IDH Limited

IDH Hereford

Inspection Report

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Overall summary

IDH is a national company which operates 600 dental practices across the United Kingdom. The Hereford practice is in the city centre. The practice team includes three dentists, a private dental hygienist, four dental nurses and a reception team. The practice manager is full time but is also responsible for two other practices.

IDH Hereford is located on the first and second floors above a row of shops in Hereford city centre. The practice provides mainly NHS dental treatment although private dental care is available on request.

There is no lift and therefore access is difficult for patients with mobility difficulties and families with babies and small children. No parking is provided although there are a number of city centre car parks nearby.

Before the inspection we sent comment cards to the practice for patients to complete. Sixteen patients had filled one in. Overall these patients were positive about the practice and described the staff team as professional, polite, helpful and pleasant. Patients commented that they were pleased with their care.

There were comprehensive policies and procedures at the practice for staff recruitment and for safeguarding children and vulnerable adults. The practice had the equipment and medicines they would need in the event of a medical emergency at the practice and staff were trained so they would know how to respond. Generally the practice had effective arrangements to ensure patients received appropriate care and treatment. Staff working at the practice had the appropriate skills and knowledge for their roles.

We found some issues at the practice where improvements were needed. These were straightforward to address and we considered that IDH should have identified and addresses these through their own quality monitoring processes.

However, there were areas where the provider needs to make improvements

Importantly, the provider must:

- Ensure that they have effective arrangements for assessing and monitoring the quality of the service at the practice.

There were also areas where the provider could make improvements and should:

- Improve their processes for sharing information with staff about clinical updates, safety alerts, audits, complaints and significant events.
- Improve arrangements to ensure effective operation of systems to prevent, detect and control the spread of healthcare associated infections.
- Explore options for improving waiting areas for patients.
- Consider developing a business continuity plan.

Summary of findings

- Implement the use of rubber dams for endodontic (root canal) treatment.
- Ensure that all dentists and dental nurses are familiar with the Mental Capacity Act 2005 and its relevance to the dental team.
- Improve the recording of complaints to provide a clear audit trail of the action taken and the learning arising from this.
- Consider the impact on the division of the registered manager's time between three practices on the leadership and management of the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Equipment at the practice was generally well maintained and regularly serviced although the practice could not find essential documents to confirm the safety of radiography equipment (used to take dental X-rays). As a result they arranged to have this equipment checked again four days after the inspection. The practice had the equipment and medicines they might need to deal with medical emergencies. Staff received training to know what to do in a medical emergency or if a patient needed first aid.

There were comprehensive staff recruitment policies and procedures to help reduce the risk of unsuitable staff being employed. There were also detailed policies and procedures for safeguarding children and vulnerable adults.

We found that the practice was not following best practice in accordance with quality guidelines for endodontic treatment from European Society of Endodontology in respect of endodontic (root canal) treatment. This was because they did not use a rubber dam. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work.

Fire safety was assessed and staff took part in regular fire drills. Precautions were in place to reduce the risk of infection from legionella bacteria. However, the practice needed to make improvements in the management of radiography and infection prevention and control.

Are services effective?

Patients' treatment was planned and discussed with them and based on their assessed needs. The dentists provided treatment with regard to current National Institute for Health and Care guidance. A written medical history was obtained before the commencement of dental treatment. Patient treatment plans were provided appropriately and their care and treatment was recorded in their dental records.

The practice was not carrying out completed clinical audit cycles to help monitor the effectiveness of the care and treatment provided.

Dentists had a general awareness about the importance of gaining patients' consent and IDH had a policy for this. However, the dentists were not all familiar with the requirements of the Mental Capacity Act 2005 and none had done specific training about this.

Are services caring?

Patients who completed comment cards told us that staff were polite, helpful and pleasant. The dentists spoke about patients and their approach to their care respectfully and showed they recognised the importance of treating patients in an individual way. We saw information from a patient expressing appreciation for the prompt and sensitive care and treatment they had received when they had been in pain. We also noted that a nervous patient was attended to with sensitivity and kindness by staff.

The lack of space at the practice meant that space in the waiting room was limited and not particularly comfortable, for example, we saw one patient sitting on a wooden ledge because all of the seats were occupied.

Are services responsive to people's needs?

