The Tower of London Surgery

Quality Report

2 Tower Green
H M Tower of London
EC3N 4AB

Tel: 020 7481 1880
Website: Not available

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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 effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tower of London Surgery on 10 January 2017. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There were arrangements in place to safeguard children and vulnerable adults from abuse
- Risks to patients were assessed and well managed. Although the practice did not have its own portable defibrillator, several were available and accessible in the immediate vicinity and the practice had the support of The Tower of London's trained first aid responders.
- The practice had a range of clinical equipment available to diagnose and treat patients and had recently put arrangements in place to have this equipment checked to ensure it was working properly.
- The practice was clean and had undertaken annual infection control audits but there were issues, for instance, chairs used by patients could not be wiped clean and arrangements to manage clinical waste did not reflect best practice.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The GP assessed patients' needs and delivered care in line with current evidence based guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to access the GP and there was continuity of care, with urgent appointments available the same day.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Put arrangements in place to mitigate risks associated with infection by providing chairs which are easily cleaned and a suitable container for clinical waste.
- Review arrangements to provide chaperones to determine whether these should include a process to carry out DBS checks on persons carrying out the role.

Summary of findings

- Consider developing a process to compare patient outcomes at the practice with those of neighbouring practices and national averages until such time as the practice participates in the Quality Outcomes Framework (QOF) programme.
- Ensure there is an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. Although the practice did not have its own portable defibrillator, several were available in the immediate vicinity and the practice had the support of The Tower of London's trained first aid responders.
- The practice had a range of clinical equipment available to diagnose and treat patients and had recently put arrangements in place to have this equipment checked to ensure it was working properly.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

- The practice maintained accurate clinical records and used this information to monitor and improve outcomes for patients. However, there was no process in place to compare patient outcomes against those of other providers or against national averages.
- The practice had undertaken three clinical audits in the previous two years and two of these were completed two cycle audits where the outcomes were used to improve outcomes for patients.
- The GP had the skills, knowledge and experience to deliver effective care and treatment.
- The GP assessed needs and delivered care in line with current evidence based guidance.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey was unavailable as the number of responses received was below the threshold for publication. The seven comment cards completed by patients during the two weeks before the inspection were all positive.
- The GP frequently provided patients with written details of consultations, particularly when these involved complex or extensive information.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- There was no clear Information about how to complain.
- The GP reviewed the needs of its local population and had structured the practice to reflect these needs, for instance by providing a highly flexible approach to appointments and length of time allowed for consultations.
- There was only one GP which meant there was continuity of care, with urgent appointments available the same day.
- All patients could request home visits and these were always accommodated.
- The GP was aware of the importance of the tradition and culture of the community in which the practice was set and operated the practice in a way which was sensitive to the situation.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The practice was involved in on-going discussions with NHS England about developing a more for relationship with the NHS and other providers.
- The practice had a number of policies and procedures to govern activity and we saw that these had been recently reviewed.
- There was a governance framework which supported the delivery of the strategy and good quality care. This included

Summary of findings

arrangements to monitor and improve quality and identify risk although there were areas where improvements could be made, for instance assessing the risk of not having a portable defibrillator at the practice.

- The provider was aware of and complied with the requirements of the duty of candour. The GP encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured that appropriate action was taken.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
There were no patients over the age of 75 registered with the practice, so we did not rate it. It must be noted, however, that the practice demonstrated an awareness of the needs of patients over the age of 75.

Not sufficient evidence to rate

People with long term conditions
Numbers in the population group of people with long-term conditions were insufficient for CQC to pass comment, so we did not rate it. It must be noted, however, that the practice demonstrated an awareness of the needs of people with long-term conditions and all patients with these conditions were able to continue working normally with the care and support of the practice.

Not sufficient evidence to rate

Families, children and young people
There were a very small number of families with children aged under 18 years of age registered with the practice. Numbers in this population group were therefore insufficient for CQC to pass comment, so we did not rate it. It must be noted, however, that the practice demonstrated an awareness of the needs of families, children and young people.

