

**Education Quality Assurance Inspection Report**

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| Education Provider/Awarding Body | Programme/Award |
| University of Bristol | BSc in Dental Hygiene & Therapy |

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| Outcome of Inspection | Recommended that the BSc in Dental Hygiene & Therapy is 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 Annex 1\***

**Inspection summary**

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| **Remit and purpose of inspection:** | **Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a Dental Hygiene Therapist.** |
| **Learning Outcomes:** | **Preparing for Practice (Dental Hygiene and Therapy)** |
| **Programme inspection dates:** | **8-9 December 2021 (Remote)** |
| **Examination inspection dates:** | **10-11 May 2022 (In-person)**  **Exam Board: 8 June 2022 (Remote)** |
| **Inspection team:** | **Jane Jones (Chair and non-registrant member)**  **Sarah Balian (DCP member)**  **Khalid Mushtaq (Dentist member)**  **Natalie Watson (Education Quality Assurance Officer)** |

The BSc Dental Hygiene and Therapy programme (“the programme”, “the BSc”) had previously acquired provisional approval following a new programme submission in 2019.

A panel of education associates conducted a full two-day inspection of the BSc. This was the first programme inspection and was carried out remotely due to the new variant of COVID and the concerns for the safety of staff, students, patients and the panel.

The School provided the panel with extensive documentary evidence prior to the inspection, which outlined the policies and processes followed by the School. The panel were presented with supporting evidence to provide assurance against each of the 21 Requirements.

During the inspection, the panel met with staff and students to gain a clear understanding of the programme.

This was a positive inspection, and the panel would like to commend the School on their efforts during this remote visit. The students articulated themselves in a professional manner and were very enthusiastic about the programme and all staff. One of the strengths of this programme is the relationships between staff and students, and the open-door policy is valued by all students undertaking this programme.

The panel received a full demonstration of the student monitoring system and were impressed with how CAFS is utilised.

The panel conducted an on-site inspection in May 2022. During this visit, the panel observed the exams process and met with the external examiner involved with the programme. The panel also reviewed further documentation and student portfolio data, that was not seen as part of the remote inspection in December 2021.

In June 2022, the panel observed the Exam Board meeting remotely.

The School are making suitable arrangements for the transition to the new site in 2023. The panel are assured that this will be a seamless process and that the new site will facilitate valuable student experience.

19 Requirements are determined to have been ‘Met’ by the panel and 2 Requirements are ‘Partly Met’ with actions that will be monitored by the EQA team. The panel would like to address informally, the need for further consideration of succession planning.

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

**Background and overview of qualification**

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| Annual intake | 12 students |
| Programme duration | 3 years full time |
| Format of programme | Year 1: Basic Science teaching, preclinical teaching, operative techniques (periodontology), direct clinical care, PPD.  2: Operative techniques (restorative adult and paediatric), dental radiology outreach placement, PPD  3: Oral surgery, integrated clinical practice, PPD completion of dissertation |
| Number of providers delivering the programme | 1 |

