

General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
Teesside University	BSc (Hons) Dental Hygiene and Dental Therapy	3 & 4 December 2019 (programme) 10 July and 14 August (post-inspection panel meetings)

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

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

Inspection summary

Remit and purpose of inspection:	Inspection referencing the <i>Standards for Education</i> to determine approval of the award for the purpose of registration with the GDC as a dental hygienist and dental therapist. Risk-based inspection focusing on Requirements 1, 4, 5, 6, 7, 9, 11, 12, 13, 14, 15, 17, 19 and 21
Learning Outcomes:	Preparing for Practice dental hygiene and dental therapy
Programme inspection dates:	3 and 4 December 2019 (1.5 days)
Examination inspection date:	Post-inspection panel meetings held 10 July and 14 August 2020
Inspection team:	Eileen Skinner (Chair and Non-registrant Member) Joanne Brindley (DCP Member) Mohammad Khalid Mushtaq (Dentist Member) Jackie Spencer (GDC staff member) Kathryn Counsell-Hubbard (GDC staff member)

The BSc (Hons) Dental Hygiene and Dental Therapy programme (“the programme”) offered by Teesside University (hereafter referred to as “the provider”) is led by a team of enthusiastic and invested professionals. Steps have been made to strengthen the safety aspects of the programme following a pre-inspection meeting in June 2019. This meeting was triggered by information provided as part of a regular monitoring exercise and related to staffing levels and the supervision of students.

The team has undoubtedly worked hard to resolve the issues highlighted by the GDC in 2019. A full update on the action plan given to the GDC at that time was provided at this inspection. A greater range of requirements were examined during this inspection to ensure that the programme continues to produce safe beginners.

Supervision remains an issue for the programme (detailed under Requirement 4). The student experience requires some work to be considered equitable. The panel generally experienced difficulty obtaining a sufficient amount of evidence to be able to reach conclusions. This coupled with evidence of incorrect marking of assessments led to the panel deciding to observe the assessment board meeting in June 2020. Unfortunately, this visit could not take place due to COVID-19 restrictions and consequently a paper-based assessment was completed by the panel in July and August 2020.

The panel left the School with the belief that the issues highlighted can be rectified and that the main issues were mitigated by a content student base providing vital work to the

community. The investment of time and resource from those senior to the programme team at the University should assist in meeting the actions detailed in this report.

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

Background and overview of qualification

Annual intake	24 students
Programme duration	107 weeks across 3-year duration
Format of programme	<p>Year 1:</p> <p><u>Theory</u></p> <ul style="list-style-type: none"> - anatomy and physiology -dental prevention and oral health promotion -foundations in dental care (health, safety and security within the workplace, legislation, GDC standards) -evidence based practice <p><u>Clinical</u></p> <ul style="list-style-type: none"> -simulated clinical skills (periodontal, LA & Preventive treatments) -commence restorative skills towards the end of the year in simulated environment -shadowing (peer learning) on clinic -direct contact with patients following gateway assessment in periodontal and preventive treatments and LA (onsite facility) <p>Year 2</p> <p><u>Theory</u></p> <ul style="list-style-type: none"> -periodontal and oral diseases -development in evidence-based practice -dental radiology and radiography -theory of restorative dentistry (adult and paediatrics) <p><u>Clinical</u></p> <ul style="list-style-type: none"> -simulated clinical skills development (restorative skills) -shadowing (peer learning) on clinic -direct contact with patients following gateway assessment in restorative management (onsite facility) -continuation of direct contact with patient periodontally (onsite facility) -radiography 5-day placement (dental hospital radiography dep't) <p>Year 3</p> <p><u>Theory</u></p> <ul style="list-style-type: none"> -management of complex cases (dental diseases and systemic diseases incorporating risk management and treatment planning for elderly & paediatric care) -dissertation -leadership and management skills <p><u>Clinical</u></p> <ul style="list-style-type: none"> -simulated clinical skills development (final complex restorative skills within SoP) -continuation of direct contact with patients with full SoP (onsite facility & external placements)
Number of providers delivering the programme	N/A

Outcome of relevant Requirements¹

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

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

Standard 1 – Protecting patients

Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.

