General Dental Council

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Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
University of Central Lancashire	BSc (Hons) Dental Hygiene and Dental Therapy	5 and 6 December 2018; 22 and 29 May 2019

Outcome of Inspection	Recommended that the BSc (Hons) Dental Hygiene and Dental Therapy is approved for the graduating cohort to register as a dental hygienist and a dental therapist.

Full details of the inspection process can be found in the annex

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine whether the BSc (Hons) Dental Hygiene and Dental Therapy programme is approved for the purpose of registration with the General Dental Council as a dental hygienist and a dental therapist.**
Learning Outcomes:	***Preparing for Practice (dental hygienist and dental therapist)***
Programme inspection dates:	**5 and 6 December 2018**
Examination inspection dates:	**22 and 29 May 2019**
Inspection team:	**Ruth James (Chair and Non-registrant Member)** **Fiona Sandom (DCP Member)** **Shazad Malik (Dentist Member)** **Martin McElvanna (GDC Education & Quality Assurance Officer)** **Kathryn Counsell-Hubbard (GDC Quality Assurance Manager)** **Natalie Watson (GDC Education & Quality Assurance Officer)** **Hermione Brown (GDC Quality Assurance Manager)**

This is the first inspection of the BSc (Hons) Dental Hygiene and Dental Therapy (DHDT) programme delivered and awarded by the University of Central Lancashire (UCLan). The programme was given provisional approval by the General Dental Council (GDC) on 23 May 2016 to commence in 2016. The purpose of this inspection was for the panel to assess whether this qualification is approved for the purposes of GDC registration as a dental hygienist and dental therapist.

The panel were tasked with conducting a full programme and examination inspection to determine which of the 21 individual Requirements under the *Standards for Education* have been met. Of the 21 Requirements, 18 were considered to be Met and 3 were considered to be Partly Met (Requirements 3, 5 and 12). The rationale for this is explained in the commentary under the respective Requirements. The inspection took place during the academic year when the first graduating cohort of students were in their final year of the DHDT programme. It involved three visits: the first was the programme inspection which took place on 5 and 6 December 2018; the second was a Structured Oral Examination on 22 May 2019 and the final visit was the Module Board and Assessment Board meetings on 29 May 2019.

The education associates comprising the inspection panel were grateful that the documentation received in advance of the inspection was comprehensive. The evidence was clearly presented so the panel were able to easily find the evidence demonstrating how each Requirement was met. Any documentation requested during the inspection was provided in a timely manner.

The DHDT course at UCLan is a modular course and students must pass each module via a variety of assessment methods which is appropriate to assess knowledge and clinical skills. The course is delivered in a manner which emphasises the practice of primary care dentistry.

We were impressed with the solid and supportive network between the School, Dental Education Centres (DECs) and Enhanced Training Practices (ETPs). It was clear that students could gain a broad range of experience in a number of clinical settings.

The panel was impressed by the strong leadership skills evident within the School, together with a cohesive team approach amongst all of the staff involved in the delivery of the learning outcomes, assessment and administration of the programme. The panel acknowledge that the students were extremely enthusiastic and positive about both the DHDT programme and the relationship with staff involved in its delivery.

The education associates had no major concerns with the programme and agreed it was well organised and ensures thorough assessment of students across the learning outcomes contained within the GDC publication ‘Preparing for Practice’.

The panel wishes to thank the staff, students, and external stakeholders involved with the BDS programme for their co-operation and assistance with the inspection.

Background and overview of Qualification

Annual intake	14 students
Programme duration	43 weeks over 10 months each year for 3 years
Format of programme	Year: 1 – Preclinical dental sciences, foundation clinical skills and knowledge, clinical skills and knowledge (all simulated), professionalism. All at Preston campus. Students go out to the Dental Education Centre (DEC) in June following clinical progression tests. 2 – DEC for direct patient treatment. 3 – DEC for direct patient treatment. 1 day per week at an enhanced training practice for direct patient treatment.
Number of providers delivering the programme	1

Outcome of relevant Requirements[1]

Standard One	
1	Met
2	Met
3	Partly Met
4	Met
5	Partly Met
6	Met
7	Met
8	Met
Standard Two	
9	Met
10	Met
11	Met
12	Partly Met
Standard Three	
13	Met
14	Met
15	Met
16	Met
17	Met
18	Met
19	Met
20	Met

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

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 an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.

Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients. *(Requirement Met)*

During the first two terms of the course in Year 1, students are familiarised with the DECs and are prepared for clinical treatment on patients by undertaking a simulator course. From the first week of the course, students develop skills using a sophisticated phantom head laboratory which simulates the real-life clinical environment.

The inspection panel noted that students begin to treat patients at the DEC in term 3 of year 1 only if they have demonstrated adequate knowledge and skills by passing pre-clinical progression assessments. The associates considered these were good and included the use of manakins. Before students continue to treat patients at the DEC in years 2 and 3, they must undertake a clinical knowledge examination and an Observed Structured Clinical Examination (OSCE).

In year 3, students also spend one day per week at Morecambe ETP where they continue to gain clinical experience in all aspects of primary care dentistry within their scope. The ETPs are multi-surgery general practices with surgeries dedicated to students. There is one dedicated member of staff to supervise at all times and students have a dedicated dental nurse.

The 'Leopard' database is used for recording clinical activity data. The team considered that student progression was clear to see on this system. We identified evidence within the student clinical portfolios of completed procedures, marked on the appropriate areas. We also saw evidence that the use of the School's policy on Policy for Supporting Clinically Challenged Students was being applied.

It was clear to the associates that reflection by students is encouraged and there is also an entry field in their portfolios for them to reflect and comment on their strengths and weaknesses.

The team heard feedback from students who indicated they were positive about developing their practical skills.

We were satisfied with clear and comprehensive evidence that students only provide patient care only when they have demonstrated adequate knowledge and skills through thorough in-course assessment.

Requirement 2: Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing. *(Requirement Met)*

The panel saw evidence of systems informing patients that they will be treated by students in all clinical environments. An example is notices in DECs and ETPs explaining that treatment may be carried out by students.

The need for patients to give informed consent to treatment is taught from the very early stages of the programme. All clinical procedures require a written and signed consent form which explains that a student will be carrying out the procedure.

We noted that students are required to wear visible name badges clearly identifying them as students.

Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place. ***(Requirement Partly Met)***

The panel noted that each of the DECs and ETPs are registered organisations with the Care Quality Commission (CQC) to be a provider of dental services. We saw CQC reports and were satisfied that the School complied with all relevant legislation and requirements regarding patient care.

The team reviewed the DEC and ETP Equality and Diversity Staff Training Record. We were informed that at the DECs all staff have University equality and diversity training which is updated regularly and compliant with the UCLan Equality, Diversity and Inclusion Policy 2016. However, we noted that some staff at the ETPs had not received this training. We therefore recommend that the School should provide evidence that all staff at the ETPs have undertaken this training when completed.

Requirement 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development. ***(Requirement Met)***

The panel considered that given that the programme has relatively small cohorts, supervision ratios of staff to students were impressive in both the course as well as throughout the clinical training sites. This was confirmed by students who felt they had an excellent relationship with supervisors, feeling well supported by them and they were readily available if required.

Supervisors are either Clinical Supervisors or Senior Clinical Teachers and not dentists at the practice. There is usually at least one full time UCLan member of supervisory staff at the DECs to provide academic support to the Clinical Supervisors. The four DECs have Senior Clinical Teachers who are employed by UCLan. At the ETP there are named Clinical Supervisors. The school confirmed that patients would not be allowed into clinics unless given permission by the appropriate member of staff. The panel was informed that this first cohort of students only attended one ETP, Morecambe.

The team had sight of the School's policies for the supervision of students and supporting clinically challenged students and was assured these were being adhered to.

Requirement 5: Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical Supervisors must have appropriate general or specialist registration with a UK regulatory body. ***(Requirement Partly Met)***

At the inspection, the panel saw Clinical Supervisor job descriptions, rotas and various training and induction records which demonstrated that supervisors are appropriately qualified and trained. All members of clinical staff are duly registered with the relevant regulatory body and we saw a log of staff who are registered with the GDC. We heard that training is also monitored centrally at the University's Human Resources section.

We were informed that there is always at least one Senior Clinical Teacher at each DEC who advises and assists Clinical Supervisors.

Staff are required to complete online training in equality and diversity every two years. We noted however, that two staff members at the ETPs had not received this training.

Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so. *(Requirement Met)*

The panel saw evidence that the School and its partners have clear policies and procedures in place for staff and students to raise any patient safety concerns. The team had sight of the Structured Event Reporting Form (SERF), flowchart and guidelines which illustrate clear processes for how it is used and for escalation if required. We noted that the SERF can be used by any member of staff, students and patients. Staff and students indicated they were clear about the SERF and aware of their obligations under respective staff and student policies.

