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INSPECTION REPORT

Education Provider / Awarding Body:	**Cardiff University**
Programme / Award / Qualification:	**Bachelor of Dental Surgery (BDS)**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine the continuing sufficiency of the award for the purpose of registration with the General Dental Council (GDC) as a dentist**
Learning Outcomes:	***Preparing for Practice***
Programme inspection dates:	**5 & 6 March 2014**
Examination inspection dates:	**9-11 June 2014**
Inspection panel:	**Annie Turner (Chair and Lay Member)** **Steven Farmer (Dentist Member)** **Iain Mackie (Dentist Member)** **Michael Mulcahy (Dentist Member)**
GDC staff:	**Kathryn Counsell-Hubbard (Lead)** **James Marshall (programme inspection only)**
Outcome:	**Recommended that the BDS remains sufficient for registration as a dentist**

Inspection summary

The BDS programme in the School of Dentistry (hereafter referred to as 'the School') at Cardiff University is an established programme that has sought to renew itself and deliver excellence in dental education. Several internal reviews and audit projects have enabled the programme to map effectively to Preparing for Practice and introduce a new stream to focus on professionalism from the start of the programme.

The early clinical contact that students undertake is one of the exemplary parts of the programme. Students begin supervised patient contact from Year One, observing patient treatment and learning about the dental environment. This strategy allows for first year students to be immediately engaged, especially as the majority of teaching happens at the Biosciences School and therefore away from the Dental School itself. Attending the Dental School for one day a week helps to integrate the theory with the practical, which is further consolidated in Year Two.

The Modernising Dental Education (MDE) project has been the biggest driver for change within the Dental School. Early patient contact was introduced as a result of the MDE project and blueprinting of the programme to the learning outcomes within Preparing for Practice was also completed at this time. The School have also utilised this time of change to implement more student support structures, including the Clinical Activity Monitoring & Mentoring Scheme (CAMMS). This scheme allows for students to be supported in identifying the types of patients they need to treat, and also allows for continuous monitoring of student achievement.

CAMMS is one initiative that has been implemented partly in response to the feedback received from the National Student Survey (NSS). The School endeavours to keep an ongoing dialogue with students so that issues can be discussed and addressed. This is an ongoing piece of work but the efforts of the School in regards to the NSS were evident.

The panel noted many areas of good practice but also recognised areas where improvements could be made. The level of feedback received on academic assignments was routinely mentioned by students as something that they would like to see changed. The arrangements for sharing patients between students was a concept that the panel felt could be formalised to allow for greater scrutiny.

The outreach provision for students is a cornerstone of the programme and highly commended by the students. Concerns were raised in regards to the quality assurance of placements which is not standardised across all sites. The supporting Service Level Agreements (SLA) for the placements were not in place and the panel were concerned overall that at least one placement was left to function independently with a lack of tangible, continuous interaction with the School.

Both the areas of good practice and those in need of improvement will be detailed in this report.

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

Inspection Process and Purpose of Inspection

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 and new qualifications where it is intended that the qualification will lead to registration.

2. The aim of this quality assurance activity is to ensure that these institutions produce a new registrant who has demonstrated, on graduation, that he or she has met the outcomes required for registration with the GDC. This is to ensure that students who obtain a qualification are fit to practise at the level of a safe beginner.

3. The inspection focuses on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education*.

4. The purpose of this inspection was to make a recommendation to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist in the UK. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended) to determine sufficiency of the programme.

5. Inspection reports may 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 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, the report and observations would be presented to the Council of the GDC for consideration.

The inspection

7. This report sets out the findings of an inspection of the BDS awarded by Cardiff University. The GDC publication *Standards for Education (version 1.0 November 2012)* was used as a framework for the inspection. Inspection reports may highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider.

8. The programme inspection took place on 5 and 6 March 2014. During the inspection, the inspectors met staff involved with the management and delivery of the BDS programme. The inspection team also met with clinical teaching staff, outreach tutors, and students on the BDS programme.

9. On 9 to 11 June 2014 the inspectors attended the practical elements of the final examination. These were the Case Report and the Unseen Patient Case vivas.

10. The inspectors also attended the Final Examination Board meeting which was also held on 11 June 2014.

Overview of qualification

11. The five year BDS programme is primarily based at the University Dental Hospital (UDH). Each cohort is approximately 80 students strong including four international students. The programme aims to build the students' knowledge, skills and attitudes required for them to enter dental practice as a safe beginner.

12. Clinical contact with patients starts early in the programme with students visiting outreach placements from the end of Year Three onwards. Placements include primary care facilities, community dental facilities, and district general hospitals. The majority of clinical experience is gained at UDH.

13. The programme is divided into yearly themes with a series of topics contained within each. The Skills of a Professional theme runs through all five years, covering professionalism, communication, ethics, behavioural sciences, team working, and 'the GDC and the Dentist'. The assessment strategy is mapped in a series of blueprints which are updated each year.

Evaluation of Qualification against the *Standards for Education*

14. As stated above, the *Standards for Education* were used as a framework for this inspection. Consideration was given to the fact that the *Standards for Education* were approved in late 2012 and that it may take time for providers to make amendments to programmes to meet all of the Requirements fully and to gather the evidence to demonstrate that each Requirement is being met. The inspection panel were fully aware of this and the findings of this report should be read with this in mind.

15. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement was met, partly met or not met and to provide evidence in support of their evaluation. The inspection panel examined this evidence, requested further documentary evidence and gathered further evidence from discussions with staff and students.

16. The inspection panel used the following descriptors to reach a decision on the extent to which the BDS of Cardiff University meets each Requirement:

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.

Standard 1 – Protecting patients **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised**			
Requirements	**Met**	**Partly met**	**Not met**
1. Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients	✓		
2. Patients must be made aware that they are being treated by students and give consent	✓		
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care		✓	
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development.	✓		
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body		✓	
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety	✓		
7. Should a patient safety issue arise, appropriate action must be taken by the provider		✓	
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	✓		

GDC comments

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

The acquisition of skills for patient care starts in Year One with the Foundation for Clinical Practice and Introduction to Clinical Skills I themes. Students undertake specific training on preparing for patients in Year 2 in both the clinical environment and phantom head laboratory. Gateway assessments are in place for progression between years and utilise a range of methods including professionalism vivas, Objective Structured Clinical Examinations (OSCE), Structured Clinical Operative Tests (SCOT) and observed clinical tests. Clinical competency

portfolios are also reviewed at the end of each year

The programme offers students early clinical contact with patients from Year One which is closely supervised. The Skills of a Professional strand runs through the entire programme and assists in consolidating the professionalism required of new students entering the clinical environment for the first time.

Requirement 2: Patients must be made aware that they are being treated by students and give consent *(Requirement Met)*

The panel found that there was a thorough consent procedure in place at the UDH. Patients receive letters prior to being treated by students and there are numerous signs around the clinical area to further inform patients.