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

The evidence provided demonstrated adequate assessments on the appropriate subjects to constitute an effective clinical gateway. However, the robustness of the gateway was undermined by a limited amount of assessment data being presented to the panel. One example provided within the available data showed an error in the marking of the assessment.

Difficulty in obtaining the relevant data to make fully evidenced decisions was a theme throughout the inspection. Whilst the programme team responded to requests for documentation, the information provided was limited in volume or was only provided after numerous requests. Based on the limited amount of assessment data seen, both in evidence for this requirement and others, the panel made the decision to return to the School for the Assessment Board meeting where the full range of assessment data would be provided.

Due to the lockdown imposed in response to the Covid-19 pandemic, the second part of the inspection relating to the Assessment Board was cancelled. The amount and type of information that could be provided remotely by the provider was limited.

Based on discussions with the provider, gateway assessments appear to be effective at separating those students who are ready to progress and those who need to gain additional competence. There was no evidence, either from staff or students, that students attended clinical areas without being properly prepared.

A high number of patient safety incidents were reported. As a result, this issue combined with inadequate documentary evidence of a robust gateway assessment meant that the panel could not consider this Requirement to be 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)

The panel were keen to address the issue of clinical supervision, particularly staff-to-student ratios. The programme team provided an informative presentation and updates on the action plan following the pre-inspection meeting in June 2019. The School clearly demonstrated that it had taken the GDC's concerns on board and had made great efforts to rectify clinical supervision ratios after a period of staffing instability.

However, it does not appear that the student and patient experience is being prioritised. Despite evidence of steps being made to increase the numbers of supervisory staff on clinic, the panel observed students sitting on clinic studying instead of treating patients. This was apparently because several patients had been rearranged due to staff sickness. Whilst the School was able to rearrange these patients without cancelling them at short notice, at least two members of staff who have the clinical abilities to supervise were present in the inspection meeting. The panel were concerned that those members of staff had attended the inspection meeting as opposed to being allocated to the clinical floor.

Those students with patients who had been rearranged were required to study in the clinical area. The panel was critical of this as the clinical area is not necessarily suited to studying, and an element of supervision would still be required to ensure the students' safety in a clinical setting. Further, these students were denied the opportunity to develop skills and knowledge and gain experience through treating patients.

We considered this requirement is partly met. The panel found that work is still required to ensure constant, effective supervision which is the priority of the programme team. The programme team must continue to evaluate supervision plans in place and should also find an alternative activity for non-operative and non-assisting students rather than studying in an operative area.

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)

Within this requirement, the panel specifically looked at staff training and the recording of such training. A University procedure is in place that governs the completion and recording of staff training, and follow-ups with staff if such training is not completed. Evidence from members of staff was provided and consequently the panel found this Requirement to be 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 were impressed with students' knowledge and understanding about raising concerns. This is introduced at the beginning of the programme and included within an exam at week three. The School are to be commended for instilling such an entrenched understanding of the need for raising concerns and candour. The Requirement is 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 Partly Met)

At the inspection, the process for dealing with patient safety incidents was explained. The GDC met with the School in June 2019, at which point such incidents were discussed. As a result, a flowchart has been introduced to govern how an incident should be recorded and followed up. Risk is utilised in several ways, including the use of a risk register and students complete a risk assessment prior to commencing treatment on a patient.

Evidence was provided demonstrating the use of the updated patient incident process. This showed the recording of incidents and dissemination of advice to students via email. However, it did not provide evidence of learning, such as from student tutorials, team meetings or updates to the programme to ensure that any such issues would be avoided in future. The panel recognised that the process is relatively immature in terms of when the flowchart was introduced and implemented but it was not satisfied that this is currently a joined-up, cohesive system

The panel was satisfied as to the recording of incidents and consideration of risk, but the dissemination of learning and evidence of changes made to the programme as a result of any incidents was not provided. The programme team advised that changes would be implemented if necessary. The Requirement is therefore found to be partly met at this stage.

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)

A cohesive quality management structure was evidenced to the panel. Both programme and school-level groups are in place with individuals sitting across both levels to ensure issues are escalated or disseminated appropriately. The formal processes are also supported by team meetings amongst the programme leads and weekly huddles on clinic.

