

General Dental Council

Education Quality Assurance Report Standards for Specialty Education

Training commissioner	Training programmes
Health Education London and Kent, Surrey and Sussex	Dental and Maxillofacial Radiology Dental Public Health Endodontics Oral and Maxillofacial Pathology Oral Medicine Oral Surgery Orthodontics Paediatric Dentistry Periodontics Prosthodontics Restorative Dentistry Special Care Dentistry
Outcome of Specialty Training self-assessment against the Standards for Specialty Education.	Five GDC actions identified for the training commissioner.

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 London and Kent, Surrey and Sussex.
Standards for Specialty Education:	All
Dates of submissions:	22 November 2019 and 6 August 2020
GDC Staff:	Patrick Kavanagh (Policy Manager) Martin McElvanna (Education & Quality Assurance Officer) Natalie Watson (Education and Quality Assurance Officer) Amy Mullins-Downes (Quality Assurance Manager)
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This report sets out the GDC’s analysis of the self-assessment and evidence submission by Health Education London and Kent, Surrey and Sussex (hereafter referred to as “LKSS” or “training commissioner”) against the *Standards for Specialty Education* (“the Standards”). The submission was received in December 2019.

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

Of the 20 Requirements under the Standards, the GDC considers that the submission from the LKSS team demonstrates:

	Total Requirements	Requirements
Met	17	P1; P2; P3; P4; P5; P6; P7; P8:P9; P11; P12; P15; P16: P17; P18; P19; P20
Partly met	3	P10; P13; P14
Not met	0	

Requirements that were considered to be partly met have resulted in five actions which LKSS must address by the end of Q2 of 2022 to demonstrate progress against these Requirements.

Outcome of relevant Requirements:

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

In their submission, the LKSS referred to the application of HEE-wide policies as well as dedicated LKSS policies. They explained the shared responsibility between the Trusts working with the LKSS team and the team itself. We considered that the evidence submitted was extensive, with 12 documents outlining the process for recruitment and induction of specialty trainees, as well as the process around critical incident recording.

The GDC noted within the evidence submitted under Requirement P4 that specialty trainees be appropriately supervised in the interests of patient safety. This was described as an iterative process as trainees progress through the Annual Review of Competence Process (ARCP).

Although we were grateful for the extensive evidence presented, we considered that most of the evidence presented was in the form of policies. It would have been helpful to have seen further evidence such as the timetable demonstrating supervision ratio for orthodontic trainees at a teaching hospital and the LKSS incident reporting implementation plan, which would have demonstrated practical application in the training environment.

We determined that this Requirement was met based on the evidence submitted under this Requirement as well as the evidence submitted under P4. This demonstrated the existence of systems that confirms the safe practice of specialty trainees under appropriate supervision both as part of an iterative process and in response to any adverse incident.

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 Met).

LKSS provided supporting evidence for this Requirement as follows:

- Bart's Health Qualified dentist (including trainees) consent form
- KCH consent form
- Patient Experience Report KCH (2019).

LKSS explained that on training commissioners' public websites, information is provided to patients confirming that the site is a training location and that trainees may be involved in their care.

LKSS provided a draft NHS Education Contract 2021-2024 (EC) which replaces the Learning Development Agreement (LDS) and is due to be issued in September 2021. This document details the audits LKSS can undertake of NHS trusts. It details the suspension process and explains the definition of "suspension events".

The process of raising concerns and addressing patient complaints is also covered in detail in the EC.

LKSS also informed us that a clause explaining to patients that they may be treated by trainees will be inserted into version 2 of EC no later than 1 April 2022.

We determined therefore that this Requirement was 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).

Under this Requirement, LKSS submitted sample policies governing NHS HEE and LKSS activity concerning such as the “HEE Emerging Concerns Brief”, “HEE Incident Reporting Policy” and “HEE Escalation of Concerns Guidance” to demonstrate how they meet this requirement. Further evidence presented also demonstrates that these policies are subject to regular review and that actions have been identified to ensure compliance with the policies.

We had sight of the Learning and Development Agreement (LDA) which is a comprehensive document covering LKSS’s expectations of the placement providers with which they work. We also noted the explanation of the work of the London Quality Surveillance groups, the London Joint Strategic Oversight Group and the national Joint Strategic Oversight Group which discuss Trusts of concern.

We also noted the role and specific activities undertaken by LKSS’ Dental Quality and Operational Group having had sight of the redacted agenda and action log.

LKSS may wish to consider the use of exception-reporting as a means to quality assure patient safety measures and to keep a record of summary data (including nil returns).

Given the range of detailed evidence presented, we consider that this Requirement was 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).