The process varies on outreach depending on the site. Two of the outreach centres screen patients for their suitability for student treatment, and patients are therefore aware throughout that process that, if accepted, all of their subsequent treatment will be provided by a student dentist. Other placements also use letters to inform patients, either from the outreach site directly or in the referral letter from the general dental practitioner.

The School also makes use of standard Cardiff University scrub tops and badges that further inform the patient of the dentist's student status.

Requirement 3: Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care *(Requirement Partly Met)*

The UDH is an NHS facility, as well as being part of the University, and is therefore subject to the appropriate health and safety policies. The School has an internal health and safety infrastructure which allows for clinical governance to be undertaken.

Outreach placements are also NHS facilities. There are close relationships between the relevant Health Boards and the School, meaning that issues with outreach placements could be discussed and resolved. However, the SLAs with the outreach placements were out of date. There was some concern amongst the panel that the appropriateness of the environment could not be wholly evidenced without the supporting agreements in place. There are structures in place for student feedback, however, so any concerns over the patient environment could be identified in that way.

The School must ensure SLAs are up to date at all times to ensure the appropriateness of the patient care environment.

Requirement 4: When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development *(Requirement Met)*

The levels of supervision given in the documentary evidence were felt to be appropriate. The numbers of staff to students in the clinical environment may vary depending on the complexity of the procedure.

Some students reported they are often responsible for conveying their level of ability to the supervisors, rather than the supervisors being aware of what stage the students should be at. When questioned, the programme leads acknowledged they were aware that this can be a potential issue for Year Three students where the crossover from phantom head to the clinic may not exactly match. Staff have been made aware of the issue at away days and asked to

check a students' level of skill on clinic but the message needs to be more clearly communicated. The programme leads also felt that it was occasionally appropriate for students to progress and gain new skills on clinic as this is part of the learning process.

The programme leads also advised that students develop a close relationship with some of the teaching staff from Year Two due to the early clinical contact. This helps promote working relationships and helps to ensure that students aren't always relied upon to inform their supervisors as to their stage in the programme.

The panel felt that the level of supervision was satisfactory. The issue with supervisors not being aware of a students' level of ability appeared to be isolated rather than widespread. Students are also taught about professionalism from the beginning of the programme, and are aware of their duty to only complete procedures that they are competent to perform. For these reasons the Requirement is considered to be met.

Requirement 5: Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body *(Requirement Partly Met)*

All clinical staff involved in supervising students are GDC registrants. Registration is checked yearly by NHS processes. NHS staff are covered by honorary contracts from the University to enable them to supervise students.

School staff are subject to a period of probation and must pass the Postgraduate Certificate for University Teaching & Learning (PCUTL) within three years of appointment. When appointed, staff are expected to undertake an induction and the staff handbook features a section specifically for clinical staff. Within that guidance is a section dedicated to the supervision of students, including the grading scheme, timetable for when certain cohorts are on clinic, and detailed information on the different facets of dentistry to give the supervisor direction as to how students should be supervised. It is not clear from the staff handbook or supervisor guidance whether these documents are covered in a taught session with staff during their induction.

Some supervisory issues were disclosed which suggested that the induction is not effective in ensuring that supervisors are appropriately trained. Students reported being asked at times to perform a procedure that they had not yet covered in the phantom head laboratory because the supervisor was unaware of which cohort they belonged. A further issue was reported by programme leads that some staff were not adequately supervising students completing root surface debridement treatment. Both reports suggest that more needs to be done in the training of supervisors to ensure that patients are not harmed and students appropriately supervised and trained.

Additionally, it is not clear whether the staff handbook and supervisor guidance are shared with outreach staff. While good communication exists with two of the outreach placements and the school, other sites are more remote. Outreach supervisors are invited to staff training days at the School but attendance is not mandatory and additional training days do not appear to take place if not all of the supervisors are able to attend.

The panel were satisfied that appropriate registration is held by all supervisors. However, the training of the clinical supervisors does not appear to be stringent enough and must be developed to include outreach supervisors. The Requirement can therefore only be considered to be partly met.

Requirement 6: Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety

(Requirement Met)

The School is subject to whistleblowing policies both from the University and the Cardiff & Vale University Health Board (UHB). Separate policies exist for complaints to be made about staff and the panel saw evidence of this policy being utilised.

The programme leads advised that students receive lectures specific to raising concerns. Students themselves reported feeling confident in raising concerns and would speak to a senior member of staff if required. The student handbook includes guidance on raising concerns and defines exactly what methods of contact should be used and under which specific guidance a concern should be raised. For example, bullying and harassment should be raised using the equality and diversity policies. The student guidance is also contained within the staff handbook.

The Requirement is considered to be met but could be strengthened with the introduction of a School-level whistleblowing policy, as there is currently only a University-level policy in place. Such a policy would be specific to the field of dentistry and take into account the clinical implications of malpractice.

Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider *(Requirement Partly Met)*

The Cardiff & Vale UHB have an incident reporting structure in place which is underpinned by the use of DATIX. Programme leads reported that DATIX has been used far more stringently within the last six months so the resolution of tracking and resolving issues has improved. All DATIX reports come to the Directorate and Clinical Board at the School and discussed every four weeks. The Quality & Safety Committee and additional audit groups can be involved if required. The School reported that there were no patient safety issues involving students.

The process for incident reporting for outreach is not defined in policy. How such issues would be formally reported, and what the School's obligations would be, were not described in the pre-inspection evidence or during the inspection. The two outreach placements where students gain the most experience come under the remit of the Cardiff & Vale UHB but it is not clear whether the DATIX reports from those sites are forwarded to the School. Students are asked to provide extensive feedback on the outreach placements, so it is hoped that issues would be reported in this, but the process is not formal or easily evidenced.

The School must implement a process as to how patient safety issues from outreach would be reported and what input the School would have in taking appropriate action.

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 *(Requirement Met)*

A Student Fitness to Practise policy is in place and is underpinned by a yearly lecture, given during the induction week at the beginning of each Year. Students are required to sign a declaration after the lecture to confirm their attendance and understanding. Attendance is compulsory and students can obtain the content of the lecture in hard or soft copy afterwards. The policy is also included within the student handbook.

