General Dental Council
Revalidation Stage 1 Feasibility Study
Final Report

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1 EXECUTIVE SUMMARY

1.1 Understanding of and Support for Revalidation

At a conceptual level, there was widespread understanding that revalidation has been inevitable for some time; a consequence of:

- High profile malpractice cases;
- Movements in the medical profession towards revalidation of doctors and;
- Increasing accountability of professionals to the GDC.

In terms of support, the views of the profession towards revalidation are widespread. A significant proportion thinks it is both necessary and likely to have an impact, whilst a smaller, though significant proportion feels it is unnecessary, a waste of time and unlikely to have any impact.

Those least likely to be supportive of the initiative appear to be those with many years of experience (in excess of 25 years) and, surprisingly, those most recently qualified.

1.2 Potential Impacts of Revalidation

The majority of respondents agreed that revalidation is unlikely to uncover 'the next Harold Shipman'; however, there was some agreement that there could potentially be some smaller – though significant – impacts, including:

- The establishment of a set of minimum standards to which all professionals must perform;
- Prioritisation of other regulatory initiatives which are currently being ignored by some, e.g. PDPs and appraisal;
- An opportunity for those less well organised to improve.

1.3 Areas for Assessment

There was widespread agreement that three of the four key areas of assessment for revalidation were intuitive – Professionalism, Communication and Clinical. Many however felt that Management and Leadership was not an area which should be assessed on an individual professional level. The view was that for Associates, VTs and others, Management and Leadership is not an important issue. Oftentimes,

participants felt that this was more an area for practice-based assessments, rather than practitioner.

When asked of the key attributes of good dentists, responses tended to group into four specific categories:

- Professionalism / Conduct
- Clinical competence / aptitude
- Patient Focus
- Compliance-related / Quality assurance.

1.4 The Evidence Gathering Process

The range of time spent on the collation process was vast, from simply taking all information contained in one file / filing cabinet, to a full working week. The most significant impact on the time commitment was the extent to which evidence submissions were based on the interpretation of the individual. Some participants felt that a single certificate, e.g. Denplan Excel, was enough to cover the process, whilst others felt that they had to submit every document held in the practice for the last five years or so.

The most frequently cited time taken to complete the process across all groups was 1 – 2 hours (32%), followed by 2 – 4 hours (26%).

Around two thirds (66%) of respondents felt that it was very or quite easy to collect the relevant evidence to revalidate, whilst around a fifth (21%) felt it was very or quite difficult. The key issue appeared not to be locating the evidence, but rather discerning what was relevant for inclusion.

The actual types of evidence submitted were incredibly diverse and analysis of submissions was very difficult on the basis of the diversity and also the varied levels of organisation – whilst some submitted evidence referencing the standards and evidence framework, others simply sent in hundreds of sheets of paper in no logical order (which may account for the short time spent by many collating evidence).

1.5 Views on a Portfolio Based Approach

Nearly two thirds of all participants (63%) were positive about the appropriateness of a portfolio-based approach to revalidation, whilst around a fifth (22%) were more negative in their outlook.

The main perceived strengths in this approach included:

- The majority (83%) had retained all documents which they felt would be relevant to revalidation – only 17% had documents which had not been retained but could have been used;
- Administering the process in this way was a good way, for the majority, to avoid a face-to-face assessment;
- Practices with a well organised practice manager were able to delegate much of the work and;
- It allowed some individuals to ensure their filing was in order and well organised.

On the other hand, the key perceived weaknesses included:

- The potential administrative burden on the individual practitioner and their associated practices;
- The potential cost implications on the side of the GDC in evaluating portfolios and the subjective nature of success;
- The lack of 'live' experience with dentists in surgery;
- The extent to which revalidation relies on patient feedback in the framework.

1.6 Patient Feedback

Patient feedback was a subject which attracted a widespread degree of concern from participants. When asked in the telephone interviews about what types of required evidence were not good indicators of performance, the most frequently received answer related to patient feedback. The principal argument was that for the majority of standards, patients are not well placed to assess the extent to which the dentist is performing acceptably.

A number of participants commented that patients in general only care about three things: how long the treatment will take, how much it will cost and how much it will hurt. Therefore whilst expensive and painful treatments may be the most appropriate solution, patients run the risk of being dissatisfied after appropriate treatment.

1.7 Integration with Other Initiatives

It is essential that revalidation is integrated with other, already established initiatives. Many felt that, as a superior certification to revalidation, a Denplan Excel certificate should be enough on its own to revalidate. Others argued that the BDA Good Practice Scheme, together with CPD logs and certificates should be enough – though there was some suggestion that other initiatives too should be included.

1.8 The Standards and Evidence Framework

There was widespread agreement that the use of a framework as guidance for portfolio collation was essential. In general, the outcomes listed on the framework, though often difficult to provide evidence for, were generally warmly received. in addition to concerns about the over-reliance on patient feedback, participants were also concerned about the lack of specificity in the framework in terms of evidence required and for how many retrospective years evidence was required.

Much of the discussion around the framework focussed on its need to be simple and prescriptive. Much of the information in the outcomes was left open to interpretation or was seen as too non specific in terms of the amount – and type – of information required. The consequence of this was that participants were often left feeling uncertain about what to include and often would send too much information, or too little.

1.9 Alternative Approaches

Participants struggled to determine any alternative, suitable methods of revalidation beyond that which is being proposed. Throughout the interviews and focus groups, three possible alternatives were suggested:

1.9.1 Face-to-Face Assessment

For many, this was the only way to ensure the acquisition of reliable, clinical information about a professional. Nevertheless, most understood that the prospect of carrying out in excess of 20,000 face-to-face assessments was both costly and impractical.

1.9.2 Auto-CPD Updates

This suggestion, although again potentially impractical, was for the GDC to take on the burden of revalidation. This would involve submission of all CPD course

certificates directly to the GDC for each registrant to automatically update personal registration accounts.

1.9.3 Educational Approach

The final suggestion was that, rather than an evidence-based approach, registrants should be required to attend core training days / conferences, hosted by the GDC covering the key points of revalidation. Those who do not attend for any reason would then go on to some form of face-to-face assessment.

1.10 Recommendations

Based on the experiences of participants in this study, we would recommend consideration of the following.

- Reconsider the reliance within the framework on patient feedback;
- Improve the specificity on the standards and evidence framework in terms of outcomes, what evidence is required / acceptable and over the course of how many years evidence should be produced;
- Ensure revalidation is effectively integrated with other, well established initiatives;
- Consider the production of a storage facility (a file or a box) for registrants to store evidence as they collect it, together with a CPD log diary / pro forma;
- Invest in the capacity to manage revalidation online, through eGDC;
- Reconsider the importance of a census approach, versus random sampling;
- Reconsider the inclusion of Management and Leadership in the four key areas of assessment.

2 BACKGROUND AND OBJECTIVES

2.1 The General Dental Council and Revalidation

Once they are registered with the GDC, dental professionals have to show they have kept their knowledge up-to-date by meeting the GDC's continuing professional development (CPD) requirements. Over a five year period, all dentists must complete 250 hours of CPD, of which at least 75 hours should be verifiable, and the remainder non-verifiable. Dental Care Professionals (DCPs) should complete 150 hours of CPD in this time, of which 50 hours should be verifiable.

In light of its principal aim to protect patients through effective regulation, the GDC identified a need to expand the scope of its regulatory activity beyond compulsory CPD (which only ensures that knowledge is kept up-to-date), to ensure dental professionals can demonstrate continued fitness to practise by meeting the standards required for registration on a regular basis. As such, the GDC has proposed a programme of revalidation for all dentists. The principal aim of revalidation is to allay concerns about patient safety, by reassuring the public that professionals are up-to-date and fit to practise.

Revalidation through the GDC means that, in addition to CPD requirements, dental professionals will need to be able to demonstrate that they are fit to practise in the respective fields in which they perform and meet the standards required for registration through the GDC.

The GDC has outlined the following series of objectives and principles in the development of revalidation, to which it is committed:

- The principal objective of revalidation is to give reassurance to patients and the public that dental professionals meet a satisfactory standard to maintain their registration with the GDC. It is not a guarantee that nothing will ever go wrong;

- The GDC will take the views of patients into account when developing revalidation;

- The GDC aims to develop a process which requires all dental professionals to be able to show, on a regular basis, that they meet the standards required for continued registration in the field(s) of practice in which they perform;

- The GDC will set the standards against which registrants must demonstrate their suitability for continued registration;

- The product of revalidation will be a binary decision; either the dental professional is revalidated or (s)he is not;

- The GDC will not delegate revalidation to employers or commissioners of services.

2.2 Revalidation Development Principles

In the development of the revalidation programme, the GDC has committed itself to the following set of principles to ensure protection for the public whilst also peace of mind for the profession:

- The process of revalidation should be proportionate to the problem it seeks to address;

- The process should not place burdens upon registrants except insofar as it is necessary to protect the public interest;

- The GDC will use pre-existing mechanisms and evidence where possible and appropriate;

- Revalidation will be simple and flexible, summative and formative;

- The GDC will develop work in partnership with key stakeholders in the development of revalidation; including professional associations, employers and governmental organisations and departments;

- The approach, where relevant will be comparable with other professional bodies' approaches;

- The GDC will identify and seek to mitigate equality and diversity implications arising from the development of revalidation;

- Intensity, frequency and content of revalidation will be proportionate by role in terms of public protection.

2.3 The Process of Revalidation

The current proposals outline four key areas against which individuals are revalidated:

- Professionalism
- Clinical
- Communication
- Management and Leadership

The process is intended to be developed and implemented through three stages:

- **Stage 1: Sifting of all dental professionals**; whereby each practitioner must provide a portfolio of evidence to demonstrate aptitude in a key set of minimum standards. The required evidence is set against a standards and evidence framework which outlines the principles against which practitioners must show they meet the requirements. It is expected that most will be revalidated at this stage whilst a small number will be identified who require a "further look".

- **Stage 2: Assessment of selected dental professionals**; those who fail to provide sufficient evidence at Stage 1, will then be subject to a programme of peer assessment.

- **Stage 3: In-depth (external) assessment**; those assessed at Stage 2 will be whittled down further whereby those not meeting the standards set at Stage 2 will be subjected to an external assessment – this will be the final opportunity to be revalidated.

2.4 The Revalidation Stage 1 Feasibility Study

In December 2008, George Street Research was commissioned by the GDC to carry out the Revalidation Stage 1 Feasibility Study amongst a cross section of dentists in the UK. The study took the form of a pilot programme whereby proposed Revalidation Stage 1 is tested in terms of its feasibility. This evaluation is intended to form the basis of the development of the revalidation process and to assess the extent to which the current process is effective and practical.

Participants were recruited through three channels: by Denplan, South Yorkshire and East Midlands Deanery, or through a random sampling approach by George Street Research.

2.5 Research Objectives

The principal aim of this research was to evaluate experiences of the pilot community of dentists in the collation of evidence for their revalidation and as such, establish the extent to which the current revalidation model is adequate and maintaining of its core objectives.

Specifically, the research sought to address:

- What the time commitment is for the process of gathering revalidatory evidence;
- The extent to which the proposed process will work in practice and for what reasons;
- To what extent is the requisite information appropriate, relevant and useful and what evidence should be required / should not be required;
- Other recommendations required to ensure a comprehensive and cohesive revalidation process that benefits patients and professionals alike.

3 METHOD AND SAMPLE

This section of the report outlines the method of approach undertaken across the three different subgroups throughout the fieldwork period.

3.1 Recruitment

As mentioned, participants were recruited through one of three channels – through Denplan, South Yorkshire and East Midlands Deanery, or 'free-found' by George Street Research. As part of their commitment to participation, all were recruited on the basis that they should submit a portfolio of evidence and would be required to participate in a focus group, or a semi-structured telephone interview.

Around 2,000 UK-based, Denplan registered dentists were sent a letter from Roger Matthews, Chief Dental Officer at Denplan, explaining the background to revalidation and asking for willing volunteers. Those interested in participation declared their interest by signing a Participant Consent Form to a named representative from Denplan who passed the relevant details to George Street Research. A total of 100 Denplan dentists were recruited to participate in the study, of whom 91 actually submitted evidence and were spoken to in either a focus group (17) or a telephone interview (74).

A similar process was undertaken by Julie Platts at South Yorkshire and East Midlands Deanery who sought out volunteers from the deanery to take part in the study. Again, those willing to participate sent in a signed consent form and the relevant information was forwarded on to George Street Research. In total, 89 dentists from the deanery were recruited to participate in the study, of whom 61 actually submitted full portfolios of evidence and 79 were spoken to in either a focus group (18) or a telephone interview (61).

To supplement the sample, George Street Research was also asked to recruit an additional 100 participants from around the UK. Quotas were imposed on the sample structure to include dentists from London, Scotland and Northern Ireland. To achieve this sample, prospective participants were telephoned at their practices by George Street Research's in-house telephone team and the project was briefly explained to them. Those who were potentially interested were sent the relevant information and appointments were arranged to speak to them in either a focus group or telephone interview at a later date – allowing for time to collect the relevant information.

All prospective volunteers, from each of the three sites were sent a document – *Information for Participants* – written by the GDC. The information outlined the background to revalidation and explained what was required of those volunteering. Enclosed in this booklet was the *Draft Standards and Evidence Framework*, a spreadsheet which outlined the standards against which individuals were to be revalidated. As outlined in the information document, prospective volunteers were told that they would be required to collate and submit a portfolio of "evidence" which shows they adequately meet the standards, or 'outcomes', explained. A copy of the framework is appended to this report at Appendix A.

3.2 The Evidence Gathering Process

Once registered as taking part, participants were sent a reply-paid envelope in which to place their evidence portfolio; this was to be returned to George Street Research. To preserve the anonymity of those participating, each respondent was asked to 'anonymise' all evidence sent in; i.e. to remove any information from the evidence which would identify them, their practices or their patients. To ensure an accurate record was kept of those who had returned their portfolios, George Street Research assigned each participant with a unique identifying number (URN).

Participants were instructed that if they felt unable to provide the relevant evidence for any particular outcome, they should not try to acquire it, but rather estimate the time that would be required to do so.

All volunteers were given a maximum of six weeks to complete and submit their evidence portfolios.

3.3 Focus Groups

In total, nine focus groups comprising up to eight respondents in each were carried out over the course of the fieldwork, three in each participating site. The Denplan groups were carried out on Monday 21st April, 2009 at the Cadbury House Hotel, just outside Bristol; the South Yorkshire and East Midlands Deanery groups were carried out on Tuesday 12th May, 2009 at the Derbyshire Hotel in Alfreton. Two focus groups were held in the BDA offices in Wimpole Street, London on 14th July and the remaining group was carried out at the Culloden Hotel in Belfast on Friday 24th July. All groups lasted up to 1½ hours and were moderated by Neil Costley from George Street Research. Respondents who attended the focus groups were given the Dental Guild rate of £257 for their attendance.

The focus groups followed a loosely structured Topic Guide, which was devised by the project teams at George Street Research and the GDC. All groups were audio recorded for subsequent transcription and analysis. A copy of the Topic Guide used can be found at Appendix B at the end of this report.

Across the three sites, a total of 49 participants attended a focus group – 17 Denplan participants, 18 South Yorkshire and East Midlands Deanery and 14 from the free found sample.

3.4 Semi-Structured Interviews

Those not participating in a focus group were contacted by George Street Research and instead, took part in a telephone interview lasting on average, 20 – 30 minutes. These interviews followed a semi-structured questionnaire devised by George Street Research and the GDC which covered the key areas for analysis. A copy of this questionnaire is appended at Appendix C.

All interviews were conducted by the executive team and senior interviewers from George Street Research. All interviews were audio recorded for subsequent transcription and analysis. The style of the questionnaire was designed to generate quantitative data whilst also allowing a freedom for the interviewees to explain their answers in greater detail, adding caveats and extraneous information to ensure all requisite information was adequately covered. Quantitative analysis of the interviews was carried out using the Snap analysis package whilst qualitative information was acquired through analysis of interviewer annotations, along with full transcriptions of the interviews.

203 telephone interviews were completed, 74 with Denplan participants, 61 from the deanery and 68 from the free found sample.

