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, patient feedback and through interviews with staff and others connected with the service.

Overall rating for this service	**Good**	
Are services safe?	**Good**	
Are services effective	**Requires improvement**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Good**	

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 08 February 2024.
As a result of this inspection the medical centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

Are services safe? – good
Are services effective? – requires improvement
Are services caring? – good
Are services responsive? – good
Are services well-led? – 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:

Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

The management of medicines given under Patient Group Directions (PGDs) and high-risk medicines (HRMs) management was good.

The programme in place to recall patients with long-term conditions required strengthening including ensuring the correct clinical coding is used.

The medical centre had good lines of communication with the unit, welfare team, local NHS, social services, and the Department of Community Mental Health to ensure the wellbeing of service personnel.

All staff knew how to raise and report an incident and were fully supported to do so.

There was some evidence of clinical audit based on patient population need and adherence to national guidance. A plan was in place to further develop the audit calendar throughout the upcoming year.

Facilities and equipment at the medical centre and within the Primary Care Rehabilitation Facility (PCRF) were sufficient to treat patients and meet their needs.

The medical centre benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos.

Staff were aware of 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). Examples we reviewed showed the medical centre complied with these requirements.

The governance systems were effective with all relevant information captured to monitor service performance.

The Chief Inspector recommends to Benson Medical Practice

Review the high-risk medicines (HRM) register to ensure correct coding and that only patients currently prescribed HRM are listed on the HRM register.

All medics that complete second checks when dispensing medicines must complete their dispensing/checking competency.

Continue to work through the plan to reduce the backlog of clinical notes that require summarising.

Adopt a consistent approach to clinical coding for patients to ensure the management of these patients through clinical searches is fully effective.

Adopt an approach to actively manage children’s vaccinations status.

All the nurses should be offered opportunities to take part in formal clinical supervision

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, a pharmacist, a practice manager, a physiotherapist, an exercise rehabilitation instructor and a nurse. In addition, two new specialist advisors shadowed this inspection.

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 1300 service personnel and 500 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.

The medical centre were working hard to provide support to Abingdon with an official merger pending this included clinical and administrative support. 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.

The staff team

Senior Medical Officer (SMO)	1
Deputy Senior Medical Officer (DSMO) Unit Medical Officer (UMO) General Duties Medical Officer Locum doctor	1 1 2 1
Civilian medical practitioner	3 (currently 1 deployed)
Management	3
Nurses	5
Pharmacy technician	2
Exercise rehabilitation instructors (ERI)	2
Physiotherapists	2

Administrators	5
Medics	12 (includes 2 vacant posts)

Are services safe?

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

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. The Senior Medical Officer (SMO) was the lead for safeguarding. All staff within the medical centre had received up-to-date safeguarding training at a level appropriate to their role. The medical centre's standard operating procedures (SOPs) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams.

Safeguarding concerns were discussed at monthly meetings. Each unit had their own named doctor attached to them for continuity. Vulnerable persons registers, including patients under the age of 18, were maintained and a search of DMICP (electronic patient record system) was undertaken monthly. We noted there were 2 separate registers for vulnerable and complex patients, the SMO was going to review this to include updated coding and close cases as required. Quarterly meetings were held with representatives from the Department of Community Mental Health and Monthly Station Personnel Support meetings included the medical team, the padre, a representative from the Soldier's Sailor's and Airmen's Families Association (SSAFA) and the welfare team. One of the doctors also attended the local Oxfordshire safeguarding board meetings every 2 months. The medical centre wrote letters, every 6 months, to the local schools and NHS GP practices giving them the contact details at RAF Benson in particular those individuals responsible for safeguarding.

We met with a member of the welfare team who described the relationship with the medical centre as excellent, they told us communication between them was good with the medical centre being very responsive to patient's needs. `

Notices advising patients of the chaperone service were displayed in each room and in the reception area. There was a list of trained chaperones and chaperone training had last been held in November 2023. All training was recorded so staff could review at any time. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people.

