St Athan Dental Centre

MOD St Athan, Barry, Vale of Glamorgan, CF62 4WA

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Overall rating for this service	**No action required**	✓
Are services safe?	**No action required**	✓
Are services effective	**No action required**	✓
Are service caring?	**No action required**	✓
Are services responsive to people's needs?	**No action required**	✓
Are services well-led?	**No action required**	✓

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection of St Athan Dental Centre on 4 November 2025.

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

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

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

At this inspection we found:

- 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.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults.
- 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.
- The contractor had not notified the practice when water temperatures were outside of the acceptable range.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste that reflects the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.

The Chief Inspector recommends to the practice:

- Ensure a record is maintained of when the spillage kits are checked.
- Ensure the contractor provides the practice with the outcome of the monthly water temperature checks. Review these water temperatures to ensure they are in line with the Health Technical Memorandum 04-01: Safe water in healthcare environments. Follow up with the contractor if the temperatures are outside of acceptable parameters.

Mr Robert Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Background to St Athan Dental Centre

Co-located with the medical centre in a single storey building, the dental centre is a 3-chair practice providing a service to a military population of 900. The population includes a main unit that is highly deployable, a range of minor units and reservists from all 3 forces. In addition to the provision of general dentistry, enhanced dental treatments are provided as the Senior Dental Officer is an NHS Wales Tier II accredited dentist with enhanced skills in oral surgery. The practice also accepts referrals from other defence dental centres for this enhanced dental service.

The dental centre is open from 07:30 hours to 16:30 hours Monday to Thursday and from 07:30 hours to 13:00 hours on Friday. An out-of-hours service is provided by the South region coordinated by St Athan, Chepstow, Hereford and Innsworth dental centres.

The staff team

Dentists	Military Senior Dental Officer (SDO) Civilian dentist
Dental hygienist	Civilian hygienist
Dental nurses	Civilian nurse x 3 (1 post covered by a locum)
Practice management	Military practice manager

Our inspection team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and a dental hygienist specialist advisor.

How we carried out this inspection

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

Are services safe?

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

Reporting, learning and improvement from incidents

Adverse patient-related incidents were reported through the Automated Significant Event Reporting system (referred to as ASER), a DMS-wide process for the management of significant events. A register of events and incidents was maintained and records confirmed all staff had received ASER training this year and were registered to use the system.

Staff we spoke with accurately described the types of incidents reported through ASER. ASER was a standing agenda item at the practice meetings. No ASERs had been raised in the last 12 months.

Staff related accidents and incidents not involving the patient care pathway were reported through the 'MySafety' system. Such incidents were escalated to the practice manager or Senior Dental Officer (SDO). The practice manager 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). These types of incidents were reported through the ASER system.

Both the practice manager and SDO were registered to receive medical alerts. They were notified of alerts via the Central Alerting System (CAS) and through 'direction and guidance' from Regional Headquarters (RHQ). Action taken by the practice was recorded on the regional CAS register. An alert register was maintained and alerts was a standing agenda item at practice meetings.

Reliable safety systems and processes (including safeguarding)

The SDO was the designated safeguarding lead. The child and vulnerable adults safeguarding policy was displayed in reception. All staff were in-date for level 2 safeguarding training. There were no under 18's registered at the practice.

Staff we spoke with were aware of their responsibilities if they were concerned about the safety of patients who were vulnerable due to their circumstances. Vulnerable patients were identified through DMICP (electronic patient record system) alerts.

Duty of candour (DoC) guidance was in place and the training register confirmed staff completed annual DoC training. The DoC principles are a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Dentists were always supported by a dental nurse when treating patients. In accordance with Defence Primary Healthcare Policy (DPHC), the dental hygienist did not routinely work with a nurse unless there was a nurse available. If the patient felt uncomfortable with the hygienist working alone, then the support of a nurse would be requested or treatment postponed until a nurse was available. Hand-held personal alarms were used by staff and these were audible given the small size of the practice. A lone working policy was in place along with a risk assessment that was reviewed in January 2025. The practice aimed to ensure there were 3 staff available at all times. If this could not be achieved then the medical centre (which was open later than the dental centre) was informed of the reduced staffing level.

The chaperone policy was displayed in the waiting area and patients could access a chaperone if they wished. Patients could be observed in the waiting area from the reception.