The team saw minutes of meetings of the BDS/DHDT Management Committee which illustrated where concerns had been raised and subsequent action taken.

The associates had sight of the Students Raising and Escalating Concerns policy. When we met students, they confirmed that they were aware of this policy as well as the whistleblowing and duty of candour guidance contained therein.

Requirement 7: Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified. *(Requirement Met)*

The panel had the opportunity to review the SERF materials which explained how incidents raised would be handled as discussed above at Requirement 6. We also considered the Never Events policy which defines a 'never event' and how these should be reported and escalated if they occur. At the inspection we also reviewed the Risk Register and were satisfied that it was being appropriately used.

In the event of a patient safety issue, the panel observed that the training centres used on the programme are subject to both NHS and UCLan's reporting procedures. Given the strong relationship between staff at the training sites and the School, the team was assured that an appropriate response would be taken if such an incident arose.

Finally, we were informed that there has not been any occasion when the regulatory body needed to be informed.

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standards for the Dental Team are embedded within student training. *(Requirement Met)*

The panel had sight of the UCLan's Fitness to Practise (FTP) Procedure and Regulations for the Conduct of Students.

During the inspection, the associates saw evidence that students were exposed early on to the concept of fitness to practice during their induction on day 1 and during lectures delivered in a Professionalism module in year 1 and in subsequent years. The School indicated that lectures in the Professionalism modules took into account provisions in GDC's Standards for the Dental Team. Students demonstrated to us that they had a good understanding of the GDC's Student FTP guidelines having recently attended a GDC presentation on student FTP and professional standards which they considered to be very beneficial. They also confirmed they were aware of the School's FTP processes. Students indicated that they are exposed to the concept of professionalism from the very beginning of their course and the panel had sight of some sample Student Professionalism portfolios at the inspection.

The School confirmed that there had not been any student fitness to practice matters and staff confirmed they were aware of the relevant policies and procedures should such a matter arise.

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.

Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function. *(Requirement Met)*

During the inspection the panel learnt that the School has introduced a new Quality Assurance (QA) framework. We had sight of this which gives a thorough description of the procedures, management structure and audit processes within the School.

The team heard that the Head of School has clear over-arching responsibility for ensuring that any changes in GDC outcomes, legislation and external guidance is reflected in the curriculum. They also ensure mapping of the curriculum against the current GDC learning outcomes. We learnt that individual subject teaching staff are responsible for responding to any changes in legislation and guidelines and that these are appropriately updated within the curriculum in adherence with the relevant policy.

At the inspection, the associates saw minutes from the BDS/DHDT Management Committee, Undergraduate Dental Course Management Committee and Dental Academic Committee. These illustrated that issues arising were being duly followed up according to the QA processes. We found evidence that amendments were made and there is a process for this. For example, we saw evidence of a change from one substantial assessment at the end of year 1 into two assessments, which was the result of student feedback. In addition, we saw evidence of action plans and implementation arising from the School's own annual monitoring process. These provide an overview and commentary reflecting feedback from students, external examiners, employers, etc.

Evidence demonstrating that the programme maps to each of the latest GDC learning outcomes was provided to the team as part of the pre-inspection documentation. The panel had sight of Maxinity software which shows the mapping of examinations to the learning outcomes. We were given a demonstration of the sophisticated Access database which

detailed where the full set of learning outcomes were being addressed in teaching and lectures. Only four of the learning outcomes were missing from Access but staff had full knowledge of how and where they were covered. Although this database is not yet completed, the demonstration we received illustrated how it was easy to interrogate the learning outcomes in a dropdown list and identify where these are being addressed and taught in the programme.

For commentary on the quality assurance of outreach placements, please refer to Requirement 12.

Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements. ***(Requirement Met)***

The panel had sight of the SERFs, guidelines and flowchart underpinning the process for raising concerns. The School indicated that if any concerns arose, they were dealt with as quickly as possible and where appropriate, dealt with at a local level to ensure a speedy resolution to any issues. We saw various annual reports where issues where reported and addressed.