The process is also supported by the professionalism strand that runs through the programme. When an issue is identified, the School has the power to withdraw a student from clinic immediately, and an investigation will be completed by the Dean. A School-level panel will be

convened by the Dean to evaluate the evidence gathered followed by a referral to a University Fitness to Practise panel if necessary. Evidence was seen by the inspectors of the identification and resolution of student fitness to practise issues.		
Actions		
Req. Number	**Actions**	**Due date**
3	Up to date SLAs to be obtained to ensure appropriateness of the placements.	Annual Monitoring
5	Training of clinical supervisors to be strengthened and developed to include outreach supervisors.	Annual Monitoring
6	The provider should consider implementing a School-level whistleblowing policy that is specific to the field of dentistry.	N/A
7	A process for the reporting and resolution of patient safety issues at outreach placements must be implemented.	Annual Monitoring

Standard 2 – Quality evaluation and review of the programme **The provider must have in place effective policy and procedures for the monitoring and review of the programme**			
Requirements	**Met**	**Partly met**	**Not met**
9. The provider will have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function	✓		
10. The provider will have systems in place to quality assure placements		✓	
11. Any problems identified through the operation of the quality management framework must be addressed as soon as possible		✓	
12. Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity	✓		
13. Programmes must be subject to rigorous internal and external quality assurance procedures	✓		
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow QAA guidelines on external examining where applicable		✓	
15. Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment	✓		

GDC comments

Requirement 9: The provider will 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)*

Quality management is governed by two processes. The Annual Review & Enhancement (ARE) was recently implemented, replacing another review process, and is a formalised approach to evaluating and reflecting on the programme's performance during the preceding year. The process is a University initiative to support their strategy for 2012-2017 and also seeks to mirror QAA principles. Two main objectives of the review are to ensure accountability of the School in delivering the programme and to determine student engagement.

The second process is the Periodic Review (PR) which happens every five years. This is also a University initiative but the intent is to be strategic and set the agenda for the programme for the next five years.

Both processes are formulated into reports which are provided to the University's Academic Standards & Quality Committee. The reports are discussed primarily at a College level, the School being part of the College for Biomedical and Life Sciences, with action points being fed back to the School. The responsibility for the implementation of the action points lie with the Head of School and School Board who are supported by the internal committee structure.

The structure was well-evidenced to the panel and there was a clear indication that there is consistent interaction between groups. Staff from across the programme are involved including Year Leads and Theme/Topic Leads. The frequency with which different committees meet varies but the main operational group, being the BDS Executive, meets monthly to ensure that urgent issues can be dealt with quickly. One positive aspect was the dedicated quality committee, the Learning, Teaching & Quality Committee (LTQC), which allows for the programme to be discussed and improved at a local level.

Dissemination of information from the various committees occurs through the distribution of minutes and regular staff newsletters. The Dean also has regular contact with other dental schools and the NHS which allows him to be a point of contact for legislative changes and to receive external guidance. Such information can be fed into the BDS Executive and then disseminated into other relevant committees.

Another positive was the high level of student representation across all committees. Student engagement appeared to be high and the Programme Director holds a monthly meeting with student representatives to further inform them of changes to the programme, in addition to termly student and staff meetings. The student groups interviewed all knew who their year group representative was and felt happy to bring up issues and concerns with them.

The programme has benefited from the MDE project in 2009. This saw a change from a department-led School structure to the introduction of Themes and Topics, and also allowed for the professionalism theme to run across all years. The project gave the School an opportunity to re-map its' learning outcomes to the new ones published by the GDC. In this way, cohesive and effective blueprinting has been introduced. While the MDE project has finished, its remit and action points have been taken over by the BDS Executive so the School continues to refine and improve the programme.

The panel felt that the various initiatives and projects had helped to build a strong quality management framework which is supported by the committee structure. Despite this, there are areas where improvement would be welcome.

Students reported that the overall quality of the management of the programme was variable. Administrative issues mean that lectures are often cancelled at the last minute. The delivery of the Human Diseases theme was felt to be flawed as sessions can be ad hoc and the lecturer did not appear to be aware of what stage of the programme the students were at before delivering the lecture. These concerns were reported across years but do not appear to have been picked up by any of the quality management processes.

Another area of concern was the rollout of the new curriculum. The curriculum was re-written following the MDE project to change the structure of the programme and to introduce the new learning outcomes. The programme leads reported that the curriculum was implemented all at the same time, rather than a phased approach. The leads reported that students adjusted well to this but some student groups reported that the teaching of some areas, such as radiology, was impaired because the teaching was due to happen at a stage earlier than that dictated by the new curriculum. This was rectified but students further into the programme could see the additional teaching that students in earlier years were receiving as a result of the new curriculum and felt disadvantaged.

Little evidence on the old curriculum and the rollout of the new one was provided, and based on student feedback the panel felt that the School could have engaged with the students more effectively to ensure that no cohorts felt disadvantaged.

In regards to evidence, the panel also felt that some of the spreadsheets and minutes used to record committee decisions and data lacked in detail. Actions were often not noted so it was not always possible to determine when an issue had been signed-off. It was not possible to see the life-span of an issue or programme change from the recording documents. The management framework is undermined by its' recording.

The Requirement is considered to be met. There are areas of improvement that would help to enhance the quality management of the framework and the panel is confident that the School can improve where required.

Requirement 10: The provider will have systems in place to quality assure placements *(Requirement Partly Met)*

Quality assurance of all placements is undertaken by using student feedback. Students are asked to complete questionnaires on each of the placements and these are then reviewed and collated to identify areas where improvement is required.

The programme leads also endeavour to maintain a timetable of visits to the community dental service outreach placements. Those located close to the School, Mountain Ash and St David's, are visited most often with meetings taking place between programme and placement leads every six weeks. Leads from those placements are in regular contact with the school. Leads from all placements are invited to staff training days at the school. Contact is further underpinned with SLAs.

The School also utilise district general hospital (DGH) placements where students can observe minor oral surgery. A special care placement is also offered. Both of these specialised placements are monitored through student feedback and through direct reporting from the leads at those placements. The placements are not visited because they are located some distance from the School but a dedicated supervisor has been appointed to maintain regular contact.

While the measures outlined for community dental services do provide some quality assurance, the overall process is flawed. The feedback from students is valuable at providing a 'grass roots' view of the placements but, according to evidence provided to the panel, the majority of students did not return the questionnaires. Quality assurance in this way is based on the views of the minority.

The timetable of visitations has not been stringently maintained. The links with the local placements are strong but those further afield, such as Wrexham, have not been visited for three to four years. Attendance of staff from those sites at training days is not mandatory. The Annual Review process is meant to include an oversight of all placements but this is not being followed. It was also found that the SLAs held were all out of date and that a completed SLA for the Wrexham placement was not held on file.

The placement at Wrexham was of particular concern. In addition to the lack of visitation, the new lead at the site has received no instruction or guidance on supervising students or information on how advanced the students are that visit the site. The lead has received a handbook but has not received any other support. The panel spoke with the Wrexham lead via teleconference and were told that support from the School would be welcomed. It became evident to the panel that the Wrexham placement has been viewed as being entirely separate from the School and has not been quality assured in recent years. Considering that students

attend for a two-week block and gain sedation experience at Wrexham, the fact that it has not been quality assured was a particular area of concern.

The School has recently introduced a new supervisor of the community dental service placements, including Wrexham, who is aiming to establish regular contact and visit all sites soon. The supervisor also intends to visit every placement annually, including Wrexham, and the panel felt that if such contact is established then the quality assurance of the placements will improve.

The School must deliver on their objectives with the new supervisor for community dental service placements and place particular attention on the Wrexham placement. Completion of feedback questions must be made mandatory for students and the SLAs must also be maintained and kept up to date at all times.