There was a dedicated lead for infection prevention and control (IPC) although they had not yet completed the IPC link training (this was booked for April 2024). Audits were undertaken monthly and actions taken as required. All staff were given half a day each quarter to complete updated training.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Rooms were colour coded to clearly identify the cleaning requirement and there was a signature sheet for each room which correlated to the cleaning schedule. The management team conducted spot checks but these were not documented. The management team periodically walked around with the cleaning management and any concerns were documented by email to seek resolution. Required arrangements were in place for deep cleaning, the last had been carried in the medical centre in July 2023 and in the Primary Care Rehabilitation Facility (PCRF) in September 2023.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the medical centre code before being recorded in a waste log held in the dry store. The waste was then placed in one of 2 waste skips which were locked and secured to the building. Consignment notes could be accessed online. There was no evidence that the consignment notes were being aligned to the waste log but this was rectified during the inspection. The last annual waste audit was undertaken in January 2024 and there were no concerns identified.

One staff member in the PCRF was currently providing acupuncture to patients. There was an acupuncture standard operating procedure (SOP) and risk assessment in place and this had been reviewed regularly and all staff were aware of. Written consent was gained and scanned onto DMICP.

Gym equipment in the PCRF treatment area was maintained, serviced and monitored. Checks on equipment were completed daily.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Alerts. Evidence was seen of an in-date electronic MHRA Alert register and that the medical centre had a system in place to ensure that they are receiving, disseminating and actioning all alerts and information relevant to the practice. One alert from August 2023 was missing from the register, but evidence was seen that the information had been disseminated to a clinician by email. Evidence was seen that there was a section in the practice meeting for alerts to be discussed.

Searches were undertaken on DMICP to identify any women of child -bearing age prescribed sodium valproate. The search was last completed in January 2024. The pharmacy technicians were aware of the recent changes that sodium valproate must be dispensed as a full pack and were able to locate the patient information leaflets as part of the pregnancy prevention programme.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. The management team believed that the establishment of the practice was adequate for the patient list size. Vacant posts had been filled with temporary healthcare workers whilst recruitment took place. Within the PCRF the Officer Commanding was on a short-term deployment for 2 months before deploying later in the year for a further 6 months. A temporary healthcare worker request was in place but there

had been no applicants to date. The clinical caseload was being absorbed by the Band 7 physiotherapist. The clinical caseload was prioritised between the physiotherapist and the exercise rehabilitation instructor (ERI) to ensure the safe effective care of patients was ongoing. There was a local agreement in place that patients from Abingdon with urgent needs would be seen at their own practice.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken. An automated external defibrillator (AED) was kept in the medical centre and all staff knew where it was located.

All doctors had completed Aviation Medicine training (MAME). One doctor was qualified to undertake occupational diving medicals, another had completed a family planning diploma so the medical centre were able to provide all forms of contraception including coils and implants. One doctor was providing minor surgery and another had undertaken the training and planned to gradually increase their availability to provide minor surgery. One nurse was trained in dermoscopy (the examination of skin lesions with a dermascope). Two nurses were trained to complete spirometry.

All staff working in the medical centre had completed basic life support, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the medical centre including a large display at reception that included photographs and information for patients. Clinical staff had received training in climatic illness and sepsis. One of the GP trainees had recently delivered a practical scenario to staff of how to manage a patient trapped in a car.

Unplanned admissions to hospital were managed well including effective communication and monitoring between the medical centre and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolley were appropriate and in-date and a risk assessment was in place. Ambient temperature monitoring was being completed in accordance with the DPHC SOP for temperature monitoring. Oxygen was held and was accessible with appropriate signage in place. There was a defibrillator kept in the medical centre and staff knew of its location.

Waiting patients could be observed at all times by staff working on the front desk.

Information to deliver safe care and treatment.

An SOP was in place for the management of the summarisation of patients' records. However, the medical centre were aware that this was not being managed effectively nor in a timely way. The SMO had audited the number of notes requiring summarisation and a plan had been developed to address this. On the day of the 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.

Peer review was used to measure and ensure quality of care delivery across most of the staff team at the medical centre. The doctors had commenced a system of peer review within the last month. The plan was that 1 doctor 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 PCRF a notes audit was completed annually. There were plans in place to change this to 6 monthly across both Benson and Abingdon sites when staffing numbers increased.

