Northolt Dental Centre

RAF Northolt, West End Road, Ruislip, HA4 6NG

Defence Medical Services inspection report

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

Are services safe?	**No action required**	✓
Are services effective?	**No action required**	✓
Are services caring?	**No action required**	✓
Are services responsive?	**No action required**	✓
Are services well led?	**No action required**	✓

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Northolt Dental Centre on 25 May 2022.

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

The 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 CQC's observations and recommendations.

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

Background to this practice

Co-located with Northolt Medical Centre, the Dental Centre is a three-surgery practice providing a routine, preventative and emergency dental service to a patient population of 900 military personnel. Just two chairs were in use at the time of the inspection. The dental centre has a dedicated central sterilisation department.

The practice is open from 08:00 hours to 17:00 hours Monday to Thursday and from 08:00 hours to 12:00 hours on Friday. Out-of-hours emergency access is facilitated by the regional duty dental team.

The staff team

Dentist	Civilian Senior Dental Officer
Dental hygienist	One day a week
Dental nurse	Civilian dental nurse Military dental nurse (post vacant) Civilian locum dental nurse (since January 2022)
Practice manager	Vacant post

Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and a practice manager/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 dental nurse and Senior Dental Officer. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We checked the premises, equipment and facilities. We also reviewed patient feedback and interviewed patients by telephone during the inspection.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice effectively used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events. Lessons learnt from significant events were not clearly articulated on practice meeting minutes.
- Local systems were in place to support the management of risk, including clinical and non-clinical risk. Arrangements to ensure safe water temperatures for the building were in place and managed by an external stakeholder but the process was not effective. The practice addressed and resolved this matter after the inspection.
- Arrangements for monitoring the environmental cleaning contract were not clear.
- Suitable safeguarding processes were established and staff understood their responsibilities for safeguarding adults.
- Appraisals and required training for staff were up-to-date, and staff were supported with continuing professional development.
- Clinicians provided care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.
- Leadership at the practice was inclusive. Despite staff vacancies, the team worked well together and managed the staff gaps to ensure patient care was not unduly impacted. Taking on additional duties meant there was a risk to staff health and wellbeing.
- Medicines and life-saving equipment were available in the event of a medical emergency. The monitoring of medicines requiring cold storage was not carried out in accordance with organisational policy.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Systems for assessing, monitoring and improving the quality of the service were in place.

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

- Review staffing levels to ensure the practice has sufficient capacity to provide continuity of care for patients and effectively oversee the governance of the practice.

The Chief Inspector recommends to the practice:

- Ensure arrangements are put in place to monitor the cleaning contract.
- Review the radiation file to ensure all required information is included and up-to-date.
- Ensure fridge temperatures are monitored in accordance with DPHC policy.
- Follow-up on the works request to review ventilation in the Central Sterilisation Services Department to ensure improvements are made in a timely way.
- Liaise with the unit/contractors to secure evidence of routine equipment and infrastructure checks.
- Review internal governance processes to ensure all relevant information is captured to demonstrate effective service monitoring.

Dr John Milne MBE BChD, Senior National Dental Advisor

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

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

All staff had log-in to the Automated Significant Event Reporting (ASER) DMS-wide system to report a significant event (SE) and had completed ASER training in January 2022. An ASER reporting flowchart was displayed and staff were clear in their understanding of the types of SEs that should be reported, including never events. Although a standing agenda item at practice meetings, we noted from minutes that discussions about SEs were not sufficiently detailed, including lessons learnt. We highlighted this during the inspection.

Accidents were reported through the ASER system. Staff were aware of when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

National patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority and the Department of Health Central Alerting System were a standing agenda item at the practice meeting. Although alerts were logged, the log would benefit from including staff signatures to indicate the alert had been read.

Reliable safety systems and processes (including safeguarding)

The Senior Dental Officer (SDO) was the safeguarding lead for the practice. The safeguarding children and vulnerable adults policy was displayed, including contact details for the Central and North West London children's safeguarding team. Staff had completed both adult and child 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 age or circumstances. The practice had a small number of registered patients under the age of 18 but these patients had not yet been seen at the practice. The chaperone policy was displayed at reception.

Clinical staff understood the duty of candour principles, a set of specific legal requirements that services must follow when things go wrong with care and treatment. From an example provided by the SDO, it was clear that duty of candour principles had been applied, including informing the patient and offering an apology.

