General Dental Council | protecting patients, regulating the dental team

INSPECTION REPORT

Education provider:	**King's College Hospital NHS Foundation Trust**
Programme/Award:	**Diploma in Dental Hygiene and Therapy**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine continuing approval of the award for the purpose of registration with the GDC as a dental hygienist and therapist**
Learning Outcomes:	***Preparing for Practice (Dental Hygiene and Therapy)***
Programme inspection dates:	**23 to 24 February 2016**
Examination inspection dates:	**14 to 16 June 2016**
Inspection panel:	**Philip Bunnell (Chair and Lay Member) Christine Cotton (Dental Care Professional Member) Isobel Madden (Dentist Member)**
GDC Staff:	**Kathryn Counsell-Hubbard**
Previous inspection:	**18 to 19 January 2007**
Outcome:	**Recommended that the King's College Hospital NHS Foundation Trust Diploma in Dental Hygiene and Therapy programme remains approved for registration as dental hygienists and therapists**

Inspection summary

The Diploma in Dental Hygiene and Therapy programme delivered at King's College Hospital is funded by the King's College Hospital NHS Foundation Trust (hereafter referred to as the 'Trust') with final examinations being provided by the Royal College of Surgeons of England (hereafter referred to as 'RCSEng'). The qualification is awarded by RCSEng following successful completion of its examinations at the end of 2.5 years of full-time study.

The content and delivery of the programme is well-organised and clearly-structured by a dedicated course team, with students being able to visit a range of Trust clinics as part of their outreach training. The course team work closely with one another and are able to share information, including that relating to student performance and clinical incidents, quickly and easily.

The inspectors identified three key challenges for the programme that require action: lack of investment from the Trust in terms of information technology (IT) and administrative staff to support the students and course team respectively; limited integration with the undergraduate dentistry programme delivered by King's College London (KCL) in terms of mixed theoretical and clinical teaching of students from both programmes; and a lack of formalisation of processes and recording (formalisation is addressed in the main body of this report).

The panel recognised that Trust investment and student dental care professional and student dentist integration are issues that the course team cannot solve alone, but are still important issues that must be highlighted. Improved IT and administrative support would allow for better monitoring of students and allow the course team to allocate more time to the analysis of student data, without spending unnecessary time inputting data and undertaking non-clinical audit tasks, such as identifying student non-attendance. Without student integration, the exposure DCP students have to working as a part of a team is limited because they have a very short amount of time with dental students. The dentistry and dental hygiene and therapy programmes are delivered by different providers, one being the Trust and the other being KCL. The hygiene and therapy students could benefit from an increased range of clinical settings should they be able to mix with dental students more regularly and the sharing of facilities, including the clinical skills facility and lecture rooms, would improve the teaching environment for hygiene and therapy students. Some pressure on the course team, which is part-time, would be alleviated if some theoretical teaching of the two student groups were combined. Both are issues that the panel agree should be considered and discussed by the relevant authorities.

The panel wishes to thank staff and students for their participation with and hospitality during the inspection.

Background and overview of Qualification

Annual intake	30 students
Programme duration	2.5 years full-time
Format of programme	**Year 1:** ***Modules:*** ▪ Anatomy ▪ Physiology ▪ Histology ▪ Microbiology ▪ Human disease ▪ Pharmacology ▪ Periodontology ▪ Embryology and Dental Histology ▪ Intro to Law and Ethics Standards for the Dental Team ▪ Oral Health Education (OHE) – oral hygiene, diet advice, fluoride advice, smoking and alcohol advice ▪ Pain management module, including anxiety and Local Analgesia ▪ Introduction to clinic module, including history taking, patient assessment, cross infection control, medical emergencies and Basic Life Support (BLS) ▪ Communication module ▪ Law and Ethics – dental record keeping, confidentiality, consent ▪ Clinical Hygiene Skills Course (CHSC) ▪ Adult Restorative Skills course (ARSC) ***Assessments:*** ▪ End of Term 1 written examination ▪ CHSC written and practical assessment (June/July) - summative ▪ Introduction to Clinic Examination (July) - summative ▪ End of Year 1 written mock examination (September) ▪ End of Year 1 written examination (October) - summative ▪ End of Year 1 OSCE (November) - summative ***Assignments:*** ▪ Practice placement and completion of practice placement booklet **Year 2:** ***Modules:*** ▪ Completion of ARSC ▪ Child Restorative Skills Course (CRSC) ▪ Periodontology ▪ Law and Ethics – team working, complaints handling, clinical and information governance ▪ Reflective Practice module