**Outcome of relevant Requirements[[1]](#footnote-1)**

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

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| **Standard 1 – Protecting patients**  **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.** |
| **Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients. *(Requirement Met)***  During the inspection, the panel explored supervision for students. In clinical skills laboratories, the ratio during the remote inspection was 1:13, however when we returned in May for the exam inspection, this had increased to 2:12, following the recruitment of new staff. We were advised that the ratio of staff to students is 1:6 on clinic. This has also now increased to 1:4 or 2:8 on clinics. In a group of six students, three chairs operate whilst three students provide nursing support. Aerosol Generated Procedures (AGP) are 1:1 supervision, and students have taken a lot from these 90-minute sessions. There are two additional qualified dental nurses that provide support to the students.  Clinical skills labs are utilised further when students require additional support to progress. A supervisor would discuss the need for additional support with a student’s personal tutor, so that arrangements can be made for the additional sessions. We were also advised by both the School and students that there is a lot of value in the open-door policy, and they would feel comfortable seeking additional support if needed.  Clinical experience is captured on the CAFS student monitoring system and there is an opportunity for feedback and reflection. The monitoring system allows for identification of simulated versus patient treatment. We were provided with a demonstration of the monitoring system during the inspection, and it is evident that any areas that need to be addressed would be highlighted.  Regular meetings with personal tutors, accompanied by the end of term progress committee meeting, provided assurance to the panel that a student would be identified and held back should that be necessary.  **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 panel were assured that patients are provided with adequate information which informs them they will be treated by a student. This includes the use of patient leaflets, letters, and posters.  Students can be identified in various ways, which include:   * Hygiene & Therapy coloured uniform * Lanyard * Yellow Trust Name and Title badge * Posters in waiting room with student photos   Patient consent is obtained and recorded appropriately. Both verbal and written consent is gained and saved in the patients’ clinical notes prior to the commencement of treatment. The School advised the panel that dental jargon is not used on the consent form, and that a patient understands and is content, with the treatment they will receive.  A translation service can be utilised if required, however would need to be pre-booked in advance of the patients’ appointment. If the translator did not attend the appointment, the patient and translator would need to be re-booked, and the student would not go ahead with treatment.  The outreach sessions that are utilised by hygiene and therapy students are in line with University polices and the same processes and forms are applied.  **Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place. *(Requirement Met)***  All clinics are suitably staffed which allows for safe supervision of students.  Students undertake an induction programme which includes lectures around health and safety, professionalism, and EDI. There is also an Anti-racism and inclusion lead that works with students from year 1 until year 3, who informs students of how to deal with communication barriers they may face and what cultural adaptations they may need to make within their area of work. The induction programme is integrated with BDS students.  Although there have been no EDI concerns raised within the BSc Dental Hygiene and Therapy programme, the School are not complacent and there are robust policies in place as well as staff being suitably trained.  Staff non-compliance of mandatory EDI training is identified on the electronic staff record during the annual staff review and discussed as part of the appraisal process. Non-compliance results in annual leave being restricted and individuals would not progress through payment pathways. The School advised the panel that if the training was not completed, ultimately it would be escalated further, such as FTP proceedings.  **Requirement 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student’s stage of development. *(Requirement Met)***  The panel were content with the staff to student ratios specified under Requirement 1. It was also evident that there are robust processes in place which allowed for contingency planning if staff are unwell. The timetable in place for the BSc programme allows for flexibility and where a staff member has admin time, this would be utilised for the clinics if required to cover illness.  Students confirmed they felt the supervision levels were suitable, they were well supported and that supervisors were easily accessible. From evidence submitted and during a student meeting, it was disclosed that previously there was a shortage of dental nurses and once the students raised this with the School, this was rectified, and an additional dental nurse was employed. The students noted this was because of their feedback and were impressed that their opinion had been considered.  