

General Dental Council

Quality Assurance Report Standards for Specialty Education

Education Provider/Awarding Body	Programme
NHS Education for Scotland Dental Directorate	Specialty training

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

Summary

Remit and purpose:	To quality assure the specialty training and education being delivered by NHS Education for Scotland Dental Directorate.
Standards for Specialty Education:	All
Dates of submissions:	17 January 2020 (revised 29 October 2020), 26 July 2019, December 2019.
GDC Staff:	Manjula Das (Head of Education) Patrick Kavanagh (Policy Manager) Natalie Watson (Education Quality Assurance Officer) Martin McElvanna (Education Quality Assurance Officer)
Education associates:	Eileen Skinner; Tim O'Brien

NOTE: This report was originally reviewed and approved by the GDC Registrar in January 2020. However, subsequent discussions about the timeline for follow-up actions were impacted by the Covid-19 pandemic. Devoting sufficient resource to accomplishing the follow-up actions was also impacted.

Following discussions with the provider NHS Education for Scotland Dental Directorate, a revised timetable has been agreed.

This report sets out the GDC analysis of the self-assessment and evidence submission by the provider NHS Education for Scotland Dental Directorate (for ease “the NES team”) against the *Standards for Specialty Education* (“The Standards”).

The document also places this self-assessment and evidence submission in the context of policy development for the quality assurance of specialty training together with next steps for the NES team and the GDC.

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

	Number of Requirements	Requirements
Met	16	P1; P4; P5; P6; P8; P9; P10; P12; P13; P14; P15; P16; P17; P18 P19; P20.
Partly met	4	P2; P3; P7; P11.

Where Requirements have been assessed as partly met, this is the result of a very frank and transparent response by the NES team. We have identified 4 actions we ask the NES team to address by Q3 2021 to demonstrate progress against these Requirements.

We have also identified GDC actions arising from Requirements that the NES team have met. These actions acknowledge good practice by the NES team, particularly around their

quality management model, where we wish to develop model or specimen answers to assist future assessment by other providers against the standards.

Outcome of relevant Requirements

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

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

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

The programme provider has assessed themselves as meeting this Requirement. Their narrative and evidence rely upon the coherent and thorough analysis of their own evidence returns from the Dental Training Specialties.

The narrative and evidence usefully make explicit a shared responsibility between the trusts working to the NES team and the team itself for meeting this Requirement and, whilst normally the GDC might not consider accepting one piece of evidence as sufficient for so significant a Requirement, we recognise that the Evidence returns collated workbook (DD04) draws together a range of evidences, a representative sample of which have also been forwarded to the GDC (notably the ARCP Process Document (DD11) and Sample ARCP outcomes 2018 (DD13)).

The GDC notes that, in addition to the evidence presented to this Requirement, a process is ongoing whereby further Training Programme Director (TPD) reports are being commissioned by end September 2019 which permits TPDs to comment upon ARCP (the Annual Review of Competence Process) and individual trainee progress.

We anticipate that this process will permit future measurement of performance against this standard by evidence of exception activity. As individual TPDs may have a small number of specialty trainees, the NES team's collation of information will be crucial to identify and to report upon specific instances of what has happened on any occasions when action is required to confirm assurance in a specialty trainee's skills.

We also anticipate that this process will permit in the future a granular demonstration that this Requirement is being addressed throughout specialty trainees' training. As they progress through training, specialty trainees may be treating patients at times when skills are recently acquired and therefore this Requirement can be seen to lead to an iterative process to be considered throughout a period of training. We consider that the TPD reports, together with clinical incident documentation, can provide valuable evidence against this Requirement.

We agree that this Requirement is met on the basis that the evidence submission demonstrates the existence of systems that can confirm the safety of specialty trainees both as part of an iterative process and in response to any adverse incident.

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

The programme provider has assessed themselves as meeting this Requirement. They also acknowledge that there are a range of approaches and levels of proactivity in systems relevant to this Requirement.

The NES team provide a policy document which demonstrates the existence of a patient consent process for restorative dentistry (DD18) to meet this Requirement as well as narrative examples of ways and means by which patients are made aware of the status of the individuals treating them.