A dental dam was used for all endodontic (root canal) procedures, composite restorations and moisture sensitive cements. A risk assessment was in place for the use of a dental dam.

The business continuity plan (BCP) was reviewed in October 2025. It was exercised by the team to ensure they were familiar with the response in the event of a fire or compressor failure. The BCP was activated for a real live event when the water supply to the camp was turned off in error.

Medical emergencies

The SDO was the lead for medical emergencies. The civilian dentist checked the medical emergency kit daily and weekly, and the checks were confirmed by the SDO. All staff were up-to-date with annual medical emergency training, including Basic Life Support (BLS), use of the automated external defibrillator (AED) and anaphylaxis. BLS training was delivered by a doctor from the medical centre in May 2025. The SDO provided sedation for some treatments so was trained in Intermediate Life Support.

Staff participated in scenario-based training every 6 months. The most recent session was in September 2025 and involved the management of a non-responsive patient. Staff reported that they valued this type of training as it was a very useful learning approach involving the whole team. Local medical emergency protocols were displayed in each surgery. We were given an example of when staff responded promptly to a patient who fainted. The response described was appropriate and staff sought support from the medical centre.

Out-of-hours, the medical emergency kit was stored in a wheelie bag on a clinical trolley in a locked surgery. During working hours, it was moved to an optimum location for prompt access in the event of a medical emergency. The AED was stored alongside the emergency bag. The position of the emergency bag meant the oxygen cylinder contained in the bag was stored flat when it should be held upright.

Controlled drugs (medicines with a potential for misuse) were held within the emergency bag. We noted the box containing the out-of-hours antibiotics was not secured, although it

was unlikely patients would have access this area without a member of staff present. Medicines were disposed of through the medical centre. Safe arrangements were in place for the disposal of controlled drugs.

The razor was missing from the emergency kit. Although personal protective equipment (PPE) was not held on the trolley, it was easily accessible in the nearby clinic rooms. Promptly after the inspection, the SDO confirmed the trolley bag and oxygen was moved to an upright position. The missing razor had been replaced and the antibiotics had been secured.

There was no first aid trained staff in the dental centre. However, multiple first aiders were available in the co-located medical centre. Both the SDO and 1 of the nurses had requested to attend the next available first aid course.

Biohazard, eye care and mercury spillage kits were available. The health and safety audit conducted by the unit in August 2025 identified the first aid kit was out-of-date and needed to be replaced. This had not happened as we found it was out-of-date. As a remedial action, a first aid kit was borrowed from the medical centre during the inspection. The SDO confirmed after the inspection that a new first aid had been received and installed. Monitoring arrangements for all the kits was unclear as there were no records maintained of when they were checked.

Measures were in place to ensure patients understood what to do if they experienced pain or their condition deteriorated following treatment. The dentists discussed potential risks with patients and written post operative instructions were given to patients following an extraction. Patients were advised to contact the practice during working hours and the dentist on-call or NHS 111 out-of-hours (OOH). Opening times and OOH arrangements were displayed on the front door.

The staff had completed sepsis/deteriorating patient training in September 2025.

Staff recruitment

The practice manager had oversight of the recruitment for permanent and locum staff. Although the full range of recruitment records for permanent staff was held centrally, evidence was in place to confirm recruitment checks had been completed for all staff. This 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 required for their role were monitored.

A member of staff who recently joined the practice described a thorough induction involving shadowing/observation, time to become familiar with policies and time to complete the required training.

Monitoring health & safety and responding to risks

The practice manager was the lead for safety, health, environment and fire (referred to as SHEF). They had completed the risk assessors training course and were scheduled to undertake the Institution of Occupational Safety and Health course. A SHEF audit was completed by the unit in August 2025 and no corrective actions were identified. The practice manager for the medical centre was the building custodian.

The risk register reflected the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. There were 3 risks on the register with staffing levels identified as the top risk. Two members of staff were due to leave in December 2025 and measures had been taken to ensure the recruitment process commenced promptly for 1 post, and locum cover was secured for the other position. The land where the dental centre building was located was no longer owned by the MOD but was an asset of the Welsh Government. A 6-month tenancy agreement was held with the Welsh Government. Plans were in place for the dental centre to relocate to St Athan West Camp. However, this was unlikely to be achieved until 2028. RHQ were monitoring the tenancy arrangements. The third risk related to the broken chair in surgery 2 meaning a loss of operational capability for several months. The SDO confirmed the chair had been fixed shortly after the inspection.