Supervisors accompany students to outreach and therefore receive a consistent level of supervision. The processes utilised during outreach are identical in how students are graded, and all patient interactions are also recorded on the CAFS student monitoring system.  CAFS is updated by both the student and supervisor and includes grading, feedback, and reflection. This is reviewed at the end of each term; any immediate areas of concern are flagged, and an email is sent to the personal tutor.  Students undergo termly progress committee meetings with their personal tutors and receive a breakdown report which allows for individual reflection on their progress. During the exam inspection, the panel had sight of this document and it includes a good level of detail for the students.  **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 staff based at the University have been in place for some time, however during the remote inspection there were plans for two full time members of staff to be recruited in January 2022.  The School advised that they will be developing a bespoke four-week induction package for the new intake of staff, as well as the formal Induction procedures that will be required as part of the trust and University policies. The new staff were appointed as planned, and following their induction, they were encouraged to give feedback on the induction process so that it can be improved for future new employees. The panel had sight of this feedback following the exam inspection in December.  If staff do not hold a teaching qualification, there is an opportunity to achieve this whilst in the role.  All staff hold GDC registration and this is recorded.  The panel were provided with staff training records during both the remote inspection and the exam inspection. During the inspection the training records identified gaps, however since the visit, the School provided updated records, which confirm staff had undertaken the necessary training which also included equality and diversity.  **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)***  Students are introduced to raising concerns in year 1.  When speaking with the students during our visit, all groups felt confident that they would be able to raise a concern and were aware of the process, and that they have access to policies on Blackboard.  The panel were advised that the University encourages students and create an environment to speak out. Students raise concerns initially with their personal tutor however can inform the programme director directly if preferred.  There was an instance where a concern had been raised on behalf of a whole year group via the student representative and the panel were satisfied with how this had been managed.  The students were also pleased with how this was taken seriously and dealt with, and they informed the panel that the matter was resolved appropriately.  In this instance there was no shared learning, however the School informed the panel if there was an opportunity to share learning from an issue raised an email or bulletin would be sent to students.  Students reported that they noted staff going ‘above and beyond' on responding to concerns or queries which can happen beyond working hours and weekends.  Raising concerns and whistleblowing policies are in place at the School.  **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)***  Patient safety issues are captured on Datix, which is then identified by the management team, before being acknowledged by the Director of the DCP School. Students confirmed that they are aware of the process for reporting patient safety incidents and where they would find the documentation required.  The panel were informed that a student would participate in a one-to-one session with their personal tutor to allow for reflection on the incident. The personal tutor would work with the student to mitigate the risk and close the incident and allow for lessons learned and a discussion on how the incident could be prevented going forward.  Data collected is audited on a regular basis to monitor trends. Action plans are developed where required.  Patient safety issues that arise between either the BDS or BSc programme would be shared.  The CAFS system allows supervisors to comment on any immediate areas of concern that need to be addressed in relation to students’ clinical experience and this would be discussed with the personal tutor.  **Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC’s Standard for the Dental Team are embedded within student training. *(Requirement Met)***  The University have a student fitness to practise policy in place and all staff are aware of what constitutes a SFtP concern.  Students undertake pre-clinical training lectures on GDC standards, Fitness to Practise and professionalism in year 1, term 1.  During the student meetings, the panel were made aware of the role play sessions that students participate in with actors during their training. They felt that those sessions encouraged them to consider professionalism and how to respond in difficult situations.  Students are graded on professionalism following all patient interactions throughout the programme. This is recorded on CAFS and reviewed during progress committee meetings.  Students have access to all relevant SFtP documents on blackboard which can be used when required.  The School has had one SFtP incident which was as a result of inappropriate social media use. The School does have a social media policy in place and followed the SFtP process in this instance. The School dealt with this incident appropriately and the student was given a written warning. |