Requirement 11: Any problems identified through the operation of the quality management framework must be addressed as soon as possible *(Requirement Partly Met)*

A primary method for identifying issues is via student feedback. As described earlier, students are well represented throughout the committee structure and have several opportunities to alert programme leads to problems, as well as being able to approach tutors directly. This level of student involvement is also supported by the fact that programme staff hold responsibility for a variety of roles, from supervising to teaching to sitting on committees. The interaction, therefore, between staff and students takes place at many levels, further aiding the identification of issues. The timeframes within which the committee structure operates was well defined and lends assurance to problems being dealt with quickly.

The clinical incident system DATIX is utilised within the School and across outreach placements. This is an NHS-wide system and allows for clinical incidents to be tracked. All incidents are reported to the Health Boards although it was not clear whether reports sent to Health Boards outside of Cardiff & Vale UHB are shared with the School.

The communication between some of the outreach placements and the School will hopefully improve and contribute further to the process of identifying problems. At present, the regular meetings with local outreach allow for issues to be discussed and rectified, and formal reporting from the DGH placements also assist with this.

Unfortunately, the remoteness of the Wrexham placement and the accompanying gap in the quality assurance of this placement raises concerns as to how an issue there would be identified. Student feedback still takes place but is not consistently provided amongst the entire cohort. Feedback is also only provided at the end of the placement so how issues are dealt with contemporaneously is not known.

The quality system also suffers from insufficient reporting. A spreadsheet for key recommendations is in use to track issues gleaned from the formal reporting measures, but this spreadsheet includes limited detail on when an issue was identified and when it was resolved. It is therefore not possible to be assured from this evidence alone that problems are being addressed as soon as possible.

Due to the gaps in reporting between the School and outreach, coupled with the insufficient internal reporting, the Requirement can only be considered to be partly met.

Requirement 12: Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity *(Requirement Met)*

A cohesive quality management framework and the requisite University policies regarding whistleblowing and raising concerns gave the panel assurance that this Requirement was met. The programme has not been affected by any serious threats to date. The learning outcomes are comprehensively mapped to the assessment strategy so the School can easily track which learning outcomes would be affected if there were an issue with a placement, for example. The panel felt confident that the programme leads would contact the GDC if a serious threat did arise.

The School did report that the funding of the programme may be affected in future as the numbers of students granted places may reduce. The School should keep the GDC informed of what the reduction in student numbers will be and what the effect on student attainment, if any, this will create.

Requirement 13: Programmes must be subject to rigorous internal and external quality assurance procedures *(Requirement Met)*

As detailed for Requirement 9, the internal quality assurance procedures are extensive. The LTQC is responsible for the day-to-day quality assurance of the programme, and this is fed into by the BDS Executive who has responsibility for the programme operationally.

Externality is informed by QAA Benchmarking and undertaken by the University. There are clear links between the School to the College and the University, with the Dean sitting on committees outside of the School's structure. The MDE project also included the use of two project officers, allowing for some oversight from outside of the programme.

External examiners are also utilised and required to provide reports on assessments and the final exams. The reports are considered by the exam officers in the first instance before being referred to the LTQC for discussion. Examples of the reports were provided to the panel.

Requirement 14: External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow Quality Assurance Agency (QAA) guidelines on external examining where applicable *(Requirement Partly Met)*

The programme utilises four external examiners for the final exams, all of whom work at similar institutions and have knowledge of the learning outcomes. The School had convened a working party to examine the QAA guidelines to ensure that their external examiners were working in line with these.

The external examiners' ability to provide overarching quality assurance, as required by QAA, is diminished as the externals actively examine students during the final clinical assessments. Each external examiner is grouped with two internal examiners to question students. They do not have the opportunity to observe other examiner groups and cannot provide full, objective feedback on the assessments as a whole because they are directly involved in them.

While the panel felt that the use of the external examiners to directly examine students was positive when considering the abilities of the internal examiners, which is detailed under Requirement 21, the School must devise a strategy to allow for the overarching quality assurance to be achieved as a matter of urgency. As there is a team of four external examiners, it may be useful for three to examine while the fourth observes. The Requirement is considered to be partly met until this element of the QAA guidelines is achieved.

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *(Requirement Met)*

Formal reports are received from a number of sources: external examiners, students via feedback, and from the ARE and PR measures (defined for Requirement 9). The MDE also formally assessed the quality of the programme.

Responses are sent to all external examiners after a review of their reports. Such responses, as well as the reports themselves, are forwarded to and discussed at a University-level committee. External examiner reports were included within the MDE project. The recommendations from ARE and PR reports are distilled into action plans with proposed timeframes. Evidence of these action plans were seen by the panel.

The School also considers the National Student Survey (NSS) carefully each year and works hard to improve the student experience. NSS outcomes are monitored by the University as well as the School and there are benchmarks in place. Programme leads reported that they continually strive to meet the concerns raised in the survey and have published "You Said, We Did" posters to help respond to students directly.

Actions

Req. Number	**Actions**	**Due date**
9	The provider should improve the recording of committee meetings and actions. The administration of lectures in regards to when these are cancelled (if necessary) and who delivers the lectures should be evaluated.	N/A
10	Quality assurance of outreach placements must be improved including better monitoring by staff and increased feedback from students. All SLAs must be kept up to date.	Annual Monitoring
11	Improved internal recording of issues to be introduced. School must also implement regular communication with all outreach placements.	Annual Monitoring
12	The School should inform the GDC of future changes to student numbers and funding.	Annual Monitoring
14	A method for allowing the external examiners to provide overarching quality assurance must be introduced.	Annual Monitoring

Standard 3– Student assessment **Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task**			
Requirements	**Met**	**Partly met**	**Not met**
16. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards.	✓		
17. The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes	✓		
18. Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed	✓		
19. Students will have exposure to an appropriate breadth of patients/procedures and will 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	✓		
20. The provider should seek to improve student performance by encouraging reflection and by providing feedback1.	✓		
21. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body		✓	
22. 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	✓		
23. Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments	✓		
24. Where appropriate, patient/peer/customer feedback should contribute to the assessment process		✓	
25. Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion	✓		

[1] Reflective practice should not be part of the assessment process in a way that risks effective student use

26. 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	✓		

GDC comments

Requirement 16: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards *(Requirement Met)*

Student attainment throughout the programme is measured through a variety of assessments and reviewed at different times. Formative assessments are built into the assessment timetable and are used to identify those students who may be underperforming. Such assessments are considered in conjunction with summative assessment data and feedback on patient contact records so that the student's entire performance can be triangulated. Triangulation is aided from the various electronic recording systems in use, including a summative assessment database, called SIMS, and one for recording patient contacts, Salud.

The mechanisms for the review of student progression exist at two levels. CAMMS allows for regular reviews between the student and their tutor. These sessions are an opportunity for students to identify in which areas they need to gain more experience. It is then the duty of the Academic Review & Feedback Committee (ARFC) to make the formal decisions as to student progression year on year as well as the sign-up for the final assessments in Year 5.

