General Medical Council

Regulating doctors
Ensuring good medical practice

Review of the Defence Postgraduate Medical Deanery

This visit is part of a regional review and uses a risk-based approach. For more information on this approach see our Regional Review webpage.

Review at a glance

About the Deanery

Geographical area	The Defence Postgraduate Medical Deanery is based at Defence Medical Services in Lichfield. Postgraduate medical education and training is delivered across the United Kingdom (UK) and internationally at military sites, and in partnership with 12 Local Education and Training Boards (LETB) and two deaneries in devolved nations.
Number of trainees	As of March 2014: 420 (consisting of 99 directly managed and 321 indirectly managed defence doctors in training).
NHS organisations	Defence doctors in training are placed in 65 NHS acute and mental health trusts and 39 NHS GP Practices. There are 24 military training sites across the UK and internationally.
Last GMC visit	2010-11: Combined Quality Assurance of Foundation and Specialty including General Practice visit.

About the visit

Visit dates	Defence Postgraduate Medical Deanery: 18 June 2014
LEP sites visited	Defence Medical Rehabilitation Centre, Headley Court: 9 May 2014 Queen Elizabeth Hospital, University Hospitals Birmingham NHS Foundation Trust: 15 May 2014 Derriford Hospital, Plymouth Hospital NHS Trust: 21 May 2014 HMS Drake: 22 May 2014 Frimley Park Hospital NHS Foundation Trust: 29 May 2014
Programmes reviewed	Foundation Programme, General Practice (GP), Anaesthesia, Emergency Medicine, Acute Care Common Stem (ACCS), Public Health Medicine and Occupational Medicine.
Areas of exploration	Patient safety, quality management and governance, equality and diversity, recruitment and selection, delivery of curricula and assessments, clinical placements, support and development of trainers, supervision, transfer of information, Fitness to Practise and Doctors in Difficulty, careers advice and progression, educational resources and capacity, relationships with host LETBs and Local Education Providers (LEPs).
Were any patient safety concerns identified during the visit?	We identified two potential risks to patient safety and reported these to responsible staff within the LEPs and LETBs where they were found. See Requirements 4 and 5 for further information.
Were any significant educational concerns identified?	No
Has further regulatory action been requested via the responses to concerns element of the QIF?	No

Summary

This report gives a picture of the Defence Postgraduate Medical Deanery's (DPMD) management of medical education and training for doctors (defence doctors in training) sponsored by the Ministry of Defence. The findings come from our visits to the DPMD and five of its partner LEPs in 2013-14.

Why did we choose the DPMD?

We chose to review DPMD for three reasons:

- to investigate the way DPMD quality assures indirectly managed training programmes as well as directly managed programmes, which was not included in the last review of DPMD.
- to look into changes to the structure of the defence medical workforce and its potential impact on postgraduate medical education and training.
- we last visited DPMD in 2010-11, during a period when the GMC merged with the Postgraduate Medical Education and Training Board (PMETB)[1]. The review of DPMD in 2013-14 forms part of a cycle of visits that incorporates best practices from the GMC and the PMETB, with practices being evaluated and improved upon on an annual basis.

What do we know about defence postgraduate medical education and training?

Defence Medical Training

Defence doctors in training are employed by one of the three Services: the Royal Navy, Army and Royal Air Force. DPMD is responsible for managing postgraduate medical education and training on behalf of these Services. DPMD is accountable to the Defence Medical Services (DMS), which is responsible for the delivery of all medical, dental, nursing, allied health professionals, paramedical and support personnel across the three Services.

Management of training

Defence doctors in training are managed directly by DPMD or indirectly by host LETBs and deaneries, depending on the specialty in which they are training. Directly managed training specialties delivered by DPMD are General Practice, Public Health Medicine and Occupational Medicine. Defence doctors in training on these directly managed programmes have clinical placements in military and NHS training sites across the UK and overseas.

1

[1] PMETB and the GMC merged in April 2010.

DPMD transfers responsibility for the delivery and quality management of the Foundation Programme and all other training specialties to host LETBs and deaneries, but retains a general oversight through a variety of mechanisms.

Defence doctors in training on these indirectly managed programmes are located across 65 LEPs in 12 host LETBs in England, the National Health Service Education for Scotland (NES) and Wales Deanery. They are integrated with civilian doctors in training and managed as such.

DPMD utilises a system of memoranda of understanding (MOU) with host LETBs and deaneries to agree respective expectations and responsibilities, which is revised annually.

What did we do?

We used a risk-based approach to find areas to explore during the review. These areas were chosen on the basis of evidence from:

- the GMC's National Training Survey (NTS)
- DPMD's bi-annual Dean's Report
- extensive documentation submitted by DPMD and LEPs and LETBs where defence doctors in training are located.

We visited trusts and military LEPs where defence doctors in training are present: two military sites that deliver directly managed training programmes and three NHS LEPs delivering some of the indirectly managed training programmes.

The sample of LEPs visited were chosen because these sites provide placements for a large proportion of defence doctors in training across a range of directly and indirectly managed training specialties.

Where did we go?

We visited Defence Postgraduate Medical Deanery and three NHS sites and two military sites in three LETB regions:

- Queen Elizabeth Hospital, University Hospitals Birmingham NHS Foundation Trust in Health Education West Midlands
- Defence Medical Rehabilitation Centre and Frimley Park Hospital NHS Foundation Trust in Health Education Kent, Surrey and Sussex, and
- Derriford Hospital, Plymouth Hospital NHS Trust and HMS Drake in Health Education South West.

Who did we meet with?

We talked to a range of people, including:

- defence doctors in training
- their clinical and educational supervisors
- LEP senior managers and education staff
- LETB quality management teams and senior representatives, including Postgraduate Deans
- DPMD and DMS staff
- Lay representatives.

We did not interview civilian doctors in training as part of this review.

Whilst there are defence doctors in training in deaneries in the devolved nations and at international sites, we did not visit these sites due to the relatively small numbers based there. We did discuss the relationship and working with the devolved nations when we met with DPMD.

What did we find?

DPMD is compliant with most of the standards set in *The Trainee Doctor*. We found high quality training provision across the sites we visited, often in unique and innovative clinical and educational environments. The majority of defence doctors in training we met expressed their satisfaction with the training and support provided. We particularly note the extensive pastoral support available to defence doctors in training.

A wide range of additional educational opportunities: defence doctors in training benefit from this as part of their military careers. Although separate to clinical training, we found that the military-specific training and culture adds considerably to trainees' development as effective leaders and medical professionals.

Highly motivated doctors in training: in general, the defence doctors in training we met were a highly motivated group of individuals. The defence doctors in training we met were fully engaged in their education and training. They were well aware of their educational and training needs, plus the competencies required of them as both doctors in training and defence personnel.

We could see the influence and impact that DPMD and its training has on the defence doctors in training, in particular their excellent organisation, motivation and leadership skills.

Potential patient safety concerns: we identified two potential concerns in two of the LEPs where there are defence doctors in training. The concerns included:

- patient allergy recording (see Requirement 4)
- inadequate supervision in a single-handed GP practice (see Requirement 5).

Both of these issues were identified during site visits and immediately reported to LEP and LETB senior managers to be addressed. The DPMD was also informed.

Potential risks: We identified a number of potential risks arising for DPMD, particularly regarding resources, capacity and sustainability.

We found evidence that the DPMD's quality management systems would benefit from further development and investment to ensure more systematic collection of data to identify and respond to educational concerns at LEPs and host LETBs.

We did recognise the extensive quality management and control processes within host LETBs/deaneries and LEPs - standards are currently being met in this area.

The risks we identified will need to be addressed to ensure the long-term sustainability and resilience of DPMD and the training programmes it manages.

Areas of good practice

We note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in *The Trainee Doctor*	Areas of good practice for the LETB
1	TTD: 6.7, 6.19 Standards for Deaneries: 2.2	**Comprehensive pastoral support for doctors in training** • The support provided to defence doctors in training is excellent. • Educational supervisors, military clinicians and senior DPMD staff are accessible and responsive to trainee needs. • The military culture and targeted support provided by LEPs and other military organisations enhances the overall education and training experience.

2	TTD: 2.3, 6.17	**Innovations in clinical placement sites**
		• The clinical placements at DPMD's partner education providers demonstrate elements of innovation and good practice.
		• Trainees value:
		  ○ the good clinical exposure
		  ○ positive and supportive learning environments
		  ○ good supervision and support.

3	TTD: 2.2, 6.33 Standards for Deaneries:5.1, 5.2, 5.3	**The Defence Consultant Advisors** • The work of the Defence Consultant Advisors (DCAs) fosters positive relations with DPMD's educational providers. • The support provided by the DCAs to defence doctors in training. • The DCAs disseminate specialty specific information across UK and international training sites.
4	TTD: 8.2, 8.5	**The Defence Medical Services Library** • The resources and services provided by the library are exceptional. • The library is responsive to defence doctors in training needs and provides remote support to others across the UK and international training sites.

Good practice 1: **Comprehensive pastoral support for trainees**

DPMD and its education partners demonstrate good practice in their approach to supporting defence doctors in training. We note particularly:

- the extensive, tailored support provided by the Royal Centre for Defence Medicine (RCDM)
- the positive contribution of military specific support in nurturing leadership skills, which also enhance clinical training.

Supporting defence doctors in training across locations - challenges

The defence doctors in training we met explained the inherent challenges of working with and reporting to multiple agencies – including DPMD, single Services, trusts and host LETBs. There was evidence that some defence doctors in training find the different chains of command, including where to seek help in different circumstances, challenging. We also found that the geographical spread and frequent transfer of defence doctors in training presents the risk of them being isolated from support networks. However, we found a wide range of mechanisms were in place to ensure that defence doctors in training have access to appropriate support when needed.

