Larkhill Medical Centre

Willoughby Road, Larkhill, Wiltshire, SP4 9QY

Defence Medical Services inspection report

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 given to us by the practice and patient feedback about the service.

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of Larkhill Medical Centre on 13 January 2026.

As a result of this inspection the practice is rated as good overall.

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

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 observations and recommendations within this report.

This inspection is 1 of a programme of inspections CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- The tailored mission statement was embedded into working practice and decision making and had been formulated with input from all staff.
- An inclusive whole-team approach was supported by staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The practice had good lines of communication with the regional team, welfare team, the Regional Rehabilitation Unit and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- The arrangements for managing medicines, including the management of medicines given under Patient Group Directives and Patient Specific Directive were good. Of note, the practice had developed a robust in-house system to manage patients on high-risk medicines.
- There was good compliance with mandated training for staff, in particular the 10 courses identified by Defence Primary Healthcare (DPHC) as priority.

- A comprehensive programme of quality improvement activity was in place and this was driving improvement in services through innovation and a focus on patient need.
- All staff knew how to raise and report an incident and were fully supported to do so. The systems and management of significant events was effective and utilised as a driver for change.
- Referral management was governed by a robust process which ensured regular monitoring.
- In spite of the connectivity problems for mobile telephones, patients found it easy to make an appointment. Urgent appointments were available the same day and managed by a duty team who had adopted a workaround to the total triage system to overcome the lack of connectivity.
- Governance systems were well established. All relevant information was captured to monitor service performance.
- 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). There was a duty of candour register on the healthcare governance workbook and patients had been informed when needed.
- There was a strong culture of continual improvement for the benefit of both patients and staff.

We found the following area of notable practice:

- A clear strategy to maintain staff wellbeing to support them in proving a high level of service to patients was evident throughout the inspection. Initiatives included reward schemes, collaborative working and team building events. This had been recognised with the practice having been awarded the John Fry Prize in December 2025
- Having identified that they had capacity, support had been provided by the PCRF to a nearby military medical centre to help reduce patient wait times for treatment.
- The health promotion lead had engaged with several charities to obtain support with initiatives. Of note, an initiative with Oddballs, a foundation for men's health awareness, had started at Larkhill and was now used widely throughout military medical centres including those overseas. Health promotion material had been strategically positioned with the building to target specific groups of patients, protect privacy and facilitate easy access.

The Chief Inspector recommends to the wider Defence organisation:

- Review the diabetes template on DMICP so that it can be used effectively for pre-diabetic checks.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team.

The inspection team was led by a CQC inspector and supported by specialist advisors including a primary care doctor, practice manager, nurse, physiotherapist and a pharmacy technician.

Background to Larkhill Medical Centre

Situated in the Central Wessex Region, Larkhill Medical Centre delivers routine primary care services to a patient population of 4,262, including families of service personnel. The site has phase 2 and 3 training for the Army and Larkhill is home to the Royal Artillery, the recently formed Kings Gurkha Artillery and it supports a minor unit based nearby at Netheravon. The population fluctuates throughout the year when patients register on a temporary basis whilst attending training courses or exercise within the Salisbury Plain Training Area.

An occupational health service is provided for military personnel. A dispensary is also located within Larkhill Medical Centre for patients to collect their prescriptions. Located in a separate building, a short distance from the main building, the Primary Care Rehabilitation Facility (PCRF) is an integral part of the medical centre and provides service personnel with a physiotherapy and rehabilitation service. The medical centre building is outside of the perimeter fence whereas the PCRF building is inside.

Secondary healthcare (SHC) is provided primarily by Salisbury District Hospital. Local minor injuries units are available at Andover War Memorial Hospital, Salisbury Walk-in Health Centre and Trowbridge Hospital. Maternity services are hosted at Larkhill each week (midwife on a Friday). Sexual health services are provided from a regional hub at Tidworth where a walk-in service is provided by an in-house team. The nearest Department of Community Mental Health and Regional Rehabilitation Unit are at Bulford, approximately a 10-minute journey by car.

Larkhill Medical Centre is open from 08:00 to 16:30 hours Monday to Thursday and closes at 16:00 hours on a Friday. Wednesday afternoons are protected time but urgent appointments are accommodated. An MOD medical advice line is available between 16:30 and 18:30 hours Monday to Thursday and from 16:00 hours on a Friday. Calls are connected to a doctor and nurse within the region. There is a regional rota that rotates between Bulford, Tidworth, Larkhill and Warminster medical centres. A daily ‘emergency clinic’ is used to triage same day access requests; patients are seen by a member of the duty team and protected appointment slots are available each day. Outside of these hours including weekends and public holidays, patients are signposted to the NHS 111 and 999 services. E-Consult is also available

at any time for patients to make requests for an appointment, repeat prescription, administrative support or to provide information on a health concern.

The staff team

Doctors	1 Senior Medical Officer 2.5 whole time equivalent (WTE) MOD GPs 5 Regimental Medical Officers (RMO) they are unit assets, not part of Defence Primary Healthcare (DPHC) - 1 post vacant 1 GP Registrar 0.4 WTE
Nursing Team	1 Senior Nursing Officer 1 Nurse Warrant Officer 1 Band 6 civilian nurse 2 Band 5 military nurses - 1 post vacant 1 civilian healthcare assistant (HCA) 1 military HCA post vacant and due to be filled in March 2026
Medics	18, non-DPHC, 5 posts vacant
Practice management	1 practice manager (post temporarily vacant until April 2026) 1 deputy practice manager
PCRF Team	1 Officer in Command B7 physiotherapist 6 Band 6 physiotherapists (5 WTE) 1 military exercise rehabilitation instructor (ERI) 3 civilian ERIs
Dispensary	1 civilian pharmacy technician 1 military pharmacy technician (post vacant)

Administration	1 Administration Office Manager (post vacant) 6 administrators (1 post vacant, 1 post administrates for the PCRF)

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

One of the MOD GPs was the was the overall safeguarding lead for the practice and was supported by the Senior Medical Officer (SMO) as deputy. This provided continuity with the lead protected from deployment and reassignment to another military medical centre. Staff working at the practice had received safeguarding training at a level appropriate to their role and this also formed part of the induction for all staff. Extra 'real life sessions' on safeguarding cases provided by the safeguarding lead supported staff in their understanding of processes. There was a practice safeguarding policy (last updated in April 2025) that included children and vulnerable adults. This was available to all staff on SharePoint and a link was provided on the healthcare governance (HcG) workbook. A number of examples highlighted that practice staff were proactive in identifying and reporting safeguarding concerns. The practice facilitated a dedicated safeguarding group mailbox to ensure that concerns were not delayed in general email traffic.

The overall safeguarding lead had established direct communication and forged good working relationships with the midwife, health visitors, Chain of Command and welfare team. There was a safeguarding group across the Salisbury Plain area to streamline processes across the military practices. The 'new born baby register' was discussed regularly with a particular focus given to those children who had not attended for their routine immunisations and checks, 9 had been noted for January 2026. Regimental Medical Officers (RMOs) attended the monthly Commander case review meetings and the safeguarding lead attended the monthly Wiltshire safeguarding meetings.

Safeguarding information that included local contact details was clearly displayed in the patient waiting area, in all clinical rooms and in the toilets. Instead of written links or website details, quick response or 'QR' codes were utilised to provide a discreet way to capture the information. Coding and alerts were used to highlight vulnerable patients and a register was held on the electronic patient record system. The safeguarding standard operating procedure (SOP) was comprehensive and included all internal and external contacts.

A review of the records of patients on the vulnerable patient register and the minutes of the meetings where cases were discussed, highlighted notes of discussion were recorded on DMICP (the clinical operating system). Alerts and correct codes were in place for all 5 of the records for those we checked.

There was a list of chaperones displayed in each clinical room and in the administration office. This included male and female staff, all of whom had completed training delivered 6 monthly by the SMO. A chaperone audit carried out in September 2025 found procedures were applied and no recommendations for

improvement were made. The chaperone policy was included in the practice leaflet and displayed at reception, including in the primary care rehabilitation facility (PCRF). We reviewed a selection of patient records and found that a record had been added when patients had been offered or used a chaperone. Both the clinician and the chaperone had made a record in the consultation notes. Patients aged under 18 years were routinely offered a chaperone. Templates included a tick box to support good record keeping.

Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. The practice had a system in place for recruitment checks which included a check on the criminal record through the Disclosure and Barring Service (DBS).

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body, extended to all including those working in the PCRF. Professional registrations were recorded on the HcG workbook for all staff including locums, and this was monitored by the practice management team. Staff had professional indemnity cover and information was in place to confirm staff had received all the relevant vaccinations required for their role. Pre-employment checks for permanent staff were conducted during the onboarding process and locum checks were conducted by the practice manager via an online system. Professional registrations and DBS certificates were monitored via the staff database. All clinical staff were in-date for their professional registrations and DBS checks were in-date for all staff. Locum staff were added to the staff database to monitor onboarding requirements.

There was a lead and deputy responsible for infection prevention and control (IPC), both had completed appropriate training for the roles. Other members of staff were up-to-date with IPC training. The practice followed the Defence Primary Healthcare (DPHC) mandated monthly IPC audit timetable. Regular audits were completed and supplemented by monthly reviews carried out by the cleaning supervisor. The standards were being met. One of the exercise rehabilitation instructors was the IPC lead for the PCRF and had completed the role-specific training. Reminders to refresh staff on their handwashing technique and management of sharps were sent out via email as required. The twice daily clean of the PCRF included the gym and all clinical rooms.

Deep cleaning was carried out 6-monthly during stand-down periods, the last took place in August 2025. Cleaners carried out an enhanced clean of each room as part of a quarterly cleaning plan. Privacy curtains were changed 6-monthly as a minimum and spill kits were available and in-date.

There was an outbreak of infectious disease plan and designated isolation rooms were available if needed. The layout of the building facilitated free flow or restricted flow for patients so any potential infections patients could be separated. Personal protective equipment that included masks was available. Sinks and hand gel were in each clinical room and the SMO had a risk brief as part of the weekly meeting.

Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established and extended to the PCRF. The contractor provided a team with a lead individual who attended daily between 05:30 and 14:00 hours. A daily cleaning log was kept and signed off weekly by the deputy practice manager in line with the full cleaning schedule for the buildings. During the inspection we observed the practice and PCRF buildings were visibly clean. Alongside cleaning duties, the cleaning team lead carried out weekly flushing of taps to minimise the risk of legionella.

Clinical waste was well managed and overseen by the IPC lead who was also the healthcare waste manager. Consignment notes were signed electronically at each stage of handover and all clinical waste was bagged and tagged with a sticker and serial number before being added to the register. The last pre-acceptance waste audit was completed in March 2025 with no concerns identified. The external waste bin was locked and secured in place.

Acupuncture was provided in the PCRF and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment, a form for obtaining written consent and a patient information sheet, which we saw had been completed. This was detailed in an SOP which contained links to DPHC policy. An acupuncture audit was carried out in August 2025 and a repeat was scheduled for January 2026 because an error in the clinical coding had been identified.

Risks to patients

Although staffing levels were included on the risk register, clinical capacity and leadership across the medical team was sufficient to provide safe and effective care. There were only 2 vacant clinical posts and these had been covered by locum staff. The practice manager post was temporarily vacant but the deputy practice manager provided continuity and knowledge. The office manager post was vacant and on hold due to a recruitment freeze with duties and lead roles distributed between the administration team. Networking, teamwork and collaboration across the Defence medical centres in the Salisbury Plain Training area was effective and provided resilience. For example, Bulford Medical Centre had provided cover to Larkhill during a short period when the pharmacy technician had been absent.

Planned staff absences were managed in advance. Rotas were reviewed and adjusted to ensure safe cover for clinical and administrative staff. From our discussions with staff, we were advised that current staffing levels were adequate. There was an effective system to ensure that doctors were always available to cover on the day including a duty doctor and a clinical supervisor. This provided capacity to see patients who needed to be seen urgently.

The practice had a named lead and deputy for resuscitation. The staff team was up-to-date with basic life support training (BLS), anaphylaxis and the use of an automated external defibrillator. Staff were trained in paediatric BLS. Previously a paediatric registrar, 1 of the doctors delivered a training session to all clinicians,

including medics, on common conditions with children. Other training, such as minor illness courses, sepsis and vaccination training included treating children. The emergency trolley included paediatric resuscitation kit and drug dosages. Emergency response training formed part of mandated and moulage (simulation) training.

There was a sepsis policy in place. Sepsis red flag posters were displayed in clinical rooms and at reception. Sepsis training was last conducted in March 2025 and completed by both clinical and non-clinical staff.

Moulage training was held and all available staff could attend. The most recently held session in May 2025 was on heat illness ahead of the summer exercise on Salisbury Plain. Cold injury formed part of the Army's annual in-service training programme. The SMO ran moulage training for the medics that focussed on medical emergencies. The RMOs delivered Battlefield Advanced Trauma Life Support training (BATLS).

The seal on the medical emergency trolley was checked and recorded daily by the nursing team and a full check of the kit and emergency medicines was undertaken each Friday or if the trolley had been opened/used. All the emergency equipment was in-date.

Waiting patients in the reception areas could be observed at all times by staff. This allowed staff to monitor any patient that may be in need of urgent treatment or deteriorating.

Information to deliver safe care and treatment.

Patient and clinic information was available via the electronic patient record system. A selection of records were examined and were of good quality, with clear history, examination findings, management plan and safety netting recorded when a patient's condition or diagnosis is uncertain to inform what should be done if their condition worsens.

Staff we spoke with told us that any instances of the DMICP system not being available was for a short period in most instances and had minimal impact on patients. Some challenges had been encountered during the Windows 11 upgrade. We saw the business continuity plan (BCP) was enacted to manage any outages. Each evening, the next day's clinic lists were printed off to ensure staff had what they needed should the system go down. A 'battle box' which contained MOD medical forms so clinics could continue. Manual records were kept that were later added to DMICP. The PCRF had its own BCP that covered IT outages.

The administrative team managed referrals. We reviewed the process for both internal (within DPHC) and external referrals to secondary care. One of the administrators received a task from the referring clinician, added it to a tracker spreadsheet and liaised with secondary care services. The tracker was comprehensive and well maintained with the status of referrals checked daily including urgent and 2-week-wait referrals. The administrators reported that urgent

referrals were addressed promptly with appointments confirmed within 2 weeks. A local working (LWP) practice policy provided guidance on the process.

Referrals for PCRF patients were monitored through the DMICP administration list and staff had protected time fortnightly to review their caseloads. Referral trackers were not used to prevent duplication of work. Orthopaedic and radiology referrals made by the PCRF were monitored by the administration team and integrated into the referral tracker.

There was a safe system in place for requesting, receiving and summarising new civilian patient records into the practice. The practice separated out military and civilian patients notes for summarising so they could prioritise civilian patients with children being given priority. Electronic summaries were provided to nursing staff, paper summaries were processed by the administration staff and any issues escalated.

The DPHC SOP was used for notes summarising. This covered checking for alerts on the system, diary records, vulnerable status and chronic diseases. There was a plan to have a regional hub responsible for all summarising.

Summarising was included on the risk register and on the practice development plan. It had been a significant issue up until 1 year ago due to capacity issues. A recovery plan that commenced during the Christmas period at the end of 2024 aimed to clear the backlog of new patient notes. Patients arriving from NHS practices were prioritised having been deemed the highest risk. There was a focus on improving the backlog of military patients now RMOs were available to support. Training had been delivered to unit medics to enable them to complete summarising for new arrivals.

Data showed that the recovery plan was working. The total number of notes awaiting summarising was approximately 2,500 in August 2025. Overtime funding had been approved by region to support notes summarising during the Christmas standdown period when most service personnel left the camp for leave. A total of 590 sets of notes had been completed in the 60 days prior to the inspection visit, 896 were still outstanding with an estimated completion time of 6 months. Families of service personnel were prioritised as they were more likely to require an initial summarisation.

Nurses and the healthcare assistant were trained in taking blood samples. There was an effective system in place for doctors to request a sample for testing. A sample log was managed by the healthcare assistant who ensured the timeliness of results received. If results were normal, the healthcare assistant sent a text to the patient notifying them of the result. Abnormal results were dealt with by the requesting doctor, supported in their absence by the duty doctor.