UCLan's Academic Quality and Compliance Unit Annual Monitoring Process specifies that any issues identified through the operation of the quality management framework are addressed as soon as possible and reported to the Course Lead. The School confirmed that any operational issues would be resolved by the course team. School level actions would be addressed by the School Executive Team and wider actions referred to the relevant University service either directly or through the Annual Monitoring process.

Further evidence of concerns being identified through the QA framework was the use of external examiner reports. These are received centrally into the University then forwarded to the Head of Dentistry and cascaded to the Programme Lead and the Module Lead for consideration. We saw examples of concerns and suggestions being made and the School responding quickly to these.

When meeting students, they indicated they felt confident that any issues they may have with the programme would be addressed and resolved.

The team did not see any evidence of any serious threats to students achieving the GDC's learning outcomes throughout the programme. We were informed that any major incidents or threats to students achieving the learning outcomes are the responsibility of the Head of the Dentistry and any such risks would be placed on the School Risk Register. This Register is also used for continuity planning.

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development. ***(Requirement Met)***

The panel were provided with various documents before and during the inspection detailing internal and external quality assurance procedures. The School confirmed that the UCLan Quality Assurance and External Examiners policies comply with the Quality Assurance Agency's guidelines.

Internal procedures were illustrated through various reports including the Annual Head of Dentistry Report and Annual Course Leader Report. Minutes of relevant meetings also recorded that issues of concern were acted upon.

External quality assurance of the programme is provided by the external examiners. The team was impressed with the number of external examiners being used and observed from their CVs that some are subject experts. They are given plenty of notice prior to any assessments or examinations taking place. They are present at the yearly OSCEs and at the final Structured Oral Examination. As mentioned under Requirement 10, the external examiners' reports are received centrally into the University then circulated to the Head of School and Leads. We were pleased to hear that the external examiners were very positive about the programme. We were also able to see that concerns raised in their reports were addressed, leading to changes to the assessment process for future cohorts.

The associates heard that feedback is collected from patients at the DECs and ETPs and was noted to be all positive. We suggest that the patient feedback form at the DECs and ETPs could include a question about the patient's understanding of the consent process.

The panel saw minutes of Staff Student Liaison Committee (SSLC) meetings and saw that any student concerns raised were being clearly addressed. Students spoke positively about the effectiveness of the SSLC and indicated that members of staff welcomed suggestions and acted promptly on feedback received both informally and via the Committee.

We concluded that the School has a strong and effective framework for assuring the quality of this programme.

Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. *(Requirement Partly Met)*

During the inspection process, the panel heard evidence that outreach placement centres are monitored in the same way as the School under the Quality Assurance Framework and are inspected against this framework. We learnt that the School's relationship with the DECs is different from ETPs. This is because the DECs are considered to be part of the school and day-to-day management of them is in the hands of the Senior Clinical Teachers who are directly employed by UCLan. All of the DECs are parts of primary care facilities and are located within three Trusts and as such are not considered to be outreach centres to the same degree that ETPs are. The four ETPs each have named Clinical Supervisors who are directly employed by the practice. We were impressed with the various lines of communication that exist between the training placements and UCLan and this demonstrated a solid supportive network.

The team had sight of various notable documents. The Specification of Service within DECs is a service agreement which clearly describes the roles and responsibilities of the placement providers and of UCLan. This also ensures an effective quality assurance process is in place for assuring student experience and outcomes. For example, it explains how the Clinical Co-ordinator acts as a regular contact between the School and the Senior Clinical Teachers of the DECs.

The Quality Assurance Placement Visit Framework is provided to the DECs and ETPs which explains the process by which DECs and ETPs are monitored. The Framework also details the evidence that is required across seven key areas for audit purposes against various quality standards criteria. This includes checks of all premises and facilities, materials, medical

emergency equipment, as well as teaching, assessment, staffing and management. There is a quality assurance visit to the practice before students commence their placements with follow-up audit reports. The School explained to the panel that when the new QA framework was being designed, the specification of service between DEC and ETPs and the School was also taken into account.

Regarding the collection of student and patient feedback relating to placements, the associates noted that this was detailed in the Placement Visit Framework document including methods of collection. At the inspection, we had sight of 360 feedback which proved to be positive.

The team was advised that audits had been done at all DECs. The audit at Morecambe DEC had been undertaken on 30 November 2018. Due to the GDC inspection taking place on 5and & 6 December 2018 the full report had not been completed. However, the Clinical Education Co-ordinator who undertook the visit provided testing schedules and samples. The School should provide evidence of completion of audits of all outreach centres as we would expect this to be done at least annually.

