General Dental Council

protecting patients,
regulating the dental team

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
University of Manchester	Bachelor of Dental Surgery (BDS)	13-14 February 2019 31 May 2019 (Exam Board)

Outcome of Inspection	Recommended that the Bachelor of Dental Surgery (BDS) continues to be approved to register as a dentist.

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

Inspection summary

Remit and purpose of inspection:	Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dentist. Risk based: Focused on Requirements 4, 5, 6, 9, 11, 12, 13, 14, 15, 18 and 19
Learning Outcomes:	***Preparing for Practice (dentist)***
Programme inspection date(s):	**13-14 February 2019**
Examination inspection date(s):	**31 May 2019 (exam board only)**
Inspection panel:	**Carl Stychin (Chair and Non-registrant Member)** **Fiona Sandom (DCP Member)** **Timothy O'Brien (Dentist Member)** **Richard Cure (Dentist Member)**
GDC Staff:	**James Marshall** **Jackie Spencer (exam board)**

The inspection undertaken at the University of Manchester was risk-based, focusing on specific areas of their Bachelor of Dental Surgery (BDS) programme. The GDC quality assurance team and a panel of experienced education 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, 5, 6, 9, 11, 12, 13, 14, 15, 18 and 19.

The BDS programmed delivered by the University of Manchester has undergone a number of changes since the last GDC inspection, including both a faculty and university restructure, which has resulted in a strain on staff resources. The panel was pleased to note a commitment from the new Head of Division to ensure staffing issues remain a priority, with a focus on recruitment.

The Division has also recently moved away from using the LIFTUPP clinical recording system and is now using iDentity. The GDC will continue to monitor the use of iDentity through the regular Monitoring exercise, to ensure it remains a fit for purpose system. The panel agreed the move towards the Milestone attainment system was innovative and will also continue to monitor its performance.

Students were very positive about the experience they gained at their outreach placements and the panel encourages the programme team to continue to utilise and support the experienced teams within the outreach centres.

Background and overview of Qualification

Annual intake	75-80 students
Programme duration	173 weeks over 5 years
Format of programme	Year 1: Basic sciences, EBL, Weekly symposia, small group teaching, simulated clinical experience, clinical experience towards the end of the academic year Year 2: Basic sciences, EBL, Weekly symposia, small group teaching, learning on dental public health, simulated clinical experience, direct patient contact Year 3: Basic sciences, EBL, Weekly symposia, small group teaching, Teaching on law, ethics, and professionalism, simulated clinical experience, direct patient contact Year 4: EBL, Weekly symposia, small group teaching, Teaching on critical appraisal and research methods, direct patient contact, outreach programme, medicine and surgery programme Year 5: EBL, Weekly symposia, small group teaching, Teaching on clinical governance, direct patient contact, sedation training
Number of providers delivering the programme	1

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.

Outcome of relevant Requirements[1]

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

[1] All Requirements within the *Standards for Education* are applicable for all programmes. Specific Requirements will be examined through inspection activity through identification 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 Partly met)* During the inspection the panel noted issues had arisen regarding staffing levels in the Division. The inspectors were informed that a number of factors had contributed to heightened staffing pressures, which included a recent university restructure, resulting in a number of redundancies, and the use of GDPs within the teaching environment. As a result of these issues, on occasion teaching clinics were cancelled. While this action is not desirable for the students' learning experience, the inspectors agreed this was an appropriate approach to take in order to ensure patient safety was maintained. The panel noted that for future teaching years, the University should review staffing levels within the Division on a regular basis to ensure clinics are able to run as scheduled and not to the detriment of the students, whilst still maintaining patient safety. As noted above, the programme utilises GDP teaching support on the clinics, which the inspectors agreed was a positive approach and provided students with the opportunity to work with dental professionals from a wide range of clinical backgrounds. Inspectors agreed that the programme team must ensure standardisation, calibration and appropriate use of university documentation are utilised to guarantee they are all assessing to the same standard. The panel also agreed that regular training opportunities must be provided to the GDP teaching team to mitigate the risk resulting from a high turnover of these staff members. Despite concerns raised above, the inspectors were provided with satisfactory evidence of the supervision levels for students while undertaking clinical activity both in the dental hospital and in outreach settings. Within the dental hospital, students always work in pairs with one acting as operator and one assisting. On hospital clinics there is a ratio of one member of staff to every six students. The inspectors noted a high level of experienced nursing support for students on the BDS programme, this was especially evident within the outreach environment, where students have a dedicated nurse to support them.

