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General Dental Council

protecting patients, regulating the dental team

Annual Review of Education

2013/14

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Introduction

The General Dental Council's (GDC) primary purpose is to protect patients. Part of this role includes a statutory responsibility to quality assure education and training programmes so that newly qualified dentists and dental care professionals (DCPs) are fit to apply to join the GDC's registers and practise independently as safe beginners. The defines a safe beginner as a 'rounded professional who, in addition to being a competent clinician and /or technician, will have the range of professional skills required to begin working as part of a dental team and be well prepared for independent practice'. They will be able to assess their own capabilities and limitations, act within these boundaries and will know when to request support and advice.

The GDC quality assures a wide range of programmes across all four UK nations. These programmes cover a number of qualifications and types of institution, and vary in the size of their student cohort from as few as five to 160. In addition, the GDC quality assures some qualifications provided by national awarding bodies and delivered across a range of further education settings to thousands of students and trainees.

In 2013/14, the GDC concluded the cycle of first inspections of UK dental schools using the new ***Standards for Education*** framework and conducted six inspections of Dental Care Professional (DCP) programmes using the new standards framework.

Inspections provide detailed information about education programmes, and inspection reports help providers to maintain and improve the quality of provision. Where necessary, inspection reports require providers to take a number of actions to improve the programme. Progress in undertaking these actions is monitored through annual monitoring (or in some cases re-inspection). Inspection reports are published on the GDC's website and provide information to the public, including students, their parents and employers.

The GDC promotes high standards of education and training. Training as a dental professional marks the beginning of a professional's career throughout which they will be expected to meet our professional standards, demonstrate a commitment to continuing professional development, and respond to changes to technology, oral health and treatments. Training and education therefore provides an essential opportunity to lay strong foundations for the future dental workforce.

We have considered what more can be learned from our inspection activity and have produced this report: the second GDC Annual Review of Education, following the publication in 2014 of the Annual Report of Education 2012/13. This report is designed to provide an overview of education and quality assurance and to stimulate wider debate about what is working well and those areas in which providers may find it more challenging to meet our requirements fully. We hope providers may find it useful to discuss the issues raised in this report and to work together to find effective ways to share good practice and tackle common challenges.

Our inspectors identified some areas where programmes are doing well, including ensuring that:

- students are assessed adequately on their knowledge and skills before undertaking patient care and clinical procedures;
- patients are aware that they are being treated by students, and give consent; and
- students understand the importance of professionalism, equality and diversity, personal reflection, and raising concerns.

There are also a number of areas that providers have found more challenging. These include:

- attracting sufficient numbers of appropriate patients requiring the range of procedures needed for students to gain necessary experience;

- ensuring that patient/peer/customer feedback contributes to the assessment process; and
- standard-setting, tracking of assessment in the workplace and outreach, and blue-printing of exams and other assessments against the learning outcomes.

Last year, we made a number of recommendations for action based upon the analysis of inspections in 2012/13. As a result, the GDC has:

- developed our approach to annual monitoring (see page 22). Further development will take place prior to the next annual monitoring round;
- gathered detailed information from providers in relation to students' clinical experience;
- placed an increased emphasis on raising concerns in both *Standards for Education* and *Preparing for Practice;* and
- discussed our findings with a range of external stakeholders, including COPDEND and the Dental Schools Council.

We would welcome feedback from our stakeholders on the report and its findings as well as suggestions for themes we might report on in future annual reviews of education. You can find out how to get in touch with us on page 40.

We are grateful to all of the staff and students we met during the course of our inspection visits for their cooperation and assistance.

Performance of the GDC

The GDC is overseen by the **Professional Standards Authority** (PSA). Each year the PSA produces a Performance Report that sets out the effectiveness of each of the professional regulators. In 2014, the PSA found that the GDC met all five Standards of Good Regulation in Education and Training. The PSA also commended the GDC's approach of using its data to identify themes and trends in the first Annual Review of Education.

Background

As part of its role as the regulatory body for dentists and DCPs, the GDC has a responsibility to set out requirements for programmes leading to registration as a dental professional. The GDC also has a responsibility to quality assure these programmes to ensure that each of them meets our requirements.

The GDC published ***Standards for Education*** in November 2012. The Standards are the regulatory tool used by the GDC to ensure that a programme is fit for purpose. The Standards are central to the GDC's quality assurance processes and contain a total of 29 requirements. For the period between 2012 and mid-2015, the Standards covered the following areas:

1. Patient protection.
2. Quality evaluation and review.
3. Student assessment.
4. Equality and diversity[1].

Education providers must be able to demonstrate that upon qualification, students have achieved all the required learning outcomes. These are set out for each of the professions that we register in ***Preparing for Practice.***

Both the *Standards for Education* and *Preparing for Practice* were revised in June 2015 and these revised versions will be used in our quality assurance activity from the beginning of the 2015/16 academic year. Further information on these revisions is included on page 32.