There was a clear peer review system in place that was completed annually to ensure consistency in approach to the recording of patient information. We saw that where improvements were needed actions had been put in place. For example, an issue raised regarding allergies not being documented. This was discussed in the

audit findings review and it was agreed that allergies were appropriately captured via the DMICP alert system.

All PCRF staff engaged with the quarterly peer review process. This was documented on the PCRF HcG workbook with further details of individual actions recorded within each staff member's own continued professional development file.

Notes' audits were carried out annually and findings fed back to individuals and any trends discussed with the wider team at staff meetings. Patient Group Directive (PGD) and notes audits carried out in April 2025 showed the practice was compliant.

Each medic was confirmed as either 'supervised' or 'unsupervised' to practice based on their clinical currency and exposure. DBS, vaccination training and other requirements such as BATLS were also reviewed at this point and recorded on their portfolio tracker. Portfolios were checked twice each year.

Medics involved in the daily sick parade were overseen by a clinical supervisor and 1 of the regular doctors who saw each patient. A duty medic was also part of the team to ensure patients were appropriately triaged. Medics' records were audited and this was the responsibility of the unit mainly the RMOs. In the absence of an RMO, the medical centre stepped in to provide clinical assurance. For example, the SMO was auditing the records of medics from a unit which currently did not have an RMO. Any concerns regarding performance management resulted in an in-depth notes review being carried out.

Safe and appropriate use of medicines

One of the doctors was the appointed lead for medicines management and point of contact for the pharmacy technician (PT) and prescribing clinicians. The PT had delegated responsibility for the day-to-day management of medicines and working practices within the dispensary. This was reflected in their terms of reference (TORs).

The PTs had access to the electronic organisational-wide system (referred to as ASER) and demonstrated that they could log in and record an ASER. ASERs were discussed and the learning shared with the wider team together with any quality improvement plans (QIPs) from the dispensary. A near-miss log was in place and trend analysis was carried out. We were given a recent example of a near miss that had been recorded.

Searches were run on DMICP to identify any patients prescribed sodium valproate. Staff 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.

There were 2 non-medical prescribers (NMP) in the practice. The NMPs were listed on the Nurse and Midwifery Council register as independent prescribers. Evidence was seen that the DPHC headquarters authorisation to prescribe was in place and

training was current. The NMPs attended annual update days and competencies recorded on the online system matched the areas of practice described.

Repeat prescriptions were requested by email, eConsult or by patients dropping off their repeat slips. A minimum lead time of 4 days was advised but, workload permitting, requests were normally completed sooner. All requests were clinically coded appropriately on DMICP. A text message was used to notify patients when their medicines were ready for collection. Through discussion, it was confirmed that no repeat requests were completed by telephone. A spot check of the dispensed repeat prescriptions found that all had been dispensed within 8 weeks. This showed that staff effectively informed patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they were not collected within that period. Prescriptions for antibiotics and psychoactive medicines (that affect how the brain works) were removed and the prescribing doctor notified if not collected within 7 days.

A total of 54 patients were on a repeat medication for 4 or more medicines, 53 were in-date for a medication review. Medication reviews for patients with long-term conditions could be strengthened with a more systematic review process to ensure the removal of old medicines (no longer prescribed) and consistency of Read coding. Medication reviews are important to ensure the medicines prescribed remain the best, safest and most effective treatment.

Staff 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 in-line with the DPHC SOPs. The PTs printed any request that was in-date for the doctor to sign. Any requests that were past their review date were given to the duty doctor.

A process was established for the management of and monitoring of patients prescribed high-risk medicines (HRM). The register of HRMs used at the medical centre was comprehensive and managed by 1 of the doctors, all relevant clinicians had access to this. We looked at a sample of patient records and saw it was in line with the LWP, all had been coded or had shared care agreements in place. The practice had developed a colour coded spreadsheet that provided clear visibility of monitoring and actions required or completed. The recall system was found to be effective in the records we checked, monitoring was completed in its entirety, old medications removed and Read coding used consistently.

Patients were informed of side effects to ensure they take their medicines safely. The dispensary held appropriate warning cards. Evidence was seen of comprehensive medication counselling when prescriptions were collected. Costs of prescriptions were clearly displayed along with prepayment certificate information.

Arrangements were established for the safe management of controlled drugs (CDs, medicines with a potential for misuse) including their destruction. Monthly checks were carried out by the PT were supported by quarterly checks. A CD audit had been completed annually by the SMO. There was an LWP in place that named the keyholders and advised on access into the dispensary and the CD cupboard if

required out-of-hours. The keys were kept in an inside a locked safe located within the dispensary. There was a ‘safe log’ that documented access to the dispensary and CD keys. CD destruction certificates were checked against the documentation (BMed12) and all were in place. Details, including identification when required, of the person collecting the CD prescription were included on the BMed12. We highlighted 2 gaps in second checks when adding stock to the CD register and on the monthly check for a specific medicine used to treat insomnia.

Emergency medicines were kept on the emergency trolley within easy access for staff and secured during non-working hours. Gases were at least half full and in-date. The medical gas store was clean and the empty cylinders were segregated from full in-date cylinders. Correct HazChem signage was in place for the medical gas stores and on the front door of the treatment bay where the oxygen and Entonox (a gas used to control pain or anxiety) were kept. Medicines on the emergency trolley were in-date and recorded on a separate list to DMICP. Quantity and expiry dates were included but not batch numbers. The PT planned to change the format to include these. Items held matched with the DPHC resuscitation policy, last updated in November 2025, which included medicines to be held by families and coil fitting practices.

Well defined processes were in place for the ordering and receiving of vaccines. All vaccines were in-date and vaccines were stored correctly allowing for air circulation. The fridges were cleaned regularly in accordance with the DPHC SOP. Pharmaceutical thermometers were used and the temperatures monitored daily. Cold chain packaging was used to transport any vaccines so that the temperature parameters were not breached. We highlighted that the stock of a number of items did not match the DMICP total, this was corrected on the day.

DMICP was updated if changes to a patient’s medication were made by secondary care or an out-of-hours service. There was also an SOP for shared care agreements.

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. Regular checks were carried out to identify any discrepancies. Two blank prescriptions were kept in the emergency trolley (signed for then returned at the end of duty) and the duty doctor had controlled access to the pharmacy when the PT was absent.

Practice nurses used PGDs for immunisations and primary care treatments. Nurses had been authorised to use the PGDs using the correct form. All were in-date and signed. A review of 5 DMICP consultations found that the PGD template was being used and the batch number and expiry of the medicine supplied was being recorded in the template. Audits were completed annually, the most recent in April 2025, by one of the Band 6 practice nurses who held a comprehensive record of all PGD vaccines.

Administration of treatment from a Patient Specific Direction (PSD) was used and audited regularly. In the 5 records checked, all information requested on the template had been completed. The PSDs were in-date and had been signed off by the SMO.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

There was a separate shelf in the dispensary holding over-labelled medicines for the supply out-of-hours (used by exception only as routinely prescriptions would be outsourced to a civilian pharmacy). A stock check of 5 medicines found the stock levels to be correct and transaction reports showed evidence of good stock accounting and stock management. The dispensary was locked and access was controlled.

Track record on safety

The practice manager and SMO maintained oversight of the risk register on the HcG workbook. Each risk was reviewed quarterly as a minimum and a summary of the review added. A health and safety board was displayed and included essential information. The 4T principles (terminate, treat, transfer and tolerate) were applied to all risks and were reviewed regularly. Electrical safety checks were up-to-date for both hard-wire and electrical equipment testing.

Regular water safety checks took place and were recorded by the cleaning lead. The log was checked and was in-date. A full legionella risk assessment was carried out in May 2023. The last report showed a high residual risk of legionella. This had been added to the risk register and was expected to be retired at the next assessment in May 2026. An updated legionella risk assessment sent the day after the inspection showed the risk was now classified as ‘medium’ and there were minor actions required that were planned for completion in the next 60 days.

The fire risk assessment was in-date having been completed in February 2023. Equipment tests including fire extinguishers were current, external checks were backed up by a monthly check caried out by the deputy practice manager. Staff were up-to-date with fire safety training and were aware of the evacuation plan. The appropriate Control of Substances Hazardous to Health risk assessments were in place, up-to-date and supported by the associated safety data sheets.