Reviewed in the last 12 months by the SDO, a range of risk assessments were in place including assessments relevant to the premises, staff and clinical care. Some risk assessments were joint with the medical centre.

The practice manager was the designated lead for Control of Substances Hazardous to Health (COSHH). Reviewed in September 2025, the COSHH risk assessments were held electronically and each included a link to the data sheets. We discussed with staff how electronic risk assessments were not readily accessible if someone was exposed to a product, such as through inhalation or ingestion. After the inspection, we sent the practice manager a 'quick reference template' for exposure to COSHH products that was identified as 'notable practice' for another Defence dental centre. The SDO confirmed it would be completed specifically for the COSHH products used at the practice and displayed so was easily accessible to staff. Cleaning staff were responsible for monitoring the COSHH products they used and held risk assessments for them.

The practice manager at the medical centre was the fire lead for the building. The 5-yearly fire risk assessment (FRA) was undertaken by the fire safety officer in February 2024. It identified the building as a moderate risk. We confirmed the requirements made as part of the risk assessment had been actioned. As the compressor storage unit was not accessed during the FRA, the SDO raised the matter with the Fire Safety Officer. It was agreed they would check the compressor by the end of December 2025 although would not necessarily up-date the February 2024 FRA. The SDO had developed a local fire risk assessment, which clarified the arrangements for the checking of the compressor.

Records showed the weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. The fire action plan was displayed and staff confirmed they participated in fire evacuation drills every 6 months with the last taking place in August 2025.

The practice legionella risk assessment was completed in October 2024. The contractor completed water temperature checks each month. The temperatures were not routinely shared with the practice but were available because they had been requested as evidence for the inspection. The records we looked at showed many occasions over the last year when both the hot and cold water temperatures were outside of parameters to prevent legionella bacterial growth. The contractor had not informed the practice on the occasions when water temperatures were outside of the expected range.

Promptly after the inspection, the SDO discussed the matter with the contractor. In relation to the hot water, the contractor acknowledged they had been working with the baseline of 50°C and not 55°C as stipulated in the Health Technical Memorandum (HTM) 04-01: Safe water in healthcare environments. Furthermore, the contractor identified there was a potential error in the water sampling related to the use of mixer taps to prevent scalding water injuring the user. The contractor agreed to look at ways to test the water before it reached the mixer tap to avoid invalid results. In addition, the contractor acknowledged the temperatures for the taps in the surgeries were not checked frequently enough and confirmed these taps would be included in the monthly tests. In hot weather, the contractor advised that the pipes leading into the building from the mains supply may be inadvertently raised due to the warm conditions. The SDO planned to stress test this theory in the summer months and raise the issue if results for cold water temperatures increased above 20°C.

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. A spreadsheet was maintained with all testing dates and results. The reverse osmosis (water purification process) machine was broken at the time of the inspection and the unit were providing purified water delivered directly to the dental centre. The SDO confirmed after the inspection that a new machine had been purchased and fitted. 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.

Infection control

The practice manager was the lead for infection prevention and control (IPC). They were nearing completion of the IPC training required for the role. Their training was being undertaken via the Dental Nurse Network. The staff team were up-to-date for IPC training.

We found that IPC measures at the practice were of a high standard, which supported with minimising the spread of infectious diseases. Hand washing guidance was displayed in clinical areas and toilets. Hand sanitiser was available and there was access to a sufficient stock of personal protective equipment. The IPC audit was completed every 6 months with the most recent completed in May 2025.

Staff had access to the HTM 01-05: Decontamination in primary care dental practices. A thorough process was established for the decontamination of dental instruments, which aligned with HTM 01-05 and DPHC standards. A dedicated ultrasonic bath for each surgery was held in the central sterilisation services department (CSSD). There were 2 sterilisers, although 1 was undergoing repair at the time of the inspection. Used dental instruments were pre-soaked in the surgery, which we checked and confirmed met requirements. They were then transported in lidded boxes to the CSSD. The CSSD was well-organised with a clearly defined flow from dirty to clean areas to ensure the safe and efficient handling of instruments to minimise the risk of cross-contamination.

