Coningsby Dental Centre

Lincoln, Lincolnshire, LN4 4SY

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?	**Improvements required**	X
Are services effective	**No action required**	✓
Are service caring?	**No action required**	✓
Are services responsive to people's needs?	**No action required**	✓
Are services well-led?	**No action required**	✓

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Summary

About this inspection

We carried out an announced comprehensive inspection of Coningsby Dental Centre on 13 January 2026.

As a result of the inspection, we found the practice was effective, caring, responsive and well-led in accordance with the Care Quality Commission's (CQC) inspection framework. We found that action was required to ensure a safe service was being provided

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the observations and recommendations within this report.

This inspection is 1 of a programme of inspections CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- 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, collaborative and the team worked well together.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events.
- Effective systems were in place to support the governance and risk management of the practice.
- Staffing levels were identified as a risk with key members of staff about to leave the practice and minimal permanent staff to offer continuity.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults and young people.
- Staff were up-to-date with appraisals, training and continuing professional development.
- The dental centre was visibly clean throughout. However ongoing issues with the cleaning contract required action to ensure ongoing compliance.

- 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 recommend to the station/unit:

- The cleaning contract and arrangements should be reviewed as a matter of urgency and improvements made to ensure effective cleaning is sustained in line with nationally recognised standards.

CQC recommends to Defence Primary Healthcare (DPHC)

- Review staffing levels 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:

- 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.
- Ensure locum clinicians receive training in the use of DMICP and record keeping as part of their induction and ensure regular auditing of locum records.

Mr Robert Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Background to Coningsby Dental Centre

Located in Lincolnshire, RAF Coningsby Dental Centre is a 3-chair practice providing a routine, preventative and emergency dental service to a military population of 2,000 service personnel.

The dental centre is open Monday, Tuesday and Thursday from 08:00 to17:00 hours and on Fridays from 08:00 to13:30 hours. Wednesday afternoons are dedicated time for staff training and operational meetings.

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

The staff team

Dentists	Senior Dental Officer (SDO) Civilian dentist (locum)
Dental Nurses	Four (2 civilian job sharing, 1 civilian full-time, 1 military (currently on temporary leave and locum covering).
Dental Hygienist	Civilian hygienist (locum)
Practice manager	Military practice manager.

Our inspection team

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

How we carried out this inspection

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

Are services safe?

We found that this practice was not safe in accordance with CQC's inspection framework

Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting (referred to as ASER), the DMS-wide system for the management of significant events. In the past 12 months, 2 ASERs had been submitted, relating to an administrative error with DMICP (electronic patient record system) and the clinical process involving laboratory work entitlement for service leavers. Both these ASERs had been managed well within the 90-working day time frame. Training requirements were identified, actions implemented where required and then the ASER was closed.

The staff team had received annual ASER training with the last being in June 2026, and all were registered to use the system. Staff appropriately described the types of incidents reported through the ASER system. They confirmed they would use 'MySafety', the Safety and Environmental Protection system, for staff incidents.

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

Incidents and significant events were communicated to the team through regular practice meetings, which included a dedicated agenda item for discussing them. Additionally, weekly huddles and weekly HUB meetings provided an opportunity for further discussion and updates. For example, during the practice meeting in September 2025 we saw 2 ASERs had been reviewed and discussed with the team.

Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS) alerts were received by the dental centre via email dissemination as well as via the Direction and Guidance from Regional Headquarters (RHQ). They were recorded electronically on a CAS log. The dental centre acknowledged receipt of these alerts and documented any actions taken. Alerts were shared with the team through practice meetings, weekly huddles and email communications. Evidence of this process was noted in all practice meeting minutes as a link to the CAS alert register. In addition, to ensure timely notification of CAS alerts, the practice manager had registered the Group Mailbox with MHRA as a contingency measure.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead and 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.

Vulnerable patients were discussed at case discussion meetings with the medical centre Senior Medical Officer when required. Safeguarding information was displayed and was a standing agenda item at the practice meeting.