There was a formal process in place for the exercise rehabilitation instructors (ERI) to receive formalised peer review, clinical supervision or mentoring on musculoskeletal assessment skills. There was a less robust process in place currently for the physiotherapists due to lack of staff but there were plans in place to address to include the team at Abingdon.

There was no formal process in place for the peer review of nursing records. There were monthly nurse meetings with all nurses from both Benson and Abingdon where they had the opportunity to discuss more complex cases. Formal clinical supervision was sometimes undertaken at the monthly meetings but was on an ad hoc basis.

The medical centre and PCRF had moved to using Microsoft Teams to communicate and found this useful to record and disseminate information to all. This system allowed retrospective information to be available for new staff as they could see previous posts, not just those after their start date.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. Staff said the main issue was with printers ‘dropping off system’ which occurred intermittently most days. The average time to log onto DMICP at the beginning of the working day was about 5 minutes but could be up to 20 minutes. In the event of a DPHC-wide outage, the medical centre would refer to the Business Resilience Plan (BRP) seeing emergency patients only and routine clinics maybe cancelled. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP when available.

The management of referrals was failsafe. Tasks were received either into a group task box on DMICP or via a group mailbox. All administrative staff were trained to action and monitor referrals. Staff were able to describe the process in detail. Benson Medical Centre also managed referrals for Abingdon Medical Centre and these were recorded on separate trackers. The registers were held in a limited area on SharePoint with DMICP number as the only identifier. Internal referrals such as for the Department of Community Mental Health were also monitored. Referrals stayed active until the secondary care clinic letter had been received after the patient had attended their appointment. The register was routinely filtered to show referrals in order of importance with 2 week wait (urgent) at the top. All 2 week wait referrals had been noted with either an appointment date or follow up action taken. There was also an extensive One Note in place which included detailed standard operating procedures (SOPs) and contact details for relevant secondary care providers.

An effective process was in place for the management of specimens and this was supported by an SOP. Samples taken were recorded on an online spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were then reviewed daily by the duty nurse to confirm receipt and action any urgent results. They were then allocated back to the requesting doctor or the duty doctor for any further action. We noted the medical centre

often received specimen results for RAF Brize Norton. Instead of just rejecting the results they had arranged with Brize Norton that they would accept the result, document this on the patient's notes then contact Brize Norton to let them know. This ensured there were minimal delays to patients getting their results.

Safe and appropriate use of medicines

The pharmacy technicians (PTs) were aware that the management and working practices of the dispensary were delegated to them. This was reflected in the Terms of Reference (ToRs). The ToRs were signed electronically and were in date.

Arrangements were established for the safe management of controlled drugs (CDs), including destruction of unused CDs. Internal and external quarterly checks were being completed in line with policy. A CD audit had been completed and an action plan written. We saw the annual self-audit had been completed. The dispensary had a key safe log and key safe for security. The CD keys were kept separate from the dispensary keys. There were clear processes in place for the access to CDs out of hours (OOH). A review of the most recent destruction certificate confirmed that accountable and controlled drugs were being destroyed in accordance with policy.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Stocks were in line with DPHC SOPs.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

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. No evidence of 6 monthly checks was seen over the last two years, however there was evidence of a recent monthly check. Through discussion, the PTs confirmed 6 monthly checks would be completed in the future.

We saw when patients were collecting their medicines that good information was given to them and that they were informed of the patient information leaflet in the medicine's container.

Practice nurses used Patient Group Directions (PGDs) for immunisations and primary care treatments. Nurses were authorised to use the PGDs using the correct policy and documentation, they were aware of the policy and of the importance of consulting the PGD when immunising or supplying medicines through the PGDs. A stock check of 2 items from the PGD over-labelled cupboard confirmed that the stock was accounted for correctly. A PGD audit had been completed in the last year and it was confirmed that the findings from the audit had been reviewed with the nursing team. The medical centre did not use Patient Specific Directions.

