General Dental Council | protecting patients, regulating the dental team

INSPECTION REPORT

Education provider/ Awarding Body:	**Plymouth University Peninsula Schools of Medicine and Dentistry**
Programme/Award:	**BSc (Hons) Dental Therapy and Hygiene**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dental hygienist and therapist**
Learning Outcomes:	***Preparing for Practice (*Dental nurse)**
Programme inspection dates:	**Programme Inspection 17 and 18 January 2017 Sign up meeting 22 May 2017 ISCE 23 May 2017 Exit case presentations 5 June 2017 Exam Board 23 June 2017**
Inspection panel:	**Annie Turner (Chair and Lay Member) Fiona Sandom (Dental Care Professional Member) Janine Brooks (Dentist Member)**
GDC Staff:	**Krutika Patel (Lead QA Officer) Rachael Mendel**
Outcome:	**Recommend that the Plymouth University Peninsula Schools of Medicine and Dentistry BSc (Hons) Dental Therapy and Hygiene is approved for registration of dental therapists and dental hygienists to the GDC Register.**

Full details of the inspection process can be found in Annex A

Inspection summary

This is first inspection of the BSc (Hons) in Dental Therapy and Dental Hygiene. The programme was given provisional approval to begin in 2014, by the General Dental Council (GDC). The aim of this inspection was for the inspection panel to assess whether this qualification could be approved for the purposes of registration as a dental therapist and dental hygienist with the GDC.

This programme benefits from having an experienced, committed and enthusiastic team of staff, that are dedicated to providing an interesting, innovative and challenging learning experience for every student. Other areas of note included the implementation of a spiral curriculum, enabling fundamental concepts such as professionalism to be reinforced throughout the duration of the course.

The inspectors were particularly impressed with the clinical facilities the School offered to its students. The Life Sciences Resource Centre houses a virtual cadaver, giving students a realistic experience of the histology of the entire human body; the well-equipped Simulated Dental Learning Environments (SDLEs) allow students to gain 'real-life' experience, before progressing to treating actual patients, in one of the four equally well-resourced Dental Education Facilities (DEFs).

The School has established processes in place to collate feedback from staff, students and patients. This information is utilised to develop and improve the programme for future cohorts. This again has resulted in creating a positive learning experience for the students on the course.

The School is located in an area of considerable need, meaning that students are able to treat large numbers of patients. However, the panel was of the view that the School needs to review its processes governing the triaging of patients for third year students, to enable these students to focus more on therapy-based clinical procedures.

Background and overview of Qualification

Annual intake (current and projected):	16 students
Programme duration:	106 weeks over 3 years
Format of programme	The BSc Dental Therapy and Hygiene programme is studied over three years. In Years 1 and 2 of the programme, teaching and learning is initiated by clinical cases and patient narratives and uses a blend of structured, enquiry-based small group learning, large group plenary sessions, interactive workshops, and supported independent study working alongside BDS students. The learning occurs within an intensely supported environment, including expert tutor-facilitated sessions in the: • Life Sciences Resource Centre • Simulated Dental Learning Environment • Clinical Skills Resource Centre • Reflective Portfolio Assessment sessions and workshops. State-of-art technologies and Technology-Enhanced Learning resources are also a key aspect to help support learning through the 3 years. Patient contact commences mid-way through Year 1, assists in laying the scientific foundations upon which the later more clinically intensive part of the course are built. By the end of the second year of the study, students will have been introduced to the evidence-based core clinical and technical skills required of modern dental therapists and hygienists will have developed early competencies in basic dental care. In Years 2 and 3 students gain extensive experience of a wide range of common and important core oral conditions, with continued reference to the science base that underpins dental practice. Year 3 provides a thorough grounding for contemporary dental therapy and hygiene practice through detailed preparation for the

	skills and competencies required immediately after graduation and through gaining understanding of the patient journey through both primary and secondary dental care. The final year is also distinctive in preparing students for their working life on qualification, consolidating and strengthening comprehension, application of information as well as enhancing skills.
Number of providers delivering the programme:	N/A

The panel wishes to thank staff, students and external stakeholders involved with the BSc (Hons) in Dental Therapy and Hygiene, for their co-operation and assistance with the inspection.

