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INSPECTION REPORT

Education Provider / Awarding Body:	**University of Central Lancashire (UCLan)**
Programme / Award / Qualification:	**Bachelor in 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 GDC as a dentist**
Learning Outcomes:	***Preparing for Practice (Dentist)***
Programme Inspection Dates:	**22 & 23 January 2014**
Examination Inspection Dates:	**29 April 2014** **28 & 29 May 2014**
Inspection Panel:	**Alan Kershaw (Chair and Lay Member)** **Janine Brooks (Dentist Member)** **Samuel Cadden (Dentist Member)** **Shazad Malik (Dentist Member)**
GDC Staff:	**Laura Harrison (Lead)** **Luke Melia (Programme inspection only)** **Krutika Patel (Exam inspection only)**
Outcome:	**Recommended that the UCLan BDS Programme remains sufficient for registration as a dentist**

Inspection summary

The inspection panel was impressed by this modern, modular programme which is delivered, in the main across a number of Dental Education Centres (DECs) and Extended Training Practices (ETPs). The course has been designed to emphasise the practice of primary care dentistry without jeopardizing the students' exposure to secondary care. In the Dental Education Centres all clinical work is carried out in multipurpose clinics to ensure that students achieve a good experience of integrated care.

There is excellent standardization across training locations in terms of student experience and in the approach to supervision and assessment. Solid central management and co-ordination of the programme in addition to the good communication and relations between the various stakeholders involved in the programme undoubtedly plays a very important role in achieving this high level of consistency.

The culture within the School and DECs is very positive and there is excellent support provided to the students by a team of dedicated and committed staff, which is matched by a high level of maturity and enthusiasm in the students. The relatively small cohorts benefit from high levels of staff supervision and there is a collaborative approach towards learning, which clearly instills confidence and inspires the students.

The programme is well organized and ensures thorough assessment of students across the learning outcomes contained within the GDC publication *'Preparing for Practice'*. There is evidence of a modern and robust approach to assessment, with the assessment methods subject to regular review and development. Some attention should be paid to the Seen and Unseen case presentations to ensure greater consistency in the questioning and marking of students.

The programme is subject to good internal and external quality assurance procedures. Care needs to be taken to ensure there are clear and full records kept of all meetings, training and decision trails and some procedures require formalization.

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 leading to registration 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 from 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.

6. 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.

7. 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

8. This report sets out the findings of an inspection of the Bachelor of Dental Surgery awarded by the University of Central Lancashire (UCLan). The GDC publication *Standards for Education* (version 1.0 November 2012) was used as a framework for the inspection. This inspection forms part of a series of BDS inspections being undertaken by the GDC between 2012 and 2014.

9. The inspection comprised three visits. The first, referred to as the programme inspection, was carried out on 22 and 23 January. This involved a series of meetings with programme staff involved in the management, delivery and assessment of the programme and a selection of BDS students. The second visit took place on 29 April and involved an observation of the Clinical Assessment Panel, during which student sign-up decisions were made by the School, and a meeting with the Associate Dean. The third visit took part on 28 and 29 May when the panel observed the final examination and examination board meeting.

10. The report contains the findings of the inspection panel across the three visits and with consideration to the supporting documentation prepared by the School to evidence how the individual Requirements under the *Standards for Education* have been met.

Overview of Qualification

11. There are 32 students per cohort. Students spend most of their first year of study (BDS year 2) at UCLan School of Dentistry and from the end of their first year until the end of the programme (BDS year 5), they are based in and develop their clinical skills in one of four Dental Education Centres (DECs) that are located in Accrington, Blackpool, Morecambe and Carlisle. Eight students per year group for BDS years 2-4 are placed in each DEC and they are generally allocated one of their two preference locations.

12. The DECs each have their own on-site UCLan-employed clinical teaching staff, in addition to hospital-based secondary care consultants and specialists who deliver the curriculum for years 2, 3 and 4, in association with the UCLan dental school.

13. Each DEC is co-located within a primary dental care centre, through which the majority of patients are triaged. Students access a high number and range of primary care patients and screening of patients by the clinical teachers ensures they are allocated patients with increasingly complex treatment plans.

14. During their third year, the students commence a range of secondary care placements, alongside their clinical training in their DEC. Students gain most of their experience of secondary care dentistry within hospitals local to their particular DEC. Students spend two sessions of 3 – 4 hours per week in specialist clinics in both the third and fourth years. In respect of Oral Medicine, all the students spend sessions at Liverpool Dental Hospital.

15. In addition to continuing their clinical training in their DEC and attending hospital placements, final year students also treat patients in one of four 'Enhanced Training Practices' (ETPs). The ETPs are general dental practices which are located close to each of the four DECs and are designed to offer the students a less supervised training environment to prepare them for independent practice.

Evaluation of Qualification against the *Standards for Education*

16. 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 fully meet all of the Requirements under the Standards 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.

17. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards. This involved stating whether each Requirement is 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.

18. The inspection panel used the following descriptors to reach a decision on the extent to which the UCLan BDS 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)*

In February of BDS year 2, satisfactory completion of the Foundation Clinical Skills and Knowledge modules is required before students may start their clinical activity. Module descriptors indicate that the Foundation Clinical Skills module is assessed via a Clinical Progression Test (50% weighting) and a series of Directly Observed Procedures (DOPs) (50% weighting) and that the Foundation Clinical Knowledge module is assessed via a written paper

and a series of in-course tests. It was stated in the pre-inspection material that students need to pass a Clinical Readiness Exam. Inspectors attempted to clarify during the inspection whether this was another name for the Clinical Progression Test but were unable to gain a clear understanding of the difference, if any, between the two. It is important for all concerned that the School is consistent in their terminology used.

The Clinical Readiness Exam/ Clinical Progression Test and the DOPs test students' cavity and restoration skills on human teeth in phantom heads. There was some confusion as to whether every one of the DOPs had to be passed, and also whether compensation was allowed between the DOPs and the exam/test. Pre-inspection material from the School indicated that the Clinical Readiness Exam had to be passed independently of the DOPs and students the panel spoke to indicated that this was also their understanding. However, minutes of the Module Assessment Board in March 2013 indicated that a failed Clinical Progression Test could be compensated by successful results in the DOPs. This approach was reinforced by tutors during the inspection who advised that in the event of a student failing one of the assessments, the Chair of the Assessment Board would be able to use their discretion to make the ultimate pass/ fail decision and they would do this by looking at the student experience in its entirety. The inspection panel was surprised to note that there was no evidence that the Chair of the Assessment Board used any guidelines or marking framework to reach their decision.

Students benefit from extremely close supervision and excellent support during their pre-clinical training and the students to whom the inspectors spoke indicated that they felt ready and confident to treat patients once they had passed the pre-clinical assessments. In the event of students having to re-take any part of the assessment, they are provided with considerable remedial training. Once they have passed the pre-clinical assessment in BDS year 2, students' clinical abilities are also reviewed by tutors in the DECs before they are allowed to treat patients.