During a transitional period, education programmes may continue to produce professionals who demonstrate the learning outcomes set out in the previous guidance, ***The First Five Years*** (for dentists) and ***Developing the Dental Team*** (for DCPs). These documents are available on the GDC's website.[2]

Our process

The GDC's Quality Assurance process includes:

- Reviewing proposals for new programmes and qualifications from providers and awarding bodies;
- Inspecting course providers and awarding bodies;
- Annual monitoring (paper-based).

GDC Quality Assurance inspectors undertake inspections of programmes leading to registration, working in panels of three or four, supported by a member of the GDC's Quality Assurance team. Inspections vary in length but are generally undertaken over two consecutive days for the programme inspection and between one and four days for the examination inspection. Providers are required to submit evidence in advance of the inspection to demonstrate whether programmes meet our requirements.

Inspectors make a recommendation to the Council of the GDC as to whether or not a programme is 'sufficient' or should be 'approved' for registration[3]. The GDC's Council delegates consideration of this recommendation to the Chief Executive and Registrar, who is informed by inspection reports and the observations of the provider on the report findings. Once the Registrar has made a decision, inspection reports are published on the GDC's website. Reports may require a provider to take certain actions and/or

[1] Following a review of the Standards for Education this standard has been integrated across the remaining three standards

[2] http://www.gdc-uk.org/Aboutus/education/Pages/Education-sector.aspx

[3] The terminology used for the recommendation is determined by the language used in the Dentists Act: 'Sufficiency' is the term used that relates to dentistry (BDS) programmes and 'approval' is the term used for DCP programmes.

make improvements, and may recommend a re-inspection to check that the necessary improvements have been made. The GDC does not rank or grade programmes.

In the 2013/14 academic year, we inspected 11 dentistry (BDS/BChD) and six DCP programmes. **Annex 1** provides the full list of programmes we inspected. Inspection reports provide a snapshot of a specific programme at a particular moment in time – therefore, care needs to be taken when comparing this report with last year's Annual Review of Education.

This report contains an analysis of these inspections, which has revealed good practice in programmes delivered by UK education providers across a range of the requirements set out in the *Standards for Education*. Similarly, we have been able to identify areas where our requirements are not yet being fully met and where there might be learning points which would be of use to all education providers – whether or not they have been recently inspected by the GDC.

2013/14 Inspections: key findings

All 16 programmes inspected in 2013/14 against the *Standards for Education* were found to be sufficient to enable the qualifying student cohort to apply to join the GDC's registers. However, in some cases the GDC could not be confident that future cohorts would be satisfactory and re-inspections were required in the case of five programmes. In addition, our inspectors identified a number of areas where each programme could be improved. We will be monitoring providers' progress in responding to these actions.

Annex 2 provides a more detailed summary of which requirements were met, partly met and not met by programmes during this period. (**Annex 4** provides definitions of these terms.)

Table 1: Mean number of GDC Requirements met by programmes in 2013/14

Met	Partly Met	Not Met
19.5	8.63	0.88

Which Requirements were most frequently met?

(Number of programmes fully meeting the requirement is given in brackets.)

- *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. (14)*

- *Requirement 2: Patients must be made aware that they are being treated by students and give consent. (15)*

- *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 the 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. (15)*

- *Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity. (15*)

It is reassuring that three of the eight **patient protection** requirements feature on this list and that the majority of training providers fully met the five other requirements under this standard.

Fourteen of the sixteen providers fully met the requirement on assessing students adequately before undertaking patient care and clinical procedures. Robust gateway assessments included written papers, observed competency assessments in skills laboratories and appropriate testing in medical emergencies and decontamination protocols. We also saw evidence that students understood the importance of working within their own limits, which is key to minimising the risk of harm to patients.

Requirement 2 was covered very well by training providers (see above). Schools and individual clinics use a variety of ways to let patients know they are being treated by students and to distinguish students from registrants. Examples of good practice included: information tailored to patients referred from outside the treatment centre, who may be less well informed; explaining the time and cost implications of being treated by students; annual reviews of patient literature and guidance to supervisors. Consent could be verbal (for a patient examination) or written (for certain procedures). Verbal consent could still be recorded in the

patient's file. From conversations, there was evidence that students understand that consent extends beyond informing patients that they are being treated by students; dental professionals should also ensure patients' understanding of the treatment, for example.

We were reassured that 15 out of 16 training providers met Requirement 9, which relates to Student Fitness to Practise. Policies were generally aligned to the GDC's guidance, made available to students, and inspectors saw evidence of how these policies were applied in practice. The importance of fitness to practise was also taught through modules on professionalism.