Within the PCRF, there was ample space for the training equipment which was checked daily. Oversight for the maintenance and servicing included comprehensive records of all equipment including any faults and the dates when servicing was due. The servicing of all equipment was in-date. The building used was shared with the Garrison gym but the area used by the PCRF was locked and entry was via a key-coded door. Lone working did not take place during any patient activity. A lone working SOP was in-date but working patterns and the number of staff made lone working situations a rarity. The PCRF was climate controlled, wet bulb monitoring (environmental measure of heat stress) took place to ensure the environment was safe to train in.

The SMO was the named risk manager and was deputised by the practice manager who had completed the Institution of Occupational Safety and Health training. The deputy practice manager was a trained risk assessor and had completed building

custodian training. Risk assessments were reviewed in December 2025. All were fully completed and were scheduled to move onto the updated MOD form at the next review. The practice had current and retired risk registers and an issues log in place. Risks and issues were a standing agenda item at the monthly HcG and practice meetings. There was a range of clinical and non-clinical risks in place and, in the temporary absence of the practice manager, any new risks were sent to the SMO and SNO for review and for the register to be updated. The SMO and SNO carried out monthly reviews

There was a fixed alarm system in place that extended to the pharmacy and in each clinical room, including those in the PCRF. The system provided a panic alarm as well as one for fire. The panic alarm system was tested weekly, one room at a time, and this included a check on response times. The dispensary had a red panic alarm button that could be used to call for assistance.

Fire evacuation drills were carried out annually. The main system was serviced annually by an external contractor. The fixed alarm system did not extend to the gym but staff could request personal alarms if required. For example, the accessible toilet and audiometry room alarms were checked by the lead cleaner. The fire alarm, accessible toilet alarm and panic alarm had distinct sounds to prevent confusion. The panic alarm in the PCRF was also tested weekly.

Lessons learned and improvements made.

All staff in the medical centre and the PCRF had access to the ASER system for recording and acting on significant events and incidents. Training on the ASER system was mandatory for each staff member and the compliance rate was 100% at the time of the inspection. There was also an online regional significant event analysis tool.

All incidents reported were logged through the system and a register was maintained. Incidents were discussed at the monthly practice meetings where they were included as a standing agenda item. The details of entries on the system were concise and lessons learned were clearly identified. The meeting minutes were detailed and the ASER log was linked to the meeting where it was discussed.

From speaking with staff and evidence provided, it was clear there was an open culture of reporting incidents. Both clinical and non-clinical staff could give examples of incidents and learning as a result of investigations. Root cause analysis of incidents was undertaken which ensured that any underlying cause was identified so appropriate action could be taken. We reviewed a number of incidents and found that the process was effective in identifying lessons learned. For example:

- Following the raising of an ASER when an email was sent out to the wrong patient, a 3 point check was implemented to provide more vigilance when sending correspondence.

- The nursing team provided a recent example of when a patient had fallen from the bed onto the floor following a procedure. Plinths with sides had been requested with support from region.
- A near miss was recorded in the dispensary when a dispensed item was handed out before realising that the doctor had generated a prescription to the wrong patient. The error was rectified after the patient highlighted that the details on the label were incorrect. We discussed the threshold for raising an ASER and ensuring there is an audit trail to show that the duty of candour was followed.

The practice had a system in place to distribute National Patient Safety Alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and what action had been taken. The alerts were also discussed at key meetings. Alerts were managed by the PT who received details via the practice email and was also signed up to receive alerts direct from the MHRA. Relevant staff were notified and appropriate action taken. The information was added to the Central Alert System register held on SharePoint. In the absence of the PT, the deputy practice manager managed the process.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network. Updates to NICE guidance, reminders and new indications were summarised in the minutes of the healthcare governance (HcG) and practice meetings.

Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month. As well as providing advice during consultations, patients were signposted to websites for guidance in self-management for long-term conditions such as diabetes.

Primary Care Rehabilitation (PCRF) staff held team meetings fortnightly and attended the monthly HcG meetings at which evidence-based guidance was shared and discussed. These were also shared at a monthly ‘journal club’. The PCRF staff were familiar with Defence Rehabilitation Best Practice Guidelines (BPGs) and staff we spoke with provided examples of treatment delivered based on the guidance and care pathways. Staff were aware of the new online platform for Defence rehabilitation BPGs and used ‘Project Apollo’ to monitor aspects of service delivery and output. Our review of PCRF patient records showed use of exercise prescription, via an app that allowed medical professionals to send structured exercise programmes and educational information to individuals.

The PCRF ensured that it took a holistic view of patients. One staff member acted as the main point of contact for each regiment to allow for a build-up in communication and awareness of patients. As part of the new patient questionnaire, there were prompts to ask about sleep, mood, diet and stress. Patients were referred to the dietician, smoking cessation and the medical centre when needed. The musculoskeletal health questionnaire and other reported outcome measures were utilised by staff during treatment.

Monitoring care and treatment

The nursing team took the lead for all long-term conditions, clinical oversight was maintained by the doctors. Registers were held on DMICP with leads named for each. An effective patient recall process was in place. The DMICP searches were

compared against the register and the patient contacted by a combination of telephone and text message.

There was a register of patients with diabetes in place and, on review, we found their care indicated positive control of both cholesterol control and blood pressure. For 15 of the 34 patients on the register, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 30 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. Patients at risk of developing diabetes were identified through the DPHC protocol which included relevant testing (HbA1c -average blood glucose (sugar) levels), lipids (for QRISK), body mass index, waist circumference, lifestyle factors (diet, alcohol, smoking status). QRISK is a scoring tool that estimates the percentage chance of a person having a heart attack or stroke in the next 10 years.

We reviewed the clinical records for 34 patients on the diabetes register. We found no concerns but identified a coding issue that was systemic across the organisation and was being reviewed by DPHC. The template did not automatically apply the clinical code placing the patient on the diabetes register. Conversely it included gestational diabetes and pre-diabetes as diabetic therefore requiring a manual check to exclude these from searches. This was a DPHC-wide issue and required the template to be updated.

There were 86 patients on the hypertension register. Of the 86, 80 had a blood pressure recorded in the past 12 months in line with best practice guidance. Sixty-eight patients had a blood pressure reading of 150/90 or less, a sign of positive control. We reviewed 3 patient records from the hypertension register and all had a record of blood pressure made in the last 12 months.

We found that 108 of the 129 patients with a diagnosis of asthma had had a review in the preceding 12 months in line with best practice. The DMICP asthma template was used for reviews to ensure continuity and correct Read codes. A sample review of 3 patients with a diagnosis of asthma showed good quality reviews were being undertaken.

Patients with a mental health need were provided with initial mental health support, which included sign posting to mental health resources, the padre, third sector support and welfare support. Service personnel were referred to the Department of Community Mental Health if more specialist support was required. Civilian patients were now able to access Improving Access to Psychological Therapies through self-referral to local services provided by a mental health charity. Service personnel would soon be able to access the same services. Safeguards had been put in place to refer them back for any occupation health concerns, such as weapons handling. Access to Child and Adolescent Mental Health Services, known as CAMHS, was in place and children and parents could self-refer into the service. We reviewed a sample of patients notes and found that note taking was detailed and clinical coding correct.

Hearing Conservation Programme searches were undertaken each month, audiometry assessments were in-date for 86% of the patient population. Our review

of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The Senior Nursing Officer and Nurse Warrant Officer were the overall audit leads. There was an established, comprehensive programme of audits that was discussed at HcG meetings and held centrally in the DPHC HcG SharePoint site. Clinical and administrative audits all had named leads with responsibilities shared widely among staff. Audits in place were a mixture of DPHC mandatory audits and internal audits. These extended to the dispensary where the DPHC audits were carried out at 6 and 12 month intervals. There was an audit calendar on the HcG workbook with links to each. All entries on the calendar included the date for both the last cycle completed and the date for the next when due, responsible individual, cycle number and frequency. Retired audits were archived in a separate area. We reviewed examples from an extensive set of audits to find that they were of good quality and drivers for change. Examples included asthma and diabetes audits. Antibiotic prescribing audits were carried out annually to ensure good antimicrobial stewardship.