In order to progress through the programme, students must pass a number of further pre-clinical assessments on more advance procedure types. In BDS year 3 they are required to pass 3 Endodontic (basic, single-rooted and multi-rooted) DOPs on a phantom head; in BDS year 4, they must pass an MOS DOP and 2 Crown DOPs before proceeding in these areas and in BDS year 5 successful completion of a Bridge DOP is required before they are allowed to offer this treatment to patients. The inspectors felt the timings and content of the pre-clinical assessments were sound and they were impressed at the high level of pre-clinical supervision of students. In spite of some confusion about the BDS year 2 progression criteria, they felt confident that students were allowed to treat patients only when they were clinically ready to do so. For this reason, they found the requirement to be 'Met'. The inspectors were a little disappointed though by the lack of clarity about the decision-making processes in the Clinical Readiness Exam/ Test and this should be rectified as soon as possible by the School.

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

The School indicated that notices, which indicate that treatment may be provided to patients by students, are displayed in each of the DECs and the ETPs. Patients in the DECs and the ETPs are routinely advised before their first appointment that they may be treated by students and they are offered the opportunity to decline. The inspectors were informed that the majority of patients are happy to be treated by students.

Students from each of the year groups the inspectors spoke to indicated that they would introduce themselves as a student to patients and they would reassure nervous patients by also introducing their tutor. The students all wear distinctive coloured tunics which distinguish

them from registered professionals. They also wear name-badges highlighting their status as a student.

The students indicated that they routinely obtain written consent from patients to treat them and that the consent forms, which are counter-signed by the students' DEC-based tutors, are kept on the patient files.

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 Met)*

Each of the DECs and ETPs used by the School for dental training have Care Quality Commission (CQC) registration and the School provided evidence to demonstrate that each training location complied with routine NHS inspection and audit processes.

In addition, evidence was provided of the School's audits of all the training locations. Any concerns identified by the audit are raised with the clinical directors at the site and are escalated as appropriate. The inspection panel was informed that the clinical members of staff who are based at the DECs closely monitor patient feedback. They relay immediately to the School any concerns they have about the clinical environment so that any necessary follow up action can be taken.

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 inspectors considered there was an excellent level of supervision provided to students throughout the course and in all training locations.

The School adheres to its 'Policy on Supervision of Students' and ensures a high number of clinical supervisors are available to students in all teaching locations. Students clearly benefit from the relatively small cohort size (average intake of 32) and the impressive ratio of staff to students. When working on phantom heads, the student-staff ratio is 16:3 and students commented that they regularly benefit from 2:1 and sometimes 1:1 supervision in the DECs .

Students commence clinical activity in DECs under very close supervision: clinical tutors oversee every part of a procedure the student is carrying out. Students will always be observed when taking radiographs. Students commented that teaching and clinical staff were very responsive to their needs and provided them with reassurance and guidance whenever it was requested. Students stated there was consistency between supervisors and excellent communication. It was clear to the panel that the student-staff relationship is one based on trust and respect and that this creates a very positive learning environment for the student and promotes their development.

ETP supervisors indicated that they make an initial assessment of the student's level of skill and the placement commences with one to one supervision. This will decrease in line with the student's development. The ETP trainer will only ever have a maximum of four students in their practice at any one time and the students reported their trainers would always be available quickly if needed. The ETP trainers indicated that they always closely supervised students when they undertake extractions. Students were very positive about their experience in the ETP's and stated that the lower levels of supervision in these training locations prepared them well for independent practice.

Whilst students do not undertake many clinical activities in the secondary care clinics and the emphasis is on observation, they are still supervised on a 1:1 or 2:1 student: staff ratio. The inspectors felt this maximised the learning potential of the placement.

All the students to whom the inspectors spoke, were very happy with the supervision provided to them at all stages of the course and it was clear that they found staff approachable and very supportive. The students' enthusiasm for the training model at UCLan and the level of support they received from clinical staff throughout their course was striking. The School is to be commended on the professional and supportive culture it has engendered in the School, the DECs, ETPs and Secondary Care Placements.

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

All members of clinical staff on the course are registered with the relevant regulatory body and the inspectors formed the view that they were all offered appropriate training to undertake the role of a supervisor.

A policy on the clinical supervision of students sets out the responsibilities of all clinical supervisors. There is always at least one senior clinical tutor at each DEC who advises and assists clinical supervisors. In addition, a range of informal training is offered to individuals joining the DECs and ETPs, which includes shadowing other supervisors, discussions and informal supervision. Informal induction also takes place for secondary care consultants.

UCLan members of staff are encouraged to undertake a Post Graduate Certificate in Training in addition to a School-based 'teaching toolkit'. Clinicians who work on the programme on a part-time basis spoke highly of the support and encouragement they receive from the School to undertake training related to their role as a supervisor and assessor of students. NHS training packages are also available to clinical supervisors including a 'Train the Trainers' course.

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 inspectors noted that the School and its NHS partners have relevant whistle-blowing policies. A 'Raising Concerns' policy and flowchart which shows how a patient safety concern should be raised within the School, was also made available to the panel. Clinical supervisors are required to highlight any risks to patient safety to the senior clinical teacher of the student in question. Dental nurses in the DECs are also aware of the need to be proactive in highlighting any concerns they may have. The inspectors were assured that Senior Clinical Tutors at each of the DECs would escalate appropriately any concerns made known to them, to senior management within the School in accordance with the 'Raising Concerns' flowchart. The inspectors considered that the guidance provided by the School to clinical supervisors on the programme relating to patient safety was good. During the inspection, however, they were concerned to note an example of a patient safety issue which was identified by a supervisor and apparently not reported to the relevant Senior Clinical Tutor. The inspectors considered this was probably an isolated incident but one which nonetheless highlights the need for the School to reinforce to supervisors across all training environments, the process for reporting patient safety concerns. It is essential that all incidents are recorded, even if they seem minor, as this may show a pattern of behaviour developing.

Students the inspectors spoke to were clear on whom they should report any concerns to and they were confident that their clinical supervisors would deal with any concern raised appropriately and promptly. They indicated that they are made aware of, and instructed on, the 'Raising Concerns' flowchart during the annual 'Professional Awareness' modules. Students advised that it had been 'drummed into them' that the patient was the most important person and the inspectors were in no doubt that the students recognised their obligation as dental professionals to prioritise patient safety.

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

The training centres used on the programme are subject to both NHS and UCLan Dental School reporting procedures. In accordance with the UCLan 'Untoward Incident' Policy, any such incidents must be reported on the designated reporting form, the contents of which are discussed at clinical academic meetings. A School 'Untoward Incident' log is maintained and regularly reviewed at senior level and necessary follow up action is made clear to senior staff and DEC staff. In view of the clear reporting lines between the training locations and UCLan via the Senior Clinical Tutor, the inspectors considered that appropriate action would be taken in a prompt and effective manner, should the need arise. An example of a patient safety concern involving a DEC supervisor was provided as an illustration of the procedures in place.

