General Dental Council

protecting patients,
regulating the dental team

# Education Quality Assurance Inspection Report

| Education Provider/Awarding Body | Programme/Award | Inspection Dates |
|---|---|---|
| University of Birmingham | Bachelor of Dental Surgery (BDS) | 13 &14 February 2019 (Programme inspection)<br>3-4 June 2019 (Exam Inspection) |

| Outcome of Inspection | Recommended that the BDS continues to be sufficient for the graduating cohort to register as dentists. |
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***Full details of the inspection process can be found in the annex***

## Inspection summary

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| **Remit and purpose of inspection:** | **Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dentist**<br>**Risk based: Focused on Requirements 4, 7, 9, 11, 13, 14, 15, 16, 19 and 21** |
| **Learning Outcomes:** | **Preparing for Practice (Dentist)** |
| **Programme inspection dates:** | **13 &14 February 2019** |
| **Exam inspection dates:** | **3 &4 June 2019** |
| **Inspection panel:** | **Cindy Mackie (Chair and Non-registrant Member)**<br>**Joanne Brindley (DCP Member)**<br>**Angela Magee (Dentist Member)**<br>**Khalid Mushtaq (Dentist Member)** |
| **GDC Staff:** | **Rachael Mendel (GDC Quality Assurance Officer)**<br>**Amy Mullins-Downes (GDC Quality Assurance Manager)** |

The inspection undertaken at the University of Birmingham was risk-based focusing on specific areas of their BDS programme. The GDC's Education and Quality Assurance (EQA) team and a panel of Education Associates (hereafter referred to as "the panel", "the team" or "associates") undertook an independent evaluation of information available to determine the content of each inspection. The information considered included annual monitoring returns, previous inspection reports (including progress against actions), responses to wider recommendations in the GDC Annual Review of Education, Fitness to Practise data and complaints received.

Following this assessment, it was decided that the inspection panel focus on Requirements 4, 7, 9, 11, 13, 14, 15, 16, 19 and 21.

The panel noted the significant and positive changes that have taken place since the previous inspection. It was evident to the panel that the leadership team had been proactive and extremely dedicated in progressing the previous recommendations and staff have been working in a collaborative manner. We observed a cohesive and effective working relationship at senior and staff level, one which has ensured students have and are being supported throughout the programme. The panel also noted the excellent facilities and additional resources now available to the students, such as the stress management and resilience programme and the extension of the programme timing to ensure students gain as much practical experience as possible.

The panel recognised and were impressed by the support and training provided to staff and how the programme is working with the wider medical team and other faculties to support staff training and development. This has provided a positive foundation to ensure the staff team are suitably equipped to support the programme.

The team would like to commend the programme on the proactive manner in which patient feedback is now collected and utilised. Considerable progress has taken place in this area since the last GDC visitation in 2014. The students now obtain feedback from approximately 100 direct patient contact sessions per week. This is collected via the Computer Assessment & Feedback System (CAFS) system and is currently student driven, under the supervision of staff.

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:

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| Annual intake: | 71 students |
| Programme duration: | 193 weeks over 5 years |
| Format of programme: | Year<br>BDS 1: basic biological sciences, professionalism & foundations of dental practice, clinic attendance/shadowing & reflective logbooks.<br><br>BDS 2: Craniofacial and oral biology, dental public health, fundamentals of clinical practice including simulated clinical experience, clinical orientation and basic clinical practice exercises (e.g. infection control, administration of LA, scaling and prophylaxis, impression taking etc.).<br><br>BDS 3: Simulated clinical procedures, direct patient treatment in clinical practice and specialty areas, dental pathology/ immunology/materials/radiography, introduction to human diseases<br><br>BDS 4: Advanced simulated procedures, intermediate clinical direct patient care in general practice and specialty disciplines, oral pathology, radiography, hospital placements and residency, clinical human diseases.<br><br>BDS 5: Advanced clinical practice, dental public health in practice, radiography/ology, specialty clinical care, outreach placements. |
| Number of providers delivering the programme: | 9 different Trusts (human diseases)<br>4 different Trusts for placement provision. Major Trust is Birmingham Community Health Trust, where placements are provided at the Dental Hospital and also in 10 different community dental clinics. |

## Outcome of relevant Requirements[1]

| Standard One | |
|---|---|
| 1 | Met |
| 2 | Met |
| 3 | Met |
| 4 | Met |
| 5 | Met |
| 6 | Met |
| 7 | Met |
| 8 | Met |
| **Standard Two** | |
| 9 | Met |
| 10 | Met |
| 11 | Met |
| 12 | Met |
| **Standard Three** | |
| 13 | Met |
| 14 | Met |
| 15 | Met |
| 16 | Met |
| 17 | Met |
| 18 | Met |
| 19 | Met |
| 20 | Met |
| 21 | 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)***

**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)***

**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 Met)***

**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 was tasked with looking specifically at staffing levels and whether this has had any impact on this Requirement.