We note the open acknowledgement by the NES team that TPD self-assessments show a variable ability in meeting this Requirement.

Given that the development of this Requirement has been the subject of considerable discussion in the specialty QA pilot, both Standards consultations and may well receive further thought to its development, we recognise that this Requirement continues to pose difficulties for education providers.

In the circumstances, we commend the openness of the evidence suggested by the NES team and we will ask for further evidence in Q3 2021 about the wider take-up of the policy and its potential application across further specialties.

The NES team will explore further consistency in meeting this Requirement with the Directors of Dentistry in each Health Board. We note their indication that an individual Health Board's position will be determined by their own evaluation of the effectiveness of their existing Clinical Governance and Safety Procedures which effectively means that this is outwith the NES team's control.

NES will keep the GDC informed of developments regarding the practical delivery of this Requirement in Q3 2021.

We consider that this Requirement is partly met.

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

The programme provider has assessed themselves as meeting this Requirement and, in addition to providing their collation, has supplied sample policies concerning such matters as Code of Conduct, Equality and Diversity, Bullying and Harassment and an Incident Reporting Process (DD14-17).

We recognise the relevance of these policies to this Requirement but consider that further evidence may be necessary to demonstrate both that these policies are receiving regular review and that there are actions arising to ensure compliance with the policies.

For example, the sample Dental School visit report (DD20) supplied with the evidence submission confirms that the visit team were advised of the existence of co-ordinated policies and procedures but there is no discussion of any actions undertaken. Of course, it may be that no incidents have arisen within the timeframe covered by the visit but, in such circumstances, it would be useful to see an indication of "nil return".

Similarly, the sample TPD self-assessments (DD 05-06) confirm the existence of policies and, in one case, confirm how adverse incidents are reviewed. There are limited indications whether such incidents have occurred and, if so, of the outcomes of review.

The GDC is not suggesting that it wishes to be involved or fully advised of the details of issues arising from the policies provided. We consider that a useful way to quality manage these issues is by exception-reporting and we will be interested in seeing summary data (including nil returns) in the future. We will monitor progress in Q3 2021.

The GDC acknowledges the actions that NES are undertaking in connection with this Requirement as well as noting the Postgraduate Dental Dean's assurance that where any incidents do arise that directly affect the provision of training or safety and well-being of trainees, that the Health Board will inform him of the issue and the actions being taken.

NES will update the GDC with developments of this Requirement with the NES team in Q3 2021.

In the circumstances, we consider this Requirement to be partly met.

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

The programme provider has assessed themselves as meeting this Requirement.

The evidence submitted for this Requirement is Evidence returns collated workbook (DD04) where, inter alia, TBDs confirm that relevant policies exist across the range of NES specialty training or give illustrations of trainee/supervisor ratios that exist.

As with P3, we recognise the relevance of these policies and illustrative examples to this Requirement but consider that further evidence may be necessary to demonstrate both that these policies are receiving regular review and that there are actions arising to ensure compliance with the policies.

It would be useful to understand the quality management response (in addition to local responses) on any occasion when action is required to confirm assurance in a specialty trainee's skills, whether as a result of, or independent of, ARCP processes, before they treat patients at the relevant level of their development.

Again, this may be an area where exception reporting (where divergence has occurred from policies or the management of any scenarios where trainee/supervisor ratios experience strain) may be the clearest way of demonstrating compliance with this Requirement. As before, a nil return is entirely possible but an indication that the policies are being actively tested or monitored by the NES team would be very useful.

Given the level of information supplied, we agree that this Requirement is met but, as with P3, we will be interested in seeing summary data (including nil returns) in the future. We will monitor progress in Q3 2021.

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

The programme provider has assessed themselves as meeting this Requirement.

We agree and our comments are aimed primarily at clarification. The narrative and the information supplied in the Evidence returns collated workbook (DD04), while comprehensive, could have been supported by sample (redacted) staff training records.