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)*

There is a University 'Fitness to Practise' policy which makes provision for professional regulatory requirements. Most of the clinical supervisors with whom the inspectors met, showed awareness of the policy and students indicated that they are introduced to it during their first year. The School refers to it throughout the course. The inspectors considered that the introduction of a School-specific 'Fitness to Practise' policy with clear guidance on remit, which aligns to the GDC student fitness to practise guidance, and with a related set of procedures and appeals process, would be useful. Students sign a contract at the beginning of each year which obliges them to act in a professional manner. Students are also provided with the GDC 'Fitness to Practise' Guidance. All the students with whom the inspectors met appeared to fully recognise their professional obligations.

The School uses a Red and Yellow card system whereby students are issued with a card if they are deemed to have acted in an unprofessional manner. They are allowed a set number of Red and Yellow cards per term and if they exceed the stated amount, they will fail the professionalism module for that year. The students the inspectors spoke with appreciated why the Professionalism Card system had been introduced. They did, however, provide mixed feedback about the way the system was operated, with some showing enthusiasm for it but others commenting that it wasn't applied consistently and that there had been circumstances where there seemed insufficient justification for the use of a card.

The inspectors noted that there was confusion amongst some students and supervisors about the difference between the 'Fitness to Practise' policy, the 'Raising Concerns' policy and the Professionalism Red and Yellow card system. Whilst the inspectors recognise that each of these may address very similar issues, there is a need for the School to make clear to students and staff, the situations when it will be appropriate to use each of them and to ensure consistency in the application of the different procedures.

Actions		
Req. Number	**Actions for the provider**	**Due date (if applicable)**
1	The School should clarify the difference between the Clinical Readiness Exam and the Clinical Progression Test	Update to be provided through the 2015 GDC Annual Monitoring exercise
1	The School should clarify the compensation rules relating to the BDS 2 pre-clinical assessment to students and in course documentation	Update to be provided through the 2015 GDC Annual Monitoring exercise
1	The School should provide clear guidelines to the Chair of the Assessment Board and strengthen the mechanism used to determine whether a student passes in the event of a pre-clinical assessment being failed.	Update to be provided through the 2015 GDC Annual Monitoring exercise
6	The School should strengthen the training and induction for staff and students to emphasise their duty within their respective roles to raise concerns about patient safety.	Update to be provided through the 2015 GDC Annual Monitoring exercise
7	The School should reinforce to supervisors in all training environments the process for reporting patient safety concerns.	Update to be provided through the 2015 GDC Annual Monitoring exercise
8	The School should develop its own Fitness to Practise policy with clear guidance on its remit and an associated appeals policy.	Update to be provided through the 2015 GDC Annual Monitoring exercise
8	The School should make clear to students and staff the circumstances when the Raising Concerns and Fitness to Practise policies and the Professionalism Card system should be used; and ensure consistency in the application of the various procedures.	Update to be provided through the 2015 GDC Annual

		Monitoring exercise

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)*

The Programme Director has ultimate responsibility for the management of the quality of the programme and this responsibility is devolved to the Associate Dean and Clinical Educational Manager.

The framework for the management of the programme at School level has had to evolve over a relatively short space of time to accommodate two recent significant changes: the changeover from UCLan delivering the Liverpool University BDS to delivering its own BDS, which occurred in 2012; and the creation of the new School of Medicine and Dentistry in

September 2013.

When the Dental School opened in 2007 it offered the Liverpool University BDS and the Dental Academic Committee (DAC) was the key committee for managing the programme. UCLan began awarding its own BDS in September 2012 and at this point the DAC was re-named the BDS Academic Committee. This Committee became increasingly multipurpose, with agenda items ranging from day-to-day operational matters, programme monitoring to strategic planning. There was a need to review and refine the remit of the Committee and this opportunity arose when the School of Dentistry merged with the School of Postgraduate Medical and Dental Education to form the School of Medicine and Dentistry in September 2013.

The Dental School was still in a transitional phase in terms of management structure at the time of the GDC programme inspection in January 2014. Terms of Reference for new Committees were in the process of being written and the School advised that some staff and Committee meetings had temporarily petered out due to the merger of the Schools. There was an intention to implement a new, more cohesive, clear and streamlined reporting structure as soon as possible.

By the time of the GDC examination inspection, there was evidence of a functioning and defined management and reporting structure. Committee meeting minutes provided were brief but clear and there was evidence of follow through on issues discussed. Documented terms of reference for the two key Committees revealed that a new BDS Management Committee has as its main function the role of monitoring on a weekly basis the progress of actions originating from the BDS Academic Committee and Stakeholder groups, and also the School Executive Team, to which it reports. The BDS Academic Committee, which meets on a monthly basis, is the main forum for discussion about the delivery, development and monitoring of the programme. Recommendations from the monthly DEC Operational Group, twice yearly Staff Student Liaison Committee (SSL) and annual Consultant Group meetings feed into these discussions. The DEC Operational Group discusses feedback from DEC staff and ETP trainers.

Students spoke positively about the effectiveness of the SSLC and indicated that members of staff welcomed suggestions and acted promptly on feedback received both informally and via the Committee. The inspectors were informed that, whilst the School doesn't yet ask for formal student feedback after each module, there are plans to introduce this. Secondary care and ETP placements are routinely evaluated by students through formal mechanisms.

The quality of the programme content is managed in line with UCLan's Academic Quality Standards Policy. There appears to be a clear and straightforward reporting structure between the School and the University and matters transit between the two, via the Senior Executive Team, with apparent ease. An annual course report, which is based on annual subject reports, is submitted to the University and recommendations are acted upon promptly.

In line with University regulations relating to new courses, after its first full year of operation the UCLan BDS underwent an interim review. A University appointed Review Panel reported to the Academic Standards and Quality Assurance Committee and made a few recommendations. The inspectors noted that these were duly discussed by the relevant School Committees, and acted upon within timescale, providing further evidence of an effective internal quality assurance mechanism.

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

For the purpose of this report, the DECs, ETPs and Secondary Care Placements will all be considered in this section.

The inspectors were very impressed by the measures in place to quality assure the various training establishments on this programme. There are effective lines of communication between the training placements and UCLan; regular opportunities for all supervisors, patients and students to provide feedback; regular meetings and training opportunities in addition to the rotation of clinicians across DECS. These measures assured the inspection panel that this de-centralised model of teaching and assessment provides a standardised learning experience for all students. The quality assurance mechanisms in place are robust without being overly burdensome or restrictive and the Dental School is to be commended for managing so well this extremely important aspect of the programme.