The panel was content that a framework is in place although we noted that the repeat membership of individuals across different groups could also be detrimental, particularly in relation to unexpected absence and succession planning. Overall, however, the panel found this Requirement to be met.

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 programme leads were open in acknowledging that they struggle with areas of this requirement. The programme's processes were reviewed in summer 2018 when it joined the School of Health and Life Sciences and some changes were made as a result. The programme is also subject to the University's periodic review process.

An external examiner is utilised, but the panel saw limited evidence of the programme leads responding to suggestions made by the external examiner, for example, regarding the use of multiple case studies and the difficulty of standardisation as a result. The templates used by external examiners to report on the quality of the programme were felt by the panel to be narrow in scope. The use of tick boxes did not appear to encourage detailed commentary, as the reports provided to the panel were sparse in detail.

Additionally, the panel did not see any evidence of feedback, from any source, being used to develop the programme nor was the claim that feedback is gathered from 100% of patients corroborated by the students.

To meet this Requirement, the programme leads must develop better mechanisms to record changes to the programme including the provenance of those changes. External examiner report templates must encourage detailed commentary on the programme and must be responded to formally in a timely fashion. There should be a clear audit trail and records such as meeting minutes must be kept documenting whether suggestions from the external examiners have been accepted or not, and the reasons for this.

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)*

Generally, the panel was content that this requirement was largely met. The provider has a formal audit process to ensure the ongoing suitability of placements and there is good communication between staff at the placements and the programme leads. Students reported that they enjoy the placements.

Evidence of patient feedback was not provided, however, as this is given directly to the students. Students are expected to share this with the provider but there is no mechanism in place to ensure that this happens. The panel was concerned at the potential for students to withhold critical feedback and therefore found the requirement to be partly met. The provider must introduce an alternative method to gather patient feedback is gathered on outreach placements to ensure that it is directly shared with and retained by the School itself.

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 Partly Met*)

Within this requirement, the panel specifically looked at the sign-up to final assessments and clinical experience.

Year Three of the programme contains the Dental Hygiene & Therapist Clinical Development clinical module which culminates in three components: consideration of competencies and two viva voce exams. The sign-up process to the final exams involves the module team meeting with students and reviewing not only the clinical competencies but also their professionalism. The team uses a red, amber, green (RAG) rating system to determine which students are fit to sit the final exams, and action plans are drawn up for those students rated as red.

The action plans were seen to be an element of good practice within the sign-up process. However, the action plans and final experience numbers highlighted an issue in the timing of the sign-up process. Many students had low levels of experience in areas such as paediatrics quite late into their final year. While all students had their clinical experience cut short due to COVID-19, the national lockdown was not imposed until late March, by which point students should have completed the core amount of the required skills. The fact that multiple students still had key experience to gain by this point of their final year indicates an issue with the sign-up process and ongoing monitoring.

Gaps in experience should be identified earlier in the year so that students are not subject to undue pressure in the final stages of their programme. Identifying gaps earlier would also allow the programme team to implement effective remediation processes far earlier. The panel accepted the unprecedented pressure on the programme team to assess students in paediatrics in a simulated environment due to the national lockdown but were not satisfied that the assessment utilised for the current Year Three was effective enough to counteract the lack of patient experience (covered in more detail under Requirement 21).

Considering the clinical experience itself, the panel saw that the provider utilises a grading scheme that marks student interactions with patients as a whole. Because the entire encounter is marked together, different components can compensate for each other. For example, exemplary communication could increase the grade although the clinical elements may be graded as barely competent. This method of grading not only lacks detail that is vital to students to assist them in improving their practice but also does not allow for a true record of the student's ability to be recorded.

Overall, the panel had trouble in extracting the detail from evidence provided, either concerning the accurate grading of students or what final numbers actually represented, in terms of competency, from the clinical recording system, ARC.

The Requirement is found to be partly met. The programme team must review the grading system for patient interactions, explore bringing the sign-up process forward and introduce measures for the ongoing review of student experience to ensure gaps in experience and/or competence are identified early, particularly in Year Three.