Staff had a good understanding of the duty of candour principles; a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The dental centre maintained an electronic duty of candour log, stored electronically in a limited folder.

Staff expressed confidence in raising concerns, citing an open-door policy within the team. They stated that any concerns would be raised at the earliest opportunity, initially with the practice manager or SDO. If the issue could not be resolved locally, staff would seek advice from the regional diversity and inclusion lead, or the Defence Primary Healthcare (DPHC) Freedom to Speak Up champion. The SDO and practice manager actively supported and promoted this culture, encouraging staff to speak up. This reassurance was regularly reinforced during team meetings and training sessions. Additionally, the dental centre had a ‘Leads List’ which was displayed and detailed specific roles and contact details should staff need to seek advice or guidance.

The chaperone policy was displayed in the waiting area and was reviewed regularly. Patients could access a chaperone if they wished.

A lone working risk assessment and policy was in place for the practice; it clearly laid out the procedure to follow should any member of staff be alone in the department. There were emergency alarms in each surgery and these were tested regularly.

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

A business continuity plan (BCP) was in place and was reviewed regularly. It covered all issues from loss of IT, power, water, compressors to staff illness and radiation faults. It outlined critical business activities and provided up-to-date contact details. We discussed a recent event where the dental centre experienced an unplanned loss of power which affected the whole Station. The issue was reported to RHQ. The dental team had a day list which was printed prior to the outage so were able to contact patients by telephone. All appointments were cancelled (rescheduled within a day after the event, when power to the Station was restored). The neighbouring dental centre at Cranwell provided cover for dental emergencies.

Medical emergencies

The SDO was the lead for medical emergencies and resuscitation. All staff were up-to-date with the required medical emergency training, including Basic Life Support, use of the automated external defibrillator and anaphylaxis. Scenario-based training in managing medical emergencies was held regularly with the last being in August 2025 in conjunction with the medical centre.

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

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

In-house training in sepsis/deteriorating patient had been completed by the staff team. There was no information displayed for staff to refer to but this was rectified on the day.

Staff recruitment

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

Monitoring health & safety and responding to risks

A range of local health and safety policies and protocols were in place to support with managing potential risk. The practice manager was the lead for safety, health, environment and fire (referred to as SHEF) and was trained in this role. Their role involved providing health and safety advice, implementing and monitoring policies, conducting risk assessments, ensuring staff training, investigating incidents, and conducting audits. They also liaised with departments such as the Station SHEF to maintain a safe working environment. These responsibilities were outlined in their terms of reference. The practice manager attended Unit SHEF meetings on a quarterly basis, when workforce allowed. If they could not attend, they sent any points they wished to be raised on behalf of the practice to the Station SHEF lead.

A fire risk assessment had last been undertaken in July 2024 and the fire alarm was checked weekly and firefighting equipment was checked each month. A fire

evacuation drill was carried out every 6 months and was last was undertaken in December 2025.

Risks for the practice were recorded on the regional risk register which the team reviewed monthly. Currently, the dental centre had 13 active risks, which were categorised under the following areas:

- infrastructure
- people
- capability.

The dental centre was experiencing significant workforce and infrastructure challenges. There were 4 gapped positions (1 civilian dentist, 1 hygienist, and 2 dental nurses). There was a high locum turnover leading to ongoing workforce instability. The civilian dentist role remained difficult to recruit to and was currently covered by locums; a recommendation had been submitted to convert the position to a military role for continued stability. Temporary locum support for a dental nurse had been requested but was not sustainable once funding was exhausted. The dental centre had not had a full staff complement since approximately 2018. Operational capacity was further constrained by the absence of a dedicated receptionist, creating additional administrative burden and safeguarding risks due to no member of staff overseeing the waiting room. The current dentist workforce was insufficient to meet existing patient demand. A projected increase in the patient numbers from approximately 2,039 to 2,807 over the next 4 years would further exceed safe staffing ratios. Service delivery was already impacted. Furthermore, the current infrastructure could not support increased demand due to the lack of a fourth surgery and a dedicated central sterile services department (CSSD), to support an increase in patients. Within the next few months the SDO will be changing, 1 dental nurse was due to leave and the practice manager was due to take temporary leave.

