Mr. Alwyn Miller

West Malling Dental Practice and Implant Centre

Inspection report

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Overall summary

We carried out this focused unannounced inspection on 19 November 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following three questions:

• Is it safe?

• Is it effective?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found this practice was providing effective care in accordance with the relevant regulations.

Summary of findings

Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations.

Background

West Malling Dental Practice and Implant Centre is in West Malling and provides private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes four dentists, two dental nurses, four trainee dental nurses, two also cover reception a dental hygienist, and a receptionist. The practice has three treatment rooms.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

During the inspection we spoke with two dentists, two dental nurses, a trainee dental nurse and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday and Thursday 8.30am to 5.30pm

Tuesday and Wednesday 8.30am to 7pm

Friday 8.30am to 4.30pm

Saturday 9am to 1pm

Our key findings were:

- The practice appeared to be visibly clean, but improvements could be made to areas of the practice. We saw some areas that were not well-maintained.
- The provider had infection control procedures which did not wholly reflect published guidance.
- We were not assured staff knew how to deal with emergencies, as some staff were not trained and did not know where some emergency equipment was kept. Not all the required appropriate medicines and life-saving equipment were available.
- The provider had some systems to help them manage risk to patients and staff, this requires improvement.
- The provider did not have sufficient safeguarding processes and some staff did not know their responsibilities for safeguarding vulnerable adults and children.
- The provider did not have staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.

Summary of findings

- The provider did not have an effective leadership and a culture of continuous improvement.
- Staff told us they felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had some information governance arrangements.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation/s the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Implement protocols for domiciliary visits taking into account the 2009 guidelines published by British Society for Disability and Oral Health in the document “Guidelines for the Delivery of a Domiciliary Oral Healthcare Service”.
- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

Develop systems to ensure an effective process is established for the on-going assessment, supervision and appraisal of all staff. Including the training, learning and development needs of individual staff members at appropriate intervals.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action**
Are services effective?	**No action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff did not have clear systems to keep patients safe.

Some staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider did not have safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that only one member of staff had received safeguarding training. Some staff knew about the signs and symptoms of abuse and neglect and how to report concerns, however, some did not. Staff did not know any safeguarding referrals require notification to the CQC. Following our inspection, we were sent three certificates for safeguarding training. Only one of these was at the correct level for clinical staff. We were sent an updated safeguarding policy but no procedures.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. They did not wholly follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Not all staff had completed infection prevention and control training, we saw two members of staff had completed training. We were sent three certificates for infection control training following our inspection. Five members of staff had not completed infection control training.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments which we found was not in line with HTM 01-05. The records, which were incomplete, showed some equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance for one of the autoclaves. However, there was no servicing information for the autoclave in the upstairs decontamination room. The logbook for this autoclave had last been completed on 05 July 2021. The logbook for the maintenance of the ultrasonic bath was not completed regularly the last dated entry was 19 August 2021, no further records were available. We saw that the decontamination of re-usable instruments was compromised on a number of levels. There was a heavy oil film on top of the enzymatic detergent used to manually scrub the instruments. Oil can produce a layer on the instruments that interferes with the steam contact on the instrument surface. This compromises sterility of the instrument and can also harbour bacteria and other pathogens. Oil contamination can reduce the efficacy of the enzymatic detergent. *The provider had suitable numbers of dental instruments available for the clinical staff.* We found a wire brush which is not recommended to clean instruments as it causes damage to the passivation layer of the instrument. This then makes it difficult to clean effectively as bacteria and pathogens can remain in the scratches and pits created by the wire brush. The practice had a magnified illumination device, this was connected by a USB connection. However, there was nowhere to plug the illuminator in. The illuminator should be used to ensure that instruments are free from debris, contamination and deterioration before being sterilised in the autoclave.

Are services safe?

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations in the assessment had been actioned and records of water testing was carried out. However, we found that the hot water in the upstairs decontamination room did not reach the required temperature to ensure that Legionella cannot develop. This had not been identified. The dental unit water lines were maintained. We were told that dip slides for water quality testing were conducted however,here were no records of this being conducted, or of the results.

