

General Dental Council

Quality Assurance Report Standards for Specialty Education

Education Provider/Awarding Body	Programme
Health Education England South West, Thames Valley and Wessex (HEE SW TVW)	Specialty Training

Outcome of Specialty Training self-assessment against the Standards for Specialty Education.	Four GDC actions identified for the provider
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Full details of the process can be found in the annex

Summary

Remit and purpose:	To quality assure the specialty training and education being delivered by Health Education England South West and Health Education England Thames Valley and Wessex.
Standards for Specialty Education:	All
Date(s) of submission:	July 2021
GDC Staff:	Natalie Watson (Education and Quality Assurance Officer) Amy Mullins-Downes (Quality Assurance Manager)
Education associates:	Barbara Chadwick Eileen Skinner Tom Thayer

This report sets out the GDC's analysis of the self-assessment and evidence submission by Health Education England South West, Thames Valley and Wessex (hereafter referred to as "HEE SW TVW" and "commissioners") against the *Standards for Specialty Education* ("the Standards").

This report should be read in the context of the GDC's policy to develop the quality assurance of specialty training.

Of the 20 Requirements under the Standards, the GDC considers that the submission from the HEE SW TVW team demonstrates:

	No of Requirements	Requirements
Met	17	P1, P3, P4, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P19, P20
Partly met	3	P2, P5, P18
Not met		-

Requirements that were considered to be partly met have resulted in four actions across three "Partly Met" Requirements, which HEE SW TVW must address by the end of quarter 1 of 2023 to demonstrate progress against these Requirements.

The GDC wishes to thank HEE SW TVW and the team for their co-operation and assistance with this submission.

Outcome of relevant Requirements:

Standard One	
P1	Met
P2	Partly Met
P3	Met
P4	Met
P5	Partly Met
P6	Met
P7	Met
Standard Two	
P8	Met
P9	Met
P10	Met
P11	Met
Standard Three	
P12	Met
P13	Met
P14	Met
P15	Met
P16	Met
P17	Met
P18	Partly Met
P19	Met
P20	Met

STANDARD 1 – PROTECTING PATIENTS. Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of a correct and justifiable standard. Any risk to the safety of patients and their care by specialty trainees must be minimised.

P1: For clinical procedures, the programme provider should be assured that the specialty trainee is safe to treat patients in the relevant skills at the levels required prior to treating patients. (Requirement Met).

HEE SW TVW submitted a thorough self-assessment in addition to relevant supporting evidence against this Requirement.

It was noted by the education associates (EAs) that there is a robust Quality Management (QM) process. Both QM reports and the new post checklist document demonstrates that the SW and TVW commissioners review placements to ensure appropriate support to trainees, patient safety and clinical supervision. The evidence clearly demonstrates that the local offices have been carefully reviewed to confirm that they have all processes in place, to ensure trainees are supported.

There is clear evidence that the National Recruitment exercise for speciality trainees is robust and based on merit, despite the process being affected by the COVID-19 pandemic. The person specifications make clear the minimum entry requirements and the competences required. The competences set out the requirements in terms of applicants' skills, knowledge, and experience. A benchmarking process ensures applicants meet the necessary standard. The self-assessment aspect of the submission particularly addresses issues which effect patient safety, including the Specialty Trainee's clinical skills, health, and any fitness to practise issues. The structures in place and the processes to be followed once a trainee has been appointed, are also clear.

In the evidence submitted, it was apparent that the content of the "Introduction to Dental Specialist training in the South West" is clear, concise and easily comprehensible, which is aligned with the version utilised by Thames Valley and Wessex. This provides assurance that there is consistency in their approach.

Statutory and mandatory training appears to be delivered via online e-Learning modules during the HEE Dental Induction Programmes. This includes key information about local offices' expectations of Specialty Trainees, and how Specialty Trainees raise any concerns they may have about patient safety, serious incidents, duty of candour and what support is available to them.

The Induction processes, which include pre-employment assessments, are the responsibility of the employing trusts. The Learning and Development Agreement (LDA) outlines the requirements in relation to the level of support, supervision, and assessment of trainees. We were provided with examples of the completed Quality Management visit forms and checklists utilised as part of this process.

There initially appeared to be a lack of evidence demonstrating how trainees are assessed at different stages, so that the local office can be assured that trainees are safe to treat patients at the levels required prior to them treating patients. Assurance was provided under Requirements 8 and 12, and it is clear that trainees are safe to treat patients through the system of supervision and appraisal by Educational and Clinical Supervisors and Annual Review of Competence Progression (ARCP) panels. Evidence was submitted that provided assurance that incident reporting is in place for HEE SW TVW.

We consider that this requirement is **met**.

P2: Programme providers must have a policy in place to inform patients that they will be treated by specialty trainees and providers should confirm patient recognition of this policy. (Requirement Partly Met).

There are two aspects to this requirement:

- programme providers must have a policy in place to inform patients that they will be treated by Specialty Trainees
- providers should confirm patient recognition of this policy.