The practice provided NHS dental care and was accepting new NHS patients.

Summary of findings

The practice was located on the second and third floors above shops in Hereford city centre. There were steep stairs from the pavement outside to reach the first floor and stairs inside the practice were also steep. The practice was therefore not accessible to patients with disabilities who were unable to climb stairs or for families with babies and young children.

The practice was open from 8.30am to 6.30pm which provided some flexibility for working age people and families with school children. Appointment times were brief with most being for 10 minutes and we observed that all three dentists were very busy throughout the day. One patient specifically commented on how brief their appointment was and a dentist told us they were able to manage the pace of work due to the experience of the dental nurses.

Extensive periodontal (gum) treatment was only available at the practice with a hygienist if patients paid privately; alternatively the practice referred patients to other NHS dental services.

Are services well-led?

The practice manager was responsible for three dental practices and the division of their time appeared to have an impact on their ability to effectively manage all aspects of the day to day running of this practice. We found that the quality monitoring of the practice by IDH had not identified areas for improvement in a timely way and that some issues reported by the practice had not been acted on by the organisation.

IDH was undergoing significant changes centred on the development of a new national brand for the organisation. Information from staff meeting minutes and our discussions and observations during the inspection indicated that the organisation had not effectively engaged with staff in respect of these changes.

IDH Hereford

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC.

- We carried out this inspection on 18 December 2014. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dentist specialist advisor.
- We informed the NHS England local area team that we were inspecting the practice. They did not raise any concerns.
- We looked at information from patients on the NHS Choices website and the responses to these from the practice.
- During the inspection we looked at the premises, spoke individually with three dentists about their methods of working and reviewed documents. We also spoke individually with the practice manager and a dental nurse.

Are services safe?

Our findings

Learning and improvement from incidents

We saw that a number of minor accidents, including some sharps injuries were recorded in the accident book. One incident involving a patient who became unwell was recorded on an incident recording form. Neither this incident nor any of the minor accidents were reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

We saw a log book that staff used this to record issues they had reported to head office. This included issues such as repairs that were needed or events such as power or computer problems. This contained limited information and did not include details of any action taken to resolve the issues recorded. We learned of some issues which were not recorded and where no action had been taken. For example, a bin in a treatment room used for clinical waste was broken and would not shut. The nurse said this had been reported some time ago but there was no record of this or of what action was being taken to repair or replace it.

The practice manager said they would ask staff to record more detail in the facilities book, including any action taken and confirmation that each item had been resolved. They also said they would start to do separate records for more significant events where the team would benefit from shared learning.

We saw evidence that within the IDH group there was recognition of the value of shared learning when things went wrong. We saw three IDH health and safety bulletins issued during the previous year. One of these related specifically to learning from sharps related injuries. One outcome in accordance with legislation in 2013 making it illegal to re-sheath needles in most situations was that it was now IDH policy that all clinicians must use a safer system of syringe. This help to minimise the risk of a dentist or nurse stabbing themselves with a needle. The practice manager informed us that some of the dentists in the Hereford practice were still using traditional syringes and needles.

The other two health and safety bulletins related to a range of different incidents where accidents, incidents or health and safety checks had identified potential risks that could happen in any practice. Each issue was described together with learning points for staff in all IDH practices. We did not see evidence confirming that this information was shared with staff in a structured way. For example, the bulletins were not included in the minutes of staff meetings that we were shown.

The practice manager told us that they received any national alerts regarding patient safety. They explained that they printed these and gave all of the dentists a copy and put copies in the staff room for the dental nurses to read. They did not have a system to record that the alerts had been checked for relevance to the practice or that they had been circulated, read and understood by all of the team.

Reliable safety systems and processes including safeguarding

An internal IDH audit on 11 December 2014 had identified areas for improvement. The audit had found that there was no DBS certificate for one member of staff (DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable), not all practice staff knew who the safeguarding lead was, staff had not signed to confirm that they had read the company safeguarding policies, staff did not all know where to find contact details for local safeguarding teams and evidence regarding staff safeguarding training was not available for one of the dentists. The audit report showed that the practice manager had been asked to address these shortfalls and to send an updated action plan to managers at IDH.