Oversight of the various placements is undertaken, in the main, by the Clinical Co-ordinator who is in regular contact with the Senior Clinical Teachers of the DECs. They also attend monthly DEC operational meetings and conduct an annual audit of the four DECs and the four ETPs. Outcomes and action points from the audits are discussed and addressed at the BDS Academic Committee and reported to the Associate Dean. The School is currently organising a method by which action points can be logged and monitored centrally.

The Senior Clinical Teachers also play an important role in quality assuring the placements. They attend meetings at UCLan on a weekly basis. DEC Operational Group meetings are attended by the Senior Clinical Teachers from each of the DECs and UCLan-based clinical staff, and these meetings are an opportunity to discuss operational issues affecting equality of experience and teaching at the DECs and ETPs. The focus of the discussion is to ensure that the DECs and, to a degree, the ETPs, continue to work in a similar manner, that there are equitable resources, consistent teaching and assessments, and that students have comparable access to patient types and procedures.

The Clinical Co-ordinator is a contact point on a daily basis for the Senior Clinical Teachers from each of the DECs and is able to discuss, resolve, or escalate issues as needed. The open and co-operative culture within the School encourages staff to share ideas, thoughts or discuss issues informally. It was felt that this openness further contributes to the joined up thinking across the DECs.

The four Senior Clinical Teachers are the point of contact for the Clinical Supervisors within their own DECs, and the ETP trainers ‘linked’ to their DEC. DEC meetings are held amongst tutors on a formal and informal basis. ETP trainers attend two meetings a year with the Senior Clinical Teacher: once when the student starts the placement and then again when they are half way through. Secondary Care Placement supervisors also have direct and regular contact with the Senior Clinical Teachers, the Clinical Co-ordinator or other senior members of the teaching staff at UCLan. Their views are also fed in to the DEC Operational Group meetings and the BDS Academic Committee meetings. In addition, the School holds an annual meeting with the Secondary Care Placement Supervisors to discuss issues relevant to the programme and any matters arising from student evaluation of placements.

Consistency of teaching and assessment is further facilitated by training sessions for clinical supervisors if required, well planned inductions for any new staff, a clear supervisor handbook and the co-ordinated rotation across the DECs of Clinical Supervisors and Senior Clinicians with particular areas of expertise.

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

UCLan's Academic Quality Standards Policy requires the Course lead to confirm that action has been taken to address any issues identified through the operation of the quality management framework, within specified time scales. As already mentioned, the panel found evidence that the School had responded promptly and effectively to the points raised within the Internal Course Review. Equally, the School is responsive to comments raised by external examiners: this will be dealt with more fully under Requirements 13 and 15.

Students whom the inspectors spoke with felt confident that any issues they may have with the course would be addressed and resolved to the best of the School's ability in a timely and helpful manner.

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)*

There was no evidence of any serious threats to students achieving learning outcomes through the programme. The panel was confident that the quality management systems in place and the culture of openness within the School would ensure that the GDC would be notified at the earliest possible opportunity, should any such threats arise in the future. The School advised that any such risks would be placed on the School Risk Register and closely monitored.

The inspectors noted there was dialogue between the School and Commissioners, Deaneries, teaching hospitals used for secondary care placements and the ETPs, which include corporate bodies. The School may wish to consider creating a formal mechanism for regular discussion and formally documenting all discussions and meetings. This would safeguard against any issues being inadvertently overlooked.

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

The internal quality assurance procedures at School and University level have been commented on under Requirements 9 and 11. The new quality management structure has only very recently been implemented in the School, due to the creation of the new School of Medicine and Dentistry, but it appears to be functioning well with regular oversight of the programme.

The programme is subject to regular external scrutiny. At present there are ten external examiners who operate in accordance with the University policy on External Examiners. This policy requires of them to '*ensure standards and comparability are maintained and to judge whether students have fulfilled the objectives of the programme and reached the required standards'*.

The external examiners are invited to report on the learning and assessment processes for specific modules, and to make recommendations where necessary. The panel had sight of external examiner reports and actions taken by the School in response. It was clear that the external scrutiny of the examinations adds rigour and fresh perspective to the process and external examiners' comments are welcomed by the School and dealt with in a constructive manner.

The examiners are asked to comment on examination papers before they are set and they attend the final examinations. The inspectors met with the three external examiners for the

final year Integrated Clinical Care Module. The external examiners told the inspectors that they felt the School was very well organised and gave them plenty of time to return their comments in advance of the examination. Their role at the examinations is essentially to ensure consistency and fairness and, apart from one 5th year BDS examination which they were involved in (although not examining), they attend as observers. The external examiners are required to sample high passes, borderline passes and failed examination scripts and coursework but they do not moderate marks and they are not allowed to change the marks awarded. They can, however, comment on any unsafe practice and formally draw this to the attention of the Chair of the Assessment Board should they need to. The panel was a little surprised that only one of the external examiners reviewed the clinical log books of the students. In order to gain a comprehensive understanding of the clinical standard achieved by the students, the School should consider requesting each of the external examiners to sample these highly informative sources of material.

Requirement 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 *(Requirement Met)*

The Dental School utilises suitably qualified external examiners in an appropriate manner and in accordance with QAA guidelines.

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

External examiner reports are dealt with in accordance with University policy and responses to the findings are provided within specific timescales. The School creates an action plan to respond to the reports and external examiners are advised as to whether their comments are being taken forward. Their reports are subsequently made available to students. The external examiners indicated that the School acts promptly on any suggestions and it appeared that they have good, constructive dialogue.

Actions

Req. Number	Actions for the provider	Due date (if applicable)
12	The School should consider formalising its communication with key stakeholders	Update to be provided through the 2015 GDC Annual Monitoring exercise
13	The School should consider whether to make available student clinical log books to each of the 5th BDS external examiners	Update to be provided through the 2015 GDC Annual Monitoring exercise

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 feedback[1].	✓		
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	✓		

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

be taken to ensure the validity and reliability of the assessment conclusion

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)*

As part of the pre-inspection submission, the School provided a detailed paper-based mapping of the programme against the GDC learning outcomes in *Preparing for Practice.* This document suggested that many of the learning outcomes were assessed by different assessment methods and across more than one year of study. Most of the learning outcomes are assessed across most or all of the years of study when clinical activity is undertaken. Module descriptors and assessments within the modules are mapped against GDC and course Learning Outcomes. The School informed the panel that as many areas as possible are tested during the final 5th BDS examination and this was evidenced by the range and content of the assessments observed by the panel. There is a clearly defined exam setting procedure and the panel was confident that the programme maps comprehensively to *Preparing for Practice.*

The inspectors observed that the School has put in place a coherent, thorough and well managed assessment framework. The programme is made up of 21 modules, most of which are categorised as double modules in terms of credit value. The modules have learning aims and objectives aligned to the programme's five core themes: 1) Development of Clinical Skills, 2) Supporting Clinical Knowledge, 3) Health Promotion and Population Studies, 4) Human Health and Disease and 5) Professional Awareness. Generic concepts are re-assessed throughout the programme.