The PTs could not locate a local working practice for the management of information about changes to a patient's medication out of hours or by secondary care. However, they were able to discuss, describe and demonstrate a thorough process for the management of secondary care prescription requests, there was a clear process with an audit trail. All

written communication from OOH or secondary care would be handed to reception. If the patient deemed the request as urgent and needed a prescription, the patient would then be booked onto the duty doctor clinic and the paperwork handed to the duty doctor.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. On discussion with the PTs and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. The PTs showed good awareness of their responsibilities and knew when requests should be tasked to a senior clinician. The PTs knew that they should only re-issue repeat prescriptions if the patient's review date was in-date and there were available repeat counts on the patients prescribing record. The process for handing out prescriptions to patients was discussed and witnessed and was in-line with policy.

A spot check of the dispensed repeat prescriptions found that all repeat prescriptions had been dispensed within 8 weeks, showing that staff were effectively informing patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they are not collected within the 8 weeks. We saw medics were completing second checks of dispensed medicines. However, the medics had not completed their dispensing or checking competency.

There was some evidence that the high-risk medicines (HRMs) register supported the safe management of patients prescribed HRMs. Appropriate HRMs and shared care alerts were raised on patient's DMICP records, but some codes and alerts were missing. From a spot check of 5 DMICP records, we saw all patients that were currently prescribed HRMs had appropriate and timely blood monitoring had been undertaken. There were patients listed on the HRM register that were no longer prescribed HRMs.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety checks were regularly carried out. A Legionella risk assessment had been completed in August 2023.

A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

There were active and retired risk and issues registers. The 4T's have been applied to the risks and all had been given a review date. The active risk register included risks transferred to Regional Headquarters and all the main risks identified by the management team. There was a range of clinical and non-clinical risk assessments in place including lone working. All the known Control of Substance Hazardous to Health (COSHH) items in use at the medical centre had an appropriate risk assessment in place. Risk was a standing agenda item at the fortnightly Heads of Departments meeting.

There was a BRP in place that had been reviewed in November 2023. The BRP provided a means of ensuring the continuation of the medical centre's functions in the event of a

peacetime disaster affecting the infrastructure and/or its personnel. Examples of a disaster could be fire, flood, total IT failure or terrorist attack.

The medical centre and PCRF had a mixture of fixed alarms. There was an alarm system checklist on the healthcare governance workbook which documented monthly testing.

Lessons learned and improvements made

All staff at the medical centre had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. They were discussed at whole team and practice meetings and an ASER register was maintained.

The PCRF team had a good understanding of the ASER system and all had logins. We saw an example whereby the ERI had put in an ASER relating to having limited access to a patient's notes. that the limited access could have impacted on their care plan because sometimes further information could be beneficial and important to planning rehabilitation and care. The outcome of this was positive and it was agreed that if anything needed highlighting to the ERIs, one of the doctors would change the confidentiality status of their consultation or would liaise with the ERI directly.

The PTs had access to the ASER system and demonstrated that they could log in and record an ASER. Through discussion, the PTs understood the importance of reporting significant events and were able to discuss the correct process for reporting a significant event in line with policy. The medical centre held a team-based meeting to discuss significant events. An electronic near miss log was in place. No near misses had been recorded for over two years.

Are services effective?

We rated the medical centre as requires improvement for providing effective services.

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. Clinical meetings were held monthly where National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidance were discussed. There was a formal timetable of meetings to hold clinical reviews. The Unit Medical Officer was responsible for determining which guidelines needed to be looked at more closely. All doctors delegated those that needed a more detailed review and a summary was given at clinical meetings. There was a monthly timetable of practice, governance and clinical meetings.

The range of primary care rehabilitation facility (PCRF) clinical records we looked showed evidence of multi-disciplinary discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. Rehab Guru (software for rehabilitation exercise therapy) was in use to monitor individual patient progress. Quick response or QR codes were available for patients to complete outcome measures. The use of the MSK-HQ was clinically coded via the DMICP template.

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 and the appropriate templates had been used. There was a comprehensive LTC register in place. There was some evidence of recalls, but this was not consistent with a lot of variation of the clinical codes used. Conditions not represented on the clinical system but which needed active recall (e.g. pre-diabetes) did not appear to be actively managed, recalled or coded correctly.

There was no active management of children's immunisation status. Currently stations rely on Child Health Immunisation Service (CHIS) to send them a list of children who are due or outstanding various childhood immunisation, via email. There are no DMICP searches, available for searching vaccination status of children. However, the medical centre had no local systems in place that gave assurance that the children registered had been recalled or had an appointment booked at the appropriate time.