The practice had IDH's comprehensive policies for child protection and safeguarding vulnerable adults. There was a list of staff signatures indicating that they had read this, however, the list was not dated to show when they had done so. The policy referred to current legislation and national guidance regarding safeguarding adults and children and included clear and easy to follow flow charts for staff to refer to. The policy also included a detailed training framework setting out the level and frequency for each role within the dental team. Details of local child protection contacts were displayed in the staff room.

The British Endodontic Society uses quality guidance from the European Society of Endodontology regarding the use of rubber dams ffor endodontic (root canal) treatment. The practice did not have a rubber dam kit although dentists there told us they had asked for one. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being

treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice manager told us they were not aware that the dentists wanted a rubber dam kit and said they would order one straight away.

Infection control

Whilst the practice had infection prevention and control (IPC) systems to reduce the risk and spread of infection some elements of these needed to be improved.

Staff told us and we saw staff records to show that staff had received training about infection prevention and control during the last year. The practice had a policy for IPC covering minimising blood borne virus transmission, hand hygiene, personal protective equipment (PPE) such as gloves, eye wear, masks and aprons, clinical waste management, blood spillage and environmental cleaning, and decontamination of instruments used in dentistry. There was information available to confirm that staff had been tested and immunised as a precaution against the hepatitis B virus.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. Due to the constraints of the rented premises the practice was not able to achieve best practice as described in HTM01-05 because there was no space for a separate room for the decontamination of instruments. The equipment used for this was located in each treatment room. We saw an IPC action plan for working towards best practice, however this did not clearly set out what the plans were for this or the timescales involved.

One of the nurses described to us their process for decontaminating instruments in the treatment rooms. There was a clear flow of work from dirty to clean to avoid cleaned and sterilised instruments being re-contaminated. The practice had two washer disinfectors but staff explained that they did not use them. One was out of order and they did not use the other because they did not have sufficient instruments to wait for the time the wash cycle took. They therefore used a manual cleaning process following the essential standards guidance for this in HTM01-05. The nurse showed us that they had heavy duty rubber gloves for this to help avoid the risk of injuries when scrubbing instruments by hand. Staff could not confirm when the gloves were last changed because they did not have a system for monitoring this. They said they thought this was done every few months. The guidance in HTM01-05 is that gloves should be changed weekly.

Following sterilisation, instruments were bagged and stamped with the date of sterilisation and the expiry date. The nurse told us that because more than one of them did this task they initialled the packs as well as date stamping them.

Staff showed us the records they kept to monitor that equipment for cleaning and sterilising equipment was working correctly and that the necessary checks had been done. The test strips used to monitor the effectiveness of the sterilising equipment were secured to the handwritten records. This helped to maintain a clear audit trail of information. We saw that the nurses were doing daily and weekly checks of one of the washer disinfectors although this was not in regular use. No tests were being done for the other washer disinfector which was not working. No quarterly or annual engineer's reports were available for the washer disinfectors. Staff told us that they had run out of protein testing strips used to test that washer disinfectors are working effectively.

A nurse described the cleaning tasks they completed in the surgery between each patient and at the end of the session. This included cleaning worktops, the dental chair and equipment such as the spittoon and dental light. The practice manager conformed that all general cleaning such as treatment room floors and other rooms in the building was done by a cleaner employed by IDH. The practice manager told us that the cleaner did not keep records to confirm the cleaning they did although they were supposed to do this. The treatment rooms were visibly clean. Other parts of the building were generally clean although the carpet in the second floor waiting area looked worn and stained from use.

We noted that computer keyboards in the treatment rooms were not covered or of a design that could be thoroughly cleaned. The practice manager told us that wipeable keyboards had been ordered but did not have a record of the date the order was placed. A bin in one treatment room was broken. Staff told us that this had been reported but we could not find information about this in the facilities book used by the team to report faults. No one at the practice was able to tell us what action was being taken about this or when it would be repaired.

Are services safe?

We looked at an audit of infection prevention and control at the practice which they had carried out in October 2014. This had identified that improvements were needed to the standard of some fixtures and fittings in treatment rooms. The document showed that these improvements would not take place until after the new IDH brand '{My} Dentist' was adopted.