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 School utilises the ARC recording system for clinical interactions with patients. The students are graded by the clinical supervisor and data can be extracted to create management reports for the entire cohort. The system is purely for the clinical environment and does not serve as a management system whereby student attendance can be managed. Due to that, several students were noted as having deficiencies in their attendance during the meeting for the sign-up to final assessments. Identifying such an issue at a late stage in Year Three, particularly when this could constitute a professionalism issue, is a significant defect in the monitoring process of student experience and attainment.

The lack of a formal recording for the attendance of students on clinic was also a concern to the panel. It was not felt to be appropriate for students to self-report their attendance on clinic and should comprise one of the responsibilities of the clinical supervisor. The notion of students having to collate data for personal tutor meetings was also found to be poor practice due to the opportunities this would present to unscrupulous students. This also does not allow at-a-glance monitoring of students, which feeds into wider issues of attendance and the late identification of gaps in experience (detailed under Requirement 13).

The panel considered the central recording systems lacked cohesion and could potentially allow information to be lost. Student portfolios were due to be reviewed as part of the second inspection visit which was not possible to complete. While it is accepted that the portfolios may have provided additional information relevant to this Requirement, in their absence the panel can only find the Requirement to be partly met based on the evidence that it was possible to review.

Requirement 15: Students must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes. (Requirement Partly Met)

The documentary evidence considered by the panel was insufficient to demonstrate that this Requirement is met. There is notable disparity in the levels of experience amongst the current Year Three cohort.

Paediatric experience is a concern (as highlighted under Requirement 14). Some students had not met the minimum procedures indicated for various paediatric procedures. A simulated assessment had to be implemented to enable those students to meet the standards required of the programme and to graduate.

The panel noted there was disparate and/or low levels of experience in multiple procedures. The final clinical numbers provided for the current Year Three cohort demonstrated that the experience was not equitable across the student group. Some students had up to three times the amount of experience in some procedures, or groups of procedures, as their colleagues. Such a disparity could indicate an issue with the way in which the clinical recording system is utilised, and this must be investigated by the programme team.

The Requirement is partly met.

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 Partly Met)*

Feedback about the assessments in the programme is captured within a system called Evasys. Students provide feedback mid-module directly on the system and will include assessment-specific feedback depending on when the assessments take place.

The external examiner has the opportunity to provide assessment feedback both directly to the module leader and to the assessment boards.

Feedback from other sources is limited. Peer feedback from the wider dental team is not formally sought or recorded. Although patient feedback is obtained, the panel identified a discrepancy in that the programme team stated that 100% student feedback is gathered yet this was not corroborated by students at the inspection.

The panel found the evidence overall to be limited. A variety of feedback was not demonstrated. This requirement was therefore found to be partly met.

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

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

The panel was provided with evidence of clinical supervisor training. Guidance is available for marking students and all outreach staff are invited to the University for training. We saw a comprehensive training programme for new members of staff examining students was evidenced as well as a checklist for annual staff training.

The panel found this Requirement to be met.

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 Partly Met)*

A range of marked assessments were due to be reviewed during the second inspection visit. As the visit was cancelled as part of the COVID-19 lockdown, the panel only saw limited amounts of data.

Examples of marked summative assessments were provided at the programme inspection. Unfortunately, out of the small sample provided, one of the assessments was marked incorrectly. Examples of marked assessments for the simulated paediatric assessment utilised for some of the graduating cohort were provided and reviewed by the panel.

The assessment comprised an open book examination and examples of the student's experience with paediatric patients, including feedback sheets following those interactions. The panel was concerned by the lack of detail in the feedback sheets. For example, tick boxes are utilised for the clinical supervisor to indicate their grade for various parts of the treatment. The treatments, however, are grouped together broadly, so that everything to do with restorative treatment is grouped together.

Such grouping together does not allow the person providing the feedback to comment on individual aspects, such as preparation, approach, posture, and other elements which are important in the decision as to whether that element of treatment was adequate or poor. The feedback is therefore of limited value to the student and does not allow anyone reviewing the student's portfolio, assuming that this is where such feedback is kept, to build an accurate picture of a student's strengths or potential areas for improvement.