3.5 Sample Structure

Classification data was recorded on participants and Fig. 1 overleaf shows the breakdown of participants and their respective professional backgrounds.

Fig. 1: Sample Structure

Site	%	Time in Practice	%
Denplan	36	Less than 2 years	1
South Yorks, East Mid Deanery	31	2 – 5 years	4
Free found	33	6 – 10 years	9
- London	7	10 – 20 years	82
- Scotland	11	20 years +	3
- Northern Ireland	8	DK/Ref	1
- Wales	7		
Dentists in Practice	**%**	**FT or PT**	
Sole practitioner	16	Full time	78
2 – 5 dentists	71	Part time	21
6 or more	13		
Type of Practitioner	**%**		
NHS Only	15		
NHS & Private or Independent	57		
Private or Independent	24		
Salaried Services	5		

[NB May not add to 100% due to rounding]

4 MAIN FINDINGS

This section of the report outlines the main findings from the 203 semi-structured interviews and the 9 focus groups with participants. The report is structured to outline initially how respondents felt at a conceptual level about revalidation to set in context the attitudes towards the initiative. Once the context has been established, it will explain what respondents experienced through the feasibility study, before conducting a discussion on the relative merits and drawbacks of a portfolio based approach to revalidation. Finally, this section will discuss the draft Standards and Evidence Framework and the implications of using this in revalidation.

4.1 Concept of Revalidation

Each of the focus groups tended to open with a discussion about revalidation at a conceptual level – looking at the perceived reasons why the GDC has started to implement the initiative, together with the extent to which respondents supported it and why. Many of those participating were keen to point out that, as volunteers for participation in the project, they could be considered amongst the better performers in the UK. Denplan dentists commented on the fact that they considered themselves amongst the top dentists in the country, whilst others commented that their participation was a sign that they had "nothing to hide". Nevertheless, upon greater discussion around this, there was a view that this has positive implications when developing revalidation as these individuals could potentially be the most effectively qualified to comment on what they felt would be acceptable when discussing "minimum standards".

> "[As Denplan dentists], *and the fact that we signed up for this:* One *- we've got nothing to hide;* Two *- our standards are probably at the upper end, or the upper 50%"*
>
> (Focus Group, Denplan)

> *"I'm sorry, but I don't need this… If all goes according to plan, I want to retire in 10 years and I can't be bothered with any of this… it's just a way of approving that what we're doing is best practice… and I'm confident about what I have been doing…"*
>
> (Focus Group, Belfast)

Whilst the semi-structured interviews tended to focus more heavily on respondents' direct experiences during the pilot, certain issues at this conceptual level were also addressed.

4.1.1 Why Revalidation

There was a sense from a majority of participants in both the focus groups and the semi-structured interviews, that the implementation of some form of revalidation has been an inevitability and for a considerable length of time. Respondents were aware that the combination of malpractice disputes within the sector, together with high profile, medical-related malpractices have led to the need for some extra level of

patient protection. Indeed, in all the focus groups and a high proportion of the semi-structured interviews, respondents made reference to Harold Shipman and the impact he has had on the medical profession.

> "[Revalidation] *has been thrust upon us by various things, like Harold Shipman – everyone having to prove they're not murderers or psychopaths – this is as good a way as any."*
>
> (Telephone Interview, Denplan)

> *"Did this not come from Shipman? It's down to the medics, no doubt about it. The trouble is, the medics – when it goes wrong for them, it goes very very wrong for them. And we get that via the ripples of the splashes in the pond"*
>
> (Focus Group, Denplan)

The second quotation above, from a focus group respondent, highlights a commonly held view, that initiatives implemented within the medical profession by the General Medical Council (GMC), will often be transposed into the dental profession soon after. From the 16th November, 2009, the GMC is introducing the *license to practise*, whereby all doctors practising in the UK will be required by law to hold both registration and a license to practise; a condition of the latter is periodic revalidation. As highlighted on the GMC website:

> *Revalidation is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practise.*[1]

Indeed, many other participants commented on the similarities between developments in the medical and dental professions.

> *"Ultimately are we not just copying the medical model and the way the GMC is going? I mean I think, yes, in principle it's a good idea… what it boils down to is ensuring quality patient care."*
>
> (Focus Group, SY Deanery)

[1] http://www.gmc-uk.org/doctors/licensing/revalidation/index.asp

Most were aware that the impending implementation of revalidation is purely for the protection of patients. Some respondents went further to suggest that, whether or not revalidation will be able to impose fundamental and real change in the standards of the profession, it should at least serve to instil some degree of trust in the profession from the perspective of patients.

> *"The GDC's remit… used to be for the benefit of the profession… it categorically states it is now for the patients. So revalidation, essentially it's for the patients."*
>
> (Focus Group, Denplan)

4.1.2 Support for Revalidation

Overall, there was a widespread degree of debate and discussion about the extent to which participants were supportive of revalidation. Again, it is worth bearing in mind that many of those participating had volunteered for it themselves, which could have the potential to skew the sample structure to one which is either very positive or very negative. The diversity of opinion generated however would suggest that the sample was fairly representative overall. On balance, Denplan registered dentists appeared the most positive, whilst those in the free found sample were arguably amongst the most negative.

Those who were most positive agreed that revalidation was both inevitable and necessary and were fully supportive of it.

> *"It's about time this happened! It is an onerous procedure, but it needs to be seen to be there, seeing as the remit of the GDC is to protect patients – I am grateful to be involved at this stage."*
>
> (Telephone Interview, Denplan)

> *"In essence, this could be beneficial as far as advancement and training programmes for dentists go, because I mean the profession changes. You know, it's not the same as it was ten years ago, or even five years ago and there needs to be something to help you perform better and be able to manage better."*
>
> (Focus Group, London)

> *"Protecting patients: I think that's the most important thing and I think revalidation is important. If I went to a doctor and saw that on his plate he had 'Revalidated in 2009', I would think 'good'."*
>
> (Focus Group, SY Deanery)

On the other hand, as may be expected, there were many who felt that revalidation is unnecessary and, despite a full understanding of the theory behind it, were not as supportive as some peers. Often the basis for this was either that revalidation is another initiative in an already initiative-laden sector, or a view that dentists should not have to 'prove' themselves and that there should be a degree of professional trust.

> *"I can see why revalidation is happening – I just question why we have to prove ourselves. If done voluntarily and professionally, it's much more effective and I wonder what's going to happen to all this information that's being gathered."*
>
> (Telephone Interview, Denplan)

More often than not, this more negative attitude tended to exist amongst the more mature participants; though this was not exclusively the case. A likely cause of this more negative perspective is the view that an individual who has been practising for, say, 20 years or more, should not have to prove his or herself as meeting a set of minimum standards, as any shortcomings would have been unearthed by now through patient complaints or problems.

> *"For the last 20 years I've been involved in disciplinary hearings for dentists. When you've got a poorly performing dentist, clinical records are always very poor – with a practice assessment on a regular basis… you'd have the thing sussed immediately as you can always tell."*
>
> (Telephone Interview, Denplan)

On the other hand, some of the most experienced participants (c. 30 or more years in practice) felt positive towards revalidation, however tended to feel it was probably unnecessary for them. These participants shared the view that younger dentists would be amongst the most supportive; possibly on the basis of being more readily indoctrinated to regulation and examination.

"… new graduates who are coming through, they're aware of this. For people like us, it's a different story! I've been in practice for many years and this is new, it's different – nobody likes change – but for the new graduates that are coming, this is … something that can be taken care of."

(Focus Group, SY Deanery)

It should be noted however that, on balance, the younger, more recently qualified dentists were the most vehement in their aversion towards revalidation. One of the three focus groups was comprised only of individuals who had been qualified for fewer than five years. This group was the most negative in their perceptions of revalidation and most notable in their objections.

"I was thinking, is this really necessary, beyond all the CPD stuff we're doing anyway?"

"You're qualified as a dentist, you register with the GDC, you do this, you do that, and it's another thing that comes along on top!"

"I think the reasons for doing this are inadequate… if I thought it was worth it, then I would support it and would put time aside to do it."

(Focus Group, SY Deanery, Younger Dentists)

"Em… I'm really fresh out of university and I'm concerned about this, because you've got your CPD amongst so many other things, and then you've got revalidation on top of all this? Because that's a lot of work on top of your 9-5 job!"

(Focus Group, Belfast)

A possible reason for this negativity is the fact that these individuals are at the beginning of their careers, freshly released from several years within a high pressure environment which is heavily reliant on testing and examination – the prospect of "repeating" this on a five year cycle for the rest of their careers may be a heavy burden.

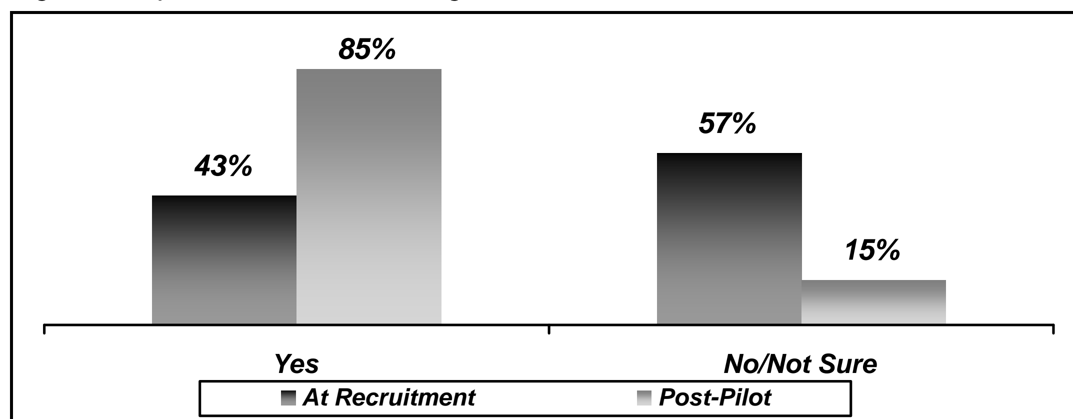
Further still, was a group for whom there was a conflict in opinion about the concept; on one hand, they felt that they personally were of a certain standard whereby revalidation would not be required, on the other, they recognised that there are individuals for whom it could be beneficial, if not necessary:

> *"I mean the people that really need revalidating are the ones that are already known to the authorities somewhere… they've already had a complaint made about them to the PCT or to the GDC."*
>
> (Focus Group, SY Deanery)

4.1.3 Understanding of Revalidation

There appeared to be a widespread understanding of revalidation amongst participants in terms of its purpose and desired outcomes. When signing up to the pilot, just over two in five (43%) felt they had a good understanding of revalidation and after going through the process, as shown in Fig. 2 below, the majority (85%) said they felt they had a good understanding.

Fig 2: Respondent Understanding of Revalidation



Q2a/b Did/Do you feel you had/have a good understanding of revalidation?
[Base: All Telephone Participants (203)]

The following, highlights some of the comments received from respondents in the semi-structured interviews relating to their understanding of revalidation having gone through the process.

> *"I had a pretty good idea before and actually having to do it has given me an even better idea of what it's all about."*
>
> (Telephone Interview, Denplan)

"I very much understand the principle, but the evidence that is actually required is still a little hazy."

(Telephone Interview, Denplan)

"Having gone through the process, it's even worse; I'm now completely confused!"

(Telephone Interview, Denplan)

Participant understanding of revalidation was investigated further during the focus groups whereby participants tended to agree that they understood the principle of revalidation and the reasons behind it. For many however, there was a considerable degree of confusion in terms of what was expected of participants and the inherent values of a purely evidence based approach. The key issue here is that whilst the principle was easily grasped, for some, the execution was unclear, whilst others still disagreed that an evidence based approach, through submission of hard copy documents alone, can effectively revalidate practitioners.

4.1.4 Potential of Revalidation

In light of the debate towards the relative merits of revalidation, it is perhaps not surprising that there was also a considerable degree of debate on the extent to which the process can have a significant impact on the protection of patients. The most salient issue related to the suggestion that revalidation is being enforced in retaliation to malpractice cases and similar issues. In this regard, many felt that revalidation would not be able to effectively protect the public from the likes of Harold Shipman:

"It won't protect the public from the likes of Harold Shipman, because he knew how to operate…"

(Focus Group, SY Deanery)

"The GMC introduced revalidation for Doctors a few years ago because of Harold Shipman. This process will not prevent a 'dental Harold Shipman'. A lot of it is to be seen ticking boxes."

(Telephone Interview, Denplan)

"The problem with Shipman was that clinically, he was actually very good… he was just mental! Shipman would have walked through revalidation…"

(Focus Group, Denplan)

The issue here is that Harold Shipman was not clinically incompetent, but mentally unstable and therefore would have been capable of passing any process of revalidation – possibly reflected in the fact that his criminal activity went undetected for a very long time. This again relates back to the point made earlier that participants felt that the GDC will already be aware of those most likely to struggle to meet the requirements of a revalidation process.

Many participants however did agree that revalidation has the potential to have some impact through the establishment of a baseline measure of operational competency:

"Well, it maintains a level playing field for everybody… I think we're looking for a level playing field, so that the standards to which we volunteer ourselves are matched by everybody else."

(Focus Group, Denplan)

"The benchmark idea is good, but it's not going to be something that you're going to do, to do it better than anyone else… it's just something that's going to need to be done..."

(Focus Group, Denplan)

These two comments are reflective of the opinion widely held that revalidation could serve to act as affirmation of a minimum set of standards. The second comment above suggests that a dentist who revalidates would not necessarily see this as a "selling point" of either the dentist or of the practice and that revalidation is not something anyone could excel at. The views of those Denplan Excel accredited professionals is that revalidation will be an "inferior" certification to that already held. Nevertheless, these views are not in conflict with the principal objective of revalidation which states that:

The principal objective of revalidation is to give reassurance to patients and the public that dental professionals meet a satisfactory standard to

maintain their registration with the GDC. It is not a guarantee that nothing will ever go wrong.

The key issue however, is to what extent participants feel that revalidation has the capacity to protect patients and instil patient trust in the profession. As mentioned, most would agree that it is unlikely to have the capacity to unearth those acting deliberately out of criminal malice. Some feel that revalidation has the potential to coerce less motivated dentists to work harder and to increase the efficiency of their operations, others feel it will assist in organisation. The implication here is that revalidation does have the potential to make a positive impact, though perhaps not to the extent that the GDC may hope. In the groups, there was some discussion about whether or not patient *trust* in the profession could be augmented. Whilst some felt that revalidation could act as a seal of approval, others felt that it could come across as a meaningless accolade set amidst a wide range of other established initiatives, such as BDA Good Practice.

"I think this will encourage reflection, in that it may well help perhaps some who have lost their enthusiasm to regain it and, in doing so, produce better dentists."

(Focus Group, SY Deanery)

"It was a real pain to do, because I've got things all over the place; if revalidation was a regular thing and you'd be doing it more than once, it will be easier the subsequent times – I can't see any other way of doing it… and it encouraged me to get everything in order."

(Telephone Interview, SY Deanery)

4.1.5 Underperforming Practitioners

There seemed to be widespread opinion that many practitioners in the dental sector are not currently meeting the minimum standards in terms of operational competency. In particular, there were two key groups considered to fall into this category: dentists who studied, trained and/or practised formally in countries outside of the UK and "younger" dentists, or those in vocational training (VTs). The perception with respect to the former is that they have had different standards and a different level of training that does not necessarily translate directly to the UK and that, occasionally, language and communication issues can arise. With respect to the latter, many commented that clinical training and clinical experience is not as

sophisticated as it once was and consequently, newly qualified dentists are not entering the profession with the key competencies required. Some felt that revalidation, if operated correctly, could effectively play a role in raising the standards amongst these groups of individuals.