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.**			
Requirements	**Met**	**Partly met**	**Not met**
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.	✓		
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.	✓		
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.	✓		
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.	✓		
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.	✓		
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 parities how concerns will 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.	✓		
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.	✓		
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 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)***

It is mandatory that students attend weekly sessions in the Simulated Dental Learning Environment (SDLE). Attendance at these sessions is monitored, and the Year Leads will meet with students who fall below the required threshold.

When in SDLE, students must complete several capability assessments for irreversible procedures, and some reversible procedures. Each of these procedures is recorded on an 'Form A', which enables tutors to provide feedback on student performance, and identify areas that may require additional teaching support.

If a student were to fail at a first attempt of an SDLE capability assessment, they are provided with an hour of remediation and, where appropriate, extra time in the SDLE to attain the necessary competence. If a student fails an assessment at a second attempt, they are provided with two hours per week extra practice until the next meeting of the Award Assessment Board, which will discuss whether that student should be allowed to continue on the programme.

In addition to the capability assessments, students must complete other assessed elements of the Introduction to Clinical Practice module, which includes students being assessed on their knowledge of and ability to deal with medical emergencies, before progressing to treating patients in one of the Dental Education Facilities (DEFs).

Once in clinic, students are directly observed and assessed by tutors administering local anaesthetic and taking radiographs, until they are deemed competent to undertake these procedures independently.

Students' clinical skills are continually monitored in every year of the programme. Any student awarded a borderline grade, is given chairside remediation. If a student receives an unsatisfactory grade, they are not permitted to carry out that procedure again on a patient, until a satisfactory programme of remediation has been completed in the SDLE.

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 importance of - and rationale for - obtaining patient consent to treatment, is a topic covered during the induction given to all first-year students on the programme.

Evidence of how patients are informed that students are treating them was provided to the panel in the form of a poster which is displayed in the reception area of each of the DEFs; patient leaflets stating patients had a right to refuse treatment by a student and an example 'patient agreement to treatment form', which each patient must sign to provide consent.

During a visit to one of the DEFs, the panel noted that reception staff inform/remind every patient who calls, that they will be treated by a student; that all staff and students wear visible name badges denoting their role and status in the clinic; and that every student introduces themselves to each patient they treat, re-iterating they are a student and therefore providing the patient with yet another opportunity to refuse treatment.

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)*

All the DEFs have undergone and passed a Care Quality Commission (CQC) inspection, meaning the actual premises and equipment are clean, fit for purpose, used properly and secured when appropriate.

The panel was provided with evidence in the form of policies, which have been implemented to ensure patient safety, including guidance on first aid and decontamination.

Both clinical and non-clinical patient safety incidents are listed in the monthly Patient Safety and Governance Report, which is distributed to all staff and students, discussed at staff meetings and reported to Plymouth University. Annually, all the incidents and the subsequent lessons learnt, are collated in the Peninsula Dental Social Enterprise Annual Patient Safety Report, and then discussed at the Health and Safety Committee.

To enable Plymouth Dental School (PDS) to gain a greater accuracy over their incident reporting process, Ulysses, a computerised safeguarding risk management system, was implemented in 2015. Ulysses has improved the School's ability to act, investigate and determine the cause of patient safety incidents, which supports PDS's on-going goal of improving both patient and staff safety.

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)*

Staff to student ratio in clinic is one supervising dentist plus one hygienist or therapist to a total of eight BDS and dental therapy hygiene students. The cover for clinics is monitored by the PDS Academic Services, and the panel was informed that clinics will be cancelled if these ratios cannot be guaranteed on any particular day.

The clinics at each of the DEFs are designed to allow supervisors to have a clear view of each of the individual chairs, meaning students in difficulty can be assisted when required, with the aim of reducing patient harm.

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)*

The panel was provided with evidence that all staff involved with the programme, had the necessary GDC registration.