Cleaning of the premises was completed by contracted cleaning staff twice a day. A cleaning contract was in place and the schedule outlined the cleaning arrangements for each area and frequency. Mop heads were changed weekly. A log was maintained by cleaning staff to confirm cleaning had taken place. Arrangements were in place for a 6 monthly deep clean with the next scheduled for January 2026. Routine checks of cleaning standards were carried out by the contract cleaning manager.

Clinical waste was safely managed including extracted teeth, gypsum (for taking dental impressions) and amalgam. The waste process was overseen by the medical centre and the dental centre received transfer notes for its clinical waste. We reviewed the documentation at the medical centre; a waste log and consignment notes were in place and these were up-to-date. The dental centre received a copy of the consignment notes. The clinical waste was locked in an external storage area.

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. We were advised by DMSR that the revised clinical waste policy was awaiting approval by the 25 November 2025, following which it would be circulated to Defence dental practices.

Equipment and medicine

The practice manager was the lead for equipment care. Records showed equipment was appropriately checked and maintained, including the annual servicing of clinical equipment by the medical and dental servicing section (a military capability referred to as MDSS). All MDSS equipment was serviced in April 2025. Electrical Equipment Testing was undertaken in February 2025. An equipment audit (referred to as a LEA) was carried out in March 2025. The equipment care directive audit was reviewed monthly by both the practice manager and the SDO. A comprehensive faults log was maintained to ensure all issues were accurately recorded and tracked.

Organised by the contractor and carried out by qualified engineers, the compressor was routinely checked and serviced. Monitoring arrangements included an air quality inspection every 6 months, an annual service and an insurance inspection every 2 years. Although access to the locked compressor storage unit was restricted to the contractor, the practice requested the key to carry out a monthly check for debris and clutter. The business resilience plan included a section on the action to take in the event of compressor failure.

The stockroom was well organised and all stock included expiry dates. Regular checks of the stock were undertaken to ensure stock rotation and to monitor materials were available and in-date. Ambient temperatures were monitored. We checked the surgeries and they were clean and tidy. All equipment was latex free.

The pharmaceutical fridge was located in the stockroom. Fridge temperatures were checked and recorded twice a day, including both high and low temperatures. Prescription forms were held securely and prescriptions used were logged. The use of antibiotics was audited and assessed against professional guidelines. The most recent audit covered the timeframe 31 July 2025 – 31 October 2025.

Radiography (x-rays)

Suitable arrangements were in place to ensure the safety of 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.

X-ray equipment was configured to maximise safety. Appropriate signage was displayed on the door of the surgery to indicate X-rays took place. A rectangular collimator (used to reduce unnecessary radiation exposure) was available on the intra oral units. In-service daily checks, including test X-rays, were completed prior to use.

Signed and dated Local Rules were displayed in each surgery. When undertaking an X-ray, staff stood outside of the ‘scatter zone’. Dosimeters (used to measure ionizing radiation exposure) were used in line with DPHC protocol. We had access to the dosimetry reports for individual staff.

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

The last radiology audit for both dentists was completed in September 2025.The SDO acknowledged that the 6 monthly audit prior to September was missed. To minimise the risk of a reoccurrence, the practice set up Outlook calendar prompts to ensure the audits took place every 6 months.

Are services effective?

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

Monitoring and improving outcomes for patients

From discussions with clinicians and a review of patient records, we confirmed the treatment needs of patients were assessed in line with organisational policy and recognised national guidance, including National Institute for Health and Care Excellence (NICE) and College of General Dentistry guidance. NICE guidelines were followed for the management of wisdom teeth or third molars, and dental recall.

The Senior Dental Officer (SDO) considered occupational requirements when planning treatment for patients, such as the prioritisation of deploying personnel. Furthermore, each individual's occupational role and tasking was taken into account.

Due to a rapid turnaround from diagnosis to treatment, patients had not needed to be downgraded to prevent them from deploying. However, they would be downgraded for more complicated diseases that require them to be protected from deployment, such as a diagnosis of oral cancer.

Our review of a range of dental records confirmed an assessment, including information about the patient's current dental needs, past treatment, medical history and treatment options were routinely undertaken. The diagnosis and treatment plan for each patient was 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. Records showed the appropriate pathway for Basic Periodontal Examination (BPE) was followed and treatment provided recorded. A BPE was carried out at each periodic dental inspection (PDI).

