General Dental Council | protecting patients, regulating the dental team

# INSPECTION REPORT

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| **Education provider/ Awarding Body:** | **University of Northampton** |
| **Programme/Award:** | **Foundation Degree Science Dental Nursing** |
| **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 Nurse.** |
| **Learning Outcomes:** | ***Preparing for Practice* (Dental Nurse)** |
| **Programme inspection dates:** | **15 & 16 March 2017** |
| **Examination inspection dates:** | **14 & 15 June 2017** |
| **Inspection panel:** | **Alan Kershaw (Chair and Lay Member)**<br>**Sarah Murray (DCP Member)**<br>**Mike Mulcahy (Dentist Member)** |
| **GDC Staff:** | **Rick Bryan**<br>**Ross Scales** |
| **Outcome:** | **Recommended that the Foundation Degree Science Dental Nursing continues to be approved for the graduating cohort to register as Dental Nurses.** |

## Inspection summary

The Foundation Degree Science in Dental Nursing provided by the University of Northampton is a two-year programme delivered at the Park Campus in Northampton, however, is due to relocate in the near future to the 'Daventry' campus.

The programme benefits from having a dedicated and enthusiastic team who are constantly communicating with each other, ensuring that any issues are identified and discussed at the earliest opportunity. The student experience is at the forefront of their work with a good rapport in place between student and teaching staff; something that was clear in the panel's meetings with each cohort.

The panel identified a detailed and well-received outreach placement experience, something that was further confirmed in discussions with the students. Communication between School and Student whilst in placement remained efficient and positive throughout this time, with any issues raised and actioned appropriately.

The main area for concern identified by the inspectors was around assessment, and more specifically the School's approach to standard setting. This report highlights this concern in detail and invites the School to review in order to facilitate longer term improvements to the programme.

During the inspection, the panel found the programme leads to be open and engaged throughout. The panel remain confident of the receptiveness of the School in order to facilitate change and embrace the opportunities to improve the programme for future cohorts.

The panel wishes to thank the staff, students, and external stakeholders involved with the Foundation Degree Science Dental Nursing programme for their co-operation and assistance with the inspection.

## Background and overview of Qualification

| Annual intake | 25 students per academic year |
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| Programme duration | 2-year full time<br>Year 1 – 40 weeks<br>Year 2 – 40 weeks |
| Format of programme | Year 1: basic knowledge, clinic attendance, shadowing<br>Year 2: knowledge, simulated clinical experience and placements |
| Number of providers delivering the programme | 1 |

| Standard 1 – Protecting patients<br>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)***

The inspectors were provided with evidence of a range of methods the University uses to ensure students provide patient care only when they have demonstrated adequate knowledge and skill. The University teach a 'Practice Portfolio of Evidence – NPR1011P' unit in which students will be assessed before beginning to carry out clinical work and have contact with patients.

Within this, year 2 students undertake a three-week pre-clinical skills programme in which they attend three days a week (NPR2049P). This allows the dental team to assess the students' clinical skill before allowing them to practise in a clinical environment; concentrating on specific areas if necessary. This is a very useful period as it ensures that any early areas for concern are identified and addressed efficiently, with minimal disruption to the students' learning experience. The panel were provided with evidence of this in practice and therefore were satisfied that this requirement had been 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)***

The inspectors were impressed with the information provided to patients prior to treatment, which clearly informed them that they were being treated by students. The panel noted that the coloured and titled uniforms worn by students enabled patients and staff to clearly identify them. The panel was also made aware of the use of consent forms, which patients are invited to sign prior to any treatment commencing. The inspection panel was satisfied that this requirement had been 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)***

The University of Northampton enables its Dental Nursing students to attend outreach locations as part of its placement programme. The panel was informed that placement audits are carried out before a student would commence attendance however evidence of this suggested that this audit is not as thorough as it potentially could be. This is largely due to resource constraints such as staff availability; however, placement locations are in regular contact with the programme staff. In the audit process, placement locations are visited only if they are within a 50-mile radius of the university. This is understandable considering the resource commitment that would be required, but carries a degree of risk. As a result of this constraint, inspection reports from the Care Quality Commission (CQC) are considered as part of the audit process. The panel held the view that these reports should be used as a guide and not as a definitive criterion. It is noted that the CQC reports include equality and diversity protocols for practices. Placement locations are also provided with documentation such as handbooks and student timetables so that they can plan their workloads effectively.