At a University level, all staff are required to undertake mandatory health and safety, equality and diversity and unconscious bias training, every three years. Additional training is available if required, covering topics such as supporting those with mental health issues, and alcohol and drug awareness. Training needs are also identified during the annual staff appraisal, and

during this meeting, staff must provide evidence they have completed any mandatory CPD. The panel was informed that the University is currently working to ensure all teaching staff have, or are studying for, an official teaching qualification.

All new clinical supervisors must participate in an induction programme and sign an agreement to attendance and understanding of all the information they have been provided with. Copies of the agreement provided to the inspectors included a checklist setting out what knowledge a clinical supervisor on the programme must possess.

PDS also run an annual training day in September, where attendance by clinical supervisors is compulsory. A further opportunity to discuss training needs, is at the six-weekly clinical supervisor meetings which are scheduled during the academic year. PDS do not allow a new supervisor to immediately be responsible for students in clinic, until they have undergone a period of shadowing a more experienced colleague and are deemed ready to supervise independently.

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 University have a raising concerns policy in operation, and the panel had the opportunity to review the types of concerns raised during 2015/16. The policy defines what constitutes a concern, and the support available should a staff or student ever raise a concern.

This topic is covered as part of the yearly student induction, with each cohort having to attend mandatory plenary sessions on professionalism and raising concerns. The subject of whistleblowing, is also one of the themes of the enquiry based learning scenarios, which the inspectors were able to review.

Prior to seeing patients at one of the DEFs, all students attend a full day clinical induction, and reporting patient safety issues is explicitly addressed at this time. Inductions also take place when students move to treating patients from one DEF to another. When on clinic, there is a process in place to record incidents, including instances of unprofessionalism, with students being required to reflect on why an incident occurred and how this situation could be prevented in the future.

The panel noted that there is a culture embedded within the School, where both students are and staff are actively encouraged to raise concerns when necessary, and the appropriate mechanisms are in place to facilitate this. The inspectors considered the use of a pocket card which sets out the raising concerns policy, was helpful in reminding all those involved with the programme, of their responsibilities to maintain patient safety.

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)*

All patient safety incidents are logged and collated in a regular report, which is discussed at the relevant committees, including the six-weekly clinical supervisor meetings. A copy of one of these reports was made available during the inspection, and the panel was able to see the incidents identified and the resulting follow-up actions.

PDS has established processes in pace to identify issues, and everyone involved with this programme is aware of what issues need to be reported, how and when. Students causing concerns, are identified through multiple sources including by individual tutors during the regular portfolio appraisal meetings. Such students will be given a tailored action plan to address any deficiencies, and may be prevented from having any patient contact until all the actions have been addressed sufficiently.

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)*

The panel was provided with the School's student fitness to practise policy, which had recently been amended to align with the GDC's revised guidance published in 2016. This policy is revisited by staff with students, at the beginning of every academic year.

Each cohort must also annually attend a plenary or interactive workshop on professionalism and the GDC Standards for the Dental Team. The importance of fitness to practise is reinforced further during the assessment process, with questions relating to fitness to practise always included in the Applied Dental Therapy Knowledge (ADTK) progress tests.

Actions – NONE IN RELATION TO THIS REQUIREMENT

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.**			
Requirements	**Met**	**Partly met**	**Not met**
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.	✓		
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.	✓		
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.	✓		
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.	✓		

GDC comments

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)*

Changes to the BSc and any subsequent action plans, all have to be approved by the University's Teaching, Learning and Quality Committee. All relevant staff, meet regularly both informally and formally to discuss what changes are required, and whether or not, these amendments need to be authorised by the University or actioned immediately by programme staff. From reviewing committee and staff meeting minutes, the panel noted that the programme has established pathways to enable changes to be made quickly if University-level sign-off is not deemed necessary.

Changes to individual modules, begin with a review of the module handbook by the programme and module leads. Any potential changes are then discussed at the Dental Programme Committee and the Dental School Teaching, Learning and Quality Committee. Part of the remit of both these committees is to ensure that the programme is in-line with

current legislation and external guidance, and will approve or reject proposed changes on this basis.