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 inspectors were generally satisfied with the methods used by the Division in order to ensure all staff members were appropriately trained and qualified. All clinical tutors are required to have GDC registration and tutors outwith the Division (e.g. Trust employees) are required to evidence their registration by providing a hard copy of their GDC certificate to their employer on an annual basis.

In order for staff members to have the greatest opportunity to attend training and development sessions, the Division organises lunchtime meetings across the week in order to allow part time staff to attend. These lunchtime training opportunities are repeated on a two to three monthly basis.

In addition to this, the dental hospital runs MegaWeek consultant clinics on a twice yearly basis. During the MegaWeek, the majority of the routine teaching on the restorative clinic is cancelled and the students participate on consultation clinics instead. Consultants in restorative dentistry are assisted by postgraduate students who are capable of supervising students in these sessions, with little need for the part time clinical tutors to assist. As a result of this, the Division schedules its away day during the MegaWeek so that the majority of the teaching staff are able to attend. The Division also produces a monthly newsletter for staff, which includes details on items discussed at the away days.

The University provides online training on Equality and Diversity, which is mandatory for all staff members to undertake. The inspectors were satisfied with the evidence provided that all members of staff were completing this.

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 inspectors were informed that all teaching staff involved with the delivery of the BDS programme are required to have an honorary contract with Manchester University Foundation Trust. A requirement of this contract is for all holders to complete online mandatory training on an annual basis, which includes training on raising concerns. The panel was also provided with copies of the Trust Raising Concerns and Duty of Candour policies. Further to this, the Trust cancels all teaching and clinical activities four times a year so all members of staff can attend clinical governance meetings.

Students on the BDS programme are initially introduced to the concept of raising concerns during their initial induction, this training is then repeated at the beginning of each new academic year. When students undertake their outreach sessions, they are required to treat vulnerable patients and receive safeguarding training during their induction to this aspect of the course.

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)*

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)*

Overall responsibility for quality management of the programme sits with the Undergraduate Programme Committee (UPC), which provides the framework through which the Division manages all changes to the programme. The UPC is chaired by the Director of Undergraduate Education and has representatives from each of the years as well as the Senior Tutor and Undergraduate Manager. In addition to this, student representatives attend the UPC. Additional members of the committee include the Director for Evidence Based Dentistry, the Director of Student Experience, the Chair of the eLearning Group and the Chair of the Assessment and Examination Group. The inspectors were satisfied that through this group, any changes to the curriculum would be appropriately and effectively managed.

The inspectors noted that the issue of a high turnover of GDPs involved with the programme was discussed and managed via the UPC. While the inspectors agreed the high turnover of GDP staff members was not ideal, they were satisfied there were suitable mechanisms in place to ensure timely recruitment of new team members. The provider gave assurance that it was prepared to take the decision to cancel clinics on the rare occasions where supervisions levels were too low and patient safety risked being jeopardised.

Staff Student Liaison Committee meetings, chaired by Director of Student Experience, are held monthly and the inspectors were provided with minutes of these meetings, which were deemed an effective tool to escalate concerns from the student body. During the inspection the panel met with representatives from each cohort of students, who were satisfied there were appropriate and effective mechanisms to raise concerns and discuss aspects of the programme that could benefit from improvement.

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 Partly Met)*

The panel noted that External Examiners were utilised for all five years of the BDS programme and their feedback is shared and discussed during the Assessment and Examination Group meetings. Action plans following these meetings are shared with the External Examiners to ensure transparency. The inspectors were provided with copies of the External Examiners

reports, responses from the University and minutes from Assessment and Examination group meetings.

In addition to quality assurance provided by the External Examiners, all programmes must complete an Annual Monitoring report, which is submitted to the Faculty to monitor progress against set actions and objectives. All programmes must also submit to the Faculty a risk-based framework that focuses on students' experience throughout each academic year.

The inspectors noted that the Division does have various methods for collecting patient feedback, including the Trust's Friend and Family Test, iDentity students' grading system, and via paper feedback forms. However, the panel agreed that the Division must make a concerted effort to use this information more effectively in order to inform 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)*

As part of the BDS inspection, panel members had the opportunity to visit an outreach centre where students treat vulnerable patients. The inspectors interviewed staff involved in the teaching and supervision within the centre, who praised the effective and open communication channels between the Division and outreach facility.