> *"I think [revalidation] is necessary because of the mix of dentists that are coming into dentistry in Britain now… and I think it's important that we do have a standard that is achievable… European dentists coming into Britain, working in Britain with different qualifications and different standards and different expectations."*
>
> (Focus Group, Denplan)

> *"The foreign dentists coming in… that's an issue… and the younger dentists are going straight into the health service untrained… When we qualified, the day you qualified you were deemed to be competent to practise unsupervised; that was what your degree meant… now, they aren't even deemed to be competent…"*
>
> (Focus Group, Denplan)

> *"It's a horrible thing to say… I'm so sorry to say it, but if you look at the back of the GDC, who is it that's had complaints made about them? It's always the non-British graduates… I'm sure we all think – maybe all think that in private, but I don't know. It's not really PC… there's some foreign graduates who've done wonderful work, but they're not trained to British standards and expectations…"*
>
> (Focus Group, SY Deanery)

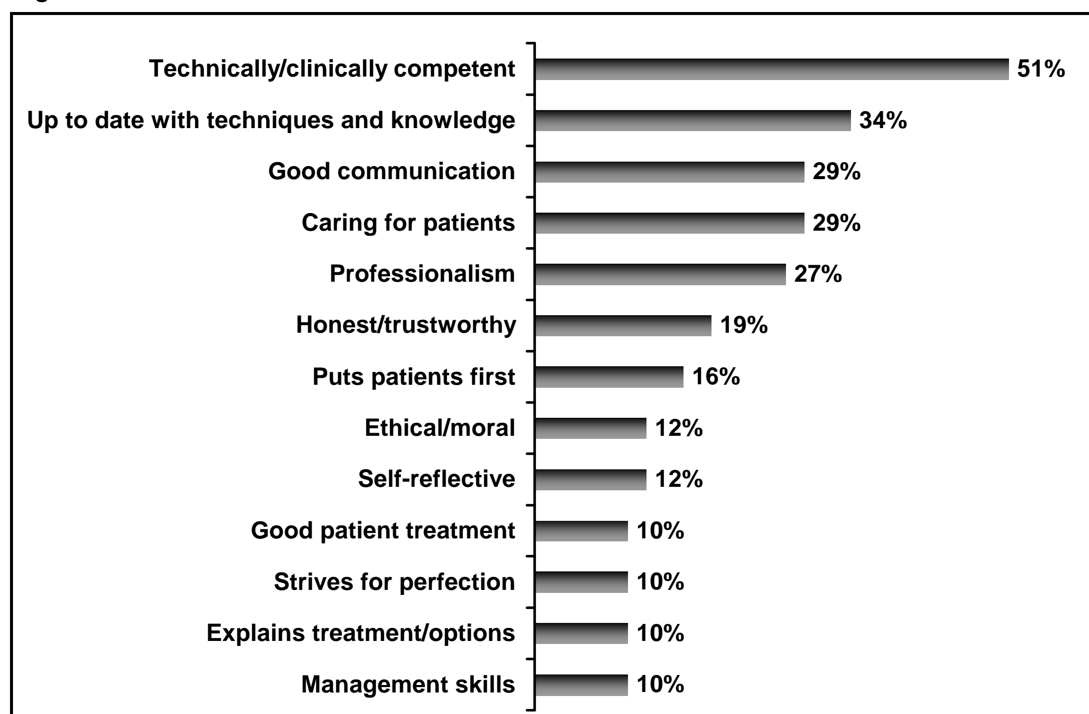
It is important to note, that almost universally, based on the experiences undertaken, almost all were confident they could easily pass the requirements of revalidation. Indeed, when asked in the telephone interviews whether respondents felt they would be able to comply with the revalidation requirements if this was implemented in five years time, all but three respondents (96%) said that they would – one said 'no' and two said they were unsure.

4.1.6 Attributes of a Good Dentist

During the telephone interviews, respondents were asked of what key attributes they feel make a "good dentist". The full list of responses collated from this question is

very lengthy; however, Fig. 3 below shows those responses generated by 10% or more of respondents.

Fig 3: Perceived Attributes of a Good Dentist



Source: Q16 What do you feel are the key attributes of a good dentist?
[Base: All Telephone Participants (203)] Those mentioned by 10% or fewer not reported

As shown in the chart, the principal focus for dentists about the key attributes of a good dentist are based around technical and clinical competence (51%). Indeed, in the focus groups also, when asked similar questions and when discussing what should be included in the revalidation assessments in general, clinical abilities and competence were always the first key areas mentioned. The key issue surrounding this was that ultimately, a dentist's work amounts to his or her capacities in oral healthcare above and beyond other key measures. Indeed, all agreed that the other key areas were very important; however, this was the issue attracting the highest level of focus. The focus on technical and clinical competence is reflected in the next most widely cited key attribute of a dentist, keeping up to date with techniques and knowledge (34%). Here, respondents recognised the need to nurture and develop key competencies to ensure that the highest standards are always met.

"What we actually do on a day-to-day basis, is repair teeth… so there needs to be a focus on how effectively we can repair teeth!"

(Focus Group, Denplan)

With respect to the notion of professionalism, this ranked fifth overall (27%). When discussing the nature of professionalism, there was widespread agreement that this term encapsulates most of what is involved in terms of clinical standards, communication with patients, caring for patients, honesty and integrity etc. and was therefore an important component to be considered in revalidation.

All the responses to the question of what are the key attributes of a good dentist were collated. An analysis of the responses generated shows that all responses appear to fall effectively into one of four key areas:

- Professionalism / Conduct
- Clinical Competence / Aptitude
- Patient Focus
- Compliance-related / Quality Assurance

Under these umbrella terms, the dentist's capacity to behave in a professional manner was the issue which arose most frequently (84%) – this included good communication, acting with integrity and maintenance of ethical conduct amongst other things. Respondents in the focus groups also placed a heavy emphasis on this. Clinical competence and ability was the second most frequently mentioned attribute (80%) – including simple, effective maintenance and reparation of teeth. Just under half (47%) mentioned something related to having a 'patient focus', e.g. caring for patients, listening to patients and communicating effectively with them. More than a quarter (28%) focussed some attention on the need for a dentist to be compliant with health and safety procedures, audits and maintaining confidentiality and so on.

"I think any good dentist is one who is ethical and professional towards both patients and colleagues – they will keep up to date with renewed techniques and ideas… I also think peer review is very important; dentists need to reflect on what they are doing and challenge themselves and peers consistently."

(Telephone Interview, SY Deanery)

"It's a difficult one this, the key elements you need are kindness and compassion and things like that; you need to have good hands and to be able to do the job properly and effectively – that's number one! Ehm, It's also important to keep updated on current information in the profession."
(Telephone Interview, Northern Ireland)

These four areas mentioned above do not necessarily exist in conflict with the four key areas currently outlined for revalidation, but are rather, largely complementary. The one key area which perhaps falls between two stools would be that which relates most heavily to compliance of procedures and regulations. Furthermore, "patient focus" is something which features quite heavily under the current plans, but not as an explicit, stand alone assessment. To unpack this further, it is important to discuss the relative attitudes towards the four key areas.

4.1.7 The Four Key Areas

The relevance and importance of each of the four key areas for assessment attracted a degree of discussion and debate. At this stage, the key areas will be discussed at a conceptual level – a more in-depth analysis of the key competencies included in the standards and evidence framework, will be discussed at section 4.4, later in this document.

Of the four key areas, the only area in which there was a split in opinion, related to Management and Leadership. For a number of respondents, this was an area where many dental professionals would struggle to find the relevant evidence, and the one area perceived to be of least importance in dentistry. On balance, the majority of focus group respondents felt that this was an area where revalidation should not apply. Although Principals would require management and leadership skills, the majority felt that it would be unfair to test the likes of surgeons, Associates and newly qualified VTs in this area as the majority of this information is practice based, rather than individual based; this appeared to be especially important for those who worked only as private dentists.

"I honestly cannot understand – and I cannot see why management and leadership… I mean, as an associate, it's just not relevant… And you could, I mean, certainly as a clinician working perhaps in a corporate,

you've got very little to do with management and leadership and that kind of organisation. So that… you know, might not be part of it."

(Focus Group, Denplan)

"You've got two different groups – you've got associates and you've got principals and the principals are going to do the management and the associates are going to do the clinical side… the associates don't have a clue on the management side. If they haven't got a clue, they will not actually be able to have any input. You know, you've got a big proportion of that dental population that's got no input whatsoever."

(Focus Group, SY Deanery)

4.1.8 Summary

Revalidation at a conceptual level received support from many, whilst the perception was that it is unlikely to be fully effective at implementing significant change. One of the key issues arising from this was that those participating in the study considered themselves – as volunteers – to be amongst the most proficient practitioners in the UK. As such, they felt that an extra level of regulation was unnecessary for them personally. Most agreed that there were many practices and indeed practitioners which could benefit from a process of revalidation whereby standards are assessed and a minimum standard of operation is imposed to which all practitioners must adhere.

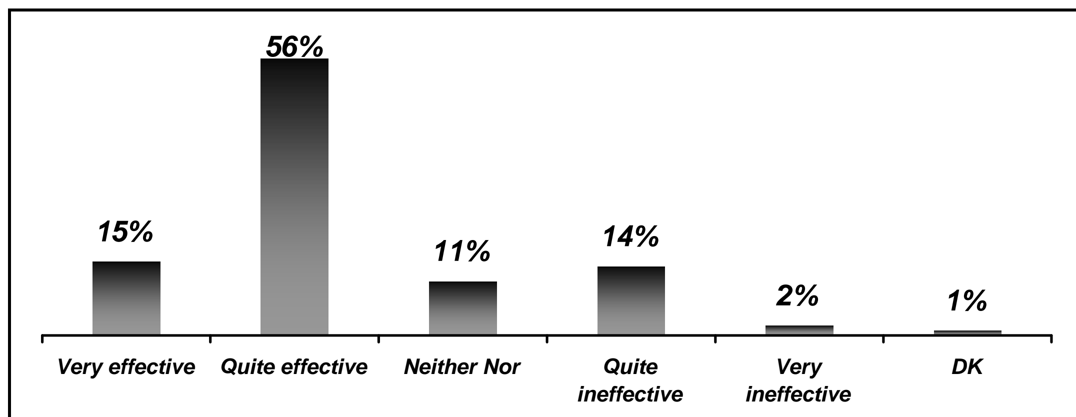
4.2 The Evidence Gathering Process

All participants were sent an information pack, *Information for Participants* which outlined the background and process of revalidation along with the *Standards and Evidence Framework* draft. Participants were informed that any areas for which they could not produce evidence should be referenced and, rather than taking the time to produce it, they should estimate the time taken to generate such evidence.

4.2.1 Information for Participants

At an anecdotal level, at the outset of the project and before volunteers had begun to collate evidence, there were a number of problems encountered in terms of fully understanding what participants were being asked to do. Frequently, individuals contacted us to ask for more guidance on what was expected of each. There was widespread understanding that each was expected to produce a portfolio of "evidence", but often there was uncertainty of what specifically was required. Indeed, in the early stages of a pilot programme, one would expect a degree of uncertainty.

Fig 4: Effectiveness of Information for Participants Document at Explaining the Process of Revalidation



Source: Q3 How effectively did the 'Information for Participants' (and other material that was provided) explain the process of revalidation? [Base: All Participants (203)]

As Fig. 4 shows, the majority of respondents felt the information provided from the outset was effective at outlining the process of revalidation (71%); fewer than one in five (16%) felt the information provided was ineffective at outlining the process. These findings were unpacked further during the focus group discussions. The general consensus of opinion from respondents was that, whilst the information provided was comprehensive and informative, it did little to briefly and succinctly

outline what was required of volunteers. Many felt that the wording used in the document was more "academic" than informative and the result was that often the most salient and important information required, often went undetected.

> *"A simple side of A4 would have been enough… keep it simple… we just want the background in one short paragraph."*
>
> (Focus Group, Denplan)

> *"I don't know, but I can't see very much dental language here. It's obviously been written by a bunch of academics, not dentists."*
>
> (Focus Group, Denplan)

> *"It explains the basic process well; i.e. why they want to do it and all, but the way to go about it I found tricky – it doesn't really explain what to do and what to produce."*
>
> (Telephone Interview, SY Deanery)

The key issue arising seemed to be related to the nature and conditions of volunteering. Many of those taking part were senior practitioners highly integrated with dentistry and with heavy demands on their time. The information booklet was lengthy and heavily laden with academic terminology and information which was conceivably irrelevant for participants at this stage in the process. Further, where occasionally there was an overabundance of information, often specificity was lacking. Many commented in the groups and during the telephone interviews on the need for a simple, succinctly worded script of required activity. The key implication here is that, whilst participants agreed that there was lots of information and it was reasonably well presented, there was a desire for something shorter and more prescriptive, offering more guidance and less information.

It is important to note that, during the focus groups, when discussing the proposed processes of revalidation, there seemed to be widespread awareness of what was involved, suggesting that much of the information was digested.

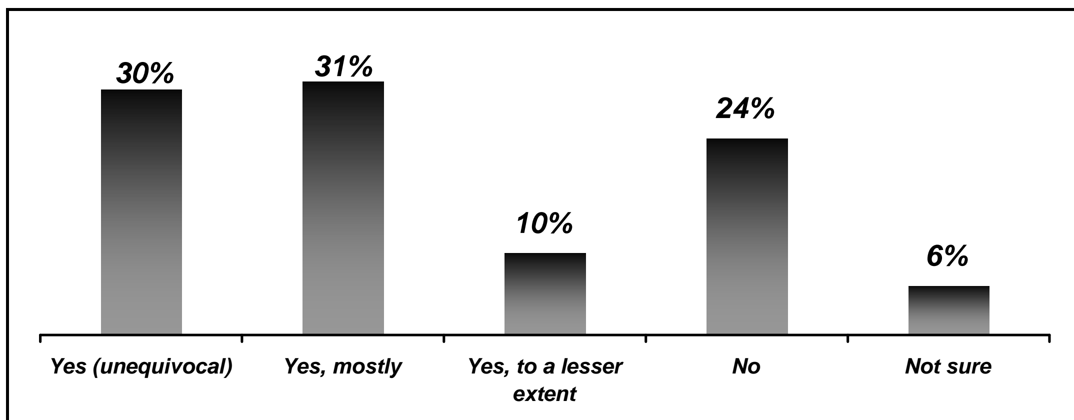
4.2.2 The Evidence Gathering Process

The extent to which participants found it easy to gather all the necessary evidence to revalidate was something which generated a considerable degree of discussion and debate.

4.2.2.1 *Ability to Collate the Evidence*

As shown in Fig. 5 below, there was a widespread diversity of opinion in terms of how easy the process was. Just under a third (31%) said they were able to collate all the relevant evidence with relative ease. A similar proportion (31%) felt they were mostly able to get the evidence together to effectively revalidate, whilst 10% were also able to collate evidence, but to a lesser extent.

Fig 5: Whether respondents were able to gather all the necessary evidence



Source: Q5 And do you feel you were able to gather all the necessary evidence to successfully complete the revalidation process? [Base: All Participants (203)]

A rather significant finding was that just under a quarter of all participants (24%) commented that they were unable to gather the necessary evidence to complete the process. This was a significant proportion of participants that simply were unsure what to produce and did not have the relevant systems or administrative capacity to complete the process.

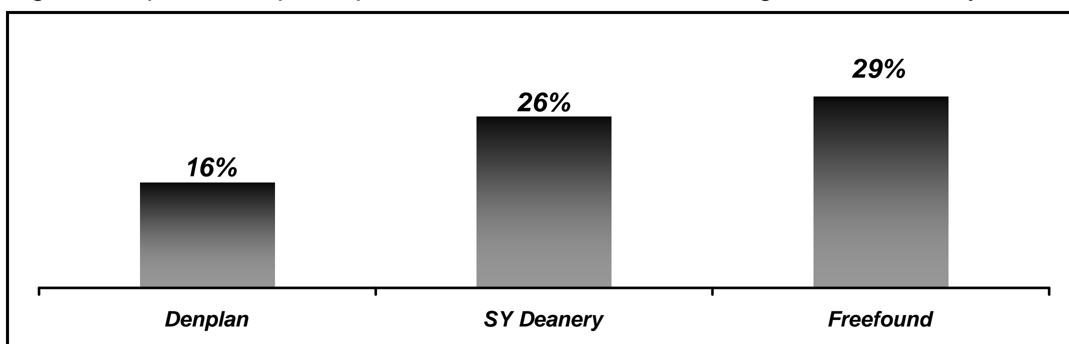
> *"No, I couldn't complete it at all… I find the really difficult thing was it was very very vague and there was no guidance given at all… and it's the same the whole way through – it just wasn't specific."*
>
> (Telephone Interview, SY Deanery)

4.2.2.2 *Groups unable to collate evidence*

An interesting outcome from the research was that there is an apparent difference in the extent to which participants were able to complete the process dependent on the 'site' of recruitment. Fig. 6 overleaf shows a breakdown of participants who answered no to the question "… do you feel you were able to gather all the necessary evidence to successfully complete the revalidation process?" As shown in

the chart, Denplan dentists appear to be the group who were most widely able to collate all the required evidence (16% said 'no'). More than a quarter (26%) of those recruited though South Yorkshire and East Midlands Deanery, said 'no' to this question, whilst almost a third (29%) of those from the free found sample said 'no'.