LKSS submitted extensive documentation in support of this Requirement. This included timetables demonstrating supervision ratios for orthodontic trainees at a teaching hospital, trainee placements demonstrating the allocation of educational and clinical supervisors, learning agreements, feedback forms and trainee assessment forms for various specialties,

We also noted the following documents in relation to the ARCP process:

- Panel Member Briefing (2019)
- Appeals National SOP (2019)
- Lay Representative report (2019)
- Outcome 3 Trainee Handout
- ISCP Action List for Orthodontic ARCP St1-3
- Checklist for ISCP and ARCP Monospecialties.

We were also provided with the SAC Guidelines for the UK three-year training programmes in orthodontics for specialty registrars (2012) (sections 3.2, 3.8).

LKSS provided examples of occasions when action was required to ensure that specialty trainees have the requisite skills to treat patients at the appropriate level of their development. This may be the result of, or independent of, the ARCP process.

We recommend that LKSS consider the use of exception-reporting where policies have not been fully applied, or where trainee/supervisor ratios have fallen short and what actions were taken to address this. We consider this style of reporting, including the use of summary data, would be the clearest way of demonstrating ongoing compliance with this Requirement.

We considered that the evidence provided under P4 as well as P1 demonstrates that this Requirement was met. We also consider that the evidence provided assures us that these policies are receiving regular review and that there are actions arising to ensure compliance with them. It illustrates how LKSS's ensures the safety of specialty trainees both as part of an iterative process and in response to any adverse incidents.

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 Met).

LKSS provided an extensive set of documents under this Requirement which included:

- HEE Professional Development Framework for Educators (2017)
- HEE LKSS Dental Higher Specialty Training Study Day Programme (2016)
- Presentation 'Training the Trainer – what do we need now', LKSS HST Study Day (2016)
- HEE LKSS Educational Supervisor Accreditation Course (2017)
- Educational Supervisor Accreditation Course (UCLH)
- Educational Supervisor Accreditation Course (Bart's)
- HEE LKSS ES database with details of training and accreditation/re-accreditation dates (2019).

The LKSS team indicated their confidence that the majority of educational and clinical supervisors were appropriately trained for their role. They hold a database of all education and clinical supervisors who are registered with the GDC.

All LKSS dental specialty educational and clinical supervisors are employees sit within the relevant Trust and HEI governance structure. Equality and diversity training is a mandatory requirement for all Trust and HEI employees.

All of the trainers are required to maintain continuing professional development (CPD) relevant to their area of practice.

LKSS explained that employers conduct an annual appraisal process which provides assurance that the necessary skills, experience and training of trainers and supervisors is adequately reviewed.

We noted that a HEE LKSS ES database was being developed which will indicate the training status of all supervisors within the next 12 months. This database will be updated annually to reflect any changes in allocated supervisors.

We consider this Requirement was 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).

LKSS explained the clinical governance structures that are in place to review any incidents, to ensure appropriate escalation of issues and to make necessary developments to policies and procedures.

We noted the Freedom to Speak Up (FTSU) Guardians' systems which highlighted the importance of a safe and positive work culture. The training commissioner cites the example of LKSS inviting the National FTSU Guardian to speak at their Higher Specialty Training Study Day in 2018.

LKSS provided a HEE document entitled "Identifying and sharing good practice in health education and training across London", pilot phase one, which sets out the quality expectations for the work-based learning environment. We noted the three phases and the anticipated developments within each.

LKSS provided detail around the reviews of two hospitals, London North West and Eastman Dental, both in 2019. These detailed the concerns raised, actions to be followed up and the outcomes. These reviews illustrated how lessons could be learned and good practice could be shared.

We also had sight of the HEE "Supporting and Escalating concerns in Clinical Learning Environments" document. This detailed the protocol for escalating concerns in the event of Covid-19 "surges" and the escalation path should resolution of concerns not be addressed adequately. The document also explains that this process does not replace the "Serious Incident Reporting" procedure in trusts, and that local processes should be followed for serious incidents. We noted that the document finishes with reference to "further advice and guidance in relation to education and training within the context of the Covid-19 pandemic" citing guidance from other regulators and we suggest the addition of reference to the GDC's guidance also.

We considered that this Requirement was 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).

LKSS explained that reporting mechanisms were reviewed and updated in 2019. Procedures are in place for the reporting and escalation of concerns, serious incidents and never events. Trusts are obliged to report clinical incidents involving trainees to the regulatory body and where necessary to inform the Regional Postgraduate Dental Dean. There is also an expectation of trainees themselves to declare any such incidents in their e-portfolio. This information is also escalated to the Associate Dean and Regional Dean of Postgraduate Dentistry. Any trainee involved in a patient safety issue is referred to the Case Management Team for support.