In the Self-assessment we were advised that HEE SW TVW are assured that all Specialty Trainees are aware of their obligation to identify themselves as a trainee, and to wear a name badge at all times. The new post checklist document confirms that HEE ensure local offices are adhering to this and it was evidenced that trainees are confirmed to have worn identification badges.

We were provided with a range of evidence under this requirement including:

- Quality Management (QM) reports
- Induction presentation slides
- HEE Checklist for new and replacement posts
- Examples of consent forms
- Patient information leaflets
- Consent to Examination or Treatment Policy

The evidence confirmed that trainees are made aware of their responsibility to identify themselves as trainees prior to treatment and that the consent form must state their job title. This is covered as part of the HEE Induction training. The consent form examples confirmed that patients are informed that they will be treated by Specialty Trainees.

Although there is evidence of a consent form being utilised, it does not give the patient an opportunity to give their explicit consent to be treated specifically by a specialty trainee. The statement that informs patients “there is no guarantee for who will perform a procedure, but that person will have appropriate experience” does not allow for recognition from patients that they will be treated by a specialty trainee and the opportunity to decline treatment, should they have concerns.

HEE SW TVW suggested that there have been no patient safety issues raised or patient complaints involving dental specialty trainees.

There were two occasions of which QM visits had raised issues regarding identification, however, these were subsequently resolved. This provided assurance that concerns had been highlighted and rectified.

We recognise that this Requirement continues to pose difficulties for commissioners of Specialty training, however as the patient recognition aspect of this Requirement has not been evidenced, we consider this Requirement to be **partly met**.

P3: Programme providers must ensure specialty trainees provide patient-centred care in a safe learning environment. The provider must comply with relevant legislation, including equality and diversity, and requirements regarding patient care. (Requirement Met).

The legislative requirements set out in the Learning and Development Agreement (LDA) have been implemented and are evidenced in the documentation provided. The LDA places

responsibility on local offices to meet the requirements of the agreement, legal obligations, mandatory training (including Equality and Diversity (ED), clinical supervision and requirements of supervisors and patient safety. This is reviewed in QM visit reports which present clear evidence of monitoring.

Oversight is also provided by committees such as the HEE-TVW Quality Committee and the Quality Scrutiny Oversight Group for the South West, which consider and deal with issues which have been identified. They meet every six weeks and dental training is reviewed alongside medicine. The recent establishment of the HEE SW and TVW Speciality Trainee Group provides another forum for concerns relating to patient centred care in a safe learning environment to be raised, shared (with the Post Graduate Dental Dean (PGDD) and HEE and resolved.

Handbooks were provided to us which set out HEE's strategy for ensuring that there are high quality learning environments for all healthcare learners in England and outlines different stakeholders' responsibilities.

Evidence that patient safety is considered at trainee, supervisor, unit, deanery and nationally is presented in the narrative and evidenced.

During the COVID-19 pandemic, HEE SW TVW continued to monitor the wellbeing of trainees, which also gave the opportunity to identify issues in the training environment.

We consider this Requirement to be **met**.

P4: When providing patient care and services, specialty trainees are to be supervised at a level necessary to ensure patient safety according to the activity and the trainee's stage of development. (Requirement Met).

The LDA clearly sets out the obligations of local offices in relation to education, training and appropriate supervision. The QM visits carried out by HEE ensure that local offices are held to account in relation to the LDA agreement.

In relation to QM visits, it has been noted that trainees are given the opportunity to provide feedback on their education and training during Quality Management Review meetings/visits. It is clear from the content of reports that feedback has been obtained, although the trainees' attendance has not been minuted.

The Educational Supervisor (ES) appointment letter includes the requirement to arrange appropriate clinical supervision and seek regular feedback from Clinical Supervisors (CS). The role and responsibilities of the ES are clearly defined, and they are required to complete training prior to a new specialty trainee starting. We were provided with examples of specialty trainee timetables indicating CS on all sessions. This was evidenced in the QM reports with both trainees and supervisors confirming that there are no concerns. As well as this, HEE checklists from replacement posts specify clinical supervision levels which are completed by the local offices. The trainee logbook example demonstrated the number of different supervisors involved in training.

In addition, it is clear that each Specialty Advisory Committee (SAC) has oversight of the progress of each trainee undertaking that speciality. Approval is also sought from the SAC in relation to new/modified trainee posts.

Trainees shadow for the first 1-2 weeks to allow trainers to assess their knowledge,

skills and competencies, so that the correct patients can be allocated to them for treatment. Evidence was provided which assured us that there is a good level of detail obtained from local offices prior to trainees commencing their role.

As there have been no Serious Untoward Incidents (SUIs) involving Specialty Trainees (in the last seven years) it is another indication that they are appropriately supervised.

We consider this requirement to be **met**.

P5: All educational and clinical supervisors must be appropriately qualified and trained, including training in equality and diversity where relevant to the role. Clinical supervisors must have registration with a UK regulatory body. There must be a clear rationale underpinning whether individual clinical supervisors are/are not included on a specialist list. (Requirement Partly Met).

Structures are in place setting out the person specification and terms of appointment of Training Programme Directors (TPD), ES and CS.