Fig 6: Proportion of participants from each site unable to gather necessary evidence



Source: Q5 And do you feel you were able to gather all the necessary evidence to successfully complete the revalidation process?

Based on the qualitative information extracted from the semi-structured interviews and the focus groups, there are a number of possible reasons for this disparity in the data.

Firstly, on the whole, Denplan dentists appeared most confident in the study, with the portfolios of evidence submitted – especially those who were Denplan Excel accredited. Often, many had gone through a very similar process recently, whilst others felt that the Denplan Excel certificate was worthy of revalidation on its own.

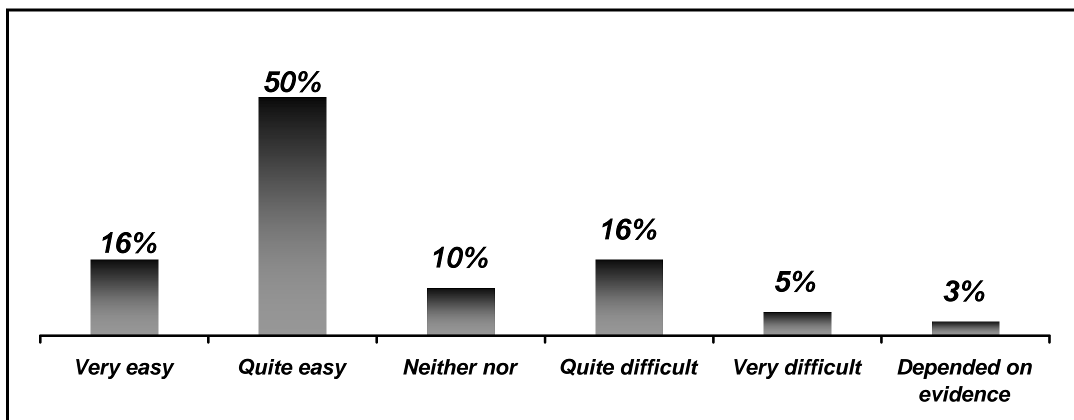
Secondly, those recruited through Denplan and South Yorkshire and East Midlands Deanery were most commonly volunteers who had had some time to prepare and had been provided with more time and support available to complete the process. The free-found sample on the other hand had no institutional support outside of George Street Research and their own practices, and had slightly less time to prepare and submit evidence.

A key implication here is that – logically – those dentists and practices who are signed up to additional schemes and initiatives, e.g. Denplan Excel, BDA Good Practice, Investors in People and so on, will find revalidation significantly easier than those who do not, as evidence is readily available and these schemes effectively cover significant portions of the framework.

4.2.2.3 Ease of Gathering Evidence

When asked of the perceived difficulty in accessing the required information, two thirds of those participating in the telephone interviews (66%) felt that this was easily done. Specifically, 16% said *very easy*, whilst 50% said *quite easy*. Fig. 7 below highlights the relative distribution of responses generated in this regard. As shown in the chart, 10% felt it was *neither easy nor difficult*, whilst 16% described it as a *quite difficult* process. A minority of 5% felt it was *very difficult* to obtain the relevant information.

Fig 7: Perceived ease of the evidence gathering process



Source: Q11 Overall, how easy did you find the evidence gathering process for this pilot? [Base: All Participants (203)]

A majority of participants commented on the fact that locating the actual evidence was not so much a problem as discerning what specific evidence was required. This is the most likely cause for a high incidence of responses in the *'quite easy'* bracket. The following comment is indicative of the responses generated from this question.

> *"Gathering the evidence was easy and the collation of the evidence wasn't too hard. The bigger problem was understanding what evidence they actually wanted..."*
>
> (Telephone Interview, Denplan)

The key implication here is that, although much information was easy enough to locate, the majority of participants were keen for more specific direction. So for example, rather than simply requesting "patient feedback", participants would have preferred the instruction, *please provide three examples of feedback from a patient which acknowledges they were well treated*.

"Once I understood what I was doing, it was ok; the hard part was working out what they actually wanted me to send in."

(Telephone Interview, SY Deanery)

The key reasons mentioned qualitatively for why the evidence gathering process was difficult included:

- The time taken to put everything together in the one place;
- The extra time taken to photocopy – and anonymise – everything;
- The fact that this was the first time many had done it – i.e. in future years, the process *should* be easier;
- The difficulty in discerning just how much information was required.

It is important to note that the uncertainty of many participants resulted in a very widespread diversity in terms of the portfolios of evidence produced. Indeed, a small number of participants provided little more than a Denplan Excel certificate and/or a BDA Good Practice certificate and any associated paraphernalia. On the other hand, some participants were concerned that they could not locate an envelope of enough substance to contain all the information which was being sent. These latter individuals tended to be sending everything from 5 year old CPD logs, to staff appraisal reports and even bank references.

4.2.3 Evidence Used

As mentioned, the diversity of information collated and submitted was vast. This, together with the way in which information was presented (i.e. as a collective, often unorganised mass), made analysis of the submitted information very difficult and highlighted the apparent need for a more prescriptive approach to revalidation – this shall be discussed later in this report. Nevertheless, there were some key trends in terms of the most frequently submitted evidence – shown in Fig. 8 overleaf.

As shown in the table, the most widely submitted type of evidence related to CPD certificates and logs – i.e. both verifiable and non-verifiable CPD. More than three quarters of participants (77%) submitted this as part of their evidence portfolios. The possible reason for this is based on the mandatory CPD hours which dentists are obliged to undertake to maintain registration with the GDC – as such, the evidence is there, storage of it is prioritised and thus, access to it is easy and swift. Additionally,

many respondents commented in the groups that many of the desired outcomes highlighted in the framework are covered by CPD courses.

Fig 8: Table to show the most widely submitted types of evidence

Evidence	%
CPD Certificates / logs	77
Patient surveys / questionnaires	29
Denplan Excel accreditation	28
BDA Good Practice certification	25
PDP (Personal Development Plan)	24
Patient record inspections / audits	19
Inspection evidence	16
Minutes of practice meetings	11
Peer reviews	10
Practice protocols and policies	10
Patient surveys for specified accreditation schemes	10
Appraisals	9
Clinical governance evidence	9
Denplan inspection evidence	6
PCT inspection evidence	6
Complaint forms	6
Radiation protection certificates (IRMER)	6
Cross-infection control certificates	6
Significant event analysis	6
Radiology audits	5
CPD evidence for staff	5
Investors in People	5

Source: Q6 What have you used as evidence? [Base: All Participants (203)]
NB c. 90 individual types of evidence were mentioned (those cited by fewer than 5%, are not reported)

Although the standards and evidence framework places a degree of weight on patient feedback, the proportion of participants who submitted patient feedback and questionnaires was arguably quite low (29%). Although the second most frequently submitted type of evidence, the framework requests patient feedback as evidence in no fewer than 12 of the 17 outcomes. Indeed, as will be shown in the discussion about the standards and evidence framework later in this document, many felt that the framework relied too heavily on patient feedback and access to meaningful, cohesive and at times, coherent patient feedback was not easily achieved. Some commented that, under Denplan Excel and other accreditation schemes, a degree of patient feedback was automatically generated every couple of years and, as such, these certificates alone should effectively cover the area of patient feedback.

Only a quarter (24%) submitted a Personal Development Plan or information from PDPs as part of their evidence portfolios – this figure appears reasonably low given the frequency with which PDP is mentioned in the standards and evidence

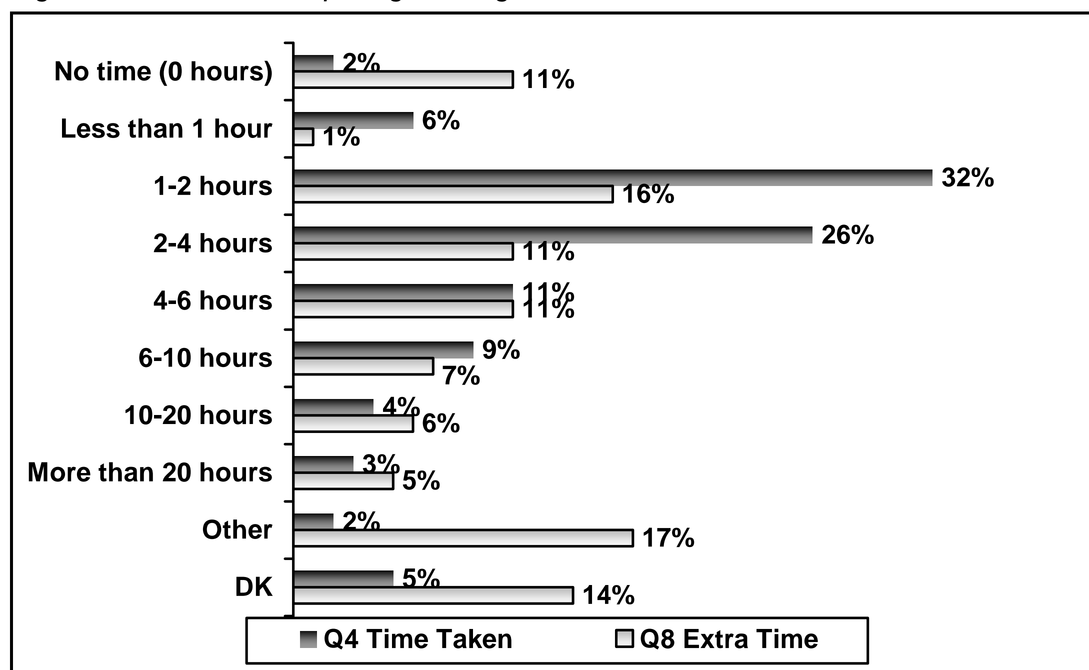
framework. It is perhaps interesting to note that PDPs are relied on most heavily in the *Management and Leadership* section of the framework – the category which many felt should not be included in revalidation.

Continuing Professional Development and Personal Development Plans are dealt with in more detail in the next section of this report.

4.2.4 Time Taken

The feedback on the actual time taken to gather and collate the requisite evidence from participants was widespread and varied. An initial consideration is that many were not alone in the collation process; employing the services of practice secretaries and other individuals, whilst some delegated the whole process to another individual within their practice – on the other hand, a significant proportion of those participating took on the responsibility of evidence collation on their own.

Fig 9: Estimated time spent gathering evidence



Source: Q4 Overall, how much time have you have spent gathering evidence for revalidation?
Source Q8: Over and above what you do anyway, how much time is required…?
[Base: All Participants (203)]
[NB May not add to 100% due to rounding]

Fig. 9 above shows the distribution of estimates for the length of time taken to complete the revalidation pilot. As shown, the modal average time taken to complete

the process during the pilot, was between one and two hours (32%), followed by between two and four hours (26%). However, it is worth bearing in mind the aforementioned uncertainty in the evidence portfolio production amongst many participants, in addition to the proportions saying they were unable to find certain types of evidence. Furthermore, as mentioned, the apparently low levels of patient feedback and PDP submissions may suggest that if these were enforced more stringently in the future, more time would be required to complete the process.

From a more positive perspective, many commented that the majority of time taken was not so much in locating the evidence to submit, but rather in photocopying and anonymising it.

In general – as may be expected in light of previously mentioned differences – Denplan dentists were able to complete the process more quickly than their South Yorkshire Deneary and free-found counterparts.

Fig. 9 also shows the extent to which revalidation takes time over and above what is being done already; i.e. dentists are already collating information for CPD logs and will inevitably file important information which could be used. Again, there was a strong difference of opinion towards this question; 11% felt it takes no extra time at all, 16% said between one and two extra hours, whilst similar proportions said between two and four or between four and six hours (11% each).

> *"Well because I am salaried services, I have to do a portfolio assessment similar to this… so for me, I don't think this will take me any longer than what I am already doing."*
>
> (Telephone Interview, SY Deanery)

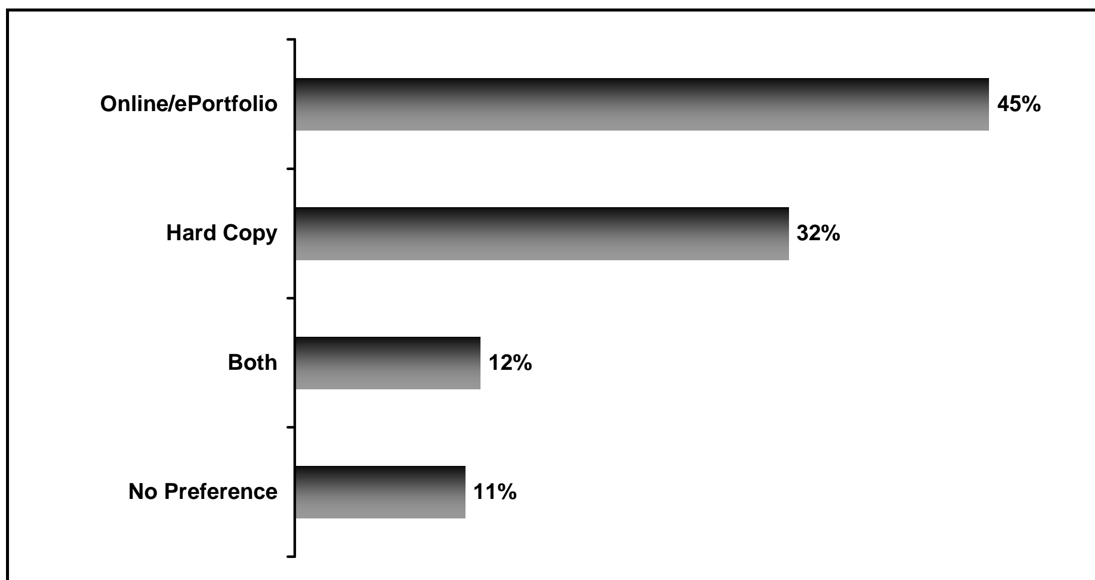
> *"A lot of the evidence will take a bit of time to organise – it will be easier to prepare when I've got 5 years to do it! I am only an associate, so I don't have access to much of the stuff I need – there's lots of running around trying to scramble things together."*
>
> (Telephone Interview, Free-found, Scotland)

> *"This really did take me a long time – I was with a member of staff for the best part of 2 whole days… maybe 20 hours or so, maybe a little less."*
>
> (Telephone Interview, SY Deanery)

4.2.5 Portfolio Management

A key issue for consideration in the pilot, was the method in which dentists manage and store evidence and what the implications of this are in the light of revalidation. On balance, there was a preference to see the introduction of some sort of online e-portfolio system, thus moving away from a hard copy system which was considered to be environmentally unfriendly and a burden on time and resources in light of the need to photocopy. As shown in Fig. 10, 45% expressed a desire for an online e-portfolio system, whilst around a third (32%) expressed a preference for a hard copy storage system. The technical concerns of those with a preference for hard copy would suggest that it may be worth continuing to have an option for hard copy.

Fig 10: Perceived best method of storing evidence



Source: Q14 What do you think is the best method for storing evidence moving forward?
[Base: All Participants (203)]

Some however, mentioned lacking the relevant technical competence or equipment to manage an online / e-portfolio, whilst others mentioned the time burden of scanning documents and others still mentioned issues of security through a computer-based approach. If an online system was selected, it would be important to ensure that this is easy to use, easily accessed and takes less time than photocopying. One thing that was suggested was the option to have CPD and other certificates emailed to individuals upon completion to ease the uploading procedure.