Not sufficient evidence to rate

Working age people (including those recently retired and students)
The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- All patients could request home visits and this happened regularly.
- There was a flexible approach to appointments, for instance patients could call to the private residence of the GP at any time and would be seen.
- There was no time limit on the length of time taken during consultations.

Good

People whose circumstances may make them vulnerable
There were very few patients whose circumstances may make them vulnerable registered with the practice. Numbers in this population

Not sufficient evidence to rate

Summary of findings

group were therefore insufficient for CQC to pass comment, so we did not rate it. It must be noted, however, that the practice demonstrated an awareness of the needs of patients whose circumstances may make them vulnerable.	
People experiencing poor mental health (including people with dementia) There were no patients experiencing poor mental health (including people with dementia) registered with the practice, so we did not rate it. It must be noted, however, that the practice demonstrated an awareness of certain cultural barriers which may inhibit the diagnosis of mental health conditions and remained vigilant to the needs of patients who may require additional support with mental health needs even if a diagnosis was not in place.	**Not sufficient evidence to rate** 

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. Seventy two forms were distributed and 12 were returned. This meant that the data was suppressed to prevent individuals and their responses being identifiable in the data.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 7 comment cards which were all positive about the standard of care received.

The Tower of London Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to The Tower of London Surgery

The Tower of London Surgery is a practice located within the grounds of Her Majesty's Tower of London and the practice list is restricted to residents of The Tower of London. The practice currently provides GP primary care services to approximately 90 people. The majority of residents consist of Yeomen Warders of Her Majesty's Royal Palace and Fortress the Tower of London and their families. Yeomen Warders are recruited from retired senior non-commissioned officers of the armed forces who have a minimum of 22 years of active service. Yeoman Warders may stay in post until the normal retirement age of 67, at which age they leave the service and cease to be residents at The Tower of London.

A medical practice has been located in the grounds of The Tower of London for several centuries, and up to 1969, the service was provided by medical staff of the British Armed Forces. In 1969, the military ceased the formal provision of medical services and a succession of doctors were appointed by the authorities at The Tower to the role of 'Medical Officer' at the location. Although these appointees had no formal relationship with the NHS, their role was acknowledged and the surgery was permitted to remain at the location without direct support from the NHS. Initially, appointees were retired senior military medical officers but more recent appointees have had no military connections.

In the mid-1980s, administrative responsibility for The Tower of London passed to a self-governing charity known as Historic Royal Palaces and efforts were made to formalise the status of the practice as a branch surgery of an established local practice. This was not successful and the status of the practice and its relationship with the NHS has continued to be informal and undefined. The practice has been operating as a sole provider by the GP who was appointed to the role of medical officer in 1989. Although this appointment was confirmed by NHS management in 1993, the practice does not have a contract with the NHS and the incumbent medical officer is currently unpaid for their services.

There is currently one male GP and no other staff at the practice. There is no formal appointment system. The practice provides two formal GP sessions per week, between 6pm and 8pm on Monday and Thursday evenings and these are managed as walk-in sessions. However the GP lives on site and by tradition, patients can also visit the medical officer's residence without an appointment and we were told this is the preferred option for many patients. All patients may request a home visit. The location has particularly stringent security arrangements in place which means that there are regular periods when no-one is permitted to enter or leave the grounds. Consequently, the practice provides its own out of hours service and the GP is on call twenty four hours per day.

The practice is registered with the Care Quality Commission to provide the regulated activity of treatment of disease, disorder or injury.

The practice is located in a single consulting room within the grounds of The Tower of London. There is a waiting room adjacent to the consulting room but this is shared as a rest area for Yeoman Warders. The consulting room used by the practice is several centuries old and its structure and decoration have been listed as Grade 1 by Historic England

and as a World Heritage Site by the World Heritage Committee of UNESCO. (Buildings which have been listed as Grade I have been identified as being of exceptional national interest and are obliged to retain historical features).