The sign-up process involves input from the teaching staff and the individual Topic/Theme leads. All staff provide their input as to a students' performance and the ARFC then award a grade from 1 to 4, 1 meaning that the student presents no concerns and may proceed to finals, 4 meaning that the student must undergo the fitness to practise process with the possibility of that student deferring their finals for up to six months. The intermediate grades may indicate that no action is required but that the student could improve, or that they require mentoring and the ultimate decision as to progression will be deferred until the next ARFC. Out of the 80 student intake in 2009, 70 of those students progressed to the final exams, with some of the remaining ten having left the programme in earlier years or repeating Year 4.

The BDS is graded by incorporating five elements of student performance: the final exams (compromising three elements in total), course work and projects, and an OSCE in Year 4. All elements, aside from the OSCE, represent a percentage of how much that assessment type will contribute to the final grade, with the written exams representing 45% of the total BDS grade, for example. The OSCE must simply be passed and acts as another method of sign-up rather than a direct contributor to a student's attainment. Compensation exists within each of the elements but not between them, so exemplary performance in the final exams cannot compensate for poor performance throughout the programme in course work and projects. The final exams themselves comprise three multiple short answer question papers, a Clinical Case Presentation with viva, and an Unseen Case which students must diagnose and present.

It was seen at the Board of Examiners meeting how the students' marks for each element were recorded and converted into a percentage for the process of combining with the other elements. The process dictated in the Schedule of Assessment was followed at the meeting, and the panel were satisfied that the assessment conclusion was valid. However, the objectivity of the Board of Examiners in ratifying the students' marks was questioned because the Chair of the Board also examined students. While this was not felt to compromise the validity of the results, the ability of the Board to provide a last level of quality assurance is

compromised because the objectivity of both the Chair and the external examiners cannot be guaranteed (mentioned previously under Requirement 14). The School may wish to reconsider the role of the Chair in examining students.

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes *(Requirement Met)*

Student continuous clinical assessment is reviewed through the CAMMS. This process involves a review of data collected through SIMS and Salud. CAMMS informs the ARFC, specifically the information recorded on the student's ARFC data sheet, which is used to decide student progression at the end of each year.

CAMMS also gives staff a valuable opportunity to address any gaps in knowledge or skills directly with students. With CAMMS being separate from the end of year progression process, students are given the opportunity to address their deficiencies in ample time before this may affect their ability to continue on the programme to the next year. The assessment strategy has been fully mapped to the learning outcomes for each year. This gives assurance that if a student has passed all of their assessments in a year, then they have achieved the requisite learning outcomes.

The Salud system is used on the majority of UDH clinics and at the two major outreach placements. For those clinics and placements without Salud hard copy patient record sheets are used. Sheets are submitted to the Dental Academic Office (DAO) where the data is presented for inspection in hard copy to give a continuous picture of student activity.

The electronic, central recording of assessment and competency data allows staff to review a student's progression at any time. CAMMS reviews are felt by the panel to underpin the process and provide an opportunity to formally analyse the data and discuss achievement with students. Supported by the ARFC, the process overall was felt to be robust and effective.

Requirement 18: Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed *(Requirement Met)*

Assessments are monitored by the Director of Assessments, supported by the ARFC. The MDE project provided the programme with the opportunity to overhaul assessments, and the work has since been devolved to the BDS Executive, ensuring continual review of assessments and their effectiveness. The external examiner reports are used by the School to ensure that assessments continue to be appropriate and effective.

The School is undertaking an additional review of assessments in 2014 in response to University projects. This work had not started at the time of the inspection but the panel felt assured that the School-level processes amply monitored assessments.

The panel also felt that the range of assessments used were appropriate. An array of assessments are used including project work, written assignments, OSCEs, written examinations using multiple choice and short answer questions, and vivas. A professionalism viva is utilised as a gateway assessment before students start to treat patients. The panel questioned whether a viva was the best way to test a students' professionalism, but the programme were able to give a reasoned rationale as to the vivas' use. This assured the panel that the assessment methods used are considered fully.

The programme leads reported that they will be reviewing the final clinical exams with a view to potentially changing the format of these for future cohorts. Changes would be welcomed by the

panel as it was felt that the vivas were quite long, lasting for 30 minutes, and that this sometimes gave rise to high-achieving students being asked questions simply to use up the time available. This feeling was echoed by the external examiners and appropriate feedback was provided at the Board of Examiners meeting.

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will 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 on the programme are offered a range of opportunities to acquire the required competencies. The UDH is a busy facility offering different treatment clinics, and students are able to rotate amongst these. A triage system is in place to best allocate patients to students and an Adult Student Treatment List (ASTL) is used to track the allocations. An informal sharing arrangement can be utilised whereby students may swap or reallocate patients temporarily to allow a junior student, or a dental care professional student, the opportunity to get the experience required. The ASTL is overseen by a consultant dentist who also assists students to share patients. The sharing arrangement is an informal system because the School seeks to promote full patient care, and therefore allows patients to be seen by other practitioners for individual treatments only. The arrangement appeared to be effective as the students reported that they had little difficulty in treating the patients they needed.

The experience offered on outreach supports that received at the School. Placements are primarily community based, with two primary care units offering additional adult experience and one community dental service practice offering mainly paediatric experience. Specialist experience is gained at the DGH placements. The number of patient treatments at each of these sites is recorded by the DAO, meaning that a full picture of a students' attainment can be reviewed during CAMMS reviews.

The School seeks to be a competency-based programme and therefore sets minimum numbers prior to competency assessments as a guideline only. Setting this guideline helps to ensure that students have a minimum level of experience before achieving their competency. The panel were satisfied with the guidelines in place but were concerned that students reported these guidelines as being strict criteria. The disconnection between the School's use of minimum numbers and the fact that the students believe these are rigid does mean that some competent students may be completing more procedures before obtaining a competency, which may disadvantage other students who are not yet ready for a competency assessment and require further experience. The panel would welcome further communication between the School and students to ensure that an understanding of the use of minimum numbers is reached.

The panel were able to review individual student treatment data at the programme inspection and were concerned that a number of students still had zeros for some of their competencies, despite being in the final year of the programme. These numbers were reviewed again at the exam inspection and the zeros had been rectified. Student attainment is considered during the sign-up procedures for the final exams and all but one of the students entered for finals had met the competency requirements. The student who had not met the requirements had failed to do so because their patient had been unable to attend their last appointment due to breaking their leg. The panel accepted the School's decision to enter the student anyway as the patient's cancelling the appointment was outside of their control and an appointment had already been made to remedy the deficiency after the final exams.

The panel were satisfied overall that the Requirement was met but felt that some areas need to be addressed to strengthen the process. The misunderstanding of students as to the compulsory nature of the minimum procedure numbers is an area that should be discussed

with students at the earliest opportunity. The School should also consider whether patient sharing could be formalised so that it can be recorded and tracked.