Good support mechanisms in place

Across each of the sites we visited, defence doctors in training provided universally positive feedback about the comprehensive support available to them from a wide range of agencies. Defence doctors in training reported supportive environments when on placement at the LEPs we visited. This includes supportive and accessible trainers and supervisors, proactive administrative staff and full access to the range of support services provided to civilian doctors in training.

Defence doctors in training felt well supported by their host LETBs as well as DPMD, for example the provision of revision groups and support with Annual Review of Competence Progression panels (ARCPs). However, defence doctors in training on directly managed programmes reported that they would value improved links to LETBs when on NHS clinical placements.

Memoranda of understanding developed

The DPMD uses a system of memoranda of understanding (MOU) with partner LEPs to:

- formalise the support roles of the DPMD and its NHS partners and
- ensure that trusts provide defence doctors in training with adequate support.

The Deputy Dean uses the MOU to ensure that defence doctor in training support requirements are communicated with partner LETBs and LEPs. We spoke with three

Postgraduate Deans from the host LETBs we visited and they reported that this process works well. DPMD is developing pastoral support memoranda of understanding (MOU) with non-Ministry of Defence Hospital Unit (MDHU) partner LEPs. We suggest that DPMD liaise with Health Education England (HEE) and deaneries in the devolved nations to potentially develop a national MOU to ensure parity across all placements.

Royal Centre for Defence Medicine – support provision commended

We commend the military-specific social and pastoral support provided by RCDM for providing trainees with valuable opportunities to engage with and develop their military identity.

Senior staff within the MDHUs we visited explained that RCDM provides Foundation doctors with a number of pastoral and social opportunities to help establish relationships with defence doctors in training. It teaches a military culture and supports their military bearing. RCDM's support services include:

- contact, support and advice from a named senior officer
- informal careers support
- journal and book clubs
- social events such as dinners with senior officers
- guidance on military processes and protocol.

Support, guidance and advice in other locations

The provision of a named contact for informal mentoring, support and advice for defence doctors in training was first established by the RCDM and has since expanded to other locations. Although we did not identify a formal mentoring model, the importance and value of this informal guidance and support was made clear by the defence doctors in training and staff we met. The DPMD Postgraduate Dean also highlighted the DPMD's new focus on developing mentoring and coaching relationships in partner LETBs and deaneries so that defence doctors in training have access to mentors they can call on for support.

Military education supervisors provide informal support and advice for defence doctors in training in addition to their educational supervisor roles, to ensure that trainees have access to targeted support when they are based in NHS LEPs. Military educational supervisors also have a wider pastoral role to ensure that defence doctors in training meet military requirements (ie health and fitness and keeping up to date with their military training). We recognise their role in developing defence doctors in training as military officers as well as doctors.

The three Services do not offer less than full-time training opportunities for defence doctors in training as all military employment is on a 'full-time' basis. We did find good levels of support for those returning from periods of absence due to illness or

maternity leave, with defence doctors in training gradually reintroduced to full operational service. We also identified a particular focus on mental health support for defence doctors in training, particularly for those returning from military deployment. Defence doctors in training and staff at the DPMD reported good and comprehensive support for these individuals to decompress and reintegrate into training after deployment. Senior staff at the DPMD were aware of the Academy of Medical Royal Colleges' guidance on returning to practice, however we were not able to fully triangulate the effective implementation of this policy during our site visits.

Good practice 2: **Innovations in clinical placement sites**

Throughout this review, the defence doctors in training we met were very positive about their clinical placements at the sites we visited. They reported good learning opportunities, good exposure to cases and different patient pathways, and accessible and supportive clinical supervisors and staff.

We noted examples of good practice at a number of the sites we visited, particularly in:

- involvement of doctors in training in governance
- reporting and feedback
- unique training experiences.

The LEP site visit feedback reports are included as appendices to this report and they highlight the areas working well at these sites. DPMD should disseminate these areas of good practice with their education and training partners.

Defence Medical Rehabilitation Centre, Headley Court (DMRC)

A unique and inspiring learning environment

During our visit it was clear that DMRC provides defence doctors in training with a unique and inspiring clinical and educational environment. We observed:

- a very positive, inclusive and learner focused environment
- defence doctors in training working in multi-and inter-disciplinary teams
- trainers who have the time and resources to provide high quality learning opportunities.

Focus on musculoskeletal medicine teaching

We found a focus on musculoskeletal medicine teaching, with good opportunities for defence doctors in training to investigate musculoskeletal issues in complex trauma and neurological cases.

As a centre of excellence for rehabilitation medicine, there are superb opportunities for doctors in training to work with and learn from multi and inter-disciplinary specialists and health professionals in the delivery of effective trauma management. The four day in-house musculoskeletal training programme initiated by DMRC features in the training of all post-Foundation Programme defence doctors in training to help them prepare for military deployment.

Defence doctors in training considered their experience at DMRC and their in-depth exposure to inter-disciplinary teams and musculoskeletal teaching as invaluable clinical experience, which prepared them for a variety of clinical situations.

We commend the DMRC for providing defence doctors in training with invaluable clinical exposure and educational experience.

Queen Elizabeth Hospital Birmingham (QEHB)

Feedback 'app' pilot

The pilot of a feedback app for Foundation Programme trainees at QEHB represents good practice in the reporting of patient safety and education quality concerns.

The system enables doctors in training to report immediate feedback to senior trust staff via a desktop link to a survey page. Serious issues such as clinical incidents and bullying and harassment are prioritised and immediately sent to appropriate senior staff to be addressed within 24 hours. Doctors in training are then contacted for further information or to receive feedback on the actions taken.

The defence doctors in training we met explained that the feedback app results in serious issues being addressed very quickly and timely feedback to the individual who raised the issue.

The Trust's senior management has recognised the need to improve communications with doctors in training during busy periods (ie emergency admissions during peak times). The Trust's postgraduate education manager explained that the app was developed to make it easier for doctors in training to report issues and provide a 'live' system of direct reporting and feedback. Senior staff highlighted that the app is still in development with plans to expand the system for all doctors in training.

The concept of the trainee feedback app and the process for responding to issues is very good. QEHB is encouraged to use feedback from doctors in training to further develop and refine the system and to use evidence from the app to triangulate education quality data and long-term trends.

Frimley Park Hospital NHS Foundation Trust

Open and inclusive culture

We found an open and inclusive culture at Frimley Park Hospital, where senior leaders and consultants are approachable, accessible and responsive to feedback from doctors in training. They are listened to and changes are made as a result.

Doctors in training on placement at Frimley Park Hospital are actively encouraged to get involved in local governance to improve engagement. Defence and civilian doctors in training representatives are elected to the Trust's Board and Clinical Governance Committee. They represent doctors in training as a whole in senior decision making and ensure that meeting outcomes are shared with other trainees.

The Trust's faculty groups, attended by clinicians and staff from the Trust's postgraduate centre also provide opportunities for doctors in training to report issues and concerns in their specialty. Defence doctors in training reported that the groups provide opportunities for open and constructive dialogue.

Outcomes from the faculty group meetings, along with NTS survey data and other training information, are shared with the Local Advisory Board to ensure that education and training issues are escalated appropriately.

Defence doctors in training reported that their involvement in Trust governance has resulted in organisation-wide changes to improve education and training.

Good practice 3: The Defence Consultant Advisors

We were impressed by the work of the Defence Consultant Advisors (DCA), particularly their role in building and maintaining relationships between DPMD, defence doctors in training, LETBs, deaneries and LEPs. DPMD should work with Joint Medical Command (JMC) to consider how this role could be further supported and enhanced.

Central to quality management function

The DCAs are central to DPMD's quality management function across sites and specialties. The allocation of a single DCA per specialty ensures an in-depth knowledge of specialty training issues and well established relationships with specialty practitioners in each LEP, LETB and deanery.

These relationships allow for open dialogue between DPMD and individual trusts and ensure the identification of local and national risks to training quality and capacity. They also disseminate good practice across LEPs and deliver quality inspection visits, although we note that quality visit reports could be improved (see Recommendation 2).

DCA responsibilities

The DCAs are responsible for:

- assisting DPMD in many aspects of specialty training, including involvement in recruitment and selection processes for defence doctors in training
- discussion with DPMD on clinical placements
- engagement with LETBs, deaneries and LEPs
- pastoral support
- attending ARCPs as DPMD representatives.

They provide a single point of contact for defence doctors in training and senior trust staff, and promote links between the DPMD and medical Royal Colleges, Faculties and other relevant professional groups. We found clearly identified job roles and a formal structure of command and governance for DCAs.

The DPMD Postgraduate Dean reported that DCAs facilitate a comprehensive intelligence network to identify those LETBs, deaneries and LEPs delivering high quality training in each specialty.

Defence doctors in training feedback on DCAs

The defence doctors in training we met reported good access to their respective DCAs. They were seen as supportive and understanding of their training, education and pastoral needs. DCAs meet with all general practice and specialty defence doctors in training in dedicated termly 'cadre meetings' and annual conferences to discuss education and training issues. These fora provide useful opportunities for informal feedback and relationship building and help to maintain links with defence doctors in training.

Good practice 4: The Defence Medical Services Library

The comprehensive resources and responsive services provided by the Defence Medical Services (DMS) Library are commended.

Defence doctors in training feedback on DMS Library services

The doctors in training we met across all sites were universally very positive about the resources, services and support provided by the DMS Library. The DMS Library is based at DMS Whittington and has over 18,000 books, journals and e-resources available to defence doctors in training and other relevant groups.