The responsibility of ensuring the programme maps to the GDC learning outcomes, falls to the Director of Undergraduate Dental Students. To ensure this continues to remain the case, they are supported by the Faculty Quality Assurance Team, who assist in the mapping, and contribute guidance on this topic to the University Periodic Reviews, as well as in communication with the professional regulatory bodies.

Evidence demonstrating that the programme maps to each of the GDC learning outcomes, was provided to the panel as part of the pre-inspection documentation, and evidence was deemed sufficient by the panel.

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. ***(Requirement Met)***

Clinical activities of all students are continually audited by staff at each of the DEFs. Their reports are then circulated to all staff and discussed by the Dental School Senior Management Team, who will look at the quality issues raised and recommend improvements to or creation of processes, to mitigate any identified risks. The Senior Management Teams as well as the Dental and University Teaching, Learning and Quality Committees then take responsibility for ensuring these improvements or processes are implemented as soon as possible. An example of how well this process works, relates to the programmes admission policy. The panel noted a number of students in the very first cohort of the programme were not successful in progressing through the programme. In response, the School revised their admission policy to ensure that students entering the programme, had the ability to complete the qualification. As a result, fewer students have left the programme at the end of each of the academic years.

External examiner reports are reviewed at the School and Faculty Teaching, Learning and Quality Committees, which include University representation from the Central Quality Unit (CQU). The CQU ensure appropriate monitoring of concerns raised from the perspective of the Quality Assurance Agency for Higher Education (QAA) institutional compliance, to ensure the programme retains high academic standards. From speaking with the external examiner and reviewing their reports, it was clear to the panel that School had responded to the recommendations and saw the involvement of the external examiner as a positive influence in developing the quality of the programme.

Any potential threats to students not achieving the necessary learning outcomes, are listed in the School's risk registers, which are regularly monitored by the Senior Management Team and the Faculty.

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)***

As mentioned under Requirement 10, the programme does employ an external examiner to oversee the entire programme. The External also has the opportunity to speak with all staff and students and attend the final Integrated Structured Clinical Exams (ISCEs), and will annually feedback back to PDS via a written report. Recommendations by the external examiner will then be discussed and implemented as appropriate.

Multisource feedback is collected by students, as part of the Professionalism Module. This is achieved by a student-patient questionnaire being completed after every clinical appointment. Questions asked about the student include their professionalism, communication skills, and whether things like an explanation of treatment or pain management skills need to be improved upon. Responses are then evaluated and discussed during the portfolio appraisal meetings.

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)*

Most of the students', clinical practice takes place in the PDS's DEFs. However, there are a small number of specialist placements that students will visit during the programme. These placements have a service level agreement with the PDS, which covers placement specification, IT provision, quality and monitoring requirements and financial arrangements. PDS have allocated staff members who will monitor these agreements, to ensure they remain fit for purpose.

Any issues arising in the Specialist Care Visit placements, that are raised by staff or students, and/or any clinical issues that are raised, are discussed through a variety of feedback mechanisms including the Student Staff Liaison Committee, and any necessary actions are overseen by the Dental Programme Committee and the Dental School Teaching, Learning and Quality Committee.

In relation to the DEFs, student and staff feedback is again reviewed by the Dental Programme Committee and the Dental Teaching, Learning and Quality Committee.

Actions – NONE IN RELATION TO THIS STANDARD

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.**			
Requirements	**Met**	**Partly met**	**Not met**
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.	✓		
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.	✓		
15. Students must have exposure to an appropriate breadth of patients and 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 learning outcomes.		✓	
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.	✓		
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.	✓		
18. The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.	✓		
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.	✓		
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.	✓		

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.	✓		

GDC comments

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 School have a central recording and monitoring system – the Assessment Database – which is accessible by both staff and students to monitor academic progression. Clinical experience is recorded on the system, which also captures assessment results. The system then generates a 'traffic light' report for each student, setting what procedures they need to complete or carry out more of. This report is one of the items discussed during the termly portfolio appraisal meetings, and is an opportunity for both the tutor and student to decide what additional support needs to be sought so that targets can be achieved by the stated deadlines.

