

General Dental Council

Quality Assurance Report Standards for Specialty Education

| Training commissioner | Training programmes |
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| Health Education England Yorkshire and Humber | Dental and Maxillofacial Radiology Dental Public Health Oral and Maxillofacial Pathology Oral Medicine Oral Surgery Orthodontics Paediatric Dentistry Restorative Dentistry Special Care Dentistry |

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| Outcome of Specialty Training self-assessment against the Standards for Specialty Education. | No GDC actions identified for the training commissioner |
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Full details of the process can be found in the annex

Summary

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| Remit and purpose: | To quality assure the specialty training and education being delivered by Health Education England Yorkshire and Humber |
| Standards for specialty education: | All |
| Dates of submissions: | March 2021 and June 2022 |
| GDC Staff: | Patrick Kavanagh (Policy Manager) Gail Fleming (Interim Head of Education Quality Assurance) Amy Mullins-Downes (Quality Assurance Operations and Development Manager) Martin McElvanna (Education Quality Assurance Officer) |
| Education associates: | Timothy O'Brien Gill Jones |

This report sets out the GDC analysis of the self-assessment and evidence submission by the Health Education England, Yorkshire and Humber (hereafter referred to as "HEE YH") against the *Standards for Specialty Education* ("the Standards").

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

The GDC (also referred to as the "associates" and the "panel") wishes to thank the Postgraduate Dental Dean (PGDD) and staff at HEE YH for their co-operation and assistance in this specialty submission process.

Of the 20 Requirements under the Standards, the GDC considers that the submission from HEE YH demonstrates:

| | Number of Requirements | Requirements |
|-------------------|-------------------------------|--|
| Met | 20 | P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19 and P20 |
| Not met | 0 | |
| Partly met | 0 | |

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 | Met |
| P11 | Met |
| Standard Three | |
| P12 | Met |
| P13 | Met |
| P14 | 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).

To demonstrate meeting this Requirement, HEE YH provided considerable information, including recruitment policies and procedures, trainer: trainee discussions, committee members and trainers' training, portfolios and progression statistics, Annual Review of Competency Progression (ARCP) information, dental specialty training (DST) meeting minutes and external and lay reports.

HEE YH described the national processes underpinning specialty recruitment with clear guidelines outlining the requirements for eligibility. Each specialty training programme works to a nationally agreed person specification which outlines the required attributes and competencies. All Training Programme Directors (TPDs) review the recruitment process as part of their annual appraisal.

There is evidence of externality with reports from lay and external individuals involved in relevant recruitment processes.

All trainees progress through their training programmes, acquiring appropriate new skills with clinical supervisors (CS) and constantly re-evaluating trainees' progression to ensure that they are skilled to undertake the safe treatment of patients. Formal review of this progress is undertaken at ARCP.

The panel learnt that in support of the national framework, a mandatory ARCP is undertaken after the first six months of training. If required, additional support and focused guidance for trainees is provided.

HEE YH explain that there is a shared responsibility between placement providers and HEE YH which is outlined in the Learning Development Agreement (LDA). This dictates the requirements of service provision throughout training as well as access to patients and procedures.

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 Met).

HEE YH explained that there was a campaign in the Yorkshire and Humber region to ensure that all local Trusts were extensively using identification badges to confirm a trainee's name and position. In addition, during induction at these organisations, trainees are advised about the importance of appropriate and compassionate introductions, using "Hello My Name Is" NHS consent forms when meeting any patient in a clinical context, particularly where treatment occurs.

HEE YH explained that a review of the LDA is also currently underway at HEE national level to produce a National Education Contract. This new contract will include a clause which requires Trusts to have a policy in place which will inform patients that they are being treated by a trainee. Therefore the consent process is managed primarily at Trust level, in adherence with the LDA with HEE.

All trainee levels are identified on the trainee management system (TIS) which is used for placement rotation management at the LEP to ensure the trainees are added to the correct programme and identified at the correct level.

We consider that this Requirement is 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).