Library services are exceptional

The Library's awareness and appreciation of the remote nature of defence postgraduate medical education and training is highlighted in the core selection of

clinical textbooks provided to each military training site to ensure all defence doctors in training have instant access to core reference and learning resources.

The DMS Library provides support for literature reviews and an impressive two day global delivery service to doctors in training and clinicians based in other countries. Library staff also collate global press cuttings, journal articles and historical texts on military medicine to provide a unique global resource for UK and international health professionals.

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in *The Trainee Doctor*	Requirements for the LETB
1	TTD 8.2	**Improve access to the GP ePortfolio from military computer networks** DPMD must ensure that defence doctors in training and their educational supervisors have full access to the Royal College of General Practitioners (RCGP) trainee ePortfolio at their place of work. This must be addressed as an urgent priority.
2	TTD 2.3, 4.4 Standards for Deaneries: 3.10, 4.6	**Formalise recruitment, training and use of lay representatives** DPMD must formalise the selection, training and use of Lay Representatives in DPMD governance. This must include the appointment of fully external lay representatives.
3	TTD 1.6	**Ensure full implementation of handover policy in Trauma and Orthopaedic (T&O)placements at Derriford Hospital** DPMD must work with HESW and Derriford Hospital to ensure full implementation and practice of handover policy in the T&O Surgery Unit.
4	TTD 1.4, 5.3	**Ensure that Derriford Hospital's policy for use of red bands for patients with particular conditions is applied appropriately and consistently** DPMD must work with HESW and Derriford Hospital to ensure the policy for use of red bands for the identification of patients with particular conditions is used appropriately and clearly communicated to all relevant staff and doctors in training.
5	TTD 1.3	**Ensure adequate supervision in single-handed GP practice placements** DPMD must work with partner LETBs, deaneries and LEPs to ensure doctors in training have adequate

		supervision when on placements in single-handed GP practices.

Requirement 1: Improve access to GP ePortfolio from military computer networks.

DPMD must ensure that defence doctors in training and their educational supervisors have full access to the RCGP trainee ePortfolio.

Defence doctors in training, supervisors and senior staff across all the sites we visited reported difficulties accessing the RCGP ePortfolio. We were told that access was previously available until network security arrangements were changed in August 2012.

The defence doctors in training we met considered this detrimental to their training - they are unable to record information while on site so have to access the system in their spare time. Many of the defence doctors in training and supervisors we met reported using home computers to upload information, and felt that the integrity of patient questionnaires was subsequently affected.

Staff at HMS Drake explained that some military LEPs have set up separate internet connections for this purpose but individual LEPs have to bid for funding to do so. This funding is allocated on an annual basis and is not guaranteed.

The senior leadership team at DPMD is aware of the issue and has highlighted the risk to the Surgeon General's headquarters. Despite the issue being presented as a significant risk, the leadership team felt that there are limited options to make further representations and they are still waiting for a solution.

Access to secure GMC systems such as GMC Connect is also restricted from military networks because of the rigid security controls.

Requirement 2: Formalise recruitment, training and use of lay representatives.

DPMD must formalise the selection, training and use of lay representatives and define the scope of their roles and responsibilities to ensure more effective lay involvement and external representation. This must include the appointment of fully external lay representatives.

We met with three lay representatives on our visit. All the representatives we met are military employees and there are currently no fully external representatives. We were informed that lay representatives are used mostly on committees and panels for directly managed programmes. They provide external advice and representation on recruitment panels, the General Practice Education Committee, higher education funding and ARCP panels.

The lay members we met felt valued and well supported, particularly by the GP Dean. However, we found a significant degree of variability regarding their selection, training and how and when they are employed.

The lay members told us that they were selected in different ways. One volunteered and two others were approached because they had previously worked for DPMD. The lay members were not certain if there were terms of reference for the role and reported that arrangements are relatively informal. We also found that lay membership is not appointed on a time limited basis, with one lay member in post for almost 10 years.

DPMD does not provide formal training for the role. Training is mostly via informal discussions and briefings with senior staff before committee or panel meetings about expectations and protocol. The lay members felt that if their appointment was formalised it would give clarity about their role, responsibilities and expectations.

Senior DPMD staff explained plans to expand lay representation in quality management, notably to involve lay members in quality visits and meetings. They recognised the need for further development of the terms of reference (TOR) for lay members. DPMD has reviewed the TOR used by other LETBs and deaneries with the aim to adopt a similar approach with a defence focus.

Requirement 3: **Ensure full implementation of handover policy in T&O placements at Derriford Hospital.**

DPMD must work with Derriford Hospital and Health Education South West to ensure full implementation and adherence to the Trust's handover policy in the Trauma and Orthopaedic Surgery Unit.

Defence doctors in training in Foundation and higher specialty training posts reported issues with handover of patient information in the T&O unit. The doctors in training we met reported that placements in T&O are generally good, but they did identify long-standing historical challenges with their rotas, handover and workload pressures including:

- Whilst issues with rotas and workload had been addressed by the Trust, the lack of formalised handover is still problematic.
- Examples of ineffective ward rounds and morning meetings, and staff-grade clinicians who persistently do not use the handover system.
- The doctors in training had independently developed new processes in response to some of these challenges, but there were persistent non-users of the system and subsequent patient safety concerns arise.

- Defence doctors in training sometimes work beyond their shifts to ensure that appropriate clinicians and nursing staff receive the necessary patient handover information. Despite submitting patient safety concerns via the Trust's Datex system, there had been limited feedback to doctors in training on the actions being taken to address the issue.

Doctors in training felt that whilst the consultants in the unit are aware of these issues, they are not being addressed in a meaningful way.

The clinical supervisors we met were aware that the defence doctors in training had taken it upon themselves to create their own solution to the problem by designing a better system for transferring patient information. They recognised that this has improved matters but a small contingent of staff has not engaged in the changes. This was considered a work in progress and the Trust plans to re-audit handover arrangements to establish if changes are being made.

DPMD, LETB and the Trust must investigate these issues further to:

- establish if this is a systemic problem or isolated to particular members of staff
- take action to ensure effective handover at the start and end of each shift for all relevant members of the team.

Requirement 4: Ensure that Derriford Hospital's policy for use of red bands for patients with particular conditions is applied appropriately and consistently.

We are concerned about Derriford Hospital's use of red wrist bands to identify patients with particular conditions, such as allergies.

The defence doctors in training we met reported that the red wrist bands are used to identify patients with allergies, but the application of the system is not clear and is being used inappropriately. For example, the bands are also used to identify patients with other characteristics such as those with Diabetes or challenging behaviours.

The Trust has developed a new drug chart in the patient note booklets with a dedicated section for reporting allergies. However, Trust supervisors and senior staff reported that recording of allergies is not included in Trust or departmental inductions as it is considered part of good medical practice for doctors in training.

DPMD must work with the Trust and Health Education South West to ensure that the Trust's policy and procedure for using red wrist bands is applied appropriately and consistently. This must be communicated to all relevant staff and defence doctors in training on placements at the Trust.

Requirement 5: Ensure adequate supervision in single-handed GP practice placements.

Throughout this review we found evidence of high quality training in General Practice (GP) across sites and regions. We found that defence doctors in training have access to a wide variety of clinical placements to ensure they get appropriate experience to meet curriculum outcomes. The opportunity for defence GP doctors in training to divide their clinical placements across military and NHS providers also has the potential to offer good exposure to different patient pathways and training environments.

However, at HMS Drake we were told of inadequate supervision of defence and civilian GP doctors in training on placement in a single-handed GP (NHS) practice. The doctor in training at this practice reported occasions when they had to work without direct supervision due to unforeseen, temporary absence of the trainer. We were told that the supervisor was available by telephone until they arrived at the practice.

The defence doctor in training felt that the practice provides good learning opportunities and we recognise the unique training experience offered by such placements. However periods of inadequate clinical supervision pose potential safety risks for both trainees and patients. DPMD must investigate if further support systems are required to mitigate this risk or if alternative placement arrangements need to be made for all single-handed GP practices.

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Paragraph in *The Trainee Doctor*	Recommendations for the LETB
1	TTD 6.34, 6.35	**Develop a framework, policy and register for training and accreditation of trainers and supervisors** DPMD should develop a framework, policy and register for the training and approval of trainers and supervisors of directly managed programmes.
2	TTD 2.3 Standards for Deaneries: 1.1	**Conduct more detailed analysis of quality data** DPMD should conduct more detailed analysis of available quality data, including internal sources such as feedback from defence doctors in training, and other sources such as GMC NTS data.
3	TTD 1.9, 6.8, 6.33 Standards for Deaneries:5.1	**Formalise information sharing agreements and processes with partner LETBs, deaneries and LEPs** DPMD should work with partner LETBs, deaneries and LEPs to develop more formalised information sharing agreements and processes.
4	Standards for Deaneries: 1.3, 5.1	**Formalise relationships with HEE and deaneries in devolved administrations** DPMD should investigate options to further formalise relationships with HEE and deaneries in devolved administrations.
5	TTD: 7.3	**Identify the resources needed to support and improve business continuity, sustainability, resilience and capacity within DPMD** DPMD should identify the resources it needs to support and improve business continuity, sustainability, resilience and capacity.
6	TTD 2.2	**Ensure all trainees have fair access to high quality clinical placements in a range of learning environments**

		DPMD should work with partner LETBs to ensure all trainees have fair access to high quality clinical placements in a range of learning environments.
7	TTD 6.30, 6.32, 6.34, 6.39	**Ensure training on the RCGP curriculum is provided to secondary care supervisors in partner LEPs** DPMD should work with partner LETBs, deaneries and LEPs to ensure training on the RCGP curriculum is provided to secondary care supervisors delivering training in secondary care settings.
8	TTD 6.34, 8.3	**Work with HMS Drake to ensure adequate staffing for training** DPMD should work with DPHC and HMS Drake to ensure adequate staffing to improve business continuity, sustainability, resilience and capacity for training.