	▪ Dental Public Health module ▪ Acute conditions and Oral Medicine module ▪ Radiology module ▪ Pain management – conscious sedation and general anaesthetic ▪ Implants ▪ Smoking cessation level 2 ▪ Medical emergencies and BLS refresher ***Assessments:*** ▪ ARSC written and practical assessment (January) – summative ▪ CRSC written and practical assessment (March) – summative ▪ Hygiene In-course Assessment (March) – formative ▪ Therapy In-course assessment (June/July) – formative ▪ Radiology Examination (September) – summative ***Assignments:*** ▪ Communications portfolio – summative ▪ Law and Ethics portfolio – summative ▪ Acute conditions case studies (May) ▪ OHE hygiene case study (June) ▪ Reflective Practice portfolio (June) ▪ Dental Public Health activities and posters ▪ Project – submission November & presentations December ▪ Oral medicine case studies (November) ▪ OHE case study – Adult Therapy (December) **Year 3:** ***Modules:*** ▪ Periodontology ▪ Medical emergencies and BLS refresher ***Assessments:*** ▪ Mock Finals written – March ▪ Mock Finals Case presentations – March ▪ Written Finals (May) – summative ▪ Finals Case Presentations (June) – summative ***Assignments:*** ▪ Developmental disorders presentations (January) ▪ OHE case study for Child Therapy – (March)
Number of providers delivering the programme	1 provider delivering the programme, 1 provider delivering the final exams and awarding the qualification

The Inspection

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 must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients	✓		
2. Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing.	✓		
3. Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place.		✓	
4. When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development.		✓	
5. Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body.		✓	
6. Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parities how concerns will be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so.	✓		
7. Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified.		✓	
8. Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students	✓		

and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standards for the Dental Team are embedded within student training.

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

The programme includes three comprehensive clinical modules which are supported by a range of assessments: Clinical Hygiene Skills Course (CHSC), Adult Restorative Skills Course (ARSC) and Child Restorative Skills Course (CRSC). CHSC commences prior to a written examination on medical emergencies, law and ethics, cross infection and patient assessment which determines progression onto clinic. An Introduction to the Clinical Environment course and the Communications Module further support the transition into the clinical environment.

Once on clinic students complete evaluation booklets on each of the skill sets taught in the clinical modules and are subject to supervisor feedback and formative assessment while treating patients. An Objective Structured Clinical Examination (OSCE) must be passed at the end of Year One to allow students to progress to future years.

The panel were satisfied that students are adequately trained and assessed prior to treating patients.

Requirement 2: Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing. *(Requirement Met)*

The panel found the explanatory documents for patients and the consent forms used to be examples of good practice. The patient-focused leaflet on treatment by student hygienists and therapists was comprehensive. The consent forms were highly detailed and new declarations had to be signed at different stages of treatment. These practices are supported by the use of identity badges that inform patients that their hygienist/therapist is a student and the students informed the panel that they always introduce themselves to patients as students.

Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place *(Requirement Partly Met)*

Students practise at clinics at King's College Hospital which are subject to Trust policies. A full governance framework is in operation with the programme leads attending meetings where issues are highlighted by the clinical incident reporting system Datix. The Datix system is capable of highlighting clinical incidents involving hygiene/therapy students but none have arisen.

All outreach placements are based within Trust facilities and are subject to the same governance framework. Programme leads are not involved in the governance of those

placements but are informed of any relevant issues by the Clinical Director for King's College Hospital.

Equality and diversity training is mandatory for all programme staff who hold contracts with the Trust. Evidence of completion of this training was available to the panel.

While programme staff have been involved with audits of the clinical areas, they do not have ownership of this process. They therefore plan to complete their own audits in future to ensure the clinical areas are suitable for their students' needs. These plans are approximately six months from implementation, and once implemented the panel would consider this requirement to be fully met. At present, the programme leads are not assured that the clinical areas are appropriate for student treatment and learning. While Trust processes provide a great deal of confidence, additional action by the programme leads would give greater assurance.

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

The panel were impressed with supervision guidance utilised on the programme. This gives clear descriptors of how student performance should progress at each stage during the programme and the requisite level of supervision required. This guidance is underpinned by a consistent 1:5 supervisor to student ratio which is often 2:5 depending on teaching responsibilities. As all programme staff are part-time, achieving these levels of supervision is to be commended.

Comprehensive module guides for the clinical elements are made available to all staff, including those based in outreach placements. All staff are made aware through their induction onto the programme, and in staff meetings, when these modules are taught and therefore are aware of the skills students should be competent at and when.

The panel were informed of an incident that occurred when a student was left unsupervised with a patient on placement, and was later accused of theft. While the student was cleared of any misconduct, the incident posed a significant concern to the panel about the importance for supervision to be maintained at all times.

To fully meet the requirement, the programme leads must investigate supervision levels at the outreach placements and ensure that they are consistently applied in line with their guidelines. If appropriate, additional training should be provided to outreach supervisors to further inform and highlight the risks to students of inconsistent supervision. If possible, the programme leads should liaise with the Trust to seek provision of additional dental nurses to work with students on outreach which would form an additional supervisory layer.

Requirement 5: Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body *(Requirement Partly Met)*

All supervisors hold appropriate registration with the GDC, which was checked by GDC staff, and have undergone both a Trust and School-level induction. When joining the programme, new staff undertake a year-long 'settling down' period whereby they shadow other staff and learn about the modules, gradually taking over particular areas of work. New staff do not automatically fulfil all areas of their role, such as signing off student competency booklets or supervising students without another member of staff present. These duties will only be

allowed once the programme leads are satisfied with the new staff member's progression, which is measured by reviews every three months.