Requirement 20: The provider should seek to improve student performance by encouraging reflection and by providing feedback *(Requirement Met)*

Feedback is an essential part of the programme. Students are expected to provide detailed feedback on a range of topics as well as receiving it for clinical work and summative assessments. The School has student-focussed guidance on receiving feedback and makes clear the range of ways in which this will be provided. Students receive feedback on every patient contact and are able to see marker's notes on written assignments. There is also a dedicated system for providing academic feedback called GradeMark. While the majority of students interviewed appeared to be familiar with the system, some students felt that the amount of academic feedback they received was not high enough. On raising this with programme leads, the panel found that not all students access their feedback on GradeMark, suggesting that the School need to drive students to use it.

Students are asked to provide formal feedback through questionnaires on all of the outreach placements. While this is a useful tool for quality assurance and ensuring that placements deliver the correct training, not all students appear to complete the questionnaires. In a report of feedback from the 2011/12 final year cohort, only 40 out of 73 questionnaires were received in regards to experience at the community dental service placements. 16 out of 73 questionnaires were received for Wrexham and 25 out of 73 for the DGH placements. While the feedback received is still useful, it is difficult for the School to be fully assured that the student experience on placement is valuable when the entire cohort does not respond. The School may wish to consider alternative ways of obtaining feedback to ensure that the majority of students respond.

However, as stated for previous Requirements, the School's committee structure allows for a lot of student interaction, thereby giving opportunities for the student experience to be improved through formal feedback at a committee level. The CAMMS also provides an opportunity for students to feed back to tutors.

Reflection is encouraged and the Salud system contains a link to an electronic portfolio, within which the student may log their reflection. The importance of reflective practice is included within the student-focussed guidance on feedback and is tested throughout the programme, notably in the professionalism viva in Year One, a case report assignment in Year Three, and the final year clinical viva.

The panel felt that feedback and reflection are well integrated into the programme.

Requirement 21: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body *(Requirement Partly Met)*

All clinical teachers and supervisors at the School are subject to University training policies and hold the requisite registration. Staff development days allow for marking schemes to be discussed and the staff to be calibrated. Internal examiners are provided with training to assist them in examining students. They are also part of the standard setting process by attending workshops to discuss the questions set and the marking criteria.

Both internal and external examiners are required to attend a briefing before the commencement of the final summative exams. The briefing contains full information on the marking scheme, the format of the exams, and practical information such as where the exam will be taking place and who will be in which examiner team. Teams of examiners are intended

to be specific to the branch of dentistry relevant to the case presentation or unseen case that the student will be discussing.

The panel was concerned that the training of internal examiners and the composition of the examiner teams was not as effective as required. Some examiner teams included internal examiners whose area of expertise was not directly related to the specialism being examined and examiners in that situation did not contribute an equal amount to the questioning of the student. It was also felt that in many teams, the responsibility for calibrating the team, composing questions and keeping to time was given to the external examiners. The marks between the internals could differ substantially and the external examiner was often required to moderate. While this could arguably be considered to be the responsibility of the external examiner within the scope of their quality assurance duties, the panel was concerned as to how fair the exams would be if the external examiners were to stop actively examining students. The panel were not confident that all of the internal examiners had the skills or confidence to examine students, and this could lead to a lack of equity and validity in the results in the future.

Outside of the summative assessments, the panel were also concerned that supervisors on outreach are not held to the same standard as those at the School. Training of the outreach supervisors is far more sporadic, especially for some of the more remote placements, and little information appears to be provided to those placements to assist the staff in using the marking scheme. It is not clear whether the professional credentials for each of the placement supervisors is reviewed by the School or whether their registration status is checked. Because of the disparity of interaction between different placements and the School, the panel were not assured that all supervisors had the appropriate knowledge and skills to assess students.

This Requirement is therefore considered to be partly met. The training of the internal examiners must be improved so that students may be examined effectively without the direct use of external examiners. Regular training for supervisors from all the outreach placements must be introduced to ensure that students are being assessed appropriately and fairly at all times.

Requirement 22: 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 *(Requirement Met)*

External examiners are required to report on the programme, including the final summative exams. The reports were made available to the panel. Additionally, the externals provide an oral report at the Board of Examiners meeting to flag the areas where improvements have been seen or where improvements are required. The requirement of the external examiners to report in these ways is contained within the University's External Examiners Handbook, which is updated annually.

The external examiners operated as a team during the summative exams and presented their recommendations as a group at the Board of Examiners meeting. The panel felt that working in this way was vital particularly when considering the equity and fairness of the exams because the examiners did not have an opportunity to observe any examiner teams other than the one within which they were actively examining. It was therefore imperative that there was effective collaboration between the external examiners to ensure that all the examiner teams were discussed and fairness considered.

The School needs to consider how team-working amongst the external examiners can be assured in future, particularly as one of the examiners will be retiring from their role. The external examiners need to continue to collaborate and work together if they are to continue to report effectively, especially as none of them can provide the overarching oversight of the final

exams. Any changes that the School plan to make to the format of the final exams and the use of the external examiners should be reported via the GDC's annual monitoring process for the panel's consideration.

Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments *(Requirement Met)*

The School has worked extensively within the past three years to standard set all the summative written assessments. Full completion of this work is expected by the end of 2014/15. A psychometrician has been utilised to assess the complexity and discrimination of the final exam questions, and a marked improvement is noted in standard-setting reports between 2011/12 and 2012/13.

The Angoff method is used for the calculation of pass marks and used in conjunction with the University's Registry regulations. Full evidence of the cut score and how this is then derived into a 40% minimum pass mark was seen at the exam inspection.

Formal standard-setting is not in place for the clinical exams. Question sheets are used which show the weighting that each element of the exam should be given so examiners can gauge the importance of each part of the exam. Examiners individually mark students, awarding an appropriate score out of the total number of marks available. Grade descriptors are included within the mark sheet. The use of the mark sheets does allow for some informal standardisation, but how the weighting of the different elements has been achieved was not detailed in the supporting documents. The panel recognised that the task of formally standard-setting clinical exams is a challenge but felt that more could be done by the School to ensure that an agreed standard to be achieved is evidenced and defined.

Assessment criteria are contained within student and staff-centred documents, including handbooks. A detailed assessment strategy document governs the overall process with the LTQC taking practical responsibility for scrutinising assessments and considering the appropriateness of assessments proposed by Topic/Theme leads. The assessment blueprints were felt to be very useful as these not only detail the assessments for each year but also highlight which of those are 'high stakes' and could threaten further progression or achievement of the qualification.

The Requirement is considered to be met on balance but the School should consider further action to improve how an agreed passing standard is determined for the final clinical exams.

Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process *(Requirement Partly Met)*

Peer feedback is obtained by the School. Students work in pairs early in their clinical experience, or when there is not a dental nurse to assist, and a proforma for obtaining this feedback was provided to the panel. When the proformas are collected, if they are collated and how they are then used to inform the assessment process was not evidenced.

