocol. Although the time taken to process them was variable, usually they were triaged and accepted within 4 weeks.

A referral log was maintained at the practice and was managed by the SDO. A diary reminder was in place for the SDO to check and update the referral log weekly. Referral protocols were held as a tab on the referral spreadsheet, which also recorded dental downgrades.

### Consent to care and treatment

Feedback from patients confirmed patients were given information about treatment options and the risks and benefits of these so they could make informed decisions.

Implied consent was used for a dental inspection. Verbal consent was obtained for all operative treatment. Written consent was taken for extractions, complex treatments and clinical photography. Our review of clinical records demonstrated thorough discussions with patients undergoing any operative treatment. Pictures, models and leaflets were available to support patients with making informed decisions about treatment options and outcomes.

Records showed staff had completed online and in-house Mental Capacity Act (2005) training. Staff we spoke with had a good awareness of mental capacity and how it could apply to their patient population.

# Are Services Caring?

### Respect, dignity, compassion and empathy

We received a significant amount of feedback from patients via our inspection feedback cards. We also reviewed the practice patient survey completed in July 2024, which generated 43 responses. All sources of feedback indicated staff treated patients with kindness, respect and compassion.

Alerts were used so staff were aware if a patient with a dental anxiety booked an appointment. Extra appointment time was allocated so desensitisation could be used to help with managing anxiety. Additional explanations were given to relax patients and ‘Stop signals’ used during treatment. The dental nurses enhanced the support both in reception and in the surgery.

The Senior Dental Officer (SDO) provided an example of a patient becoming agitated in the waiting area due to severe anxiety. The patient was prioritised and some desensitisation was undertaken over a few dedicated appointments resulting in the patient feeling positive about their future dental care.

The practice had access to the ‘Big Word’, a translation service for patients who did not have English as their first language. Access was via another region as the East Region access had been deactivated since 2020. The link to all numbers was attached to the policy in the reception area.

### Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support patients with making informed decisions about treatment choices.

A detailed consent process was undertaken. The results of all tests were discussed and materials, including X-rays, were shown so patients could understand the problem, make informed decisions and consent to the treatment they felt was right for them. Patients were given time to consider their treatment options and never rushed into making decisions. The dental records we looked at were very detailed and demonstrated in depth discussion took place with the patient regarding consent.

# Are Services Responsive?

## Responding to and meeting patients' needs

Clinicians followed National Institute for Health and Care Excellence guidelines and other national guidance in relation to recall intervals between oral health reviews; between 3 and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. Given the patient demographic and deployment tempo, there were few patients who were deemed suitable for recall intervals longer than 12 months. The SDO was aware that intervals of up to 24 months were possible.

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

A 'question of the month' had been introduced with a token system for patients to indicate whether they knew the answer. At the time of the inspection, the question was, 'Did you know you should not use mouthwash after tooth brushing'? Most patients who responded did not know this. A written rationale for when mouthwash should be used was displayed. A previous question included whether patients knew how to access out-of-hours (OOH) care if they had toothache (almost 50% of patients did not know how to access OOH care). A further question sought to establish if patients knew that they could be downgraded if they did not look after their oral health. When the month was up, the question was displayed with the answer and the patient response. Questions were decided at the practice meeting and were targeted to gain an understanding of the patients' knowledge of oral health matters and to provide patient education. Patient responses helped the practice to revise its patient information resources.

## Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in January 2024. The building was accessible to patients with reduced mobility as it was located on the ground floor with ramp access through the medical centre (the access point to the whole building). Accessible parking and an accessible toilet were available. A ramp was available to evacuate people in the event of a fire or other major incident. At the time of the inspection, a hearing loop was not required based on the needs of people who used the building. However, a statement of need had been submitted for a hearing loop should the need arise. The staff team had completed training in equality and diversity.