The yearly 'Clinical Skills' modules require students to meet set clinical targets, relating to both the quality and quantity of clinical activity. All of the programme modules comprise in-course and end of module assessments. Clinical skills are tested in-course via DOPs and via OSCEs. Underpinning knowledge is assessed via course-work and modular written examinations. In addition, the 'Integrated Clinical Care' module examination in BDS 5 tests clinical skills via a Seen and an Unseen case presentation.

In the final year Integrated Clinical Care module, compensation is permissible across the OSCE, Seen and Unseen cases. Students have to pass two of the three elements with an aggregated pass and no veto. The content and marking of the assessments and the aggregation of the marks was considered to be generally robust by the inspectors; these will be discussed in more detail under Requirements 18 and 23.

Progression decisions are made at various points throughout the course. In the first instance, Module Boards decide whether students have passed the module. The Board meetings are convened at the end of each module and are attended by an external examiner. The Module Board decision is taken forward to the end of year Assessment Board meeting. The Assessment Board cannot override the Module Board decision.

In the event of the student not meeting the clinical targets requirement in the clinical skills modules, the Module Board will determine whether they are likely to be able to meet them by

the end of the year, and if so, they are allowed the time to do so. Any failed modular assessments must be re-sat within a defined period. Compensation may be allowed between, but not across, assessments testing clinical skills and those testing knowledge, depending on the module.

In addition to the Module and Assessment Boards, the School also convenes Clinical Assessment Panel (CAP) meetings three times a year. The purpose of these meetings is to review the progress of each student in achieving their clinical targets in respect of the relevant clinical skills modules; in BDS 5 this is the Integrated Clinical Care module. The final CAP meeting in April makes a decision as to the suitability of the student to enter their end of year examinations. An external examiner attends this meeting. In the final year, students are required to have A grades across all clinical target domains to progress to the final examinations. Students are provided with an action plan and given extra time to achieve this requirement before the Module Board for the Integrated Clinical Care module if need be.

The inspectors observed the Clinical Assessment Panel in April and concluded that the 'sign-up' progress was comprehensive and reliable. The inspectors found the data provided for the formal review of students' clinical activity a little unclear, particularly in respect of sub and overarching procedures and qualitative scores, but assurance was provided that there is very close oversight of students' activity on an ongoing basis, hence the use of summary data at the CAP meeting.

The Assessment Board meets twice to consider the outcome for the students based on their performance in the modules for that year. The first meeting in June reviews the outcome of the modular outcomes for the year. Consideration is also given to any agreed extenuating circumstances which will have already been discussed by an Extenuating Circumstances Committee. The inspectors attended the June Assessment Board and considered that the process for establishing the pass list was rigorous, particularly as it provided opportunity for reflection and discussion on passing any student who performed below expectation in any one part of the examination. In such an event, the relevant DEC clinical tutor was asked to confirm whether they considered the student was clinically ready to graduate.

If students fail the Integrated Care Module, they are required to re-sit and the outcome is reviewed by the Assessment Board which meets again in July. Should a student fail a re-sit, the Assessment Board will usually require the student to repeat the failed module, repeat the year or terminate their studies. A re-sit is not an automatic right and is at the discretion of the Assessment Board. In years 2-4, the Assessment Board may also allow a failed module to be carried forward to the next year and retaken at the earliest opportunity, but only if it is categorised as a single module in terms of credits. This rule was not clear in the student handbook, which indicated that progression to the next year was dependant on each module assessment being passed and the School is encouraged to clarify this.

The inspectors noted that in the current final year cohort, three students had previously been held back and had been required to repeat a year. The School commented that they considered it a dereliction of duty if someone was signed up for finals without being ready. There was confidence that the assessment framework, decision making system and approach to progression was robust and likely to ensure that only a high calibre of student was allowed to sit the final examination. Importantly, the inspectors were also reassured that those students at the correct standard were able to graduate.

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)*

The systems in place to record and monitor the assessment of students are effective and

appropriate to the cohort size. The 'Leopard' database is used for recording clinical activity data and academic information is recorded on the University Banner system.

Clinical work is marked across six domains – skill, knowledge, management, integrated clinical skills, communication and management - and marks for each patient treatment is recorded on Leopard. Students are initially marked on paper forms which are signed by the supervising clinician and the students are then required to enter the data on to Leopard within a week of undertaking the activity. They must also hand in the paper forms and every third student is audited by the School on a termly basis, to check for data entry accuracy on Leopard. This is regarded as part of their professionalism training.

Students and their DEC clinical supervisors review Leopard on a weekly basis and this regular monitoring of patient exposure minimises the risk of students missing their clinical targets. Students have access to their own records on Leopard and are encouraged to monitor their own activity. The Leopard system colour codes the progress against the targets so it is immediately apparent if student is not on course to meet them. Students are provided with monthly progress reports in respect of their clinical targets and these are also provided to Senior Teachers and the Associate Dean for monitoring. If any particular concerns arise, these can be promptly addressed.

Data summaries from Leopard are relied upon during the CAP and Module Board meetings when students' progress against clinical targets is discussed, as reported under Requirement 16.

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)*

Continual assessment of clinical work involves the assessment of students initially in the phantom head laboratory and thereafter in their DECs and ETPs. As mentioned under Requirement 17, when treating patients, students are assessed across six domains – skill, knowledge, management, integrated clinical skills, communication and management. Students' portfolios were well organised and clear and revealed a wide range of exposure to clinical procedures and situations. The inspectors were also pleased to note the extent to which students were assessed on professionalism.

Grades awarded for continuous clinical assessment are verified by the clinical supervisor and there are regular checks made by the Clinical Education Manager on the accuracy of the data entered by the students in to the spreadsheet. The database is used to review the students' assessments and compare data from students across DECs and ETPs.

In-course assessment also takes the form of written course work, case presentations, clinical audit, group presentations and clinical review. The inspectors were satisfied that they effectively test knowledge and clinical skills. The assessments cover a variety of topics, with particularly good coverage of ethics in the written assessments. A selection of items of course work, including high and low grades is reviewed by the external examiner to verify that the standard of marking is correct.

The OSCE makes up 50% of the final mark of the 'Integrated Clinical Care' module. The inspectors concluded that this was a robust and educationally sound assessment of clinical skills. The use of two 'long stations' – each made up of 4 individual stations where students are required to undertake clinical activities (on this occasion taking an impression of a crown preparation and making a temporary bridge) - is well thought out and provides further assurance that the passing students have reached the required standard in these procedures.