HEE YH explained in their self-assessment that HEE YH issue a NHS Education Contract annually to all its education providers. This describes the expected levels of service provision, commitments to education and training for all employees including specialty trainees and supervisors. It also refers to mandatory requirements to undertake a programme of training and mandatory compliance with legislation regarding patient care and equality and diversity training requirements.

HEE YH has a dedicated quality team who work with the Postgraduate Dental Dean (PGDD) and senior dental team to monitor incidents reported, risks identified, patient safety issues raised and the escalation of concerns to oversee the safety of the learning environment. The clinical and educational supervisor framework supports trainees to achieve this. Trainees regularly contribute to quality improvement and audit activities within their working environment and these are recorded in e-Portfolios for evidence at the ARCP.

Regular Monitoring the Learning Environment (MLE) meetings and annual Senior Leader Engagement (SLE) visits are held to discuss the intelligence collated by HEE YH from its stakeholders. We saw evidence of the formalised agenda of MLE meetings and the recording of feedback from the National Education and Training Survey (NETS). Areas of good practice were also noted. If concerns are identified at the MLE meetings and SLE process, requirements are issued for the placement provider to address, complete with timescales and evidence of progress against these. This is covered in further detail at Requirement P8.

HEE YH also have a system of annual collection of Self-Assessment Reports (SARs) including dentistry, where stakeholders are invited to provide information on progress of the organisation and any areas of good practice in relation to education and training. Each Trust has an allocated Quality Lead who reviews and analyses the SAR to identify potential performance issues with learners or patient safety incidents. The outcome of SARs is raised at the next MLE meeting by the allocated Quality Lead.

The panel were satisfied that reference to equality, diversity and inclusion was referenced in multiple documents in HEE YH's submission. This was clearly evidenced in the national recruitment process by way of trainee requirements and it is closely monitored by education supervisors (ES) and at RCP panels.

We consider that this Requirement is 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).

HEE YH explained that the PGDD is responsible for ensuring that the learning environment and the quality of training is reviewed on a regular basis. Trainees are allocated a suitable CS and ES to ensure that they are adequately supervised. This process ensures that all trainees, through supervision and ARCP, develop their training in line with their specialty curriculum and that patients are being treated in a safe manner.

An important aspect to trainee development is the first six-month RCP. At this RCP, evidence of educational supervisor meetings, clinical supervisor reports and work-based assessments are formally reviewed and an ARCP outcome is given. HEE YH monitor the outcomes of the ARCP process to ensure trainees are supported to progress and continue to receive 6-monthly reviews when required.

We saw an examples of a LDA which illustrates the details of discussions and levels of supervision and monitoring.

We noted that staff and trainers have protected time for supervision and are supported by employers and there is confirmation that this is included in appraisals.

HEE YH confirmed that trainees are allocated a suitable ES CS to ensure that they are adequately supervised. These trained individuals provide evidence of progress through Work-based Assessments (WBA), quality improvement projects, courses attended and supervisor reports.

HEE YH gave a clear explanation of how trainees are appropriately supervised throughout programme.

We consider that this Requirement is 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 Met).

The narrative and the information supplied in the evidence, notably the extracts from HEE YH Practice Assessment Record and Evaluation System (PARE), HEE YH Mentor Support Group Record and HEE YH Dental Workforce Development Faculty Educational Appraisal Framework are comprehensive.

A Professional Development Framework for Training Programme Directors and Educational Supervisors was introduced in 2017 to establish a set of standards required to ensure the quality of medical and dental education and training clearly sets out patient safety requirements and enhances the quality of care being provided.

We noted that a bespoke dentistry training package has been developed called HEE YH MIAD Training the Trainer Log to ensure that supervisors receive the requisite training for their roles, which includes equality and diversity training.

One of the requirements of trainees' e-Portfolios is that an assessor must indicate the training undertaken prior to, and when validating assessments, to provide assurances that they are suitably trained for the role. These are reviewed at the TPD Appraisals within the HEE YH Dental Workforce Development Faculty Educational Appraisal Framework.

We consider that this Requirement is 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).

HEE YH submitted evidence demonstrating a range of systems that allow specialty trainees to raise concerns.