The inspectors were supportive of having a dedicated staff member who is responsible for the coordination of all outreach activity, as this ensured calibration and continuity across the various sites.

The inspectors noted there were regular Outreach Teachers Group meetings, where non-sensitive concerns raised by the students are discussed. The UPC also has outreach as a recurrent item on its agenda. Any feedback received by the committee that identifies a need for further development is discussed and feeds into a centre action plan. Students also have the opportunity to provide feedback on their outreach experience via the Staff Student Liaison Committee.

As noted in Requirement 11, patient feedback is collected as part of the Friends and Family Trust system and fed back to the Division, where it is discussed at the Clinical Governance meetings. Patients also have the opportunity to provide feedback on their experience via their iDentity clinical assessment system, which is used in both the dental hospital and in outreach.

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)***

In advance of the inspection the panel was provided with the Division's blueprinting document, which demonstrated that all GDC learning outcomes were being taught and assessed through the programme.

In order to be assured that students have completed the necessary elements in order to progress within the course, a sign-up meeting is held in early spring. Attendance at the sign-up meeting is comprised of the Director of Undergraduate Education, Assessment Lead, Undergraduate Manager, Academic Year Lead for each BDS cohort, Senior Tutor, and senior academic members of staff. The panel reviews the following information in order to decide whether students are fit to progress or need remedial support:

- Record of attendance
- Professionalism cards
- Record of Student Development Record (SDR) meetings
- Record of clinical activity
- Record of successful achievement in clinical skills exams/gateways
- Record of successful achievement in coursework assessments
- Record of successful achievement of clinical milestones against the timeline
- Patient feedback
- Incident reports
- Record of completion of annual NHS IT Skills course
- Record of completion of annual Trust core e-learning
- Record of suitability of two presentation cases for the BDS year five students
- Record of successful completion of Health and Safety modules

In the event that the committee has concerns regarding the progression of a student during the sign-up meeting, the student will be required to attend a Student Development Review Panel (SDRP) meeting. These meetings will review concerns raised by the committee and the student will be given an action plan with set deadlines to achieve incomplete items. In cases where the committee identifies that the progress of the student is significantly below what is expected, the committee will refer the student to the Health and Conduct Committee (HCC), whereby a potential outcome could be referral to the Fitness to Practice committee (FtP).

The inspectors were provided with examples of students who had not been signed-up following the SDRP meetings and were assured that the Division had a robust process in place for managing and supporting struggling students.

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

The Division uses a number of management systems in order to monitor and centrally record the assessment of students, including CEDAR, iDentity and formerly LIFTUPP.

CEDAR is an online database that collects and stores data on students' attendance as well as professionalism cards. The inspectors agreed it was an area of good practice to allow any member of staff to issue professionalism cards, both positive and negative, as this recognised input from all members of the dental team.

LIFTUPP was previously used to record clinical data within the Division, however this ceased to be used at the end of the 2016-17 academic year and was replaced with iDentity. The inspectors were informed that this decision was made for two reasons. Firstly, LIFTUPP only functions on iPads while iDentity is web-based and can be accessed via any platform. Secondly, the staff team felt that iDentity was more user-friendly and efficient to use compared to LIFTUPP.

iDentity is the current system used to collect data on students' performance in all clinical settings, including the clinical skills laboratories and within the outreach centres. The inspectors were given access to the system in order to scrutinise its use and effectiveness. The panel agreed that in general the system worked well, however they did note a small number of examples of clinical work on the system that had been uploaded by students but had not been marked by tutors in a timely fashion. Going forwards, the Division must review the marking strategy for iDentity to ensure it is contemporaneous and that all staff members are assessing work submitted within prescribed timeframes.

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 Division has recently introduced a new Milestone system, which scrutinises a smaller number of qualitative competency assessments. This system is used in collaboration with iDentity, which is a source of quantitative data based on a student's experience. The Milestone system was introduced to ensure students complete key procedures to a competent level.

The students take part in regular Student Development Record (SDR) meetings with their academic year leads. During each SDR meeting, performance data for the student is reviewed, which includes the breadth of patients and clinical exposure. SDR meetings are held on a three-monthly basis for students who are progressing well. Where concerns have been highlighted students are given an action plan and the frequency of the review meetings is increased to ensure students are monitored and supported appropriately.