Patients over the age of 40 were opportunistically invited to a full health check including bloods and identifying risk factors. We searched the clinical system and found that 326 of patients over 40 had not been coded as having a health check. After discussion it was clear that aircrew were having over 40s checks but these were not being coded as such. It

was unclear if civilian patients who were over 40s were proactively having their health care needs met.

There were 11 adult patients on the diabetic register. For 7 diabetic patients, the last measured QRisk3 was under 10% which is an indicator of positive cholesterol control. For 5 patients with diabetes, the last blood pressure reading was 140/90 or more which is an indicator of poor blood pressure control.

There were 45 patients on the hypertension register. However, there were 162 patients recorded as having high blood pressure >140/90 but not on the register. Upon discussion this was felt to be an issue with staff not doing serial blood pressures when the first test was high. Fourteen patients diagnosed with hypertensive disease had no recorded blood pressure check in last 12 months.

There were 43 patients with a diagnosis of asthma, 32 are recorded as having had an asthma review in the preceding 12 months. The 11 patients that had not responded were contacted monthly in an attempt for them to respond.

Routine vaccination and audiometric recalls were managed by the medics. Audiology statistics showed 72 % of patients had received an audiometric assessment within the last 2 years.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with talking therapies, charities such as the RAF Benevolent Fund and with the Department of Community Mental Health. The Oxfordshire MIND charity visited RAF Benson every month and were able to offer patients one to one sessions and also offered wellness classes, these were advertised in the medical centre and all staff were supported to attend if they wished. The medical centre had also implemented a booklet to inform patients of useful mental health resources locally.

We saw that referrals to the Regional Rehabilitation Units and Multi-Disciplinary Injury Assessment Clinics (MIAC) were made promptly with manageable wait times for the patients.

An audit calendar was in place and this extended to and integrated with the Primary Care Rehabilitation Facility (PCRF). We saw the most recent audits included infection prevention and control a Patient Group Directive (PGD) audit, a summarising audit and a disability access audit. Recent clinical audits were limited and were planned for the upcoming year and included long-term conditions audits such as asthma and hypertension.

Effective staffing

The medical centre had an extensive and bespoke induction programme, with a separate induction for locum staff. There was an induction register on SharePoint. Both the Defence Primary Healthcare (DPHC) induction and workplace induction were recorded on the staff database. There was a range of standard operating procedures (SOP's) in place and they had all been reviewed within the last 2 months. All staff were given a Strengths,

Weaknesses, Opportunities and Threats (SWOT) analysis by the practice manager to identify development needs, from this a plan was produced either in the form of training, supervisions or continual professional personal development (CPD). Staff could access CPD funding by an application to the Regional Headquarters. An example of this was 1 of the physiotherapists had successfully gained a place on the Aeromed course after discussion with SMO during their appraisal.

Mandatory training was a part of the induction pack which listed the training requirements and the links on where to find the training. There was a training log on the healthcare governance (HcG) workbook which captured internal and external trainings. There was a staff database in use which held the records of staff trainings, the certificates were held by individuals. Only the practice manager and the training manager could update the staff database once they have seen evidence of completion of training. The training manager prompted the staff on training that needed to be completed. There was protected time set aside on Wednesday afternoons (in between meetings) for training. However, dispensary staff said it was sometimes difficult for them to attend this training as there was still a duty clinic in progress during planned training sessions and they had to be available to dispense medicines. Despite this dispensary staff said they had adequate time for training and they were up to date with mandatory training.

Within the PCRF regular training was held and the team also attended bi-annual regional training days. ERIs had training with other ERIs based locally.

All doctors had an appraiser. Doctors had been on Red Whale (a training platform) courses and fed back to the rest of the team. The medical centre was fully supportive of external training and when possible, tried to allow half a day to undertake extra training in line with their CPD. One doctor was currently on 6-month Aviation Medicine Diploma Course.