For example, we note that a number of providers indicated that educational and clinical supervisors were invited to training events. If it is the case that this training should be undertaken by all educational and clinical supervisors in Scotland to ensure that delivery to Specialty trainees is consistent, records of training undertaken by educational and clinical supervisors submitted annually to the TPD/NES would provide further and stronger evidence in supporting this this Requirement.

We make these points for other providers in the future for whom a wholesale survey of their TPDs may not be possible. Essentially this Requirement is binary in nature – supervisors will either meet or not meet the criteria of this Requirement. Since the NES team indicate that all supervisors are on specialist lists, which is the only area where a supporting rationale might need to be referenced, we are content with the statement supplied.

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

It is possible to follow through the narrative and to see from the evidence supplied how Datix, the web-based incident reporting and risk management software system (DD17) can provide exception-reporting from the relevant policies governing the expectation that all trainees should be able to raise concerns about patient safety.

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

What is not wholly clear from the evidence submission is how the NES team may consider and/or report upon this information from quality management visits or other information-gathering exercises.

For example, should a “lessons learned” experience occur under one health board, how does the NES team become aware of it and is there any mechanism by which learning can be more widely disseminated?

It appears from the responses received by the NES team that there is the potential for variation in how TPD providers consider this Requirement to be satisfied. We would be interested to learn more about the NES team’s role in moderating and influencing cohesion of such policies across their providers.

The GDC notes provision of:

- sample question sets ((DD26-28) used in pre-visit questionnaires and visit focus groups
- a Process Flow diagram (DD30) explaining how the NES team review and action formal visit responses through its QM Governance Framework.

The GDC is also pleased that the NES team intends to build upon our feedback regarding the potential for the use of a “Lessons Learned” methodology and we will incorporate this point in three ways. We look forward to learning more about the embedding of this initiative.

The GDC considers this Requirement to be met.

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

The programme provider has assessed themselves as meeting this Requirement. As with P6, the evidence presented covers descriptions/copies of policy and procedure together with an indication of the Datix tool (DD17).

There is no indication of the actual incidence of any patient safety issues. Of course, it may be that no issues have arisen within the timeframe covered by the evidence submission but, in such circumstances, it would be useful to see an indication of “nil return”.

Both the programme provider and the GDC may need to give further consideration in the future to the evidence to be presented in connection with this Requirement. We anticipate that, where appropriate, concerns will be raised with the professional regulator but there is no clear indication of a threshold for this action.

From the GDC perspective, we collect information about the incidence of student fitness to practise issues in pre-registration training as part of our monitoring process. The nature of the information relating to (registrant) specialty trainees will differ but an indication, at summary level, of matters that were managed without reference to the regulator would provide a useful indicator for ongoing review of the *Standards for Specialty Education* as it moves towards integration within the planned risk-based QA processes.

We consider this Requirement to be partly met and will monitor progress Q3 2021.

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

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

The programme provider has assessed themselves as meeting this Requirement.

We agree with the narrative and evidence confirming compliance:

- a. There is a clear statement that STC and SAC committees are where the NES team review how training maps to curricula supported by the contents of the Evidence returns collated workbook (DD04).
- b. The Standard Quality Management (QM) Visits Standing Operating Procedure (DD19) (last reviewed May 2019) gives a clear overview of how NES are managing the quality of Health Boards and providers under the QM framework.
- c. The Sample visit Summary (DD20) provides evidence of a QM visit as mentioned under the SOP which triangulates evidence for this Requirement.
- d. The QM Calendar (DD21) confirms that QM visits are planned in a strategic manner incorporating internal and external QA management plus Trainee surveys.
- e. The TPD report template (DD22) gives assurance that the NES team is suitably monitoring training programmes/directors.
- f. The Quality Management framework (DD23) confirms lines of responsibility.

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

We can see from the Sample Visit Summary (DD20) supplied that a QM visit results in recommendations. However, it is not clear from the documentation supplied how meeting recommendations is subsequently monitored or what the timeframes may be for follow-up.

This contrasts with the Educational Governance review of the NES Dental Directorate document (DD25 - March 2019) which demonstrates receipt of external recommendations (though they may not address “concerns” as such) and a clear response from the Directorate with a recommendations action plan with indicative timelines.