Although a lone worker risk assessment was in place, we were advised by the SDO that staff did not work on their own in the building. The SDO was supported by a dental nurse when treating patients. The hygienist mainly treated patients unsupported. An emergency call button was located in each surgery and was used in the event of an emergency and if the hygienist had concern and needed support. A process was in place to test the emergency call system.

Staff were aware of how to raise concerns through whistleblowing processes and had completed training in February 2022. Information was displayed about whistleblowing and 'Freedom to Speak Up'.

Dentists routinely used rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment.

The business continuity plan was revised in May 2022 and outlined how the service would be provided if an event occurred that impacted its operation. The plan referenced loss of power, loss of temperature control of fridges, adverse weather conditions and loss of compressed air.

Medical emergencies

The SDO was the lead for the management of medical emergencies and the team had completed training in January and March 2022. The medical emergency kit was held in an accessible area of the dental centre. Although not the Defence Primary Healthcare (DPHC) recommended delivery system, an appropriate box was used to hold the emergency drugs. We noted Midazolam (medicine with a sedative effective) was not held securely, and when we highlighted this, the SDO removed it to a more secure area. The SDO confirmed after the inspection that Midazolam was now stored in a locked filing cabinet within a locked room. The automated external defibrillator (AED) was held in the co-located physiotherapy department and we confirmed it was regularly checked to ensure it was in working order. The medical emergency kit and medicines were regularly checked and a log maintained of the checks. Appropriate oxygen signage was in place.

Staff were up-to-date with training (between January and May 2022) in managing medical emergencies including annual basic life support, use of the AED, anaphylaxis (allergic reaction) and joint scenario training with the medical centre. The medical emergency protocol for a patient collapse was displayed on the notice board.

First aid, bodily fluids and mercury spillage kits were available and all were in-date. The DPHC protocol for managing spillages and immediate first aid were displayed at the practice. Training records confirmed staff were up-to-date with first aid training. Staff were aware of the signs of sepsis. The UK Sepsis Trust 'Sepsis Decision Support Tool for Primary Dental Care' was displayed on the notice board.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. Staff had access to the personnel management system (PMS), an organisation-wide system used to monitor training and other recruitment/personnel information. In the absence of a practice manager, staff checked their own PMS and informed the regional group practice manager (GPM) of training they had completed so the GPM could update PMS. Through access to the PMS system, we confirmed relevant safety checks were up-to-date, including an enhanced Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in line with DPHC policy. The registration of staff with the General Dental Council was current and staff had the relevant vaccinations required for their role.

Monitoring health & safety and responding to risks

We looked at the practice's arrangements for the provision of a safe service. The risk register was held by Regional Headquarters and updated by the SDO each month. A member of staff in the medical centre was the building custodian and carried out the building risk assessments. These were held electronically and accessible to dental centre staff on SharePoint. The building custodian also carried out the monthly checks of the fire system for the whole building. A fire risk assessment was undertaken in July 2019. The latest risk assessment was completed in May 2022 and the practice had not yet received the report. We checked the firefighting equipment and it was in-date for checks. The staff team participated in a fire evacuation drill in September 2021 and they were up-to-date with fire training. The dental centre was represented at the station 'health, safety, environmental protection and fire' meeting in February 2022.

Control of Substances Hazardous to Health (COSHH) risk assessments and data sheets were in place. The risk assessments were reviewed annually or if there was a change of product. They were last reviewed in July 2021. COSHH products were stored securely.

The DPHC protocol for the prevention and management of legionella was displayed and indicated it was the unit responsibility to ensure periodic testing of mains water supplies. Prior to the inspection, the practice requested and secured the building legionella risk assessment undertaken in February 2022. The assessment identified non-compliance with hot water temperatures. The monthly water temperature checks were not routinely shared with the practice. Just prior to the inspection, the practice secured the water temperatures for the last three months. Only one surgery was checked during that period and the hot water was below the required temperature to minimise the risk of Legionella in the water system. The practice had not been made aware of this by the contractor. Following this inspection, the practice liaised with the contractor and water temperatures were checked on 30 May 2022. The practice was assured by the contractor there would be ongoing regular monthly checks and any issues regarding water temperature would be raised immediately with the practice followed by an email.

The practice had a process in place for the management of waterlines. They were flushed for two minutes each morning and for 30 seconds after each patient. Each Friday the bottle was removed and left to dry. The reverse osmosis system for purifying water was serviced in February 2022.