> *"Well, look everything is moving online, so you've got to have it online. I guess on the other hand though, there are a lot of older dentists who*

don't really have the technical know-how to do this and some practices won't have scanners and the internet – so you've probably got to have both."

(Focus Group, London)

4.2.6 Summary

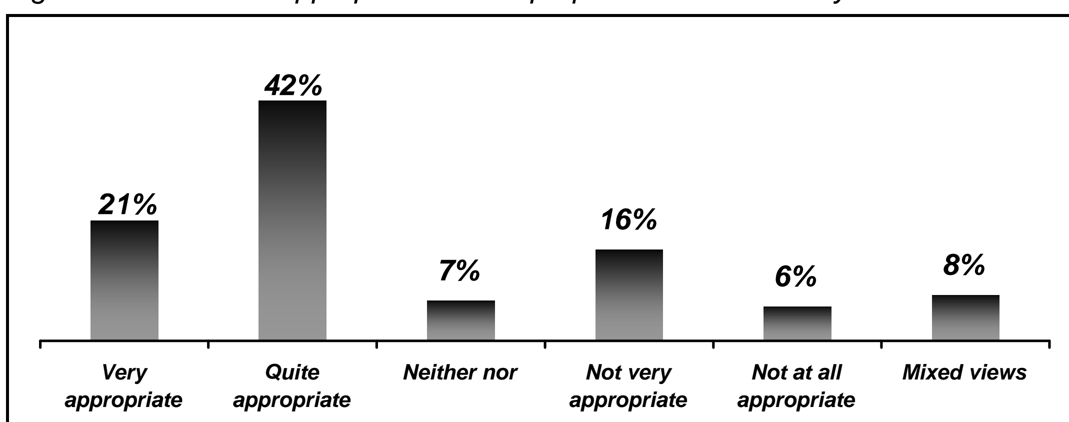
There was widespread diversity of opinion in the extent to which participants were able to effectively gather together the relevant and required evidence to complete the Stage 1 Pilot. For some, the process was as simple as accessing a file of information already held, photocopied and sent in the post – in certain cases, one certificate was all participants felt was required. On the other hand, a significant proportion struggled to collate much of the relevant information and spent long periods of their working week to gather what was required, whilst still feeling uncertain of what was being submitted.

The key implication from this diversity of opinion is that a more prescriptive approach to revalidation is required and one which will leave participants confident in the portfolios they submit. It is important to note that the nature of any feasibility study means that there are no consequences for "failure"; however, when implemented, submission of evidence portfolios will carry more significance and those in any uncertainty with respect to the requirements are likely to want to contact the GDC for more information and assistance. To minimise the administrative burden on the GDC it is essential that the framework outlines prescriptive guidelines on what evidence is required and how far back it should go.

4.3 Portfolio-Based Approach

As shown in Fig. 11 below, on balance, telephone interview participants appeared reasonably positive about the system of revalidation in terms of its appropriateness. Just under two thirds of participants (63%) felt that a portfolio based approach is either *very appropriate* (21%) or *quite appropriate* (42%). On the other hand, a significant proportion (37%) had either mixed views, or felt the system is not an appropriate approach.

Fig 11: Views on the appropriateness of proposed revalidation system



Source: Q15 Overall, how appropriate do you feel this system is for identifying dentists who meet the requirements for the Stage 1 revalidation "sift"? [Base: All Participants (203)]

This section of the report outlines the reasons why some felt this was an appropriate system, whilst others were more ambivalent in their views towards it or felt it is definitely not the right way to approach the initiative. It will also address some of the key issues which should be addressed to help increase its favourability in the eyes of dental professionals. It is important to note at this stage that a significant proportion – most notably amongst more mature and youngest members of the profession – are unlikely to ever support the initiative irrespective of what incarnation it takes.

4.3.1 Strengths & Weaknesses of Portfolio Based Approach

The relative merits and weaknesses of administering revalidation through an evidence portfolio based approach were discussed in some depth both in the focus groups and during the telephone interviews. In general, there was quite a widespread diversity of opinion on this issue and the subject attracted a strong degree of debate.

4.3.1.1 Perceived Strengths

Only a small number of perceived strengths were suggested, the most notable of which was the capacity to inspire many into a more "organised" state. Many respondents commented that either they, or selected peers, could be accused of lacking organisational skills, especially with respect to paperwork. For some, this was an issue of time management and prioritisation, for others, it was arguably an issue related to personality. Nevertheless, many commented on the fact that, although they had found it difficult to complete the stage 1 feasibility study, it had provided them with the opportunity to organise much of their amassed paperwork. Related to this was the perception that, although difficult, it would be "easier next time" as the information has now been collated and so over the course of the ensuing five years, information could be easily updated.

> *"Once you've done it once, you know where everything is, so it's just a case of building on it…"*
>
> (Focus Group, SY Deanery)

> *"I think this is ok as a 'sift'; I think it's good as a sift… if somebody can't produce the stuff, then that's maybe a good way of working out that they need to be looked at."*
>
> (Telephone Interview, SY Deanery)

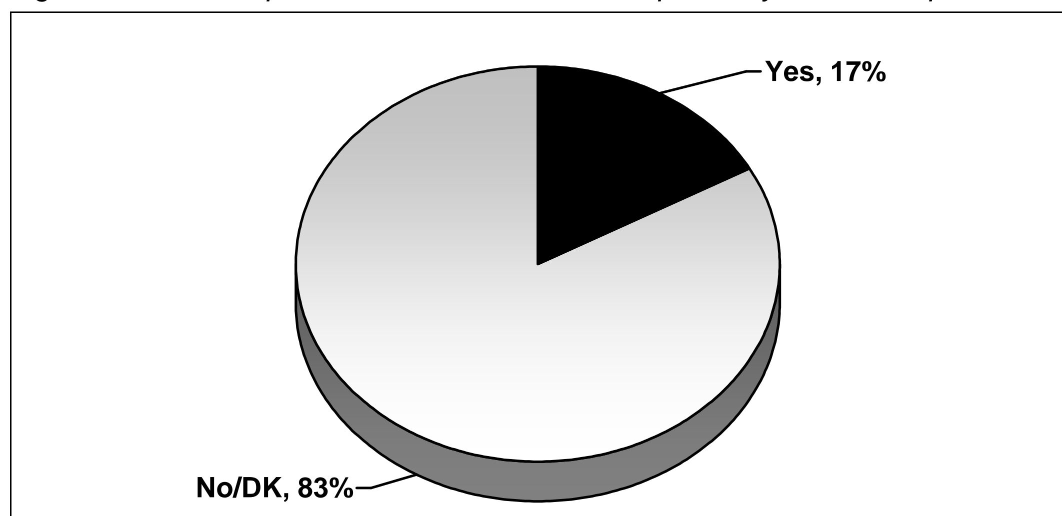
Some also commented on the fact that it is positive to administer revalidation through a three-staged process, ensuring that everyone is not subjected to an external assessment of performance.

> *"I think it's fair in a way, that the first stage they're kind of giving you another chance, and you've got steps to coming forward in the first bit. In that way, it's not trying to be all or nothing…"*
>
> (Focus Group, SY Deanery)

> *"Ok, it sounds like a logical approach, the three-staged thing, as far as the quality of standard provided for the patient… Yeah, I must admit I like that you have three cracks at the whip as it were and for the first stage you don't have anyone looking over your shoulder making you more likely to make a mistake."*
>
> (Focus Group, London)

A key strength in the approach taken, is also found in the sense that the majority felt they had retained all the documents required – as shown in Fig. 12 below. Only 17% said they had relevant information or documents in the past which they had not kept, whilst the majority (83%) had not misplaced any relevant information or documentation and thus were able to meet the requirements.

Fig 12: Whether respondents had evidence in the past they did not keep



Source:Q9 Was there any relevant information/documentation that you have had in the past, but did not keep? [Base: All Participants (203)]

Other positive aspects of the exercise mentioned by a small number of respondents in the focus groups and the telephone interviews include:

- It was relatively easy to administer if you have a practice manager and they are well organised;
- It could be a positive experience for the practice to ensure filing and certifications were all in order and effectively organised;
- Two respondents commented that it had been a useful exercise to expose other parts of the practice to staff members.

> *"I don't think there's a better way to do this; I think if we are going to make it a sensible, credible system, then it's got to be quite tough, it certainly won't be popular, but we have to ensure the public are protected and I think the framework the GDC is proposing is quite sensible."*
>
> (Telephone Interview, Free-found, Scotland)

4.3.1.2 Perceived Weaknesses

It was widely acknowledged that a portfolio based approach to revalidation carries with it conceivable shortcomings. These shortcomings most notably centred around the administrative burden and consequent costs of printing and organising. Furthermore, this issue existed on "both sides" of the revalidation process, i.e. practitioner and regulator. There was significant feedback on the administrative burden of photocopying documents, especially from those submitting substantial portfolios of evidence. Indeed, the process for this feasibility study carried the increased burden of the need to anonymise evidence – something which would not apply once revalidation is implemented (other than patients' personal information).

> *"It's the photocopying and the blanking out of personal information and making things non-identifiable that is the time consuming bit. If you keep good records to start with, it shouldn't take much time; but getting everything ready to be sent took forever!"*
>
> (Telephone Interview, SY Deanery)

Further, participants commented with some concern about the administrative and cost implications on the side of the GDC reviewing the evidence portfolios and determining those who successfully revalidate and those who merit a 'closer look'. The time and cost to the GDC involved in carrying this out was, for some, too much to justify. Furthermore, the potential disparity in terms of the evidence provided will require an active and qualified dental professional to determine the relevance of the information.

> *"Who on earth is going to sit through all this stuff at the GDC – and at what cost? Also, will they be dentists, because you can bet they won't! So it'll take forever and it'll be someone who doesn't know what they're talking about looking through all the stuff!"*
>
> (Focus Group, London)

There was a suggestion that if administering revalidation through a paper-based exercise, looking through each dentist's records would take a similar amount of time to sitting in with them and assessing their competence through a personal, face-to-face assessment. Concerns over the time taken on the GDC's side may originate from concerns that much of the evidence outcomes in the framework were open to

interpretation – unless the process is very specific, regulation can be very difficult to enforce or standardise.

Some felt that to be cost effective, all should submit evidence, but only a certain percentage should be assessed – selected through random sampling and also by assessing the portfolios of those suspected of sub standard performance.

> *"I assumed somebody from the GDC would go through all that… if they pick somebody to check the records; because I think that's how it's going to be isn't it? Everyone's going to have to do it and then they're just going to have a lottery and pick someone…"*
>
> (Focus Group, SY Deanery)

> *"There must be some sort of statistical way of working out what sort of number you would have to do to pick up the poor performers… you know, out of a thousand people you would have to look at whatever number it would be and that would give you a large percentage of all the poor performers…?"*
>
> (Focus Group, SY Deanery)

A final argument against this approach came from a small number of respondents who raised concerns about the feasibility of carrying out a long, "paper-chase", if you are a part time, or especially a locum, practitioner. The issue here is that those who do not spend as much time in practice as those working full time will be forced to spend a disproportionate amount of time on revalidation and those attached to no particular practice will struggle with many of the demands.

> *"I'm worried about locum dentists and whether they will be able to collate all this information, as they are never in one place long enough and would really struggle to have all this documentation."*
>
> (Telephone Interview, Free-found, Wales)

4.3.2 CPD and Patient Feedback

Many respondents, both in the focus groups and in the depth interviews, commented on some issues surrounding the use of CPD evidence and patient feedback in their revalidation portfolios.

4.3.2.1 CPD Evidence

With respect to CPD, many felt that it is essential that revalidation ties in with the requirements already placed upon dental professionals; i.e. revalidation should exist instead of, not in addition to the fact that all practitioners need to prepare log books and certificates to show they have effectively completed the mandatory levels of verifiable and non-verifiable CPD. The assumption that five year CPD checks would be built into revalidation warmed some respondents to the concept as this is already being done and therefore will not be an additional burden.

> *"I was thinking, is it really necessary beyond continuing professional development anyway? CPD – you know, we're all doing it anyway. As long as revalidation ties in with it, you know,… you could possibly see the plus points…"*
>
> (Focus Group, SY Deanery)

> *"I think revalidation combines everything into one really; because we've got CPD and you've got your key skills and a lot of other things, whereas looking at the pack that you've got for this, it asks you for a lot of things, but under one umbrella. So maybe the professional benefit is, once you've collected the data for one year, it's all together and re-submit it as opposed to have a number of different things requested by different bodies."*
>
> (Telephone Interview, SY Deanery)

> *"You're doing courses and staying as up to scratch as possible. That works; we've got compulsory CPD evidence already, so if they're only asking for it once then that's not so bad actually as that's something everybody will have."*
>
> (Focus Group, Belfast)

Some respondents commented on another issue related to CPD, the implications of which may extend beyond the remit of revalidation. The issue related to the potential weakness of reliance on CPD information. Participants commented on the fact that a CPD certificate will demonstrate that an individual was registered on a particular course and indeed signed in to the course; however, it does not prove that anything

was learnt on the course, or indeed that the individual actually stayed for the duration.

> *"The problem with CPD is that I can go to a meeting, but nobody checks if I was listening… I could sleep through the whole thing and still get a certificate."*
>
> (Telephone Interview, SY Deanery)

> *"The thing about CPD is that some people use it as an excuse to improve their swing – they sign in and then go out!"*
>
> (Focus Group, Belfast)

The above comment reflects the views of many respondents and tended to exist not as admissions of guilt, but rather of observations from other individuals. As such there was some debate over the validity of CPD evidence – 10% of participants felt that asking for CPD evidence was not a good indicator of performance.

It could be argued that if CPD is to be relied upon for revalidation, then it would be worth investing in the development of a pro forma CPD diary to hold certificates from verifiable activities and log non-verifiable activity. This would effectively ease the process of keeping track of hours, together with easing the analysis from the perspective of the GDC if everything is presented in a standardised format.

4.3.2.2 Patient Feedback

Patient feedback on the other hand was a subject which attracted a widespread degree of concern from a high proportion of participants. A commonly held concern was about the reliance within the framework on patient feedback, especially with respect to certain desired outcomes. When asked in the telephone interviews about what types of required evidence were not good indicators of performance, the most commonly received answer related to patient feedback (16%) – see Fig. 13 overleaf.

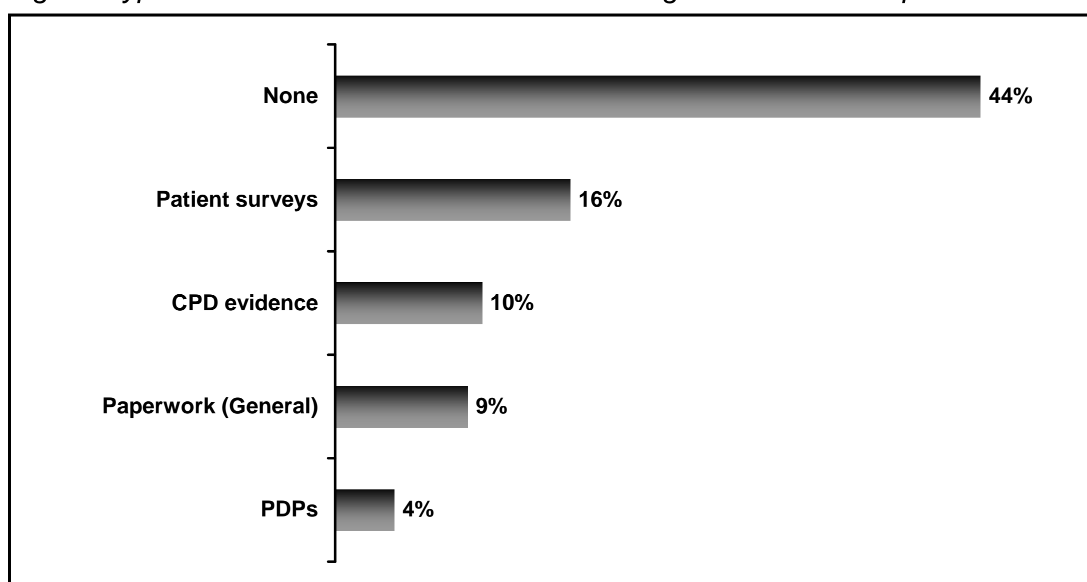
The principal argument here was that for the majority of standards, patients are not well placed to provide feedback on the extent to which the dentist is performing acceptably. This was especially prevalent in the following standards:

- P2 – *Protects the confidentiality of patient information*

- CL2 – *Patients have been prescribed drugs safely and with appropriate knowledge of potential interactions*
- CM4 – *Communicates effectively with colleagues in the dental team and other healthcare professionals*

The key issue with the aforementioned outcomes, is that patients should not be able to comment on these sorts of issues unless something has gone wrong previously. Therefore, the implication is that dentists might be able to prove when they have *not* acted in the appropriate way, but will not be able to prove when they *have* acted appropriately.