The SDO and practice manager reviewed the register monthly or whenever a new risk was identified or an existing risk changed. The register was last reviewed in January 2026.

The practice manager was the lead for Control of Substances Hazardous to Health (COSHH) and the SDO reviewed the COSHH risk assessments when they were completed. A COSHH register was in place with links to the risk assessments updated in December 2025. Items were held inside a lockable cupboard. COSHH items were only accessible to staff.

The dental centre has a legionella risk assessment in place, which was the responsibility of the dental centre. The most recent risk assessment was reviewed by the practice manager and SDO in August 2025. The safety of water was monitored and the legionella risk assessment was also reviewed by the contractor in July 2020. The practice manager confirmed the contractor carried out monthly annual water checks and they provided the results to the dental centre via email; no issues had

been identified. Additionally, a Legionella Management Plan (LMP) was in place, which was the responsibility of the contractor provided by the Local Admin Unit (LAU). The current LMP was dated December 2015 and was last reviewed in July 2020, with no comments or updates made at that time. It was noted that the LMP required review every five years, the practice manager had recently contacted the contractor to obtain the most recent version as it had not been shared with the practice, with a response still pending.

A range of tests were undertaken of the dental unit waterlines (DUW) including daily flushing for 2 minutes each morning and flushing between patients for 30 seconds. This process applied to all taps and the dental chair in each surgery. Water quality checks and monthly dip slide testing for monitoring microbial contamination were undertaken. A treatment solution was placed in the DUWs quarterly. Records were maintained with all testing dates and results. An amalgam (material used for fillings) separator (to reduce the amount of amalgam in dental wastewater) was fitted in all surgeries.

Staff adhered to relevant safety laws when using needles and other sharp dental items. The sharps exposure/injury procedure was displayed in the surgery and sharps boxes were labelled, dated and used appropriately. The 'Insafe' system was used to reduce the risk of sharps injuries and dentists disposed of the sharps they used. Staff had completed training on sharps injuries and the snapping of ampoules. Sharps injuries were managed in line with DPHC policy and incidents involving sharps were reported using the 'MySafety' and ASER systems. Details of how to access occupational health for advice and support was available.

Processes were in place for the regular monitoring of utilities and equipment. Gas and electrical safety checks were up-to-date. Regular checks of equipment (referred to as LEA) were up-to-date. Electrical equipment testing (previously PAT testing) was completed.

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. A staff protocol was in place to minimise the spread of infectious diseases, along with hand washing guidance. Hand sanitiser was available and there was a sufficient stock of personal protective equipment. Additional precautions were used when undertaking aerosol generating procedures if a patient with an infectious disease needed emergency treatment. IPC audits were undertaken annually.

Staff had access to the Health Technical Memorandum 01-05: Decontamination in Primary Care Dental Practices (HTM 01-05) online to ensure it was the latest version. The dental centre did not have a dedicated CSSD so all decontamination of instruments was completed in the surgeries and the laboratory, half of which had been repurposed as a makeshift CSSD. Our review of the decontamination process

showed a good process was in place and the dental nurse with the lead for decontamination had an in depth understanding of the process and monitored that it was being adhered to.

A statement of need for a new CSSD was submitted in February 2025, and the site has been visited by the infrastructure team. The dental centre was awaiting an outcome regarding funding and timeline for implementation.

Cleaning was undertaken twice a day. A schedule was in place outlining the cleaning arrangements for each area and frequency. A log was maintained by cleaning staff to confirm cleaning had taken place. Mops and materials were colour coded and stored correctly. The dental centre's cleaning contract was managed by the Station LAU and the dental centre did not hold a copy of the contract. The SDO and practice manager had requested this from Station Executives and were awaiting compliance.