In response to COVID-19, the practice worked to the Defence Primary Healthcare (DPHC) SOP, 'Infection Prevention and Control for Respiratory Infections (including SARS-CoV-2) in DPHC dental settings (February 2022)'. Patients were triaged by telephone before their appointment to determine whether they met the criteria for the non-respiratory pathway or the respiratory pathway. For the latter pathway, full personal protective equipment (PPE) was used along with the measures outlined in the guidance. Information about the COVID-19 was displayed around the dental centre. Hand sanitiser was provided throughout the building and the practice had procured a large stock of PPE for use by both staff and patients. Individual staff COVID-19 risk assessments had been completed.

The practice followed relevant safety laws when using needles and other sharp dental items. The local risk assessment and protocol for the management of sharps and needle

stick injuries was displayed in clinical areas. The sharps boxes were labelled, dated and used appropriately. Staff received sharps training in March 2022.

Infection control

The dental nurse was the lead for infection prevention and control (IPC) and had appropriate training for the role. The local IPC policy took account of the Department of Health's 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)' and was displayed in the surgeries. The staff team were up-to-date with IPC training. IPC audits were undertaken every six months and the last audit identified an overall compliance score of 94%. The shortfall related to ventilation in the central sterilisation services department (CSSD) as it did not meet HTM 01-05 best practice guidance. The practice had submitted a statement of need (works request) for improvements to be made.

We checked the two surgeries in use. They were well organised, clean and clutter free. Stock held was in-date. Local anaesthetic (LA) ampoules had been removed from the original packaging which meant there was a risk batches could become mixed. Similarly, amalgam had been removed from packing which meant expiry dates were not evident. The SDO provided evidence after the inspection to confirm the unpackaged LA ampoules and amalgam had been removed and replaced with items in their original packaging.

Decontamination took place in the CSSD. An efficient process was in place for the sterilisation of dental instruments. Red containers were used to transport dirty instruments to the CSSD and green containers were used to return clean instruments to the surgery. Inspections lights were used prior to sterilisation. Although there was a date on sterilised packs, the test strip was not included in the pack to confirm proof of sterilisation. The SDO confirmed after the inspection that test strips were now being included in the sterilised packs.

Environmental cleaning was carried out by a contracted company twice a day; before the practice opened and at lunchtime. The dental nurse monitored that cleaning was taking place in accordance with the contract and cleaning schedule. There was no evidence that the contact manager engaged with the practice to monitor the contract. The cleaning cupboard was located in the communal patient waiting area between the medical and dental centres. We noted it was unlocked. The SDO confirmed after the inspection that the building custodian had been contacted and arrangements had been made to ensure the cupboard was locked when not in use.

The medical centre oversaw the management of clinical waste and provided the dental centre with copies of the consignment notes. Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth and gypsum. Waste was collected every month. Clinical waste bins were located outside of the building. Although locked, they were not secured in a compound or fixed to a wall/railing. The SDO confirmed after the inspection that the building custodian had been contacted to highlight that security of the clinical waste bins had been identified during the inspection and action was required.

Equipment and medicines

How equipment was managed, including faulty equipment, was displayed on the equipment care board. Maintenance records confirmed the autoclave, ultrasonic bath and compressor were in-date for servicing. All other routine equipment, including clinical equipment, had been serviced in accordance with the manufacturer's recommendations. We were advised that routine portable appliance testing (PAT) was undertaken by the unit but the practice was not provided with a log of the testing. A faults log was in place to track the reporting and management of faulty equipment. Almost all equipment held at the practice was latex free. A system was in place for the management of stock to ensure there was adequate stock in place.

Sequentially numbered prescription sheets used were stored in a locked cupboard in reception but not accounted for in a log to demonstrate consecutive numbered sheets were used and every sheet was accounted for. After the inspection, the SDO confirmed a log had been put in place and was held on SharePoint. Prescriptions were dispensed from the medical centre dispensary. Antibiotics were very rarely prescribed (three prescriptions in five months) indicating adherence to the Faculty of General Dental Practice good practice guidelines on antibiotic prescribing. Controlled drugs (medicines with a potential for misuse) were held securely.

We looked at the temperature checks for medicines requiring cold storage and they were within parameters. Temperatures were being checked once a day rather than the required twice a day. All items were within their expiry date. A new pharmaceutical fridge had arrived and was awaiting to be installed.