Fig 13: Types of evidence asked for which are not good indicators of performance



Source: Q10 Were there any types of evidence asked for that you felt were not good indicators of performance? [Base: All Participants (203)] NB Answers with fewer than 4% not reported

Another issue surrounding patient feedback was the policing of the issues surrounding questionnaire design and dissemination of surveys to be completed. Many agreed that, if the practice is responsible, there could be some degree of abuse of the system, through self-selection of participants. Most agreed that they would naturally chose the patients with whom they have the best relationship to provide the feedback. There was a feeling that if this is required, then the GDC – or someone else – should take responsibility for the process, disseminating questionnaires at random and using a standardised questionnaire, thus absorbing all responsibilities, including the costs of printing and postage. Again for dentists

accredited through Denplan Excel, there was a feeling that proactive patient feedback acquisition should not be required as this is a feature of the accreditation.

Similar to the CPD issue, the development of a pro forma questionnaire would also be beneficial to ensure patients are asked the right questions and professionals are confident in the evidence they submit.

4.3.3 Integration with Other Initiatives

A common objection raised by those with multiple accreditations, was the issue of increasing workloads and adding another initiative into the mix, when there are several established (albeit voluntary) initiatives already in the sector. For many, the imposition of revalidation is simply "reinventing the wheel" for those signed up to a number of initiatives already. When it was suggested that revalidation could be tied in with these, there was widespread agreement that this would make the process simpler and speedier, whilst not losing out on quality. The most frequently mentioned schemes in the focus groups and interviews included Denplan Excel and BDA Good Practice.

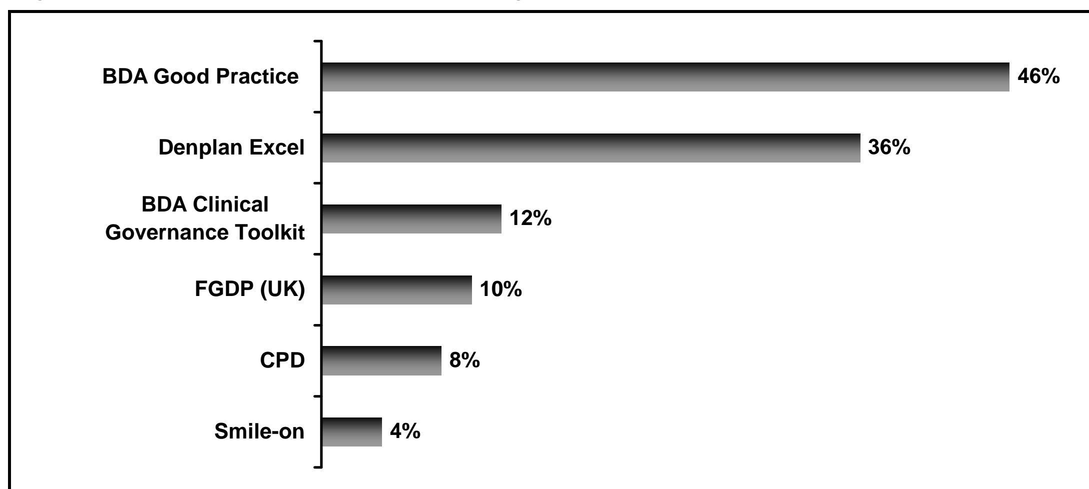
> *"I am Denplan Excel accredited... practically every single area I do through Excel – really all I need to provide is my certificate of Excel accreditation and it should tick all the boxes you want… They produce everything which is on the revalidation thing; they check my notes, my X-rays, my cross infection control procedures and the appearance and look of my practice".*
>
> (Telephone Interview, Denplan)

> *"This practice has both Investors in People status and we also hold the BDAs Good Practice award, so for us, it should just be a case of looking those two documents out, because all the things you are looking for have already been tested for these two awards; so when it comes to revalidation, for us, it's just a case of ticking a box."*
>
> (Telephone Interview, Free-found, Scotland)

Fig. 14 outlines the initiatives telephone interview participants most commonly felt should be integrated into the revalidation proposals to ensure minimal duplication of workloads, saving time, paper and costs. As shown, the two most frequently cited were those to which participants were most widely certified, the BDA Good Practice

scheme (46%) and Denplan Excel (36%) – the latter was cited by the majority of Denplan Excel accredited participants.

Fig. 14: Initiatives which should be integrated with Revalidation



Source: Q18 Are there any specific initiatives which you feel should be integrated with revalidation to help save time? [Source: All Participants (203)]

4.3.4 Practice Inspections

The majority of practices represented during the study were subject to some form of practice inspection (only 6% were not subject to inspection). The specific types of inspection cited are shown below in Fig. 15. Some respondents felt that practice inspections should not be included in revalidation as they were not a fair indicator on the individual professional's fitness to practice. Most notably, these were respondents from practices where no inspections were being carried out.

Fig 15: Practice Inspections

Practice Inspections	%
Healthboard	21
Primary Care Trust (PCT)	55
Denplan (UK)	43
Voluntary Scheme	4
Other	17
No inspections	6

Source: Q19: Is your practice subject to inspection? [Source: All Participants (203)]

Some argued that this issue was one which highlighted a victimisation of the private sole trader. One respondent commented that if the GDC wants everyone to be subject to a practice inspection, then they should make this clear and give guidance

on what standard is required; again, this follows along the key implication that dental professionals are looking for an initiative which is perspective, simple and clear.

4.3.5 Personal Development Plans & Appraisal

Similarly aligned with the last point, it is important that GDC communicates the need to have some form of formal appraisal, or peer review in place if this is to be included in revalidation. Those who underwent appraisals and/or peer review tended to be very positive about the impacts of undertaking these activities in terms of reflective practice and continuing improvement. Again, however, this added fuel to concerns that sole traders are being victimised:

> *"It's just me and [the dental nurse], so, who's going to appraise me?"*
>
> (Telephone Interview, Free-found, London)

Whilst appraisals would be valued by some and could be influential in implementing real change in the profession, there needs to be some process in place to assist principals and sole traders / those in smaller practices.

> *"If you were working for the NHS… it was very simple, we got a date, had a chat, filled in about 25 pages and then had the appraisal. When I stopped working in the hospital setting, then I wasn't working in the appraisal system any more… What worries me is who is going to do the appraisal? I don't have a problem with doing an appraisal and I think they're good at highlighting things you may not be aware of…"*
>
> (Focus Group, London)

In total, fewer than three quarters of participants (70%) had a Personal Development Plan (PDP), whether called this or known by another name. Interestingly, those most likely to have such a thing in place were those from South Yorkshire and East Midlands Deanery (97%), compared with smaller numbers of Denplan participants (62%) and those from the free-found sample (56%) – notably, the latter groups contained more sole traders and individuals from smaller practices and had a higher prevalence of exclusively private dentists.

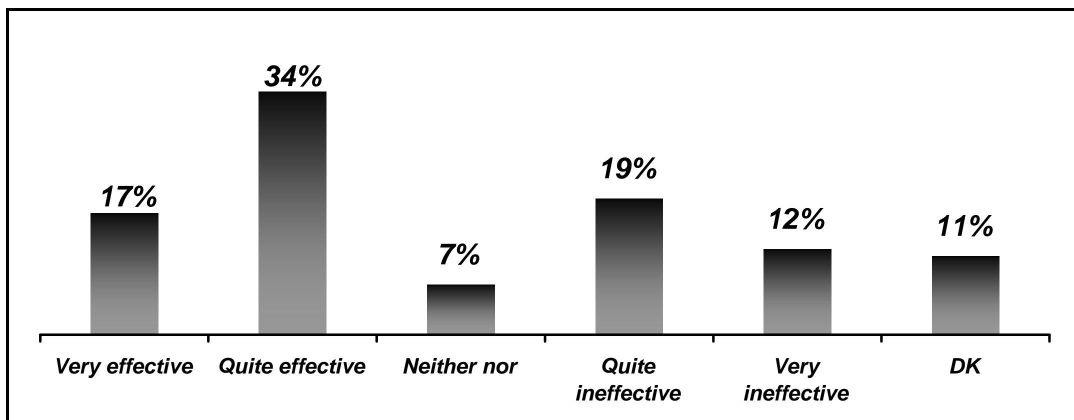
> *"One thing I didn't have done was the Personal Development Plan...I didn't know I had to have one of those. And it's compulsory... I didn't know that! So if somebody had asked me for that I would have just said*

'What?'… I do have one now. It's not very impressive, but I do have it. So from my point of view, from regulations that... that are supposed to be complying with, whether it's going to make any difference to how I treat my patients…Absolutely not in terms of I would want to do the best I can anyway. But this whole thing has been useful for me in that regard."

(Focus Group, Belfast)

The effectiveness of PDPs in their contribution to the revalidation Stage 1 'sift' was debated and participants' opinions were widespread. Fig. 16 below shows the distribution of responses generated in response to this question. As shown, just over half (51%) feel PDPs contribute effectively, whilst around a third (31%) feel that PDPs do not contribute effectively.

Fig 16: How effectively PDPs contribute to Revalidation



Source: Q23 How effectively do Personal Development Plans contribute to the revalidation process in its current form? [Base: All Participants (203)]

4.3.6 Alternative Approaches

In light of some of the aforementioned aversion to the process of revalidation, participants were asked if they could conceive of a better way to administer it. This was a crucial question in light of the support for revalidation at a conceptual level but the concerns over how it was carried out. Although there was a great degree of discussion, participants struggled to make suggestions. In total, three potential alternatives were mooted.

4.3.6.1 Face-to-Face Assessment

There was a degree of support for face-to-face assessment with all, or a selection, of dental professionals throughout the UK. For many, the argument was that the only way to get a true method of establishing a dentist's competency is through witnessing first hand, the dentist in the surgery. There was agreement however that this would be an immensely costly process.

> *"A better way to do this – though it would be a very complex system – it would be something like the dental practice board, where somebody would come and physically assess the dentists; it would be very difficult to do and very bureaucratic, but probably better… I don't know."*
>
> (Telephone Interview, SY Deanery)

> *"Practice visits – like in Denplan Excel – where they come and visit and sit in with you; that's the only way to do this and it's a good system."*
>
> (Telephone Interview, Denplan)

> *"I mean, the services; the only way to validate a practitioner – anybody who's in the schools inspectorate or the whole reference service will tell you, you know within thirty seconds of setting foot in the place whether it's operating well or not."*
>
> (Focus Group, Denplan)

4.3.6.2 Auto-CPD Profile Updates

Another suggestion, was one which evolved from the current proposals – that yes, an evidence based approach is reasonable, but which removes the burden of evidence collation from the dentists themselves. This suggestion was based on the idea that all CPD courses and practice certificates could be automatically added to an online account for each individual practitioner, whether emailed from the awarding body, uploaded by a practice manager, or through other technologies.

> *"I was wondering if they could take way the paper side of it, where you're having to keep lots of certificates etc. for years and years and years until suddenly someone wants it and half the time they don't even look at it... What if you go to, say, the BDA Conference and you have a card and you get it swiped… when you go into a lecture it comes out, and therefore they collate all your hours you've done. If there's some way of*

getting that straight to the GDC rather than us having to keep all these bits of paper, which in the end they don't actually ask for anyway. I mean surely it's more useful for a PDP tutor actually having a PDP which then talks about what you've got out of it and maybe they could ask for that in the future, rather than having lots of certificates and checking how many hours they do on that. Maybe there's some way of getting it straight. Maybe the person organising that has the responsibility for setting down the hours for each person."

(Focus Group, SY Deanery)

4.3.6.3 Educational Approach

The final suggestion came from a free-found respondent in London who, during one of the focus groups suggested that rather than a practitioner-based, proactive portfolio generation process, the GDC should administer the process educationally. The idea here would be that the GDC would organise day long conferences throughout the UK, outlining the requirements of the profession from a regulatory perspective. Rather than having to submit evidence, all dental professionals would be expected to attend one conference. Those who do not attend or who miss an allotted date for any reason, would then be subject to portfolio submission, peer assessment, or direct external assessment.

"I wouldn't do it as evidence producing, I'd do it as educational. It would be a course run by the GDC – like the NRPD doing their courses – and you get a date (and they would tell you how to do the forms you'd need to do)... Once you've done that, if you don't attend, there will be a group of people who will be put into the next stage… The individuals who deliberately miss these seminars… well then they are the ones who need to be investigated."

(Focus Group, London)

There was an understanding that by doing this, there was no evidence from the individual practitioner of meeting of the required standards and therefore, it was suggested that "spot checks" could be carried out through face-to-face assessments, to supplement the shortfall.

4.3.7 Summary

Overall, participants were able to identify a small number of benefits in administering revalidation through an evidence-portfolio submission approach. Whilst there was debate in the efficacy of administering the initiative in this way, many agreed that once it has been completed once, subsequent years will be easier to complete as it will be a simple updating process. Further, some felt the process would be effective in allowing them the opportunity to "get organised".

Additionally, there was agreement that avoiding a face-to-face assessment – whilst many felt this would be more effective – had positive implications.

On the other hand, respondents identified a series of key weaknesses in the approach, namely:

- The heavy administrative and time burden;
- Cost in time and admin for the GDC;
- Use of a census rather than sampling;
- Over-reliance on patient feedback and lack of CPD policing;

To be effective and to increase support from the profession, it is important that the approach to revalidation also addresses the following key issues:

- Revalidation must be integrated with other, established initiatives and;
- A prescriptive approach must be taken in terms of PDP, practice inspections and appraisals, bearing in mind the challenges of the sole trader.

4.4 The Standards and Evidence Framework

Overall, the information within the draft standards and evidence framework caused a large degree of discussion and debate during the telephone interviews and focus groups. On the whole, participants felt that there is still a considerable degree of work required to ensure that a cohesive and simplistic process of revalidation is established.

4.4.1 Use of the Framework

In general, participants agreed that the provision of some sort of framework was a positive thing; i.e. something outlining what is required, in what format and through what channels (if relevant). Much of the discussion around the framework focussed on its need to be simple and prescriptive – as mentioned previously, much of the information in the outcomes was left open to interpretation or was too flexible in terms of the amount of information which was required. The consequence of this is that participants were often left feeling uncertain about what to include and often would send too much information, or too little. This will have significant, time consuming consequences for the GDC when revalidation is implemented.

Due to the importance of revalidation, a very high proportion of those undergoing the process will be likely to contact the GDC for more information; furthermore, there is a strong likelihood that an overabundance of information will be sent in, thus potentially wasting the time of both the registrant and the GDC when reviewing the documents.

To ensure maximised efficiency on both sides, whilst ensuring maximum efficacy, it could be argued that a framework which is more questionnaire / checklist-based is essential.

> *"It would be really helpful if this could be a little more prescriptive… I was thinking as I went through this; 'Is this information enough?'… It was just, 'what should I put in? What bits do you want?' You know, because the choices are so much that you could put in whatever you wanted it seemed."*
>
> (Focus Group, SY Deanery)

I mean, this idea of a framework or whatever, if it works, then yeah! But this wouldn't work. It was just over-complicated – it needs to be a simple checklist."

(Focus Group, SY Deanery)

"Right, look if the GDC wants us to embrace this, then, give us a book and say 'you have to do all this'… and it's just a tick-box and you send it back in. Once you sign it, that's it; let them, you know pick at random and certain standards."