The practice manager performed weekly spot checks on the cleaning quality and reported any issues with the cleaning service to the contracted cleaning manager. As part of the last unit SHEF audit, it was identified that the standard of cleaning provided by the cleaning contractor required improvement. Staff had reported that several areas were repeatedly missed, including:

- toilets not cleaned daily.
- dust and cobweb build-up in several areas. Indicative of infrequent cleaning.
- kitchens not cleaned regularly. Kitchen waste receptacles not emptied daily.
- floors not thoroughly cleaned.

This issue has been addressed by the practice manager and with the cleaning manager and, although cleaning standards had improved, there were days where cleaning staff did not show up for the afternoon cleaning period. This issue was still ongoing. Deep cleaning was undertaken twice a year.

Clinical waste was managed effectively, including extracted teeth, gypsum (for taking dental impressions) and amalgam. Secure storage for clinical waste was located outside of the building and was collected weekly by the contractor. A waste log, waste transfer notes and consignment notes were in place and up-to-date. The annual pre-acceptance clinical waste audit had been completed

Staff were aware of the 2023 revision to HTM 07-01: Safe and sustainable management of healthcare waste. The team had completed regional training regarding the changes and had received a supply of 'tiger bags' (used for offensive non-infectious waste). As directed by DPHC, changes had not yet been made to clinical waste processes until DPHC-wide policies were updated and implemented anticipated by the end of January 2026.

Equipment and medicine

An equipment spreadsheet was in place that included the status of each piece of equipment, such as fault reporting (date of completion/repair). Staff undertook daily checks of equipment in the surgeries, laboratory and CSSD areas. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All equipment was in-date for servicing and testing including the ultrasonic bath, and autoclave. Electrical equipment testing was up-to-date.

The practice did not have access to a risk assessment for the compressor. However, the practice manager-maintained records of the servicing contract, ensuring that the contract was monitored effectively, and that the compressor was serviced and air-tested by qualified personnel provided by the LAU. The practice held in-date copies of compressor certification. The last air quality test was conducted in January 2026 and the last annual service was in July 2025. The dental centre had not conducted a visual inspection of the compressor. The dental centre had a compressor alarm system which was installed in reception although it was not working. This had been reported and it was awaiting repair. The BCP specifically identified the risks associated with the loss of air supply and outlined the actions to be taken in such an event. The fire risk assessment did not include fire risks associated with the compressor.

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

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

Radiography (x-rays)

Suitable arrangements were in place to ensure the safety of the X-ray equipment, including a radiation protection file containing the required documentation. A Radiation Protection Advisor for the practice was identified. The SDO was the Radiation Protection Supervisor (RPS) and had completed the required RPS training for the role. Signed and dated Local Rules were displayed.

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

IR(ME)R training had received relevant updates. A radiography audit was undertaken annually.

Are services effective?

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

Monitoring and improving outcomes for patients

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

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

We noted some deficits with the record keeping for the locum clinicians, mainly in relation to recording sufficient detail and how DMICP was used. We discussed this with the Senior Dental Officer (SDO) including measures taken and further options that could be taken to provide support with record keeping. We saw that locum note keeping improved during over each period of employment in response to mentoring from the SDO. However, with the high staff turnover this was an ongoing risk.

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

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

The military dental fitness targets were closely monitored by the SDO and were a standing agenda item at the practice meetings. The key performance indicators were:

- Cat 1 (fully dentally fit) 61%
- Cat 2 (dental treatment required but not expected to cause problems within a year) 14%
- Cat 3 (treatment required and expected to cause problems within a year) 11%

- Cat 4 (missing or incomplete dental records or the need for a periodic examination)14%

We discussed this with the SDO. Dental targets were lower than expected due to inadequate staffing and a reliance on locum staff. Regional headquarters were aware. staffing is poor and a large reliance on locums is the reason for not being quite at KPI's.

Health promotion and prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. If diagnosed with either gingivitis (mild form of gum disease) or periodontal disease patients were referred to the oral health nurse. During this appointment oral health guidance was given. Once plaque (film of bacteria on the teeth) levels had improved then patients were referred to the hygienist for further treatment.