Recommendation 1: Develop a framework, policy and register for training and accreditation of trainers and supervisors

We identified that DPMD's recognition and approval of trainers would benefit from a formalised framework and policy to ensure full compliance with trainer accreditation requirements. DPMD should develop an organisational policy and supporting register to record the training and approval of all trainers and supervisors of directly managed training programmes.

During our visits to NHS LEPs, clinical supervisors, senior trust staff and representatives from host LETBs highlighted comprehensive policies and processes for the training, recognition and approval of trainers of indirectly managed programmes. Across sites this included:

- formal courses for trainers
- portfolio evidence requirements
- effective tools for ensuring compliance and recording accreditation.

All of the host LETBs we visited were compliant with the GMC's Register of Trainers by the July 2015 deadline. DPMD does not keep records for the accreditation of trainers in these specialties. They rely on host LETBs and deaneries to administer and ensure trainers have completed training and are compliant with accreditation requirements. The host LETBs we visited share trainer accreditation information with DPMD, but this provision is not explicitly referred to in the MOU.

DPMD sets standards for approval of supervisors in General Practice, Occupational Medicine and Public Health Medicine. Supervisors of directly managed programmes have access to DPMD's internal *Train the trainer* courses, and local training opportunities within host LETBs and Royal College or Faculty regional groups. The Primary Care Dean is responsible for ensuring that trainers in these programmes are appropriately accredited and for monitoring completion of required training.

The defence General Practice and Public Health Medicine supervisors we met at different sites were all approved and accredited trainers. They described processes for the training and accreditation of supervisors. We were told that the small number of Occupational Medicine physicians in the three Services means there is an implicit expectation that they will become supervisors, rather than a formal selection for the role. They also reported a lack of clarity about the training they were expected to complete. The trainers we met in directly managed programmes also felt that standards and guidance for trainers and supervisors are communicated via respective Royal Colleges and Faculties rather than directly from DPMD.

Recommendation 2: **Conduct more detailed analysis of quality data**

DPMD has access to a wide range of quality data from multiple sources – both internal and external. However, we found that DPMD should conduct more detailed analysis of available quality management data. We recognise the challenge of limited resources and staffing to make immediate changes in this area but the recruitment of a dedicated Quality Assurance Manager to build capacity within DMS is a positive step.

We encourage DPMD to make better use of internal data and utilise external sources such as LETB visit reports and GMC NTS data to ensure more effective and systematic quality management.

DPMD's devolved training model means that responsibility for quality management of indirectly managed training programmes is delegated to host LETBs. MOUs with host LETBs and deaneries ensure that quality data and reports are shared with DPMD when there are issues directly affecting defence doctors in training. However, these remote arrangements mean that DPMD may not have a full picture of all quality issues affecting defence trainees in a particular LETB, deanery or LEP. Senior DPMD staff acknowledged that they have greater influence over directly managed programmes as DPMD assures all directly managed clinical placements.

DPMD conducts annual quality management visits to clinical placements in MDHUs. Survey data, NTS data and trainee feedback are used to identify areas for investigation and improvement. The Deputy Dean, Primary Care Dean and their respective teams meet with MDHU commanding officers, supervisors and defence doctors in training to triangulate local issues affecting education and training.

DPMD presents visit reports to highlight key findings which are shared with LETBs, deaneries, LEPs and the DMS Inspector General. We found that these reports and action plans could be more robust in their presentation and monitoring of requirements and recommendations for improvement. The DMS Quality Assurance Manager explained that visit reports have been reviewed with an aim to improve this. They also reported plans to pilot a new internal survey to obtain much more detailed quality data and to improve control over the type and frequency of data received.

DPMD is reviewing the focus of annual MOU meetings to provide more opportunities to discuss and address quality issues where they are identified.

Recommendation 3: Formalise information sharing agreements and processes with partner LETBs, deaneries and LEPs

At site visits we found effective working relationships between senior DPMD staff and their counterparts in partner LETB and LEPs. Staff at all the sites we visited reported direct access to the Deputy Dean, Primary Care Dean and Foundation Programme Manager, who are seen as responsive and supportive. In particular, the Deputy Dean's attendance at ARCP panels for defence doctors in training was seen as very valuable and we commend this considerable undertaking. However, we found that information sharing between DPMD and partner LETBs, deaneries and LEPs could be improved, particularly around the communication of placements information and trainee progress and performance.

We recommend that DPMD develops more formalised information sharing agreements and processes with partner LETBs, deaneries and LEPs to ensure trainee and placement information is shared in a more proactive and timely way.

Some of the defence doctors in training we met highlighted that their frequent relocation between LEPs in different LETBs and deaneries means that information sharing between providers can be inconsistent and unreliable. They recognised that communication between DPMD and partner providers has improved, but suggested more systematic information transfer to better support their training. Examples included:

- late notification of placement allocations
- training requirements not always communicated to LEPs
- ARCP outcomes not always reported back to DPMD.

DPMD's devolved training model means that they use MOUs with partner LETBs and LEPs to agree and codify each organisation's expectations and responsibilities. These are reviewed at annual meetings. All the LETBs we met confirmed that the annual MOU review meeting is an important part of maintaining links with DPMD. However, they proposed that it would be helpful to have more frequent reviews and direct

contact with DPMD to share information on a more regular basis while issues are still 'live'.

LETB and LEP staff explained the systems in place for communicating defence doctor in training information, including MOU stipulations regarding information sharing. Some staff at the military sites we visited were not aware of formal processes for information sharing. They felt that:

- the information was more often received informally via unofficial channels;
- they would like more formalised mechanisms to improve the flow, consistency and timeliness of information sharing.

They acknowledged the challenges for DPMD to improve the system when managing training remotely with limited staffing and resources across most parts of the UK.

Education management staff at the LEPs we visited reported that communications from DPMD are generally adequate and timely, with good information transfer. They do not receive detailed information about defence doctors in training unless they have specific training or support needs. Across sites we found that doctor in training information tended to be shared only when issues arise, but many training staff did not know how to escalate issues to DPMD.

Staff at all the LEPs and LETBs we visited said that the high calibre of defence trainees means there are very few occasions when they need to contact DPMD about a particular individual. When issues have arisen, DPMD dealt with this effectively and gave good support to the defence doctors in training.

Senior DPMD staff recognised that the effective transfer of information is somewhat challenging because of the unique, sometimes remote nature of military training. There was acknowledgement that formalising communication channels would be beneficial. To this effect, the Deputy Dean has conducted a programme of MOU visits to formalise and standardise information sharing. There are also plans to conduct quality management and MOUs visits simultaneously. This will give more opportunities to meet with LETB, deaneries and LEP staff, improve information sharing and work together more closely.

Recommendation 4: **Formalise relationships with HEE and deaneries in devolved administrations**

DPMD should investigate options for formalising and codifying its relationship with Health Education England (HEE) and deaneries in devolved administrations to complement and enhance its existing MOUs with individual LETBs and deaneries.

Throughout this review we identified positive working relationships between DPMD and external bodies such as Conference of Postgraduate Medical Education Deans

(COPMeD), Committee of General Practice Education Directors (COGPED) and LETBs and deaneries.

The DPMD Postgraduate Dean highlighted that other postgraduate deans are very supportive of DPMD. However, because DPMD sits outside HEE governance structures, it is not part of HEE's formalised processes for information sharing and decision making.

The DPMD Postgraduate Dean explained that while DPMD has limited formal direct interaction with HEE, they are increasingly affected by HEE policies and processes, for example HEE's initiative to broaden the foundation programme, which will increase the number of GP and psychiatry training places, whilst reducing surgical places on a national (England) level. Such interventions have an impact on DPMD's ability to place defence GP doctors in training in a finite supply of suitable NHS practices. They recognised the need to look into formalising a relationship between the two organisations. This would ensure that DPMD is involved in decisions where the implementation directly impacts on defence doctors in training.

Senior DPMD staff also recognised the need to maintain good relationships at different levels across organisations. This is in response to changes to the governance and delivery of postgraduate medical education and training in the UK at a national level. This includes DPMD presence in the Royal Colleges, ie on Specialty Advisory Committees and exam boards, to shape and influence decisions, despite being outside HEE, NES and Wales Deanery governance structures.

We commend DPMD's instrumental role in raising the profile of veterans' health at a national level. The Primary Care Dean stated a future aim to incorporate veterans' health into the curricula for general practice and psychiatry curricula and is working with the relevant Royal Colleges to this end. This links to HEE's mandate for 2014-15, which includes explicit recognition of the need for high quality care for the 4 million veterans in the UK.

Recommendation 5: **Identify the resources needed to support and improve business continuity, sustainability, resilience and capacity within DPMD**

Throughout this review we identified limited resources and gaps in staffing which could impact on DPMD's effective delivery of training and quality management.

We found that DPMD operates with a small number of permanent staff. The Deputy Dean and Primary Care Dean manage the delivery of directly and indirectly managed training programmes with small teams. They felt this impacted on their ability to develop their work programmes beyond maintaining service delivery. They also reported a reliance on temporary staff and highlighted the challenge of recruiting staff to work at DMPD.