Daily checklists for the opening, closing and cleaning of the two decontamination rooms and the treatment rooms were not regularly completed. The last completed decontamination room checklist was date 27 September 2021. And the last treatment room checklist had been completed on 20 September 2021.

The provider did not have policies and procedures in place to ensure clinical waste was stored appropriately in line with guidance. We saw that clinical waste had been segregated correctly, however, two clinical waste bins, one in a treatment room and one in the downstairs decontamination room did not have lids and were not foot operated.

The infection control lead carried out infection prevention and control audits, we saw one dated 7 June 2021. The audit had not identified the issues we found and had been incorrectly completed. We were not assured that the audit process would identify and improve adherence to HTM 01-05.

The provider had whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination. We noted that the policy did not contain the contact details of the required escalation organisations for staff to refer to. We were sent an updated policy following our inspection. However not all the required information was included.

The dentists told us they used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this had not been recorded in the patients notes or a risk assessment for not using a dental dam recorded. We did not see any records that a dental dam was used.

The provider did not have a recruitment policy and procedure to help them employ suitable staff and the checks required had not always been conducted. This did not reflect the relevant legislation. We looked at eleven staff recruitment records. We found that four members of staff did not have a disclosure and barring service check (DBS). Five members of the clinical team did not have any information regarding their Hepatitis B vaccination status. Only one member of the clinical team had information about their indemnity. Inductions for new staff did not include safeguarding, medical emergencies or fire safety. Some members of staff had not completed an induction. Following our inspection, we received two DBS certificates, indemnity for three members of clinical staff and Hepatitis vaccination status for one member of staff.

We observed that clinical staff were qualified and registered with the General Dental Council, however only one member of staff had information about their professional indemnity cover.

Staff ensured some facilities and equipment were safe, however, not all equipment was maintained according to manufacturers' instructions, Ultrasonic baths had not been subject to protein residue and foil ablation tests to evidence

the baths were free from contaminates and working effectively. We saw there was black mould in the downstairs decontamination room and there was a hole in the floor by the downstairs decontamination room covered by a mat. This presents a trip hazard and had not been risk assessed. The provider had information to show that electrical and gas appliances were safe.

The provider had conducted an in-house fire risk assessment in line with the legal requirements. Fire drills had been carried out, but fire safety was not included in the induction of new staff. Staff had not completed any training regarding fire safety. We saw fire exits were kept clear. We received a fire safety training certificate for one member of staff following our inspection.

The practice did not have sufficient arrangements to ensure the safety of the X-ray equipment and we asked for the required radiation protection information of which, not all was available.

We saw evidence the dentists justified, graded and reported on the radiographs they took. However, radiography audits had not been carried out every year following current guidance and legislation.

We did not see clinical staff had completed continuing professional development in respect of dental radiography. Following our inspection, we received one certificate which evidenced 70 mins out of the five hours of continuing professional development required for radiography.

Risks to patients

The provider had implemented some systems to assess, monitor and manage risks to patient safety, but these were ineffective and required improvements.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly but the contents and information collected did not manage potential risk and some risk had not been identified. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff did not follow the relevant safety regulation when using needles and other sharp dental items. We witnessed dental nurses handling sharps when they told us only the clinician handled the sharps. The practice had not carried out a sharps risk assessment.

The provider did not have a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We saw that five clinical members of staff had no information regarding Hepatitis B.

Staff had not completed sepsis awareness training. However, sepsis prompts for staff and patient information posters were displayed throughout the practice. Staff spoken with demonstrated a good understanding of sepsis, this helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Not all staff knew how to respond to a medical emergency and only three members of staff had completed training in emergency resuscitation and basic life support every year. One member of staff when asked did not know where some of the emergency equipment was stored.

Emergency equipment and medicines were not available as described in recognised guidance. We found staff did not keep records consistently to make sure these were available, within their expiry date, and in working order. The last entry on the checklist was dated 04 August 2021. We found the practice did not have all the required medicines to manage a severe allergic reaction, a seizure and low blood sugar. We were sent evidence that the medicines and outstanding equipment had been acquired following our inspection.

Are services safe?

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment was in place for when the dental hygienist worked without chairside support. However, this was not comprehensive and only related to one potential risk. We saw that the hygienist did not have a patient group directive in place as required under the Humans Medicines Act 2012.