15 out of the 16 providers inspected also demonstrated full adherence to current legislation and best practice guidance for equality and diversity (Requirement 27). Under this requirement, examples of good practice were identified in the recruitment of students. We also noted that the number and variety of outreach placements allowed students to interact with patients from a diverse range of backgrounds.

Across the standards, there was good evidence that **professionalism** is encouraged throughout programmes in a variety of ways. We saw examples of students attending work placements and observing clinics at early stages of training. A number of providers reported that students were not simply taught they must comply with equality and diversity laws; they were encouraged to reflect on the impact an illness or personal circumstances may have on an individual's dental health. Training providers were generally very strong on encouraging reflection and providing feedback to improve students' performance. A willingness to receive feedback in a positive way and reflect on the work one has undertaken is key to professionalism. On the whole, clear protocols were in place for raising concerns, which was seen as part of fostering professionalism and embedded longitudinally throughout programmes.

What was particularly challenging?

(Number of programmes partly or not meeting the requirement is given in brackets.)

- *Requirement 17: The provider must have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes. (7 partly met, 1 not met.)*

- *Requirement 19: 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. (7 partly met, 1 not met.)*

- *Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments. (9 partly met.)*

- *Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process. (10 partly met, 2 not met.)*

Assessment:

Key challenges for a number of training providers were: robust standard-setting; tracking of assessment in the workplace and outreach; blue-printing of exams and other assessments against the learning outcomes. Ways of addressing these issues included: methods for standard-setting and clear marking criteria for clinical exams and examiners training. A number of training providers are, or will be, using electronic portfolios to record clinical experience in the workplace and outreach. We also received good examples of

blue-printing, where providers had mapped out in advance of the programme taking place, and in some detail, how each learning outcome would be assessed.

Patient supply

A further challenge was for training providers to attract sufficient numbers of appropriate patients requiring the range of procedures needed for students to gain the necessary experience. Ways of addressing this included: use of flyers to recruit patients; extending clinic times to improve access for patients; appointing a consultant in a specialty where patient supply was low to improve referral pathways. In addition, careful logging of students' clinical experience through electronic means enables training providers to anticipate, and plan for, potential shortfalls. This allows providers quickly to identify potential or actual issues, and take action immediately to mitigate this.

Patient/peer/customer feedback

Only four training providers fully met the requirement, "Where appropriate, patient/peer/customer feedback should contribute to the assessment process". This was because clinics generally sought patient feedback on their overall experience, rather than focus on the performance of a specific student. Where feedback from patients occurred, it tended to be verbal and not gathered in a structured way. Examples of good practice did exist (such as the assessment of students' portfolios which included feedback from patients and peers) and these may provide a starting point for further work. Generally, there were more opportunities for peer, rather than patient, feedback at the programmes inspected.

Quality Evaluation and Review of Programmes

Generally, training providers performed well in evaluating and reviewing the quality of their programmes, with any difficulties tending to arise at the strategic and quality management levels. In some cases, leaders and directors were spread too thinly and strategic committees were overly focused on operational matters. In addition, in a few cases, training providers needed to provide better evidence of how action points were taken forward and whether mechanisms existed to raise and address issues quickly enough.

A further challenge lay with overseeing the quality of work placements, including outreach. In certain cases, there was room for improving formal reporting mechanisms between the training provider and training sites. In some instances, training providers need to ensure that issues raised in the workplace and in outreach can be considered quickly and required actions are tracked. Learning agreements should be in place between the training provider and work placement/outreach location to help standardise the experience for students.

Working with the Dental Team

From the inspections we undertook during the academic year 2013/14, we saw good examples of students learning alongside other members of the dental team. At the University of Belfast, for example, BDS students gain experience of working with dental technology students. There are joint lectures in Year One and BDS students attend laboratory sessions in order to gain an understanding of the processes undertaken during the manufacture of dental appliances. In Year Two, dental technicians work alongside dental students on the BDS programme. On the Certificate of Higher Education in Dental Nursing at the University of Portsmouth Dental Academy, student dental nurses work alongside both BDS and Hygiene and Therapy students in their Dental Academy clinic. Increased use of outreach, in general, facilitates greater interaction between dental team members. At the University of Central Lancashire, for example, BDS students work closely with dental nurses in their Dental Education Centres and dental hygienists and therapists in their Extended Training Practices (training in dentistry at this university takes place, in large part, at centres and practices outside the dental school).

Note on re-inspections

We undertook three re-inspections of programmes this year. Reassuringly, the re-inspections all found that significant progress had been made on the previous year's performance against the requirements. A BDS programme, for example, saw a total of thirteen requirements revised from Not Met to Partly Met or from Partly Met to Met. Under Standard 3 (covering assessment), a DCP programme now meets in full, ten of the eleven requirements, where previously it didn't fully meet any of them.