We noted the records for oral surgery would benefit from improvements in relation to the recording of both a diagnosis and consent. We discussed these with the SDO during the inspection. Our review of the clinical records following the inspection showed these amendments had been made.

The military dental fitness targets were closely monitored by the SDO and staff team. The targets were in a good place particularly with Category 1 and 2 at 88%. The status for each category in October 2025 was:

Category 1 - 78% (no dental treatment required)

Category 2 - 9% (unlikely to result in a dental emergency in the next 12 months)

Category 3 - 6% (likely to have a dental emergency in the next 12 months)

Category 4 - 7% (more than 3 months lapsed since the last PDI).

Health promotion and prevention

Guidance from the British Society of Periodontology (BSP) was adhered to in relation to periodontal disease (inflammation of tissues supporting the teeth), including staging and grading, confirmed through our review of clinical records. BSP guidelines were displayed in all surgeries. The dental hygienist was the lead for all periodontal recalls. The dentist carried out staging and grading at the patient's PDI and provided a periodontal diagnosis. Open discussions were held between the dentists and the hygienist regarding patients' periodontal needs.

The hygienist was the lead for oral health education (OHE). The way in which OHE was delivered aligned with nationally recognised guidance, notably Delivering Better Oral Health toolkit: a Public Health England evidence-based toolkit on prevention of oral diseases, such as caries (tooth decay). There was a dedicated cupboard for all OHE products used for education of individual patients and for displays in the waiting area.

Patient-orientated OHE information in the patient waiting area was regularly refreshed to reflect national and organisational strategy. A mouth cancer awareness display for the national November campaign was in place at the time of the inspection. A wide range of oral health leaflets were available for patients to take.

In conjunction with the medical centre, the practice participated in unit-led health fairs on the West Camp. The aim of participating in these health fairs was to promote the importance of oral health across the service personnel population. The last health fair was held in the summer of 2025.

From our discussions with clinicians and a review of patient records, we confirmed that patients were routinely asked about their oral hygiene regime, dietary habits, alcohol intake and smoking, including smokeless tobacco and vaping. Oral hygiene and lifestyle habits were captured on initial consultation and followed up at subsequent appointments. Patients were provided with information and advice about lifestyle choices and habits that could have an adverse impact on their dental health. Clinicians could refer patients to the medical centre for smoking cessation, dietary/nutrition advice or if there were concerns about a patient's general health.

High concentration sodium fluoride toothpaste could be prescribed for patients. Fluoride varnish was routinely applied for patients who needed it. Fissure sealant treatment was planned and undertaken when the hygienist had the support of a nurse.

The dental team took a pro-active approach to oral health education beyond what was expected of them. They visited a local school to deliver OHE advice. The children at this school had military parents so it was way of connecting with the local population and promoting OHE to the wider community. This initiative was undertaken despite Defence UK-based dental centres not treating families of service personnel.

Staffing

At the time of the inspection, the practice was fully staffed. Staff new to the practice described a thorough induction, including time to become familiar with Defence Primary

Healthcare (DPHC) policies and to complete the required training. We were advised that Regional Headquarters was supportive with approving locum cover for staff vacancies.

The practice manager monitored mandatory training for staff. Staff had access to the system to check the status of their training, and training was also a standing agenda item at the practice meetings. We had access to the system so confirmed staff were up-to-date with mandated training.

Staff were responsible for their own continuing professional development (CPD), required for maintaining registration with the General Dental Council. Each individual had dedicated time to focus on their CPD. To support with CPD, staff could attend regional training events, dental conferences and monthly in-service training sessions. DPHC webinars were available for staff via the 'Agilio' online training platform.

Working with other services

The SDO pro-actively engaged with stakeholders involved with the health, welfare and wellbeing of the patients. The staff team had a close working relationship with medical centre staff so had prompt access to procedures such as blood samples or to discuss concerns about the welfare of patients. In addition, the SDO engaged with the units through formal and informal pathways, such as the Unit Health Committee meetings.

Oral surgery (impacted wisdom teeth) could be accessed internally. Patients could also be referred to the University Dental Hospital (UDH) in Cardiff for oral surgery, oral medicine, OPG (panoramic dental X-ray) and CBCT (3D dental scan). Due to the SDO's work at the UDH, military patients could be fast tracked for a CBCT, effectively shortening the patient's waiting time for special tests and surgery. A further pathway for patient referral was to the Consultant in Restorative Dentistry for periodontal treatment, orthodontics, endodontics and implants.