The provider had six risk assessments to minimise the risk that can be caused from substances that are hazardous to health. This had not addressed all the dental materials, medicines and cleaning products used in the practice. We saw some cleaning products and paint was stored in the patient toilet and this was not secure.

Information to deliver safe care and treatment

Staff had some information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that some individual records were written and typed and managed in a way that kept patients safe. These records were implant patients. We saw that other dental care records were incomplete and did not contain information about risks and benefits of treatments proposed. Two records we looked at did not have a diagnosis recorded. Other records did not have an updated medical history. Risks were not always noted. Some records did not have a basic periodontal exam (BPE) recorded. We looked at a root canal treatment record which did not have the use of a rubber dam, which irrigant used, and no X-ray recorded. Dental care records we saw were incomplete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider did not have systems for appropriate and safe handling of medicines.

The dentists were aware of current guidance with regards to prescribing medicines. However, there was a stock control system of medicines which were held on site although it had not been completed regularly. This would not ensure that medicines did not pass their expiry date and enough medicines were available if required. However, we noted that the medicines for dispensing were not dispensed in line with current legislation. There was no log of medicines acquired or dispensed. No practice information was provided on the medicines dispensed as required under the Medicines Act 1968. We saw saline stored in the medicines fridge which was partly frozen as the temperature was 1 degrees c. The fridge temperature log had not been completed since 22 February 2021.

Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The provider had not implemented systems for reviewing and investigating when things went wrong. There was a comprehensive risk assessment for legionella but not for fire and sharp safety issues. Staff were unable to monitor and review incidents as there was no process for this. Staff did not understand risks completely which led to ineffective risk management systems in the practice. We were sent in house risk assessments for fire and sharps following our inspection.

The provider did not have a system for receiving and acting on safety alerts. We were sent evidence that the practice had signed up to receive safety alerts following our inspection.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. We saw some clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. However, we saw that not all the dental care records reflected that this had been completed as the records were incomplete.

The provider had not considered guidelines as set out by the British Society of Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence. The provider did not conduct risk assessments to determine if medical emergency equipment or medicines would be required when visiting patients in their own homes or place or residence.

The practice offered dental implants. These were placed by the one of the dentists at the practice who had undergone appropriate post-graduate training in the provision of dental implants. We saw the provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

We did not see records to demonstrate that the clinicians, discussed smoking, alcohol consumption and diet with patients during appointments, apart from the implant records. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

We looked at dental care records to see how the clinicians improve the outcomes for patients with gum disease. This involves providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. We saw that a patients periodontal index and BPE was not always recorded in the records we reviewed

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance. We saw this in the implant patient records.

The staff spoken with understood the importance of obtaining and recording patients' consent to treatment. Although some of the general dentistry records we reviewed did not have consent recorded. The dentists were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We did not see this documented in some of the patients' records we reviewed.

The practice did not have a consent policy to refer to. The dentists understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The staff did not have information regarding Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. The dentists were aware of the need to consider this when treating young people under 16 years of age.

Are services effective?

(for example, treatment is effective)

Monitoring care and treatment

The practice did not always keep detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists explained how they assessed patients' treatment needs in line with recognised guidance.

The provider did not have effective quality assurance processes to encourage learning and continuous improvement. Only one audit had been completed in June 2021 and had failed to identify issues in the infection prevention and control processes in the practice. No audits had been conducted for radiographic quality assurance and dental care records.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, this could be improved.

Staff new to the practice did not always have a structured induction programme. We could not confirm clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The principal dentist did not demonstrate they had the capacity, to deliver high-quality, sustainable care.

Staff told us they worked closely with the dentists and hygienist

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff had not discussed their training needs at an annual appraisal. We saw historical appraisals in the staff folders, but this had been over two years previously. We noted that not all training had been completed for some staff.

We saw the provider had systems in place to deal with staff poor performance. However, this needed some improvement.

The provider was aware of but did not have systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice and was responsible for the day to day running of the service. Staff knew the management arrangements.

The provider did not have an effective system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

We saw there were not clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

We could not be assured staff acted on appropriate and accurate information.