The panel was provided with sufficient evidence to be assured that the placement locations used are safe and appropriate; however, the inspectors were of the view that this area could be enhanced. The panel was unsure that, if the larger cohorts planned are achieved and the geographical spread of students widened, the current audit process would be as effective. This

could be a source of significant risk in the future: it could affect the feasibility of visiting each location, increasing the need for a more efficient system for audit. The programme staff may wish to look across other departments within the University for best practice in this area and implement a grading system when assessing potential outreach locations, for example a 'Red, Amber and Green' (RAG) system.

The panel was also informed of the University's impending move to a new location, known as 'Daventry' campus. The panel considered this move when thinking about future-proofing within the course and the potential for development of facilities and processes, especially when considering learning environments. The inspectors were in agreement that the move offers an excellent opportunity to drive change and make improvements across the course in order to further the student experience.

**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)***

Students will provide treatment for patients only when they have been assessed as competent in that area. These skills will have been signed off in the clinical skills laboratory prior to students being allowed to demonstrate them in clinic. Once in practice, a registered DCP will support and assess the student's skills and competencies and sign off the relevant skills only once they are demonstrated without assistance. Students can use the clinical skills laboratory to simulate and role play before transferring these skills in to real life settings through the placements. The inspectors were satisfied that this requirement had been met and that students took advantage of the clinical skills laboratory in order to practise skills and methods for use in the placement setting. The panel were also satisfied that students were sufficiently supported by their mentors whilst in placement and that skills were being signed off only once those competencies were successfully and confidently demonstrated.

**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 supervisors on the programme are appropriately qualified and registered. University of Northampton teaching staff continue to keep up to date with their CPD, as part of their registration requirements, and any mandatory training is monitored by their line manager during the annual appraisal process. University and outreach placement staff are also required to complete Equality and Diversity (E&D) training as part of their role. Clinical supervisors in the outreach placements are required to submit evidence of their registration with a regulatory body through the initial location audit process; however, the inspectors would encourage this evidence to be collected on an annual basis. Based on the information and evidence provided, the panel was satisfied that this requirement had been 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)***

The panel was provided with copies of the University's whistleblowing, raising concerns and safeguarding policies and were pleased with their comprehensiveness. All students are

required to read them and sign a declaration that they have done so, which was confirmed during meetings with the students. The panel was also made aware that the current Cause for Concern policy is under review.

The University has in place a policy and process to ensure that any concerns raised in the outreach placements are appropriately addressed. Each student has a pre-visit to their allocated placement location in which they receive an induction and health and safety orientation where policies and procedures are introduced to the student. During the first year of the programme, students complete online learning units which are mandatory and have a summative assessment. The panel was satisfied from the evidence provided that this requirement had been 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)***

As part of the induction and orientation for practice, mentors and practice managers sign to confirm that policies and procedures have been read by the student and that they are aware of the process to follow should an issue arise. In the event of an issue arising, the practice will contact the University and the safety issue in question will be approached in line with the University policy. The panel was provided with evidence of this requirement in practice within the student portfolio. The inspectors were satisfied that this requirement has been met. Student awareness is covered within learning modules, classroom discussions and 'escalation of concerns' procedures. University study days provide ample opportunities for students to discuss with the teaching team how they are coping whilst on placement and any issues relating to quality of patient care.