As described under Requirement 3 and 5 earlier, we identified some staff at the ETPs who had not received equality and diversity training. The School is advised to provide evidence that all staff at the ETPs have undertaken this training when it has been completed.

Given the absence of evidence that Morecambe DEC has been recently audited and that some ETP staff have not received equality and diversity training, this Requirement is considered to be partly met.

Please see the commentary on student and patient feedback under Requirement 11.

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.

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Met)*

Ahead of the inspection, the School provided the panel with extensive documentation to demonstrate how they met this Requirement. This included the UCLan Assessment Handbook, the School's own Assessment Guide, Programme Handbook, Programme Specification and various Module Descriptors. At the inspection, the associates were presented with documents related to the procedures and responsibilities around assessment, mapping documents and student data.

The team saw evidence that the GDC learning outcomes were being mapped against both the module content and assessments. The Programme Specification outlined the learning outcomes that students are expected to achieve during the programme. Within the module descriptors, the learning outcomes are covered in the University's broader learning outcomes in accordance with University-level regulations. Students are tested and assessed throughout the duration of course in accordance with the curriculum to ensure their skills acquired meet

the requirements of the Curriculum. The Skills Map is an integral part of the Programme Specification.

All of the written assessments are similarly mapped to the learning outcomes within the computer-based exam system (Maxinity). This also demonstrates delivery of GDC learning outcomes over different years and across different assessment methods.

Decisions regarding student progression takes place at various points throughout the DHDT programme. Firstly, Module Boards which are convened at the end of each module decide whether students have passed the module. The decisions of the Module Boards are taken forward to the end of year Clinical Assessment Panel (CAP). The CAP reviews the progress of each student in achieving their clinical targets set for each clinical year. These are attended by an external examiner to quality assure the process. CAP results are reported at the Module Board for the Clinical Skills modules in each year as part of the progression requirements.

Regarding sign-up to finals examinations, the team saw evidence of the sign-up procedure illustrated with a flowchart. Final year students are required to have reached their clinical targets in order to be signed-up for their final exams.

At the Assessment Board meeting, the panel noted that there appeared to be initial ambiguity over whether to award a first-class honours degree to one borderline student. The team suggest that a more formal process to deal with such borderline candidates should be considered so that the course team do not need to make hasty decisions in the final meeting. The team also noted that two students were to receive recognition awards. We suggest that the criteria for these should be agreed and made clear to students.

Requirement 14: The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes. *(Requirement Met)*

The panel had sight of the UCLan Assessment Handbook and School's Assessment Guide when considering this requirement. The latter outlines the process prior to, during and after examinations take place. The team considered that the DHDT programme complies with UCLan's Policies and Procedures on assessment, awards, results, and appeals.

We had sight of Leopard which is a central monitoring and recording system to log grades awarded for clinical procedures and student assessment in general. This also included grading criteria for supervisors which the associates considered were clearly defined. It was noted that the Leopard sheets in portfolios are completed and signed off in clinic by supervisors after each procedure and patient seen. Students are continuously assessed and monitored via Leopard with periodic reviews of student data. This helps to identify areas of concern and to arrange additional support if required. Students indicated that they are encouraged to access their own records. They considered that Leopard data was clear to them and they can easily monitor their own progression and development. The system uses colour codes against targets so it is immediately apparent if students are not on course to meet them.

In addition to regular assessment though the year, there are clinical progression tests in February and regular Academic Advisor meetings. In addition, clinical assessment panels are held twice a year. However, any struggling students would be identified in advance of those panels.

The team had sight of the Maxinity database and the results section for every examination. The system is also used for writing and reviewing examination questions. We heard evidence

that provisions were in place for supporting students with particular needs, for example, Maxinity can be tailored to make it easier for dyslexic students to use.

Requirement 15: Students 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 competency to achieve the relevant GDC learning outcomes. *(Requirement Met)*

The panel was very impressed with the breadth of patient types the students were exposed to in the DECs and ETPs. Having had sight of Leopard, we saw how student clinical activity is constantly monitored and reviewed. Supervisors can easily monitor the breadth and depth of students' clinical experience. The clear red, amber and green system also easily showed outlying students who aren't progressing so this can be picked up on early. The team were extremely impressed with the high target numbers of procedures and that students often exceeded these.