The induction process sets the expectations of specialty trainees from commencement of a training programme and this includes their duty to protect patient safety. Trainees are made fully aware of how to raise concerns at the HEE YH induction and that this should be done via the local provider's policy in the first instance. We saw an example of an induction agenda where one of the sessions is headed "Raising concerns". Trusts also sign an NHS Education Contract which is legally binding between HEE and the training provider to ensure that staff feel comfortable to raise concerns relating to patient care in an open and transparent manner via Escalation of Concerns.

The PGDD promotes an ethos of openness to support a culture of transparency, encourage feedback and whistleblowing. Trainees can also contact TPDs who will respond on a case-by-case basis to concerns raised and escalate to the Head of School if necessary. All concerns are discussed at the Specialty Trainee Committees (STC) as and when they arise. HEE YH explained that had not been any issues logged relating to dental specialty training.

The raising of concerns is also underpinned through regular MLE meetings, learner / educator visits and SLE visits to discuss the intelligence collated by HEE YH for discussion with stakeholders.

We consider that this Requirement is 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).

HEE YH explained the supporting mechanisms for dealing with patient safety issues. We noted the evidence presented covers descriptions of policies and procedure together with evidence of overarching quality meetings, agendas and minutes of the Dean's Executive Meeting for Quality TOR and Dean's Executive Meeting.

Each of HEE YH's providers have an allocated Quality Lead who maintains regular contact regarding matters relating to education and training. Significant concerns are escalated immediately to the PGDD. Intelligence from wider surveys such as NETS and the confidential ARCP Trainee Form R also feed into the mechanisms for identifying areas of concern and are reviewed by the Senior Team.

Details of serious adverse incidents (SAI) are recorded through the revalidation exception reporting mechanisms within the quality management database. These are made available to the HEE YH revalidation team and are monitored through the quality team for further discussion with the PGDD. Trainees are also expected to declare any such incidents on their e-Portfolio which are then reviewed by the ES and TPD and if necessary, raised with the PGDD or Deputy Dean. Information relating to any exception reports are recorded via the quality management database.

HEE YH report that there haven't been any SAIs relating to dental specialty training but a mechanism exists should these arise.

HEE YH submitted quality visits and associated reports with action plans for Oral Surgery and Special Care Dentistry to illustrate how risks are managed.

HEE YH reported that concerns identified in the reports were minor in nature and therefore not needed to be flagged to the GDC.

We consider that this Requirement is 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 YH explained that it follows the principles in the national HEE Quality Framework document. The document forms the basis for HEE YH to map its functions to all aspects of specialty training from trainee recruitment to recommendation of a CCST, ensuring alignment with the set curriculums and regulations.

When we met HEE YH, the PGDD explained that ultimate responsibility for the quality function is the PGDD. The quality framework is supported by national NHS Education Contracts with each placement provider which outlines service provision that must be undertaken by the respective provider. The HEE YH quality team liaise with programme providers and Trusts who are responsible for providing an appropriate range of patients to allow the relevant curriculum to be delivered. Discussions take place with clinical leads regarding placements, for example, where there are niche areas of training and specific resourcing requirements for patients.

All dental specialty training programmes are mapped to the relevant GDC curriculum and we saw an example of this in Orthodontics. This is further facilitated by the trainee e-Portfolio, where evidence of learning can be mapped to the relevant curriculum.

HEE YH currently have seven Specialty Training Committees (STC) who manage nine associated specialties. These are held independently to review the requirements of the training programme and includes representation from the PGDD, Quality Team and TPDs. The Quality Team is responsible for managing the impact of programme developments through the STCs.

As discussed earlier at Requirement P3, the Quality Team carry out regular MLE meetings with training providers. HEE YH cited a good example of this process in operation. Local intelligence of a potential patient safety issue in Oral Surgery was flagged. The Quality Team along with the PGDD subsequently held a MLE visit in March 2019 and it became apparent that there were issues regarding inconsistent clinical supervision and disproportionately high levels of undergraduate teaching time. An urgent requirements action plan was initiated via the Learner Educator Report (LER) to give the provider a clear plan of improvements required and timescales for completion. By way of follow up, a bespoke survey was circulated to specialty trainees in Oral Surgery which included a question regarding supervision to check that the necessary improvements were being made. Trainees reported being satisfied the changes to their educational supervision with more regular meetings with their ES and the large amount of undergraduate teaching had been reduced.