There was a specific audit calendar in place for the PCRF that was driven by the needs of the patient population, for example, a review of the patient assessment framework used for anterior cruciate ligament damage. An audit in progress at the time of inspection involved reviewing patients who had been in the care pathway for a long time and if a BPG timeline was missed. A physiotherapy and exercise rehabilitation instructor (ERI) notes audit was completed annually. The audit programme included plans for repeat cycles.

Effective staffing

The practice, including the PCRF, used the DPHC mandated induction which included department specific elements (a specific one for the pharmacy technicians was being developed with regional headquarters). Permanent staff had a more in-depth induction to include elements which were specific to their role. There was a well-developed induction pack specific for medics which included a comprehensive list of training specific to their duties. In addition, there was a specific safeguarding induction. Locum staff were required to complete their own specific induction that was similar to that for permanent staff. A review of 2 induction packs showed they had been completed fully within the target 4 week period. Newly appointed staff spoke positively on the process followed and were provided with shadowing opportunities as part of the induction.

Mandated staff training across the staff group was close to being fully completed at the time of the inspection, in particular for the ‘Commander DPHC top 10 courses.’ Any staff member who had not completed the top 10 courses had access to DMICP temporarily suspended until they were compliant. Protected time was afforded to staff to complete mandatory training. The deputy practice manager monitored the status of training and reminded staff when a course was due. Regional Headquarters carried out monthly checks. The unit monitored training for the medics.

The nursing team were well supported to keep up-to-date with training and maintain their professional revalidation. All staff received mid and end of year appraisals, these provided an opportunity to discuss courses required for continued professional development. The team had a broad range of experience and this was supported by training specific to the role. Examples of training courses completed within the team included the infection prevention and control link practitioner training, smoking cessation, non-medical prescriber, sexual health, immunisation and cytology. Training was provided in-house, online and through study days facilitated by DPHC.

With the practice having children as registered patients, the nurses had completed a paediatric minor injuries and illness course. Patients under the age of 1 and acutely unwell children would be seen by a doctor. One of the doctors was qualified to deliver paediatric basic life support training. Nursing staff had a very low threshold for referring children under 5 to the duty doctor with acute illness. The patient population could include a lot of young parents and, even when a child was not particularly unwell, seeing them early for advice/education and safety netting was important and recognised even when clinical need may not dictate.

Larkhill was an accredited GP training practice and supported nurse and medic trainees. Training staff and high morale was at the core of the practice's development plan and was credited for much of the recent improvement in staff morale.

Training events included inviting external speakers to attend and deliver sessions to staff. A recent example was a training session in cardiology delivered by a military cardiologist from a local District Hospital. Further examples in the last 12 months included an orthopaedic consultant teaching on shoulder and elbow injuries, a urology consultant teaching on common presentations in primary healthcare and a session on occupation medicine delivered by the Regional Occupation Health Team. The Defence lead supporting obesity and lifestyle management with Defence Public Health had also delivered a training session.

There was a formal process in place for the lead ERI to undertake notes audits, these were completed initially and then on a rolling programme with no more than 6 month intervals if there were any concerns. Any issues identified were fed back to the individual staff member in a face-to-face meeting, this was done in a supportive way with the focus on learning and improvement.

Performance appraisals were conducted by line managers for all staff. Doctors were in-date for appraisal and all doctors and nurses had completed timely revalidation.

Coordinating care and treatment

The medical centre team, including the PCRF, had forged effective links with station commanders, welfare staff, padres, the mental health team and safeguarding points of contact in the local area. We contacted the Chain of Command and welfare team as part of our inspection and they reported strong links and told us the practice were very responsive if a patient required urgent access to a doctor.

Networking in the area included all local hospitals. Staff linked in and attended meetings and workshops. These helped improve communication and care pathways for patients. Examples included a network of opticians across Wiltshire that the practice was not known to and therefore referrals were being rejected. Liaison with the Integrated Care Board had resulted in these services being opened to Larkhill Medical Practice patients.

Live and active links had been established with the local children's service, local safeguarding teams, the pathology laboratory, the Child and Adolescent Mental Health Service, Salisbury Sexual Health service, breast and bowel screening teams, health visitors and midwifery services.

The PCRF had good relationships with the Regional Rehabilitation Unit and physical training staff. With consent from the patient, ERIs discussed individuals with the physical trainers to coordinate reconditioning and timelines were shared to help manage the transition.

Helping patients to live healthier lives.

The healthcare assistant was the lead for health promotion and a nurse deputised. The programme followed the DPHC health promotion calendar. Prominent displays in the patient waiting area were utilised for a rolling programme of health promotion. At the time of inspection, the main waiting area had displays promoting 'Dry January' and screening for cervical cancer. These coordinated with national campaigns with January being cervical cancer awareness month. In addition, a wide array of health promotion materials were displayed strategically throughout the building to both promote proactive healthcare and provide education on self-care. Examples included posters in the toilet to promote support services for domestic abuse, sexual orientation, sexual health and mental health. Quick response or 'QR' codes were used widely to facilitate discretion and privacy.

Those eligible were invited for an over 40s health check including bloods and identifying risk factors, were all invited for a health check in 2025, 126 checks had been completed in the last 12 months. Lifestyle and health advice, both verbally and written, was provided as appropriate. This check was repeated every 3 to 5 years unless identified as a risk when patients were recalled annually for blood testing.

We saw information leaflets were available in the treatment rooms. There were notice boards located in various places focussed around the patient waiting areas. Example topics covered included men's health, mental health, smoking and alcohol. During consultations, patients were given leaflets or items printed from the internet to support them following the appointment.

Unit health fairs were undertaken annually and practice staff, including representatives from the PCRF, were involved. The most recent event in December 2025 was used to educate on tackling obesity. All patients with a high Body Mass Index were referred to the healthy living programme. Although this had slowed down summarising of notes, it demonstrated quality care. There was a health promotion

board in the PCRF, with topics that included women's health, rehabilitation classes and nutrition. The PCRF had also used a recent health fair to provide advice on injury prevention.

The health promotion lead had engaged with several charities to obtain support with initiatives. Of note, cushions obtained from Oddballs, a foundation for men's health awareness, were scattered throughout the building including in treatment rooms. The use of cushions had been adopted by other medical centres in the region as well as overseas in the Falklands.

One of the nursing team was trained to provide sexual health support and advice. For more specialist advice, patients were referred to Tidworth, the regional hub for sexual health where a sexual health drop-in clinic held on Wednesday afternoons. One of the doctors was qualified to fit coils and implants. If symptomatic, patients were referred to a local sexual health clinic. Teenage patients would be seen when considering contraception, the Gillick competence and Fraser guidelines were followed (children aged under 16 having sufficient understanding to consent to their own treatment without parental advice).

Prior to the inspection, the statistics submitted by the practice indicated that the percentage of eligible women whose records indicated that a cervical smear had been performed in the last 3-5 years was 89%. This was in line with the NHS target of 80%.

Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. An audit was caried out every 6 months and there was a local working practice policy to ensure patients were recalled. Data provided by the practice showed that patient recall was well managed and a sample review of patients not screened highlighted no concerns.

Unit staff were responsible for the monitoring and recall of service personnel for occupational vaccinations. The Regimental Medical Officer maintained oversight supported by the medics. At the time of the inspection, the status of vaccinations was:

- 89% of patients were recorded as being up to date with vaccination against diphtheria
- 89% of patients were recorded as being up to date with vaccination against tetanus
- 89% of patients were recorded as being up to date with vaccination against polio
- 92% of patients were recorded as being up to date with vaccination against hepatitis B
- 93% of patients were recorded as being up to date with vaccination against hepatitis A

- 99% of patients were recorded as being up to date with vaccination against MMR
- 84% of patients were recorded as being up to date with vaccination against meningitis.

Childhood Immunisations: The World Health Organisation targets a 95% vaccination rate for routine childhood immunisations. An effective recall process was utilised, some families had confirmed that they did not wish for their child to be vaccinated, others who had been joined from overseas (different vaccination schedules) were on a catch up programme. The practice provided the following data:

- 94% of children aged 1 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/HepB)
- 96% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)
- 94% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) although no longer in the schedule
- 96% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)
- 94% children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR).