Following every assessment, there is a review meeting discussing how the assessment went, the results and what improvements can be made for future sittings. Students have the opportunity to receive detailed feedback on each of their assessments, and seek additional time in the SDLE, should they want more practise on a particular clinical area.

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)***

As discussed under Requirement 13, all students' academic progress is recorded and monitored by the Assessment Database. Learning Outcomes for each of the modules, is set out in the handbooks, along with an explanation of what assessments will test which of the learning outcomes.

The external examiner will review all the assessments prior to students sitting them, and then a selection of marked scripts following the assessment. They will then provide verbal feedback to both the School and Faculty Teaching, Learning and Quality Committees, who will then implement plans to address any concerns raised.

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 Partly Met)***

PDS has a number of processes in place to ensure students achieve the necessary breadth of clinical experience, including the triaging of new patients to ensure they are directed to those students according to their scope of practise and clinical proficiency.

The panel was informed that the Community Engagement Team have recently expanded to place a dedicated staff member in each of the DEFs, to ensure there is an appropriate flow of the correct type of patient into the School. This approach has been particularly successful in the recruitment of paediatric patients.

Even though the School requires students complete a minimum set of target numbers in specific clinical procedures at a certain grade, the panel was of the view that these targets were not stretching, especially in relation to restorations. The clinical procedures completed, focused more on the hygienist scope of practice, rather than therapy. Having examined the clinical totals of each student during the exam inspection, the panel noted that even in the final year, many students still had not completed at least one of each of the clinical tasks. This was raised with the teaching staff, and the inspectors were informed that that all students would have completed and been assessed in all of the clinical tasks in the SDLE, and that these procedures would only be recorded once the student had the opportunity to carry out that particular procedure on a patient. However, the staff were assured that no student would leave the programme not having achieved the necessary clinical competencies.

This issue of low number of specific clinical procedures was discussed with the Director of Undergraduate Students. It was acknowledged that it would be helpful if those patients requiring a greater amount of restorative work be triaged to final year students, in order to enable these students to gain as much therapy experience as possible, prior to graduation.

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)*

PDS have an assessment strategy setting out the purposes of assessment, and their commitment to ensure that assessments aid student learning providing appropriate feedback; measure students' achievement objectively against each of the module learning outcomes, provide a reliable and consistent basis for the recommendation of an appropriate grade or reward; and assist staff in the evaluation of the effectiveness of their teaching. Evidence to confirm this was taking place, was provided to the panel during the programme inspection.

A range of assessment methods are utilised by the programme to test student knowledge and competence, including ISCEs, ADTKs, SCOTS (Structured Clinical Operative Tests) and multiple-choice questions. To ensure assessments continue to remain fit for purpose, module leads regularly review the mapping and effectiveness of their module assessments. Module leads also work closely with educationalists at the University, and the University's Pedagogic Research Institute and Observatory (PedRIO), who undertake research into the theory and practice of teaching methods.

Feedback from the module leads and the research from PedRIO, then feed into the work of the Assessment Working Group (AWG). The AWG meet termly and attendees include the Deputy Director of Assessments, the Director of Dental Undergraduate Studies, and student representatives from each of the three years. The AWG is a forum to discuss assessment effectiveness and collate feedback and suggested changes, from both staff and students. These amendments are then presented to the Dental Teaching, Learning and Quality Committee for agreement, before being signed off by the University.

The programme does standard set all assessments, and pass marks are determined using the Angoff and Hofstee methods. Assessment results are then analysed by psychometricians who will also look at the performance of questions, and highlight any bias. These questions will be monitored in future assessments, and removed if the bias reoccurs.

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)***

As mentioned, feedback is collected by students as part of the Professionalism module. Annually a minimum of 100 patients in each of the four DEFs are asked to complete a 'Patient Satisfaction Survey'. A copy of the January to March 2016 survey, was provided to the panel, ***and feedback collected was largely positive in support of the student care that these patients had received.***

Other sources of feedback come from the patient actors, who participate in the final ISCEs. They provide feedback on each of the students they have contact with, and this information will contribute to the development of future ISCEs. Students are able to feedback on assessments via the Student Staff Liaison Committee (SSLC), and student representatives have a presence at the termly AWG meetings, as discussed under Requirement 16.