**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)***

In the panel's meeting with students, both years one and two displayed a basic understanding of the Student Fitness to Practise (SFtP) process. It was evident that they were aware of the correct channels through which they should raise concerns and the types of situation which would warrant escalation. The University FtP policy is also available on the University of Northampton Integrated Learning Environment (NILE) as well as external links relating to SFtP on the GDC website. Also, placement locations are provided with a copy of the GDC's SFtP guidance.

The inspectors agreed that, although a basic knowledge of SFtP issues was evident amongst students, the University should revisit their SFtP and social media guidance, with a view to expanding this resource, beyond the existing examples, to cover questions about professional behaviour and language in the use of social media. This would help to provide more topical dialogue amongst students and further their understanding of SFtP and what it means to be a professional.

**Actions**

| **No** | **Actions for the Provider** | **Due date** |
|---|---|---|
| Req 3 | The provider should implement a RAG (or similar) system for placement locations | Update required in |

| | | 2018 Annual Monitoring |
|---|---|---|
| Req 5 | The provider should ensure that evidence of registration and E&D training should be collected annually as part of the audit process. | Update required in 2018 Annual Monitoring |

| **Standard 2 – Quality evaluation and review of the programme**<br>**The provider must have in place effective policy and procedures for the monitoring and review of the programme.** | | | |
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| **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)***<br><br>The panel was provided with a range of evidence to support this requirement, including course representative minutes, National Student Survey (NSS) responses and External Examiner reports. The panel also discussed any periodic reviews that might be in place for the programme in order to provide suggestions for improvement and an opportunity to ensure that change is apparent. The panel were provided with the Periodic Subject Review (PSR) which | | | |

refers to the process by which programmes and modules within subject areas are strategically reviewed and re-approved on a five-yearly cycle. The PSR process also ensures that all programmes and modules are aligned with the University's Strategic Plan and that all external requirements are met, particularly in relation to Quality Assurance Agency (QAA) Subject Benchmark Statements and the Framework for Higher Education Qualifications (FHEQ).

The panel, however, noted that the hierarchy of responsibility needed some more clarity, especially above the course teaching team. Although a hierarchy was in place, it was apparent that chains of command once outside the teaching team were not as clear as they could be. This raised some concerns around potential efficiencies should the need arise to escalate issues up this chain.

**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)***

As mentioned in Requirement 9, the panel was provided with a range of evidence to support the quality management framework currently in place. The panel was satisfied that this framework is working in practice. They agreed, however, that some improvements could be made in this area. The panel raised some questions around the utilisation and the degree of involvement of the External Examiner, such as potential for increasing communications and gauging comparisons between programmes and processes. Programme staff indicated that they are looking at exploiting the current links to address such areas as OSCE development. However, this utilisation could also be expanded for larger scale aspects including course development. The University may find it useful to employ a second External Examiner to gain further insight and knowledge whilst increasing the opportunities to share best practice with other providers. The panel would encourage this kind of information sharing and would be interested to see any future developments in this area.

**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 External Examiner produces annual reports which contain feedback on aspects of the programme and the programme as a whole. As previously mentioned in Requirement 10, the panel agreed that the University of Northampton could better utilise the relationship with the External Examiner to gather feedback about a greater range of programme elements, as well as developing stronger links with placement staff and University service user banks. The inspectors agreed that the provider would benefit from greater External Examiner involvement at summative assessments; ensuring external validation and more detailed external quality assurance for assessments.

Patient feedback is gathered as part of the student portfolio; however, the effectiveness of this exercise was questioned by the panel. This area has the potential to provide valuable feedback to enrich the student journey, but the amount of patient feedback gathered is nominal. The panel agreed that the provider should reconsider how best to gather effective patient feedback in order for it to have value for student development.

Whilst observing the OSCE, the panel discovered that the feedback mechanism in place for the service user was informal as communication was fairly constant, i.e. face-to-face conversations, in between OSCE's. As such, feedback may be toned down to preserve

relationships or simply because the simulated patient may feel uncomfortable. Where this type of communication may be beneficial in terms of building relationships, it may limit the depth of feedback which is received and, as a result, limit the effectiveness of the feedback received.