The GDC notes provision of:

- a. Information concerning three quality management visits to Health Board providers together with:
 - i. A sample formal feedback template (DD29) issued to each Health Board in respect of the detailed visits;
 - ii. A Process Flow diagram of the visit and follow-up actions (DD30)

The GDC considers this Requirement to be met.

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

The programme provider has assessed themselves as meeting this Requirement.

We agree; it is particularly useful and reassuring to see a range of quality management procedures across the breadth of the NES team’s activity. The Sample Specialty Training Committee Constitution (DD10) confirms the STCs have lay and professional representation and the Evidence returns collated workbook (DD04) confirms all specialty training programmes have appropriate external assessors.

Without suggesting there is any question about compliance with this Requirement, it would be useful for the GDC to learn more about the work of the STCs and to learn more about how their activity – perhaps identifying areas of ‘good practice’ or ‘areas of risk’ – is monitored and reviewed by the NES team under these mechanisms.

The initiative of surveying TBDs appears indicative of good practice and possesses the potential to provide the basis of additional guidance to programme providers considering their compliance with the *Standards for Specialty Education*.

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement, confirming that the ARCP process results in a minimum of an annual discussion of all placements.

We also recognise the existence of systems whereby the STC or TBD can take action when issues arise. Whilst the standard does not necessarily require a demonstration of these systems as part of an evidence submission, it would be very useful for the GDC to understand the incidence of actions taken and how they are monitored by the NES team.

Whilst there is a clear indication of the systems capturing specialty trainee feedback (DD24), the NES team’s self-assessment gives no assessment regarding the collection of patient feedback and how it may be utilised. The Evidence returns collated workbook (DD04) makes partial reference to the use of patient feedback.

It is good to learn that the NES team intends to explore the use of patient feedback further with the Directors of Dentistry in each Health Board and we look forward to further discussion around this Requirement in Q3 2021.

The GDC will take an action, in order to develop its thinking before Q3 2021, of discussing with Healthcare Improvement Scotland the importance they place upon patient feedback within quality management systems.

We consider that this Requirement is partly met.

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

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

The programme provider has assessed themselves as meeting this Requirement.

We agree:

- the STC/ARCP Schedule (DD07) confirms that regular ARCP/STC meetings are planned by the NES team
- the Sample STC SAC Reports on ARCPs (DD09) provides assurance that the ARCP process is appropriately monitored and feedback is collected regarding the process
- the ARCP Process Document (DD11) sets out a clear process for ARCPs and provides assurance that there is a consistent approach to the planned meetings
- the ARCP trainee evidences/requirements document (DD12) shows a sample of 2018 outcomes and the self-assessment narrative indicates the existence of feedback, remedial and review systems arising from ARCP outcomes. However, this document might benefit from a more detailed narrative explaining its contents, but this does not preclude our agreement that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

The NES team has self-assessed the existence of a range activities focussing upon the management of:

- (i) workplace-based assessments as articulated in the specialty curricula
- (ii) assessments in the numbers determined by the SACs and
- (iii) the ARCP process. recommendations SAC ARCP process.

The evidence draws upon the Evidence returns collated workbook (DD04) which confirms consistency of process across the specialties and the ARCP trainee evidences/requirements document (DD12) showing a sample of 2018 outcomes.

We would like more information about how the NES internalise the ARCP and other processes and integrate them within their quality management process. The ARCP trainee document DD12 indicates the existence of such internalisation but, as above, a clearer narrative concerning the use of the document may assist GDC understanding of how the outputs considered by the NES team and how outputs may result in interventions and potential amendments to ARCP processes.

The GDC notes provision of an enhanced narrative (including anonymised illustrative examples) explaining the internalisation of ARCP processes as well as additional evidence of a process flow document and accompanying notes (DD31) which lay out post-ARCP processes and their integration into the Directorate's Quality Management Framework.

The GDC considers this Requirement to be met.

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

The programme provider has assessed themselves as meeting this Requirement.