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Documented evidence was in place for the practice to share information with the Chain of Command. Consent forms were scanned onto the system and those we reviewed for coil fitting, immunisations and smears gave clear detail on the information being provided and the patient providing verbal consent. Written consent was appropriately recorded in the clinical records we looked at for acupuncture and for ear syringing. The recording of consent was checked as part of the peer review process (through notes audits).

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. All staff completed annual mental capacity training online and posters displayed listed the key principles. There was a standard operating procedure that required all children aged 12 and over to complete a form to opt in or out to consent having their information shared with their parents.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

The practice staff had a comprehensive understanding and focus on the specific needs of the patient population and services were tailored to meet these. We were given examples of where practice staff had gone the extra mile to provide care and support. These examples included care that had continued once the patient was posted out or was discharged from the army to ensure the care pathway continued safely until fully handed over.

An information network known as HIVE was available to people living on the camp. Situated nearby, the HIVE provided information about facilities available to families along with army welfare services, unit welfare staff, Padres and Salvation Army.

To ensure patient's views contributed to the inspection, we offered patients various opportunities to provide feedback on the service. Views were shared through CQC feedback cards completed by patients prior to the inspection and through conversations with patients on the day of the inspection. We received 28 patient comment cards, these were very positive about their experience. The themes were the time given to patients by clinicians to explain treatments and hear the view from the patient, the availability of appointments and the cleanliness of the facilities.

Forty-one patients responded to the patient satisfaction survey between October 2025 and December 2025. A total of 39 (95%) respondents said they were generally happy with their healthcare. During this period of time, the practice also received compliments in the free text section of the survey that praised the staff for the quality and access to care. A complimentary card was sent from the cleaning contractor expressing "immense pride and joy in the culture of the facility and its inclusivity of all workers." When asked if they felt that they were treated with kindness and compassion, all 41 patients in the patient satisfaction survey responded with good or excellent.

Staff in the Primary Care Rehabilitation Facility (PCRF) used injury recover/maintenance physical training chits alongside light duties chits and linked in with units and physical training instructors. The PCRF used the Defence Primary Healthcare (DPHC) patient experience questionnaire, feedback had been minimal so paper copies had been handed to patients for a month to boost the number of returns. These were then added to the online platform by PCRF staff. A review of consultation notes highlighted that patients were involved with decisions about their care and identified goals were patient led.

Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel they provided care and treatment for could be making decisions about treatment 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 sound guidance and clinical facts. The practice was proactive in seeking out feedback from the patients and communicated action taken as a result of feedback.

The patient satisfaction survey showed that all 41 patients who responded described how they were given clear information as good or excellent.

The practice had a named doctor who acted as a strategic lead for carers, a lead nurse was responsible for the operational support of carers and a 'carers quick guide' local working practice (LWP) that was used alongside the DPHC guidance note for the identification and support for carers. There was information for carers on a dedicated noticeboard which included a calendar of events and support services in the local area. Information was also signposted in the practice booklet. Patients with caring responsibilities were Read coded and captured by a tick box on the new patient form. Once identified, carers were invited to complete a questionnaire and then contacted for a discussion around their specific needs. After initial contact, a 'Wiltshire Carers Support' information pack was provided. Civilian staff with caring responsibilities were signposted to support provided by the MOD membership of 'Employers for Carers.' The LWP included holistic support, for example, providers were informed when a patient with caring responsibilities were referred into secondary care, and needs were assessed should the patient receive a life changing diagnosis or have a life changing accident.

The records we checked had an appropriate alert against their record on DMICP and were recalled annually for a flu vaccination and offered a regular health check. The LWP included the Read codes to be used for carers, cared for patients and young carers. The carers register was discussed at the monthly 'care and concern' meeting and a representative from the practice attended a local carer's café for a monthly meeting with the Courage to Care team. Carers who attended the appointment of a cared for patient were encouraged to book a separate appointment for themselves to discuss their own health and wellbeing.

Practice staff had access to a translation service which could be utilised for either verbal translation or written translation. Staff were aware of how to access the service, supported by prominently displayed posters that included step-by-step guidance.

Privacy and dignity

All consultations were conducted in clinic rooms with the door closed. Clinical rooms had a separate screened area for intimate examinations.

Arrangements were in place to maintain patient privacy when arriving at the medical centre. A room adjacent to the reception desk was available should patients request a confidential conversation away from the desk. A purple card was available for patients to ask for a confidential conversation without having to make a verbal request. The reception desk was open but all telephones were in the back office to avoid patients details being discussed in a public area. In addition, the seating for waiting patients was set back and a television provided sufficient background noise to prevent conversations at the desk from being overheard.

Curtains were utilised in the clinical rooms within the PCRF. For patients being treated within the gym, clinicians sought consent that they were content to be seen in an open space.

The patient satisfaction survey showed that all 41 of the patients who responded described how their privacy and dignity was respected as good or excellent.

Departments within the practice had clinicians of both genders so patients could choose if they wanted to see a specific clinician. This included the PCRF which had male and female physiotherapists and exercise rehabilitation instructors. The exception was the nursing department which was all female. Any request to see a male nurse would be met by signposting the patient to nearby Defence medical centres at Tidworth, Bulford or Warminster.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Equality Access Audits as defined in the Equality Act 2010 had been completed in 2025, no concerns were identified. There were accessible parking spaces available close to the main entrances and dropped kerbs were in place to facilitate access for people with mobility needs. The doors at the main entrance to the building were automated and clear signage guided patients to the reception desk. The reception desk was split level so was suitable for wheelchair users. A hearing induction loop was available for any patient with a hearing impairment and there was a lift to access the second floor although all treatment rooms and consultation rooms were on the ground floor.

Although not mandated by Defence Primary Healthcare, all staff were required to complete learning disability and autism awareness training. At the time of the inspection, most staff had completed the course and future dates were planned for those still outstanding.

The practice staff understood the needs of its patient population and tailored services in response to those needs. A number of specific clinics included bloods, sexual health, weight management and immunisations. Telephone appointments were routinely offered and a sick parade was held each day. This was similar to Total Triage but held face-to-face due to the lack of connectivity for mobile phones at Larkhill. Longer appointments of 30 minutes were provided those with complex needs and vulnerable patients. Carers were offered priority appointments, after-school appointments were provided to school age children and sexual health clinics were provided after hours aimed at being available outside of college hours.

Wednesday afternoons were protected for meetings and training, patients requiring treatment or medication were signposted to Tidworth, approximately a 20 minute drive from Larkhill.

Families were often seen so facilities included a private room for breast feeding and baby changing facilities. The building had gender neutral toilets and there was an appointed lead and deputy for equality and diversity. Patients transitioning were appropriately Read coded and the practice had been recognised with a 'Pride in Practice' gold award in 2023 for their ongoing commitment to LGBTQ+ inclusive healthcare.

The e-Consult service was used to support patient choice as appropriate. This service also provided information on self-care and with it being an online system, could be accessed at any time by patients.

The medical staff team were aware of the need to quickly identify and treat patients with mental health needs to ensure the best possible outcome. The welfare service could refer patients for a same day appointment.

Timely access to care and treatment

Patients had good access to treatment and care with a number of options available to them. The dispensary was flexible with the closing time should patients need to collect urgently needed medicines and there was a late night pharmacy in Tidworth.

Details of how patients could access services when the practice was closed were clearly displayed at the front entrance so could be easily seen when the practice was closed. In addition, the information was relayed in a comprehensive patient information leaflet. Outside of routine clinic hours, patients were encouraged to use e-Consult or NHS111 to access out-of-hours care.

Policy stated that home visits were not routinely provided as standard due to workforce constraints and aim of enabling patients to be seen within the practice building where equipment and clinical support was available. Requests would be considered on a case-by-case basis.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 5 days. Routine appointments to see a nurse were available within 3 days. A text messaging service was used to remind patients of their appointments as well as to communicate patient information and advice of results being received. Wait times for appointments were submitted to region monthly. When wait times increased, they would be reviewed at the monthly Heads of Department meeting and slots adjusted to meet the needs. Any changes would be relayed to the wider team at practice meetings. Data showed there was good access to appointments.