| **Standard 2 – Quality evaluation and review of the programme**  **The provider must have in place effective policy and procedures for the monitoring and review of the programme.** |
| **Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function. *(Requirement Met)***  The programme underwent School level, faculty level and University approval prior to enrolling the first cohort of students. Both the business and academic case were reviewed by external reviewers and University advisors. This outlined the framework for the programme before it began.  The programme is also subject to quality measures which includes a University team annual review, GDC accreditation and annual monitoring. They also incorporate external examiner, student, staff and patient feedback to ensure quality of the programme.  Minor changes to the programme are signed off at School level and are approved within the dental education committee. The School made the panel aware of the rigorous process for changing units or learning outcomes and explained that this was approved at School and faculty level.  There is a clinical governance committee which addresses any issues that may arise within the dental School. There are various other committees that meet regularly which address areas such as education, teaching, assessment and quality.  The University quality team meets with student representatives and reviews data such as NSS results and comments from students. The University works with the programme director to implement recommendations that may be necessary.  An education action plan and risk register are maintained and reviewed by the School.  **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)***  At the end of each term, the School gather written feedback which enables them to address any issues that may arise. Students are provided with information of what has been implemented following feedback. One example provided to the panel during the inspection, was that students felt assessments were too close together. The School adjusted their exam dates and students were content with this change.  The staff student liaison committee provides the opportunity for student representatives of both BDS and BSc programmes to raise any concerns or issues that may need to be resolved. Students feel their opinion is valued and any issues are acted up on appropriately.  The CAFS monitoring system allows for suitable download of various reports. During the inspection the panel were shown how this is carried out. This was reassuring to the panel, and it was evident that the quality of the programme is closely scrutinised.  External reports were seen by the panel as part of the pre-inspection evidence and it is clear that the School address matters in an appropriate and timely manner.  We were provided with evidence that assured the panel that there are systems in place to quality assure placements.  **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 provider utilises external examiners for the programme who are suitably qualified and are familiar with GDC learning outcomes. Evidence was seen of EE reports and response documents from the School, stating what action had been taken following the EE feedback.  The School have an external examiner policy and it is clear that the external examiners are regularly involved in the quality assurance of assessment that takes place within this programme.  Feedback for the BSc programme is obtained from patients, students, staff and external examiners. The CAFS system is used to capture patient feedback. Once a student treats a patient, they can generate a code for the patient to complete feedback on their own device. Alternatively, there is a floating iPad on clinic that can be utilised. This feedback is anonymous, and the student has access to the feedback scores and comments they receive without being identifiable to a specific patient. This is addressed during the termly progress meetings with personal tutors. Students reflect on these comments and make improvements for future patients.  The School acknowledged that patient feedback is not yet being used to inform teaching and learning or course design but that this is the intention  When issues are raised by students, they feed very quickly into the team and are acted upon promptly.  **Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. *(Requirement Met)***  When students undertake placements within South Bristol Community Hospital, the staff from University Hospital Bristol accompany the students and provide supervision. The processes are identical, and students are graded consistently. The CAFS system is utilised during the placement and completed in line with usual processes.  Any issues that arise during placements are identified by the supervisor supporting the student.  The School informed the panel that there is a large staff base who commit to clinical sessions and have a good pool of supervisors that can be utilised for placements.  Feedback is obtained and reviewed on the CAFS system and feeds into the students’ progress meetings as it would when treating patients at University Hospital Bristol.  The outreach lead attends the dental education committee meetings, and all outreach staff are aware of teaching and assessment protocols.  If any issues arise, the programme director, School Education Director and Head of School would be informed, and the appropriate action would be taken.  All students interviewed during the inspection, felt that the ‘open-door’ policy was available to them and they were comfortable offering feedback or raising concerns when needed. |