Staffing was also reported as a core concern for ensuring effective systematic quality management. We found that with limited resources, a significant time commitment is needed from the Deputy Dean and Primary Care Dean to deliver all aspects of quality management, including an extensive programme of quality visits across the UK and at sites abroad. The multi-professional focus of the newly appointed DMS Quality Assurance Manager also means that the capacity for developing and delivering robust quality systems remains somewhat limited.

The Postgraduate Dean reported that DPMD is facing a potential funding reduction of 20% in line with wider cuts to many other military organisations. DPMD is required to bid for resources each financial year and there is recognition of future resource constraints to deliver postgraduate medical education and training. We were told that with the UK military returning to contingency, resources and headcount are being reduced accordingly by 2020.

We also found that the rotation of military staff on a three yearly basis had an impact on the sustainability and continuity of DPMD's strategy and delivery. The Postgraduate Dean highlighted the benefits of the system as a means of facilitating fresh ideas. They suggested good reasoning for extending the period of senior staff rotations. This would improve continuity and provide more time for staff to become established and see through longer term projects, improvements and developments.

Senior staff in some of the LEPs we visited cited limited corporate memory within DPMD as a potential issue, caused by the change in senior staff every three years. They also reported that frequently changing administrative staff can make it difficult to build relationships. We did not find evidence that this had caused any problems in the delivery of education and training for defence doctors in training. The Postgraduate Deans from three host LETBs we visited each reported good working relations with successive Postgraduate Deans at DPMD.

Across all sites visited, the defence doctors in training we met highlighted the challenges and uncertainties of major changes to the military and NHS and the subsequent impact on their training. All the defence doctors in training we met reported:

- good access to the Deputy Dean and Primary Care Dean respectively, but
- a current state of transition within DPMD, and the military in general.

They told us about recruitment issues and high turnover of staff within DPMD's administrative support. This was having an impact on the transfer of information between DPMD and host LETBs, eg information about allocation of placements and ARCP outcomes. They felt that corporate memory of DPMD is very dependent on senior staff and therefore very fragile, but that business continuity is compounded by changing civilian staff in administrative teams.

We recognise that staff at DPMD are working in challenging financial circumstances, during a time of significant change to the composition of military organisations. We acknowledge the additional burden that these pressures add to the normal day to day management of DPMD's training programmes. Additional staff and resources may be needed to improve business continuity and resilience.

Recommendation 6: Ensure all trainees have fair access to high quality clinical placements in a range of learning environments

DPMD should work with partner LETBs to ensure all defence doctors in training have fair access to NHS clinical placements in a range of high quality learning environments.

DPMD delegates responsibility for the allocation of NHS clinical placements to host LETBs and deaneries. Throughout our site visits we encountered a variety of perceptions about the fairness of this system. Amongst the defence doctors in training and staff we met, there was a common view that the allocation of NHS placements could be fairer.

Defence doctors in training on indirectly managed programmes considered that they are generally allocated their first choice of placements. These are often the most coveted and in demand amongst defence and civilian doctors in training.

In contrast, defence trainees on directly managed programmes, particularly in general practice, thought that they didn't have access to the same quality placements as civilian doctors in training. They suggested that civilian doctors in training are allocated the best placements first, with the remaining available sites then allocated to defence doctors in training.

The Primary Care Dean highlighted that all defence GP doctors in training experience placements in approved NHS GP training practices for a minimum of six months. DPMD works with host LETBs to allocate placements with suitable NHS placement providers. Senior DPMD staff said that they have a preference list for clinical placements, particularly those in MDHUs, which are highly valued by defence doctors in training. The Deputy Dean and Primary Care Dean recognised that some defence doctors in training may feel disadvantaged by the host LETB allocation process. However, they reported no concerns with the quality of placement providers allocated by host LETBs and deaneries. They explained that if the quality of placements was not adequate, DPMD would stop sending trainees to that LEP.

Defence doctors in training felt that their allocation of placements after civilian doctors in training results in placements allocated with limited notice periods, often on a placement by placement basis rather than one year in advance. We found instances of two week and one year notice periods in advance of the next placement

being given. Defence doctors in training said that this can create problems for them, particularly for those with families or caring commitments.

Defence GP doctors in training felt that some trusts, particularly those with long-standing arrangements with DPMD, are reluctant to release trainees for local and regional training days. This is because they know that defence doctors in training have additional mandatory residential GP training.

The trainees also felt that trusts with established defence doctors in training are stricter about releasing trainees for local teaching. They said that they miss out on valuable learning opportunities because of this. The GP Dean and GP DCAs from the three Services stated that doctors in training have reported this matter at DPMD's General Practice Education Committee.

Some defence GP doctors in training also highlighted the risk of being isolated from some support networks when on NHS GP placements. This is because of their wide geographical spread and separation from the centre. Here we acknowledge DPMD's extensive pastoral support provision.

Recommendation 7: Ensure training on the RCGP curriculum is provided to secondary care supervisors in partner LEPs

During site visits to DPMD's partner NHS Trust LEPs, we found that that some supervisors of GP doctors in training in hospital placements, particularly in surgical specialties, would benefit from additional training on the RCGP curriculum. This is needed to ensure that all GP doctors in training have access to appropriate teaching, case exposure and assessments during hospital placements.

We met with supervisors, trainers and LETB representatives at each of the site visits to NHS Trusts. Across all sites we found that non-GP trainers are only required to have a good overview rather than a detailed understanding of learning outcomes in the GP curriculum. The defence GP doctors in training we met felt that this resulted in some placements not covering the full breadth of exposure and experience required of the RCGP curriculum.

Quality management staff from the three partner LETBs we visited explained that all specialty supervisors are expected to complete *Train the Trainer* courses and workshops, as well as training on the RCGP curriculum. This is to ensure adequate understanding and awareness of the programme. The defence doctors in training we met also explained that they are encouraged to tell consultants what they need to learn to meet curriculum outcomes. This only happens when they identify gaps in their own learning during placements.

DPMD should work with its partner LETBs, deaneries and LEPs to ensure that appropriate training in the RCGP curriculum is provided to secondary care

supervisors. This will help to ensure that hospital rotations provide suitable learning and assessment opportunities for all defence GP doctors in training.

Recommendation 8: Work with HMS Drake to ensure adequate staffing for training

We found a good overall training environment at HMS Drake. Defence doctors in training across General Practice and Occupational Medicine reported supportive training staff and good access to learning resources and facilities. Defence doctor in training exposure to multi- and inter-disciplinary and military specific training experiences was also viewed positively. However, HMS Drake has identified succession planning and current reliance on a limited contingent of staff as a potential risk to the sustainability of education and training delivery. We recommend that DPMD works with HMS Drake and Defence Primary Health Care (DPHC) to ensure there are appropriate numbers of trainers to maintain training in the long term.

Senior staff at HMS Drake recognised the potential of the site to expand capacity for more GP defence doctors in training given their resources and facilities, but the site is limited by number of available trainers and supervisors. At the time of our visit there were two full-time trainers based at the site, plus the primary GP Educational Supervisor for the South West region and three civilian GPs. We found a heavy reliance on the existing GP trainers, who provide clinical and educational supervision for multiple defence doctors in training. Additionally, the staff we met highlighted the challenges of retaining military and civilian clinicians and trainers due to uncertainties about future funding for staffing.

The Principal Medical Officer of HMS Drake has highlighted succession planning with DPHC and DPMD, as a risk to sustaining the number of trainers and the ability to deliver high quality education and training at the site.

Senior staff at HMS Drake and DPMD also recognised that the limited training capacity of the site is complicated further by the decommissioned post of Advisor in General Practice (AGP) for the Royal Navy (the chief GP in the service). The AGP performed a similar function to that of a Training Programme Director. The impact of this removed post means that the Royal Navy's GP training is instead managed directly by the GP Dean.

We recognise that the leadership provided by the GP Dean and the efforts of staff at HMS Drake is sustaining GP training for the Royal Navy. However, given the AGP's crucial role in supporting trainees and recruiting and developing trainers, a confirmed appointment to the Royal Navy Advisor in General Practice post would help to alleviate pressure in the system and provide greater stability for training at HMS Drake and other Royal Navy sites.

Acknowledgement

We would like to thank DPMD and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.

Appendix 1: Sources of evidence

Visit team

Team leader	Dr Steve Ball
Visitor	Ms Katie Carter
Visitor	Professor Lindsey Davies
Visitor	Dr Carolyn Evans
Visitor	Dr Jamie Read
Visitor	Professor Helen Sweetland
GMC staff	Manjula Das: Education Quality Assurance Programme Manager Joe Griffiths: Education Quality Analyst Charlotte Rogers: Education Quality Analyst Tasnim Uddin: Education Quality Analyst

Visit action plan

The document register (in appendix 2) gives more detail on the data and documentation we reviewed.