The GP lives on-site in the Medical Officer's Residence which is situated a short distance away.

The practice had not previously been inspected.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 January 2017. During our visit we:

- Spoke with the GP.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups represented at the practice are:

- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events within or involving the practice.

The practice understood the reasons and benefits of recording significant events and had a process to identify risks and improve patient safety. The practice had recorded five significant events in the previous three years and used these to bring about improvements in the practice and the environment in which it was located. For instance, the practice had recorded an incident when a local pharmacy had made contact to discuss a prescription given to a patient. The pharmacist had explained that the medicine prescribed was no longer considered to be the most effective treatment for the particular condition and had advised the practice of the recommended treatment. The practice had updated the patient record and had ensured that a more up to date medicine reference book was available at the practice.

The practice also played a role in reviewing significant events which although not within the practice itself, had implications for its patients. For example, we saw a record of an occasion when a non resident member of staff who was not a patient of the practice, who was working alone late at night, had had an accident in the vicinity of the surgery. The practice had investigated the accident and had recommended that anyone required to work alone at night should be provided with a means of raising an alarm. As a result of the investigation, authorities at the Tower of London confirmed that staff had been provided with a personal alarm system, commonly known as a 'Man Down Alarm' which was suitable for lone workers who faced high levels of risk when carrying out their duties.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. We viewed the procedures for safeguarding and these were appropriate and contained relevant information, for example who to contact to make a referral. We saw that the GP had received training in safeguarding vulnerable adults and level three training in safeguarding children.

We were told that patients were asked if they wanted a chaperone to be present during examinations and the practice had arrangements in place to provide a chaperone when this was requested. We saw that the treatment room had a privacy screen and the door could be locked to ensure privacy.

We checked medicines stored in the treatment rooms, including those medicines stored in refrigerators. We found all medicines were stored securely and were only accessible to the GP.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We were told that the nature of the practice population meant that there were very few young families on the register and frequently none at all. The practice did not undertake childhood immunisations and patients who required this service were referred to a neighbouring GP practice which was able to provide services aimed at younger families. The GP told us this was readily accepted by patients and had never been an issue.

There were processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription pads were securely stored although there were no systems in place to monitor their use.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The consulting room used by the practice was several centuries old and its structure and decoration had been listed as Grade 1 by Historic England and as a World Heritage Site by the World Heritage Committee of

UNESCO. Buildings listed as Grade 1 have been identified as being of exceptional national interest and are obliged to retain many historical features. We noted that the consultation room had a wooden floor, substantially covered by carpet. The practice told us that the floor was a feature which was protected by the building's status as Grade I listed and could not be changed or sealed. The carpet and the floor were visibly clean, well maintained and were included in the general cleaning schedule. There was equipment available to manage spills, including spills of body fluids. Chairs used by patients were upholstered in fabric and were not easily wipeable. We were told that cleaning was carried out by a professional cleaner and we saw that a cleaning schedule was in place. This included details of the frequency of cleaning different elements of the practice. The practice told us they had noticed that the paint on the vaulted ceiling had begun to flake and had asked Historic England to redecorate the ceiling using a more suitable paint. This request had been refused although a fresh coat of limewash had been approved and applied. The practice had taken samples of flakes prior to the redecoration and had had these tested for the presence of infectious cultures. Results showed that there were no concerns with the ceiling.

There were arrangements in place to deal with clinical waste. The practice produced very little clinical waste and did not have a clinical waste contract in place but arranged ad-hoc collections when required. The GP was able to describe the process dealing with needle stick injury and for the receiving, collection and disposal of specimens, for example the use of protective gloves.

We were told that the practice operated under the governance of health and safety policies of the Historic Royal Palaces organisation and relevant records were held by them. We were told that the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings) had been undertaken via the facilities department of the Historic Royal Palaces but we were unable to see records of these tests as they had not been provided to the practice. The GP told us they had a routine of running the tap in the consulting room for several minutes prior to undertaking clinical sessions.