We heard how patients can easily be referred between students as appropriate. Similarly, BDS students could also refer patients to DHDT students, illustrating a holistic and flexible approach to patient care. The associates were impressed how closely BDS and DHDT students work together for the first two years which encouraged inter-team working.

Having reviewed the students' clinical portfolios, the team was impressed with both the type and amount of clinical practice that was undertaken throughout the programme. This enabled them to develop the skills and the requisite level of competency to achieve the relevant GDC learning outcomes.

Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed. (*Requirement Met)*

The panel had sight of the UCLan Assessment Handbook, School's Assessment Guide and 2018/19 Clinical Grading Descriptors when considering this requirement. We considered that the School had a good assessment strategy which outlined its approach to assessment and the processes that take place at each stage of any assessment which help to ensure validity and reliability.

Given that the DHDT programme is modular, students have to pass individual modules, which include in-course requirements as well as summative assessments. Modules cover areas such as pain management, pathology, radiology and dental materials which are not assessed on a modular basis but throughout the course.

The team learnt that a variety of assessment methods were being used, including written examination, clinical case presentations, practical examinations and clinical scenarios. The School indicated that they recognise the challenge in balancing formative and summative assessments. Given the varying background of students, there is a greater emphasis on formative assessment in year 1 and the use of case-based learning scenarios. Throughout the professionalism module there is formative assessment. As students progress to year three, there is greater emphasis on peer assessment and feedback as a means of student assessment.

Regarding the assessment of clinical skills, formative assessments take place continuously during clinic as and when clinical procedures are carried out. The clinical modules are assessed on a summative basis through the use of practical exercises such as in-course

Directly Observed Practicals and OSCEs that take place every year. Each year the OSCEs have two long stations where students are required to complete a clinical skill in a simulated environment. At least two of the OSCE stations have actors present to test communication skills also. Every item of clinical work also has a corresponding knowledge domain which informs the requirements for the knowledge modules.

Students' knowledge is assessed through the use of written examinations which can take the format of Short Answer Questions, Multiple Choice Questions and long notes questions. In the final year, the students sit a clinical knowledge paper and submit three patient case studies. Finally, students attend a Structured Oral Examination where they demonstrate their knowledge further and explain treatment rationale.

The panel learnt that staff receive training on designing and writing questions which is followed by afternoons when they attend together to write them. The exams are created in a secure system called Maxinity and then a review of them takes place. New questions are assessed before being added to the question bank. Examinations are subject to a process of standard setting.

Maxinity also enables the DHDT curriculum to be fully mapped and to facilitate efficient delivery of the exams and we saw clear evidence that learning outcomes had been mapped to modules and assessments. Given that this mapping and blueprinting of assessments was comprehensive, we were assured that the School can effectively monitor the progress of students. We observed that the Maxinity system also contained details of standard setting, a record of changes made, internal review comments and post-hoc psychometric analysis of reliability and validity of assessments and examinations.

The team heard evidence that methods of assessment are routinely being reviewed and monitored. For example, Module Leads conduct a post-hoc exam analysis and produce a summary report with any actions that need to be taken. This also informs plans for future development of assessment and teaching. In addition, all assessments undergo an internal review through an examination panel before going to external examiners. We consider that this demonstrated the transparency of the School's exam and assessment procedures and that a robust quality assurance process was in place.

Finally, the associates noted that the School makes excellent use of external examiners to monitor, quality assure and develop the methods of assessment used. They also review whether these are appropriate to the learning outcomes. Further comments on the use of external examiners can be found at Requirement 20.

Requirement 17: Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers. ***(Requirement Met)***

Prior to the inspection, the panel had sight of 360-degree feedback forms, minutes from SSLC meetings and module change forms. We also saw Patient Satisfaction Survey forms which students give to each patient at the start of their treatment whilst based at the DEC. These forms illustrate how feedback is being used to contribute to the student assessment process. At the inspection the team also heard evidence from staff and students about the use of this feedback. We were advised that the use of peer feedback is continuing to be developed.

Requirement 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice. ***(Requirement Met)***

Having met students and staff, the panel noted that feedback on clinical activity is provided both verbally and in written form to students. Verbal feedback is given continuously when completing clinical skills. Assessment and clinical data is logged on Leopard sheets in portfolios and completed on clinic. Supervisors will discuss these with students, providing feedback before progressing to the next skill. This happens for every skill, each time it is performed.

In Year 1 Clinical Progression meetings are held and students are given verbal and written feedback on clinical activity.