We noted the contents of MLE Trust Open Requirements Detailed Reports 19/0038-19/0041 with requirements, actions and progress updates.

Within YH HEE, the national document 'Enhancing Training and Support for Learners 2018' provides clear association between the ARCP decision-making process and the feedback that is given to all trainees. The ARCP Panel is considered to be objective and outcomes are solely based on evidence submitted by trainees within their learning e-Portfolio. The ARCP process enables HEE YH to make adaptations to the training programmes as required.

We consider that this Requirement is 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).

As detailed in the HEE National Quality Framework and Approach to Quality Interventions guidance, HEE YH participates in three Quality Surveillance Groups (QSG) that brings together CQC and various key stakeholders to consider quality risks across the system as identified in the Intensive Support Framework (ISF) where higher level concerns are escalated. HEE YH confirmed there have not been any escalated dental concerns to QSG in Yorkshire and Humber.

Monthly dental Senior Team Meetings (STM) and the Dental Executive Meeting for Quality (DEMQ), attended by the PGDD, are utilised to discuss in more detail any actions resulting from quality reviews. As explained at Requirement P7, DEMQ support HEE YH to comply with the HEE National Quality Strategy and Framework. The PGDD has a regular item on the agenda with formalised minutes and the authority to escalate concerns if required.

The PGDD along with the Quality Team identify areas of concern for discussion with all stakeholders, to monitor and resolve issues identified and previously described in Requirement P3. The appropriate quality intervention is organised through a standard joint approach. An example of such an intervention took place following information relating to curriculum mapping. This resulted in a region-wide Special Care Dentistry (SCD) programme review to assess any identifiable risks within the training environment, followed by an SCD Programme Review Outcome Report. Several concerns were categorised for escalation. These were subsequently managed through the quality database and triangulated with evidence from ARCP, resulting in a satisfactory outcome.

The panel saw evidence of this in the SCD Programme Review agenda, outcome report, outcome requirements and action plans from the quality database.

The progress updates within action plans covers tasks such as the reviewing of timetables to ensure a wide range of experience and allowing trainees good access to educational opportunities, trainees based in the community being granted access to Acute Trust library facilities. A significant action is to have an overarching TPD for Yorkshire and Humber with regular access to the Associate Postgraduate Dean for specialty training.

We consider that this Requirement is 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).

There is discussion regarding the workings of the quality framework at Requirements P8 and P9.

The panel saw evidence of quality management procedures such as the HEE YH Multi-professional Dental Review November 2016 agenda and HEE YH Multi-professional Review of Dental Training Programmes 2016 Report which demonstrate the breadth of HEE YH's activity. HEE YH explain how the PGDD reports at COPDEND as well as the activity of the Dental Specialty Training Advisory Group. We saw supporting evidence comprising agendas for individual meetings.

Regarding external quality assurance, HEE YH noted the use of SAC external assessors as well as lay representatives who are key to ensure consistency and fairness of process, as well as informing and supporting change within the quality management procedures of HEE YH. SAC External Assessors and lay representatives also attend Quality Visits and are integral to quality management processes. An example of this was the SCD Review, as outlined at Requirement P9.

We consider that this Requirement is 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).

HEE YH explained that the PGDD is responsible for the management of dental specialty training and this includes the quality of placements. Support is provided through the established quality functions within programme management and quality teams. STCs undertake ongoing surveillance of placements and programmes (for example Oral Surgery STC 2019), with input from trainee representatives.

The quality monitoring intervention and report referenced in Requirement P9 illustrates feedback from specialty trainees on the quality of placements and rotations to ensure that patient care and assessment in all locations meets the standards expected. Response to the feedback is also outlined at Requirement P9 and involves setting requirements, action planning and requesting evidence of changes made.