Equipment to carry out diagnostic examinations, assessments and treatments consisted of a blood pressure monitor, a mechanical peak flow meter and weighing scales. Although the scales had recently been damaged, we saw a letter from Historic Royal Palaces confirming that this would be replaced at no cost to the practice. We asked how the practice diagnosed or monitored conditions when other equipment was required. We were told that arrangements were in place for patients whose conditions required more complex examinations to be seen by secondary care providers. For instance, patients with more complex respiratory conditions could be seen at the Royal Brompton Hospital.

The practice did not have arrangements in place for checking clinical equipment to ensure it was working properly. However, the GP told us they had recently made arrangements to have this done at a neighbouring practice during that provider's annual calibration checks. We were told that electrical equipment had been tested to make sure it was safe to use but there were no records of portable equipment testing (PAT) available to view as these records were kept by Historical Royal Palaces.

The practice did not have any staff so there were no personnel records to view.

The practice was included in Historic Royal Palace's general safety arrangements including annual and monthly checks of the building and the environment and did not have its own systems or processes in place to manage and monitor risks to patients, staff and visitors to the practice.

We were told that in the absence of the GP, emergency medical support was provided by the Historical Royal Palace's trained first aid responders. For longer GP absences, there was a long standing arrangement with a locum GP to undertake the twice weekly GP sessions. We found that appropriate recruitment checks had been undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Arrangements to deal with emergencies and major incidents

Oxygen was available on the premises and we saw that the oxygen cylinder was full and had masks for adults and children. There was no defibrillator in the surgery, but we were told that six portable defibrillators were distributed

Good

Are services safe?

around The Tower of London and these were maintained by The Tower's first aid responders. The practice told us that the nearest portable defibrillator was less than 100 metres away.

We were told that the practice did not provide medical services to visitors to The Tower of London and had not had to deal with any emergencies within the last ten years.

There was no practice specific business continuity plan but we were told that the surgery had been included in and was an intrinsic part of, the Historic Royal Palace disaster plan. The GP said the first aid centres based in the Tower of London could be used temporarily if the surgery become unsuitable for use although we did not see a formal agreement to this effect.

The practice had been included in fire risk assessments undertaken by Historic Royal Palaces and as the surgery was included in these fire safety arrangements, fire marshals were appointed from amongst Tower staff. We were told that the fire equipment was tested and serviced by Historic Royal Palaces daily and fire drills were held regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GP had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice did not have a contract with the NHS which meant it was not included in the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). The practice had created a detailed spreadsheet which was used to monitor outcomes for patients, including those with long term conditions, however, there was no process in place to compare these with patients of other practices or national averages. We discussed this with the GP who told us that they were currently negotiating with NHS England with a view to the practice taking part in the QOF programme.

Although the practice was not currently included in in the Quality and Outcomes Framework, it had its own IT system in place to monitor patients who had been diagnosed with long term conditions. For instance, we looked at records for patients diagnosed with diabetes and saw that these patients had well controlled blood sugar levels and that arrangments were in place to refer patients to specialist diabetes clinics when this was appropriate. We looked at records of patients who had been diagnosed with hypertension and saw that all of these patients had well controlled blood pressure.

The number of patients with other long term conditions were in single numbers which meant it was not appropriate to describe outcomes in this report. However, there were no concerns with how these patients were being monitored or how their conditions were being managed.

The practice list did not include any patients diagnosed with mental health conditions. However, the GP was vigilant for symptoms of mental health conditions, particularly post-traumatic stress disorder (PSTD) and had in the past referred patients to support organisations with expertise in this field.

The practice had undertaken four clinical audits in the previous three years; patients with diabetes, an audiology audit, prescribing audit and an audit of vitamin D levels. Audits were self-initiated by the practice and the topics selected had a direct relationship with the needs of the practice population. For instance, the audiology audit had been undertaken following the introduction of a radio communication system which involved Yeoman Warders wearing earpieces for long periods of time.