Students are supervised appropriately according to their activity and skills. It was evident from reviewing the documentation and speaking to both the students and staff that there was appropriate supervision throughout the programme and that all staff were aware of their roles and responsibilities.

Since moving to the new premises, additional clinical staff have been recruited to ensure there is always an appropriate blend of specialist and generalist staff on each clinic. The school requires a minimum of 3 staff to 20 students on clinic. It was also evident that should there be staffing shortfalls on clinic, there are enough staff available to rotate resources to ensure all students are supervised appropriately. The panel observed evidence that the school requires higher levels of supervision for students during outreach to ensure that they are appropriately supervised during their placements.

**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 Met)***

**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)***

**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 was tasked with looking specifically at patient safety issues and the process for logging, escalating and addressing the management of concerns.

Overall responsibility for patient safety lies with the Clinical Director of Birmingham Community Healthcare Foundation Trust (BCHCFT). The School collaborates closely with the BCHCFT to manage the delivery of dental care for patients by students. Management structures, lines of responsibility and processes exist within each establishment to achieve this. The panel observed evidence of close working partnerships and representation at every level of key staff from both bodies on appropriate committees to ensure delivery of safe patient care.

The use of CAFS for recording student progression also allows any patient safety issues to be recorded and patterns of behaviour flagged. Safety issues are reported through the joint Health and Safety Committee up to the College Health and Safety Committee and also through the Trust Divisional Management Board.

The panel saw a clearly evidenced process for recording, managing and addressing patient safety concerns, as well as completed logs for incident reports. It was evident that all clinical and professional concerns relating to patient care were being managed appropriately. It was clear that when any incident occurred, a 'lessons learnt report' was written and disseminated to both students and staff and processes were changed in order to prevent the same issue of concern arising again.

To further reinforce and develop their approach, the panel would encourage the school to consider the inclusion of Patient Safety within the area of Professionalism in their related assessment marking sheets.

**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 Standard for the Dental Team are embedded within student training. *(Requirement Met)***

**Standard 2 – Quality evaluation and review of the programme**
**The provider must have in place effective policy and procedures for the monitoring and review of the programme.**

**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)***

The School has a number of committees managing the quality assurance of the programme, starting with the School of Dentistry Curriculum Development Committee that feeds into the Quality Management Committee, College Quality Assurance and Approval Committee, University Quality Assurance Committee and the University Education Committee.

The panel observed clear and effective evidence of changes which had been introduced to the quality management framework since the previous inspection, with a new lead appointed to drive focus and provide oversight on all related quality assurance matters. It was also evident that the programme has now introduced an integrated approach into the University quality structure, thus providing a more collaborative and supportive approach within the wider University quality management structure.

The panel also saw evidence of how changes were made to the programme resulting from student feedback and how that process was communicated through all of the committee structures, resulting in practical and effective change.

The panel were satisfied with the quality framework functions and where responsibility for these functions specifically lie.

**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)***

**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 was tasked with looking specifically at how student feedback was used to inform the development of the programme.

The programme uses a variety of methods to collect and use student and patient feedback in programme development. Patient feedback is collected for each student after almost every clinical interaction. The leadership and staff team have actively encouraged a culture of personal reflection and responsibility through this process.

Student feedback is actively collected across a range of methods. It is collected through the staff student committee, mid-module feedback, end of module/specialty questionnaire, student focus groups and University wide surveys. Feedback is collated by the Quality Office and distributed to module/specialty leads where it is then discussed with teaching staff within the specialty area and an action plan is developed to respond to issues raised by students. This action plan is incorporated into the annual module/specialty review process, which is submitted to the Head of Education and is summarised in the School Education Plan. Modules/specialty areas review these actions to ensure successful completion and report on this at the subsequent annual evaluation. At the end of each academic year, each module and specialty lead provides a response on the key themes from the years' student feedback. These responses are collated by the College Quality Office and sent to the next student cohort to illustrate how student feedback has been used to enhance educational provision and programme development.