The panel could not be assured the Requirement is met based on the information provided. Inaccurate marking and lack of detail in the assessment paperwork providing remotely do not evidence that clear criteria are in place or that is a cohesive standard applied to assessments. The provider must improve both their recording and marking of summative assessments to ensure that anyone who needs to review such data, such as external examiners or University auditors, have a clear picture of how students are assessed and how they are performing.

Based on the evidence reviewed to date, the Requirement is partly met.

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
11	The provider must implement a mechanism for recording changes to the programme and from where such changes originate.	<p>Mechanisms for change exist through the University QA process.</p> <p>Any changes that are implemented to enhance the course based on feedback from any source must go through the QA process.</p> <p>The team will ensure that any such change is clearly recorded, documenting the stimulus for the change.</p>	Inspection 2020/21
11	The provider must encourage more detailed reports, including a review and possible expansion of the report template, and respond to external examiner reports in a timely fashion.	<p>The External Examiner report is a standardised document used by all External Examiners across Teesside University. The deadline to responding to External Examiner reports has always been met.</p> <p>In future, more detail will be encouraged from the External Examiner in their reports. Where actions or suggestions for development are identified by the External Examiner, views will be taken on board and acted upon where possible. The decision process behind changes based on comments will be clearly documented.</p>	Inspection 2020/21
11	The provider must record their response to suggestions for change in the external examiner report.	Any response to suggestions is always recorded in the final report. This was demonstrated in the 2018/19 EE report where the response to the External Examiner comments highlighted that suggestions were discussed and considered in relation to the DEN3005-N viva voce. These suggestions were in fact actioned for the 2020 vivas.	Inspection 2020/21
13	The provider must review the way in which patient interactions are graded to ensure that one element of an assessment does	We are in agreement that the recording of clinical procedures can be developed into a more coherent system. We have contacted other training	Inspection 2020/21

	not compensate for another area in which the student is not competent.	establishments to look at their recording systems and are keen to learn improved ways of monitoring our students' clinical experiences. We are in the early stages of developing a more comprehensive system that we hope to be able to share with you on your return. The proposal is for the system to enable a more detailed monitoring of specific clinical skills such as caries removal, matrix band placement, cavity design etc. This will give much more detailed and reliable evidence on student progress and will remove the opportunity for grading to compensate for one area over the other.	
13	The provider must review the ongoing monitoring of students to ensure that they are getting the appropriate level of experience to a competent level throughout the programme. The process for signing-up students to final assessments must also be considered at an earlier stage so that students do not enter the final stages of Year Three with significant experience gaps.	Monitoring of students already takes place at regular intervals. However, with an enhanced electronic recording system (as mentioned in the row above) the monitoring of students will be a more robust process. The team take on board comments to bring the sign-up process forward and will be factoring this in to plans for subsequent final year cohorts.	Inspection 2020/21
14	The central recording system must be reviewed and, if possible, a joined-up system that removes the need for students to record their own attendance, introduced.	The team take on board comments for self-recording attendance on the Student Dental Facility. The clinical supervisors do countersign the attendance register; however, the team will look towards a more robust system for the recording of attendance at clinical sessions.	Inspection 2020/21
15	The provider must review the student experience and introduce measures to ensure a more equitable experience across a student group. Measures to improve the students' experience with paediatric patients must also be introduced.	With the introduction of an enhanced electronic recording system it is the intention of the team that the monitoring of students will be a more robust process. The proposal is for the system to enable a more detailed monitoring of specific clinical skills such as caries removal, matrix band placement, cavity design etc. With this system in place, it will identify gaps in	Inspection 2020/21