Two of the clinical audits were completed audits where the improvements made were implemented and monitored. For example, the audit of vitamin D levels had been undertaken when the GP developed concerns that even though Warders spent most of their working day outdoors, the type of uniform worn allowed for very little exposure of skin to direct sunlight. The GP recognised that this meant there was a risk of vitamin D deficiency amongst this population group. The practice reviewed vitamin D levels of 23 Warders, using data from their spouses for comparison to rule out any influence of diet on the results. Results had shown that Warders had an average vitamin D level of 32.9 nmo/l (nanomoles per litre) compared to an average of 52.9 nmo/l amongst spouses. Warders with low vitamin D levels were advised to take vitamin D supplements, and had been given advice about diet and the benefit of safely receiving more direct exposure to sunlight. The practice repeated the Vitamin D testing programme twelve months later and this showed that the average vitamin D level amongst Warders had increased from 32.9nmo/l to 56.3nmo/l.

Effective staffing

The practice was a sole provider with no other staff. The GP could demonstrate how they kept up to date with current practice through professional journals and by attending lectures and had been revalidated within the previous 12 months. We were told the GP had most recently attended a lecture on aspects of mental health and had attended this to ensure they maintained their ability to recognise and support patients experiencing poor mental health even when a formal diagnosis was not possible.

Good

Are services effective?

(for example, treatment is effective)

- The practice did not undertake childhood immunisations or cervical screening and had made arrangements to refer patients eligible for these services to a local GP practice.
- A long term locum provided cover when necessary and this person was a lead partner in their own practice.
- The GP took part in training programmes and emergency drills which were organised by authorities at The Tower of London, including fire safety drills, emergency evacuations and serious incident training.

Coordinating patient care and information sharing

The practice list consisted of fewer than 100 patients and information needed to plan and deliver care and treatment was maintained using a paper record system. The lack of a computer system presented difficulties with sharing relevant information with other services in a timely way. Some referrals were made by email but most were made by written letter. Pathology and other test results were received by fax or written letter and we saw that these were handled in a timely manner. The GP told us that urgent test results were communicated by telephone.

The practice did not have a formal contract with NHS England and this had affected how referrals to other provider were managed. For instance, one local hospital did not recognise the existence of the practice and would not accept routine referrals but would accept urgent cancer referrals whilst another local hospital accepted all referrals, based on a long standing relationship between itself and The Tower of London.

We were told the practice was involved in negotiations with NHS England to migrate to a computerised clinical system and we saw that some of the equipment required to facilitate this had already been delivered to the practice. We spoke with managers at NHS England who confirmed that these negotiations were ongoing and were intended to modernise this and other aspects of the practice, including inclusion in the QOF programme.

Consent to care and treatment

The GP sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice had processes to identify patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and mental health concerns. Patients were signposted to the relevant service.

Practice patients were not offered NHS health checks, however, the practice did offer annual health checks to all patients at the practice and would arrange follow-up appointments where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that the practice was arranged to treat patients with dignity and respect.

- A screen was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Although no consultations took place during our inspection, we noted that conversations taking place in the consulting rooms could not be overheard.

All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and that the GP was attentive, accessible and caring. We spoke with one patient who used the service and they told us the GP was sensitive to the needs of the patients as well as the culture of the location and was always accessible when they were needed.

The practice was included in the national GP patient survey but as the number of responses was below the threshold required for publication, data was suppressed as it was possible that individual respondents could be identifiable.

Care planning and involvement in decisions about care and treatment

The practice provided facilities to help patients be involved in decisions about their care:

- We were told that translation services were available for patients who did not have English as a first language. However these were rarely required as the practice population was drawn from former British military personnel and their families, all of whom had English as their normal working language.
- The practice maintained a stock of leaflets which were relevant to conditions which were prevalent amongst the Tower community.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's limited patient list meant that the GP knew every patient well and was aware if a patient was also a carer. The GP had identified organisations that provided advice and support to ex-military personnel and their families and would signpost patients to these organisations when this was required.