Patient feedback is an area that the School need to address as soon as possible. At present there is no mechanism for patients to feedback exclusively about their treatment from a student or any supporting policy dictating how such feedback would be utilised. The University has a patient complaint and compliment policy and process, but this is not student-centric and does not seek to obtain regular feedback. Should a compliment or complaint be in regards to student treatment, there is no specific policy on how this would be provided to the School nor how the School would utilise this into the assessment process.

The School have stated that a pilot scheme for obtaining patient feedback will be implemented

in 2014/15. Upon review of the pilot documents, it was found that this was actually a student project and has not been contributed to or expanded upon by the School. The panel felt that the student project was insufficient as evidence of an impending pilot scheme and questioned how long the School would have continued without seeking patient feedback had that student not covered this in their project.

The School must implement a proper strategy for obtaining patient feedback. Supporting policies for the use of patient and peer feedback must also be implemented. The Requirement was felt to be partly met only on the basis that evidence showed the collection of peer feedback. Substantial work is required before the panel will consider the School to have met the Requirement.

Requirement 25: Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion *(Requirement Met)*

The programme is fully mapped to the learning outcomes, with blueprints in place for each academic year. The blueprints map to the pre-inspection documentation and the panel were satisfied that the learning outcomes are covered and assessed on a number of occasions throughout the programme.

The School is assured of a student's performance through CAMMS reviews and the yearly progression meetings. Students are exposed to a range of clinics within UDH and are therefore subject to a variety of different supervisors. This range assures the programme leads as to the reliability of a student's progression data because different dentists will be marking and assessing them.

The reliability and validity of the competency assessments is undermined by the lack of training for some of the outreach supervisors. There are no processes in place to ensure that there is effective calibration and the School cannot be assured that all supervisors are marking to a true and consistent level. This concern is mitigated to a small extent by the amount of experience students gain at UDH and at the two outreach placements close to the School which are subject to regular meetings with the programme leads. The interactions between those placements and the School assured the panel that for the majority of their clinical experience, students are being assessed to a consistent standard.

Requirement 26: 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 *(Requirement Met)*

Students are informed of the assessment standard through handbooks and access to the assessment blueprints. There was a mixed response from students when interviewed as to the amount of information they receive verbally but much of this was related to the honours component of the programme. Some students wanted to achieve a high standard academically in order to receive a higher degree classification, and the distinction between grades was not always felt to be clear.

The marking criteria are included within the student handbooks. Students reported that they understood the grades for clinical procedures but found the feedback more useful. As stated for an earlier Requirement, the amount of academic feedback was not felt to be sufficient but this may be improved through increased usage of the GradeMark system.

Teachers and supervisors are also informed of the assessment standard and mark schemes through handbooks. These topics are also covered in staff development days and pre-exam briefings.

The amount of active instruction supervisors receive on the assessment standard varies as supervisors at some outreach placements have not received any training or calibration guidance. However, the handbooks are circulated to those placements so information is readily available. The panel felt that much more could be done by the School to address this but, on the balance of the evidence provided, felt that the Requirement can be considered to be met overall.		
Actions		
Req. Number	**Actions**	**Due date**
21	Training for internal examiners must be improved. Regular training for outreach supervisors to be introduced.	Annual Monitoring
23	Formal standard-setting for final clinical exams should be implemented and documented.	N/A
24	A strategy for collecting patient feedback must be implemented. Policies to describe how patient and peer feedback contribute to the assessment process must also be introduced.	Annual Monitoring
26	School to introduce additional measures to ensure the assessment standard is understood by outreach supervisors.	N/A

Standard 4 – Equality and diversity The provider must comply with equal opportunities and discrimination legislation and practice. They must also advocate this practice to students			
Requirements	**Met**	**Partly met**	**Not met**
27. Providers must adhere to current legislation and best practice guidance relating to equality and diversity	✓		
28. Staff will receive training on equality and diversity, development and appraisal mechanisms will include this		✓	
29. Providers will convey to students the importance of compliance with equality and diversity law and principles both during training and after they begin practice	✓		

GDC comments

Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity *(Requirement Met)*

The School uses a range of University policies to govern their equality and diversity practices. An overall policy is used with additional policies that are more specific in dealing with particular issues, such as religion and sexual orientation. All policies encompass the Equality Act 2010.

The University and the School of Dentistry both hold Athena Swan bronze awards for their commitment to the advancement of women's careers. The School are pursuing the silver award and hope to apply for this in 2015. The bronze award was achieved in May 2013.

There have been no reported incidents regarding equality and diversity. Students with specific needs, such as dyslexia, have been integrated into the programme and records of reasonable adjustments to exams were evidenced.

Requirement 28: Staff will receive training on equality and diversity, development and appraisal mechanisms will include this *(Requirement Partly Met)*

Teaching staff at the School hold either a substantive or honorary contract with the University, and are therefore subject to regular equality and diversity training. Human Resources maintain staff records on the completion of training. Staff may receive their training outside of the University or School but evidence of this must be provided. Completion of training does form part of the appraisal process but the panel were disappointed to see that some members of staff, approximately 3%, had not completed training for some time, despite prompts to do so.

Equality and diversity training does not form part of the SLAs with outreach placements. Staff at Wrexham have not completed University equality and diversity training. The School is assured as to the training of the outreach teachers, to some extent, because the placements are NHS facilities with the requisite requirements for training that the NHS imposes.

The panel felt that the training of outreach teachers must be monitored by the School and the option to undertake University training extended. A clear policy on any repercussions for those staff members who have not completed their training should be introduced.

Requirement 29: Providers will convey to students the importance of compliance with equality and diversity law and principles both during training and after they begin practice *(Requirement Met)*

The professionalism strand runs throughout the programme and includes teaching on equality and diversity. The differences in legislation between the four UK nations are covered. Students are taught through a variety of methods including presentations and scenario-based learning.

Students were able to describe key principles of equality and diversity, and understood the need to not stereotype patients and treat everyone with respect. The recognition of 'equality and diversity' as a term was not widely understood and had to be discussed in further detail. Year One students appeared to have better knowledge and understanding of the concepts than more senior students.

The panel felt that the Requirement was met on balance although teaching on this for senior students could be strengthened.