(Focus Group, Belfast)

An effectively produced framework will help to ensure that participants are clear on what is required and how to achieve it. The apparent levels of uncertainty from a significant proportion of participants, would suggest that the current framework is missing the mark.

4.4.2 Evidence Interpretation

One of the key issues with the current framework is the extent to which much of what is to be supplied is left open to interpretation in terms of what evidence would be acceptable, the depth to which this evidence should be produced – e.g. how many years back does it have to go – and the extent to which one piece of information is applicable to several different outcomes.

The key issue here was that participants felt quite strongly that if information is being requested from them, then it is essential that the requests are specific, succinct and easily understood.

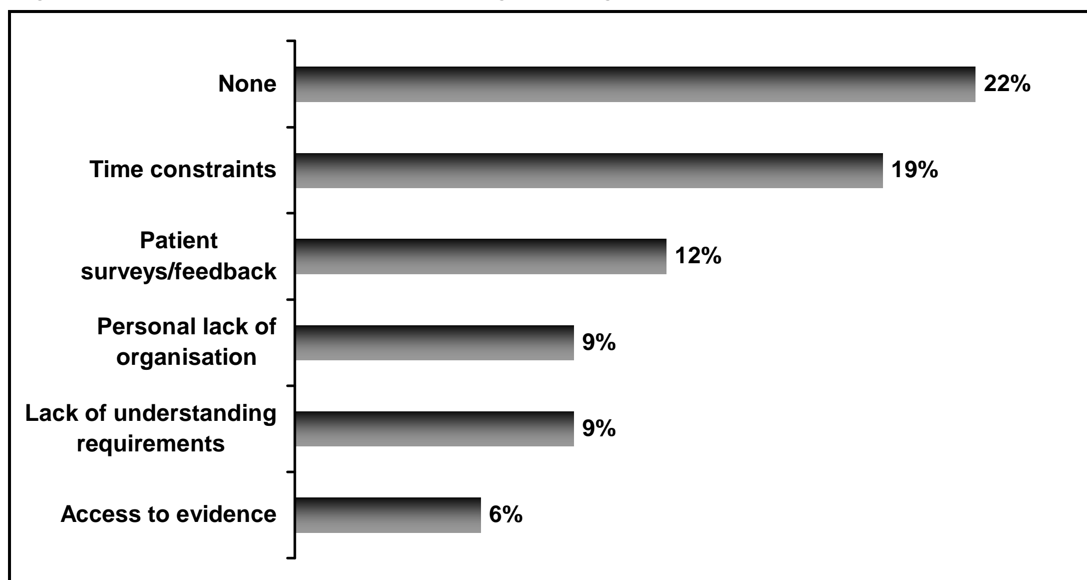
4.4.3 Difficulties in Gathering Evidence

When respondents were asked about what difficulties they could see in gathering evidence in the future, the majority of responses collated, related more prevalently to specific types of evidence or interpretation of what was required, rather than other issues.

As shown in Fig. 17 overleaf, around a fifth (19%) felt that the most difficulty in collating evidence would be having the time to do so. This issue was unpacked further in the focus groups and seemed to be rooted in the uncertainty of what was required, in addition to an occasional lack of organisation. In the case of the former,

with more warning (i.e. less than 6 weeks to collate everything) and more specific direction, respondents felt it would have been an easier process.

Fig 17: Perceived future difficulties in gathering evidence



Source: Q12 What difficulties, if any, would you see in gathering evidence in the future?
[Base: All Participants (203)]
Responses below 5% not reported

The key implication here is that when undergoing the process of revalidation, dentists are keen to ensure that they are given clear, specific guidelines, which will effectively aid the time taken in the process.

4.4.4 The Need to Ensure Practice Time is Prioritised

There is a wider issue at stake here that whilst a majority of those participating understand and support the inspiration behind the initiative and the desire to see standards improved, trust reinstated and patients protected, there is also an overarching desire to ensure that the vast majority of time is spent in treating patients, rather than getting "bogged down in bureaucracy".

The effects of an unstructured and 'open' framework are such that, when information is left open to interpretation, the regulation becomes more subjective and the array of evidence submitted will grow. However, it is equally important that the right types of information are asked for – note the over-reliance on patient feedback in the framework.

4.4.5 Victimisation of the Sole Trader

As mentioned previously, some participants who were operating as sole traders tended to be quite negative in their opinions towards revalidation, most often of the basis of feeling 'victimised' by the process. Upon consultation of some of the evidence requirements, this view was often intensified as sole practitioners would often find difficulty in providing evidence such as appraisals and practice inspection reports.

> *"The GDC wants to regularise dental practitioners who are working independently – a bit like Shipman – and nobody knows what they are doing. Nobody knows what sort of treatment they are providing… so you're going to have to go through all these loops… but you will still never know what the practitioner is doing… it's not going to guarantee patient welfare at all."*
>
> (Focus Group, SY Deanery)

> *"They're just victimising the sole trader because they want everyone to have these practice inspection reports."*
>
> (Focus Group, Denplan)

Interestingly, it could be argued that NHS dentists appeared to be more positive overall than many others (excluding Denplan Excel participants), possibly on the basis that much of the required evidence was easily acquired on the basis of pre-existing requirements; e.g. PCT Inspections for NHS dentists and most outcomes in the case of Denplan Excel dentists. Similarly, those registered on other schemes also found the process more easily completed overall.

> *"Well, we've leaned heavily on the BDA Good Practice Scheme and the Investors in People award… for us it was very straightforward and that's all we've put in. We might consider perhaps expanding the CPD coverage if that was required. But really, it was very simple as we've done it all before for the BDA."*
>
> (Telephone Interview, Free-found, Scotland)

4.4.6 The Need to Simplify and Expand the Framework

Whilst there was an agreement that the standards and evidence framework is quite comprehensive and at times, excessive, many respondents also commented that there were key areas missing from it – most notably the simple, daily procedures.

> *"It doesn't ask if I can do the simple daily tasks – scaling and polishing, actually doing a filling; I mean it's all well and good seeing if my cross infection control is in order, but if I can't do a simple scale and polish… well!"*
>
> (Focus Group, Denplan)

Whilst a potentially elementary issue, many commented that the framework was at times overcomplicated and long and yet didn't assess the extent to which simple procedures were being effectively and efficiently done. Interestingly, this was one area were patient feedback could, for the most part, be considered reliable.

In terms of priorities, participants agreed that if revalidation was to cover three main areas, they would most likely be as follows:

- The dentist's ability to carry out his / her work professionally and skilfully;
- The environment of the practice – i.e. health and safety;
- The dentist's ability to communicate well with patients.

> *"I think the utmost thing is that the patient can walk in through the door and is safe – from the environment to the work that you do. Clinical aptitude, cross-infection and the environment – you know, if there's a loose wire on the ground…"*
>
> (Focus Group, London)

4.4.7 Summary

In general, participants felt strongly that there was a need to simplify and improve the standards and evidence framework through:

- Creation of a less ambiguous and more prescriptive framework;
- More direct guidance on how much information to provide;
- Clearer leeway for those already registered on multiple schemes;
- Less reliance on patient feedback.

5. CONCLUSIONS, IMPLICATIONS & RECOMMENDATIONS

Based on the main findings highlighted above, we feel the following effectively summarises the key conclusions and implications of the research, from which we have based our recommended next steps.

5.1 Conclusions and Implications

Overall, there is an understanding amongst dental professionals that, for a long time, the introduction of some form of revalidation has been inevitable. Whilst the majority would prefer not too see this happening, some think it is both necessary and likely to have an impact on the profession. There was some debate over support for and the potential efficacy of a portfolio-based approach.

5.1.1 Time Commitment

The range of time spent on the collation process for the Stage 1 Feasibility study was vast, from literally no time at all to a full working week. This range was affected by the organisational skills of specific individuals and the extent to which filling systems were accurate and up to date, but only in part. The most significant impact on the time commitment was the extent to which evidence submissions were based on the interpretation of the individual. Whilst some felt that individual certificates and small examples of good practice were enough to meet the requirements, others felt that they had to produce every document held in the practice for the last five years or so.

On balance, once the process is established and the requisite information is readily available in practices, the likely average time taken to complete the process will be between two and fours hours.

Furthermore, the time commitment, in this study, was increased due to the fact that large scale photocopying and editing of documents (to anonymise submissions) was required.

As expected, the ideal process of revalidation would be one which is simple and requires minimal time and effort from those undergoing the process.

5.1.2 Extent to which the proposed process will be effective

There was widespread debate about the potential efficacy of revalidation based on the current proposals. The majority of participants agreed that there is still a

considerable degree of work to be done to ensure maximised effectiveness of the initiative.

Whilst there was agreement that introducing this method could have an impact on raising minimum standards and assisting the more organisationally challenged, the extent to which such a programme can expose a potential “Harold Shipman” was more doubtful. Whilst many participants agreed that revalidation is unlikely to have a significant impact on uncovering individuals who intentionally deceive patients or intentionally engage in malpractice, there was agreement that the standards of those who are more well-intentioned but below a satisfactory level could be improved. Some stated that the introduction of revalidation would create a set of minimum standards to which all should be accountable.

5.1.3 Extent to which required evidence is appropriate, relevant and useful

Whilst there were few questions around integrity or inspiration behind the framework outcomes, there was considerable debate over the types of evidence required and the perceived ease of acquiring such evidence in a reliable way. Most agreed that use of CPD evidence was both logical and useful, whilst the reliance in the framework on patient feedback was considered inappropriate. Whilst patients are able to comment to a certain extent on customer service, the abilities of a normal patient to discern what was an appropriate course of action and indeed how effectively done this was, are often incorrect. Patients’ concerns are limited to three key things; waiting time, cost and pain. Whilst some treatments may be very painful, they are often the most appropriate and as such, feedback from such treatments could provide misleading feedback.

Furthermore, there are concerns of the reliability of patient feedback as there is a degree of autonomy in the selection of which feedback to submit – the natural course of action is to submit that which is most favourable.

Participants tended to agree that the standards and evidence framework falls short on the extent to which it provides coherent, unambiguous guidance.

5.2 Research Based Recommendations

In light of the key conclusions and implications from this study, we would recommend implementation of the following.

5.2.1 Reconsideration of Patient Feedback

One of the most important areas for consideration, is the extent to which patient feedback is relied upon for revalidation. To ensure the right areas are covered, it is important that the GDC explicitly states on what basis dentists should be acquiring feedback. To do this, we would also recommend the production of a feedback pro forma for use in revalidation.

Furthermore, it would be worth considering taking the burden of questionnaire dissemination to patients through a random sampling approach to ensure that dentists are not self-selecting the most favourable patients. We understand however that this will have significant cost implications and may not be practical.

5.2.2 Specificity in the Framework

The standards and evidence framework should be developed in a more prescriptive "tick-box" manner. This would include specific guidance on the type of evidence required, in what format and how far back the information needs to go. So, in the example of CPD evidence, an example could be:

- *Please provide evidence to show completion of 250 hours of CPD (verifiable and non-verifiable) over the last 5 years.*

Or if there is a need to show that practices are currently meeting the required health and safety standards, an example outcome could be:

- *Please provide inspection reports for the last 5 years which show that your practice meets the required standards. We would accept any one of the following – PCT inspection report, BDA Good Practice certificate, Denplan Excel certificate, etc.*

It is essential that those participating are confident that the evidence they are sending capably meets the requirements outlined in the framework and this means that each outcome should clearly specify:

- What needs to be proven;
- What specific evidence types are acceptable – e.g. certificates alone or full reports and;
- How many years the evidence is required for.

Specificity is essential and it is important that the GDC is explicit in its aims for revalidation. For example, if the GDC wants to ensure that all practices undergo a certain type of inspection, then this needs to be clear, together with information on how this can be achieved in the examples of the small number of practices who currently go without inspection.

5.2.3 Ensure Integration with other Initiatives

It is essential that revalidation ties in with other, already established initiatives to ensure that workloads are minimised for both the individual practitioner and the GDC. On the testimony of dentists themselves, we would recommend that the Denplan Excel certificate is enough to meet the requirements of revalidation as many feel that this covers off all of the outcomes more than adequately. Other popular initiatives such as BDA Good Practice should be considered so that certification from this is enough to meet the requirements of relevant outcomes.

In addition, we would recommend that mandatory CPD requirements should be subsumed within revalidation.

5.2.4 Production of a Revalidation Storage File & CPD Diary

One of the key difficulties with revalidation going forward, will be the method in which evidence is stored and submitted and it is therefore essential that the GDC takes steps to try to seek some form of "standardised" submission strategy. Our view is that the development of some form of storage file or folder would benefit both professionals and the GDC. During the course of a 5 year revalidation period, dentists could simply photocopy and add any relevant documents or certificates to the file and thus carry out the process on an ongoing basis, rather than trying to collate everything in a six week, or shorter, period. The production of this would also help guidance on what information is required and how it should be presented.

At the other side of the revalidation process, i.e. the analysis stage, the GDC would benefit from this as it will easily identify which areas have been effectively covered off and which have not thus easing, and increasing the efficiency of, the analysis process.

Aligned with this, and based on the array of different documents received, it would also be useful to develop a pro forma for completion of CPD information – a CPD diary. This would again aid the completion and analysis aspects.

5.2.5 Invest in Online Facility

We feel that, whilst in the initial stages it may not be used as widely as expected, it would be worth investing in the development of an online e-portfolio system through which participants can submit their evidence, with a view to driving all activity through this in around 10 years time. Again, the e-portfolio system should be designed in such a way as to facilitate ongoing uploading and registration of documentation to ensure that the process is not rushed at the end of the five years by the dentists.

Furthermore, it would be useful to investigate how this could be tied in with awards and CPD certification. Perhaps one's e-portfolio could be managed through e-GDC and certification could be added to an individual's portfolio at their request through provision of their registration number. So, for example, if registrant number 1234 5678 attends a course on cross-infection control, the attendance certification for this is emailed by the course provider directly to the registrants online account. Again, this is likely to have significant cost implications, but in the long term may save time for registrants and the GDC and thus costs.

5.2.6 Consider the importance of Census versus Sampling

Although we would recommend implementing submission of evidence from all registered professionals in the UK, the extent to which the GDC should analyse these is debatable; it is likely that a random sampling approach would be more cost effective in the long term. Thus, all who do not submit evidence portfolios at all and those who fail, having been randomly selected for analysis would enter into Stage 2.

5.2.7 Reconsideration of the Four Key Areas

Whilst Management and Leadership are important areas for Principals, it may be worth reconsidering its inclusion in the four key areas. Use of the four areas outlined in the report, may be more appropriate:

- Professionalism and conduct
- Communication skills
- Clinical aptitude
- Compliance certified.

