Benson Medical Centre

Wallingford, Oxfordshire OX10 6AA

Defence Medical Services inspection

This report describes our judgement of the quality of care at RAF Benson Medical Centre. It is based on a combination of what we found through information provided about the service and through interviews with staff.

Overall rating for this service	**Good**	
Are services effective	**Good**	

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Summary

About this inspection

We carried out an announced comprehensive inspection on 08 February 2024. The practice received a good rating overall, with a rating of requires improvement for the effective key question. The safe, caring, responsive and well-led key questions were rated as good.

This follow up desk based inspection was carried out on 14 January 2025. Although now working towards full operational capability as a combined practice, with Abingdon Medical Centre, we followed up the recommendations that had been made at the last inspection which was of Benson Medical Centre.

As a result of this inspection, Benson Medical Centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services effective - good

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

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

At this inspection we found:

The high-risk medicines (HRM) register had been reviewed through audit. Repeat cycles were embedded into the audit calendar to ensure correct coding and that patients who had moved on from the practice or no longer prescribed an HRM were removed.

Medics who completed second checks when dispensing medicines had completed their dispensing/checking competency. A policy was in place to ensure only trained staff carried out second checks. The training completion rates had improved significantly.

An effective catch up programme had been implemented to reduce the backlog of clinical notes that require summarising.

The practice had adopted a consistent approach to the management of patients with a long-term condition. The use of templates ensured a consistency with clinical coding. Through clinical searches and regular audit, the recall of patients was well managed by the nursing team and oversight maintained by the doctors.

Following a full review of children registered as patients and the introduction of quarterly searches, there was a proactive and failsafe approach to actively manage children's vaccinations status.

A comprehensive and inclusive schedule of peer review had been implemented, supported by increased number of clinicians resultant of the merger with Abingdon Medical Centre. All departments completed audits of clinical notes at least annually.

Whole Practice peer reviews of nursing records had taken place across the nursing team twice since the last CQC inspection.

There was a comprehensive audit calendar which had been developed since the last inspection and repeat cycles were driving service and quality improvement.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector supported by a primary care doctor as a specialist advisor.

Background to Benson Medical Centre

Benson Medical Centre is a Joint Helicopter Command Main Operating base operating under Joint Helicopter Command. The Station also has several lodger units including the National Police Air Service, the Thames Valley Air Ambulance, and the Medium Support Helicopter Aircrew Training Facility.

The practice provides primary and occupational healthcare to around 1800 service personnel and 520 civilian patients. They provide immediate and emergency care to an operational rotary wing airfield on a constant basis, 365 days per year. The services provided include routine nurse, doctor and medic clinics, duty doctor triage and consultation, adult and child immunisations, well woman clinics, fitness to deploy medical screening and routine occupational medicals. The Primary Care Rehabilitation Facility (PCRF) provides routine, urgent and aviation specific physiotherapy to service personnel, along with exercise rehabilitation support.

Since the last inspection, Benson Medical centre were working towards full operating capability as a combined practice with Abingdon Medical Centre having merged the patient lists in September 2024. They were working towards full operation capability as a merged practice in March 2025. The practice is open on Monday, Tuesday, Thursday and Friday 08:00 to 17:00 and from 17:00 to 18:30 for urgent cases only. The practice opens on Wednesday 08:00 to 12:00 and is closed in the afternoon for staff training. Between 18:30 hours and 08:00 hours at weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services.

In addition to routine primary care services, the practice provides a range of other services including minor surgery, immunisations, sexual health and contraception, smoking cessation, cervical cytology, over 40's health screen and chronic disease management. A PCRF and dispensary are located in the same building. Maternity services are provided by NHS practices and community teams who visit RAF Benson. Total triage had been implemented in August 2024.

The staff team

Senior Medical Officer (SMO)	1(shared with Abingdon)
Deputy Senior Medical Officer (DSMO) Unit Medical Officer (UMO) General Duties Medical Officer Locum doctor	1 (post vacant) 1 (post vacant) 1 (post vacant) 2 (1 shared with Abingdon)
Civilian medical practitioners	2
Management	3 (includes 1 vacant post)
Nurses	3 military nurses 1 civilian nurse
Pharmacy technicians	2
Exercise rehabilitation instructors (ERI)	2
Physiotherapists	2
Administrators	4
Medics	12 (includes 1 vacant post)

Are services safe?

At the last inspection, we rated the medical centre as good for providing safe services. However, as part of this follow up inspection, we followed up on 2 key lines of enquiry where improvements had been recommended.

Information to deliver safe care and treatment.