Paragraph in *The Doctor in training Doctor*	Areas explored during the visit	Documents reviewed	People interviewed	Our findings
Domain 1: Patient safety				
1.1	Patient safety policies and procedures: Child protection and safeguarding training Whistle blowing and raising concerns Incident reporting	DPMD Doc 010 DPMD Doc 008 DPMD Doc 004 DPMD Doc 035 DPMD doc 002 DPMD doc 023 Combined QA of Foundation & Specialty/GP	Deputy Dean and GP Dean at DPMD GP Trainers and doctors in training at LEPs Clinical and Educational Supervisors FY, Specialty and GP doctors in training LEP senior management teams Host LETB Quality Teams	Standard met
1.2 1.3 1.10 1.11	Accessibility and continuity of appropriately trained clinical and educational supervisors	DPMD Doc 008	Foundation and Specialty Doctors in training GP doctors in training Medical Education Directors at LEPs Education and Clinical Supervisors at LEPs DPMD specialty leads Host LETB Quality Team DPMD senior team	Standard 1.3 not met: See Requirement 5 See Recommendation 1
1.4	Taking consent: policies and quality management	DPMD Doc 004 DPMD Doc 035	Deputy Dean at DPMD Medical Education Directors at LEPs	Standard not met:

			Foundation and Specialty doctors in training at LEPs Clinical supervisors at LEPs	See Requirement 4
1.5	Doctor in training rotas and working patterns	DPMD Doc 008 DPMD Doc 002	Foundation and Specialty Doctors in training Medical Education Directors at LEPs Manager of Medical Education at LEPs Host LETB Quality Team DPMD Dean and Deputy Dean	Standard met
1.6	Handover arrangements at LEPs	DPMD Doc 008 Combined QA of Foundation/Specialty/ GP	Foundation, Specialty and GP doctors in training Medical Education Directors at LEPs Clinical Supervisors at LEPs Deputy Dean and GP Dean at DPMD Host LETB Quality Team	Standard not met: See Requirement 3
1.7 1.8	Doctors in Difficulty (DiD)	DPMD Doc 001 DiD policy (MTPB terms of reference) Doc 052 - Managing Doctors in training Performance Board DPMD Doc 053 DPMD Doc 066 DPMD Doc 004	Foundation and Specialty Doctors in training GP doctors in training Medical Education Directors at LEPs Education and Clinical Supervisors at LEPs DPMD Specialty leads and training directors Host LETB Quality Team	Standard met

			DPMD Dean and Deputy Dean	
1.9	Transfer of information between LEPs, LETBs and DPMD	DPMD Doc 001 DPMD Doc 004 DPMD Doc 035 DPMD Doc 052 DPMD Doc 053 DPMD Doc 064 Links to recruitment and selection 2010 report requirement re doctor in training sign off DPMD Doc 005 Business plan	Foundation and Specialty Doctors in training GP doctors in training Medical Education Directors at LEPs Education and Clinical Supervisors at LEPs DPMD Specialty leads and training directors Host LETB Quality Team and TPDs DPMD Dean and Deputy Dean	Standard met: See Recommendation 3
Domain 2: Quality management, review and evaluation				
2.2	Quality assurance of clinical placements	DPMD Doc 017	DPMD senior management team Host LETB Quality Teams LEP Medical Education Directors and Medical Education Managers DPMD Primary Care Dean DCAs Public Health and OM doctors in training DMS Governance and	Standard met: See Good Practice 1, 2, 3 See Recommendation 2 See Recommendation 4 See Recommendation 7
	Quality management contracts and reporting with LETBs and LEPs: Memoranda Of Understanding (MOU)	DPMD Doc 002		
	QM of indirectly managed training programmes	DPMD Doc 004		
	QM of small specialty training	DPMD Doc 028 DPMD Doc 032 DPMD Doc 034		

		Training quality manual	Assurance Leads	
	Annual governance reporting	DPMD Doc 001 DPMD Doc 018		
	Collection and use of data from LEP visits	DPMD Doc 070 Tynedale questionnaire		
	QM of RCGP curriculum delivery	DPMD Doc 023 Quality report on GP training		
	Doctor in training involvement in QM	DPMD Doc 31	GP trainers at LEPs GP doctors in training LEP senior management teams Doctors in training on indirectly managed programmes.	
2.3	Lay representation and involvement in QM	DPMD Doc 004	Lay representatives DPMD senior management team	Standard not met: See Requirement 2
Domain 3: Equality, diversity and opportunity – Training must be fair and based on principles of equality				
3.1 3.2	E&D policies and practices	DPMD Doc 13 - response to report Contextual document Individual directly managed specialties training plans (026, 028 and 029) DHET Doctor in training Companion Document (050) PH consultant report HMS Drake Doc 002 QEHB Doc 007	DPMD senior management team DPMD governance and assurance lead All doctors in training LEP medical resourcing and HR Representatives LEP education management teams DPMD senior management team LEP staff responsible for	Standard met

		Derriford Doc 002 DMRC Doc 005	doctor in training support Supervisors at LEPs	
3.3	Reasonable adjustments	DPMD Doc 35	DPMD governance and assurance lead	Standard met
3.4	LTFT policies and processes	DPMD Doc 008 DPMD Doc 010		Standard met
3.5 3.6	E&D data	DPMD Doc 023 DPMD Doc 61 – overarching MOD E&D		Standard met
Domain 4: Recruitment, selection and appointment				
4.2	Fairness and transparency of recruitment	DPMD Doc 035	DPMD senior management team DCAs All doctors in training	Standard met
4.3	Selection processes		DPMD senior management team All doctors in training	Standard met
4.4	Lay involvement in recruitment		DPMD senior management team Lay representatives	Standard not met: See Requirement 2
4.5	Careers advice		DPMD senior management team All doctors in training	Standard met
Domain 5: Delivery of approved curriculum including assessment				
5.1 5.2	Clinical placements: practical experience to meet requirements of curriculum	DPMD Doc 004	All doctors in training DPMD senior management team Host LETB Quality Teams	Standard met

5.4	Access to education and training opportunities		All doctors in training DPMD senior management team	Standard met
5.8 5.16	Delivery and assurance of assessments and workplace based assessments	DPMD Doc 008	All doctors in training LEP supervisors and assessors DPMD senior management team	Standard met
5.12 5.17	Sign off and approval of competency	DPMD Doc 4	Dean of DPMD Deputy Dean of DPMD All doctors in training	Standard met
5.18	Feedback to doctors in training on performance and progress	GMC evidence report	All doctors in training Supervisors at LEPs DPMD Specialty leads	Standard met
5.20	Assessments: delivery of ARCPs	DPMD Doc 004 DPMD Doc 023	All doctors in training Supervisors and assessors at LEPs DPMD Specialty leads Host LETB quality team and TPDs	Standard met
Domain 6: Support and development of doctors in training, trainers and local faculty				
6.1	Induction	DPMD Doc 001 DPMD Doc 002 DPMD Doc 004 DPMD Doc 023	All doctors in training LEP senior management teams DPMD senior management team Host LETB Quality teams	Standard met
6.7	Opportunities for doctor in training evaluation and involvement in QM		All doctors in training LEP senior management teams DPMD senior management team	Standard met: See Good Practice 1

			Host LETB Quality teams and TPDs	
6.8	Transfer of information		All doctors in training LEP senior management teams DPMD senior management team Host LETB Quality teams	Standard met: See Recommendation 3
6.10	Doctor in training rotas and working hours		All doctors in training LEP education management teams DPMD senior management team Host LETB quality teams	Standard met
6.15 6.21	Doctor in training support and occupational health	DPMD Doc 50	All doctors in training LEP education management teams DPMD senior management team Royal Centre for Defence Medicine representatives	Standard met
6.17	Opportunities to learn from other healthcare professionals		All doctors in training LEP education management teams DPMD senior management team DCAs LEP TPDs	Standard met: See Good Practice 2
6.19	Counselling and support services		LEP education management teams DPMD senior management team	Standard met: See Good Practice 1

			All doctors in training	
6.23 6.24 6.25	Study leave		All doctors in training LEP education management teams DPMD senior management team	Standard met
6.33	Sharing good practice		DCAs	Standard met: See Good Practice 3
6.34 6.35	Support and development of trainers	DPMD Doc 20	LEP supervisors LEP senior management teams Host LETB quality teams	Standard met: See Recommendation 1, 7 and 8
6.39	Trainer awareness of curriculum and assessments		LEP supervisors LEP senior management teams Host LETB quality teams All doctors in training DPMD senior management team	Standard met: See Recommendation 7
Domain 7: Management of education and training				
	Allocation of educational supervisors		All doctors in training LEP supervisors LEP senior management teams Host LETB Quality Teams DPMD senior management team	Standard met
7.1	Management plans	DPMD Doc 004 DPMD Doc 008	DPMD senior management team Host LETB Quality teams LEP senior management	Standard met

			teams	
7.3	Corporate memory and business continuity planning	Combined QA of Foundation & Specialty / GP DPMD Doc 008	DPMD senior management team	Standard met: See Recommendation 5 and 8
	NTS outliers	GMC evidence report	DPMD senior management team Host LETB quality teams	Standard met
Domain 8: Education resources and capacity				
8.2	Education and IT resources: Access to e-Portfolio	DPMD Doc 005 Business Plan pg 16 DPMD Doc 004	All doctors in training Medical Education Directors at LEPs Education and Clinical Supervisors at LEPs DPMD specialty leads Host LETB Quality Teams DPMD senior management team Host LETB TPDs	Standard not met: See Requirement 1
8.3	Educational capacity: adequate staffing to deliver programmes	DPMD Doc 001 DPMD Doc 036	DPMD senior management team	Standard not met: See Recommendation 8
8.4	Support for trainers: job plans		Foundation and Specialty Doctors in training GP doctors in training Medical Education Directors at LEPs Education and Clinical Supervisors at LEPs	Standard met
8.5	Library resources		DMS library staff DPMD senior management team	Standard met: See Good Practice 4

			All doctors in training DCAs	
Domain 9: Outcomes				
9.1	Collection and use of progression data		FY, Specialty and GP doctors in training DPMD Deputy Dean and Primary Care Dean DMS QA lead	Standard met: See Recommendation 2