It is clear from the evidence provided that CS who are not qualified in a particular specialty, can only operate as clinical specialists with the approval of the PGDD.

HEE SW TVW acknowledge that they have incomplete data in relation to ES and CS training, due to a change in their recording systems. HEE SW TVW are currently working to resolve this issue, however there is a responsibility for local offices, through contract, to ensure appropriate training and educational appraisal is undertaken

We were not provided with complete records of training modules undertaken, annual updates or Equality and Diversity training for TPD, ES and CS for both SW and TVW, although we did see evidence which sets out the 5 new modules to be completed by SW ES and TPD. The evidence includes a monitoring log for HEE SW for TPD, ES and CS, which includes data on GDC specialist registration. Appointment letters are sent only after modules are completed and clearly outline the need to maintain and update training.

We were informed that the modules available for ES and CS, are provided by the local office face to face, although they can also be accessed through e-learning. HEE SW TVW are in the process of obtaining more up to date information regarding the educational CPD that is undertaken by existing ES.

The information shared indicated that certain TPD, ES and CS had not refreshed their training for a significant period of time. It was not clear how any issues relating to training, not completed for a period of time, is dealt with, specifically in relation to the process for highlighting and addressing this.

We consider this Requirement to be **partly met**.

P6: Programme providers must ensure that specialty trainees and all those involved in the delivery of education and training are aware of their duty to be candid in line with the guidance issued by the professional regulator. Specialty trainees must be made aware of their obligation to raise concerns if they identify any risks to patient safety. Programme providers should publish policies so that it is clear to all parties how they can raise concerns and how these concerns will be acted upon. Programme providers must support those who do raise concerns and provide assurance that staff and specialty trainees will not be penalised for doing so. (Requirement Met).

We were provided with evidence that confirms duty of candour is included in both the local office and HEE Speciality Trainee induction. The LDA requires local offices to have systems in place to encourage raising concerns and we were provided with evidence of two Freedom to Speak policies.

Dental trainee concerns would be considered at the Quality Scrutiny Oversight Group for the Southwest. While none have been reported, "Dental" appears on all agendas. HEE-SW Senior PGDD meetings risk register, includes dental training issues with an identified action plan.

Both the local offices' and trainees' knowledge of raising concerns is triangulated via Quality visits and in the provided reports.

As there have been no issues reported by trainees in the last 12 months it is not possible to see how the process would work, however, the National Survey of Dental Specialty Training 2019 and 2020 reported that "No trainees had concerns about patient safety but knew how to raise concerns if they did."

We were provided with clear evidence that assured us that all those involved in the delivery of education and training are aware of their duty to be candid in line with the guidance issued by the GDC. HEE SW and TVW outline how a concern should be escalated and that trainers ensure specialty trainees understand how to raise issues of patient safety and feel able to do so. In addition, they set out that support must be offered to those who do raise concerns and provide assurance that staff and specialty trainees will not be penalised for doing so. Evidence was also provided in relation to HEE TVW's policies in respect of this requirement.

We consider this Requirement to be **met**.

P7: Programme providers must have mechanisms to identify patient safety issues. Should a patient safety issue arise, action must be taken by the provider with a clear rationale for the extent of the action including, where necessary, informing the relevant regulatory body. (Requirement Met).

The LDA clearly sets out the obligations of placement providers in relation to this requirement.

HEE SW TVW must be informed of any patient safety incidents involving trainees. This is evidenced in the HEE SW TPD and ES appointment letters which set out how they must escalate any patient safety concerns about specialty trainees and to whom any patient safety issues should be reported.

In the original submission of evidence, we were only provided with the HEE SW letter of appointment for a TPD and did not see equivalent evidence for TVW. Although we were provided with the ES letter of appointment for both SW and TVW, there was no reference in the TVW letter to escalating any patient safety concerns about specialty trainees. HEE SW TVW have now provided evidence of the appointment letter for TVW and the TVW ES letter of appointment has been amended to include escalation of patient safety concerns. We are assured that this will be sent to all existing ES.

We were provided with evidence for both SW and TVW in relation to the escalation of concerns: Pathway for learners.

The evidence provided under this Requirement sets out for trainees, the obligation to raise any concerns identified about patient safety and to share these with the ES.

The ARCP process requires sign off by the ES that the trainee has not been involved in any SUI, Significant Event Investigation or been named in any complaint.

HEE South Speciality Training Committees feed into HEE- South Regional Speciality Training Committee, which has a standing agenda item on incidents and learning points, which is then shared across the specialties.

We were provided with meeting minutes, however there were no safety incidents recorded as none had taken place.

The HEE Quality Handbook describes quality management systems and processes by which HEE evaluate, assess risks, manage and improve quality.

We consider this Requirement to be **met**.

STANDARD 2 – QUALITY EVALUATION AND REVIEW OF THE PROGRAMME. The provider must have in place effective policy and procedures for the monitoring and review of the programme leading to recommendation for issue of a certificate of completion of specialist training.