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| **Standard 3– Student assessment**  **Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.** |
| **Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Met)***  The BSc programme is mapped to the GDC learning outcomes and the panel are assured that all will be achieved. The panel are confident that if a student did not meet the learning outcomes, this would be highlighted, and an appropriate plan put in place for students if necessary.  The CAFS monitoring system shows a clear breakdown of clinical experience and what has been achieved by a student. It is possible to review various types of treatment as well as whether it was carried out via simulation or on a patient. This can be reviewed further by patient type and the specifics of the treatment carried out. There are various reports that can be run, to monitor students and highlight any areas that should be addressed to enable the student to progress. Alongside side each clinical experience and number of patient encounters, the School have also included a category noting the complexity of the patient following the BDA Case-mix framework.  The School acknowledged that there have been difficulties around students gaining experience in delivering care for dental implants, however students complete the competencies, carry out simulated activity and receive training in maintaining implants to compensate for this. The panel were not concerned by this as the School ensures that the learning outcomes have been achieved.  The termly progress committee meetings enable personal tutors to identify students that may have gaps in clinical experience and require additional support. An action plan would be initiated for a student and a student patient co-ordinator would assist with arranging for patients to be booked in for the specific procedures.  The University is keen to increase student numbers, however the School stated that this will not be considered until the move to the new School has taken place, and that they are confident they are able to accommodate this increase.  The School are planning to move to a new location in 2023. The patient base is currently large enough to support an increased cohort and the move will increase this further. The new hospital will have additional dental chairs and further staff will be employed. The new site is in a highly deprived area and the School is confident they will have a good patient base. The site is a short walk from the current hospital therefore, many patients will continue with their care at the new site. The move will bring improvements to the quality and experience of dental education.  The School have planned to reduce their 2022 cohort, so that they can prioritise the graduating cohort and ensure they had adequate patients to complete their programme.  Students confirmed that learning outcomes are clear when receiving lectures and they are aware of how topics link to them.  The learning outcomes have recently been reviewed and re-mapped to the curriculum and assessments to ensure the graduating cohort are on track to achieve within the next six months. The School informed the panel that the students are on track and that all learning outcomes will have been taught and assessed at the point of graduation.  During the exam inspection and exam board meeting, the panel were assured that those students graduating would have the appropriate level of experience and were satisfied with the clinical data presented.  **Requirement 14: The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes. *(Requirement Met)***  The documentary evidence provided against this Requirement prior to the inspection satisfied the panel that it is met.  During the inspection we were also provided with a demonstration of the monitoring system in which the School utilise. CAFS is a robust system that captures the students’ clinical experience.  CAFS is monitored and reviewed and the termly progress committee meetings enable personal tutors to highlight any areas of concern of commend good practice. It also allows the opportunity to flag lack of experience for particular procedures, and plan for rectifying this.  Student grades are also captured on this system and can be reviewed by the staff.  Both students and staff have access to the data and the panel were assured that the School are proactive in ensuring this data is accurate and completed in a timely manner.  **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)***  Students have exposure to an appropriate breadth of patients and if it is identified that they are struggling to gain specific experience, a patient appointment co-ordinator will assist in ensuring this is arranged promptly. The patient co-ordinator is well versed on the clinical requirements of both BDS students and BSc students to ensure even distribution.  Students felt that they have a good range of experience and do not feel as though they struggle with developing the skills required as a dental hygienist and therapist.  Student experience is captured on a robust monitoring system and both staff and students are able to identify where additional practice may be needed.  Clinical skills labs or phantom heads are utilised where possible when a patient fails to attend an appointment so that a student can practice their skills.  Tutors continually review student progression.  New opportunities of clinical activities are being piloted to offer a richer experience to BSc, the panel met with one of the supervisors of the dental emergency clinics which can be fast paced service and present with patients in challenging circumstances. Priority is given to all students to work in a safe environment however the experience offers the opportunity to work in emergency circumstances and teamwork with BDS students, which would replicate situations in dental practice.  During the exam inspection, the panel were provided with the student portfolios and at the point of attending the exam board, the School also provided the students clinical sign-up data. This provided assurance to the panel that students had exposure to an appropriate breadth of patients.  **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)***  Assessment for the BSc programme is set up at the outset of each academic year and are regularly reviewed and modified.  The BSc programme is a modular course and within each of the units there is a summative assessment. There is clear marking and grading criteria, and staff are trained on marking and giving feedback.  Students are aware of assessments and grading criteria and informed the panel that grading is fair and consistent across supervisors.  A psychometrician is used in joint assessments with BSc and BDS students. This individual supports the use of psychometric analysis with standard setting for both programmes and is a vital member of the team. Systems are in place to monitor the performance of questions and those that perform poorly are analysed and amended accordingly.  