The Trust induction is a corporate event while the School induction is specific to the programme. As the outreach placements are Trust clinics, supervisory staff there also undergo the corporate induction. Similarly, all staff fulfil Trust equality and diversity training requirements. Programme-specific training is offered to outreach supervisors but the ability to deliver this is affected by time constraints.

The training of outreach supervisors is an issue with which the panel were not satisfied. The panel understood that role-specific training would be difficult to implement given the part-time working arrangements and teaching responsibilities of programme staff, but agreed that additional measures must be introduced. Formalising the School induction into a learning package and sharing this with outreach staff, or holding short training events with the programme leads visiting outreach, could both be ways in which such training could be achieved.

Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so. ***(Requirement Met)***

The panel found that the area of raising concerns, and particularly the professionals' duty of candour, was taught to a high standard. The need for candour is explained fully in a lecture and the supporting guidance is contained within the student handbook.

Staff meetings give an opportunity for issues to be shared and discussed. Tutorials have also been implemented before each clinic which allow for clinical issues to be discussed as a group and for concerns to be raised and discussed.

The panel met with three groups of students and all exhibited a solid understanding of their responsibilities and expressed confidence that they would raise a concern if necessary. One student disclosed that they were instructed by a clinician to perform a procedure which was outside of their scope of practice. The student informed the clinician that they were unable to do this, which demonstrated exceptional confidence and professionalism to the panel.

Requirement 7: Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified. ***(Requirement Partly Met)***

Datix is the primary instrument used to record clinical issues and incidents. Students and supervisors must inform the head dental nurse for each department of any incidents. The head nurse is responsible for logging this in the Datix system. The need to report incidents to the head nurse is contained within the duty of candour guidance. Examples of an adverse incident log were provided to the panel.

As the Datix system and the associated processes are not owned by the programme leads, it was not clear how quickly an incident would be identified and whether the programme leads would be the individuals responsible for informing a regulatory body. The panel understand that the programme leads must collaborate with the established Trust systems, however, some programme-specific recording, such as notes from governance meetings or records of

investigations by the programme leads or other staff must be introduced. Additional recording that demonstrates a cyclical process from identification of an incident to its resolution and subsequent learning is required to fully meet this requirement.

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standard for the Dental Team are embedded within student training *(Requirement Met)*

Sufficient student fitness to practise policies are in place and these are supported by pre-clinical teaching. Issues may be identified via supervision of, and discussion with, students and any such issues are discussed at staff plenary meetings. Either personal tutors or programme leads will meet with students to address and attempt to resolve the issue, but any persistent failure in a student's fitness to practise will be referred to either the Clinical Progress Committee or the Academic Progress Committee.

Evidence was provided of identification of fitness to practise issues and learning plans with additional supervision requirements have been implemented. The students were aware of the GDC's Standards for the Dental Team and these are incorporated into the pre-clinical teaching. Professionalism was well understood by the students who met with the inspectors, who had no concerns about this area of the programme.

Actions

No	Actions for the Provider	Due date
3	Programme leads must implement plans for clinical audits or a similar plan to ensure that clinical areas are safe for students.	Annual Monitoring 2017/18
4	Programme leads must ensure that supervision levels are consistent at outreach placements at all times.	Annual Monitoring 2017/18
5	Programme leads must extend supervisor training to outreach supervisors.	Annual Monitoring 2017/18
7	Process must be implemented that demonstrates that programme staff and leads identify, resolve, and learn from clinical incidents.	Annual Monitoring 2017/18

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 must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.		✓	
10. Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes.		✓	
11. Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development.		✓	
12. The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements.		✓	

GDC comments

Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function *(Requirement Partly Met)*

The present quality management framework is largely based on informal agreements and procedures. The framework itself consists of a series of meetings between programme leads and staff to discuss elements of the programme. Weekly plenary meetings deal with the week-to-week running of the programme and any issues concerning students, while modules are reviewed each year. Staff meetings are held to discuss feedback received from students and what changes to the programme this feedback may require.

While the majority of these meetings appear to be minuted or recorded in some way, there are no 'living' documents that ensure items identified for action at one meeting are picked up at the next meeting or to ensure that the outcome of any changes are recorded and monitored. Recording is a weak point of the programme and this was disclosed to the panel by the

programme leads. Administrative and IT support to help facilitate formal recording has not been available for the programme.

The programme leads stated that the learning outcomes are reviewed each year but no evidence of this was provided during the inspection. Changes to the programme year-on-year are not recorded, so it was not possible for the panel to be assured that the quality of the programme has been managed effectively. The commitment of the programme leads to ensuring that the programme is of a high quality was evident but this commitment was seriously undermined by gaps in the recording process.

As identified by the programme leads in their pre-inspection documents, quality management must be formalised. The implementation of overarching recording documents that demonstrate what changes have been made to the programme and why, as well as formal mapping of the coverage of the learning outcomes, would assist in meeting this requirement. The inspectors agreed that the Trust should be informed of the inspection findings and the possibility of additional support explored. Increased administrative and IT support would allow for some of the required recording to be undertaken by someone other than the programme leads who are extremely time limited.

Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. ***(Requirement Partly Met)***

Weakness in recording also applies to this requirement as there is no evidence that external reports on quality, such as those from external examiners, are formally discussed and acted on. There are no set timeframes within which reports must be considered, and the programme leads do not formally respond to such reports.

As all clinical teaching and experience is gained across a wide range of Trust clinics, there is only a limited risk that students will not gain the requisite amount of clinical experience. However, as the programme leads undertake so many of the tasks required in terms of organising the programme, teaching, assessing, and reviewing the programme, a significant risk would be realised if one of the leads were unexpectedly absent. While the panel were confident that there is effective communication between all members of staff, without effective recording to fall back on, the notion of a programme lead being away for a period of time is one that would have a significant effect on the student's ability to achieve the leaning outcomes, particularly as all members of staff teach.

Prior to the inspection, the programme leads informed the GDC of a serious threat regarding their examining body. This gives the panel confidence that any other issues would be similarly disclosed. However, this does not negate the need for more effective recording and for consideration to be given to a contingency plan to mitigate the risk should a key staff member be unexpectedly absent.

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development. ***(Requirement Partly Met)***

The programme is subject to two main forms of external reporting: external examiner reports and an Annual Performance Review completed by the Local Education and Training Board (LETB). The Annual Performance Review is based on a self-assessment by the programme

leads and includes a review of a variety of areas including recruitment, academic performance and transparency. In addition to the LETB report, the programme must participate in audits imposed by the Trust that add an additional layer of scrutiny external to the programme team.

External examiner reports are provided twice during the programme: after the Year One OSCEs and written papers and after the final RCSEng examinations. The presiding external examiner, used for the Year One OSCEs, is recruited by the School and provides direct feedback on the content of the OSCEs and written papers and makes recommendations for future exams. The examiners used for the final RCSEng case presentations are recruited and trained by the Royal College.

Feedback is an important area for the programme leads and this is currently collected from patients after each appointment at King's College Hospital and at one of the outreach placements. However, how this feedback is formally considered and used to develop the programme was not clear. The collection of feedback is not underpinned by a policy that describes who will consider this and when and how it will be discussed. Devising a policy will help the programme to fully meet this requirement.

The programme leads told the panel that they plan to begin collecting of employer feedback to monitor the performance of graduated students. The panel were supportive of this initiative and hope that this is implemented later in 2016.

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

The School is aware of its need to develop quality assurance processes for outreach placements. There is heavy reliance on the existing Trust governance procedures with little consideration of the particular need of students. The programme leads are in contact with the Community Dental Officer in charge of the community clinics, although the level of this contact was not clear from meetings with programme leads. A member of staff at one of the outreach placements is also a tutor on the programme so there is an opportunity for regular updates about student experience at this site. This feedback is not recorded.

Student feedback in regards to placements is formally collected in an end of course evaluation. The students are not visited while at outreach and a serious issue had already occurred (discussed under Requirement 4). Students did not disclose any difficulties at outreach when they met with the panel.

The programme leads must introduce a method to quality assure outreach placements. Regular contact should be maintained with students to ensure that any difficulties on placement are disclosed. Ideally all placements should be visited at least once a year when students are at the placement.

Actions

No	Actions for the Provider	Due date
9	The findings of the inspection report must be shared with the Trust. Options for additional support must be formally explored between the Trust and the programme leads.	Annual Monitoring 2017/18
9 & 10	Formalisation of the quality management of the programme and increased recording must be implemented.	Annual Monitoring 2017/18

10	A contingency plan to counter unexpected staff absence must be discussed and defined in writing.	Annual Monitoring 2017/18
11	Policy regarding the use of patient feedback must be introduced to ensure that this information is formally considered and used to develop the programme.	Annual Monitoring 2017/18
12	Quality assurance measures for outreach placements must be introduced. Patient feedback methods must be rolled out across all sites.	Annual Monitoring 2017/18

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**
13. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards.	✓		
14. The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes		✓	
15. Students must have exposure to an appropriate breadth of patients and procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant learning outcomes	✓		
16. Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed.		✓	
17. Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers.		✓	
18. The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.	✓		
19. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role.	✓		
20. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented.	✓		
21. Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area		✓	

to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments.

GDC comments

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Met)*

Assurance regarding student attainment comes from two main sources: weekly team meetings to discuss student progression and review of log sheets. The latter are submitted to the school for collation so that an overview of each students' clinical experience can be achieved. Programme assessments have been mapped against learning outcomes so achievement of the range of outcomes can be tracked. The sign-up process for the internal final examinations is defined in policy and includes requirements for attendance, attainment and formative performance.

The panel found areas of concern within the overall framework for assuring student attainment, notably the fact that student data is collated irregularly (discussed in further detail under Requirement 14). The mapping of the assessments to learning outcomes appeared to have been completed recently and was not found to be a process that embedded in the programme. Furthermore, this mapping did not extend to the programme timetable, so the entire process of what is assessed, when and how, is not defined. Implementation of more stringent and all-encompassing mapping would have assisted the panel and would be of benefit to the programme leads in ensuring that future assessments continue to deliver appropriately trained students at each stage of the programme.