At the last inspection, although a standard operating procedure was in place for the management of the summarisation of patients' records, the medical centre were aware that this was not being managed effectively nor in a timely way. On the day of the last inspection, we found 221 sets of notes were requiring summarisation. There were approximately 500 civilian families, including children registered and of these 159 of their notes had not been summarised. The Senior Medical Officer had audited the number of notes requiring summarisation and a plan had been developed to address this. An audit carried out in January 2024 and a plan of action agreed to allocate overdue notes to clinicians each week to summarise. Priority was given to those patient notes that had never been summarised. The audit was repeated quarterly and in June 2024, the re-summarising frequency was amended (in a new Defence Primary Healthcare SOP 1-4-6) from 3 years to 5 years and when leaving the service. A target of 8 weeks was given for the summarisation of newly registered patients' notes. In response to this, the practice introduced their own local working practice to reflect the new targets. The audit continued quarterly and highlighted progress until the patient list was merged with Abingdon Medical Centre. Data showed that a there was a backlog of Abingdon patient notes requiring summarising. The action plan continued and a focussed effort during the 2024 Christmas break proved successful as highlighted in an audit carried out in January 2025. All 3192 registered patients' notes had been summarised, 128 sets of notes were due the 5 year summary and 15 sets of civilian patient notes were due.

Peer review was used to measure and ensure quality of care delivery across most of the staff team at the medical centre. The practice still planned to increase the frequency from annually to 6 monthly as staffing levels increased. Doctors checked the notes of one of their colleagues using a standard check sheet for 10 consultations and this was to be rotated. Feedback would be given to each person individually. Within the Primary Care Rehabilitation Facility (PCRF) a notes audit was completed annually. There was a formal process in place for the exercise rehabilitation instructors to receive formalised peer review, clinical supervision or mentoring on musculoskeletal assessment skills. A robust process for the physiotherapists had been implemented since the last inspection facilitated by the cross site working with the PCRF team at Abingdon and fortnightly meetings with the Regional Rehabilitation Unit.

We had previously highlighted that there was no formal process in place for the peer review of nursing records although monthly nurse meetings with all nurses from both Benson and Abingdon provided opportunity to discuss more complex cases. Formal clinical supervision was sometimes undertaken at the monthly meetings but was on an ad hoc basis. Peer reviews of nursing records had taken place across the whole nursing team twice (biannual) since the last inspection. All military and civilian nurses had benefited over the course of a year with the majority participating twice. Nurses reviewed the consultation

notes of a colleague and had their consultation notes reviewed. Ten consultations were selected at random for each participant with the aspiration of capturing a broad representation of consultations. Time was protected for both reviewing the notes and discussing the feedback within the weekly nursing team meeting to ensure staff were not required to find additional time for the activity. Staff were encouraged to reflect on the feedback provided and develop an action plan. Collective learning was discussed within the nursing team meeting. Two examples of peer review results were provided with learning points included for both and an action plan for one. Examples included the agreeing of synonyms that the team would find beneficial to improve efficiency during clinics. Staff we spoke with commented that the audit tool included standards not applicable to the nursing team, for example, prescribing. We highlighted there are other tools available that may be better targeted for the nursing consultations common at Benson. We also discussed that key learning formed part of the minutes of the nursing team meeting, rather than simply who audited who. This would then provide a collective learning reference.

Safe and appropriate use of medicines

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber. Six monthly checks had now been implemented and the practice confirmed these were being completed.

Previously, we saw medics were completing second checks of dispensed medicines before completing their dispensing or checking competency. A full audit of second checks was completed after the last inspection. A table of those completed was held on the workbook. Those yet to have done their dispensing and competency checks were aware not to dispense until completed. Completion rates had improved significantly since the last inspection, 82% of medics had completed their competency and 45% had completed their second checking competency. At the last inspection, none of the medics had completed these. The dispensary was staffed by 2 registered pharmacy technicians so checks from medics were only required when 1 was absent.

Processes to manage high-risk medicines (HRMs) were highlighted as an area for improvement at the last inspection. Although a register supported the safe management of patients prescribed HRMs and shared care alerts were raised on patient's DMICP records, we had previously found that some codes and alerts were missing and there were patients listed on the HRM register that were no longer prescribed HRMs. We saw at this inspection that the practice had an appropriate policy for HRM management; a full audit of the HRM register and compliance with best practice was carried out subsequent to the last inspection. The results from a June 2024 audit were reassuring with minor areas for improvement, all of which had been actioned. A repeat of the audit was carried out in December 2024 following the merger with Abingdon to ensure accuracy. Access to DMICP records at this follow up inspection confirmed that systems supported the safe management of patients prescribed HRMs; no omissions were identified in the sample reviewed. Monthly checks continued and repeat cycles of the audit were integrated into the audit programme.

Are services effective?

We rated the medical centre as good for providing effective services.