The use of the annual NETS to trainees for feedback on areas relating to induction, curriculum delivery and patient safety also identified any issues with placements. Any significant concerns that are identified are escalated to a risk-based review, where impacts on the training environment are raised through HEE YH's process for escalating concerns.

Further feedback from trainees is also obtained via completion of confidential Training Post Assessment Forms that are viewed only by the PGDD or Deputy as part of the ARCP process and are designed to allow trainees to provide honest feedback on their training environment.

HEE YH explained that the practice of collecting and considering patient feedback is an essential component of training. This is also mandated as part of the ARCP process, although the requirements for MSF vary between specialties as discussed at Requirement P13.

An example of this are the developments that took place within the seven STCs, to ascertain whether programme placements delivered a sufficient breadth of training and consider whether rotational arrangements to other placement providers were required to allow for a broader experience for all trainees. Following trainee feedback and consultation, a rotational structure in Oral Surgery was implemented to allow for trainees to broaden their educational opportunities.

Finally, all trainees participate in an exit interview when leaving a programme, either through natural progression or resignation. These are also a valuable source for trainee feedback on their educational experience.

We consider that this Requirement is 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 their submission, HEE YH explained that there is robust support, guidance and evaluation for trainees, beginning with trainee recruitment, throughout training and leading to the recommendation of a CCST.

In particular, the use of the 'real-time' e-Portfolios by trainees is key to demonstrating progress against the full range of the relevant specialty learning outcomes. ES's can review trainees' progression and progress against the relevant curriculum requirements. The ES can offer guidance to trainees to identify areas of targeted support. Evidence is collected throughout the training period and can be reported and acted upon at any time. We saw an example of one trainee who started training in September 2020, but the evidence regarding the trainee's performance led to an ARCP being held several months earlier than scheduled to address deficiencies identified and to support the trainee further.

Within the e-Portfolio, trainees can select the evidence and assessments undertaken to demonstrate achievements across the full range of the learning outcomes relevant to their specialty training programme. This also meets the requirements of the Dental Gold Guide and the HEE ARCP Standard Operating Procedures.

The panel saw evidence that the ARCP is a robust process to ensure that a full review of all trainees' progression continues throughout training. It is dictated by the requirements in the Dental Gold Guide. It enables the ARCP panels to be satisfied that the training period undertaken is compliant with SAC recommendations and provides clear guidance on any outstanding requirements needed to achieve the award of CCST.

The ARCP panels take into account a variety of evidence, such as time in training, WBAs, e-Portfolios, professional examinations, multi-source feedback (MSF) and research if applicable. These are detailed in the HEE YH ARCP checklist. The evidence is triangulated and assessed using a structured ES report and the attendance of several assessors, as well as the ES, SAC external member, associate dental dean, TPD and a lay representative. A Clinical Supervisors Assessment Form is also presented which asks CS's to indicate a specific outcome for the trainee in five separate domains and this is applicable to all specialities.

HEE YH helpfully explained the detailed breakdown of ARCP outcomes during 2020. We were also provided with an example of an Oral Surgery trainee who was awarded an Outcome 6 in summer 2021. This illustrated the ARCP in action, leading to the recommendation of a CCST.

We consider that this Requirement is 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).

HEE YH explained that activities focusing upon the management of WBAs are dictated by the specialty curricula.

HEE YH indicated that the numbers of assessments being undertaken are determined by the SACs, as a component function of the ARCP panels.

As discussed at Requirement P12, the HEE YH ARCP checklist demonstrates the range and breath of assessments that take place.

HEE YH explained that it adheres to the assessment strategies as described in the specialty curricula.

Regarding feedback, trainees are strongly encouraged to raise and discuss feedback with their CS and ES. This can be formalised through the three ES meetings that take place and these are recorded in the e-Portfolio. Trainees complete their MSF annually and trainees are supported through this process to identify shortfalls in training and progression. The ARCP checklist also includes patient feedback as another input into the assessment process. Each specialty page on the HEE YH dentistry website has a patient feedback section where the form and further details are available. Trainees are also asked to check the SAC guidance on the numbers of MSF required.