The dental assessment committee focus entirely on assessment and meet regularly to review the processes utilised at the School.  Calibration of staff across both BSc and BDS School takes place frequently, and the panel were advised that there is an opportunity for BSc staff to moderate BDS practical work and vice versa.  There is a robust code of practice around assessment in the handbook which is available for both staff and students.  The CAFS system enables the School to identify staff hawks and doves and a grading behaviour report is compared against the mean. The panel were assured that staff are monitored in relation to scoring performance.  **Requirement 17: Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers. *(Requirement Met)***  As described under Requirement 11, feedback is collected from staff, students, patients and peers.  Feedback is recorded on the CAFS monitoring system and is reviewed regularly and where possible informs programme development.  **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)***  Reflective practice is taught to students in the first month on the programme. Students participate in a comprehensive session and students are aware from the outset that they are required to complete regular reflections throughout the programme. Students are introduced to CAFS at the start of their learning journey and reflect regularly. They also have access to a reflective tool on Blackboard that can be used independently if required.  There are opportunities for staff to receive training in giving feedback and all new staff engage with the CREATE University platform which provides teaching support to tutors and supervisors.  Students receive one to one feedback from their personal tutor and both verbal and written feedback from the supervisors on clinics. This feedback is captured both on CAFS and in the termly progress report.  Feedback is regularly obtained from patients and students have access to the anonymous data on CAFS. This data is also reviewed at progress committee meetings. Patients are also encouraged to attend events when planning for new programmes or revision of the curriculum.  The School informed the panel that patient feedback is reviewed and used to make amendments to teaching of the programme in relation to teaching. Examples they provided were making changes to the professionalism/communication lectures to ensure patients are satisfied with their experience. The BSc and BDS programme use the same patient questionnaire when obtaining feedback.  Students work in pairs on clinic and felt that peer feedback is valuable to their learning experience. They are confident in seeking feedback on their performance from their peers and feel this helps with their own reflection and enables improvements to be made.  Students advised the panel that they receive well-rounded feedback with good variation, which regularly improves their learning.  **Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. *(Requirement Partly Met)***  The panel saw evidence that all programme staff hold appropriate registration and those undertaking assessment are suitably qualified and trained.  EDI training is also caried out by programme staff and non-compliance is dealt with appropriately.  It was unclear if external examiners had completed EDI training and the panel therefore determine that this requirement is Partly 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)***  The BSc Dental Hygiene and Therapy programme have two external examiners that report on the assessment processes utilised by the School.  The evidence submitted to the panel provided assurance that the processes are rigorous and that assessments have been fairly conducted.  The evidence provided included:   * EE policy * EE CVs * EE appointment letter * EE reports * EE moderator checklist * Response documents to EE reports   The reports are clearly reviewed by School and addressed where appropriate.  During the Exam inspection, we spoke with the external examiner, and they explained that they felt well supported in the role and that documentation is available to enable efficient assessment. The external examiners provide feedback on all assessments, and it was clear that the feedback is considered, and changes are made.  **Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. (*Requirement Met)***  Students are aware of assessment criteria as well as understanding the grading criteria they are being marked against.  The School utilise standard setting processes as well as ensuring staff calibration and training takes place to ensure fair and consistent assessment.  The students advised the panel that they feel well informed in relation to assessment and felt the grading is fair and consistent across supervisors.  During the exam inspection, the panel observed the exam briefing, and it was evident that the marking criteria is standardised and the process that would be followed during the exams was explained. The exams were being recorded and sent to the external examiner to review. A de-brief also took place following the exams and the panel made suggestions in relation to areas for improvement. |

**Summary of Action**

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| **Requirement number** | **Action** | **Observations & response from Provider** | **Due date** |
| 11 | 1. Utilise patient feedback to inform teaching and learning or course design. | This is something we are keen to build on and progress further. The move to the new School next year will give us the opportunity to do this and is something that has been discussed as part of external engagement processes for the new School. | Q2 2023 |
| 19 | 2. Provide training records for external examiners, specifically in relation to EDI. | In terms of an action, we are very happy to look at this for both the BDS and BSc programme. We will seek advice from the Academic Quality and Policy Office (AQPO), in addition to raising this with the Faculty of Undergraduate Studies Committee (FUGSC) to ensure we have a consistent and robust approach. | Q2 2023 |

**Observations from the provider on content of report**

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| The content of this report is an accurate account of the discussions and findings following the inspection to the BSc (Hons) Dental Hygiene and Therapy. |

**Recommendations to the GDC**

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| **Education associates’ recommendation** | The BSc in Dental Hygiene & Therapy is approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council. |
| **Date of reinspection / next regular monitoring exercise** |  |

**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 education associates 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 education associates must 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 monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The Education Quality Assurance 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.

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. [↑](#footnote-ref-1)