Appendix 2: Document Register

Defence Postgraduate Medical Deanery

Document number	Document name	Description	Publication date and version	Source
Doc 001	DHET Quality manual management final doc	Overarching quality management document. Explaining strategic intent	Mar 2014 V1	DHET
002	DHET Assurance and governance of education and training	Key strategic document explains performance indicators, risks, sentinel events, inspections, visit, audits, Quality improvement projects processes	Mar 2014 v1	DHET
003	DHET management of training manual	Key strategic document explaining assurance processes of training and education. Includes first , second party audits , military process includes as annex GP plan, SHC plan, PH plan, Occ Med plan nurse plan etc.	Mar 2014 v1	DHET
004	Defence Deanery contextual document	Contextual document report for GMC	Mar 2014	DHET
005	DHET Strategic business plan	Key strategic document explains strategic objectives, communications plan, battle rhythm, Human resource management, policies, organograms, mission statements	Mar 14 V1 to replace previous version	DHET website

006	CRB / DBS register	CRB /DBS spreadsheet and DHET policy	Mar 14	DHET Website
007	Assurance organogram	Organogram of assurance	Mar 14	DHET
008	DHET audit tool	Report on first party internal audit	Feb 14	DHET
009	AUDIT spreadsheet	Results of 1ST Party Audit	Feb 14	DHET
010	GP audit results	Results of 1ST Party Audit	Feb 14	DHET
011	SHC Audit results	Results of 1ST Party Audit	Feb 14	DHET
012	Occ Med Audit results	Results of 1ST Party Audit	Feb 14	DHET
013	DHET Quality Improvement Projects	Current DHET QIPS	Live doc	DHET
014	DHET Risk Register	Current risk register	Live doc	DHET
015	Defence medical services strategic risk management policy	Procedures on how to manage risk	Dec 2013	DHET
016	DMSTG Ofsted and welfare inspection	OFSTED report on DCHET	Oct 13	DHET
017	The assurance of clinical placement for military doctors in training	Brief and procedures	Aug 13	DHET
018	Annual Governance report	Yearly report to surgeon General	Aug 13	DHET
019	Defence Deanery quality report	Report from GMC	Nov 13	DHET
020	Delivery quality public health training	Quality report on public health	Mar 14	DHET
021	Quality report DMS OM Training	Quality report on Occupational medicine training	Mar 14	DHET
022	DPMD Draft 2 responses to GMC report	Response to GMC report	Mar 14	DHET
023	Quality report GP training	Quality report on GP training	Mar 14	DHET
024	DHET Visit programme	List of visits	Live doc	DHET

025	DPMD combined visit report	Visit report on assurance of spec training	2011	DHET
026	Gp training manual education and training plan	GP doctor in training processes	Mar 14	DHET
027	DHET quality manual nursing	Nurse training processes	Mar 14	DHET
028	Occupational Medicine training plan	Occupational Medicine training processes	Mar 14	DHET
029	SHC quality training plan	SHC training processes	Mar 14	DHET
030	Public Health Training	Frequently asked training questions about public health	Mar 14	DHET
031	Quality report DMS OM training	Quality report on Occ med training	Mar 2014	DHET
032	Quality report- delivering quality public health training	Report on Public health training	Mar 2014	DHET
033	DMS public health DCA report	Report on Public health Defence Consultant advisor	Mar 14	DHET
034	Quality report GP training in DMS	GP Training report	Mar 14	DHET
035	Defence Deanery Foundation Training report	Foundation quality management report	Apr 14	DHET
036	Management of sentinel events	Policy on SE reporting	Apr 14	DHET
037	DHET org chart	Organisational chart of DHET departments	Mar 14	DHET website
038	DMRC Org chart	Organisational chart Of Defence Rehabilitation Centre	Mar 14	DHET
039	JMC Org Chart	Organisational chart of Joint Medical Command	Mar 14	DHET
040	DMSTG Wiring Diagram	Organisational chart of Defence Medical Surgical Training Group now DCHET.	Mar 14	DHET
041	Assurance org chart	Organisational chart of assurance within DHET.	Mar 14	DHET

042	ACE org chart	Organisational chart of analyses, commissioning and evaluation department.	Nov 13	DHET
043	MDHU Derriford HQ	Organisational chart of MDHU Derriford's Headquarters	Mar 14	DHET
044	RCDM Org chart	Organisational chart of Royal Centre Defence Medicine.	Mar 14	DHET
045	Public health Training org Chart	Public health Organisation chart DHET	Mar 14	DHET Website
046	General Practice Department Org Chart	General Practice Department DHET Organisation chart	Mar 14	DHET Website
047	Occ Med Department	Occupational Medicine Training Department Organisation DHET	Mar 14	DHET Website
048	SHC Org	Secondary Healthcare Department Organisation DHET	Mar 14	DHET Website
049	DHET Communication strategy	Internal DHET communication strategy	Mar 14	DHET
050	DHET Doctor in training Companion document	Doctor in training companion document for students inducting to DHET	Mar 14	DHET
051	DHET Command Board TORs	Command Board Policy	Mar 14	DHET
052	TORS MTPB DHET	Managing Doctors in training Performance Board	Mar 14	DHET
053	Spec Training Generic MOU	DHET Generic Memorandum of understanding	Mar 14	DHET
054	MOU Health Education East Midlands	Example of DHET MOU with other LETB	Mar 14	DHET
055	AVB- JSP 950 – Employment outside of official duties for medical staff.	Policy document on part time working for medical staff	Nov 11	DMS

056	AVB- JSP 950 Participation in PHC out of hours cooperatives.	PHC staff working out of hours policy	Nov 13	DMS
057	JSP 757 Appraisal reporting	Annual reporting	Sept 13	DMS
058	DIN Lesbian, Gay Transgender	Defence Internal instruction/policy on Lesbian, Gay and Transgender.	Jan 13	MOD intranet
059	Services Complaints Process	MOD services complaints policy	Jan 13	MOD intranet
060	DIN SIKH Support networks	Sikh support Defence Policy.	Jan 13	MOD intranet
061	Equality and diversity whitley council	Meeting and guidance on Equality and Diversity	Jan 13	MOD intranet
062	DIN Bullying and Harassment	Defences internal Instruction on Bullying and Harassment	Jan 13	MOD intranet
063	DHET CRB/DBS Policy	DHET Criminal Records Bureau/ Disclosure and Barring Service Policy.	Feb 14	DHET
064	DHET Safeguarding Children's policy	DHET internal safeguarding policy	Mar 14	DHET website
065	Quality and diversity DHET policy	DHET internal policy on equality and Diversity	Mar 14	DHET website
066	Managing performance concerns for doctors and dentists	Managing performance concerns for doctors and dentists	Jan 14	DHET website
067	Mod Equality and Diversity Strategy	Mod Equality and Diversity Strategy	Mar 14	MOD intranet
068	JSP 763	The MOD bullying, harassment complaints procedure	Jul 13	MOD intranet
069	JSP 893	Policy on safeguarding vulnerable groups. Joint Service Publication.	Aug 12	MOD intranet

070	QA visit to MDHUD	Visit report to MDHU Derriford	Feb 14	SHC
071	Exceptional review of foundation university hospital Birmingham	Exceptional review of foundation university hospital Birmingham	Feb 14	SHC

Queen Elizabeth Hospital Birmingham

Document number	Document name	Description	Publication date and version	Source
Doc 001	Education and Training Organisational Chart 2013 -14	Management structure up to Executive Director level across all education and training functions in the Trust, medical, nursing and corporate.	2013 – new document	Trust internal document
002	Education Committee Structure March 2014	Structure of specific medical education committees that feed into main Education Strategy Group which considers education and training across the Trust.	Mar 2014 Previous version 2013	Trust internal document
003	Revised Draft TOR Education Management Group March 2014	Revised TOR for this group to reflect change in membership; change in meeting schedule and move from operational to more strategic focus.	Mar 2014 Previous version 2009	Trust internal document
004	UHB 2013-14 Annual Plan Core Purpose Workforce	Key objectives in relation to workforce which includes education and training.	Apr 2013	Trust document

005	MOU Draft Template April 2011	Template of the agreement between DPMD and the Birmingham Foundation School detailing DPMD requirements for the training of military Foundation doctors in training	Apr 2011	Trust document
006	UHB Education KPIs 2013-2014	Key performance indicators across the Education and Training Directorate set against risks	Apr 2013	Trust internal document
007	UHB Equality and Diversity in Employment Policy	Trust's principles of equality and diversity to promote equality for all staff and remove any unlawful discrimination.	Feb 2014	Trust Controlled Document
008	Equality and Diversity Objectives 2014-15	Annual Equality and Diversity objectives for the Trust	Mar 2014	Trust Document
009	E-mail to doctors in training about doctor in training questionnaire	Initial e-mail to doctors in training to introduce the purposes and structure of the questionnaire	Jan 2014	
010	e-mail to supervisors about doctor in training questionnaire	To introduce purposes and structure of the questionnaire	Jan 2014	
011	UHB Incident Reporting Management Policy	Trust policy for reporting incidents, the responsibility of staff to report incidents and how the incidents reported are managed.	Sep 2013	Trust Controlled Document
012	UHB Incident Reporting Procedure	Detailed procedural document to support the above policy	May 2013	Trust Controlled Document

013	HEWM Professional Support page on their website			http://www.westmidlandsdeanery.nhs.uk/ProfessionalSupport.aspx
014	CEAG GMC Survey	Paper to Chief Executive' Advisory Group on process for the management of issues raised in the GMC doctor in training survey	Nov 2013	Trust Board Paper