P8: Programme providers must have a quality framework in place that details how the quality of the programme/examination is managed. This will include ensuring necessary development to programmes that maps across to the GDC approved curriculum/latest learning outcomes for the relevant specialty and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this quality function. (Requirement Met).

HEE SW TVW submitted a thorough self-assessment in addition to relevant supporting evidence against this Requirement.

The HEE Quality Framework sets out HEE's expectations for quality within the learning environment and represents a single framework through which HEE will measure, identify and improve the quality of education and training for all healthcare learners. This framework provides a platform which maps its functions to all aspects from recruitment to recommendation of Certificate of Completion of Specialist training (CCST).

The narrative provided by HEE states that "Overall responsibility for the quality framework lies with the Regional Postgraduate Medical Dean." The narrative also states that "All Dental Specialty Training programmes are mapped to the relevant GDC curriculum and learning outcomes, which is further facilitated by the trainee e-Portfolio, where episodes of learning can be evidenced to reflect mapping to the curriculum ". The Trainee e-Portfolio demonstrates learning agreements with episodes of learning indicating mapping to the curriculum.

The Regional Quality Scrutiny Oversight Group reports, demonstrate oversight of issues related to dental trainees and confirm actions have been completed appropriately. For example, one trainee was moved to another placement due to "problems with the trainee/educational supervisor". We were provided with a report by the Southwest which investigates the risks assessed, this provided evidence that concerns are escalated, investigated, and resolved.

The ARCP summary demonstrates oversight across all trainees.

Four Specialty Training Committees (STCs) meet separately to review the requirements of the training programme with representation from the PGDD and TPD. There is a standardised agenda ensuring training is adapted to reflect changing legislation and external guidance.

We consider this Requirement to be **met**.

P9: Providers must address any concerns identified through the operation of this quality framework, including internal and external reports relating to quality, as soon as possible. (Requirement Met).

Evidence provided under Requirements 3 and 8 also provided assurance in relation to the quality framework and processes.

Areas for concern are identified via the PGDD and Quality Team. Any concerns are discussed with all stakeholders to resolve issues identified and where appropriate, Quality Intervention takes place.

The following evidence provided assurance and demonstrated that specialty concerns are identified and considered:

- Dental Senior Team Meetings risk register
- The Specialty Training Committee and the Regional Committee for Specialty Training in Dentistry SW TVW minutes

The meeting minutes provided to us for both deaneries follow the same format, and each has a standing item "Issues being addressed". Representatives of specialty trainees have the opportunity to attend and raise issues directly with the committee, which includes the PGDD.

Evidence was provided that confirms that concerns are escalated to the PGDD and when they are sufficiently serious, they are entered on the risk register and kept under review. In both SW and TVW, meetings are held monthly and the PGDD appears to have detailed knowledge of what is happening "on the ground".

The quality reports for both HEE SW and HEE TVW demonstrate that issues are escalated and addressed.

We were provided with a document which sets out clearly the terms of reference, including reporting responsibilities for the Quality Scrutiny Oversight Group for the SW. This includes reporting responsibilities from HEE SW and HEE TVW Quality Committees.

We consider this Requirement to be **met**.

P10: Quality Frameworks must be subject to rigorous internal and external quality management procedures. External assessors must be utilised and must be familiar with GDC approved curriculum/latest learning outcomes and their context. (Requirement Met).

The narrative provided in the self-assessment is clear and the documentation referred to supports the requirement.

The HEE Quality Framework is a nationally developed document which details the framework to support the Quality function by collaboration between educational providers, outlined in the

National HEE Quality Handbook. The HEE Quality Handbook describes quality management systems and processes by which HEE evaluate, assess risks, manage and improve quality.

Internal and external quality management procedures appear to be rigorous and robust. Internal management is led by the PGDD in conjunction with the Quality Team. Concerns are discussed with dental education and senior teams at Trusts to monitor and resolve issues via a standard joint approach. Minutes of these meetings and quality reports confirm regular oversight.

Evidence provided demonstrates involvement and scrutiny of ARCPs by external lay and specialty panel members. SAC external reports provide reassurance of development against the GDC curriculum via standard reporting templates. The external SAC members rated the process and quality of training as either "excellent" or "above average".

ARCP meetings at both SW and TVW constituted both external SAC and Lay panel members, all of whom provided feedback. It appears that Lay members of the panel had access to trainees in TVW, which seems to be good practice, but not in SW. There is also evidence of scrutiny on a quarterly basis. The Quality Reports by the PGDD from SW and from TVW are detailed.

The Specialty Training Committee (STC) reports, via the Chair, to the PGDD through the action plan notes. These are shared with all members of the group.

We consider this Requirement to be **met**.

P11: The programme provider must have systems in place to ensure the quality of placements/rotations to ensure that patient care and assessment in all locations meets these Standards. The quality management systems should include the regular collection of specialty trainee and patient feedback relating to treatment provided within placements/rotations. (Requirement Met).

Quality visits take place every 3 years but have been suspended in 2020 due to the COVID-19 pandemic. We were provided with clear evidence that if concerns are raised, visits are triggered, and that trainers and trainees have the opportunity to give feedback during visits.