Staff advised us that patients originated from a wide range of backgrounds and cultures, including patients from Commonwealth countries. The Senior Dental Officer (SDO) described how there were high levels of neurodiversity within the patient population. To ensure inclusivity, the practice developed a simplified patient triage process; all patients with an urgent need (usually dental pain) completed this on arrival at the practice. The questions were targeted and predominantly required yes/no responses. A picture of the mouth was included so patients could circle the area causing them a problem. The SDO highlighted that this process supported with understanding the issue from the patient's perspective.

## Access to the service

At the time of the inspection, the next available routine appointment with a dentist was within 4 to 5 weeks. Staff advised that the wait would likely increase to 6 weeks when the locum dentist leaves. Individuals or units deploying were prioritised. Often the practice 'block booked 'appointments for deploying units. Patients requiring an emergency appointment during working hours could be seen on the same day. The next available appointment with the dental hygienist was the first week in October 2024; a wait of 9 weeks.

Cottesmore and Wittering dental centres are 11 miles apart so patients could attend either practice. Although not often needed, transport could be arranged for patients to attend one of the dental centres.

Dental out-of-hours (OOH) care was provided all year round through a regional duty on-call rota, which staff at both Cottesmore and Wittering dental centres participated in.

Information about the service, including opening hours and access to an emergency OOH service was displayed on the front door of the practice and in the practice information leaflet.

## Concerns and complaints

The SDO was the lead for complaints and the practice manager was the deputy lead. Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. Staff had received update complaints management training in July 2024. A process was in place for managing complaints, including the recording of complaints on the Regional Headquarters SharePoint. Complaints were a standing agenda item at the practice meetings. No complaints about clinical care had been received since the SDO took up post.

Patients were made aware of the complaints process through the practice information leaflet and information in the waiting area. Feedback from patients indicated they knew how to make a complaint.

# Are Services Well Led?

## Governance arrangements

As a networked dental practice, both Cottesmore and Wittering dental centres worked and trained together as an integrated dental team. This was the first Defence networked dental centre involving 2 different dental centres comprised of 2 different Armed Forces (British Army and RAF) and its success was reliant on effective teamwork and collaborative resource management. The Senior Dental Officer (SDO) along with the practice manager coordinated the governance arrangements for the networked practice. Although staff had a 'primary site of work' to support continuity of care, they worked flexibly between both services.

The SDO encouraged a collaborative leadership culture to ensure all staff were able to raise issues at the earliest opportunity. The team was empowered to take on additional responsibilities where capacity and training permitted. Individual staff had lead roles in specific areas and these roles were captured in their terms of reference. In terms of succession planning, mentorship and training was encouraged to develop junior staff for future management roles.

Integrated training with both dental centres was held each Wednesday to support team building and to ensure that all staff were trained to an equal standard. There was a risk of the SDO and practice manager becoming overburdened with the additional workload from this merger, compounded by uncertain staffing levels. We were advised Regional Headquarters (RHQ) were aware of this risk.

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

> "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental service for entitled personnel to maximise their health and to deliver personnel medically fit for operations."

The ethos for the networked practice was defined as:

> "We are an adaptable workforce committed to delivering high quality patient care to all we serve. Our goal is to provide an agile and holistic service centred around the needs of our PAR (population at risk) to support the oral health of service personnel to ensure that they are occupationally fit for role and fully deployable."

The SDO described effective communication with the various regiments. They attended the Unit Healthcare Committee meetings on a regular basis. Communication pathways were in place with RHQ, including routine engagement with the Principal Dental Officer and with the newly appointed Regional SDO for advice as required. The SDO also engaged with the Senior Medical Officer and Unit Medical Officer to discuss patient care and facilitate joint training between dental and medical centre staff.

The leadership team regularly reviewed governance and risk management systems to ensure they were up-to-date and reflected the networked dental practice arrangements. A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were local dental specific protocols and standard operating procedures that

took account of current legislation and national guidance. General Dental Council standards were displayed in the practice.