Role-specific training was available for relevant staff. For example, the Infection Prevention and Control (IPC) lead was scheduled to complete IPC Link Practitioner training in June 2024. Service Personnel that held a line managerial role had completed the Managing Civilians course. The practice managers although very experienced, had not completed any practice managers specific training. All doctors were MAME qualified for Aviation medicine. Nurses were trained in spirometry.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they kept up-to-date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS Midwifery and Health Visiting service, and voluntary organisations.

There were good lines of communication established with the individual squadrons having their own named doctor assigned to them. Aviation Medicine dial in calls were held every month.

It was clear that the PCRF were an integral part of the medical centre. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician. For patients leaving the military, pre-release and final medicals were offered. Patients were given a 'Service Leavers Guide to Healthcare' to help them navigate through the services available to them once they had left. During the pre-release phase, all patients received a summary of their healthcare record, including immunisations and medication and information on how to obtain a full copy of their records. An individual handover was given for any of patients of concern.

Helping patients to live healthier lives

Health promotion was run from the National Health promotion calendar with information posters displayed. The health promotion displays were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. At the time of the inspection there was mental health and wellbeing information and 'Flu Season' information on display.

One of the doctors had a family planning diploma and was trained in sexual health (referred to as STIF). Patients could also be signposted to Oxford Sexual Health services. There were quick reference (QR) codes around medical centre so that patients could get 24-hour advice.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 97% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

Vaccination statistics were identified as follows:

95% of patients were in-date for vaccination against diphtheria.

95% of patients were in-date for vaccination against polio.

97% of patients were in-date for vaccination against hepatitis B.

97% of patients were in-date for vaccination against hepatitis A.

95% of patients were in-date for vaccination against tetanus.

60% of patients were in-date for vaccination against MMR.

48% of patients were in-date for vaccination against meningitis.

Child Immunisation

The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e., three doses of DTaP/IPV/Hib/Hepatitis B) was 82%.

The percentage of children aged 2 who had received their booster immunisation. for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 91%.

The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 91%.

The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 91%.

The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 81%

Consent to care and treatment

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population, all staff had received training in the Mental Capacity Act.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited.

Are services caring?

We rated the medical centre as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre. A total of 41 patients responded and feedback was positive with the exception of 1 which we passed to the SMO for information. The last patient survey, undertaken by the medical centre between September and October 2023, showed 100% (of applicable patients) said they would recommend the medical centre to their family and friends. We spoke with 3 patients on the day and they were highly complementary of the care they had received.

Through discussion with the team we learnt how medical staff centre routinely went the extra mile to ensure that the mental health and holistic needs of patients were met in a timely, respectful and compassionate way. We saw several examples on the day of staff being helpful and kind to patients. For example, 1 person arrived having been delayed in getting to their appointment and was concerned they would not get to see the doctor of their choice, the receptionist reassured them and made sure their appointment was secured with the same doctor. Another example was of a patient who was worried about needing a prescription, an appointment was made for them to discuss with one of the doctors within 30 minutes of them arriving at the medical centre, the patient was visibly grateful and expressed much thanks to the receptionist.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We spoke with one member of the welfare service, who said staff at the medical centre were always available when needed and were kind and compassionate.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel receiving care and treatment could be making health care decisions that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on evidence-based guidance and clinical facts.

Patients identified with a caring responsibility were captured on a DMICP register. It included what had been discussed at the monthly practice/clinical meeting and any actions identified. There was a practice leaflet which included information for carers. Alerts were made on individual patient’s notes to ensure that longer appointments were given if needed. There were 16 carers registered. Searches were conducted to ensure that the flu vaccine was offered appropriately. There was a carers poster on display in the waiting area and the toilets. There was a carers policy in place that had been reviewed in December 2023 and all newly identified carers received a letter from the medical centre with all the information they should need.

Staff explained that they rarely saw patients who spoke English as a second language but they could access a translation service if they needed it.

Privacy and dignity

Patient feedback showed that they were confident that the medical centre would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. There was a sign asking patients to stand back if there was another patient at the front desk allowing them some privacy. There was also a television on in the waiting area that showed calming images and played soothing music.

The physiotherapist assessment and treatment area within the Primary Care Rehabilitation Facility was in separate clinical rooms, the rehabilitation gym was open plan with curtains so conversations could be overheard. This had been mitigated by having music playing. Staff also have the option to use a private office for confidential conversations. Staff also worked in other rooms if not seeing patients to allow staff to have more privacy when carrying out patient assessments.