Due to the relaxed approach towards internal and external quality assurance that is evident currently within the programme, the panel agreed that this requirement is only partly met. The panel did, however, agree that some improvements in this area were achievable in the short-term such as utilising links already in place, for example with External Examiner resources and inter-departmental sharing of best practice.

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

As noted under Requirement 3, any placement locations outside a 50-mile radius are not subject to the same detailed audit process. This raises some uncertainties around progression planning and, in particular, how the programme will react to an increase in cohort size when the team eventually move to the 'Daventry' location. This report has already discussed the possible introduction of a risk-based RAG rating system when auditing placement locations; however other options such as compulsory placement training days or inductions must be considered.

Due to the potential risk attaching to the planned increase in future cohorts, the panel agreed that this requirement is only partly met. The current audit process for placement location is just about sustainable for this cohort size; however, the potential for a wider spread of student locations will carry too much risk and resource expenditure for the system in its current format.

**Actions**

| No | Actions for the Provider | Due date |
|---|---|---|
| Req 10 | The provider should explore the current relationship with the External Examiner and look to utilise links and relationships already in place. | Update required in 2018 Annual Monitoring |
| Req 11 | The provider must increase the minimum patient feedback numbers required to enrich the student experience. | Update required in 2018 Annual Monitoring |
| Req 11 | The provider must develop a formal feedback mechanism for the simulated patient in the OSCE assessment. | Update required in 2018 Annual Monitoring |
| Req 12 | The provider must revisit the current audit process and 'future proof' where possible. | Update required in 2018 Annual Monitoring |

| Standard 3– Student assessment<br>**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.** | | | |
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| **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. | ☐ | ✓ | ☐ |

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| 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 Partly Met)***

During the inspection, the inspectors were provided with a blueprinting document which outlined the links between learning modules and the GDC learning outcomes, showing where these are assessed across the programme. The teaching staff told the panel that they understood the importance of this type of document, but the panel note the absence of a central mapping document that could be updated as the programme progresses.

The inspectors were provided with examples of the Year 1 and 2 Practice Portfolios, NPR1011P and NPR2049P. These portfolio's contained module specifications, assessment structures, criteria, timing and strategy as well as aims for the module and learning outcomes which should be met upon successful completion. NPR1011P specifically contains three elements; Pre-clinical skills, Clinical skills and Interpersonal skills, which the inspectors agreed were essential elements to cover within the first year of the programme. The student portfolios were to be signed off as the student demonstrates progression in each area, however in practice sign off should be completed by a qualified GDP, DCP or agreed Practice Educator. Although the panel agreed that this process is sufficient to ensure that the students progression is being documented appropriately, some questions were raised around ensuring the security of signatures, as they observed some inconsistent signatures and also some blank areas in places. The panel also noticed that although the University's expectation of the Student Learning/Service Level Agreement is covered at the placement audit, there is no tangible contract or agreement of understanding in the student portfolios. This would ensure that both parties are aware of expectations and provide a basis for issues that might arise throughout the duration of the placement.

The panel was satisfied that the current range of assessment methods was acceptable under the programme's current model and size. However, the inspectors were doubtful that these methods would be transferable should a larger student cohort be recruited as planned. This would be particularly evident in the OSCEs; specifically reflected in strains put upon resources required to facilitate the increased numbers. Consideration should be made by reviewing the current and external staff resource such as lecturers and the external examiner. This would allow for a greater degree of externality in assessment and for multiple OSCE stations to run simultaneously, assessing a wider range of areas and allowing student to demonstrate their understanding of the learning outcomes.

Based on the evidence provided, the panel agreed that this requirement was partly met. They highlighted areas for improvement, however, the panel were confident that safe beginners were being produced.