Students met by the team said that they felt they received good levels of feedback during the programme and were often given immediate feedback on clinic enabling them to reflect on their progress and personal development. They indicated that they get feedback in a timely manner. They also indicated that when giving scores, supervisors give sufficient feedback to allow students to understand the rationale behind the score and how to improve for higher scores. Students considered there was a good culture of support and encouragement.

The panel noted that a range of methods were being used to give feedback to encourage reflective practice. This includes multi-level and 360-degree feedback around performance, dealing with patients and professionalism. As they progress to year three there is a greater emphasis on peer assessment and feedback, for example, students give feedback to each other on clinic when working in pairs. Peer feedback is also provided during class-based learning sessions.

Regarding student reflection, the team saw how this was embedded throughout the programme. Students were actively encouraged to reflect on their clinical performance from the beginning of the Foundation Clinical Skills and across the three years within the Professional Practice modules. This includes reflection taking place informally within clinics and during subsequent clinical skills courses. Students at the DECs are required to submit monthly reflective logs online as well as on blackboard and in their portfolios. We heard that students were being given clear guidance on how to be a reflective learner from the start of the programme through lectures and workshops. Students indicated that they felt reflection was a valuable tool and they could use it to monitor their own progression.

Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. *(Requirement Met)*

Ahead of the inspection, the panel saw a list of all internal and external examiners and assessors with their registration details and CVs. This confirmed that various staff had appropriate skills and experience to carry out student assessment and have appropriate registration with a regulatory body. We were advised that most staff have a Postgraduate Certificate in Education and those staff who don't, including DEC supervisors, can work towards obtaining this within two years of appointment. The School indicated that all internal examiners and assessors are required to have or be working towards D2 (Fellowship level) of the nationally recognised UK Professional Standards Framework and which is accredited with the Higher Education Academy.

The team were impressed with the high level of training and calibration undertaken by DEC and ETP supervisors who are not employees of the University, for example, there is an annual training day in November which includes training in calibration. New members of staff are closely supervised and inducted into the programme and provided with the Guide for Clinical Supervisors which contains guidance on assessment grading.

With regard to equality and diversity training, the associates considered UCLan's Equality, Diversity & Inclusion Policy 2016 which indicates that all examiners and assessors must undergo this training as part of their induction and this is updated annually as part of mandatory training. When inspecting the Equality and Diversity training log, it was apparent that some staff had not yet received this training. This is discussed at Requirements 3, 5 and 12.

Requirement 20: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented. (*Requirement Met)*

Ahead of the inspection, the panel had the opportunity to review clear guidelines set out by the University outlining the external examiner system and the expectations of them. The policies also place an onus on the School to consider and act upon any concerns raised by them.

The School indicated that external examiners are appointed for each module in the programme and given relevant information by way of induction. Some examiners cover several modules. By way of quality assurance responsibilities, they review these modules and the corresponding formative assessments. They are invited to comment on the content, range and level of these and to determine if they are robust enough to test the requisite knowledge and skill of students.

The external examiners report on content and conduct of the assessments. Following examinations, the examiners are supplied with examination scripts and marked results for comment well in advance which allows any early suggestions to be adopted prior to the assessments taking place. They observe the yearly OSCEs and at the final Structured Oral Examination and provide feedback on these. The team had sight of these reports, some of which contained significant detail and demonstrating good familiarity with the GDC's learning outcomes. The reports are received centrally into the University then sent to the Head of School before being cascaded to the Programme Leads and the Module Leads. The University co-ordinates a response to their feedback and comments with involvement of the Module Lead in and assessment lead and/or the Programme Lead. The examiners are also are required to produce an annual evaluation report for the University.

The team also learnt that external examiners are involved in various other aspects of the assessment process. They are invited to attend the Programme Board meetings and their involvement was recorded in minutes that were provided to us. They also attend Module Boards and annual CAP meetings to observe the conduct of these meetings and how marking and performance of students is discussed. We had the opportunity to attend both of these meetings. We observed external examiners who were present and their positive comments were acknowledged by senior School staff.

Following the Structured Oral Examination, the panel met external examiners. They considered that this examination was robust and fair and that it sufficiently addressed the GDC's learning outcomes. They were given relevant information and marking criteria well in advance of the meeting. They indicated that if they were to make any suggestions or comments, they would be kept up to date by the School as to how these were being addressed.