The programme leads explained which students were not progressing and why. The panel queried why some students had progressed, as the logbooks demonstrated gaps in competence. The programme leads gave assurances that there is supporting documentation that is consulted to ascertain whether gaps in the logbooks are legitimate reasons for holding a student back. The panel agreed that some additional recording in such instances should be introduced to ensure there is an appropriate audit trail.

The programme's sign-up process is a precursor to the official sign-up completed by the RCSEng, who administer the final examinations. The final examinations consist of two written papers and two case presentations, one being for dental hygiene and the other for dental therapy. The RCSEng sign-up requirements were provided to the panel. The panel were satisfied that only those students with the necessary knowledge and attainment to date were allowed to sit the final examinations.

The panel found this requirement to be met overall, but would strongly recommend that additional recording of progression decisions is introduced. An increased level of mapping that includes guidance about when and how each learning outcome is assessed, and is used as a 'living' document that is updated regularly, should also be introduced.

Requirement 14: The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes *(Requirement Partly Met)*

Student attainment is recorded both for clinical experience and for achievement in formal assessments. While the amount of clinical experience and results in assessments are considered together, this is not reconciled with the learning outcomes so there is no overarching document the programme leads can consult to check if students are meeting all of the learning outcomes.

A significant issue is that clinical experience data is only collated twice a term. The lack of administrative support means that the programmes leads must input the numbers from log sheets themselves and this task is often relegated in the face of other duties, such as teaching and supervising students. The panel was of the opinion that such a task could be completed by non-clinical personnel which would allow for more regular collation, and therefore more regular review of the data to find gaps in student experience more contemporaneously.

The panel would support any additional support the Trust can provide to the programme leads in allowing for such administrative tasks to be devolved from the programme leads themselves. In the absence of such additional support, the programme leads must introduce a mechanism to increase the frequency of reviews of student data. Increased and more wide-ranging reconciliation of attainment against learning outcomes should be considered as a tool to bring all information pertaining to students together and to create more effective monitoring.

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

The panel found the prescribed numbers for differing types of clinical procedures set by the programme leads to be sufficient to allow the required level of competency for a safe beginner. Evidence was seen that student clinical data is discussed at team plenary meetings. Students advised the panel that they are often alerted if they are falling behind in achieving the numbers of procedures required.

While patient supply in some areas was described by the programme leads as an issue in the past, this has been rectified by advertising for patients in the local press. As a result, the numbers of specific patient types available for treatment by students has risen, allowing students to gain sufficient experience. Additionally, one of the outreach placements allows for walk-in patients so students may experience a range of issues and gain a better understanding of what general practice will be like.

Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed. (*Requirement Partly Met)*

A variety of assessment types, both formative and summative, are utilised during the programme. The programme leads advised that the assessments are discussed each year and changed if required. An example was given of recent changes to a poster project, which must now cover a topic not included within the teaching of the programme to better test students' research skills, but evidence of such changes to other assessments was not provided. The changes to assessments year on year is not recorded.

Clinical assessments are completed by the supervisors on clinic and supported by clear marking criteria. The marking criteria differentiate between the levels of skill expected of students at each stage of the programme.

Student data was seen at the examination inspection. These data demonstrated that the assessments preceding the final RCSEng examinations discriminate between those students ready for the examinations and those that are not. A small number of students were required to undertake additional clinical work or repeat their final year before being entered for the final examinations at a later date.

The written papers and the case presentations for the final RCSEng examination are subject to scrutiny and comment from the internal and external examiners alike. All comments are recorded and are fed into a Faculty level examination board meeting at the College. Similarly, the programme's final examination in Year One is also reviewed by an external examiner who provides a report of their findings to aid quality assurance and fairness.

Despite the scrutiny afforded to the RCSEng final examinations, the panel found that the case presentations did not test the student's knowledge to an adequate level. According to mapping documents, the final case presentations are meant to test students on the following GDC learning outcomes:

1.1.3 Explain general & systemic diseases and their relevance to oral health

1.1.4 Explain the aetiology & pathogenesis of oral disease

The questions asked during the case presentations did not include enough depth to satisfy the panel that the above learning outcomes were being adequately tested at this final stage of the programme. Students were not routinely asked to explain their answers to provide more detail of the underlying aetiology of the conditions identified in their patients. The case presentation guidelines from RCSEng stipulate that a satisfactory case presentation will involve the candidate demonstrating "understanding of [the] scientific basis for treatment". The panel did not find that all satisfactory case presentations met this criteria.

The panel found that the students were appropriately marked as satisfactory and noted that the learning outcomes are covered within other assessments. However, the depth of the questioning needs to be reviewed by the College and fed back to examiners, particularly if programmes are relying on the RCSEng examinations to test learning outcomes 1.13 and 1.14.

To meet the requirement, RCSEng must address the level of questioning required for students to demonstrate achievement of the requisite learning outcomes. The programme leads must ensure that the learning outcomes are robustly tested in the assessments indicated in the mapping documents.