**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)***

As outlined under Requirement 13, the panel saw evidence of blueprinting via a mapping document which linked the current modules to the GDC learning outcomes and showed where each outcome was assessed. The panel would like to see how the University develops this document as the programme develops. As also noted under Requirement 13, the student portfolio of evidence is present to track student progress however the provider must ensure that this is completed under the expected processes.

The inspectors were given a virtual tour of the NILE system, including where assessment performance is recorded in the system. This allows students to view their overall performance, broken down by module and also view comments from markers. The panel noted that the NILE system was a good example of an interactive learning environment and could see some of its features being used in a positive way which would benefit the students. It was also discussed that the use of e-portfolios and PebblePad could be an opportunity to drive change as part of the move to the Daventry campus. This would create a possibility for the NILE system to be further utilised for central recording where students could upload their progress, manage their information and increase security such as potential loss of paper portfolios.

The inspectors were advised that final grades are compiled in line with University policy, meaning that results were sent to a number of University Boards for discussion and processing before being distributed back to the students. The panel understood that this process is required in order to be to be compliant with University policy; but raised further questions around moderation and highlighted the importance of a robust marking structure. Within this process, exceptional circumstances and intermediate awards are considered and confirmed before final reports are created. These reports are then made available to the University Records team and subject/course leaders for review to further confirm accuracy. Once agreed by course leaders, the reports are sent to the Standing Board Panel which includes the External Examiner and Chair for final approval; at which point Award Letters and result outcome emails are sent out to the students. However, the inspection panel were unable to attend and view this process due to data protection concerns and so could not be assured of its impact in practice.

**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)***

As previously mentioned in Requirements 13 and 14, the panel was provided with evidence of blueprinting which demonstrated that students are exposed to all the GDC learning outcomes across the length of the course.

The panel visited some of the placement locations in order to view the facilities and speak with some of the lead staff in these locations. The panel agreed that the placements offered a good breadth of experience, including within the Oral and Maxillofacial Surgery department at Northampton General Hospital. The panel noted the range of experience it provides and the large spectrum of patients and situations that are available as a result.

**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 Not Met)***

The recent Performance Summary Report (PSR) for the programme states that the range of assessments is good, a statement that the panel agreed with. The panel would like to see the University make the best use of the resources and opportunities by drawing upon the wider range of individuals available to assess the students such as current staff, visiting lecturers and other internal staff within the faculty of Health and Society. The panel agreed that this would increase the impartiality and efficiency of assessment methods. The University may also wish to embrace the opportunity to reach out and create stronger links with other dental nursing courses as well as utilising the potential link with Cardiff University via External Examiner associations.

Based on the evidence provided, the panel considered the assessment methods were broadly fit for demonstrating coverage of learning outcomes; however, it was found that the assessment strategy, reliability and validity of the assessments required improvement. The inspectors agreed that developments in this area must be explored for the next cohort.
The OSCE used in the final assessment was developed in 2009 and has remained relatively unchanged ever since. The panel appreciated that this may have been suitable when developed, but noted that assessment practice had moved on since and that this current model is not structured in the same way that a typical OSCE normally would be. The inspectors agreed that assessment methods have advanced and that a typical OSCE has multiple stations and student running simultaneously, with a marking criterion that can be followed objectively. The School used a pass mark of 80% within this assessment; the justification of this pass mark was unclear. The panel noted that the weighting of marks left little room for distinguishing between satisfactory, good and excellent performance.

The panel spoke with the recently appointed Head of Health Professions, who had extensive experience in assessment design. The panel agreed that his experience would be valuable in the development of future assessment strategies which would be necessary with the potential increase in future cohort size.