		<p>student experience to allow the team to redistribute upcoming experience to those in need.</p> <p>Progress had been made in 2019/20 to improve paediatric experience for the graduating cohort which unfortunately could not take place due to COVID-19. In 2020/21 we are contingency planning as a result of COVID and the subsequent reduced student/patient contact. Our plans are in alignment with other training facilities nationally and they will be discussed with the GDC through the GDC COVID-19 provider update.</p>	
17	The provider must introduce methods to gather and record feedback from multiple sources. The recording of this must demonstrate where the feedback was obtained and how it has been used by the programme team.	<p>The team recognise that the recording of feedback from a variety of sources can be enhanced.</p> <p>This will form part of our action plan in moving forward.</p>	Inspection 2020/21
21	The provider must review their assessment strategy and supporting documentation to ensure that appropriate regulations are being adhered to for marking assessments and that documents capture the information required by both those within and external to the programme.	<p>At the inspection, one of the examples of the feedback sheet given contained an administrative error. Assurances were given at the time that the student concerned was under no illusions that he had failed the assessment. The student followed the process for any student who fails a clinical skills assessment including tutorial support and extra simulation sessions in the lead up to the reassessment. This was an unfortunate anomaly and not at all usual in our assessment process.</p> <p>The marking of clinical work will be included into an action plan of points for development in the course. We have contacted other training establishments to look at the marking systems they use for every patient contact and we are keen to develop a more robust system that grades each aspect of the appointment. This will allow a more coherent monitoring process of student</p>	Inspection 2020/21

		<p>development, identify gaps in learning and intervention when necessary.</p> <p>To align internal and external supervisor marking and feedback, a new mentorship course has been developed and will be delivered prior to placements and clinics reopening. One of the focuses of the training is to standardise feedback across the supervisors both internally and externally.</p>	
--	--	--	--

Observations from the provider on content of report

Refer to guidance

- Requirement 4 - 'However, it does not appear that the student and patient experience is being prioritised. Despite evidence of steps being made to increase the numbers of supervisory staff on clinic, the panel observed students sitting on clinic studying instead of treating patients. This was apparently because several patients had been rearranged due to staff sickness. Whilst the School was able to rearrange these patients without cancelling them at short notice, at least two members of staff who have the clinical abilities to supervise were present in the inspection meeting. The panel were concerned that those members of staff had attended the inspection meeting as opposed to being allocated to the clinical floor.'

Provider response: The comment relating to redeploying clinical staff away from the inspection and towards the clinic seems unreasonable. The two members of staff wanted to fully support the GDC inspection and as noted absence played a part in staffing on that day. If the staff had redeployed to clinic, it was the University's position that we would not be supporting the inspection appropriately.

- Requirement 11 & 17: 'Additionally, the panel did not see any evidence of feedback, from any source, being used to develop the programme nor was the claim that feedback is gathered from 100% of patients corroborated by the students.'

Provider response: There was a discrepancy in that the panel have stated the team's claim that 100% patients provided feedback. The team would like to clarify that we do not gather feedback from 100% patients. This was not claimed nor corroborated by the team during the inspection and the panel's statement is not factually correct. As discussed at the inspection, 100% patients have the opportunity to complete

comments cards, but not every patient takes up this opportunity. We do carry out 360-degree feedback forms as well as the comments cards and these are used as evidence towards student competencies. This is not every patient but reserved for learning opportunities that relate to the competencies.

- Requirement 14: 'The School utilises the ARC recording system for clinical interactions with patients. The students are graded by the clinical supervisor and data can be extracted to create management reports for the entire cohort. The system is purely for the clinical environment and does not serve as a management system whereby student attendance can be managed. Due to that, several students were noted as having deficiencies in their attendance during the meeting for the sign-up to final assessments. Identifying such an issue at a late stage in Year Three, particularly when this could constitute a professionalism issue, is a significant defect in the monitoring process of student experience and attainment.'

Provider Response: Student attendance is closely monitored throughout the course via the School's attendance monitoring system. Students also complete clinical timesheets in line with University Protocol. These are submitted monthly and added onto a clinical attendance log spreadsheet by the dental team. These were made available to view at the inspection. The results of each of these mechanisms are fed through to regular team meetings. These processes were discussed in the inspection.

Where a student is identified as being low in clinical hours, opportunities are identified for those students. Where attendance is highlighted as a professionalism issue, the University processes would be followed. This was not however the case in any student from the graduating cohort.

Recommendations to the GDC

Education associates' recommendation	The qualification continues to be approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council
Date of reinspection	Due to the cancellation of the second inspection visit in 2019/20, an additional inspection will take place in 2020/21 which will assess action taken in response to the actions of this report as well as reviewing progress against the 2019 action plan.

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.