One of the dental nurses took the lead on health education campaigns. There was a Defence Primary Healthcare (DPHC) monthly topic but dental centres had the autonomy to develop their own promotional calendar tailored to their population. Other oral health information and leaflets were available for patients to read and/or take away. There had been no unit health fairs in the last 12 months but it was anticipated this would improve in the upcoming year.

The patient records we reviewed showed proposed treatment pathways and information given to individual patients. The practice utilised the Delivering Better Oral Health toolkit: a Public Health England evidence-based toolkit on prevention of oral diseases, such as caries.

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

Staffing

The induction programme included a generic programme and induction tailored to the practice. The practice manager monitored the status of mandatory training and training was recorded on the DPHC Dental Personnel Management System. A regional spreadsheet was supplied to ensure all topics were covered at the correct time this was shared to all dental centres in the region, so topics were covered by everyone at the same time. Staff were given time to complete training. At the time of

the inspection, staff were up-to-date with all mandated training. The dental team had also completed training around supporting patients with a learning disability/autistic spectrum disorder in line with the national requirement for all healthcare providers.

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

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 Lincoln or Boston hospitals for secondary care. For advanced, rehabilitative or restorative care treatment could be provided at the Defence Centre for Restorative Dentistry at Aldershot. The waiting time for treatment was 6 weeks.

The Chain of Command was informed if patients failed to attend their appointment. The practice manager attended the Commander Case Review meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the unit were provided an update on the dental targets

A process was in place to manage referrals, including the use of the Defence Primary Healthcare centralised process for the management of all referrals. These were monitored weekly. Urgent referrals (2 week waits) for oral surgery were made with minimal waiting times.

Consent to care and treatment

Clinical staff demonstrated a clear understanding of the importance of obtaining and documenting patient consent for treatment. Patients were provided with information about their treatment options, including associated risks and benefits, enabling them to make informed decisions. Verbal consent was obtained for routine treatments, while written consent was secured for more complex procedures such as extractions. Patient feedback also indicated that they received clear and comprehensive information regarding their treatment choices.

Clinical staff showed a good awareness of the Mental Capacity Act (2005) and its relevance to their patient population. Completion of an online course on The Act formed part of the annual mandatory training programme for all staff.

Are services caring?

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

Respect, dignity, compassion and empathy

We received feedback from 18 patients through pre-inspection feedback cards. All respondents were positive about the service, commenting that staff were kind, respectful, and supportive. The practice also carried out patient experience surveys during September 2025, which received 21 responses. All respondents indicated they were treated with care and kindness.

There was no receptionist at the dental centre and the waiting area was not overseen by a member of staff unless the practice manager chose to work there. Although there were no direct negative responses regarding care, a general theme was that a having a permanent receptionist would be helpful and save patients time, instead of having to ring through, leave a message and await a call back. There was a sign in reception directing patients what to do on arrival, to fill out a form and take a seat and wait to be called.

The practice had access to the ‘Big Word’, a translation service for patients who did not have English as their first language.

Involvement in decisions about care and treatment

Patient feedback indicated that clinicians communicated information clearly, helping individuals make informed decisions about their treatment options. Our discussion with the Senior Dental Officer confirmed that a variety of methods were used to ensure patients fully understood their condition and the available treatments.

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

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

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in December 2025. The premises was not accessible for patients with reduced mobility or those who used a wheelchair. Several actions had been identified and raised on the risk and statement of need register as a result of findings from the access audit; all had been addressed or deemed not essential. Patients could go to other local dental facilities in Waddington and Cranwell if they required assistance such as:

- ramp access
- accessible toilet facilities
- portable hearing loop system.

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

Access to the service

At the time of the inspection, the next available routine appointment with a dentist was within 2 weeks. Individuals or units deploying were prioritised. If patients cancelled an appointment, then the staff offered the appointment to patients on a waiting list. Patients requiring an emergency appointment during working hours could be seen on the same day. Dental out-of-hours (OOH) care was provided all year round through the regional duty on-call rota. Patients were seen at the practice

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

Concerns and complaints

Complaints were managed in accordance with the Defence Primary Healthcare complaints policy. A process was in place for managing complaints, including the recording of complaints on the Regional Headquarters SharePoint. Complaints were a standing agenda item at the practice meetings and all staff had competed complaints training.