The stations are marked by one internal examiner. The use of a clear and precise marking sheet achieves a good level of consistency and there is a clear and helpful examiner guidance sheet available. There was oversight of the 'long stations' to provide further assurance of standardised marking. In addition the external examiners observed each of the stations. Marking is also calibrated in advance by pre-OSCE training days and pre-OSCE briefings. Examiners are able to register a minor alert if a student makes a mistake which is serious but not likely to damage the patient; or a major alert where a student seriously comprises the patient's safety. In the event of a major alert, the student would fail the OSCE, in the event of a minor alert, a zero is scored for the station where the error has occurred. Examiners must justify their alerts in the 'de-brief' meeting before they are accepted. Each station carries the same marks and the average across all stations generates the final result. The external is requested to comment on the fairness of the process and the examination.

The inspectors noted good practice in the running and examining of the OSCE and were impressed with this well organised, varied and rigorous assessment, which tests both clinical and non-clinical skills. The inspectors observed the examiner de-brief at the end of the assessment and noted that examiner feedback forms were also collated. The 'de-brief' provided for a useful reflection on the examination and facilitated the refinement of some of the stations for future examinations. A few learning points noticed by the inspectors were not commented on; in one station, there was insufficient separation between the student undertaking the task, the discussions of their performance by the examiner and actor and the next student who was reading the scenario in preparation for it. There was also evidence of limited time available for examiners to thoroughly review and mark students in the change-over period, particularly in respect of the 'long stations'. The inspectors also considered that one of the scenarios would have benefitted from slightly less content in the allocated time. Overall, the inspectors were very impressed by the OSCE though.

The Seen Case comprises 25% of the final modular mark. Students present a 15 minute case to two internal examiners The School indicated that the aim of this assessment was to examine how students could identify and present a diagnosis and to test both communication and clinical skills. The external examiners rotated between examining pairs and their role was primarily to ensure consistency in approach and marking.

The inspectors considered it was good practice to ensure that the students were examined by supervisors from a DEC different from the one they had been based in; and that the case report had previously been marked by two different examiners. They considered that the pairs of examiners were broadly consistent in their areas of questioning and enabled students to justify and explain the rationale for treatment. The probing of stronger candidates is a useful way to discriminate between different abilities and the inspectors felt that there could have been more in depth questioning to fully test the students' knowledge and maximise the usefulness of the assessment. There was a lack of clear guidance on the extent to which prompting was allowed and how the degree of prompting was reflected in the marks. The School may wish to reflect on this and slightly refine the agreed approach to the questioning of students. The marking scheme should align clearly with the questioning to avoid inconsistencies between examining pairs. The inspectors were impressed with the case reports but a little surprised that 15% was attributed to the written mark and only 10% to the oral presentation.

The Unseen case also makes up 25% of the final mark. Students were all provided with the same case scenario, which they were questioned on for 20 minutes by two internal examiners. An external examiner was also involved for a small part of the examination and was invited to contribute views on the performance of the student. There were three examining rooms in which a pair of internal examiners and an external examiner assessed students. Throughout the day the external examiners rotated through the rooms.

The benefit of offering exactly the same 'unseen' scenario to students was slightly undermined by the variable questioning, prompting and marking between the pairs of examiners and the differing levels of intervention by the external examiners, who played the role of the patient in the scenario. The inspectors considered this probably occurred due to the loose set of examiner prompts. It was not clear if the variation in examining styles of the internal examiners was highlighted to the School by the external examiners; and whether the external examiners were made aware of their differing approaches by the School. The inspectors noted that the teaching staff had rehearsed and discussed the examination to agree approach. Whilst this undoubtedly helped, it would be useful to further refine the agreed approach to questioning and marking and the School may want to introduce scripts to ensure greater standardisation. These issues aside, the inspectors considered the scenario tested students' clinical knowledge and communication skills well.

The final assessments test a range of skills and techniques and the inspectors are confident that the School will continually review and refine them to ensure they discriminate in a consistent manner.

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)*

The inspectors were extremely impressed by the amount of patient exposure the students benefit from on the programme. As mentioned under Requirement 17, detailed recording and regular monitoring on Leopard ensures the clinical supervisors can easily establish the breadth and depth of students' clinical activity. The training model utilised at UCLan allows for a particularly high level of clinical experience in restorative, prosthodontic, paediatric and periodontic treatments and good levels of treatment experience in all other areas.

Students treat a wide range of patients in their DEC and ETP, including special care patients. Patients are allocated to the appropriate level of student following an initial assessment by a senior clinician. Referrals also occur between students across year groups within the DECs. Whilst ETP trainers do not monitor access to patients and do not have access to Leopard, they will be informed of any particular student requirements and, where possible, they will try to steer selected patients towards them. The purpose of the ETP is however to introduce students to the experience of general practice and there is therefore minimal manipulation of the patient lists. When the students attend the Secondary Care Placements, the consultants are also advised by the DEC Senior Clinical Tutor if there any particular types of patients that the students need to see.

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

Students are encouraged to reflect in their logbooks and they are required to submit monthly reflective accounts online. The inspectors found good evidence of student reflection and insight.

Students the inspectors spoke with were very positive about the feedback they received from their clinical tutors. Monthly personal tutorials are arranged with clinical supervisors during which summary data from Leopard is reviewed. In addition, there is continual informal verbal feedback, which is made possible by the fact there are only 8 students in any one DEC at a time. Students reported that the high ratio of clinical supervisor to student enabled them to easily discuss issues at any time, and they appreciated the fact they were treated as colleagues, saying this further facilitated open discussion.

Feedback is provided after DOP assessments which take place through the year, in addition to other modular in course and final examinations. Students reported that they held meetings with tutors after examinations and were provided with quick and detailed, constructive feedback. As mentioned above, the School also provides written feedback to students after CAP and Module Board meetings if there are any shortfalls in their clinical or academic data.

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 Met)*

There is excellent training and calibration of assessors involved in ongoing clinical assessment in the DECs and the ETPs. All examiners and assessors on the programme have appropriate registration with a regulatory body. All UCLan teaching staff must either hold a PG Certificate in Education or be working towards one. UCLan also provides training to DEC supervisors and ETPs who are not employees of the University. A short course, known as a teaching tool kit, is funded by UCLan and offered to all staff who are not employees of UCLan, including DEC part time clinical supervisors and ETPs. All those involved in the programme are given the opportunity to take part in UCLan educational processes and attend training days. DEC supervisors are also offered the opportunity to study for a PG Certificate in Education. Any new member of staff is closely supervised initially and carefully inducted into the programme and provided with a clinical supervisor handbook.

There is always at least one senior clinical teacher at DEC who advises and assists clinical supervisors. There is also peer review of teaching and assessment and ETP supervisors are encouraged to shadow clinical supervisors in the DECs. Annual appraisals provide an opportunity to discuss teaching and assessment skills and, in addition to informal chats between DEC supervisors, UCLan holds a number of meetings with the aim of calibrating assessors. Informal calibration of DOPs occurs as these are double marked.