Monitoring care and treatment

One of the doctors was the lead for the management of long-term conditions (LTC), this was managed day to day by a nurse. We conducted searches to identify patients with LTCs on the day of the inspection. Where chronic disease reviews had been undertaken, they were of good quality.

At the last inspection, there was some evidence of recalls, but this was not consistent with a lot of variation of the clinical codes used. In addition, conditions not represented on the clinical system but which needed active recall (e.g. pre-diabetes) had previously not appeared to have been actively managed, recalled or coded correctly. The practice had undertaken a review of procedures and implemented improvements. Templates were now being used by all clinicians to standardise coding and coding reviewed as part of the summarisation process. Pre-diabetes had been incorporated into the LTC register with active recall. An LTC practice lead had been identified with routine management carried out by the nursing team. The LTC registers were comprehensive and current with evidence of regular and recent engagement. The practice was migrating to a new system in order to improve efficiency and patient experience. Sample DMICP searches and spot checks confirmed the accuracy of the LTC register and efforts were made to engage patients who had failed to respond to recall requests.

At the last inspection, patients over the age of 40 were opportunistically invited to a full health check including bloods and identifying risk factors. However, a search carried out on the clinical system found that 326 of patients over 40 had not been coded as having a health check. A cyclical audit was added to the audit programme following the last inspection but DPHC priorities had sidelined over 40s health checks to other, higher priority tasks. Despite this, the practice maintained the completion of the checks as an aspiration once. Since February 2024, over 40s health checks had continued to be opportunistic, with aircrew and those with a LTC being actively recalled. A full review of this had been conducted and a plan was in place for early 2025 as nurse staffing levels made more screening possible.

At the last inspection, we identified that there were 162 patients recorded as having high blood pressure (BP) >140/90 who were not on the hypertension register. In addition, there were previously 14 patients diagnosed with hypertension who had no BP recorded in the preceding 12 months. Following the last inspection, the 162 patients recorded as having a BP >140/90 had been audited and where appropriate, had been actively recalled for BP checks. A new policy had been implemented for when a patient had a BP >140/90 to be recalled. Training and education was given to all medical centre clinicians to ensure that any ongoing BPs were recorded correctly. For example, if a BP was >140/90 this would be repeated and if still high, appropriate follow-up arranged. The audit was repeated quarterly, the most recent cycle in December 2024. The rate of progress forecasted that the backlog would be completed in 8 months subject to patients engaging with the recall

process. Numbers accounted for additional patients that were now included following the merger of lists between Benson and Abingdon Medical Centres.

A notes audit of the 5 diabetic patients with BP>140/90 were found to be well controlled with 24 hour blood pressure monitoring.

An audit calendar was in place and this extended to and integrated with the Primary Care Rehabilitation Facility. We saw the most recent audits included infection prevention and control, a Patient Group Directive audit, a summarising audit and a disability access audit. At the last inspection, we noted that recent clinical audits were limited although planned for the upcoming year. At this inspection, a comprehensive audit calendar was provided within the practice workbook with electronic links to completed audits. Some gaps/delays had occurred during the height of the merger process, but this was understandable given the increased workload and gaps in workforce. Audits completed appeared to be appropriately prioritised, of a good standard and demonstrated excellent use of the audit cycle to drive service and quality improvement. In addition, a copy of the comprehensive portfolio management workbook was provided detailing clear lines of responsibility and links to supporting evidence across multiple domains.

Helping patients to live healthier lives

Child Immunisation

The improvement in the number of notes summarised had resulted in better coding of vaccinations. Quarterly searches were now carried out to supplement the recall manged by Child Health Information Services (CHIS). Results from these searches found that no children were overdue a vaccination. Where diary entry codes had not been updated, the quarterly search ensured this information was added.

The last 3 audits were provided as evidence from the practice. A review of these demonstrated that a comprehensive, failsafe process enhanced the external programmed ran by CHIS.

In November 2024, the 25 registered patients under 6 years of age had their notes checked. Five of the patients were newly registered and their notes awaited summarising. Eight were up to date with their vaccinations but their dates for future recall required amendment. Seven records stated that a pneumococcal vaccination was due but further investigation highlighted that the vaccines had been administered but the schedule change was not yet reflected in DMICP. Three of the patients had no record of a pre-school MMR (mumps, measles and rubella) vaccine and 2 required vaccinations having recently cancelled an appointment. The results were passed onto the nursing team to action any outstanding issues.

Training was provided to all staff who administered childhood vaccinations to remind them to update and remove diary dates as required. Additional training had been provided where dates were not being coded correctly. The new patient registration process was amended slightly to highlight new families to the practice nurses. This allowed them to contact the families and request their ‘red books’ and enter vaccination details rather than await their records arriving for summarisation.