We saw evidence which included descriptions and copies of relevant policies and procedures such as

- HEE LKSS Incident reporting: Implementation plan (2019)
- HEE London Escalation of concerns guidance (2019)
- London Case Management Team agenda and action list (2019)
- London Case Management Team Template.

From the evidence presented, we did not see any indication of the actual incidence of any patient safety issues and as of September 2021, LKSS confirmed provided an update to us that no serious incidents have been reported in relation to dental specialty training.

We were assured that there are robust mechanisms for raising and addressing any incidents if they do arise. The training commissioner should inform us if any patient safety incidents do arise with details on how these were managed.

We therefore concluded this Requirement was 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).

We appreciate that, across England, HEE has put in place the HEE Quality Framework 2019-2020. What the GDC is looking for against this Standard and its Requirements is evidence of how the individual HEE teams have internalised, and delivered against, the framework.

In the case of the LKSS team, we note the descriptions in the narrative of:

- all dental specialty training programmes are mapped to the relevant GDC curriculum. This is further facilitated by the e-portfolios where all episodes of learning and assessment are mapped to the curriculum.
- the activities of the eight specialty training committees (STCs) reviewing ARCP outcomes and examination results with important contributions from trainers and trainee representatives.
- recent changes to the ARCP process.

We also considered the following:

- LKSS STC meeting action points Special Care Dentistry (2019)
- LKSS STC meeting action points Oral Surgery (2019).

We note that the information sourced through these processes contributes to the quality metrics against which placements can be measured and contributes to the development of the programmes.

We also note the personal responsibility taken by the Regional Postgraduate Dental Dean to meet with relevant internal stakeholders to review programmes and to advise on changes in legislation and external guidance.

We considered that this Requirement was 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).

The training commissioner clearly described how their Quality, Patient Safety and Commissioning (QPSC) department subscribes to the CQC website for each site that has dental specialty trainees.

We also note the description of how the HEE LKSS team participates in:

- three London Quality Surveillance groups (that meet every six weeks) that bring together CQC, Healthwatch, CCGs, NHSI and NHSE
- the London Joint Strategic Oversight Group
- the national Joint Strategic Oversight Group which discusses Trusts of concern.

We also noted the description of the QPSC team activities in connection with an assurance visit at a training facility and the systems underpinning any recommendations. These are logged on LKSS' Reporting Register, along with a site action plan with timeframes which are agreed and then reviewed by the Associate Deans. Additionally, prior to a quality visit, Trusts are required to provide incident reports and Local Faculty Group minutes for review.

LKSS has a Dental Quality and Operational Group, which meets monthly. This group reviews visits, decides on actions required and develops improvement plans. The group also reviews intelligence from local sources such as Training programme Directors, CQC, NHSI, and trainee whistleblowing.

In addition to the policies submitted, LKSS also provided evidence as follows:

- LKSS Dental Operational Quality Group minutes action log (2019)
- LKSS Regional Quality Scrutiny Team minutes (2019)
- LKSS Dental Learner Survey Template
- sample London Quality Assurance Report for risk-based visit (2019).

We considered that the sample London QA visit report was particularly useful.

We concluded that this Requirement was 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 Partly Met).

LKSS provided evidence of a range of quality management procedures against this Requirement.

As discussed in P6, we received details of two follow-up exercises relating to concerns at two trusts. These were instigated following lessons learned after an earlier intervention that was required at Northwick Park.

LKSS explained that the postgraduate dental dean has introduced biannual meetings with Trust DMEs in the interests of faculty development and the support of educational and clinical supervisors.

We had sight of comments in the Lay representative report for ARCP and the External representative (SAC) report for ARCP. However, no evidence was provided of any follow up actions and this indicated some absence of quality management.

As a result, we considered this Requirement was partly 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).

LKSS confirmed that the ARCP process allows for an annual discussion of all placements, as a minimum.

We also recognised the existence of systems where trainees are surveyed independently of the ARCP process and relevant reports are prepared.

In their submission, LKSS gave a clear indication of the systems capturing specialty trainee feedback and illustrated the collection of patient feedback, citing an example of this.

We concluded that this Requirement was 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).

LKSS explained to us how the Regional Postgraduate Dental Dean and the Quality, Patient Safety and Commissioning Team are assured, through the use of e-portfolios such as ISCP, that trainees are able to demonstrate achievement across the full range of learning outcomes in the relevant specialty curricula.

We noted that LKSS expressed confidence in a robust ARCP process.