Defence Medical Rehabilitation Centre

Document number	Document name	Description	Publication date and version	Source
001	Headley Court Contextual information	Contextual information	March 2014	DMRC Intranet
002a	DMRC Consultant Staff	Consultant cadre staff at DMRC	March 2013	DMRC Intranet
002b	Education Structure organogram	Education Structure organogram	March 2014	DMRC Intranet
003a	CPC Minutes 2013-2014	Minutes of the unit clinical policy committee meeting. Education and training is discussed here including recruitment of doctors in training and doctor in training numbers	Minutes are from the past 6 months of meeting	DMRC intranet
003b	20130320-PGTC_Minutes_Mar13-U.doc 20130918_PGTC_Minutes_Sep13-U.doc	Internal committee meeting minutes for post graduate training at DMRC	March 13 Sept 13	DMRC Intranet
003c	GPEC minutes	Minutes from March 26th GPEC meeting at	Not yet published	DPMD

004a	20130211-DMRC_CAF-U.doc	Common Assurance framework: governance framework for education / training	Updated weekly – rolling document	DMRC intranet
004b	Weekly divisional minutes Feb-March 2014	Minutes of weekly medical division meeting. The academic programme and any training issues that may arise are discussed with all consultants & doctors in training	Published weekly	DMRC intranet
005	210-DMRC E_D Policy Statement	Unit policy on Equality and Diversity	2013	DMRC Intranet
006	Managing doctor in training in Difficulty – TOR .pdf	DPMD policy document regarding managing doctor in training is difficulty		DPMD DMRC Intranet
007i	424d-March 2014 GMC inspection of Headley Court.doc	DPMD GPEC form 424d format – summary document of education structure at DMRC	March 2013 March 2011	DMRC Intranet
007ii) a	new dec-april 14 teaching programme(2).doc	Junior doctor teaching programme	Dec 2013	DMRC Intranet
007iii) a	new August 2013 SHO induction program .doc	Contents of induction programme 2013	April 2013	DMRC Intranet
007iii) b	April 2014 SHO induction program.doc	Contents of induction programme 2014	April 2014	DMRC Intranet
007iii) c	induction programme Contents .doc	Contents of induction pack	April 2013	DMRC Intranet
007iv) a	DMRC Junior Doctor Allocation Dec 2013.doc	Allocation of junior doctors to posts	Dec 13	DMRC Intranet
007v) a	ADMR Research Compendium - Jan 2014.doc	Summary of academic dept of medical rehabilitation	Jan 14	DMRC Intranet
007vi) a	PGMO2014 (final) timetable draft .doc	General duty medical officer course on MSK medicine	Feb 2014 annual course	Local file

007vi) b	GDMO day 1 feedback 2014 .doc	Course feedback document		Local file
007vi) c	GDMO day2 feedback 2014 .doc	Course feedback document		Local file
007vii) a	Copy of 20140110-Unit Audit Compendium.xls	Summary of unit audit processes and ongoing projects	Rolling document 2012	DMRC Intranet
007vii)b	Genital Injury paper May 14.pdf	Evidence of publication of SHO audit projects	May 2013	Injury
007viii)	Paper evidence of management of doctor in training in difficulty – personal files			Local File – DMICP electronic medical records
007ix) a	Junior doctor feedback 2013	Summary of feedback from doctors in training	April 2013	Local file
007ix) b	Junior doctor feedback 2014	Summary of feedback from doctors in training	March 2014	Local file
007x) a	CQC quote	Summary quote of findings from CQC visit of DMRC Headley Court	2012	CQC website

HMS Drake

Document number	Document name	Description	Publication date and version	Source
Doc 001	DHET GP Training Manual	DPMD policy and guidance on GP Training		DHET website
002	HMS Drake Equality and Diversity Policy	Current E&D policy at HMS Drake		MOD Intranet
003	GPEC Form 424a	GPEC report on most recent practice inspection at HMS Drake	Dec 13	MOD Intranet

004	GPEC Form 424c	GPEC report on most recent assessment of a trainer at HMS Drake	Jun 12	MOD Intranet
005	Organogram	Diagrammatic representation of HMS Drake's position within the training organisation and Defence Primary Health Care	Feb 14	MOD Intranet
006	Education Risk Register	Key areas of educational risk within HMS Drake	Feb 14	MOD Intranet
007	HMS Drake Contextual Information	Background information on HMS Drake	Mar 14	MOD Intranet

Frimley Park Hospital

Document number	Document name	Description	Publication date and version	Source
Doc 001	Frimley Park Hospital NHS Foundation Trust contextual information 2014	Background information on Frimley Park Hospital	Mar 14	Trust local file
002	Education Directorate organogram	Management organogram	Mar 14	Trust intranet
003	Equality and Diversity Policy	Current E&D policy at Frimley Park		Trust intranet
004	20130509-DPMD Visit to Foundation Doctors in training at MDHU FP Final-R	DPMD Report of QM Visit to MDHU Frimley Park – Foundation Session	Mar 14	DPMD
005	FPH Action Planning - Jan 2014 Endocrinology and Diabetes	Action Plan for LEP visit report on Endocrinology and Diabetes	Jan 14	HE KSS
006	FPH Action Planning - Radiology	Action Plan for LEP visit report on Radiology	Jan 14	HE KSS

007	FPH Action Planning - Jan 2014 – CMT OG	Action Plan for LEP visit report on Core Medical Training and Obstetrics & Gynaecology	Feb 14	HE KSS
008	FPH LAB minutes March2014	Local Academy Board Meeting minutes	Mar 14	Trust internal document
009	Harassment & Bullying policy	Harassment & Bullying policy and procedure at Frimley Park	Jul 12	Trust intranet
010	Schedule for LFG and LAB Meeting 2013-2014	Schedule for Local Faculty Group and Local Academic Board Meetings for 2013/14	Oct 13	Trust internal document
011	TiD for Local Academy Board March 2014	Doctor in training in Difficulty case summaries	Mar 14	Trust internal document
012	Whistle Blowing policy	Whistle Blowing policy at Frimley Park	Sep 11	Trust intranet

Derriford Hospital

Document number	Document name	Description	Publication date and version	Source
Doc 001	Dir Med Management	Roles and personnel in postgraduate medical education department	2003	Trust intranet
002	EqualityDiversity_and_Human_Rights_Policy1	Equality and Diversity policy	November 2012	Trust intranet
003	TID framework Dec 13	Management of concerns about doctors in training	December 2013	Trust intranet
004	TRW HUM POL 255 8 Maintaining High Professional Standards	Management of concerns about medical staff	November 2010 – version 8 Currently under revision	Trust intranet
005	Derriford Ministry of Defence Hospital Unit contextual information	Contextual information	March 2014	Trust intranet

Appendix 3: Abbreviations and Acronyms

ACCS	Acute care common stem
AGP	Advisor in General Practice
ARCP	Annual Review of Competence Progression
CCT	Certificate of Completion of Training
CO	Commanding Officer
COGPED	The Committee of General Practice Education Directors
COPMeD	The Conference of Postgraduate Medical Deans of the UK
DCA	Defence Consultant Advisor
DHET	Defence Health Education and Training
DiD	Doctors in Difficulty
DMRC	Defence Medical Rehabilitation Centre
DMS	Defence Medical Services
DPHC	Defence Primary Healthcare
DPMD	Defence Postgraduate Medical Deanery
E&D	Equality and diversity
F1	Foundation year 1
FTP	Fitness to Practise
GMC	General Medical Council
GP	General practice/practitioner
GPEC	General Practice Education Committee
HEE	Health Education England
HEWM	Health Education West Midlands
HEKSS	Health Education Kent, Surrey and Sussex
HESW	Health Education South West
HMNB	Her Majesty's Naval Base
IPL	Inter-professional learning

JEST	Job Evaluation Survey Tool (Health Education West Midlands)
LEP	Local education provider
LETB	Local education and training board
LTFT	Less than full time training
MDHU	Ministry of Defence Hospital Unit
MOD	Ministry of Defence
MOU	Memorandum of Understanding
NHS	National Health Service
NTS	National Doctor in training Survey
QEHB	Queen Elizabeth Hospital Birmingham
QIF	Quality Improvement Framework
RCDM	Royal Centre for Defence Medicine
RCGP	Royal College of General Practitioners
SLA	Service level agreement
SPA	Supporting professional activities
ST1-3	Specialty Training Years
STC	Specialty Training Committee
TAC	Doctor in training Advisory Committee
TOR	Terms of reference
T&O	Trauma and orthopaedic surgery

Colonel Scott Frazer MB ChB DA FCAI
Defence A/Dean

Headquarters Joint Medical Command

Defence Healthcare Education and training
Tamar House
DMS Whittington
Lichfield
Staffordshire
WS14 9PY
Military Network: 94422 4257
Telephone: 01543 434257
Email: SGJMCDHET-DeaneryDepDean-@mod.uk

Manjula Das
Education Quality Assurance Programme Manager
Visits and Monitoring Team
Education and Standards Directorate
General Medical Council
Regents Place
350 Euston Road
London
NW1 3JN

Reference: GMC Review 2014

Date: 29 Sep 14

Dear Manjula

REVIEW OF THE DEFENCE POSTGRADUATE MEDICAL DEANERY MAY - JUNE 2014

In replying to the GMC review of the Defence Deanery, we are grateful to the GMC team for their collegiate approach to this series of visits and especially their willingness to learn our structure and processes which are different from conventional LETBs. In addition we acknowledge the constructive nature of comments in this report and are pleased that you have recognized the high quality of training and pastoral support delivered to our trainees.

We look forward to working with all of our stakeholders to further improve the quality of training we oversee.

Please find attached a detailed action plan in response to the report.