CareQuality Commission

Drs Seehra Lockyer Davis and Tanoe

Quality Report

The Surgery
High Street
Lowestoft
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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 from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

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Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe? Overall we found that the provider had taken sufficient action to address the shortfalls identified in our previous inspection of 22 October 2014. Significant events were now reported appropriately and learning from them shared with relevant staff. Good improvements had been made to strengthen the practice’s safeguarding procedures to ensure that vulnerable children and adults were identified and managed.	**Good**
Are services well-led? The procedures for reviewing and learning from significant events had improved since our last inspection, as had the practice’s clinical audit programme. However, improvement was still required to ensure that staff training was properly recorded, that potential risks to the practice were identified and that non-clinical audits were undertaken to assess the service provided to patients.	**Requires improvement**

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- ensure that staff training is properly recorded and monitored.
- undertake non-clinical audits to assess and monitor the quality of services provided to patients.
- ensure arrangements are in place to identify, record and manage any risks to the practice.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was undertaken by one CQC Lead Inspector.

Background to Drs Seehra Lockyer Davis and Tanoe

Drs Seehra, Lockyer, Davis and Tanoe provide primary medical services from their surgery in Lowestoft. The practice has a registered list of approximately 11,570 patients. The practice team consists of four full time male GP partners and five female nurses whose combined hours are equivalent to 3.5 whole time nurse staff and a healthcare assistant. There is a practice manager and a team of administrative and reception staff.

The practice has a Primary Medical Services (PMS) contract with NHS England. The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice does not provide an out-of-hours service, but has an alternative arrangement for patients to be seen when the practice is closed.

Why we carried out this inspection

We undertook an announced focused inspection of Drs Seehra Lockyer Davis and Tanoe on 8 September 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 22 October 2014 had been made. We inspected the practice against two of the five questions we ask about services: is the service safe and is it well led.

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. During our visit we spoke the practice manager, two GPs and a nurse, and reviewed a range of the practice's documentation and policies.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At our previous inspection of October 2014 we found that the practice had not followed guidance issued by the National Patient Safety Agency (NPSA) for reporting significant events or incidents. During this inspection, we were shown evidence that four incidents had been reported to this agency since our last inspection. We viewed details of the most recent incident that had been reported appropriately involving a medication error that could have caused potential harm to the patient.

At our last inspection we also found that the practice did not disseminate learning from significant events effectively. The practice manager told us that specific significant event review meetings were now held quarterly and we viewed minutes of the meetings held in March 2015 and August 2015. We noted that the learning outcome for each one had been clearly recorded in the minutes. We also viewed staff meetings minutes of 18 August 2015 where a specific significant had been discussed, along with the measures to be implemented to ensure it would be handled differently in the future. We spoke with one nurse who told us that she had attended a meeting recently where significant events had been discussed and she was able to tell us about a recent event that had occurred in the practice.

Reliable safety systems and processes including safeguarding

At our previous inspection of October 2014 we found that records for vulnerable children were inconsistent and incomplete. Risks had not been recorded comprehensively and records did not identify the risks to children that the practice had been informed of. During this inspection we noted significant improvement. We checked the patient records for four children on the practice's risk register and found that the nature of the risk to them had been documented appropriately. In addition to this the practice had implemented a number of measures to strengthen its safeguarding procedures. A flagging system had been introduced on patients' electronic care records so that clinicians were easily alerted to any children with safeguarding concerns. The practice ensured that any safeguarding concerns were also shared with other health care professionals such as the out of hours service. Notes of case conference meetings held in relation to children at risk were now scanned into their electronic care records. A review of all the codes used to identify children had been undertaken to ensure they were accurate. Patients with safeguarding concerns were now a standing agenda item to be discussed at the practice's meetings.

A social worker visited the practice once a fortnight to go through each child on the practice's risk register, and update any information if needed.

At our previous inspection we also found that information informing patients of their right to have a chaperone during intimate examinations was not available. During this inspection we noted that chaperone posters had been put up in three of the four treatment rooms we checked, and in the patient waiting area.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection of October 2014 we found that the practice did not regularly assess or monitor the quality of the services provided and that its clinical audit programme was limited. During this inspection we were shown details of three clinical audits that were currently in process; one to identify patients with a risk of diabetes; one to check that patients on drugs to control their thyroid function were being monitored correctly and another to improve the way patients with asthma managed their condition. We were told that findings of these audits would be shared with clinicians at practice meetings. We viewed minutes of clinical meeting on 3 June 2015, where the nurse had presented the findings of the asthma audit and the new protocol to be used. The practice manager and one of the GPs we spoke with told us that the way clinical audits were undertaken and the results shared had improved significantly since our previous inspection. However, the practice had not undertaken any non-clinical audits to assess and improve other aspects of its service to patients.

We noted that some shortfalls identified at our previous inspection had not been addressed by the practice. For example, at that inspection we found that training records for staff did not contain comprehensive information about the training they had completed. We checked staff training records during this inspection and noted they remained incomplete. At our previous inspection there were no arrangements for identifying, recording and managing risks to the practice, apart from risks of fire, loss of electrical power and loss of premises. No action had been taken to address this shortfall and identify other potential risks to the practice.