In addition to the SDR meetings and Milestones, the Division produces regular reports of the clinical activity of the students via iDentity. This enables the programme team to identify any students who are not receiving enough clinical experience or a sufficient breadth of patients.

In the event that it is identified that a student requires additional support and experience the student is provided with the opportunity to attend additional clinical sessions. Further to this, the Division will identify other opportunities where similar clinical exposure can be gained. For example, in the scenario of oral surgery, arrangements will be made for students to attend extra general anaesthesia sessions to gain additional experience performing extractions.

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)*

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)*

The inspectors noted that reflection and feedback is embedded in the culture, documentation and recording systems used within the Division. The panel was pleased to see that reflection forms a key element of the iDentity system.

On completion of each clinical treatment, students are required to grade their performance and write a reflective statement. If the tutor disagrees with the student's grading of their performance, they are able to amend this and feedback with any learning points.

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 Partly Met)*

All examiners are provided with training on annual basis, which includes the mandatory requirement to complete online Equality and Diversity training.

Further to this OSCE examiners receive online training, which includes a video on the format of the exam followed by three videos of a simulated OSCE station attempted by three acting students at different levels of ability. The examiners complete the marking sheet, judge each attempt and enter their score online. Software is used to provide the examiner with immediate feedback on how all the previous examiners assessed the attempt. This software indicates where they are placed in comparison to other examiners and prompts them to self-reflect on their performance.

For the Structured Oral Exam, assessors receive face-to-face training, which is run by the Assessment Lead. Attendance at this training is mandatory.

While the inspectors agreed there were a range of opportunities for examiners to receive training, they noted some variation in the use of marking forms. Going forwards, the Division must ensure all examiners are trained and calibrated in order to use the assessment documentation appropriately.

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)*

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
4	The University should review staffing levels within the Division on a regular basis to ensure clinics are able to run as scheduled and not to the detriment of the students, whilst still maintaining patient safety.	Staffing is reported to DLT on a monthly basis. Any issues regarding replacement or proposals for new posts are forwarded to the SLT. Oral Surgery department is currently having the highest number of cancelled clinics. A full time lecturer post is currently being advertised to address this issue.	Annual Monitoring 2020
4	The programme team must ensure standardisation, calibration and appropriate use of university documentation are utilised to guarantee they are all assessing to the same standard. The panel also agreed that regular training opportunities must be provided to the GDP teaching team to mitigate the risk resulting from a high turnover of these staff members.	At the start of the academic year 2019-20 we ran 10 induction sessions during the induction week for all the staff involved in teaching undergraduate students. 10 sessions were planned to ensure we capture all the staff who work during the week. We have arranged a university away day on Wednesday 4 December 2019 with all teaching cancelled and eCPD available to encourage staff from both Dental Hospital and Outreach Centres to attend. We ensure to continue holding our refresher lunchtime meetings with our part time staff throughout the academic year for the purpose recalibration and addressing any queries.	Annual Monitoring 2020
11	The Division must make a concerted effort to use this information more effectively in order to inform programme development.	We will ensure that this becomes a standing item on our UPC reportable by our NHS Liaison member of staff.	Annual Monitoring 2020
14	The Division must review the marking strategy for iDentity to ensure it is contemporaneous and all staff members are assessing work submitted within prescribed timeframes.	This was covered in the inductions sessions held and will be repeated on a regular basis on the recalibration sessions.	Annual Monitoring 2020
19	The Division must ensure all examiners are trained and calibrated in order to use the assessment documentation appropriately.	The Division will continue its calibration strategies for OSCE, SAP and structured oral exams. The variation in markings was predominately linked to assessments	Annual Monitoring 2020

		done on the clinical skills facilities. We ensure a small pool of calibrated examiners in charge of marking work submitted for the gateway exercises. We have also made improvements on the marking sheet to address some of the problems of the old paperwork.	

Observations from the provider on content of report

The content of the report is factually correct and a true reflection of the BDS programme in Manchester. The Division would like to thank the inspecting team for their constructive comments.

Recommendations to the GDC

Education associates' recommendation	Qualification continues to be approved for holders to apply for registration as a Dentist with the General Dental Council
Date of next regular monitoring exercise	2020

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.