Calibration of assessors for the seen and unseen cases took place in advance via group discussions and the mock running of assessments. This was helpful. The OSCE had a clear and relatively prescriptive but appropriate marking guide, rendering any subjectivity or marking bias unlikely. The inspectors considered that the assessment of the final examinations was good; however, greater consistency between pairs of examiners in the seen and unseen cases could be achieved by the provision of more detailed marking guidance. This will be discussed more fully under Requirement 23.

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)*

As reported under Requirement 13, the external examiners are requested to report on the content and conduct of the assessments. The inspectors had sight of a number of external examiner reports and were happy with the content of them.

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

The inspectors noted the School's Policy on ensuring fair assessments and managing bias. This requires the use of the student 'Banner' ID and 'blind' double marking for all assessments to ensure anonymity. Optical marking is used where possible, enabling

automatic scores to be generated. All failed scripts and a further sample of scripts are internally and externally moderated to ensure correct application of assessment criteria. The policy also states that the use of model answers, marking pro-formas and examiner training will ensure fairness in assessments.

The inspectors noted the transparent marking criteria for both the continual clinical assessment and the in-course DOPs and the consistent marking across DECs. They were a little surprised at the vast number of '4's awarded for every aspect of treatment in the final year logbooks but it was recognised that this was due to the rather limited marking scale. Although marks ranging from 1-6 can theoretically be used, the descriptors for these grades result in students generally being awarded a 2, 3 or 4 (4 is the level of a safe beginner, 5 and 6 are relevant to post-graduate assessments as 5 is the level at the end of the FD1 year and 6 is supposed to be for a competent dentist). As the same descriptors are used in each year, this naturally tends to mean that final year students will generally expect to, and do indeed, attain a 4 very regularly. Whilst the inspectors did not doubt the students were of this standard, they questioned how, within this rather narrow marking scheme, a student would be able to identify where they may require further improvement.

Other in-course assessments may have a pass/ fail or actual mark outcome and the inspectors were happy that there was an appropriate range of marks awarded. A selection of the assessments, including those where students have achieved high and low grades, are reviewed by the external examiner to verify the standard of marking is correct.

Written papers are standard set in advance; the process differs between long and short-answer question types but the panel were content that the standard setting was applied fairly. External examiners are asked to review and comment on the standard set pass mark and the questions. After papers have been marked, a sample of 10% is then moderated, usually by the Associate Dean, to ensure fair and consistent marking across the cohort. The external examiners review the papers of the fail and borderline students and are allowed to comment if they feel the marks are unjust; but they are not allowed to change them.

UCLan uses accepted standard setting methods for the OSCE, which involve both ad- and post- hoc review and analysis. Actual marks and a global score for each station are evaluated after the examination to reach the final pass mark; these are derived from well-constructed mark pro-formas.

As mentioned in Requirement 18, the inspectors considered the oral part of the case presentation and the unseen examinations would benefit from more detailed marking descriptors, examiner scripts and guidance for assessors. The marking pro-forma for both assessments allowed 1 or 2 marks to be given for performances which were ' Below Expectation', 'Borderline', 'Meeting Expectation' and 'Well above Expectation' in component elements such as 'Rationale for treatment' and 'Dental History' . In the absence of any guidance on the level of prompting allowed in the examination it was felt that these marking schemes were open to examiner variance, and indeed this was observed in the unseen cases. The external examiners rotated between the examining teams, which ought to ensure any marking differences were identified, but this did not appear to happen. It was perhaps rather difficult to achieve external moderation in the unseen case due to the actual involvement of the external examiner in a small part of the assessment. For the avoidance of inconsistency, the School is strongly encouraged to implement a more clearly defined approach to questioning and marking.

The inspectors were confused as to why the mark pro-forma for the unseen case contained a box for the examiners to provide a global mark, in addition to their total numerical mark and they could not establish how the mark sheet correlated with the pass mark. They were unclear, if and how standard setting for the seen and unseen cases took place.

The inspectors concluded that the final module assessments they observed, and the final year assessments they reviewed, were generally fair. There are specific mark schemes and pro-formas and mostly clear marking criteria for each of the assessments although there seemed to be varying degrees of marks awarded for the seen and unseen cases, dependent on which pair of examiners the student were assessed by.

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

The inspectors were impressed by the fact that the School actively seeks feedback from patients and utilises this to inform the continual assessment grades given to the student for professionalism. Whilst based at the DEC, students give each patient, at the start of their treatment, a Patient Satisfaction Survey form to complete. The form has the students' number on it but is otherwise anonymised. The patients are asked to hand in their forms and these are collected within the DEC and reviewed on a monthly basis. The forms are collected every month and the contents are fed back to the student verbally. The comments also contribute to the assessment of the students' professionalism.

Students work closely with dental nurses in the DECs and although the nurses provide a lot of feedback on their activity, this is yet to be formalised. The School indicated this was something they intend to implement once they have undertaken the necessary planning. The School is encouraged also to consider incorporating the formal nurse feedback into the assessment of students.

Students work alongside dental hygienists and therapists in the ETPs but there was no indication that the feedback was obtained from these individuals and the School may also want to investigate the possibility of achieving this at some point in the future.

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

As referred to under Requirements 16, 18, 19 and 23, the depth and breadth of assessed student clinical activity is impressive. Evidence on Leopard and in students' logbooks revealed that students are exposed to a high number of clinical procedures whilst in the DECs and ETPs. The modular assessments are comprehensive and in addition to the longitudinal assessment of clinical activity and DOPS, they include robust knowledge-based assessments and well run OSCEs. In the final year, the seen and unseen presentations provide additional assessments of clinical ability. The assessment structure and, in general, the execution of the assessments is to be commended.

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)*

The documentary evidence provided, notably the student handbook and marking guides, together with comments made by students and staff, indicated this requirement was met. Students showed an awareness of the standards expected of them and were familiar with the assessments, the marking criteria and approach to aggregation. It was impressive to hear that the students appreciated the relevance of standard setting to the pass mark. Expected standards of performance in each year of the programme were made clear to them. The only slight area of confusion related to the Clinical Readiness Exam, which was discussed under

Requirement 1.		
Actions		
Req. Number	**Actions for the provider**	**Due date (if applicable)**
23	The School must create and use detailed marking descriptors, which are aligned to the mark pro-formas in the seen and unseen cases.	End of March 2015
23	The School must create clear and detailed examiner scripts and guidance on the approach to questioning, particularly the use of prompts in the seen and unseen cases.	End of March 2015
23	The School must clarify how the seen and unseen cases are standard set.	End of March 2015

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 of the four UK nations 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)*

UClan has a clear and current Equality and Diversity Policy and the inspectors were confident that, should any issues arise, they would be dealt with according to best practice and current legislation.