Evidence provided to us outlined the various systems which are in place to ensure quality of placements. It was also evident that various opportunities were provided to capture feedback, particularly from Specialty Trainees and that any concerns are taken seriously and actioned.

STC and HEE South Specialty Trainee Group allow trainees to feedback on training with "trainee feedback" being a standing agenda item. The Chair of this group is in direct contact with HEE, both locally and nationally, allowing them to work together to improve the quality of training, raise concerns and address any other workforce issues. Anonymous feedback is provided by the National Education and Training Survey (NETS) survey and trainees can use the ARCP to feedback to the committee and external SAC representative.

At the conclusion of their training, Specialty trainees have the opportunity to provide feedback on both their training experience and clinical experience through the Dental Specialist Trainee completion of training questionnaire. Examples of feedback from specialty trainees in SW and TVW who had completed their training were provided. They were extremely complimentary of the support provided by staff.

The Quality, Scrutiny Oversight Group for the Southwest receives feedback relating to training programmes and placements. Collated feedback across all specialties is presented to the STC. We were provided with good evidence of a comprehensive system in relation to feedback.

We consider this Requirement to be **met**.

STANDARD 3 – STUDENT ASSESSMENT. Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.

P12: To make a recommendation for the award of a Certificate of Completion of Specialist Training (CCST), programme providers must be assured that specialty trainees have demonstrated achievement across the full range of learning outcomes in the relevant specialty curriculum approved by the GDC, and that they are fit to practise at the level of a specialist in the relevant specialty. This assurance should be underpinned by a coherent approach to the principles of assessment referred to in these standards. (Requirement Met).

In the Self-Assessment HEE SW TVW advised that they maintain a robust process from recruitment through to CCST recommendation and that they follow the processes as laid out in the Dental Gold Guide (DGG). We were provided with evidence that the external SAC representatives on the ARCP panels for SW and TVW used the appropriate form in the DGG to provide their reports. This confirmed that all the necessary evidence had been provided and the quality of the training process was graded at 4 (above average) or 5 (excellent). The ARCP process ensures that all curriculum learning outcomes have been evidenced through the specialist training portfolio. The external and lay reports presented confirm good oversight of the process

We were also provided with evidence that confirms that there is close supervision of the work of specialty trainees. The STCs appear to undertake the responsibilities outlined in the DGG ensuring that specialty trainees are demonstrating achievement of the learning outcomes in the relevant specialty. From the documentation provided, it appears that each Specialty Trainee's progress is carefully monitored and that they are well supported by CSs and ESs, TPDs and PGDD.

We consider this Requirement to be **met**.

P13: Programme providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. Assessment conclusions should include more than one sample of performance. (Providers must demonstrate a rationale for any divergence from this principle.) Non-summative assessments must utilise feedback collected from a variety of sources, which may include other members of the dental team, peers, patients and/or customers. (Requirement Met).

The Overview of Quality Control measure documents provided to us for both HEE SW and TVW set out the Quality Management processes that are explained in the self-assessment. This process, which includes obtaining feedback from Specialty Trainees through various means; from Specialty Training Committees and external members of ARCPs, is fundamental in ensuring that assessments are fit for purpose.

The Quality Framework strategy, within HEE SW TVW triangulates data from: the ARCP Process, Educational Supervisors' reports, Patient Feedback, Annual Surveys, and Feedback from the Specialty Trainee group.

Evidence provided to support this requirement includes documentation in relation to:

- ARCPs

- Dental Senior Team
- Specialty Training Committees
- Specialty Trainee Group
- Annual Reviews of Educational Supervisors
- Training Records
- Induction Packages
- ES and TPD appointment letters,

Further documentation sets out the role and actions undertaken by HEE, the TPD, ES and CS and external members in advance of the ARCP. A meeting takes place between the Specialty Trainee and ES prior to the ARCP to review the Personal Development Plan and evidence which has been uploaded to the e-portfolio. It is evidenced that outcomes were carefully considered and that when students were not ready to progress, they had access to support to assist them. An ARCP timetable and process document is utilised to ensure ES, TPD and HEE Dental Team have a clear plan for the year.

Training was developed by the Committee of Postgraduate Deans and Directors (COPDEND) for members of SACs who are external members on ARCPs, (although it was noted it did not appear to have been updated since 2016). This outlined the SAC's role and responsibilities. We were assured that there is consistency and quality in the delivery of SAC external representation at ARCPs. SAC external panel members and lay panel member reports provide assurance that the assessment results are valid and reliable

It was clear that both senior management and the PGDD have knowledge and interest in each individual student's progress, and regularly review ARCP outcomes and issues which may affect ARCP outcomes.

Portfolio extracts demonstrated that the process set out in the DGG in relation to ARCPs is followed.

The following was confirmed in the portfolio extracts:

- that a range of work-based assessments and clinical procedures have been undertaken
- that in the Specialty Trainee's first year in DMF, there was an interim and annual ARCP
- the number and type of workplace based assessments (WPBAs) undertaken
- a learning agreement for a first-year oral surgery Specialty Trainee and the objectives agreed
- multi source feedback for an oral surgery Specialty Trainee
- reflection on patient feedback in a paediatric setting.