Based on the evidence provided, the panel agreed that this requirement was not met as significant development in this area was needed. The OSCE, for example, would greatly benefit from development for future cohorts, including a focus on setting appropriate standards to pass (see Requirement 21, below). The University could explore the utilisation of current resource in order to alter the current practical examination and move towards running simultaneous OSCEs. With more options in terms of assessor selection, the team could increase the distance between the module lead and the student; therefore, promoting externality and releasing current resources to concentrate on such activities as Quality Assurance and monitoring. Also, the panel strongly advise that the marking criteria is revisited in order to look at the weighting of questions and also the distinction between grades. The University should review the standard setting procedure behind this in order to identify feasible improvements in this area. The inspectors also identified the opportunity to widen the assessment methodologies and knowledge through communications with other providers. If relationships can be established with other providers, then it may be possible to establish a working relationship and an opportunity to share knowledge and best practice.

**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 Partly Met)***

The GDC requires that assessment feedback should be gathered from a range of sources so

that a range of views of student performance are considered. Evidence provided showed feedback was gathered from patients. However, students need only to obtain feedback from one patient, which is low. Obtaining feedback from multiple sources is valuable for student development and should not be seen as a minimum requirement and students should be encouraged to be gathered this at every opportunity. Feedback at this stage of development can be crucial and will provide a real insight into a student's performance and progress.

Regarding the OSCE, the feedback from the simulated patient directly affects the final mark for the assessment and is a possible 'fail' section. This is acceptable considering the importance of the simulated patient in the assessment. However, the simulated patient is not briefed in great depth or provided with a marking guide to promote consistency. A brief was given to the simulated patient prior to the commencement of the OSCE, via email, but this only addressed the dialogue throughout the assessment. The panel saw this as an area that should improve for the assessment of the next cohort. Based on the evidence provided, the panel were in agreement that this requirement had been partly met; however, future improvements are expected.

**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 panel were pleased to see that feedback was being given to the students within assessments although would encourage increases in volumes of patient feedback. The NILE system enabled assessors to make comments alongside marking, so that students could understand where their answers need improvement and where they have answered particularly well. The panel also noted Mentor feedback in the portfolio.

Although the panel were content that the appropriate evidence had been provided that demonstrated that this requirement was met, they were made aware of a situation where students had requested feedback on a mock exam and that this was not distributed. The students felt the need to voice this to the panel. The teaching staff explained to the panel why specific feedback from mock assessments could not be shared.

**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)***

The panel were provided with evidence of GDC registration for all key teaching staff as well as confirmation that they were currently working in practice, and so continuing to obtain CPD throughout the weeks, alongside their teaching. The panel also discussed the importance of ensuring calibration across the teaching staff in order to ensure that marking schemes are adhered to and distinctions between grades are clear.

The panel were assured that key teaching staff had received appropriate E&D training in respect to the assessment role. This training is organised by the University with support staff also offered the same training. With regards to placement locations, handbooks and guidance are provided for locations as part of the audit process and, if part of an NHS trust, E&D training is in any case compulsory.

The CV of the OSCE simulated patient was provided, with oral assurance given that this could be evidenced for all of their bank of service users within the University. The panel was also informed that training and qualifications are offered to the service users through the University.

Based on the evidence provided, the panel were assured that assessors and teaching staff

held the necessary registration, qualifications and appropriate skills and knowledge to assess effectively and fairly. Although the panel agreed that this requirement had been met, they did see opportunities for development. The programme also has a good pool of knowledge amongst visiting lecturers which could be tapped into and utilised more effectively. This could widen the pool of knowledge and bring in some impartial assessors outside the direct dental team, which would also free up the team's time for other activities.

**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 Partly Met)***

The panel met the External Examiner and discussed the assessment methodologies used. The latest External Examiner report is pending; however, the panel were provided with reports from previous years. The University also provided the panel with policies which stated the responsibilities of the external examiner. The University must ensure that these responsibilities are being carried out, the expected requirements met, and the best being made of the external examiner's involvement. The panel agree that stronger communications and links with the external examiner would be beneficial to both the teaching team and the programme as a whole. As noted in Requirement 11, the inspectors agreed that the provider would benefit from greater External Examiner involvement at summative assessments; ensuring external validation and more detailed external quality assurance for assessments. The inspectors were informed of some missed opportunities between the provider and External Examiner, for a variety of reasons such as availability issues. However, both the provider and the External Examiner must ensure that every effort is made to be present at summative assessments in order to ensure external validity and fulfil expectations of the External Examiner role. This involvement is important for the students and course development.