A legionella risk assessment had been carried out by a professional water testing company in 2012. Legionella is a bacteria found in the environment which can contaminate water systems in buildings. We saw evidence that staff carried out monthly checks of hot and cold water temperatures as an ongoing precaution against the risk of legionella. Legionella and other bacteria can also develop in dental water lines. In the staff room we saw test slides used to check that bacteria were not present in the dental water lines. We saw that there were three of these, one for each treatment room. They were dated 12 December 2014. Staff told us they did these checks each quarter. The nurse told us that the dental water lines were flushed and also treated with a recognised treatment agent in line with the manufacturer's instructions.

Clinical waste and hazardous waste were stored in a locked room in an area of the building not open to patients. We saw documents showing they were collected by a registered waste contractor for disposal in line with current legislation.

One patient commented that the practice was clean and hygienic but others did not comment on this.

Equipment and medicines

We found evidence that essential equipment at the practice was maintained and serviced as required. For example, we saw an engineer's report of an examination of the pressure vessel systems within the practice in June 2014 and details of portable electrical appliance testing that had been carried out in August 2014 by an external contractor. We also saw the annual service records of the practice supply of oxygen. A new steriliser unit was installed in November 2014 and the expected paperwork for this was available. We also saw service documentation for the dental chair and suction units.

During the inspection we learned that there was no central heating within the building and that in cold weather portable electric radiators were used. The practice manager told us that they had bought the heaters because in recent cold weather the rooms had become very cold. Following the inspection the practice manager informed us that arrangements were being made for wall mounted electric heaters to be installed.

The dentists confirmed that when they used a local anaesthetic for a patient's treatment they recorded the type and dose give together with the batch number and expiry date. We saw evidence that there had been a recent audit of antibiotic prescribing. This had included the prescription number as well as the type of antibiotic prescribed and the reason why the patient needed it. Prescription pads kept at the practice were securely stored and the practice kept a written log of used prescriptions to provide an audit trail of their use.

Monitoring health & safety and responding to risks

The practice showed us their accident records. This showed that no serious accidents had taken place and none which needed to have been reported under RIDDOR. There was a poster in the staff room informing staff of the fire assembly point and there were two named fire marshals in the staff team. A fire risk assessment was carried out by a specialist company in 2011. The copy of this at the practice contained handwritten notes to indicate that various aspects of this had been reviewed by the practice manager during 2014. The fire records showed that the practice had held three fire drills for staff during 2014.

The practice manager confirmed that the practice did not have a business continuity plan to provide the team with essential information and contact details in the event of a significant incident such as the loss of power, other utilities, a computer failure or the need to fully evacuate the premises if there was a fire.

Medical emergencies

The practice was prepared to deal with medical emergencies, as the team received annual training in basic life support and resuscitation and appropriate equipment was available for them to use. Staff training certificates showed this was last done in August 2014. However, the practice did not also do in-house simulated medical emergency practice sessions which would be best practice. We noted that an internal IDH audit on 11 December 2014 identified that the practice had not carried out a simulation since June 2014 and gave an action for one to be carried

out by 18 December 2014. This had not taken place. Staff at the practice also did first aid training and the practice had a nominated responsible person for First Aid who had a current full First Aid at Work certificate.

The practice kept the emergency medicines in a tamper proof container and this was easy for staff to access should the medicines be needed. Medicines were kept in accordance with the guidelines of the Resuscitation Council UK and checked monthly.

The oxygen cylinder was kept beside the emergency medicines in the manufacturer's bag with pocket masks and tubes, and a bag valve mask was available to help patients who were not breathing adequately. The oxygen cylinder had been inspected annually by the manufacturer. Staff checked the levels regularly to make sure it was available when needed.

Staff were trained in use of the automatic external defibrillator (AED) and the AED was stored in reception where it could be readily accessed in the event of a medical emergency. There was a glucose testing kit available for checking a patient's blood glucose levels.

Staff recruitment

The practice had a comprehensive recruitment policy. This reflected the requirements of legislation for the recruitment of staff likely to have contact with children and with adults who may be vulnerable. In addition to the main recruitment policy there was additional written guidance regarding which staff within a practice required and were eligible for Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. This guidance also covered topics such as storage and retention of DBS information and scenarios such as whether further DBS checks should be done when staff moved to different roles within IDH. We saw evidence that DBS checks had been carried out for all members of the team.