Regarding the interaction and feedback between the education and examination providers as part of the recommendation of a CCST to a trainee, refer to P19.

We concluded that this Requirement was 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 Partly Met).

LKSS provided evidence of a range activities focusing on the management of (i) e-portfolios, (ii) work-based assessments in the numbers determined by the SACs plus supervisor reports and (iii) the ARCP process.

We considered that there was insufficient information to establish the relationship between the external ARCP process and the internal LKSS quality assurance process. This was not clear to us. .

We considered that the *WBA feedback for orthodontic StR Year 1* and *WBA feedback for paediatric dentistry StR Year 3* were useful documents but appeared to be from the trainees' perspective. No evidence was provided on how this feedback was utilised to inform any changes to the ARCP process.

We had sight of evidence which demonstrated the consistency of panel decisions including the use of checklists, panel training and review of outcomes. The responsibility for improvements and changes to the assessments are the responsibility of the relevant SAC. We would be interested in seeing how relevant feedback is fed into this process.

As a result, we considered this Requirement was partly 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 Partly Met).

Evidence of work-based assessments laid out by the SACs in connection with the specialty curricula was provided. Although it appeared that there was consistency of process across the specialties and while that consistency of process provides some assurance, it does not address the fundamental purpose of this Requirement.

The evidence provided does not clearly illustrate how assessment processes are developed, refined, and monitored within LKSS' quality management framework. As with P13, it was not clear how LKSS internalises the ARCP and other processes and integrates them within their quality management process.

We note and commend the intention to carry out a review of the WBAs upon delivery of revised specialty curricula.

In the absence of clear current and ongoing review activity, we consider this requirement to be partly met.

The training commissioner should provide evidence of external reports (such as the SAC, is applicable) on ARCPs, together with a description on how these reports are reviewed. This is detailed in the actions at the end of this report.

As a result, we considered this Requirement was partly 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).

LKSS supplied us with the HEE Induction Programme (2019) and checklists for ISCP and ARCP preparation (2019) to illustrate the monitoring of trainees. An induction is given on the use of ISCP which is a key management tool in the monitoring and recording of assessments throughout the programme and is linked directly to the GDC's learning outcomes.

The training commissioner explained that they now use e-portfolios which were previously paper-based. This serves as a record of trainee competence as they progress through their training and allows for structured supervision. E-portfolios have improved the manner in which

trainees' progress is monitored and recorded. They feed directly into the ARCP process via the education supervisor and their report on trainees' progression.

We were assured that there are robust systems in place and consequently we determined that this Requirement was 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).

LKSS provided comprehensive evidence under this Requirement, as follows:
HEE LKSS Learning Development Agreement (in particular, clauses 5.2.3, 5.2.9)

- Learning Agreement and ES Report Orthodontic StR Year 2 (2019)
- Anonymised logbook paediatric dentistry
- Anonymised logbook oral surgery
- Anonymised logbook restorative dentistry
- Progress against the curriculum in ISCP Paediatric Dentistry StR Year 2
- Progress against the curriculum in ISCP Orthodontic StR Year 3.

We considered that this Requirement was 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 LKSS explained that the IRCP requires feedback to be given to trainees following work-based assessments. Educational supervisors are obliged to meet their trainees regularly to provide feedback and review trainees' progress. They are also expected to provide reports to individual trainees. ARCPs, which are supported by the use of e-portfolios, enables internal and external feedback to be given to a trainee.

Regarding reflection, trainees are given training on this and they are encouraged to reflect on their individual training sessions and on individual learning points.

Evidence presented to us included:

- a learning agreement
- anonymised trainee comments
- STC meeting agenda and actions point
- Higher Specialty Training Study Day Programme (2017)

We considered that the evidence submitted by LKSS demonstrates that this Requirement was 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 Met).

LKSS explained that the majority of assessors who undertake formative and work-based assessments are clinical and education supervisors.

As discussed under P5, we learnt of the mechanisms and database in place for ensuring that supervisors are appropriately registered and trained, undertake mandatory training and maintain their CPD. They also undergo an annual appraisal process.

As with Requirement P5, we considered that the evidenced submitted by LKSS demonstrates that this Requirement was met.

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).

LKSS provided evidence which focused on the LKSS team's relationship with external SAC nominated representatives who review a minimum of 10% of outcomes and all non-standard outcomes.

We also noted the existence of systems permitting ARCP-review and appeals against outcomes which are managed through Review and Appeal Procedure Rules.

We had sight of the document *Number and outcome of appeals at LKSS ARCP in 2018/20* which, although no appeals took place, does confirm the existence of an active process.