**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 Not Met)***

The panel was not provided with any evidence that formal standard setting processes were used within the programme. The panel discussed the importance of standard setting with the Head of Health Professions, who expressed the opinion that standard setting was not possible with such a small cohort; something that the panel did not agree with. The panel noted that arbitrary passing thresholds were set for summative assessments without reference to the relative difficulty of that assessment, and strongly recommend that the University revisit their stance on this area.

Whilst observing the OSCE assessment, the panel saw evidence of moderation taking place after the assessment. The OSCEs are also recorded using the LifeCam system which the panel found extremely useful and allows the assessors to revisit the OSCE should any discrepancies arise between markers.

The panel noted that the marking scheme was detailed but found the assessment design to be questionable. This included weighting of questions and the relative fairness to students. The marking scheme stated that the pass mark for the OSCE is 80% which equates to a D-, or a base line pass. There was no evidence provided that demonstrated how a score of 80% was appropriate for the pass mark and as previously mentioned in Requirement 16, this could make distinguishing between students difficult to achieve. Although this confusion was apparent, the teaching team clearly had an awareness of the expected standard throughout.

| Based on the evidence provided, and mainly on the lack evidence that appropriate standards had been set for summative assessments, the panel's view is that this requirement is not met. | | |
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| **Actions** | | |
| **No** | **Actions for the Provider** | **Due date** |
| Req 13 | The provider must ensure that a signed Student Learning/Service Level Agreement is present in the student portfolios. | Update required in 2018 Annual Monitoring |
| Req 14 | The provider must ensure that the assessment grading processes are available for both internal and external scrutiny, where necessary. | Update required in 2018 Annual Monitoring |
| Req 16 | The provider must develop and improve the reliability and validity of assessment methods including weighting of marks and distinction between students. | Update required in 2018 Annual Monitoring |
| Req 17 | The provider must provide the simulated patient with a formal marking guide and brief, alongside the feedback action stated in Requirement 11. | Update required in 2018 Annual Monitoring |
| Req 19 | The provider should widen their pool of knowledge and utilise current links within the University such as visiting lecturers for assessments. | Update required in 2018 Annual Monitoring |
| Req 20 | The provider must ensure that the role of the External Examiner is being fulfilled in order to ensure the quality of the programme. | Update required in 2018 Annual Monitoring |
| Req 21 | The provider must revisit the current stance on Standard Setting in a small team. | Update required in 2018 Annual Monitoring |
| Req 21 | The provider must review the marking structure within the OSCE assessment. | Update required in 2018 Annual Monitoring |

## Summary of Actions

| Req. number | Action | Observations<br><br>Response from Provider | Due date |
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| Req 3 | The provider should implement a RAG (or similar) system for placement locations | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. At present the university operates a RAG system; red, amber and green as part of the clinical audit process. However, learning opportunities outside of a fifty mile radius will now be subject to audit and long arm mentoring. | Update required in 2018 Annual Monitoring |
| Req 5 | The provider should ensure that evidence of registration and E&D training be collected annually as part of the audit process. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. All registrants involved with the sign off of the students' portfolio are asked to complete a witness status list with their GDC registration number and a sample of their signature which is kept in the students' portfolio this is updated in each placement throughout the two year's. A register of equality and diversity training is kept by the practice educators and updated every year as people drop off and come onto it. | Update required in 2018 Annual Monitoring |
| Req 10 | The provider should explore the current relationship with the External Examiner and look to utilise links and relationships already in place. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. The university has explored the relationship with the external examiner and suggested that the external examiner is present for at least one of the summative assessment during an academic year. | Update required in 2018 Annual Monitoring |