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

The School indicated that bespoke training on equality and diversity was offered by the University to UCLan staff. The inspectors did not have sight of the actual training programme, however, they formed the view that it was likely to be comprehensive and relevant. The inspectors were advised that attendance at equality and diversity training and updating is a requirement and that all members of School staff had completed their training in the last year. As evidence of this, the School provided a staff training record for an Equality and Diversity Training session held in March 2013. The inspectors were disappointed to note that the training session was not fully attended and that there was no evidence provided to suggest that a follow-up training session was arranged.

It was recognised that all clinicians involved in the programme would be obliged to undertake NHS training on equality and diversity. The inspectors did not see any records relating to the training of non-UCLan employed DEC supervisors or of ETP supervisors. The School advised that attendance at training is checked during annual appraisals and non UCLan-employed DEC supervisors stated that the School also checks on the timing of their NHS training via annual appraisals. The School monitors, via its annual audit of the ETPs, how recently the supervisory staff who are based in the practices, have undertaken NHS training.

The inspectors would have found this Requirement Met had they been provided with clear

documentary evidence that all staff had recently undertaken Equality and Diversity training.

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

The inspectors noted that throughout the course students were made aware of the need to apply Equality and Diversity law and principles for whichever of the four UK nations they are working in. Students had a good understanding of these issues and awareness of the fact there are differences across the four nations. The School should pay attention to ensuring students understand that equality and diversity considerations do not mean that everyone should be treated in the same way.

Actions

Req. Number	**Actions for the provider**	**Due date (if applicable)**
28	The School must provide evidence that it maintains full and informative training records on the provision of Equality and Diversity training to all members of staff.	End of March 2015

Summary of Actions

Req.	Actions for the provider	Observations Response from the Provider	Due date (if applicable)
1	The School should clarify the difference between the Clinical Readiness Exam and the Clinical Progression Test	Clinical Progression is tested by the outcomes of two modules, DG1001 (Foundation Clinical Skills) and DG1002 (Foundation Clinical Knowledge). Within those modules, two tests, a practical and a written, are carried out during "clinical progression week" (February in 2nd BDS). The practical test occurs in the module DG1001 (Foundation Clinical Skills), the written test occurs in the module DG1002 (Foundation Clinical Knowledge).	Update to be provided through the 2015 GDC Annual Monitoring exercise
1	The School should clarify the compensation rules relating to the BDS 2 pre-clinical assessment to students and in course documentation	The module descriptors clearly show the pass requirements for preclinical modules; DG1001 – students are examined by a series of DOPs, and the practical "clinical progression test" in February. Students are required to achieve a pass in each of the marked elements, which are both weighted 50%. DG1002 – students are examined by a series of in-course tests, and the written exam in February. Students are required to achieve a pass for each of the marked elements, the in-course tests being weighted 20% and the written exam 80% of the overall marks.	Update to be provided through the 2015 GDC Annual Monitoring exercise
1	The School should provide clear guidelines to the Chair of the Assessment Board and strengthen the	Clear guidance will be provided to the Chair of the Assessment Board – Students must pass both	Update to be provided through the

	mechanism used to determine whether a student passes in the event of a pre-clinical assessment being failed.	Foundation Clinical Skills and Foundation Clinical Knowledge modules to complete their Pre-Clinical assessment and progress to treating patients.	2015 GDC Annual Monitoring exercise
6	The School should strengthen the training and induction for staff and students to emphasise their duty within their respective roles to raise concerns about patient safety.	The School already gives clear guidance and training to students and new members of staff on their individual responsibility for raising concerns about patient safety. This will be re enforced during the yearly induction training given to all staff and students.	Update to be provided through the 2015 GDC Annual Monitoring exercise
7	The School should reinforce to supervisors in all training environments the process for reporting patient safety concerns.	The School will include an update on the process for reporting patient concerns at the regular clinical supervisors educational meetings.	Update to be provided through the 2015 GDC Annual Monitoring exercise
8	The School should develop its own Fitness to Practise policy with clear guidance on its remit and an associated appeals policy.	The School already has its own Fitness to Practice policy with clear guidance on its remit and associated appeals policy. Further information which demonstrates how the School policy links with both the University and the GDC “Fitness to Practice” procedures will be included in an update School policy.	Update to be provided through the 2015 GDC Annual Monitoring exercise
8	The School should make clear to students and staff the circumstances when the Raising Concerns and Fitness to Practise policies and the Professionalism Card system should be used; and ensure consistency in the application of the various procedures.	The School feels that the staff is clear on the circumstances when the Raising Concerns and Fitness to Practice polices are used and that these policies are clearly explained to students. All the information is included in both the BDS course handbook and the School Handbook. However this information will be re enforced in the annual induction sessions and Clinical Supervisors meetings and in addition after the induction session at the beginning of each Academic year all staff will be sent the Raising Concern policy and asked to confirm by e-mail that they have read,	Update to be provided through the 2015 GDC Annual Monitoring exercise

		understood and accept the policy. The Professionalism Card System forms part of the assessment for the Professional Awareness modules and the students are given clear information about the circumstances under which the Red and Yellow cards will be awarded. The Senior Staff monitor the consistency of the award of these cards across the various teaching sites. This information will be clearly sign posted in the course handbook.	
12	The School should consider formalising its communication with key stakeholders	The School is in the process of updating its list of key stakeholders in order to set up regular meetings and formalise communication between the School and the stakeholders.	Update to be provided through the 2015 GDC Annual Monitoring exercise
13	The School should consider whether to make available student clinical log books to each of the 5th BDS external examiners	The School will make the 5th BDS clinical log books available to the external examiners on request.	Update to be provided through the 2015 GDC Annual Monitoring exercise
23	The School must create and use detailed marking descriptors, which are aligned to the mark pro-formas in the seen and unseen cases.	The School has taken note of the comments of the inspection panel and will ensure that detailed marking descriptors that are clearly aligned to the marking proforma are used in both the seen and unseen cases.	End of March 2015
23	The School must create clear and detailed examiner scripts and guidance on the approach to questioning, particularly the use of prompts in the seen and unseen cases.	The School has taken note of the comments of the inspection panel and will ensure that the scripted questions are clearly documented in 2015, and that calibration training is available to the internal examiners.	End of March 2015
23	The School must clarify how the seen and unseen	The School has taken note of the comments of the	End of March 2015

	cases are standard set.	inspection panel and will ensure that the cut point for the seen and unseen cases will clearly reflect the marks allotted to each descriptor (below borderline; borderline; meeting expectations; exceeding expectations)	
28	The School must provide evidence that it maintains full and informative training records on the provision of Equality and Diversity training to all members of staff.	Equality and diversity training for wider University staff is available and we will continue to ensure that all staff completes this regularly and that this is recorded. Equality and diversity training is also part of regular training for NHS staff and University staff with honorary NHS contracts and we will ensure that this is also recorded. The training needs of all our staff are reviewed on an annual basis and equality and diversity training needs will be considered as part of this process.	End of March 2015

Observations from the provider on content of report

To monitor progress against this action plan it will be a standing agenda item at our BDS Programmes Management Committee

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