APPENDICIES

APPENDIX A: Draft revalidation standards and evidence framework

Professionalism **(Puts patients interests first and acts to protect them)**				
Ref.	Outcome	Compulsory evidence	Additional evidence	Comments
Patients:				
P1	Respects patients' dignity and choices	Patient feedback	Appraisal / MSF Practice accreditation schemes	
P2	Protects the confidentiality of patient information	Patient feedback	Appraisal / MSF Practice accreditation schemes	
Clinical team and peers:				
P3	Co-operates with other members of the dental team and other healthcare colleagues in the interests of patients	Clinical governance inspection Patient feedback	Appraisal / MSF Practice accreditation schemes	
Self:				
P4	Maintains professional knowledge and competence	Personal development plan CPD evidence	Appraisal / MSF Practice accreditation schemes	
P5	Demonstrates trustworthiness	Clinical governance inspection Patient feedback	Appraisal / MSF Practice accreditation schemes	

Clinical				
Ref.	Outcome	Compulsory evidence	Additional evidence	Comments
Medical emergencies:				
CL1	Medical emergencies are recognised and dealt with appropriately in the practice	Clinical governance inspection Personal development plan CPD evidence	Appraisal / MSF Practice accreditation schemes	
Drugs and prescribing:				
CL2	Patients have been prescribed drugs safely and with appropriate knowledge of potential interactions	Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	
Radiology:				
CL3	IRMER regulations and appropriate radiation protection procedures are followed in the practice	Clinical governance inspection Personal development plan CPD evidence	Appraisal / MSF Practice accreditation schemes	
Disinfection and decontamination:				
CL4	Appropriate disinfection and decontamination procedures are in place	Clinical governance inspection Personal development plan CPD evidence	Appraisal / MSF Practice accreditation schemes	
Referrals:				
CL5	Referrals to specialists and other healthcare colleagues are relevant, appropriate and timely	Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	
Clinical care:				
CL6	Patient records are peer reviewed.	Patient records peer review		

Communication				
Ref.	Outcome	Compulsory evidence	Additional evidence	Comments
Patient and family:				
CM1	Communicates effectively, respecting patients' dignity and confidentiality, ensuring understanding of all aspects of treatment options and procedures	Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	
CM2	Addresses challenging communication situations and Handles complaints effectively in line with Principles of Handling Complaints	Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	
CM3	Identifies patients with special communication needs and makes arrangements to meet those needs effectively, including those with anxiety or other special needs	Personal development plan Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	
Clinical team and other professionals				
CM4	Communicates effectively with colleagues in the dental team and other healthcare professionals	Patient feedback Patient records peer review	Appraisal / MSF Practice accreditation schemes	

Management and Leadership				
Ref.	Outcome	Compulsory evidence	Additional evidence	Comments
Personal and practice organisation:				
ML1	Good practice management	Clinical governance inspection Personal development plan CPD evidence Patient feedback	Appraisal / MSF Practice accreditation schemes	
ML2	Understands needs of own practice, including appropriate risk assessment and the need to bring in additional expertise where necessary	Personal development plan CPD evidence Patient feedback	Appraisal / MSF Practice accreditation schemes	
Legislation and guidance:				
ML3	Applies relevant legislation and best practice in employment law, health and safety, equality and diversity etc	Personal development plan CPD evidence	Appraisal / MSF Practice accreditation schemes	
Leadership and training:				
ML4	Contributes appropriately to ongoing quality improvement of practice and training of self and clinical team	Personal development plan CPD evidence Patient feedback	Appraisal / MSF Practice accreditation schemes	

APPENDIX B: GDC Revalidation Focus Groups
Topic Guide

The following question areas have been developed to provide a framework for discussion. All relevant topic areas should be discussed and covered at some stage during the group session, but should be addressed in such a way that facilitates a relaxed and natural flow of conversation.

Introduction / Background (5 mins)

- Introductions and recap on the aims of the discussion i.e. *we are evaluating the Revalidation Feasibility Study on behalf of the GDC – as part of this, we are speaking to all those who took part either in a focus group or by telephone interview. We are not involved in any way in "revalidating" dentists but rather, we are keen to understand the experiences of those who took part and ways in which the Revalidation process could be improved or amended in the future.* Remind respondent of MRS Code of Conduct which ensures full confidentiality and anonymity for all respondents;

- How long have you been involved in the dental profession for and how have you seen issues surrounding regulation evolve over that time;

- For what reasons did you decide to volunteer to participate in the Revalidation Feasibility Study;

- The Standards framework developed by the GDC is intended to provide the key attributes expected of a dentist who is performing acceptably. What do you feel are the key attributes of a good dentist;

The Revalidation Concept (15 mins)

- What are your views on the idea of revalidation and why; to what extent do you think that it will have an effect on the protection of patients; what are the benefits afforded to **patients** through revalidation of dentists in the UK; what, if any, do you feel are the benefits to **dentists**; probe fully for reasons

- What, if anything, do you think could be the drawbacks to patients of the revalidation process; and what are the drawbacks for dentists; probe fully;

- How have your views of revalidation changed since you signed up to be involved in the pilot phase; probe for differences attitudinally and in terms of pragmatic understanding – having gone through the revalidation process, do you feel you have a good understanding of what revalidation is;

- You may be aware that revalidation is expected to be a 3 staged process – we're looking at Stage 1, where all dental care practitioners have to submit evidence. When revalidation is implemented, a small number from stage 1 will then have to undergo some level of peer assessment and then some from this group are likely go to stage 3 which will involve an external assessment (offer explanation);

  How do you feel about this process overall and why; probe fully for each stage; Probe to what extent do you feel stage 2 is 'necessary' and why;

- To what extent do you feel this 3-staged process will effectively revalidate dental care practitioners in the UK and why; what are the relative benefits and disadvantages of this approach;

- You will also be aware that revalidation is based under four key strands, to what extent do you feel that these key areas are appropriate and relevant for revalidation and why;

  - Professionalism
  - Communication
  - Clinical
  - Management and Leadership

- To what extent do you feel that the 'weight' given to each of these four strands right and appropriate; which areas need more attention and which need less;

- Are there any of these which you feel are superfluous to needs or irrelevant in the context of revalidation; what if anything, should they be replaced with; are there any other areas you can think of which are not already covered but perhaps should be; ensure participants are asked about specific standards, and not just domains;

Revalidation Stage 1 (30 – 40 mins)

- How effectively did the 'Information for Participants' explain the process of revalidation and what you were required to do; what other info would be useful;

- Overall, how easy did you find the process; what difficulties, if any, would you see in gathering evidence and meeting the requirements of revalidation, in the future;

- How did you set about gathering all the required evidence for revalidation; how much involvement did you personally have in the process and how much was carried out by others, e.g. admin staff;

- Where there any gaps where you were unable to, or found difficulty in, obtaining the relevant evidence;

- How easy was it to collate the evidence and anonymise it; were most things easily accessible and stored in the one place or did you have to look around several places;

- Would you prefer an alternative system for storing and / or submitting evidence; i.e. would you prefer an online system whereby you could scan / upload documents as you are collating evidence, or do you think a hard copy system would be best; probe fully for reasons;

- What role did the standards and evidence framework play in the process; e.g. constant referral back to it vs a quick glance every now and again;

- Overall, how much time would you estimate you have spent in gathering evidence for the revalidation process; to what extent do you feel you were able to gather all the necessary evidence to successfully complete the revalidation process;

- Overall, how appropriate do you feel this system is for identifying dentists who meet the requirements for the Stage 1 revalidation 'sift';

- Looking through the standards and evidence framework, how well do you think this outlines the requirements of the revalidation process; how do you rate it in terms of:

    - Specificity
    - Guidance in what types of evidence might be sufficient
    - Ease of understanding and use of jargon
    - Layout
    - Its usefulness in the revalidation process

- If you were responsible for revalidation, what changes would you make to the framework;
- Looking briefly at the standards laid out in the framework, what evidence did you use or would you use to meet the requirements of each – i.e. just the compulsory evidence, or also the additional evidence;

- For which elements were you unable to provide the compulsory evidence; for each of these elements, to what extent do you agree with that the compulsory evidence is necessary to revalidate;

Evidence Issues (15 mins)

- What are the relative strengths and weaknesses of the portfolio approach to revalidation in its current format; how "fair" and / or logical a system is it whereby you are effectively asked to produce your own evidence;

- In what ways, if at all, did revalidation provide you with ideas for other forms of evidence you could be gathering – i.e. what would make it easier for you in the future; e.g. patient surveys, practice evaluation forms, etc.

- How effectively do Personal Development Plans contribute to the revalidation process in its current form; probe fully for reasons why;

- Do you think you should be allowed to include self-assessed evidence as part of the revalidation process, which has not been confirmed by a 3rd party – what sorts of things would this include and why do you feel it would be valid;

Time and Costs (10 mins)

- How much time is involved in the revalidation process and at what cost to you personally / your practice / the NHS **over and above** what is currently being done;

- Does the cost:benefit ratio justify the time and resources taken to revalidate dentists, again focusing on the costs over and above current operating procedures

- What other costs were involved in the process; probe for: admin time / other staff; cost of paper / printing; other costs;

- What do you feel would help make the revalidation process shorter; to what extent would this affect the quality of the output; are there other measures which would aid in the efficiency;

Conclusions (5 mins)

- Having taken part in this revalidation study, do you think that you will be able to comply with the revalidation requirements if this was implemented in 5 years time

- Do you think there is a better way to revalidate dentists; if so, how would you do it.

APPENDIX C: 6010 GDC REVALIDATION
Telephone Interview

STRICTLY PRIVATE AND CONFIDENTIAL

This questionnaire is the property of George Street Research Limited, 24 Broughton Street, Edinburgh, EH1 3RH. Telephone 0131 478 7520.

Respondent's Name . . . .

Job Title . . . .

Practice Name . . . .

Address . . . .

. . . .

Postcode . . . . Telephone Number . . . .

Date of Interview . .. . Respondent ID Number . . . .

CLASSIFICATION

SITE

Freefound	1
South Yorkshire Deanery	2
Denplan	3

How long have you been registered with the GDC?

Less than 2 years	1
2 – 5 years	2
6 – 10 years	3
10 – 20 years	4

Are you currently working full-time or part-time?

Full-time	1
Part-time	2

How many dentists are in your practice?

Sole practitioner	1
2 – 5 dentists	2
6 or more	3

How many of the following groups of DCPs do you have in your practice?

Dental Nurses (write in no.) …………………………………………	1
Other DCPs (e.g. hygienists, therapists) (specify and write in no) ……………	2

What type of practitioner are you at the moment?

NHS only	1
NHS and Private or Independent	2
Private or Independent only	3
Salaried Services	4

Region

Northern Ireland	1
Scotland	2
Wales	3
London	4

Length of Interview: … mins

Job Number: 6010

REMIND RESPONDENT THAT THE CALL IS BEING RECORDED FOR ANALYSIS AND REASSURE THAT ALL INFO IS CONFIDENTIAL IN LINE WITH MRS CODE OF CONDUCT. Check if we have received the respondents' evidence and if not, remind them that it needs to be sent in to us. Explain that there are some specific aspects of the revalidation process we need their views on but that we are very happy for them to make any additional comments or suggestions throughout the discussion.

Moderator note – in all circumstances, please probe answers fully; refer to the standards and evidence framework for more information. HAVE A COPY OF THE STANDARDS AND EVIDENCE FRAMEWORK IN FRONT OF YOU DURING THE INTERVIEW

1 How did you come to be involved in the revalidation pilot? PROBE FULLY

SUMMARY CODE BELOW FOR ANALYSIS:

Volunteered for it	1
Was put forward/encouraged by someone else, e.g. deanery	2
Other	3

2a When you initially became involved in the pilot programme, did you feel you had a good understanding of revalidation? PROBE FULLY & RECORD COMMENTS

2b And now that you have gone through the evidence generation process, do you feel you have a good understanding of what revalidation is? PROBE FULLY & RECORD COMMENTS

	Q2a	**Q2b**
Yes	1	1
No	2	2
Not sure	3	3

3 How effectively did the 'Information for Participants' (and other material that was provided) explain the process of revalidation?

SUMMARY CODE BELOW FOR ANALYSIS PURPOSES

Very effective	1
Quite effective	2
Neither effective nor ineffective	3
Quite ineffective	4
Very ineffective	5
DK	6

4 Overall, how much time would you estimate you have spent in gathering evidence for the revalidation process? WRITE IN NUMBER OF HOURS AS WELL AS RECORDING ALL COMMENTS

NUMBER OF HOURS ……………………………………………

5 And do you feel you were able to gather all the necessary evidence to successfully complete the revalidation process? PROBE FULLY

SUMMARY CODE BELOW FOR ANALYSIS:

Yes (unequivocal)	1
Yes, mostly	2
Yes, to a lesser extent	3
No	4
Not sure	5

6 What have you used as "evidence"? PROBE FULLY AND ADDRESS THE FOUR KEY ARES IN THE FRAMEWORK

IF APPROPRIATE

7 Where there any gaps where you were unable to, or found difficulty in, obtaining the relevant evidence? REFER BACK TO THE STANDARDS FRAMEWORK

8 Over and above the things you will need to do anyway, to meet contractual or other requirements, how long do you estimate it would take you get the necessary evidence to complete the revalidation process? PROBE FULLY

NUMBER OF HOURS ………………………………………………

9 Was there any relevant information/documentation that you have had in the past, but did not keep? PROBE FULLY FOR SPECIFIC DOCUMENTATION

SUMMARY CODE BELOW FOR ANALYSIS:

Yes, lots	1
Yes, some	2
No	3
Not sure	4

10 Were there any types of evidence asked for that you felt were not good indicators of performance? PROBE FULLY FOR EVIDENCE AND REASONS WHY

11 Overall, how easy did you find the evidence gathering process for this pilot? PROBE FULLY

SUMMARY CODE BELOW FOR ANALYSIS PURPOSES

Very easy	1
Quite easy	2
Neither easy nor difficult	3
Quite difficult	4
Very difficult	5
Depends (on specific evidence)	6

12 **What difficulties, if any, would you see in gathering evidence in the future? PROBE FULLY**

13 **How have you stored the evidence as you have been collecting it? What do you think is the best method for storing evidence moving forward?**

14 **Would you prefer an online system whereby you could scan/upload documents as you are collating evidence, or do you think a hard copy system would be best?**

Online / ePortfolio	1
Hard Copy	2
Both	3
Either-Or/ No preference	4

15 **Overall, how appropriate do you feel this system is for identifying dentists who meet the requirements for the Stage 1 revalidation ‘sift'? PROBE FULLY FOR REASONS**

SUMMARY CODE BELOW FOR ANALYSIS PURPOSES

Very appropriate	1
Quite appropriate	2
Neither appropriate nor inappropriate	3
Not very appropriate	4
Not at all appropriate	5
Mixed views	6

16 The Standards framework developed by the GDC is intended to provide the key attributes expected of a dentist who is performing acceptably. What do you feel are the key attributes of a good dentist?

17 Do you think there is a better way to revalidate dentists? If so, how would you do it?

18 Are there any specific initiatives which you feel should be integrated with revalidation to help save time, without losing quality of evidence?

Appraisal schemes (probe for specific) …………………………………………………………….	1
BDA clinical governance toolkit	2
BDA Good Practice scheme	3
Denplan Excel	4
FGDP (UK) (Faculty of General Dental Practice)	5
Smile-on clinical governance scheme	6
Other (write in) …………………………………………………………….	7
None	8
DK	9

19 Is your practice subject to inspection by a Health Board (Scotland only) or PCT (Primary Care Trust) or Denplan (UK) OR under a voluntary scheme?

Healthboard	1
PCT (Primary Care Trust)	2
Denplan (UK)	3
Voluntary scheme	4
Other	5
No, not subject to inspection	6

IF INSPECTED

20 What kinds of evidence does the inspection produce and how do you think inspections could tie in with the revalidation process? PROBE FOR HOW MUCH WEIGHT SHOULD BE GIVEN TO INSPECTION DETAILS

21 And can I ask whether you personally have any form of personal development plan?
(You may already be doing this as part of your CPD, but you may not describe it as a personal development plan. Typically this is an assessment of your strengths and weaknesses and a tailored personal plan to help you improve relevant skills).

Yes	1
Yes, but call it by a different name (write in) …………………………………………………………	2
No/DK	3

IF PDP

22 How has this been developed and with what input, if any, from others e.g. Deanery, Denplan, FGDP? PROBE FULLY

23 How effectively do Personal Development Plans contribute to the revalidation process in its current form? PROBE FULLY

SUMMARY CODE BELOW FOR ANALYSIS PURPOSES

Very effective	1
Quite effective	2
Neither effective nor ineffective	3
Quite ineffective	4
Very ineffective	5
DK	6

24 Do you think you should be allowed to include self-assessed evidence as part of the revalidation process, which has not been confirmed by a 3rd party? PROBE FULLY FOR DETAILS

Yes	1
No	2
DK/Depends	3

25 Having taken part in this revalidation study, do you think that you will be able to comply with the revalidation requirements if this was implemented in 5 years time? If not, why not?

Yes	1
No	2
DK/Depends	3

26 Finally, are there any other comments you would like to make about the revalidation pilot that we have not already discussed? PROBE FULLY

REMIND RESPONDENT IF WE HAVE NOT RECEIVED IT, THEY WILL NEED TO SUBMIT THEIR EVIDENCE (NES SHOULD DO THIS THROUGH E-PORTFOLIO)