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The medical centre considered the occupational needs of the patient population when planning clinics. For example, the emergency clinic (referred to as sick parade) was held at 08:00 hours to accommodate those starting or finishing work shifts. Clinics were also set around school times and families. Clinics specific to deployment were held in liaison with the Chain of Command. The medical centre conducted medicals twice weekly in the afternoons. Well woman, minor injuries and chronic disease clinics were also available. Telephone appointments were routinely available and there was a home visit log on the healthcare governance workbook.

The exercise rehabilitation instructors (ERIs) were continually auditing their delivery and listening to patient's feedback about the appropriate and best times for classes. The current feedback showed that patients were happy with the timings.

The practice manager was the lead for diversity and inclusion. There was good communication with the station leads and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 was completed in November 2023. Any points identified were discussed and put onto the issues register.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender and PRIDE training had been conducted to raise awareness and to promote equality and inclusion.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline and was outlined in the practice information leaflet. Shoulder cover was provided by the duty doctor until 18:30 hours, then patients were directed to the NHS 111 service.

Direct access referrals into physiotherapy had been temporarily paused due to insufficient staffing levels but this was hoped to begin again in the near future. Despite this, access to see the physiotherapist was good. Urgent physiotherapy appointments were available within 1 day, a routine new patient physiotherapy appointment and follow up appointment was available within 2/3 weeks. Waiting times for a new patient appointment to see the ERIs was 5 days and a follow up appointment was available within 1 day.

Urgent doctor and nurse appointments were available the same day. Routine doctor appointments were available within 1 week and aviation medicals were available within 3 weeks. Routine appointments to see a nurse were available within one day.

We spoke with 3 patients on the day, they all confirmed they could get an appointment easily and that they were usually on time.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, 3 written complaints had been recorded within the past 2 years. A trend analysis was completed in August 2023 and as a result of this further complaints training was delivered to staff.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room. The latest patient survey results from January 2024 showed 100% of applicable patients said they felt listened to.

Are services well-led?

We rated the medical centre as good for providing well-led services.

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.
The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was:

'DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power'.

RAF Benson had their own mission statement which was:
'to facilitate operational readiness and high-quality healthcare that inspires confidence, through collaborative, innovative and effective patient centered care.'

There was clear engagement and support from the medical centre to support the Primary Care Rehabilitation Facility (PCRF) priorities.

The medical centre were working hard to improve the protection of the environment and had a member of staff who was the 'Environmental Champion'. The medical centre actively promoted the need to recycle and there were many recycling bins around the building. They were also trying to reduce paper wastage within the medical centre where possible. They were doing this by using laptops and large screens to share information, for example not printing minutes of previous meetings or agendas but having them on screens. Duty medics had a daily checklist completed on sheets of paper which needed to be kept for 1 year. To improve this, a QR code was generated linking to an electronic form so the individual could complete this on their mobile device or laptop. The returns were then downloaded each month and kept on the practice workbook. This had been done for all duty medic checklists. If successful this will be rolled out to include all other checklists within the medical centre.

Leadership, capacity, and capability

The staff spoke of a good working relationship with the regional team, the Senior Medical Officer (SMO) and management team had regular dialogue with the Regional Clinical Director and Regional Headquarters. The staff team at the medical centre worked hard to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team. PCRF staff said they felt part of the team despite working in a separate building. They were very complimentary about the culture and atmosphere that has been created by the senior leadership team. They felt valued and included and free to have open dialogue.

The medical centre were working hard to provide support to Abingdon with an official merger pending this included clinical and administrative support. All the staff we spoke with were supportive of this work and were looking forward to working collectively as 1 team.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos. It supported learners in a variety of trade groups including doctors, nurses and medics which ensured teaching and learning was always a high priority. On Wednesday afternoons the medical centre was closed and this time was used for practice meetings and in-service training. Staff we spoke with had a positive attitude towards learning.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the practice. Staff felt that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

Staff wellbeing was given a high priority at the medical centre and several team challenges were in place that showed a team culture and one of staff inclusion. For example, on the day of the inspection there was a team ‘Bake Off’.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information, and a verbal and written apology. 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. We were provided with examples of when duty of candour had been applied. Staff within the PCRF had a basic understanding of this but had not had any formal training or education to support them.