One complaint was received in 2025 we saw this was managed in accordance with policy and had been resolved. Concerns were raised about hygienist appointments being repeatedly cancelled and not receiving treatment for an extended period. The Senior Dental Officer invited the patient for a face-to-face discussion to explain the reasons for the delay in their treatment. Since then, a locum hygienist saw the patient, who was now satisfied with the outcome.

Patients were informed about the complaint process through a prominently displayed notice within reception, which outlined the procedure for submitting a complaint. Complaints and compliments forms were also available for submission in a complaints box, securely mounted on the wall and checked daily by a member of staff. Further details could be found in the patient information leaflet, which was accessible at the practice and on SharePoint.

Are services well-led?

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

Governance arrangements

The practice worked to the Defence Primary Healthcare (DPHC) mission statement: “Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power”.

A framework of organisational policies, standard operating procedures and protocols underpinned governance activity. Local protocols were held online and used during induction and staff training. Staff skillsets were effectively used, such as for lead roles. Terms of reference were up-to-date for all staff. External and regional processes were established to monitor service performance. Key performance indicators and dental targets were monitored by the Senior Dental Officer (SDO) with both regional headquarters (RHQ) and the Chain of Command having oversight.

The practice used the Health Assessment Framework (HAF), an internal quality assurance system used to monitor safety and performance. The last internal assurance review was undertaken in August 2024. Most actions had been completed and a management action plan had been developed, any issues remaining were on the risk register.

A team communication structure was established, including a monthly practice meeting. Healthcare governance and assurance was a standing agenda item at the monthly practice meetings. Meeting minutes indicated that governance and risk management systems were routinely reviewed to ensure they were up-to-date and reflected the current operation of the practice.

The SDO described effective communication with the various units and they attended the station Executive Meetings every month. Effective communication pathways were in place with RHQ and the SDO also had good links with the medical centre next door with daily interactions.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Staff completed mandatory training in data protection 3 yearly. Training in the Caldicott principles to protect confidential patient information was undertaken. All staff had a login password to access the electronic systems and were not permitted to share their passwords with other staff.

Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. A reporting system was in place should a confidentiality breach occur.

To address environmental sustainability, the practice aimed to reduce the use of paper through digitisation. Recycling bins were in use for food waste and mixed recycling. Stock was effectively managed to reduce wastage.

Leadership, openness and transparency

All staff we spoke with were happy in their work environment and said the team was cohesive and worked well together. Staff spoke highly of the inclusive and transparent approach of the SDO and practice manager, indicating they promoted a collaborative leadership culture.

The leadership team had an open-door policy; staff were encouraged to express any concerns. Staff were encouraged to promote their ideas in staff forums and felt empowered to speak up. A thank you scheme was used to give staff rewards.

Learning and improvement

The SDO was the lead for clinical audit/quality improvement activity. All the required audits had been completed, including infection prevention and control, equality access, clinical waste, prescribing and radiography. The SDO would have liked to enhance the audit activity but due to lack of additional staffing this was difficult to fulfil.

Staff were involved with other dental practices and networks for sharing of information, including regional peer review twice a year.

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

The practice was committed to incorporating patient feedback into service development. To monitor performance, patients were encouraged to complete the Patient Experience Tool survey via a quick response or QR code, which was displayed in the premises and included in the patient information leaflet. In 2025, the practice received 145 patient feedback response forms and we saw that 98% of patients reported being happy with their oral healthcare.

Patient feedback has been used to make service improvements by addressing specific concerns raised by patients. The most recent example was to have a receptionist at the desk. The practice assigned a member of staff temporarily to work at reception for a month to conduct administrative duties as well as monitoring reception area. The feedback from patients during this period was overwhelmingly positive and the practice manager was able to focus on their own work without disruption. However, this was not sustainable due to staffing shortages.