We consider that this Requirement is 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).

HEE YH explained that each of the specialty curricula define the types of assessment required for specific learning outcomes. Many curricula also have a specified number of WBAs to support the assessment of trainee progression throughout training. Requirements for assessments are defined by the relevant SAC.

The achievement of specific learning outcomes is tested by a variety of recognised and current methods and include WBA's, logbooks, trainee reflection and patient and colleague feedback.

HEE YH explained that it utilises a range of methods to ensure regular monitoring and to identify improvements and developments to assessments through its quality framework and in line with the Dental Gold Guide. This involves input from stakeholders such as providers and the SAC. As described earlier at Requirements P9 and P11, HEE YH can avail of quality interventions to maintain dialogue with providers, validate concerns and introduce suitable adjustments, so that curriculum requirements are met. This is in addition to the regular local monitoring that takes places with providers and local and national surveys. The PGDD, with support from the Quality Team, is ultimately responsible for ensuring that the learning and training environment is satisfactorily reviewed on a regular basis.

HEE YH provided an example of an issue which led to improvement. It became apparent some clinical supervisor feedback was sometimes difficult to interpret, or trainers were reluctant to judge trainees' performance negatively. To address this, HEE YH designed an additional assessment sheet which is more prescriptive to enable supervisors to make judgements on trainee progress in five key domains, applicable to all specialties. This document is unique to HEE YH and is now used regularly.

We consider that this Requirement is 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).

As explained earlier at Requirements P4 and P12, the ARCP is a key tool for identifying and assessing trainees' progression in accordance with their learning outcomes.

HEE YH explained that in 2011, all of the dental specialties moved from paper-based evidence to e-Portfolios, which is more reliable for the ARCP process. The e-Portfolio checklist provides detailed information relating to the learning outcomes is a tool for ensuring that appropriate monitoring of trainee progression takes place.

HEE YH explained that the e-Portfolio system is essentially the main tool used for the planning, monitoring and recording of assessments. Various platforms are used by trainees to do this, with the Intercollegiate Surgical Curriculum Programme (e-Portfolio) being the main one. Other e-portfolios have also been developed for other specialties such as Oral Pathology (Learning Environment for Pathology Trainees (LEPT), used by the Royal College of Pathologists),

Dental Maxillofacial Radiology (Kaizen, Royal College of Radiologists) and Dental Public Health (NHS e-Portfolio).

We consider that this Requirement is 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 explained at Requirement P1, HEE YH enter into a LDA with each provider, setting out the contractual requirements of service provision.

Each of the specialty curricula provides clear expectations on the number of patients and procedures that are expected of trainees.

Alongside the LDA and supervisors, HEE YH can be assured that trainees have appropriate exposure to complex patients and procedures throughout the progression of their training. Training activities are measured via evidence submitted by trainees for WBAs and recorded in the e-Portfolio. This is where exposure to complex patients and procedures is also logged, demonstrating development of trainees' competency.

WBAs are essential to record procedures by trainees which align to their learning outcomes. As trainees' knowledge and ability to independently manage a higher complexity of cases, the educational and clinical supervision requirements are adjusted accordingly. Trainees only undertake procedures when they feel competent.

The panel noted the description of the HEE YH Trainee Logbook Oral and Maxillofacial Radiology, an anonymised e-Portfolio and a HEE YH Progress Against Curriculum Example to illustrate trainees' progress.

We consider that this Requirement is 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).

All trainers (TPD, CS, ES, etc) are expected to have ongoing feedback discussions with trainees to discuss educational and clinical aspects of their training performance. This is recorded within trainee's portfolios which are reviewed during the ARCP. The final ES report also includes feedback from CS's and is essential in the ARCP process.

HEE YH explained that the ARCP is not the only means for trainees to receive feedback on their placements. There is an expectation that supervisors engage with trainees in providing feedback regularly and prior to ARCP.