Radiography (X-rays)

A radiation file was held in reception and it had been maintained by the practice manager who had since left the practice. We noted it needed to be re-organised and brought up-to-date. For example, the Health and Safety Executive (HSE) notification was not included in the file. In addition, it would be useful to include the Local Rules and radiology in the file so they are easily accessible. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for the practice. Signed and dated Local Rules were available in the surgeries along with safety procedures for radiography. Documents were in place to show equipment was maintained in accordance with the manufacturer's instructions. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

A radiology audit was completed in December 2021 and was next due in June 2022. The SDO also audited each digital image and provided justification, quality assurance grading and an outcome in the patient's clinical records.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients were assessed in line with recognised guidance, such as the National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. The Senior Dental Officer (SDO) followed guidance from the British Periodontal Society in relation to periodontal staging and grading. A basic periodontal examination (BPE) - assessment of the gums and caries (tooth decay) was carried out at each periodontal inspection (PDI). Taking into account operational need, the SDO referenced SIGN and the Faculty of General Dental Practice guidance in relation to the management of wisdom teeth.

We looked at the dental records for 15 patients to corroborate our findings. Clinical records were maintained of an excellent standard; sufficiently detailed, up-to-date and in line with best practice guidance. They included 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 and showed treatment options were discussed with the patient. Patients completed a medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment.

Defence dental fitness targets for the patient population was closely monitored by the SDO and presented at the monthly practice team meeting.

Health promotion and prevention

In line with the Delivering Better Oral Health toolkit, the practice was pro-active in supporting patients to maintain optimal oral health. The dental nurse provided oral health education (OHE) and a brief intervention to assist with smoking cessation. Patients could also be referred to the medical centre for smoking cessation. Records showed that the alcohol consumption of patients was assessed using the AUDIT-C screening tool and intervention provided as appropriate. Other lifestyle risk factors assessed included diet, medication and standards of oral hygiene. High concentration sodium fluoride toothpaste and fluoride varnish were treatment options considered by the SDO based on patient need.

A range of oral health promotion leaflets and toothpaste samples were available for patients in the waiting room along with an informative display in support of National Smile Week.

Staffing

Staff were up-to-date with Defence Primary Healthcare (DPHC) mandatory training. A schedule of in-service training was in place. It was not clear from the records who attended the training. We confirmed they were current with their continuing professional development required for maintaining registration with the General Dental Council.

The practice manager recently left the service and recruitment was underway for a replacement. The practice manager role was being undertaken by the dental nurse and

SDO. A locum dental nurse was supporting the practice while a military nurse was being recruited. Cover for leave and absence was provided by the region.

Working with other services

The SDO referred all patients who required oral surgery to NHS services. A detailed log was in place to monitor the progress of referrals, including patients referred for suspicious lesions. The wait was lengthy for NHS secondary care and the SDO explained this to patients at the point of referral. Patients were given the contact details for the NHS Patient Advice and Liaison Service to follow up on the progress of their referral. The SDO advised us that patients referred as a two-week-wait were seen on time.

Consent to care and treatment

Patients we spoke with confirmed they were given information about treatment options and the risks and benefits of these so they could make informed decisions. The patient records we reviewed showed implied consent was recorded for each PDI. Verbal consent was taken from patients for routine treatment.

Information about the Mental Capacity Act (2005) was displayed in the practice and staff had a good awareness of how mental capacity applied to their patient population.

Are Services Caring?

Respect, dignity, compassion and empathy

We reviewed patient feedback which was obtained using a variety of methods. These included direct interviews with seven patients, the Defence Primary Healthcare (DPHC) patient feedback forms and the Defence Medical Services Regulator (DMSR) patient satisfaction survey (five respondents) which complemented this inspection. All sources of feedback indicated staff treated patients with kindness, respect and compassion.

The DMSR survey and the patients we spoke with indicated adequate time was allocated for patient appointments, so they did not feel rushed. The Senior Dental Officer (SDO) confirmed appointment times could be extended for discussions and explanations, particularly for anxious patients. Patients told us the SDO went ‘the extra mile’ in terms of follow-up, which included a telephone call a few days after complex treatment to check how the patient was recovering.

Access to a translation service was available for patients who did not have English as their first language.

Involvement in decisions about care and treatment

All sources of patient feedback suggested the SDO provided clear information to support patients with making informed decisions about treatment choices. This included verbal explanations, visual aids and printed information. The dental records we looked at indicated patients were involved in the decision making about the treatment choices available. Patients told us their occupational needs and work schedule were discussed to assist with choosing and timing a suitable treatment plan.