We saw that the practice manager had carried out checks to make sure that dentists working at the practice remained registered with the General Dental Council (GDC).

Radiography

We were shown a copy of a compliance quality assurance audit carried out by an IDH manager on 11 December 2014. One of the areas they had checked was radiography, the technology and processes used to take dental X-rays. This audit identified 11 areas as needing action to be taken, some immediately. The audit record showed that a new radiography folder was set up as a result of the audit. The areas for improvement identified by the internal IDH audit included record keeping and in particular the lack of a written radiography risk assessment and a written procedure for processing and filing patients' X- rays.

We looked at the radiation protection file. This detailed the required information regarding who the named radiation protection advisor and supervisors were. Other required information including the local rules, and inventory of radiography equipment and confirmation that the Health and Safety Executive (HSE) had been informed that radiography took place on the premises. However, the file did not contain critical examination or acceptance records or the expected three years of maintenance logs for the radiography equipment. The practice manager confirmed that they could not find this documentation. The practice sent us critical examination and acceptance documents on 5 January. These showed that the equipment in all three treatment rooms was examined following our inspection by a specialist company on 22 December 2014. The checks for each treatment room confirmed that the equipment was operating safely and no actions were required. The practice manager confirmed to us that because the practice could not provide the original documentation or confirm the date the checks were last done IDH had arranged for an engineer to come out.

We looked at the contents of an audit file kept by the practice manager. This contained a copy of the IDH radiation protection policy, risk assessments for each radiography unit and audits relating to the use of radiography equipment and quality of X-rays.

A dentist told us that dental X-ray images were not always saved in the system and were sometimes lost as a result of this. This reflected the findings of the internal IDH audit which had identified the lack of a procedure for processing and filing radiographs. Another dentist told us they had concerns about the definition of the radiography images the equipment at the practice provided. They told us that they reported this to IDH nine months ago but that no action had been taken.

Are services safe?

There was no evidence to show that the overall results of the radiography audits were collated and the results fed back to the dentists and dental nurses as part of shared learning within the practice.

The team wore radiography dose meters to monitor their exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and care

We spoke with three dentists and found that they assessed patients treatment needs in an organised way. Patients' treatment plans were recorded on NHS forms provided for this and we saw that staff asked patients to sign these. The dentists described how they asked patients about their present and past dental care and carried out the expected examinations. These included checking patients' soft tissue and gum health as well as their teeth. The dentists were aware of the importance of looking for signs of mouth cancer and told us they would make referrals to the local hospital if they had concerns. The dentists also asked patients about alcohol consumption and smoking and requested details of patients' medical histories when they first attended the practice and at subsequent appointments. The dentists used national guidelines to decide when they should take x rays. They told us they recorded the reasons for taking any X-ray and confirmed that the outcome was recorded in patients' records. The patients' records we checked contained the expected information regarding the care and treatment provided.

Consent to care and treatment

In situations where people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA). This is to ensure that decisions about care and treatment are made in people's best interests.

We spoke with three dentists about their knowledge of the MCA and how they would employ the principles of this in their day to day treatment of patients. Two of the dentists had a limited understanding of the MCA and the other was not aware of this legislation. None of the practice staff had received specific training about the relevance of the MCA to the dental team. However, all the dentists showed a general understanding of the processes for ensuring they obtained informed consent from all of the patients they treated. For example, one dentist described how important it was to explain the risks and benefits of any treatment to a patient. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

We asked the practice manager to send us the practice's policy on consent. They sent us a copy of the General Dental Council (GDC) guidance for dentists and a comprehensive in house guidance document. This was dated 2010 and did not have a review date shown.

Monitoring and improving outcomes for people using best practice

The practice manager told us that they received any national clinical updates such as those from the National Institute for Health and Care Excellence (NICE). They explained that they printed these and gave all of the dentists a copy and put copies in the staff room for the dental nurses to read. They did not have a system to record that clinical updates had been circulated, read and understood by all of the team.

We found that the dentists understood and implemented national guidance from NICE. Dentists gave examples of this in respect of recall intervals and the use of antibiotics.

The practice did not have a system for carrying out clinical audit cycles as a way to monitor the effectiveness of the care and treatment provided.