The Staff Student Committee is co-chaired by a student and supported by a senior member of staff. This committee has wide representation from teaching as well as nursing staff and student representatives from each year of the programme. At each meeting, any concerns are documented and acted upon as soon as possible. Progress with actions is discussed at the subsequent meeting. Changes have been made to the Staff Student Committee to ensure that it responds rapidly to student concerns. Prior to the meeting, a document is circulated to

students, and any actions required are delivered wherever possible prior to the meeting and reported on at the next meeting.

The College has proactively created a patient public network, recruiting around 15-20 public contributors across all healthcare programmes, specifically to work with the school on education matters and programme development.

The panel were satisfied that feedback was being utilised in programme development.

**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 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.**

**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)***

The panel was tasked with looking specifically at the process of sign-up for final examinations and access to a range and number of patients.

The School retained minimum quantitative requirements for a student to be entered into the final BDS examination alongside a competency-based approach. At checkpoints throughout the clinical course (end of year progress boards in third and fourth year), students' attainment against targets is monitored. Through written and verbal feedback, students are provided with encouragement and support to keep them on course to meet the minimum quantitative requirements set by the School for entry to finals. Additionally, CAFS allows students to see in real time their individual progress and to benchmark such against their peers.

The BDS programme has a continuous assessment ethos, whereby students develop along a skills escalator, and assessment and feedback is underpinned by the CAFS system and by termly reports that are reported via progress board meetings.

Prior to finals, four meetings take place between January and April to discuss the progress of the students and sign off those who have met the minimum quantitative and qualitative requirements. The external examiner attends the final meeting to review and quality check the decisions made.

The panel were satisfied that the sign-up process for finals was robust enough to determine whether a student had demonstrated attainment across the full range of learning outcomes.

**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 was tasked with looking specifically at how student progression is monitored and managed.

Academic progress is managed through a central student assessment recording and monitoring system called “BIRMS”, alongside progression to subsequent academic years. Clinical experience and performance is managed and monitored via CAFS, a system developed for monitoring clinical, professional and technical experience as well as performance.

Robust and effective monitoring mechanisms are present as part of the monitoring progression and requirements through the years. Students are encouraged to maintain a practice of patients as part of their ongoing treatment planning and delivery; however, from time to time it is necessary to alternate patients across students to assist those students in achieving all the skills required. Additionally, the Heads of the Restorative Phase of Clinical Practice (years 3 & 4) and Heads of GDP-phase (final year) facilitate allocation of patients from specialist staff to ensure that all students have an appropriate case mix.

CAFS can be used to provide feedback to students and staff (on students and themselves). Clinical experience is assessed annually in relation to the progression requirements for that year of study.

All clinical staff are able to report concerns about student progression on an individual basis using a form system. In addition, the Head of Speciality will also monitor progress. Patterns of minor concerns can be highlighted and verified using CAFS. Throughout the programme, formative and summative progress boards are held where students’ attainment against set targets is monitored. Heads of Firm within Clinical Practice as well as Heads of Specialty areas attend these boards and report on their area. Following the progress board, written and verbal feedback is provided to students to encourage and support them in remaining on-course to meet the minimum quantitative requirements set by the school for entry to finals. If students require support for particular items, the Heads of Firm can facilitate the bespoke management of appointment books and direct a student to suitable patients. Additionally, in the fourth year there is the option not to undertake an elective project thereby allowing students to remain on clinic for an additional four weeks. Students may be advised that completing these four weeks would be beneficial in improving clinical experience.

The panel saw evidence of a clear and effective audit trail that allowed full oversight of student progression throughout the course. They also saw evidence of progress meetings with Heads of Firm on a termly basis. In instances where struggling students were picked up, monitoring and clear and timely action plans were introduced for remediation which the panel considered to be appropriate. There was clear evidence that assessment focus was continuous.

**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 tasked with looking specifically at access to a range and breadth of patients.

The programme ensures that all students are exposed to a breadth of patients and procedures, which are repeated throughout the clinical programme. To ensure this occurs, students must attain minimal requirements in order to be signed up for the final BDS examination. Students are obtaining a range of experience in a number of different settings both at the dental hospital and during outreach, providing a sufficient breadth of experience.