Are Services Responsive?

Responding to and meeting patients' needs

The Senior Dental Officer (SDO) followed appropriate guidance in relation to recall intervals between oral health reviews, which were between six and 24 months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. Patients could make routine appointments between their recall periods if they had any concerns about their oral health.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit was completed in April 2022. The dental centre was on the ground floor with step-free access and automatic doors. An accessible toilet was located in the waiting area. Staff completed training in equality and diversity in April 2022. The Defence Primary Healthcare diversity and inclusion champions for the region were displayed on the equality and diversity notice board.

Access to the service

At the time of the inspection, the next available routine appointment with the SDO was within three weeks. There was a four week wait for an appointment with the hygienist. All sources of feedback indicated patients received a timely appointment that met their health and occupational needs.

Two appointment slots were allocated for urgent requests each; one in the morning and the other in the afternoon. We were advised that the morning slot was rarely used so there was scope for the practice to review the need for this slot with the potential to use it to reduce waiting times.

Information about the service, including opening hours and access to an emergency out-of-hours (OOH) service, was displayed on the front door, at reception and on the practice leaflet. OOH emergency care was through the regional duty team.

Concerns and complaints

The SDO was the lead for complaints, which were managed in accordance with the Defence Primary Healthcare complaints policy. The team had received training in managing complaints. A complaints log was held on the healthcare governance SharePoint and a complaints audit was completed in April 2022. Complaints were a standing agenda item at the practice meetings.

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

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) joined the practice in 2020 and was overall responsible for the management and clinical leadership of the practice. In the absence of a practice manager, the dental nurse and SDO had taken on the day-to-day practice administrative duties. Lead roles were shared between the SDO and the dental nurse. The regional group practice manager provided advisory support to the practice while a practice manager was being recruited. The SDO highlighted that taking on additional administrative duties had impacted the dental targets.

Practice meetings were held each month. Although the meeting minute records were not structured in line with Defence Primary Healthcare guidelines, they did take into account the scope of governance activities at the practice.

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 referenced current legislation and national guidance. Staff were familiar with these and referred to them throughout the inspection. The General Dental Council standards were displayed in the practice.

The risks directly overseen by the practice were managed effectively. However, the management of risk by other stakeholders was not so effective, such as monitoring of safe water temperatures. After the inspection the practice promptly acted to address the management of water safety.

Internal and regional processes were established to monitor service performance. There was scope to make minor improvements to internal governance processes such as the management of medical alerts, in-service training and the radiology file. The practice had moved from the internal quality assurance tool, the Common Assurance Framework (eCAF) used to monitor safety and performance, to the new ‘Health Assessment Framework’. We had access to the regional-led Health Governance Assurance Visit (HGAV) that took place in March 2022 including the executive summary and action points. Many of the action points had been addressed. A clinician-specific clinical quality assurance visit in March 2022 involved a review of the SDO’s performance and record keeping.

The regional team monitored the performance of the practice as they had access to the governance updates the practice uploaded to SharePoint. This information was used for Governance, Performance, Assurance and Quality (GPAQ) analysis undertaken at regional level.

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 Defence Information

Management Passport training, data protection training and training in the Caldicott principles to protect confidential patient information.

Leadership, openness and transparency

Although a small team, it was clear the team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. We identified a risk to the health and wellbeing of staff as they had the added pressure of undertaking the duties usually overseen by a practice manager.

Learning and improvement

Quality improvement activity (QIA) to encourage learning and continuous development was evident. The range of QIA included environmental, equipment and inventory checks. Regular audits including infection prevention and control and radiology. There was scope to engage with service-specific audits, including a review of the length of patient appointments to free up time which would support with reducing appointment waiting times. In addition, the practice would benefit from reviewing how patient feedback is gathered and used to develop the service.

Staff received mid and end of year annual appraisal and these were up-to-date.

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

Options were in place for patients to leave feedback about the service including a suggestion box in the waiting room and a ‘quick reference’ or QR code to access the patient experience survey. Prior to COVID-19 a token system was in use to seek patient feedback. Staff said they would explore re-introducing this feedback option. The GPAQ dashboard was used by the regional team to analyse patient feedback.

Staff told us they had the option to provide feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for service and said these were listened to and acted on.