The portfolios presented to us also confirmed multisource feedback which includes patient feedback, targeted PDP and WPBA as per curriculum on multiple occasions with feedback from different supervisors and trainee reflection.

We consider this Requirement to be **met**.

P14: Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current and best practice and be routinely developed, refined, monitored and quality managed. (Requirement Met).

Evidence provided previously in this standard, demonstrate HEE SW TVW's range of approaches to ensure regular monitoring of training.

The HEE Quality Framework sets out HEE's expectations for quality within the learning environment and represents a single framework through which HEE will measure, identify and improve the quality of education and training.

Evidence was seen under P12 and 13 which demonstrates HEE SW TVW range of approaches to ensure regular monitoring of training.

Completion of competences is confirmed by review of the WPBA, logbook, trainee and trainers' reflections, and patient and colleagues' feedback, all of which are recorded in the trainee's e portfolio. To support this, ES & CS must undertake robust appraisals. HEE SW and TVW training modules include a module on WPBA, appraisal and feedback. Training compliance is monitored for new and existing trainers. During the ARCP process, external SAC representatives ensure full coverage of competencies.

As a result, we consider this Requirement to be **met**.

P15: The programme provider must have in place management systems to plan, monitor and record the assessment of specialty trainees throughout the programme against each of the learning outcomes. (Requirement Met).

The narrative and evidence provided supports this requirement to the extent that the local office has in place management systems to plan, monitor and record the assessment of specialty trainees throughout the programme. Documents completed by SAC external panel members, in relation to the process and quality of the ARCP, evidence a very high standard of monitoring and support from local offices' (TPDs, ESs and CSs) and excellent preparation of ARCPs. Where there were any concerns about progress, staff had constructive solutions to provide support.

The e-Portfolio is the management system for monitoring progress. Induction processes ensure trainees are clear on expectations during training. Both trainees and trainers plan, monitor and record assessments against each of the learning outcomes. The portfolio is regularly reviewed by the ES and discussed with the trainee at their regular meetings to ensure trainees are covering all LOs. All trainees have an interim review after 6 months in post and annually thereafter, unless they have a non-standard outcome at ARCP.

HEE SW TVW plan the ARCP's in advance and have a clear process. The ARCP process ensures evidence is mapped against the LOs, follows processes set out in the DGG and is overseen by external SAC representation, and a lay representative who both provides reports.

Further evidence to support this requirement can be found under P4,12,13 and 14.

We consider this Requirement to be **met**.

P16: Specialty trainees must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competence to achieve the relevant GDC-approved learning outcomes. (Requirement Met).

As with the previous Requirement, the narrative in the self-assessment suggests that the e-portfolio is the mechanism by which all trainee activity is recorded and monitored. Individual specialties define both the number and type of WPBA required.

In relation to the DGG, progress against the curriculum is monitored formally by an Interim RCP after 6 months of training and annually thereafter, unless a trainee receives an unfavourable outcome. For example, The Dental and Maxillofacial Radiology (DMFR) portfolio

checklist for Specialty Trainees outlines what trainees are required to provide as evidence in their portfolios for (ARCPs). Evidence provided to us demonstrates that this is being followed.

Unfavourable outcomes will be awarded where trainees are behind expected progress for the stage of training. The ARCP panel provides assurance that if trainees cannot evidence all learning outcomes and competencies, the appropriate outcome would be given.

Further evidence to support this Requirement can be found under P12,13,14 and 15.

We consider this Requirement to be **met**.

P17: The programme provider should support specialty trainees to improve their performance by providing regular feedback and by encouraging trainees to reflect on their clinical and professional practice. (Requirement Met).

The appointment letters for HEE SW TVW confirm the responsibilities set out in the DGG in relation to CS being responsible for overseeing a Specialty Trainee's clinical work and providing constructive feedback, as well as the ES being suitably trained and undertaking appraisal and feedback. There is further assurance within documentation that confirms the training modules which ES and CS are required to undertake for their roles.

The portfolio evidence provided to us confirms regular feedback is given to Specialty Trainees and also evidences that TPDs, CSs, and ESs provide regular reports on performance.

The annual Multi-Source Feedback (MSF) has a critical role in encouraging reflective practice to improve performance and we saw evidence of this alongside patient feedback required as part of the E-portfolio.

Further evidence supports this Requirement under P14.

We consider this Requirement to be **met**.

P18: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate registration with a regulatory body. (Requirement Partly Met).

There was an absence of evidence to confirm that all of the assessors in both HEE SW and TVW had the appropriate skills and experience and had undertaken the appropriate training within an appropriate timeframe to assess trainees, due to a change in the recording system, as stated under P5.