The associates noted that the University invites external examiners to attend a training day at UCLan for assessment training sessions and equality and diversity training. We were very impressed with the high number of external examiners commissioned by UCLan and the positive relationship between them and the School. The team considered that the use of external examiners was valued and their feedback was well received.

The panel did consider that a system of more formalised feedback might be beneficial.

Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. (*Requirement Met)*

When looking at this Requirement, the panel referred again to the assessment criteria detailed in the UCLan Assessment Handbook, the School's own comprehensive Assessment Guide, Student Handbook, Clinical Grading Descriptors and various Marking Criteria documents for each module. At the inspection the team saw evidence that these were being applied correctly in practice, for example, blind marking techniques. The associates consider that the programme had clear guidance in terms of marking schemes and criteria. This was confirmed by students who also indicated that they were encouraged to grade themselves and reflect. Students could also access details on marking criteria and grading descriptors on Blackboard.

The panel noted that internal verification of all assessments is carried out by the Course Team and external verification by the external examiners.

We saw evidence of the Modified Angoff standardisation system in practice and results of this method of standard setting. Is was clear that standard setting procedures for all summative assessments is undertaken. The School indicated that they periodically review the training for standard setting. The programme also makes use of the external examiners to assess the standard of the examination and are asked to provide feedback on the assessments in advance of the examination taking place.

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
3	Evidence of delivery of Equality & Diversity training to all staff	The school has evidence of all staff (both UCLan and Trust) having undertaken Equality and Diversity Training. A request was made at the inspection on 5th December 2018 to see the record of training for the member of staff at Morecambe ETP. It was agreed that this could be forwarded on 7th December 2018. This was uploaded to the GDC on 7th December 2018. All information will be included in the Annual Monitoring return.	Annual Monitoring 2020/2021
5	Evidence of delivery of Equality & Diversity training to all staff	The school has evidence of all staff (both UCLan and Trust) having undertaken Equality and Diversity Training. A request was made at the inspection on 5th December 2018 to see the record of training for the member of staff at Morecambe ETP. It was agreed that this could be forwarded on 7th December 2018. This was uploaded to the GDC on 7th December 2018. All information will be included in the Annual Monitoring return.	Annual Monitoring 2020/2021
12	The School must provide evidence of audits of all ETPs as we would expect this to be done annually. This should include E&D training.	The audit at Morecambe DEC had been undertaken on 30 November 2018. Due to the GDC inspection taking place on 5 and & 6 December 2018 the full report had not been completed. The Clinical Education Co-ordinator who undertook the visit provided testing schedules and samples to the Inspection Panel. All audits will be included in the Annual Monitoring return. This will include all ETP's where students are placed.	Annual Monitoring 2020/2021

Observations from the provider on content of report

Refer to guidance

Recommendations to the GDC

Education associates' recommendation	The DHDT qualification is approved for holders to apply for registration as a dental hygienist and a dental therapist with the GDC.
Date of next monitoring exercise	Annual Monitoring 2020/2021

Annex 1

Inspection purpose and process

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC. It also quality assures new qualifications where it is intended that the qualification will lead to registration. The aim of this quality assurance activity is to ensure that institutions produce a new registrant who has demonstrated, on graduation, that they have met the learning outcomes required for registration with the GDC. This ensures that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).
3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards for Education. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is met if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the associates with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is partly met if:

"Evidence derived from the inspection process is either incomplete or lacks detail and, as such, fails to convince the inspection panel that the provider fully demonstrates the Requirement. Information gathered through meetings with staff and students may not fully support the evidence submitted or 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 the annual monitoring process."

A Requirement is not met if:

"The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and students does not support the evidence provided or the evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to serious concern and will require an immediate action plan from the provider. The consequences of not meeting a Requirement in terms of the overall sufficiency of a programme will depend upon the compliance of the provider across the range of Requirements and the possible implications for public protection"

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term 'must' is used to describe the obligation on the provider to undertake this action. For these actions the associates may stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term 'should' is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The QA team aims to send an initial draft of the inspection report to the provider within two months of the conclusion of the inspection. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme is sufficient for registration, the Council of the GDC have delegated responsibility to the GDC Registrar to consider the recommendations of the panel. Should an inspection panel not be able to recommend 'sufficiency' or 'approval', the report and observations would be presented to the Council of the GDC for consideration.

7. The final version of the report and the provider's observations are published on the GDC website.