The evidence supplied draws upon the Evidence returns collated workbook (DD04), which confirms consistency of process across the specialties. Whilst that consistency of process provides some assurance, it does not address the fundamental purpose of this Requirement.

The workbook does not give an indication of a continuum of process about how, under the NES team's quality management systems, assessment processes are developed, refined, and monitored. As with P13, this is a question of understanding how the NES internalise the ARCP and other processes and integrate them within their quality management process.

We originally considered this Requirement to be partly met.

Following receipt of the NES team's comments on the first draft of this report and further evidence, we have formed a revised opinion.

We note provision of an enhanced narrative (including anonymised illustrative examples) explaining the internalisation of ARCP processes as well as additional evidence of a process flow document and accompanying notes (DD31) which lay out post-ARCP processes and their integration into the Directorate's Quality Management Framework.

We consider this Requirement to be met.

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

The programme provider has assessed themselves as meeting this Requirement.

We agree and consider the information presented for this Requirement to be sufficiently illustrative. The evidence presented supports and confirms the narrative.

We consider that this Requirement is met.

P16: Specialty trainees must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on

sufficient occasions to enable them to develop the skills and the level of competence to achieve the relevant GDC-approved learning outcomes. Requirement Met.

The programme provider has assessed themselves as meeting this Requirement. We agree and consider the information presented for this Requirement to be comprehensive:

- Evidence returns collated workbook (DD04)
- Sample STC SAC Reports on ARCPs (DD09).

The Sample ARCP Outcomes document (DD13) appears supportive of meeting this Requirement, however it would be useful to have an accompanying narrative explaining the outcomes from the document.

We consider the use of trainee feedback would be very useful in meeting this Requirement, however it would be useful to confirm if this has been considered or captured in the past.

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

We agree and consider the Evidence returns collated workbook (DD04), to be a most useful tool for confirming consistency of performance against this Requirement.

Whilst not an action arising from this report, the provider could consider presentation of relevant policies to confirm the parameters of the NES team's training on giving feedback as well as any supporting evidence from specialty trainee feedback.

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

We agree and consider the narrative presented for this Requirement to be consistent with the previous Requirements. The Evidence returns collated workbook (DD04) and The Equality and Diversity Policy (DD15) are effective evidence.

Whilst not an action arising from this report, the NES team could consider presentation of relevant policies underpinning the delivery of:

- bespoke training to panel members who sit on ARCP Panels,
- NES team's training to educational supervisors

We consider that this Requirement is met.

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

The programme provider has assessed themselves as meeting this Requirement.

The narrative and evidence (Evidence returns collated workbook (DD04)), focus usefully upon the NES team's interaction with the Royal Colleges. It is clear there are effective opportunities

for the NES team and the Royal Colleges to liaise and to provide feedback upon each other's systems and/or specialty trainee outcomes.

What is not so clearly addressed in the narrative and evidence presented are the NES team's internal processes. We consider that it would be useful to see some information against this Requirement concerning ARCP appeals rules and processes. This might be supported by summary evidence of actual numbers of appeals in a calendar year together with an indication of outcomes.

The GDC notes the follow-up provision of an enhanced narrative explaining the incidence of ARCP appeals as well as the useful additional evidence of a process flow document (DD34).

The GDC now considers this Requirement to be met.

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

The programme provider has assessed themselves as meeting this Requirement.

We note provision of enhanced narratives at P13 and 14 (including anonymised illustrative examples) explaining the internalisation of ARCP processes as well as additional evidence of process flow documents and accompanying notes (referenced above) which lay out post-ARCP processes and their integration into the Directorate's Quality Management Framework.

The GDC considers that this Requirement has been met.