The panel reviewed a selection of minutes from the SSLC, AWG and DTLQC demonstrating how the different types of feedback collected, has led to certain module assessments being amended/replaced to improve understanding amongst students.

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)***

The topic of reflection is integral to the programme. Students are provided with a number of reflective models and given guidance on how to reflect, and why this remains necessary throughout their time as a student, and then as a registered professional, when they commence the BSc.

Students are assessed on their reflective accounts, as part of the Professional Development module, which requires them to reflect upon personal and professional performance. Prior to termly meetings with their academic tutors, students must complete a reflective questionnaire, which is then discussed during the meetings. Students again provide a reflective account, following each patient contact at the DEF. The panel was provided with a selection of students' reflective accounts and were impressed with both the quality of the accounts, as well as the level of insight the students had into how they could develop as dental therapists and dental hygienists.

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.

The panel was provided with a number of organograms, denoting which staff on the programme have examiner/assessor responsibility. These staff must be registered with the GDC, and are chosen to undertake these roles, according to their qualifications and training. Evidence in the form of staff CVs provided to the panel, confirmed these examiners/assessors were registered and had experience or formal qualifications to enable them to fulfil these responsibilities sufficiently.
As part of the University's annual appraisal process, all staff are checked to ensure they have completed the necessary equality and diversity training.

To ensure all examiners/assessors are aware of what is expected of students, comprehensive module handbooks set out learning outcomes and how these will be assessed and marked. All

assessors and examiners also undergo calibration training that is organised by the School when necessary.

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)***

The role of external examiners for this programme is to oversee the standards of assessment, and on the content of the individual modules. Each of the modules has an allocated external examiner who will review the module and assessment and feedback to the School on the appropriateness. Award external examiners comment on the programme overall, attend the final examinations, review a selection of the written papers, and feedback on their findings during the assessment panels and exam board meetings.

All the external examiners are appointed for a four-year term, and during that time they must spend at least one day at the School to meet students and observe teaching.

To support all the external examiners in their role, the University has a number of guidance documents available on their website, including detailed guidance on the assessments utilised by the different programmes. The University also organises an annual conference, where topics including the role of the external examiner and the use of external examiner reports, are discussed.

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)***

Each of the module handbooks set out what topics will be covered, teaching and assessments methods, marking criteria and what learning outcomes will be achieved once that module is completed. Handbooks are available to all students and staff on the University's website. Module leads will thoroughly brief all staff responsible for delivering teaching, on what is required from students in order to pass the assessments. The six-weekly, clinical supervisor meetings are another opportunity for staff to raise any queries they may have about the assessment criteria.

As discussed under Requirement 16, the School standard sets using the Angoff and Hofstee methodologies, and staff benefit from working with on-site educationalists and psychometricians, who analyse the performance of assessments and subsequently specific questions that would benefit from being revised.

Actions

No	Actions for the Provider	Due date
15	To enable third year students to focus more on therapy based clinical procedures, the School should review its patient triage processes so that patients requiring restorative treatment are allocated to these students in the first instance.	Annual monitoring return 2018

Summary of Actions

Req. number	Action	Observations Response from Provider	Due date
15	To enable third year students to focus more on therapy based clinical procedures, the School should review its patient triage processes so that patients requiring restorative treatment are allocated to these students in the first instance.		Annual monitoring return 2018

Observations from the provider on content of report

Recommendations to the GDC

Recommend that the Plymouth University Peninsula Schools of Medicine and Dentistry BSc (Hons) Dental Therapy and Hygiene is approved for registration of dental therapists and dental hygienists to the GDC Register.

ANNEX ONE

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 edition[1] 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."

[1] http://www.gdc-uk.org/Aboutus/education/Documents/Standards%20for%20Education.pdf

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.