Actions

Req. Number	**Actions**	**Due date**
28	The training of outreach teachers must be monitored by the School.	Annual Monitoring
29	Equality and diversity training for final year students should be more robust.	N/A

Summary of Actions

Req. Number	GDC Requirements	School Action	Progress	Due date
3	Up to date SLAs to be obtained to ensure appropriateness of the placements.	1. Service Level Agreements for all outreach centres for the 14/15 academic year have been completed. 2. School has also introduced a Health, Safety and Environment declaration document as part of the SLA process. 3. School is currently reviewing the 15/16 Service Level Agreements with outreach providers. These will be agreed in readiness for the 15/16 academic year (1 August -31 July). 4. School has implemented an annual QA checking process in all outreach placements. 5. Working to a common template all placement clinical leads will undertake a site visitation in line with the School's SLA monitoring and review cycles (currently in progress). 6. Feedback from site visitations will be reviewed by the relevant Board of Studies for action. 7. The School has also reviewed the School's student feedback surveys for all outreach placements to include questions in relations to the agreements and expectations outlined in the SLA and Health and Safety declaration documents.	COMPLETE	GDC Annual Monitoring
5	Training of clinical supervisors to be strengthened and developed to include outreach supervisors.	1. SLA documentation requires outreach providers to release staff to attend mandatory staff training sessions delivered by the School on an annual cycle. 2. As part of the School's standardised outreach visitation template, training needs and requirements will be assessed to ensure that clinical staff have the relevant skills. This process includes the collation of an annual staff profile and evidence of training.	COMPLETE ONGOING	GDC Annual Monitoring

Req. Number	GDC Requirements	School Action	Progress	Due date
		3. Clinical training will be included within the Staff development day programmes; 1 per term for Dental School staff and annually for CDS outreach staff. 4. The Outreach lead clinic visits will include refresher training for staff unable to attend the development day. 5. The School will also use the ability to lecture capture local training sessions with School teaching staff to share and standardise practice with outreach providers.	ONGOING ONGOING IN PROGRESS	
6	The provider should consider implementing a School-level whistleblowing policy that is specific to the field of dentistry.	1. The School will implement a School-level whistleblowing policy as specified for introduction in the 2015/16 academic year.	IN PROGRESS	N/A
7	A process for the reporting and resolution of patient safety issues at outreach placements must be implemented.	1. The School has reviewed and implemented Service Level Agreements and Health and Safety declaration statements with all placement providers. 2. These documents clearly outline the requirements and expectations in relation to patient safety. Outreach leads will report patient safety issues as part of their annual report to Board of Studies.	COMPLETE	Annual Monitoring
9	The provider should improve the recording of committee meetings and actions.	1. The School has reviewed the Educational Committees to ensure they are fit for purpose. 2. Agenda templates and standardised minutes are being introduced across Committees. An Action template has been piloted and will be rolled out to all Committees.	COMPLETE IN PROGRESS	N/A

Req. Number	GDC Requirements	School Action	Progress	Due date
9	The administration of lectures in terms of student attendance and contact should be evaluated.	1. The School will continue to use text tools to inform students of any cancellations as soon as they are known. 2. A Partnership Committee has been established for a select group of School management to meet with Hospital management. With the full support of the newly appointed Hospital Manager, the School envisages significant support in resolving these issues going forward. 3. The School is a pilot School for the University's online timetabling tool. This is envisaged to ensure that changes are communicated and visible electronically as soon as the Academic Office is aware of the cancellation. The School will assess the use of this tool in 14/15 and identify areas for development and improvement to the University Steering Group. 4. Procedures have been put in place to follow in the event of a clinic or lecture cancellation or rescheduling. The report is reviewed by the UG Director and Vice Dean Education and Students each week and reviewed at SMC.	COMPLETE ONGOING ONGOING ONGOING	N/A
10	Quality assurance of outreach placements must be improved including better monitoring by staff and increased feedback from students. All SLAs must be kept up to date.	1. Please refer to Req. Numbers 3, 5 and 7 for details of actions.		Annual Monitoring

Req. Number	GDC Requirements	School Action	Progress	Due date
11	Improved internal recording of issues to be introduced. School must also implement regular communication with all outreach placements.	1. Regular recorded monitoring visits have been introduced with reports being made to the BDS Board of Studies and disseminated across the School as appropriate. A process for addressing urgent issues in place through direct reporting the UG Director for immediate action. All issues will be recorded through the Board of Studies with actions and outcomes. 2. See also Req. Numbers 3, 5 and 7 for details of actions.	COMPLETE	Annual Monitoring
12	The School should inform the GDC of future changes to student numbers and funding.	1. The School will report changes to student numbers, funding and any implications as part of the Annual Monitoring Report or directly if applicable.	ONGOING	Annual Monitoring
14	A method for allowing the external examiners to provide overarching quality assurance must be introduced.	1. As changes to the role of external examiners has implications in relation to information provided to students and to University regulations, this issue is to be taken up with the wider University and at College level. The Director of Assessment and Feedback will take this forward. The School will introduce an observational aspect to the role of an external examiner for 2015/2016.	ONGOING	Annual Monitoring
21	Training for internal examiners must be improved.	1. New training sessions for internal examiners has been developed for 2014/15.	COMPLETE	Annual Monitoring
21	Regular training for outreach supervisors to be introduced	1. Please refer to Req. Numbers 5 for details of actions. 2. School will also retain a log of all training undertaken, to include attendance logs. 3. As part of the visitation schedule with outreach centres, the clinical lead will reinforce the expectation for the outreach clinical lead attending the School's training sessions to disseminate and standardise practice to the local outreach team.	ONGOING	Annual Monitoring
23	Formal standard-setting for final clinical exams should be	1. Standard-setting has been introduced and is being rolled out.	ONGOING	N/A

Req. Number	GDC Requirements	School Action	Progress	Due date
	implemented and documented.	2. The cases for final clinical cases have been standardised. 3. The School is reviewing psychometric support.		
24	A strategy for collecting patient feedback must be implemented. Policies to describe how patient and peer feedback contribute to the assessment process must also be introduced.	1. The questionnaire and process piloted during 2013/14 has been rolled out this academic year (2014/15). See also Additional Observations.	COMPLETE	Annual Monitoring
26	School to introduce additional measures to ensure the assessment standard is understood by outreach supervisors.	1. As 21 above.	ONGOING	N/A
28	The training of outreach teachers must be monitored by the School.	1. Please refer to Req.21 and 5 for action details.	COMPLETE	Annual Monitoring
29	Equality and diversity training for final year students should be more robust.	1. A comprehensive E&D training is provided as an integrated part of the programme as a whole and has been substantially revised and updated over the last 2 years.	COMPLETE	N/A

Observations from the provider on the content of the report

Provider to record any additional observations here

The School wishes to thank the Inspection team for the constructive and helpful way in which the review was undertaken both in the main inspection and at

Finals examinations. We are pleased with the positive outcome and the areas identified for us to take forward for further improvements which we are confident will be addressed through our action plan.

There are a couple of specific comments the School wishes to make in relation to the report:

Requirement 10 - The School is addressing the areas identified. The retirement of the lead member of staff for this area had significant impact on monitoring.

Requirement 24 - In relation to the Inspectors comments regarding patient feedback, the patient satisfaction pilot project had actually been designed and fully planned by the Director of Assessment as part of an ongoing initiative to involve the patient as an assessor thereby improving the feedback a student receives on their clinical performance. An undergraduate student was invited to support the running of the data collection and subsequent analysis as part of a final research project under the direct supervision of the Director of Assessment. The questionnaire will be used on a more formal basis this academic year (2014/2015).

Recommendation to the GDC

The inspectors recommend that this qualification is sufficient for holders to apply for registration as a dentist with the General Dental Council.