Summary of Action for Provider

Req. no.	Actions due by the end of Quarter 3 of 2021	Observations & response from Provider
P2	<p>1. The NES team provide a policy document which demonstrates the existence of a patient consent process for restorative dentistry and acknowledge that TPD self-assessments show a variable ability in meeting this Requirement.</p> <p>We will look for further evidence about the wider take-up of the policy and its application across further specialties.</p>	<p>The levels of adoption of patient consent policies across the various NHS Health Boards in Scotland is something that NES cannot actively enforce.</p> <p>Whilst we can suggest that a policy would be beneficial to help us demonstrate that we have fully met this Standard, it will be for each Health Board to consider whether they wish to implement some form of revised patient consent policy.</p> <p>A revised consent form was drafted by the TPD in Restorative Dentistry and submitted to the Health Board for consideration. The outcome of that exercise is that it wasn't adopted. This underlines the fact that NES has limited ability to enforce change.</p>
P3	<p>2. We consider further evidence is necessary to demonstrate both that the policies are receiving regular review and that there are actions arising to ensure compliance with the policies.</p> <p>In both the sample Dental School visit report and the sample TPD self-assessments there is evidence to confirm the existence of policies and, in one case, confirm how adverse incidents are reviewed. There is no indication whether such incidents have occurred nor, if so, of the outcomes of review.</p> <p>We consider that a useful way to quality manage these issues is by exception-reporting and we will be interested in seeing summary data at a point to be agreed in the future.</p>	<p>The Chief Dental Officer has created a structure where each Health Board is required to have a Director of Dentistry (DoD).</p> <p>These posts are now filled and the DoDs meet regularly to discuss items and issues relevant to the delivery of dental services.</p> <p>Dr Felix is DoD for NES and participates in these meetings and as part of the evolving work of the DoD group it is anticipated that we will be able to develop a process for exception reporting consistent with the feedback from the Inspection Team.</p> <p>We are also working with the DoD group to introduce an Annual Report on Dental Training that each Health Board will provide to NES, similar to the annual reporting process for TPD's, and the first of these reports are anticipated to be received in the next few months.</p>

P7	<p>3. We would like to see further evidence presented which builds upon the descriptions/copies of policy and procedure and the Datix tool to give a summary indication of the actual incidence of any patient safety issues together with a summary of any resultant actions.</p>	<p>We are working with our respective Health Boards to see how best we can introduce a reporting framework comparable to the feedback received from the Inspection Team.</p> <p>All of our Specialty Training Committees (STC's) now have both Quality and Safety as Standing Items on their Meeting Agendas.</p> <p>All STC meetings are attended by the Associate Postgraduate Dean for Core and Specialty Training and this enables full discussion and review of any relevant information, activity, or incidents since the previous STC meeting.</p> <p>It may also allow the transfer of appropriate information or experiences from other training specialties if they have had a similar scenario, thus promoting "Best Practice", "Consistency of Practice" and "Lessons Learned" across our range of Specialty Training Programmes.</p> <p>In addition, involvement in SEA's, near misses, and patient safety are all aspects of review with each trainee as part of their ARCP Review and discussions with Health Boards are already engaged in the process of advising NES when a trainee has been involved with a Significant Adverse Event (SEA) or a near-miss, and this can be through a variety of routes such as TPD, Associate Postgraduate Dean, or directly to Dr Felix himself as Postgraduate Dean</p>
P11	<p>4. We would like to see further evidence about the use of patient feedback to inform the NES team's quality management systems.</p>	<p>NES already operates a patient feedback process for Vocational Trainees and Dental Core Trainees whereby patients are asked to complete a short feedback questionnaire via a Tablet once they have been treated/received a procedure.</p>