Governance arrangements

Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, safeguarding and PCRF meetings.

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, and non-attendance. However, chronic disease tracking/coding and notes summarising was a significant challenge. Some areas required strengthening and the leadership team had systems in place improvements to be made.

The leadership team adopted a whole team approach to governance activities. Lead or secondary roles were shared across the team for most staff groups. Terms of reference were current for staff, including those with lead roles. There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities.

The medical centre had worked hard to maintain the healthcare governance workbook, it was extensive, well referenced and absolutely integral to the effective running of the service.

Managing risks, issues and performance

There was a current and retired risk register on the healthcare governance workbook along with current and retired issues. The register articulated the main risks identified by the practice team. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

All staff were in-date for ‘defence information passport’ and ‘data security awareness’ training. Smart cards were personal issue but would be deactivated for access to the medical centre by the practice manager when staff leave.

The BCP was last reviewed in November 2023. It clearly detailed the action to be taken in the event of loss of any services. The medical centre also had a role in the Station Major Incident Plan which was reviewed during a tabletop exercise and crash exercise prior to the Families Day in the summer 2023.

Appropriate and accurate information

The HAF (health assurance framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The team worked through the recommendations from the last internal assurance review (IAR) last completed in October 2022 and used a management action plan to continue to improve. Actions were allocated to staff via Microsoft(MS) Teams which also automatically prompted completion if overdue.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice had been utilising their patient feedback to produce actions that were documented on the ‘You Said, We Did’ board. These included the purchase of more

comfortable chairs in the waiting room. All feedback was collated and discussed at the practice meetings every month. The Governance Assurance Performance and Quality (GPAQ) dashboard was used to monitor and analyse patient feedback. Quick Review or 'QR' codes were used throughout the medical centre to capture patient feedback.

Staff could provide anonymous feedback via a QR code available in the staff room. We saw 1 suggestion had been for additional training on a specific piece of equipment, we saw as a result that training had been arranged for the whole team. The medical centre have made several recent changes based on patient feedback which included amending the pharmacy opening times and providing a QR code for repeat medications.

There had been 7 compliments received in 2024 already with most being received in writing. The staff room had a 'stars and clouds' board, this was used so that staff could give praise and make suggestions.

The management team had developed a staff feedback form via MS Teams which was anonymous. They gave several examples of changes made based on staff feedback such as additional physical training sessions and a Friday afternoon standdown rota.

To improve the communication and decrease any barriers to seeking help members of the team were about to start visiting sections on a Monday afternoon for an hour with the Padre. The aim being to visit a different section each week and to develop relationships and provide a supporting role.

To increase the communication between the medical centre and patients a monthly newsletter has been introduced. This was shared via several channels including social media to all patients and the wider station.

Continuous improvement and innovation

It was clear by the extensive number and range of quality improvement projects (QIPs) that the team continually and pro-actively took opportunities to improve the quality and safety of how they supported the patient population. There had been 15 entries on the Practice QIP register since October 2023 and was a standing agenda item at HcG meetings. The management team also reviewed the regional QIP register to identify anything that they could implement at Benson. Some examples were.

A 'mental health and wellness' booklet had been developed and was a good resource for patients to refer to.

The reception area was seen to be not welcoming to patients and was a little outdated. The receptionist made some suggestions and submitted these to the management. As a result, more comfortable chairs were ordered and a Statement of Need submitted for a better front desk that would be more accessible to patients in a wheelchair. A memory stick was sourced for the television so that it could play tranquil images and music.

Posters were designed for aircrew reminding them of the self-medication rules and when to seek further support from a doctor, this was done to increase flight safety.

It was identified that a number of personnel were requesting their repeat prescriptions when their medication review date had expired. This meant that the duty doctor clinics had

to be utilised to prevent disruption to the patient's treatment/medication regime. A patient information leaflet was created and placed into repeat prescriptions to highlight to patients to take note of their medication review date and that an appointment needs to be made with a doctor if this expired. As a result, clinics became freed up for urgent and routine appointments.