The GP told us that when a patient suffered bereavement, they and their families were provided with meaningful personal support and this included families where the deceased was not a patient but their families were.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered two formal consultation sessions each week. These were held on Monday and Friday evenings between 7pm and 9pm. The practice population was under 100 patients and the practice told us it had found that although the GP was available, there was no demand for consultation sessions during the working day. Patients who wanted to see the GP during the day could call to the doctor's home and would be seen.

- All patients on the practice list lived within a five minute walk of the surgery and home visits were available to all patients. Home visits were accepted as normal practice by the GP and patients and we were told they were frequently requested. The GP told us this that visiting patients in their homes helped them to better understand their patients and the context in which they lived and this meant they were often able to deliver a more holistic service.
- There was no formal time limit on appointments and the GP told us that patients could discuss as many issues as they needed.
- The GP told us they would often follow up consultations by writing a letter to the patient to summarise the conversation and to confirm any agreed actions, particularly where more complex conditions had been discussed. We saw examples of three letters and noted that they were written in an accessible style which would help patients understand their conditions and the options available to them.
- The practice did not offer travel vaccinations but could direct patients to local NHS providers where this service was available, and to clinics who provided vaccines which were only available privately.

Access to the service

The formal opening hours for the surgery were between 7pm to 9pm on Monday and Friday evenings. However the practice had a long standing tradition of seeing patients who called to the doctor's house at any time. The GP told us that low patient numbers and the nature of the community meant that many patients did not wish to be seen to be waiting to see a doctor and valued being able to visit the GP's residence or being able to request that the GP undertook a home visit.

Listening and learning from concerns and complaints

Although there was no formal complaints process in place, the practice told us that patients who had complaints would make them directly to the GP as there were no other staff. The GP told us there had not been any complaints in recent years and this was because they had more time to spend with patients than GPs at larger practices and could resolve issues as they arose. However, this meant that some patients who had valid reason to complain may have been reluctant to do so.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice was situated in a location where tradition was often the dominant characteristic. The practice understood that many of these traditions, including those associated with the operation of medical services, helped to maintain a coherent and stable community. However, the GP told us that they were also aware that there were aspects of the practice's operations which required modernisation. For instance, the practice was actively involved in negotiations with NHS England to update how the practice operated. There were ongoing plans to install a computer system at the practice. This meant that clinical records would be held electronically and could be more easily shared with other providers when this was appropriate. We saw that some of the computer equipment had already been delivered although it had not yet been commissioned. There were also active negotiations about linking the practice to a larger GP practice in the area so that additional services and facilities could be made available to patients, including nursing services, vaccinations and the option to see a GP of another gender.

Governance arrangements

The practice had a range of policies in place to govern its activity and these had been reviewed within the previous two years. However, the practice recognised that as a sole provider with no additional staff, there were limitations to how effective oversight could be achieved. For instance, there were no formal arrangements in place to allow the GP to discuss complex patients with other GPs although we were told that a neighbouring GP had been helpful when approached in the past. Ongoing conversations with NHS England had taken this into consideration and the practice was confident that a contractual agreement would be agreed in the near future and this would help to formalise governance arrangements at the practice.

Leadership and culture

On the day of inspection the GP in the practice told us they prioritised safe, high quality, personalised and compassionate care.

The provider was aware of and had a system in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The GP demonstrated a commitment to a culture of openness and honesty.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients although we were told that patients rarely wanted to put feedback in writing. The GP explained that many of his patients were previously in positions of authority in the armed forces and were entirely comfortable giving verbal feedback and would do so unprompted and with enthusiasm. There was no patient participation group at the practice, however the practice could demonstrate regular dialogue with other key stakeholders in its small community. For instance, the practice regularly engaged with health and safety professionals, emergency responders, security staff and senior management at The Tower of London to ensure that the practice operated safely and was accessible to patients.