		<p>Our intention was to extend the process for Specialty Trainees, however this has been suspended due to the ongoing Covid-19 restrictions.</p> <p>With the emergence of the Covid-19 pandemic last year, and its current resurgence, the various Health and Safety protocols now being operated by Health Boards has resulted in the use of Tablets being suspended as they have been risk assessed as a potential for cross-contamination through either or both:</p> <ul style="list-style-type: none"> • the use of tablets by multiple users, and • the extending of the time a patient is in the treatment centre if they are asked to complete a questionnaire post-treatment. <p>As a result the use of Tablets for gathering patient feedback has currently been suspended for the training year 2020/21, and likewise the intended roll out to Specialty Training in 2021 is on hold until the circumstances and requirements introduced as a result of the pandemic subside.</p> <p>The following question set is used when patients are asked to provide feedback on the treatment and interaction event that they have had with a trainee, as follows:</p> <ul style="list-style-type: none"> • Greeting you in a friendly way; not be grumpy or rude to you • Asking you questions about the reasons for your visit and listening carefully to your response • Explaining what he/she is going to do before starting to examine you • Letting you know what he/she finds after examining you; not keeping you in the dark or confusing you • Talking through the different options for your treatment, helping you to choose; not rushing ahead or telling you what to do • Indicating the likely cost of the chosen course of treatment at the outset; never waiting until you are presented with the bill
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		<ul style="list-style-type: none"> • Treating you with courtesy, respect and as an equal; never belittling you or making you feel stupid • Being sensitive, understanding and patient with you, never rough, unsympathetic or impatient • Forewarning you of any likely pain involved and offering you ways of reducing pain • Talking in plain language, using words you can understand; never being too technical or complicated • Inspiring your trust and confidence; never appearing nervous or unsure of himself/herself • Advising you on how to look after your teeth and gums at home • Listening to any questions you have and answering you clearly, not avoiding or ignoring your question • Treating all patients fairly, irrespective of age, gender, religion, disability, ethnic group or sexual orientation • Any other comments <p>Analysis of the feedback is provided to the trainee as part of their training and development. The results are also shared with the Associate Postgraduate Dean and TPD's and are reviewed as part of the trainee's ARCP.</p>
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Summary of Action for GDC

Req. number	Actions due by the end of Quarter 3 of 2021
P1-P5	To consider integration of the P1, P2, P4 and P5 responses into “model” responses” and revise the relevant evidence prompts against these Requirements for future providers working with the <i>Standards for Specialty Education</i> .
P4	Whilst we consider this Requirement to be met, we will ask for further evidence in 2021 about the wider take-up of the restorative dentistry policy. This action is to inform our own understanding.
P8	To develop the basis of this response into a “model response” to provide an illustrative example for future providers working with the Standards for Specialty Education.
P10	To consider the NES team’s initiative of surveying TBDs which to determine its potential to provide the basis of additional guidance to providers considering their compliance with the Standards for Specialty Education.
P11	To develop GDC thinking by discussing with Healthcare Improvement Scotland the importance they place on patient feedback within quality management systems.
P12	To draw upon this response to develop a “model” response” to provide an illustrative example for future providers working with the Standards for Specialty Education.

Observations from the provider on content of report

As above

Annex 1

Quality assurance process and purpose of activity

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

Specialty training

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

The GDC's powers

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

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

Annex 2

The QA Process

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

General Principles

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

Collection of evidence

18. Therefore, the process remains based upon moderated self-assessment and includes:

- i. a data set that profiles specialty trainees and scrutinises key data including information about the trainees' progression rate through programmes and exit examinations;
- j. a self-assessment questionnaire giving providers the opportunity to indicate their performance in the context of the Standards and Requirements;
- k. the Requirement to provide illustrative and supporting evidence to support the contents of the completed self-assessment questionnaire.

19. The following descriptors are employed as a means of reference for establishing a programme provider's compliance with the individual Requirements.

a. A Requirement is **met** if:

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

b. A Requirement is **partly met** if:

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

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

c. A Requirement is **not met** if:

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

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

d. **Other**

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

20. The significance of not demonstrating compliance with a Requirement will depend upon the compliance of the programme provider across the range of Requirements and any possible implications for public protection.

21. Outcomes from the pilot specialty QA exercise typically fell into two categories of follow-up action:
- l. Where Requirements were not fully met, the need for follow-up action (either submission of further evidence or clarification of self-assessment) that could normally be addressed by annual monitoring/updates;
 - m. Joint action between the provider and the GDC to capture good practice (where Requirements were met) to further inform the evidence prompts within the Standards and so to provide additional guidance for future specialty QA activity.
22. We note that the submission from the NES team maintains this theme – although we suspect the timeframe for meeting the partly met Requirements may be still shorter and may well be accomplished in the observations period of the specialty QA process.