At the previous inspection, there had been concerns raised specifically relating to paediatric experience and whether the move to the new site would impact patient supply. The associates noted that a new paediatric dentistry lead was in place and has subsequently developed a number of innovative pathways to paediatric patient supply. While the current cohort was achieving higher numbers than the minimum requirements, the panel felt that the minimum requirement target should be raised in order to ensure that students continue to obtain the appropriate skills in paediatric dentistry.

The School has developed The Dental Foundation Training Passport to provide Foundation Trainers with a clinical transcript of a students' activity during the course. A report is generated from CAFS and is divided into two parts: a front page with key items listed, including certification of completion of Intermediate Life Support as well as Level 2 Adult and Child safeguarding, and a second part with the full data set from CAFS breaking down the procedures completed into their components. The first part has information relevant to the foundation trainer and their practice. The reverse page contains additional information that is useful when submitting data to NHS England in their Performer List application process. The panel viewed this training passport as a resource that should be commended, as it provided an excellent overview for both the student and foundation trainers of the clinical experience the student has achieved.

**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 was tasked with looking at the assessments students undertake and the standard setting process for these assessments.

Since the last inspection, the programme has developed a blueprint that maps teaching and assessment to the GDC learning outcomes. The School uses a wide variety of assessment methods, including formal examinations, OSCEs, Structured Oral Tests and group presentations. It the responsibility of the module or specialty lead to set the examinations and assessments.

Clinical performance is assessed for every session using CAFS, using an A to E grading scale, that reflects a composite of the knowledge grade and technical grade to give an overall session grade.

All assessments now consider a standard setting method, against which the assessments are marked and/or graded. The method used is identified in the assessment blueprint. Module and specialty/subject leads select the most appropriate method of standard setting for assessments within their areas.

The panel were satisfied that the assessments being undertaken were appropriate to the learning outcomes and that students were fully aware of the marking criteria and assessments they would undertake.

**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)***

**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)***

**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)***

Under this Requirement, the panel was tasked with looking specifically at staffing levels and how this may impact upon the examinations and assessments.

All staff involved in the assessment process are appropriately qualified and trained, with those who do not have post graduate qualifications being encouraged and supported to do so within the first two years of their employment. All new staff are provided with an induction folder containing relevant information. Included in this are details of the curriculum and where teaching occurs. As part of the induction, staff shadow an experienced member of staff for two weeks. They are introduced to the E-Dental Record, CAFS and the virtual learning environment called “CANVAS” and also complete Trust and University induction forms and processes. Grading guidelines are provided, however, through the use of CAFS, senior administrators can access calibration data to assess consistency of staff grading. This is monitored and discussed with individual staff at an annual performance development review. The panel would also encourage the introduction of a more formal PDR structure at the early stage of appointment so as to support staff and engage in the identification of training needs relevant to the area of assessment.

The panel viewed evidence whereby staff had undertaken equality and diversity training and were advised it is further planned to introduce Unconscious Bias training to assist and develop staff in their assessment role. The panel viewed this development positively and would like to encourage the School to ensure this training occurs on a similar cyclical basis.
The leadership team displayed a progressive approach to staff development in the area of assessment.

The panel did not see evidence to suggest that current staffing provision was having a negative impact on the assessment process. The process appeared well resourced. However, there was commentary from a small number of students that feedback and second attempt support mechanisms were not as effective as support previously received during the clinical phase. The panel advise that this should be an area of development for the programme in the future.

**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)***

**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)***

Assessments are performed against clear criteria and appeared fair. Students are made aware of the marking schemes and their standard setting protocols for each examination.

Prior to each assessment, examination questions and responses are quality assured initially with academics within the related module, subject and specialty area. Post-assessment, responses are analysed for consistent outliers and a decision made, usually with the external examiner, whether to modify or omit the question if appropriate. This is usually discussed with the Assessment lead and reported at the relevant examination board

The panel saw evidence of clear grading criteria for all assessments and examinations. It was clear to the panel, that the students and staff involved were all aware and informed with regard to the grading criteria, where to find details about these, and the type of assessments which would be undertaken.