The hospital's referral system was used to monitor and track all referrals including those referred to the Managed Care Network, external providers and patients referred from other Defence dental centres to St Athan Dental Centre for oral surgery. The hospital's referral system was held centrally. Clinicians in all dental centres could review the referrals, follow-up on patients and identify if patients had been waiting too long to be seen. The SDO maintained a referrals log and monitored the referrals bimonthly. Any urgent referrals, such as 2-week-wait referrals were closely scrutinised to ensure guidelines on timelines were not missed. Patients who deregistered from the practice had their referral details sent to their corresponding new dental centre.

Consent to care and treatment

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

The SDO advised that treatment was not undertaken until the patient provided informed consent. Verbal consent was taken for PDIs and written consent was secured for invasive

treatments, such as endodontic treatment, crowns and extraction under local anaesthetic. Written consent was also taken if the patient decided not to follow the advice of the clinician.

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

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 36 patients through our pre-inspection feedback cards. All patients were satisfied with the service indicating staff were kind, respectful and compassionate.

Patients with a known dental anxiety had an alert added to their dental record so additional appointment time could be booked. Acclimatisation sessions could also be facilitated. The impact of gaps in treatment were discussed with patients, such as patient reluctance to attend for appointments or inability to attend due to deployment.

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

The waiting area was close to reception so patients could be observed at all times. The close proximity to reception meant patient conversations with the receptionist could be overheard. Spare rooms were available if the patient wished to speak with a member of staff in private.

Involvement in decisions about care and treatment

Feedback from patients suggested clinicians provided clear information to support them with making informed decisions about treatment choices. From our discussion with clinicians, it was evident a wide variety of tools and techniques were used to ensure patients understood the problem and treatment options. These included the use of X-rays, models, videos and images. Treatment options were discussed with the patient at the end of a Periodic Dental Inspection or Basic Periodontal Examination. Patients were given time to consider their treatment options. If additional time was required, then a further appointment was arranged for the patient to agree a treatment plan.

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

Alongside clinical judgement, dentists referenced the National Institute for Health and Care Excellence and Defence Primary Healthcare (DPHC) guidelines to determine recall intervals between oral health reviews. Patients were recalled between 6 and 24 months depending on risk factors, such as medical, social and dietary history, and oral hygiene habits.

The practice was responsive to the needs of individuals and units, often at short notice. Telephone triage was used and clinics were reorganised to ensure service personnel were dentally assessed/treated prior to deployment. In addition, block appointments could be arranged for deploying units. Patients presenting with pain were always seen and this could be during the staff lunch break or beyond working hours.

In relation to enhanced surgical work, the SDO aimed to see medically compromised patients in the morning, including patients with diabetes and those taking medicines, such as anticoagulants (blood thinners).

Emergency patients received a questionnaire. It comprised 8 questions and 2 pictures to aid with identifying the location of pain. The questionnaire acted as a useful reference guide for the dentist/nurse who can then set up the surgery appropriately. The form helped save time for the dentist and ensured the patient journey was more efficient.

Patients could make appointments between recall intervals depending on the requirement or request. For example, before deployment to avoid missing their recall date or for occupational concerns.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in June 2025. The building was accessible for patients with reduced mobility as all facilities were on the ground floor. There was accessible parking, a ramp, automatic opening front door and hearing loop. An accessible toilet was easily accessible in the co-located medical centre.

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. They had also completed training in how to interact appropriately with neurodiverse people including those with a learning disability and/or autism.

Access to the service

Two emergency appointments with a dentist were available each day. There was a 1 week wait for a routine appointment with the dentist or hygienist. The waiting list for oral surgery referrals to the NHS could be 9-12 months whereas oral surgery facilitated by the Senior Dental Officer (SDO) in their capacity as an enhanced practitioner could be undertaken within 2 weeks. For prompt access, patients from the region travelled to the practice for complex treatments, such as failed extractions.

The automated GOV.UK Notify service was used to send reminders to patients when they were due a dental inspection. Equally, it was used to send mass messages to the patient population about any significant changes to the dental centre, such as an unexpected closure.

Dental out-of-hours (OOH) care was provided all year round through the regional duty on-call rota. 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, which were managed in accordance with the DPHC 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 minutes included a link to the complaint register. We discussed with the SDO the last complaint received in March 2025. It concerned the medical history questionnaire having out-of-date questions related to covid. The matter was investigated and the questionnaire adjusted.