Trainees must consider patient feedback and this is mandated as part of the ARCP process. Trainee reflection is recorded in their e-Portfolios. Trainees are encouraged to use all sources available to become a reflective practitioner and utilise publications, such as the COPMED Reflective Practice Toolkit and Benefits of becoming a reflective practitioner. Trainees are required to undertake MSF annually, which also encourages reflective practice on their training period to improve performance.

We consider that this Requirement is 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).

HEE YH explained there have been developments against this Requirement in recent years. In 2016 it became apparent that access to training and accreditation was not consistent for all dental educators across the dental specialties. In 2017, HEE introduced a Professional Development Framework for Supervisors to establish the standards required to ensure quality in and dental education. This framework has been revised several times since. HEE further developed a HEE YH Dental Workforce Development Faculty Educational Appraisal Framework document to enhance engagement with its trainers. In 2018 HEE also developed the document "Enhancing training and the support for learners" to further expand this level of support, which is a national initiative.

Equality and diversity training must be undertaken by ARCP panel members. As assessors are an integral part of the ARCP processes, they receive the appropriate specified training for the assessments they are involved with. All of these checks are validated in the ARCP process.

All clinical panellists participating in ARCP panels are provided with access details for the relevant e-Portfolio, as well as working knowledge of the appropriate curriculum.

Supervisors also receive the appropriate training to assist with supervision of learners. The development of the online PARE system has been expanded to allow for a record of all accredited trainers with the stakeholder organisations. Within HEE YH, a Mentor Group provides support for all supervisors and trainers. HEE YH explained that given the spread of the dental specialties across the region, CS's and ES's may also be trained to undertake both roles.

A requirement of the e-Portfolio states that assessors must indicate their completion of training prior to validating assessments to ensure they are suitably trained for the role.

OMFS CS's and ES's will undertake training at Trust level and this is recorded on the PARE system.

We consider that this Requirement is 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).

HEE YH explained that all ARCP panels are required to have an external SAC nominated representative and lay representative, who should review a minimum of 10% of outcomes and also review all developmental and non-progressive outcomes. The lay representative is an independent member and is present to review the process in relation to fairness and consistency. External assessors also provide assurance that appropriate standards are met and the processes involved are fair and transparent.

All outcomes are reviewed by the PGDD through the appropriate STC to consider all aspects of the review to ensure the robustness of the review process. Feedback from external assessors and the lay representative and suggestions for improvements to the process are also considered.

Within HEE YH in the past 12 months, four adverse outcomes were issued relating to exam failure and inadequate progress resulting in follow up discussions.

Trainees can appeal an ARCP outcome via the Appeals Procedures Rules. HEE YH indicated there have not been any appeals in the previous 12 months.

Standard-setting for formative assessments is addressed via examiner training. For summative assessments, this is done by the respective Royal College.

We consider 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).

HEE YH explain that trainees are made aware of the standard expected of them in each area of assessment through induction and each stage of stage, where the curriculum requirements of the SAC are explained and there are rigorous methods of assessment throughout each programme, for example, the full range of WBAs.

HEE YH assessors must complete all of their training prior to undertaking and validating an assessment.

Each of the dental specialties has a checklist to assist trainees and supervisors with using e-Portfolios and recording evidence throughout training and in preparation for the ARCP.

Briefings to all of the ARCP Panel members takes place before the panel meeting. This includes clear guidance outlining the expectations of the ARCP outcomes, either developmental or non-progressive. This allows for consistency and alignment amongst trainees and assessors.

Those trainees issued with a developmental or non-progressive outcome are offered support meetings where professional support available is explained to them.

We consider that this Requirement is Met.

Summary of Actions for HEE YH

| Req. number | Action Due date: | Observations & response from HEE YH |
|-------------|---------------------|-------------------------------------|
| | No actions | |

Observations from the provider on content of report

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 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 QA Process

13. The 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 [_](#)).

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:
- 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 providers 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 programme provider'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 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."
 - 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 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.
 - c. 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.
 - d. **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 QA 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 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 annual monitoring/updates.
- g. 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 QA activity.