Working with other services

The dentists told us that they carried out the majority of treatments needed by their patients but referred more complex treatments such as difficult extractions and root canal treatment to specialist services. These included local NHS community and hospital dental services, some private services and specialist clinicians within the IDH group.

Health promotion & prevention

We asked the dentists how they put the NHS national guidance Delivering Better Oral Health into practice. Some were more familiar with this than others. However, they all described a proactive and preventative approach to oral health care. They could describe how they supported patients (including families with children), through providing guidance and advice during appointments.

Products for maintaining oral health were displayed and sold in reception. Information was displayed about good oral hygiene, early detection of oral cancer and children's oral health.

Are services effective?

(for example, treatment is effective)

Staffing

There was a team of four dental nurses at the practice. Two were already qualified and registered with the general Dental Council (GDC). Two were training and registered on a recognised training course as required.

There were three dentists. We observed that the dentists were all very busy on the day of the inspection with most of their appointments being of 10 minutes duration even for those patients having treatments. One dentist commented that they were able to manage the volume of treatments due to the skill and experience of their dental nurse.

The practice manager was also the manager at two other IDH practices. One of these was in Hereford but the other was 22 miles away in Cinderford, Gloucestershire. The practice manager told us that dividing their time in this way was very challenging. They found it difficult addressing all of the tasks that needed to be done in each practice. At the practice in Cinderford they were supported by a team member with additional responsibility delegated to them. This arrangement was not in place at either of the two Hereford practices. On the day of our inspection the practice manager was contacted several times by staff from the other Hereford practice. At the end of the inspection the practice manager had to go to the other Hereford practice because a member of staff phoned to say they needed to see them that day.

Are services caring?

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Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

It was evident during the day that all of the dentists were very busy. We learned that most of the appointments during the day were booked for 10 minutes including those where patients were having treatments. This was reflected on a comment card form one patient who specifically commented on the speed of their appointment.

The dentists followed the National Institute for Health and Clinical Excellence (NICE) guidelines on recall according to the assessed clinical needs of each patient.

Basic periodontic treatment to help maintain patients' gum health was carried out by the dentists. This involved routine 'scale and polish' treatments under the NHS. A hygienist was employed to work at the practice to provide more complex periodontic treatment. Staff told us that these appointments were available only on a private basis. Alternatively patients were referred to other NHS dental services for this treatment.

Tackling inequity and promoting equality

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The practice was located on the second and third floors above shops in Hereford city centre. There were steep stairs from the pavement outside to reach the first floor and stairs inside the practice were also steep. The practice was therefore not accessible to any patients with disabilities who were unable to climb stairs or for families with babies and young children. We saw that the practice had a written statement about the lack of access to patients unable to manage stairs.

The practice manager told us that IDH were considering the most suitable approach regarding all of its practices where physical access was unsuitable. They were not aware whether a long term solution had been confirmed for the Hereford practice. In the short term the practice were able to see patients who could not access the building at another practice in Hereford recently taken over by the IDH group. This practice had level access to some of its treatment rooms and nearby disabled parking spaces.

The practice had a disability access statement but the internal IDH audit on 11 December had identified that a recent disability access audit was not available. We noted that the disability access statement was not displayed on the practice website and there was no information to inform prospective patients about physical access to the practice.

Access to the service

The practice was open from 8.30 am until 6.30pm Monday to Friday. This provided some flexibility for working age people and families with school children. The practice was closed on Saturdays and Sundays. Some emergency appointments were kept free each day so that the practice could respond to patients in pain.

Concerns & complaints

IDH had a comprehensive complaints 'toolkit'. This provided practice managers and staff with detailed information about all aspects of handling formal and informal complaints from patients.

Information for patients about how to make a complaint was available at the practice. Brief information about making a complaint was referred to on the IDH national website and in the 'contact us' section of the practice's website. This was not prominently highlighted as a feature available to patients.

We looked at the practice's log of complaints they had received. This included information about entries by patients on the NHS Choices website. The practice or an IDH manager had responded to all of these entries (positive and negative). Where these raised concerns they had used their response to ask the person to contact the practice manager to discuss their concern. This was good practice. However, there was no record available during the inspection to confirm the action or learning from either these concerns or those made direct to the practice.

Are services well-led?