Requirement 17: Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers. *(Requirement Partly Met)*

The variety of feedback collected on the programme is limited. Evaluation forms are completed at the end of each module, but the feedback students may give on clinic or during personal tutor meetings is not logged. There is no formal mechanism for peer feedback.

Within one outreach placement patient feedback is collected after every interaction, but this system has not been rolled out across other placements or the community dental services that students attend. Some feedback may be obtained from the Patient Advice and Liaison Service (PALS) but this will not be specific to the student who treated that patient. The school has trialled a paperless system for collecting patient feedback but this was not found to be robust. There are plans to introduce a rolling method of comment collection whereby patient feedback

would be gathered over a series of appointments and then shared with the relevant student by the programme leads. No timeframe was given for when such a process would be in place.

To fully meet this requirement, the programme leads must implement additional collection of patient feedback from all clinical areas to inform students of patient views relating to their performance. The panel would strongly support any method that would allow for student-specific feedback, with a supporting policy that defines how this will be disseminated and used by students.

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

Feedback to students is a regular part of the programme. All clinical log sheets include a section for supervisors to give constructive feedback to students, and these are completed after every patient interaction. The students also meet with their personal tutors on a twice-termly basis which gives the opportunity for feedback on their overall performance and progression.

Reflection is also built into the programme with the completion of reflective logs. The students that the panel met with all reported that the reflective logs were useful, even if their purpose was not immediately obvious at the outset of the programme. Those students from the graduating cohort stated that they were able to see how much progress they had made since the first year, which was also helpful for their development.

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

All members of staff involved with examining or assessing students are registered with the GDC. Those responsible for teaching on the programme and supervising students on clinic are also employees of the Trust, and therefore subject to statutory training including that on equality and diversity.

All those responsible for assessing students during the final exams have been trained to assess students by RCSEng. Some variances in examiner practice was noted by the panel; for example, some examiners used subjective comments such as “good” or “fine”. The examiner pairs were not always consistent in the questions they asked, for example, reflective practice was not covered at every case presentation. Some examiners allowed students to continue answering a question after the signal was given for the exam to stop, whereas others did not. The RCSEng does provide a QA Examination Lead, who acts as an overseer in order to quality assess the exams. The subjective commenting was noted by the QA Examination Lead who advised that examiners had been told not to do this in past training sessions. The issue of some examiners allowing students to go over the allotted time to answer a question was not raised.

External examiners are used to actively examine students, and must be involved in teaching in order to be eligible for the role. Considering the presence of the QA Examination Lead, the panel found that oversight of the exams’ quality as a whole was still achieved.

The panel found the requirement to be met but would urge RCSEng to ensure that all examiners are reminded as to examination best practice.

Requirement 20: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented. (*Requirement Met)*

External examiners are utilised by the programme leads for the final examination at the end of Year One. The examiner reports on the robustness and administration of the examination. Their role is defined in policy.

The external examiners for the final examinations are recruited and retained by RCSEng. The terms of their tenure are also defined in policy and they must attend training provided by the Royal College. External examiners comment on all aspects of the examinations, including marking criteria and standard setting, but are not responsible for these areas. The QA Examination Lead is responsible for ensuring equity and fairness during the exams, while a board of examiners at the RCSEng standard sets the exams, calculates the pass mark and maintains a question bank.

Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. (*Requirement Partly Met)*

The RCSEng final examinations and in-programme assessments are all well-documented. Students have a handbook which sets out the assessment timetable. The students who participated in panel meetings reported that they understood what was expected of them and were clear on the assessments. Mock examinations were held in preparation for the finals.

The final case presentation examinations were exceptionally well run. Ample members of staff were available not only to supervise waiting students and direct them to the correct locations, but were also utilised as scribes to note the questions asked during the case presentations. All timings were adhered to and students were examined on time. A technical difficulty with the provider's server meant that it was not possible to see radiographs during the case presentations. This was addressed by a set of standardised questions being imposed by RCSEng onto all examiners to ensure that this area of the exam was covered adequately. The Royal College are to be commended on finding a solution and working around what could be a significant issue with apparent ease.

As discussed under Requirement 16, the level of questioning led the panel to find that the case presentations had not been conducted wholly under the set criteria. In addition to this, each student was examined by an internal and external examiner, who took turns in asking questions yet had very little time for calibration. Approximately five minutes was allowed between a student finishing and examiners receiving notes on the next case presentation. The panel were not satisfied that this amount of time was sufficient to allow the examiners to read the notes in detail and then formulate questions, particularly as examiners do not have sight of these notes before the exams. The panel found that, in conjunction with the issue regarding the depth of questioning, this amount of preparation time was insufficient.

The programme leads had undertaken some standard setting exercises with the course team. Some staff have completed RCSEng training on this topic but not all, due to time constraints. Those who attended disseminated learning to the rest of the team. The standard setting methodology for clinical assessments was not clear. For written examinations, the Angoff method is employed with the course team meeting at the beginning of each term to agree the pass mark. Those that write examination questions are responsible for writing the ~~answer~~ marking guides.