## Summary of Action

| Req. number | Action | Observations & response from Provider | Due date |
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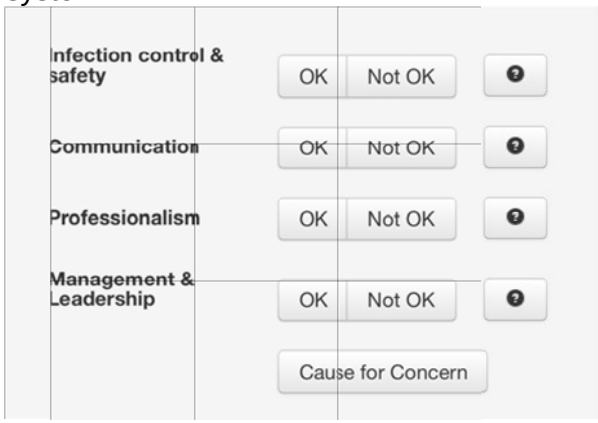
| 7 | To further reinforce and develop their approach, the panel would encourage the school to consider the inclusion of Patient Safety within the area of Professionalism in their related assessment marking sheets. | We welcome this recommendation. Critical domains in student performance such as *Infection Control* or *Communication* are recorded in CAFS in a binary manner as “OK” or “Not OK” (see below), whereas technical grades are recorded using a competency system.<br>  <br><br>Student level reports are produced that highlight recent unsatisfactory sessions as an early warning to the school, based on these existing OK/Not OK grades as well as other clinical grades. The recent addition of the *cause for concern* button allows staff to quickly raise serious concerns, including patient safety to senior members of school staff.<br><br>Adding *patient safety* to this binary system will be implemented via re-programming. We will work with INVENT Partners to develop CAFS to enable report generation at the student level on “safety”. | Annual Monitoring 2020 |

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| 15 | While the current cohort was achieving higher numbers than the minimum requirements, the panel felt that the minimum requirement target should be raised in order to ensure that students continue to obtain the appropriate skills in paediatric dentistry. | Following discussions with the academic lead in Paediatric Dentistry, it is clear that the CAFS report data presented during the inspection did not reflect the holistic student experience of Paediatric Dentistry. The most critical skill to ensure preparedness for practice is the ability of the new graduate to manage the child's behaviour and wellbeing, as well as parental factors, to ensure safe and successful delivery of the most appropriate care. Each student manages a minimum of 15 child treatment episodes, within which interventions may be behavioural or surgical. We will ensure these are all reported via CAFS and we will review the surgical intervention minimum criteria further. This may require further programming of CAFS via INVENT. | Annual Monitoring 2020 |
| 15 | The panel would also encourage the introduction of a more formal PDR structure at the early stage of appointment so as to support staff and engage in the identification of training needs relevant to the area of assessment. | We appreciate the intention of this suggestion but interpret it to mean more of a "Training Needs Assessment" than a PDR, as a PDR requires the part-time staff member to have worked for a period of time to enable meaningful review. We welcome the suggestion of a TNA and this will be developed alongside the existing induction material as part of a required but self-directed online assessment. Training needs will be identified, and staff signposted as appropriate to specialty teaching areas or other academic resources, prior to further review at the annual PDR. Grading standardisation has been recently further developed through CAFS to allow all staff to see their own grading profile against an anonymised data set, this will allow early self-intervention without the need to wait for feedback at an annual appraisal. | December 2019 |
| 19 | There was commentary from a small number of students that feedback and second attempt support mechanisms | We recognise this and will implement the following:<br>1. Inclusion via the resilience training programme this academic year, a session on how to cope with | July 2020 |

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| | were not as effective as support previously received during the clinical phase. | unsatisfactory grades/ not being top of the class. 2. We will improve signposting for students to engage with the academic support services, available at the university.<br>3. We will undertake educational sessions with our staff to understand the needs and changes to how this generation of students respond to constructive criticism, especially in year 3, and to explain the basic psychology of “constructive” criticism and the need to balance this with praise when deserved.<br>We will ensure specialty/subject leads meet with each student who fails an exam and supports them towards the second attempt. | |

## Observations from the provider on content of report

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| The provider was satisfied with the content of the report and made no further comments. |

## Recommendations to the GDC

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| **Education associates’ recommendation** | Qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council |
| **Date of next regular monitoring exercise** | Academic year 2020/21 |

# 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 inspectors 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 inspectors 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.