Our findings

Leadership, openness and transparency

The practice manager was also the manager at two other IDH practices. One of these was in Hereford but the other was 22 miles away in Cinderford, Gloucestershire. The issues identified by the IDH quality audit on 11 December 2014 and during the inspection suggested that this had an impact on their ability to effectively manage all aspects of the day to day running of this practice. At the practice in Cinderford they were supported by a team member with additional responsibility delegated to them. This arrangement was not in place at either of the two Hereford practices.

The practice manager told us that IDH were 're-branding' its dental practices to make the name more meaningful to members of the public. The new brand name was going to be '{My} Dentist' and the change was planned for the end of 2015. We saw that there had been a staff meeting in November 2014 to inform the team about this initiative. The notes of this meeting suggested that IDH had not engaged successfully with the practice team about these planned changes.

The dentists described a good working relationship with each other and with the dental nurses at the practice who they described as very good and experienced. They said that they could always speak to each other to discuss cases at any time and that there were staff meetings every two months. They explained that IDH provided clinical support by telephone and face to face.

We noted that the minutes of staff meetings did not reflect back on actions identified at previous meetings. This meant that there was no information to show whether or not issues had been resolved. For example, minutes showed that there were discussions in February 2014 and May 2014 about problems over appointment timings. There was no information to evidence what the action and outcome of this had been. The staff meeting minutes for November 2014 related only to the IDH re-branding initiative.

Governance arrangements

We saw that there had been an internal IDH quality audit at the practice on 11 December 2014. This identified a range of improvements that were needed. The practice manager provided a copy of the report of this visit for us to review.

The practice manager informed us that the previous quality audit was in April 2014. They explained that the length of time between was due to changes of staff at IDH. We found that the quality monitoring of the practice by IDH had not identified areas for improvement in a timely way and that some issues reported by the practice had not been acted on by the organisation.

The practice manager told us that an IDH area manager visited the practice about every four to five weeks for a "catch up". They said they did not receive written reports following these visits.

We looked at the contents of an audit file kept by the practice manager. This contained audits relating to the use of display screen equipment, X-ray equipment and quality of X-rays, and an audit of antibiotic prescriptions issued. We saw that the practice had also carried out audits of each dentist's clinical records and referrals to specialists by one of the dentists. The outcomes of these audits were not discussed at practice meetings to enable the team to benefit from any shared learning. A dentist told us they had concerns about the definition of the radiography images the equipment at the practice provided. They told us that they reported this to IDH nine months ago but that no action had been taken.

The practice was registered with the Data Protection Register of the Information Commissioner's Office in accordance with the Data Protection Act 1998.

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

We noted from an internal IDH newsletter that the organisation had patient survey processes and that the December 2014 edition of this highlighted the outcome of recent survey results. We asked to see patient survey results for the Hereford practice. The practice manager told us that none were available. They were not able to describe any changes made following suggestions by patients or as a result of complaints received. We noted that the 'contact us' section of the IDH national and practice websites invited patients to use an online feedback form to share their views about their dental practice. This was not prominently highlighted as a feature available to patients. The practice did not keep records of minor concerns raised by patients to show whether they used these to contribute to shared learning by members of the team.

Are services well-led?

Management lead through learning and improvement

The dentists told us that they completed training to support their continuing professional development (CPD) requirements for their continuing registration with the General Dental Council (GDC). They confirmed that IDH provided online training in a range of dental topics but some of the dentists also funded additional training themselves through other avenues. We saw evidence of training staff had done in the staff files.

IDH used national bulletins about significant events and other health and safety related issues to communicate learning points to all of its practices. Copies of these were available at the Hereford practice. We looked at the minutes of four staff meetings during 2014. These did not contain information to show that the meetings had been used to discuss learning from significant events such as those circulated in these bulletins.

An internal IDH audit on 11 December 2014 identified that 50% of the staff team had received an appraisal within the last twelve months.

Whilst they carried out some audits the practice did not have a system for carrying out completed clinical audit cycles as a way to monitor the effectiveness of the care and treatment provided.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider was not protecting patients and others against the risks of unsafe or inappropriate care and treatment because they did not have effective operation of systems for regularly assessing and monitoring the quality of the service provided at the practice and for identifying areas for improvement in a timely way.**