| Req 11 | The provider must increase the minimum patient feedback numbers required to enrich the student experience. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. For this academic year patient feedback will be gathered from every placement and this will be initiated by the assessor not the student. | Update required in 2018 Annual Monitoring |
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| Req 11 | The provider must develop a formal feedback mechanism for the simulated patient in the OSCE assessment. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. The service user will be subject to observed moderation and receive feedback in relation to their assessment and comments made to ensure rigorous moderation of the case based assessments. | Update required in 2018 Annual Monitoring |
| Req 12 | The provider must revisit the current audit process and 'future proof' where possible. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. Discussions between the practice educators are to take place if placements out of the 50 mile radius are to be sourced if the cohort grows in size and will now be subject to audit and long arm mentoring. | Update required in 2018 Annual Monitoring |
| Req 13 | The provider must ensure that a signed Student Learning/Service Level Agreement is present in the student portfolios. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. The dental team will design a student learning agreement that must be signed by the student and their placement provider for each placement and the overall service level agreement which is signed at the beginning is also scanned into their portfolio. | Update required in 2018 Annual Monitoring |
| Req 14 | The provider must ensure that the assessment grading processes are available for both internal and external scrutiny, where necessary. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. Following staff development with the learning development team the portfolios' will be assessed using a rubric. The rubric will be available on NILE and in that way it | Update required in 2018 Annual Monitoring |

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| | | is evident and available to all. | |
| Req 16 | The provider must develop and improve the reliability and validity of assessment methods including weighting of marks and distinction between students. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. Following a review of the clinical assessments it has now been decided to change from OSCE to clinical simulated tests with a pass mark of 40% in line with the university's under graduate assessment framework. A rubric will be developed to enable marking to distinguish between a satisfactory, good and excellent performance. | Update required in 2018 Annual Monitoring |
| Req 17 | The provider must provide the simulated patient with a formal marking guide and brief, alongside the feedback action stated in Requirement 11. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. A tool will be created to provide a formal marking guide for the simulated patient. | Update required in 2018 Annual Monitoring |
| Req 19 | The provider should widen their pool of knowledge and utilise current links within the University such as visiting lecturers for assessments. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. Visiting lecturers and practice educators have been invited to be part of the summative assessments of the clinical simulated tests. Training on assessments and awarding marks using a rubric will form part of the process. | Update required in 2018 Annual Monitoring |
| Req 20 | The provider must ensure that the role of the External Examiner is being fulfilled in order to ensure the quality of the programme. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. The external examiner will have the opportunity to sample all summative assessments including practical assessments throughout the academic year and provide verbal and written feedback to the team and university on the assessment process. | Update required in 2018 Annual Monitoring |

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| Req 21 | The provider must revisit the current stance on Standard Setting in a small team. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. To expand the wider knowledge base visits to Cardiff university to view their clinical assessments have been agreed. | Update required in 2018 Annual Monitoring |
| Req 21 | The provider must review the marking structure within the OSCE assessment. | We welcome this recommendation, and have already made progress in addressing some aspects of the recommendation. In line with change of approval the OSCE will be replaced by clinical simulated test, new rubrics will be developed to enable the students to achieve satisfactory, good and excellent performance. | Update required in 2018 Annual Monitoring |

## Observations from the provider on content of report

| The dental team at the University of Northampton welcome the recommendations posed by the GDC and are already in the process of addressing them. Progress of this will be included in the 2018 annual monitoring exercise. |
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## Recommendations to the GDC

The inspectors recommend that this qualification continues to be approved for holders to apply for registration as a Dental Nurse with the General Dental Council.

The School must provide detailed information regarding how they have met, or are endeavouring to meet, the required actions set down in this report in the 2017/18 academic year.