Quality and operational information such as audits, were not conducted or did not address issues to improve performance. The practice sought the views of patients.

The provider had some information governance arrangements which requires improvement. Staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved patients to support the service.

The provider used patient surveys and encouraged verbal comments to obtain patients' views about the service.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

Are services well-led?

The provider did not have effective systems and processes for learning, continuous improvement and innovation.

The provider did not have effective quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control.

Staff did not always complete 'highly recommended' training as per General Dental Council professional standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Safe care and treatment Health and Social Care Act (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users. **There were insufficient arrangements for the safe use of sharps.** • There was no sharps risk assessment that covered all the potential sharps that could cause injury. • We witnessed nurses handing sharps in the decontamination room when they had told us that only the dentists and hygienists handle sharps **The control of and assessing the preventing, detecting to spread of infections, including those that are healthcare related was ineffective.** • Only two members of staff had completed training in infection prevention and control • Logbooks for the upstairs autoclave had not been completed regularly. • Logbooks for the ultrasonic baths had not been completed regularly. • The ultrasonic baths had not been maintained in line with HTM 01-05 and the manufactures instructions. • Manual cleaning and effective sterilisation of re-useable instruments was compromised due to oil contamination of the enzymatic detergent • A wire brush was in use which is no longer recommended. • The magnified illumination device was not used as there was no USB port to connect it in the downstairs decontamination room **Legionella**

This section is primarily information for the provider

Enforcement actions

- Water temperature monitoring had failed to identify the hot water in the upstairs decontamination room did not reach 50 degrees c.

Cleaning schedules

- Daily cleaning schedules for the treatment rooms and the two decontamination rooms had not been completed regularly

Clinical waste

- Storage within the practice was not in line with HTM 07-01 two clinical waste bins did not have lids and were not foot operated

Medical emergencies

- Not all the equipment required by current guidance was available
- Not all the medicines required by current guidance was available
- Weekly checks of the equipment and medicines had not been recorded since 04 August 2021
- Eight members of staff had not completed training in medical emergencies
- Medical emergencies were not part of the induction process

Medicines

- Medicines dispensed by the practice did not have the practice information provided
- Stocks of medicines held in the practice were not checked regularly to ensure they had not passed their expiry date
- Logs of medicines acquired and dispensed were not kept by the practice.
- Stocks of medicines were not audited to ensure any had gone missing.
- Domiciliary visits were not risk assessed and medical emergency equipment and medicines were not available during these visits.

Recruitment

- Four members of staff did not have a disclosure and barring service check

This section is primarily information for the provider

Enforcement actions

- Five members of clinical staff did not have information regarding Hepatitis B
- Six members of staff did not have their indemnity information
- Inductions of new staff were ineffective or in some cases not conducted

Safeguarding

- Ten members of staff had not completed safeguarding training for vulnerable adults and children to the required level
- There were no contact details for staff to refer to for the local authority

Fire

- No fire risk assessment had been conducted
- No fire drills had been carried out
- Fire safety was not part of the induction process
- No training in fire safety and been completed

Control of Substances Hazardous to Health COSHH.

- Not all the dental materials and cleaning products had been risk assessed.

Radiography

- There were no documented arrangements for radiation protection as no radiation protection file was available.
- Visual inspections of X-ray units were not regularly conducted to identify safety faults.
- Three members of staff did not have evidence that they had completed training in radiography as required.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17. Good governance. Health and Social Care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Dental Care Records

- Some dental care records were incomplete. Some did not have a Basic periodontal score (BPE), risks and benefits discussed, consent and updates to medical histories were not recorded.

Risk assessments

- There were no risk assessments for fire safety, Control of substances hazardous to health and sharps
- Risk assessments that were available were incomplete and had not identified all the risks

Audit

- An audit had been conducted for infection control. The audit was not completed correctly and risks and gaps in the infection control process found during the inspection had not been identified.
- Audits for radiographic quality assurance had not been conducted.

Recruitment

- Not all the Schedule 3 documentation was available for staff employed at the practice as required by legislation.
- Inductions completed had not included medical emergencies, safeguarding or fire safety.
- Not all staff were subject to an induction
- Staff did not receive regular appraisal and learning needs had not been identified.