Internal and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the SDO and both RHQ and the Chain of Command had oversight of these. The practice used the Health Assessment Framework (referred to as HAF); internal quality assurance system used to monitor safety and performance.

The last internal assurance review was completed in April 2024. The safe, effective and well-led key questions were rated as limited assurance. Caring and responsive were rated as green. The recommendations made had been actioned.

A 'failure to attend' (FTA) policy was displayed in the patient waiting area. All FTAs were reported to the Chain of Command. The attendance rate was monitored each month and displayed. For July 2024, it showed 18 hours of clinical time was lost due to non-attendance.

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

To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper leaflets. The patient information leaflet was available in hard copy but also via a quick response or QR code clearly indicated at reception. Recycling bins were in use.

### Leadership, openness and transparency

We heard that frequent leadership changes over the last 3 years had not been beneficial to the wellbeing of individual staff or the morale of the team, including a period of time when there was no SDO at the practice. The current SDO had been in post for 6 months and was keen to make positive change, particularly in the context of the networked dental practice (with the potential to progress to a combined practice model). At the same time, the SDO recognised the need to ensure the staff team embraced the changes. Some staff told us change had been 'too rushed' without enough time to adjust to a new way of working, including additional roles.

Overall, we noted a culture that was positive and supportive. To support a healthy culture, the SDO promoted a 'whole team approach', including the use of mentoring and white space used for team building. An award system was in place for civilian team members.

Staff told us the leadership team was visible, approachable and supportive. They said the team worked well together with the collective aim to provide patients with a good standard of care. We heard there was an open and transparent culture and staff were confident any

concerns they raised would be addressed without judgement. Staff were familiar with whistleblowing arrangements. Whistleblowing information was displayed on the notice board, including a 'raising concerns and whistleblowing process flow chart'. A dedicated monthly 'white space' session was scheduled to allow for team building opportunities.

### Learning and improvement

The SDO was the lead for clinical audit/quality improvement. The staff team placed great emphasis on quality improvement. An in-service quality improvement log was maintained as well as regional log. As an example, the simplified triage form for patients experiencing dental pain was developed based on the needs of the population; this quality improvement project was shared with the region for other dental centres to use. A further example included the monthly patient educational question with tokens. In addition, the team were highly pro-active with oral health educational (OHE) as demonstrated by the level of input with the units and provision of OHE at the local school.

All the required audits had been completed, including infection prevention and control, equality access, clinical waste, prescribing and radiography. In addition, waiting times for appointments and clinical effectiveness audits had been undertaken. The SDO had scheduled a records audit for clinicians in September and November 2024. They confirmed that a clinical record audit was completed as part of their Clinical Quality Assurance and Appraisal (known as CQAA). All audits had a summary point that was shared with staff and discussed at practice meetings.

There was evidence of audits leading to positive change. For example, the antibiotic prescription audit highlighted a variation in the review period between clinicians following a prescription of antibiotics, which was not entirely in accordance with the guidance. This issue was discussed between the dentists and it was agreed that the review would be conducted 2-3 days later unless there was a reason it could not be undertaken, in which case it was recorded on the prescription log. The SDO planned to repeat the audit in 6 months to follow this up.

Mid and end of year staff appraisals were up-to-date.

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

To monitor how well the practice was performing, patients were encouraged to complete the Patient Experience Tool (referred to as the PET survey). To access the survey a QR code was visible in the dental surgery and printed copies were also available. A complaints, compliments and suggestions box was held in reception, which was checked by the practice manager each week. Patient feedback was shared with the team via email and during practice meetings. A feedback board was displayed in the patient waiting area highlighting the feedback comments from patients and how feedback had been used to make changes. For example, a PowerPoint display with tips for a healthy smile was displayed in reception as a result of patient feedback.

Staff could give feedback about the service verbally at the practice meeting or via the dental centre feedback tool.