The final exams are entirely standard set by RCSEng. The Angoff method is also employed by the College and the calculation of the pass marks was explained to the panel. There is no compensation between different parts of the final examinations. The written examinations are double blind marked by the external and internal examiners. The papers are divided into different parts so no examiner will mark an entire examination. The examiner pairs for each part met during the finals to discuss their individual marks and come to a joint decision. This process was underpinned by marking guides.

The panel were satisfied with the process of standard setting by RCSEng although this may need to be reviewed and modified as the issue of question depth is considered. For the programme assessments, standard setting needs to be embedded further and to be better documented. The processes used to ensure fairness of assessments must be documented, to create both an audit trail and for the leads' own reference and use should a student dispute the accuracy or fairness of their marks.

Additionally, the opportunity for effective calibration and review of the final case presentation notes must be increased. The panel would advocate the notes being available for review prior to the examinations taking place. Not only would this allow for more effective examination of the individual student but would assist in achieving the depth of questioning deemed necessary by the panel.

Actions

No	Actions for the Provider	Due date
13	Increased recording regarding student progression and mapping of the programme to the learning outcomes should be introduced.	N/A
14	The programme leads must collate and review student data regularly. Additional sources of support should be sought to facilitate this regular review, potentially with the assistance of the Trust.	Annual Monitoring 2017/18
16 & 21	The examinations provider must improve the depth of questioning employed to test students on all relevant learning outcomes. The programme leads must ensure that all assessments robustly test the outcomes they are designed to cover.	Annual Monitoring 2017/18
17	Regular and comprehensive patient feedback must be collected across all clinical sites. Programme leads must gather all relevant forms of feedback, including peer feedback and implement a mechanism to gather, record and act on this.	Annual Monitoring 2017/18
19	Examiners should be reminded of examination best practice in line with RCSEng training. Particular attention should be drawn to the elements raised in this report.	N/A
21	Standard setting of in-programme assessments must be implemented across all assessments and well documented.	Annual Monitoring 2017/18
21	RCSEng must allow additional time for calibration between examiner pairs.	Annual Monitoring 2017/18

Summary of Actions

Req. number	Action	Observations Response from Provider	Due date
3	Programme leads must implement plans for clinical audits or a similar plan to ensure that clinical areas are safe for students.	This has been placed as an item for the Jan 2017 plenary agenda to be assigned to staff and areas for auditing will be discussed. In addition, there is to be collaboration with the Trust's auditing team to ensure that practical and useful audit takes places that offer a good learning and reflective experience.	Annual Monitoring 2017/18
4	Programme leads must ensure that supervision levels are consistent at outreach placements at all times.	The staff-student ratio will remain at 1:5 (in outreach placements this will be 1:2). We have now recently taken on several staff and the team numbers have been increased, at times the staff ratio is 2:5.	Annual Monitoring 2017/18
5	Programme leads must extend supervisor training to outreach supervisors.	This has been enhanced and training has already been discussed with community clinic supervisors. Arrangements are in place to meet community outreach supervisors once a term however, discussed can be raised 'as and when' via email. The lead for community outreach is to be invited to future plenary meetings and community tutors are invited to attend child restorative skills course session to calibrate teaching techniques.	Annual Monitoring 2017/18
7	Process must be implemented that demonstrates that programme staff and leads identify, resolve, and learn from clinical incidents.	Incident reports from clinical governance meetings will be forwarded on to all staff. In addition, this will be added to termly staff meetings. Any clinical incidents	Annual Monitoring 2017/18

		will be shared at the weekly morning meetings. This ensures all staff are included as minutes are sent out.	
9	The findings of the inspection report must be shared with the Trust. Options for additional support must be formally explored between the Trust and the programme leads.	This will be completed once finalised and the programme leads have already discussed ways to restructure to provide more support to the department. The initial draft report has already been shared with the Trust's General Manager.	Annual Monitoring 2017/18
9 & 10	Formalisation of the quality management of the programme and increased recording must be implemented.	This will be done in collaboration with item 9, to ensure this is implemented. However, both items would require business proposals and negotiation with the Trust and is likely to be a lengthy process.	Annual Monitoring 2017/18
10	A contingency plan to counter unexpected staff absence must be discussed and defined in writing.	With recent staff recruitment, this means the clinics are staffed with potentially a 'floating' member of staff which will accommodate for absences.	Annual Monitoring 2017/18
11	Policy regarding the use of feedback must be introduced to ensure that this information is formally considered and used to develop the programme.	This will be developed over the course of the year and will be placed at every termly staff meeting.	Annual Monitoring 2017/18
12	Quality assurance measures for outreach placements must be introduced. Patient feedback methods must be rolled out across all sites.	During the next summer term programme leads will meet and assess the outreach clinics as part of a quality assurance process. However, communications with these leads of these sites will continue to be ongoing as they have been. The feedback forms will be rolled out into each of these clinics.	Annual Monitoring 2017/18
13	Increased recording regarding student progression and mapping of the programme to the learning outcomes should be introduced.	This will be incorporated into the staff structural changes assoc in item 9 as this will give opportunity for this to happen.	N/A
14	The programme leads must collate and review student data regularly. Additional sources of support should be sought to facilitate this regular review, potentially with the assistance of the Trust.	This will be incorporated into the staff structural changes assoc in item 9	Annual Monitoring 2017/18