We particularly noted how feedback from trainees and the ARCPs is collated regarding professional examinations and the outcomes/actions taken. This illustrated LKSS' interaction with the Royal Colleges. It is clear there are effective channels through which for LKSS and the Royal Colleges can liaise and provide feedback on each other's systems and/or specialty trainee outcomes.

We considered that this Requirement is 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).

We concurred with the Regional Postgraduate Dental Deans' and the Quality, Patient Safety and Commissioning Team's assurance that assessments are fair and undertaken against clear criteria.

We noted the appropriate training of assessors in relation to work-based assessments and the ongoing development of a training database as referred to in P5 and P18. E-portfolios were used within the ARCP process, along with the use of checklists for all specialties.

Furthermore, external assessors provide assurance that appropriate standards are met, and the processes are fair and transparent.

Checklists are utilised to assist with the use of e-portfolios and the requirements for an ARCP and we noted that these checklists proved very helpful in ensuring trainees and their supervisors are fully aware of the requirements during training and at an ARCP.

We considered that this Requirement was met.

Summary of Actions for LKSS

Req. number	Actions to be completed by Q2 2022	Observations & response from LKSS
P10	1) LKSS should provide evidence of any follow up actions from the comments in the Lay representative report for ARCP and External representative (SAC) report for ARCP.	HEE LKSS previously provided evidence of follow-up actions to both of these reports in our submission p.5 July 2020. All SAC and Lay representative reports are reviewed by the PGDD or Associate Dean and, as necessary, action plans created with the specialty TPD. Review and tracking of actions take place at regular quality meetings. For ease of reference, we will attach the July report with this submission.
P13	2) LKSS should provide clarification on the relationship between the external ARCP process and the internal LKSS quality assurance process. 3) LKSS should provide evidence on how trainees' WBA feedback for orthodontic StR Year 1 WBA feedback for paediatric dentistry StR Year 3 was adopted by the SAC to inform changes and improvements to the ARCP process .	2) A description of how external reports feed into the quality management process was provided in July 2020 p 8-9 3) The individual WBA feedback is not designed to inform changes to the ARCP process but to provide evidence to the panel of the trainee's acquisition of competencies and to allow them to make a judgement as to their progress in training.
P14	4) LKSS should provide evidence of how assessment processes are developed, refined, and monitored within the quality assurance framework. 5) LKSS should provide evidence of external reports (such as the SAC, is applicable) on ARCPs, together with a description on how these reports are reviewed.	In July 2020 p8-9 we submitted additional evidence for P14 which we feel demonstrates the robust nature of ARCPs conducted in HEE LKSS and how it feeds into the quality management processes. In the July submission we summarised what is reviewed by the panel at the ARCP, and details have been given as to how we ensure consistency of panel decisions by the use of checklists, panel training, panel briefings and external SAC representatives. We are assured that ARCPs in HEELKSS are conducted in a robust manner and all outcomes are reviewed as illustrated in the narrative and in Figure 1 of the evidence. ARCPs take into account a range of assessments but HEE is not responsible for setting or reviewing what those assessments should be, as this is determined by the relevant SAC.

Observations from LKSS on the content of the report

The Regional Postgraduate Dental Dean and the Quality, Patient Safety and Commissioning Team are very appreciative of the opportunities to engage with the GDC during this process. It has been most beneficial in the development of this Self-Assessment Questionnaire as well as providing valuable discussions on how the process may be improved in the future.

Annex 1: 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 training commissioners, 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 training commissioner 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 training commissioners 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 training commissioners 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 quality assurance activity focuses on three Standards for training commissioners, 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 training commissioners.
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 training commissioners and examination providers.
 - b. Introducing an overarching requirement to provide evidence (of the training commissioner’s choosing) to support their self-assessment.

Collection of evidence

18. Therefore, the process remains based upon moderated self-assessment and includes:
 - c. a data set that profiles specialty trainees and scrutinises key data including information about the trainees’ progression rate through programmes and exit examinations.

- d. a self-assessment questionnaire giving training commissioners the opportunity to indicate their performance in the context of the Standards and requirements.
 - e. 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 training commissioner's compliance with the individual requirements.
- a. 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 training commissioner demonstrates compliance with the requirement. The training commissioner'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."
 - b. 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 training commissioner 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.
 - c. A Requirement is **not met** if:

The training commissioner 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 training commissioner.
 - d. Other

Use of this descriptor is exceptional and will usually be applied if the training commissioner'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 training commissioner across the range of requirements and any possible implications for public protection.
21. Outcomes from the pilot specialty QA exercise typically fell into two categories of follow-up action:
- f. 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 specialty monitoring.

- g. Joint action between the training commissioner 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 QA activity.