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?

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:

> "DPHC is to continue to provide safe and effective healthcare, which meets the needs of the patient and the chain of command in order to contribute to Fighting Power".

In addition, the practice had developed its own 'ethos of care' defined as:

> "Dental St Athan are dedicated to providing the highest quality of care to all of our patients. We will maintain a patient centred approach and will tailor our care to the needs of our patients. We will strive to assist our units through efficient and timely clinical care that will maximise force generation."

The Senior Dental Officer (SDO) was the clinical lead and lead for healthcare governance. The practice manager had the delegated responsibility for the day-to day administration of the service. A framework of up-to-date organisational and local policies, standard operating procedures and protocols underpinned governance activity. Staff skillsets were effectively used, such as for lead roles. Terms of reference were in-date for all staff.

Local and regional processes were established to monitor service performance, including the Healthcare Assurance Framework (HAF), an internal quality assurance tool. Regional Headquarters (RHQ) had oversight of the HAF to ensure it was kept up-to-date. Staff completed a self-assessment of 1 HAF 'key line of enquiry' each month. Key performance indicators and dental targets were monitored by the SDO and RHQ had access to the practice's performance data.

A practice and wider communication structure was established, including a 4 weekly practice meeting, informal weekly meeting and 'hot debriefs' when required. In addition, regular governance meetings were held between the Senior Dental Officer (SDO), Regional SDO and Principal Dental Officer held meetings each month to discuss governance and performance matters.

Healthcare governance 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. Workforce resilience was the key risk for the service. The other key risk was potential implications of the tenancy agreement with the Welsh Government.

The SDO was the Caldicott Guardian to ensure the confidentiality of patient information was protected. The Caldicott principles and practice policy were displayed by reception. The practice manager was the data protection supervisor. Information governance arrangements were in place and staff were aware of the importance of these in protecting

patient personal information. Data protection was covered through the in-service training programme.

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.

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

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

Leadership, openness and transparency

We found that leadership at the practice was collaborative and promoted inclusive decision-making. The team worked well together and the knowledge and experience of all staff was valued and effectively used to improve the service. Some staff losses were due, including the temporary loss of a member of the leadership team. Plans were in progress to ensure these staff vacancies were filled.

All staff we spoke with, including the locum, were happy in their work environment and said the team was cohesive and supportive. Staff spoke highly of the inclusive and transparent approach of the SDO and practice manager. We heard they were empowered to share ideas and were involved in decision making about the service, including service developments. ‘White space’ team building events were held on a regular basis.

Staff told us they were confident any concerns they raised would be addressed without judgement as practice leaders were approachable. They were familiar with organisational whistleblowing protocol for the practice and said would approach the regional team if it was not appropriate to raise a concern at practice level.

Learning and improvement

The SDO was the lead for clinical audit and quality improvement activity; a standing agenda item at the practice meetings. An audit schedule was in place with links to the audits. All mandated audits had been completed, including infection prevention and control in June 2025 and radiography in October 2025. An antibiotic audit had been completed.

Record keeping had been reviewed for individual clinicians as part of the Clinical Quality Assurance and Appraisal (referred to as CQAA) and the SDO confirmed no concerns were identified with record keeping. Peer review took place with the dentist at Brawdy Dental Centre. The hygienist reported that they participated in regional peer reviews, which included a varied range of case discussions. They confirmed that a clinical record audit was completed as part of their Clinical Quality Assurance and Appraisal (known as CQAA).

The SDO was in the early phase of an audit/service evaluation to determine if placing a material in the socket of a recently extracted tooth reduces the occurrence of dry socket; a painful condition which is prevalent in patients who smoke or who have difficult extractions.

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) via a quick response or QR code. This code was displayed in the practice. Furthermore, patients had the option of leaving feedback in the suggestion box in the waiting area. Patient feedback was reviewed by the practice manager and discussed with the staff team at practice meetings. A 'you said, we did' notice was displayed outlining how the practice had responded to feedback. For example, patients indicated they found the dental centre difficult to find since the closure of the camp. The practice now sends patients maps and directions on how to find the building.

All staff we spoke with said they felt comfortable raising suggestions, improvements or feedback to the practice manager or SDO.