The Primary Care Rehabilitation Facility (PCRF) offered direct access to physiotherapy (DAP appointments) and this referral pathway was utilised appropriately with approximately 2 thirds of the caseload via DAP (50% of these were after sick parade). A routine new patient physiotherapy appointment was available within 1-2 weeks dependent on which regiment the patient was from (each regiment had their own clinician assigned for continuity). A routine follow-up physiotherapy appointment was available the following day. There was capacity to see patients urgently on the same day. Appointments to see the exercise rehabilitation instructor for a new or follow-up appointment were available within 2 working days. There was no waiting list for rehabilitation classes.

Key performance indicators (KPIs) for access to the PCRF were being met. As a result of recognising spare capacity, Larkhill PCRF were supporting Tidworth (as long as Larkhill remained within KPIs). This had been formalised to looking after a specific unit and was currently in the middle of a 6 month trial with the results still to be written up.

Waiting times for the Multidisciplinary Injury Assessment Clinic was 2-3 weeks. These appointments would normally be at the Bulford Regional Rehabilitation Unit, an approximate 10 minute journey by car. Protected appointments for urgent referrals could be accessed within 48 hours.

By exception, units could contact the Senior Medical Officer (SMO) or Regimental Medical Officers out-of-hours to arrange vaccinations for high readiness deployments. Specialist medical wait times were not excessive, same day for urgent aviation medicals and 4-6 weeks if routine.

Listening and learning from concerns and complaints

There was a clear complaints process in place that facilitated learning. The deputy practice manager was the lead for complaints supported by the SMO as deputy. The administrative tasks involved were managed by the deputy practice manager who populated the complaints log. Any complaint of a clinical nature would be referred to the SMO. There was information regarding the complaints process in the practice booklet, posters in the waiting rooms which detailed the complaints' policy, through social media and QR codes to access the online patient survey. When making a complaint in person, patients were encouraged to use a templated form that included a request for consent to access their records. All complaints were monitored on a database that detailed key dates throughout the process and provided a record that was audited annually. Staff were trained on how to deal with complaints and had named points of contact which were detailed on the complaints noticeboard.

All complaints were recorded, verbal or written (a total of 4 recorded in 2025), had been discussed in practice meetings, PCRF meetings (when departmental specific) and healthcare governance meetings and had led to changes being made. For example, the triage process was changed to include an initial assessment that prioritised any patient considered in priority need of treatment. Further examples of complaints that we reviewed demonstrated that significant events were raised and/or duty of candour followed when appropriate, the timeframe of responses met with policy.

Are services well-led?

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

Leadership, capacity and capability

The practice was close to being fully staffed and the balance of civilian and military clinical input provided resilience and continuity. This had not been the case until recent months and the practice had been manging priorities through declaring OPAL status as 'amber' (the OPAL rating of amber meant routine care provision, routine force preparation and occupational health activity may be delayed or diverted). This was predicted to improve to 'yellow' by mid-2026. The leadership team had a clear strategy and vision that was formulated into a practice development plan. The practice manager and deputy practice manager had attended and passed the Joint Practice Manager's course and support was being provided by the Regional Warrant Officer whilst the practice manager was on extended leave. The office manager's role was vacant and a recruitment freeze had been enforced.

The team spoke of inclusive leadership and felt valued and well supported. These positive comments extended to the regional team who made regular visits to stay engaged.

Forward planning helped manage temporary gaps created by deployments. For example, temporary healthcare workers had been used to provide some resilience for when Regimental Medical Officers deployed. Any resultant risks from capacity limitations, for example, summarising, had been added to the risk register. The heads of department (HoDs) monitored capacity in order to declare an accurate opal status to the wider Defence Primary Healthcare (DPHC). There was a 'staff sickness' standard operating procedure to help the team monitor pressures and respond to any impact on patient access.

The Primary Care Rehabilitation Facility (PCRF) was managed well and demonstrated resilience including providing support to nearby PCRFs to help them meet their key performance indicators. The PCRF was well embedded into the practice and managed many of the governance functions internally whilst integrating into the main practice governance structure at senior level.

There were well-established links with the regional team and staff confirmed that input and support was provided whenever possible. Support was provided regularly through regional days, visits in person and regular discussion. The regional team were located at Tidworth and the management team felt they could contact Regional Headquarters (RHQ) staff for support when required. A Band 8a physiotherapist at RHQ was in post to provide specialist support to the PCRF.

Historical challenges had been overcome by the current team adopting a 'back to basics' approach and a drive on culture to make staff feel valued and be fundamental to a team approach to improving the care provided to patients. These

achievements had been recognised when the practice was awarded the John Fry Prize in December 2025, given to a practice (that supported Army units to be eligible) where the greatest improvements in standards and service delivery. The practice was an approved training practice and demonstrated a strong training ethos throughout.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality, sustainable care. This was supported by a clear practice development plan with ideas and priorities discussed at HoDs meetings. Throughout the inspection it was clear that the strategy was applied consistently to decision making and policy. As well as working to the DPHC overarching mission statement, they had also developed their own which was:

> *"Larkhill Medical Centre will provide a safe and effective healthcare service to the military and civilian population of Larkhill, responding to the changing needs of our patients and local units and, through compassionate leadership at all levels, will create a kind and caring environment for all staff and patients using our facility".*

It was evident that the collaborative team working resulted in the practice development plan being a whole team approach. Ideas and prioritise were sought out from all staff members and tabled at the HoDs meetings. Information to patients was relayed through social media, part 1 orders and display posters. Updates were communicated to unit senior officers.

Environmental sustainability was upheld wherever possible. Electronic working was now routine, with SharePoint used to store documents and reduce paper use. A search engine was used that supported tree planting. All coffee granules were used for compost. Recycling bins were in place, and the team recycled inhalers, inkjets and batteries. There was a crutch amnesty in the PCRF to encourage patients to return crutches when no longer required. To cut waste further, the large storage room was moved into a smaller one and reduced unnecessary stock and spending, keeping consumables to a minimum. The team also networked with the Royal College of General Practice to gain sustainability advice, and with nearby Defence medical centres in the Salisbury Plain Training Area to share consumables and prevent waste.

Culture

Staff we spoke with described a strong team ethic across the practice whereby the patient's requirements were held central to all decision making. The leadership team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open-door policy for staff to use. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process.

Staff said morale was good and there was an inclusive meeting structure and open staff forums to raise concerns and offer suggestions. The practice used 180 degree feedback, a process of appraisal where feedback is provided from 2 sources, the line manager and the self-assessment. In addition, all staff were recently invited to complete 6 monthly staff satisfaction survey and leaders maintained an open-door policy so staff could speak up at any time. All staff had completed freedom to speak up (FTSU) training and leaders had also completed the 'Listen' course to help create a culture where concerns were taken seriously and acted on.

The practice team participated in team building activities such as a walking group, held baking competitions between departments and supported charities through events. Medics were included in these activities despite belonging to the unit, this helped strengthen teamwork and shared working practice. Staff were recognised with thank you awards and these extended to civilian staff. All staff were welcomed or farewelled at 'tea and toast' mornings, and the practice organised 2 Christmas functions to ensure everyone could attend regardless of cost. Staff at every level, military and civilian were encouraged to share ideas, and junior ranks were empowered to speak up. The healthcare governance (HcG) and practice meetings were open to all staff, and there was a separate meeting for medics to make sure their views were heard if not comfortable to speak out at one of the wider staff meetings. Whitespace time was afforded to all staff members to give them time away from their daily duties.

There was a positive trend throughout the inspection of staff speaking about the working environment being supportive, inclusive and open. Of note, the improvements made by the leadership team which had led to stability and improved morale.

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. There was a duty of candour register on the HcG workbook and it was cross referenced to the ASER and complaints registers. A review of the register at this inspection evidenced that entries were comprehensive. One example was when patient information had accidentally been given following an email being sent to the wrong address. A review of the actions showed a detailed investigation had taken place and appropriate communication with those impacted including followed the duty of candour. Additional checks were implemented to minimise the possibility of reoccurrence.

Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support governance and management. The practice had built in more resilience with leads and deputies in all areas. These were supported by signed terms of reference (TORs) that defined the role and associated responsibilities. TORs were not only in place for core roles, they also covered associated duties including safeguarding, whistleblowing and chronic disease management. Reviews or all TORs were carried out annually.