The "New and Replacement Speciality Training Post Checklist" seeks information including whether trainers have professional registration, are on a specialist list and have undertaken the appropriate mandated training modules. It was noted that the information provided by HEE SW showed that in some instances, training had been undertaken some years previously. We were not provided with the equivalent information by HEE TVW, although we were provided with the ES letter of appointment

TPD, ES and CS must complete training modules and a log of training is maintained. However, the data provided did not evidence that all assessors had undertaken all relevant training (including equality and diversity training) within the relevant time frame. It was also not confirmed that examiners and assessors had appropriate registration with a regulatory body.

Additional evidence supports this Requirement under P5 and P14, however as the experience and training is not captured for all assessors for HEE SW and HEE TVW, we consider this requirement to be **partly met** and would expect the records to be updated

P19: Programme providers must document external examiners/assessors reports on the extent to which examination and/or assessment processes are rigorous, set at the correct standard, ensure equity of treatment for specialty trainees and have been fairly conducted. (Requirement Met).

All ARCPs include an external SAC and Lay representative, each of whom provides a report to HEE.

The narrative and evidence provided supports this requirement. Reference has already been made under previous Requirements in relation to the contents of reports provided by external lay and SAC members.

The ARCP appeal process is clear, and Specialty Trainees can request a review within 10 days, which may lead to an appeal against their “outcome” decision. This is managed through the process outlined in the Dental Gold Guide.

We consider this Requirement to be **met**.

P20: Assessment must be fair and undertaken against clear criteria. The standard expected of specialty trainees in each area to be assessed must be clear and trainees and staff involved in assessment must be aware of this standard. A recognised standard setting process must be employed for assessments. Exceptions from this principle must be clearly justified. (Requirement Met).

Documentation provided under this Requirement provides assurance that there are a variety of WPBA formats, and that trainees should ensure that they choose the one most appropriate to the skill being assessed. All trainees issued with a developmental or non-progressive outcome are offered a support meeting and made aware of all the professional support available.

In the Introduction to Dental Specialty Training PowerPoint, there is a diagram showing that intended learning outcomes (based on the particular specialty curricula and set out in the learning agreement), have to be evidenced by assessments of performance and experience.

The COPDEND ARCP Training PowerPoint (from 2016) provides guidance to members of SAC members, who sit as external members on ARCPs. ARCP panel guidance is used to ensure parity between panels.

We consider this Requirement to be **met**.

Summary of Actions for Provider

Req. number	Action	Observations & response from Provider	Due date
P2	1. HEE SW TVW must provide a description of process and an assurance that patients that are treated by specialty trainees, but not consented by them, are able to decline treatment by a trainee if they so wish	We do not believe this is achievable or that any other region has been asked to do this. Our proposal is to undertake specialty patient feedback survey, which specifically asks patients whether the dentist introduced themselves by name and job title.	Q1 2023
P5	2. HEE SW TVW must provide complete records of training modules undertaken, including annual updates or Equality and Diversity training for TPD, ES and CS for both SW and TVW 3. HEE SW TVW must provide evidence which demonstrates how issues relating to training not completed for a period of time is dealt with, specifically in relation to the process for highlighting and addressing this.	We now have evidence of this and can submit	Q1 2023
P18	4. HEE SW TVW must provide evidence of all assessors' records for both HEE SW and TVW setting out: -their Specialty -length of experience -training records including what training was completed in relation to the new training modules and when they were completed -date of renewal of registration with GDC/GMC	See above	Q1 2023

Observations from the provider on content of report

In response to Action P2:

We do not believe this is achievable or that any other region has been asked to do this. Our proposal is to undertake specialty patient feedback survey, which specifically asks patients whether the dentist introduced themselves by name and job title.

In response to Action P5:

We now have evidence of this and can submit

In response to Action P18:

See above

Annex 1: Education Quality assurance process and purpose of activity

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council's (GDC) Strategic Review of Education (2008) recommended that the Council should actively quality assure all training and awards which lead to entry to all GDC registers and listings (Dentist, Dental Care Professionals (DCP) and Specialist).
2. The aim of this quality assurance activity is to ensure that dentist registrants, at the point of inclusion upon one of the GDC's specialist lists, have demonstrated, on completion of their training, that they have met the outcomes required for specialist listing on the dentists register with the GDC. This will underpin and add value to the GDC's responsibility in issuing a Certificate of Completion of Specialist Training (CCST) as part of the listing process.
3. Consideration and development of our quality assurance processes therefore apply to training programmes in all 13 current specialties. Whilst our statutory responsibilities (see section 17 below) focus on orthodontics and oral surgery we do not currently possess an evidence base, drawing upon public protection arguments to differentiate between the specialties in quality assurance activity.

Specialty training

4. The primary route by which specialists join the Specialist lists, and the route upon which the GDC focusses its quality assurance activity, is successful completion of a national training programme in the individual UK specialties, where training is based upon a GDC-approved curriculum¹, overseen by the regional postgraduate deaneries/LETBs, and where the trainee also passes the relevant Royal College examination.
5. Following these successes, the trainee is recommended for entry to the GDC Specialist Lists by award of a Certificate of Completion of Specialist Training (CCST). The postgraduate deanery/LETB recommend the award and the GDC awards the CCST.
6. Training in the dental specialties under the route described above is, typically, a three-year full-time hospital-based programme. This can involve trainees receiving training in a variety of hospital settings and other clinical environments. This form of delivery, together with the provision of exit examinations by a further provider has required changes to the GDC's model of pre-registration QA inspection which is typically based on a single training centre under the auspices of a university or other educational body.