16 & 21	The examinations provider must improve the depth of questioning employed to test students on all relevant learning outcomes. The programme leads must ensure that all assessments robustly test the outcomes they are designed to cover.	This will be discussed with College at the next examiners meeting. The RCS have been made aware of the comments made from this inspection. In regards to internal assessments formative or summative – learning outcomes in each module are mapped against (and clearly stated within documentation) the Preparing for Practice document.	Annual Monitoring 2017/18
17	Regular and comprehensive patient feedback must be collected across all clinical sites. Programme leads must gather all relevant forms of feedback, including peer feedback and implement a mechanism to gather, record and act on this.	This is currently taking place on the KCH and Norwood sites. However, measures will take place to roll out to community clinics. The feedback forms are collated on a database and then redistributed to the students as part of their Personal Development Portfolio, additionally they must use these forms to present in their reflective practice sessions. Responses that require action have been forwarded to the Trust/department for a response/action.	Annual Monitoring 2017/18
19	Examiners should be reminded of examination best practice in line with RCSEng training. Particular attention should be drawn to the elements raised in this report.	This will be discussed with College at the next examiners meeting. As per item 16/21 the RCS have been made aware of the comments from this inspection.	N/A
21	Standard setting of in-programme assessments must be implemented across all assessments and well documented.	This is ongoing and must be done incrementally – due to 100% part-time faculty. The majority of the assessments have been completed.	Annual Monitoring 2017/18
21	RCSEng must allow additional time for calibration between examiner pairs.	This will be discussed with College at the next examiners meeting. As per item 16/21/19 the RCS have been made aware of the comments from this inspection.	Annual Monitoring 2017/18

Observations from the provider on content of report

Requirement 1 – for progression of Year 1 to Year 2 requires successful completion of an OSCE but also a 12 part essay examination

Requirement 3 – the programme leads are assured that the clinical areas are appropriate for treatment and learning. The sites used by the students have undergone regulatory inspection processes in additional to educational inspection. All the sites are used by other teaching departments such as the school of Dental Nursing and King's College, London BDS students. These establishments in collaboration with the Trust have deemed the environments safe and appropriate for the skills that need to be attained from these facilities.

Requirement 4 – Following this incident the Director met with the Lead clinician at Norwood Academy. Steps have now been taken to ensure that no student works alone. If a student is absent for any reason nursing support must be supplied by the nursing staff at Norwood. The clinical set up of Norwood is individual surgeries thus simulating the practice setting therefore the member of staff in charge of hygiene and therapy students supervises two surgeries, so there will be moments where tutors will not be present in the room but he/she is always available if required.

Requirement 9 – The programme is mapped in the individual modules. However, blueprinting for each assessment will be mapped against the learning outcomes and each student will be monitored against this.

Requirement 12 - Communications with the community clinic dental officers/lead of community services and clinical director is frequent. Should incidences/feedback occur then communication is immediate along monthly meetings with the clinical director (who is lead of community services). We are in regular communication with the Deputy Clinical Lead who is directly responsible for the staff in the community clinic.

Requirement 17: Personal Tutor Meetings – are logged and placed in the students personal file (which is held secure in the department – due to their confidential content), it would be inappropriate to place these in the logbooks. The template of the personal tutor meeting was included in the evidence folders of the pre-documentation - Standard 3 – 3.18 – Appendix 2.

Requirement 17: The hardcopy system was in place during the time of the inspection an example of the patient feedback form was presented in the pre-inspection data Standard 3 – 3.18 Appendix 6 – Student Patient feedback form. The collation of these feedback forms was presented at the time of the inspection along with a meeting with the feedback co-ordinator. The individual identity of the students was withheld in the results of these feedback forms, which were presented in the additional documentations folder which was available during the inspection and held by the panel to date.

Recommendations to the GDC

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

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

Appendix 1

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 three Standards, with a total of 21 underlying Requirements. These are contained in the document *Standards for Education*.

4. The purpose of this inspection was to make a recommendation to the GDC to determine whether the Diploma in Dental Hygiene and Therapy should continue to be approved as a route for registration as a dental hygienist and therapist. The GDC's powers are derived under the Dentists Act 1984 (as amended) under The General Dental Council (Professions Complementary to Dentistry) (Qualifications and Supervision of Dental Work) [DCP] Rules Order of Council 2006.

5. Inspection reports may highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term 'must' is used to describe the obligation on the provider to undertake this action. For these actions the inspectors may stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term 'should' is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme be approved 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 approval, the report and observations would be presented to the Council of the GDC for consideration.

Evaluation of Qualification against the *Standards for Education*

7. As stated above, the *Standards for Education* were used as a framework for this inspection. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement 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 additional evidence from discussions with staff and students.

8. The inspection panel used the following descriptors to reach a decision on the extent to which the Diploma 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."