The HcG workbook was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints. The workbook was populated with information to provide internal assurance that systems were effective. The practice manager, deputy practice manager and office manager managed the workbook. All staff had access.

The health assurance framework (HAF) was kept up-to-date and showed substantial assurance in all areas. It was discussed as a standing agenda item at HcG meetings and HAF actions were included within the management action plan, monitored by the Senior Nursing Officer, and used to ensure progress was monitored through to completion.

A meeting schedule was established, and this included clinical meetings, HoDs meetings, complex patient meetings and monthly HcG and practice meetings for all staff. Discussion at each was recorded and made available to those unable to attend. Departmental meetings included the administration staff, the PCRF team and the doctors. The nurses also held regular meeting each week and used a ‘communication book to relay messages within the team. The pharmacy technician attended the HoDs, clinical and practice meetings.

There was robust clinical oversight of the medics that although the responsibility of the Regimental Medical Officers, was underpinned by the Senior Medical Officer (SMO) to provide resilience and continuity.

Managing risks, issues and performance

The SMO and practice manager maintained oversight of the risk register on the HcG workbook. There were also issues, retired risk and retires issues registers. Risk was discussed at the weekly heads of department meeting and reviewed at the monthly practice HcG meetings as a standing agenda item. There was a range of risk assessments in place covering both clinical and non-clinical risks.

The leadership team was mindful of risks to the service and were proactive in anticipating potential upcoming issues and adding them to the risk register. The top risks identified were workforce due to the recruitment freeze in place and lack of phone signal that could result in communication failures. The risk of workforce had been transferred to regional headquarters and the risk of telephone signal had been classified as ‘tolerable’ due to the workarounds in place.

A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risks to the service were recognised and logged on the risk register. All risks on the register were signed as reviewed by the SMO.

There was a comprehensive business continuity plan (BCP) that was in-date for the annual review. The plan included a key contact list of regional staff, contractors, heads of department and nearby military medical centres. The BCP had been

utilised in May 2025 when connectivity for both telephony and DMICP was lost times in 2025 due to loss of IT, telephone lines and power. The plan was actioned and workarounds found to be effective in maintaining services for the period of the outage.

The leadership team was familiar with the policy and processes for managing staff performance. Initial concerns would be addressed by identifying if there were any welfare issues that required support. Training and mentorship would also be offered alongside the appraisal process. Formal performance management would be considered if appropriate or of other processes were not successful.

Appropriate and accurate information

The HAF commonly used in DPHC to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The HAF was overseen by the nursing team who acted as HcG leads. Staff had access and used it as a management and information resource.

An Internal Assurance Review was undertaken in May 2025. This graded the practice with “substantial assurance”. The HAF had been fully populated which had driven the development of the Management Action Plan. These actions were discussed within regular staff meetings enabling the whole team to understand risk and progress on improvement initiatives and requirements.

There was a well maintained audit register located in the HcG workbook. Findings from audits were fed back to the wider team together with any resultant changes in working practice. The programme included repeat audit cycles in some circumstances where further potential improvements had been identified. We reviewed a number of examples that included a PCRF audit on anterior cruciate ligament injuries that resulted in the introduction of a synonym (shortcut to standardise clinical activity) within the notes to improve the collection of outcome measures. This audit had been repeated to check on progress. A further audit in the PCRF was on red flags that helped inform the in-service training programme. Further examples of audit included those for asthma, hypertension and diabetes that provided assurance of consistent and appropriate treatment being provided. Audit was also used proactively for health promotion; for example, ensuring that all asplenic (without a spleen) patients had been offered a flu vaccination and patients with a raised body mass index had individually been offered access to the ’Healthy Living Programme’. A higher than average uptake of the programme had been achieved.

Systems were in place that reflected data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. All staff had received training in the management of confidential information which included Caldicott principles. Caldicott reports on DMICP were reviewed by the administration team and any inappropriate access or

anomalies were escalated via the practice manager or deputy. A central register was held for Caldicott searches. Military staff were encouraged to be seen at other medical centres to reduce the risk of any Caldicott or medical-in-confidence breaches. For additional protection, family members of staff had an alert on their records so all clinicians were aware and could ensure appropriate access controls.

Engagement with patients, the public, staff and external partners

Patients had the opportunity to make suggestions about the care delivered. The DPHC patient experience survey was displayed in the waiting area and showed 95% respondents described the service as good. Patients were encouraged to scan the QR code to give feedback. It was evident throughout the inspection that the views of patients were sought and considered when making decisions. The SMO sat on the Garrison Board to understand the needs of service personnel.

The practice responded to patient needs and changed the service to resolve issues as they emerged. For example, the information for the out-of-hours service was displayed at the main entrance, inside the patient information leaflet and relayed on the answering machine message after patients had fed back that information was not always clear. Sick parade had been reintroduced following patient feedback on wanting better access. Service personnel based at Upavon had fed back that sick parade timings presented them with a challenge so were permitted to report in unwell by telephone to access.

The PCRF had a ‘you said, we did’ board to communicate change made as a direct result of patient feedback. A PCRF patient feedback questionnaire had been carried out with 17 responses gained in 2025. There had been no changes as a result of feedback as the returns were all positive and had not included any suggestions on ways to improve the service. Efforts had been made to establish a patient participation group but an initial meeting was not supported by patients’ attendance.

Staff had opportunities to provide feedback to leaders. This included individual, 180-degree and verbal feedback for locum staff. There was 360-degree feedback on the leadership team and the doctors. Staff participation surveys were conducted regularly and staff could share feedback informally through an open-door policy. The practice communicated a ‘you said, we did’ response to staff feedback. Following the 360-degree feedback obtained in October 2025, clinical rooms not in use were offered out to staff, in particular medics, when there was insufficient desk space. Clinical training was increased and built into the programme that ran until May 2026 and a ‘signal group’ was established to help improve communication.

Doctors engaged with local NHS and community services to identify and enhance care pathways for practice patients. Links had also been developed with NHS Talking Therapies, safeguarding teams, obstetrics and orthopaedics. Nurses had an advice link and were supported with newly diagnosed and pre-diabetes education.

Continuous Improvement and Innovation

The Senior Nursing Officer and Nurse Warrant Officer oversaw the quality improvement and audit programme. There was evidence of innovative practice raised as quality improvement projects (referred to as QIPs), of note, the leadership continued the strong training ethos to be innovative to support staff and improve the patient experience. Examples of QIPs included:

- A sustainability drive. Minimal stock levels were held in the dispensary and repeat prescriptions limited to 56 days. The inhaler initiative had been followed to facilitate patients returning used or no longer required inhalers to be recycled.
- To reduce the reliance on DMICP records and provide close monitoring of the immunisation status for children, links had been formed with the local NHS GP practice to highlight which patients had been vaccinated and use a report produced from the national database to determine those still outstanding and in need of following up.
- A ‘newborn baby register’ was used to notify maternity services. This was used as part of a proactive approach with weekly checks carried out to ensure new babies are registered and a tracker was kept to monitor attendance for the 6 week check and 8 week immunisations. A total of 9 had been noted since the beginning of January 2026.
- The women’s health team had developed a video on pelvic floor exercises and were exploring access to the gym for service personnel on maternity leave so that they could bring their baby with them if required.
- The PCRF had formalised the support provided to a unit from Tidworth having recognised spare capacity to facilitate this.
- Based on injury surveillance and collaborative working with the unit, PCRF staff had initiated a change in physical training to include ability groups and reduce further injuries.
- An audit on occupation health management which identified how the transfer of information between Phase 1 and Phase 2 training would improve the patient care pathway.
- A coeliac audit that identified patients with a full or partial diagnosis to ensure they had been managed in accordance with guidelines and had benefited from education that included awareness of how to access specific ration packs.
- A standardised ‘consent to share confidential information’ document for vulnerable patients that had been adopted by other Defence medical centres in the region.
- A ‘safeguarding OneNote’ that provided a centralised, up-to-date repository of key information. This was shared with other local practices.
- Centralised equipment trolleys and women’s health equipment kits that replaced having 1 in each room. This reduced the administrative burden and ensured they were well equipped and ready to use at all times.