The GDC's powers

7. The GDC's powers in relation to specialist education and training differ from its powers for pre-registration training:
8. The Dentist Act 1984 (the Act) restricts our ability to require training providers to provide information to those with Dental Authority (DA) Status. Of postgraduate providers, the Royal Colleges possess dental authority status as do universities undertaking postgraduate or specialist dental training. We can request information from other postgraduate training providers such as postgraduate deaneries/LETBs who do not hold such status in connection with section 1(2)(a) of the Act.

9. We have powers under Section 9 of the Act to appoint visitors to inspect programmes and examinations of both undergraduate and postgraduate/specialist programmes. However, the concept of “sufficiency” applies only to DAs and there is no formal mechanism to approve or withdraw approval from postgraduate/specialist training providers who do not possess such status.
10. The Specialist List Regulations provide us with powers to determine who is eligible to join the lists.
11. The GDC is, in relation to specialist dental qualifications in orthodontics and oral surgery, the competent authority in the United Kingdom for the purposes of the Recognition Directive and the Dental Training Directive. The Council has a statutory duty to supervise training in these two specialties.
12. We have taken legal advice and have established that our statutory duty to supervise training in orthodontics and oral surgery can support quality assurance activity across the 13 specialties.

Annex 2: The EQA Process

13. The education quality assurance activity focuses on three Standards for programme providers, with a total of 20 underlying requirements. These are contained in the document *Standards for Specialty Education* (current iteration published 2019 and available [here](#)).

General Principles

14. Our historic consultation and stakeholder engagement on the Standards signalled the GDC’s expectations in relation to specialty education. Publishing the first iteration of Standards for Specialty Education in 2015 was seen to send a clear message to the sector about the quality the GDC expects in order to protect patients and the public.
15. In addition to publishing the GDC standards, we recognised that the UK Committee of Postgraduate Dental Deans and Directors (COPDEND) already publishes a quality management tool in the form of *The Gold Guide*. We also recognised that specialty trainees are in the main already GDC registrants; and that we needed to be sensitive to the fact that specialty training (where it takes place in NHS Trusts and roles) operates in an already highly regulated environment.
16. We have been mindful that that our regulatory approach, both in its piloting and in its current operational introduction, must not introduce disproportionate or unnecessary burdens on providers.
17. The second iteration of Standards for Dental Education, referenced above, maintains this proportionate approach whilst also containing two major developments:
 - a. Separating the Standards so there are discrete requirements for programme and examination providers.
 - b. Introducing an overarching requirement to provide evidence (of the provider’s choosing) to support their self-assessment.

Collection of evidence

18. Therefore, the process remains based upon moderated self-assessment and includes:
- a. a data set that profiles specialty trainees and scrutinises key data including information about the trainees' progression rate through programmes and exit examinations.
 - b. a self-assessment questionnaire giving providers the opportunity to indicate their performance in the context of the Standards and requirements.
 - c. the requirement to provide illustrative and supporting evidence to support the contents of the completed self-assessment questionnaire.
19. The following descriptors are employed as a means of reference for establishing a programme provider's compliance with the individual requirements.

A Requirement is **Met** if:

There is sufficient appropriate evidence derived from the pilot process. This evidence provides the GDC with broad confidence that the programme provider demonstrates compliance with the requirement. The provider's narrative and documentary evidence are robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is **Partly Met** if:

Evidence derived from the pilot process is either incomplete or lacks detail and, as such, fails to convince the GDC that the programme provider fully demonstrates compliance with the requirement. There may be contradictory information in the evidence provided.

There is, however, some evidence of compliance and it is likely that either (a) the appropriate evidence can be supplied in a short time frame, or, (b) any deficiencies identified can be addressed and evidenced in follow-up processes.

A Requirement is **Not Met** if:

The provider cannot provide evidence to demonstrate compliance with a requirement or the narrative and evidence provided are not convincing.

The evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to concern and will require an action plan from the programme provider.

Other:

Use of this descriptor is exceptional and will usually be applied if the provider's narrative and evidence would be considered **Partly Met** but it appears to the GDC that evidence and/or indications across the breadth of the submission mean that during the observations period of the EQA process this requirement can be **Met**.

20. The significance of not demonstrating compliance with a requirement will depend upon the compliance of the programme provider across the range of requirements and any possible implications for public protection.
21. Outcomes from the pilot specialty EQA exercise typically fell into two categories of follow-up action:

- a. Where requirements were not fully met, the need for follow-up action (either submission of further evidence or clarification of self-assessment) that could normally be addressed by annual monitoring/updates.
- b. Joint action between the provider and the GDC to capture good practice (where requirements were met) to further inform the evidence prompts within the Standards and so to provide additional guidance for future specialty EQA activity.