Recommendations
Training providers need to develop ways of obtaining feedback from patients for the purpose of student assessment, including how this could be more formal and structured than at present and specific to individual students.
The GDC will work with training providers on promoting the importance of standard-setting for assessments, including for practical and clinical exams.
The GDC will draw out good practice in the assessment and fostering of professionalism during future quality assurance activity, which would link with the policy work on professionalism and work with training providers on standard-setting for assessments.
Training providers should develop and improve programmes so that they fully meet the Standards for Education and so that qualifying students demonstrate the full breadth of learning outcomes set out in Preparing for Practice.

The following sections provide details of our overall findings for each Standard. We hope this will be a useful tool in providing a picture of the current state of play within recently inspected education and training providers.

Standard One: Protecting Patients

Standard 1: Providers and students 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.

Table 2: Programmes meeting Standard One requirements based on 2013/14 inspections

Requirement		Met	Partly Met	Not[4] Met	Total
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 environment prior to treating patients.	14	2	0	16
2	Patients must be made aware that they are being treated by students and give consent.	15	1	0	16
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.	12	3	1	16
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.	11	4	1	16
5	Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body.	11	4	1	16
6	Students and those involved in the delivery of education and training must be made aware their obligation to raise concerns if they identify any risks to patient safety and should be supported to do so.	11	5	0	16
7	Should a patient safety issue arise, appropriate action must be taken by the provider.	10	6	0	16
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	15	1	0	16

[4] Where a requirement has been found to be "not met", this means that the inspection panel were not provided with sufficient evidence to demonstrate compliance with that requirement during the inspection. Inspection panels make a recommendation on whether a programme is sufficient/approved for the purposes of registration based on consideration of each programme as a whole and with particular regard to patient and public safety. Full descriptors of 'met' 'partly met' and 'not met' can be found at the end of this document.

	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 performed very well across the requirements for protecting patients.

15 of the 16 programmes inspected fully met two of the requirements under this standard (see Requirements 2 and 8 in the key findings section, above).

14 of the providers fully met the requirement on assessing students adequately before undertaking patient care and clinical procedures. Robust gateway assessments included written papers, observed competency assessments in skills laboratories and appropriate testing in medical emergencies and decontamination protocols. We also saw evidence that students understood the importance of working within their own limits; this is a key professional quality.

Ten out of the 16 providers fully met Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider. Reasons for not fully meeting this requirement (occurring in just a few instances) were: lack of clarity on how work placements and the training providers interact (including the threshold for workplace trainers reporting incidents to the provider); insufficient evidence available to inspectors of whether action had been taken in response to reported incidents; unclear governance mechanisms; concern that training providers relied upon generic protocols for patient safety, rather than ones tailored specifically to dental students.

Datix is a supplier of patient safety software for healthcare risk management, incident and adverse event reporting. Increased usage of the Datix system at dental hospitals to identify trends and risk matrices for deciding when an issue should be escalated is a positive step However, whilst mechanisms for logging incidents and making decisions are helpful, the type of data entered must be consistent. Inspectors need evidence of the action that had been taken. Trainers and students in work placements and clinics should have a clear procedure for reporting relevant incidents and general findings to training providers.

Examples of good practice observed include: a dental school providing training to outreach staff in reporting incidents; a system whereby incidents are logged within 72 hours and a root cause analysis undertaken to produce learning points; mechanisms for detecting clusters of (more minor) incidents that may have a significant impact overall; patient safety issues appearing as standing items on committee agendas; committees or boards covering patient safety that have representation from both hospitals (and other workplaces) as well as the training provider.

Requirement 6 calls for students and those involved in the delivery of education and training to be encouraged to raise concerns if they identify any risks to patient safety. Five of the training providers partially met the requirement (11 fully met the requirement). It was reassuring to inspectors that protocols are generally in place for raising concerns, along with mechanisms for ensuring that students and others are aware of these protocols. Discussion between inspectors and students demonstrated that students had a strong understanding of the significance of raising concerns, even in the few noted cases where training providers had been unable to provide the inspectors with written protocols. One training provider confirmed that the Francis Report[5] was specifically covered in lectures and we would encourage all providers to do this. On the whole, raising concerns was seen as part of fostering professionalism, which is embedded longitudinally throughout programmes. In one instance, students showed a particularly good approach to

[5] http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/

raising concerns, reporting that they didn’t view this in a negative light; instead, it provided a means of preventing small problems from becoming bigger ones.

In the inspection reports, we have underlined that, for work placements, it may be more difficult for some students to raise concerns; this could be particularly the case for orthodontic therapy students, because their trainers are commonly their current employers. In these cases, we have recommended that training providers should reassure trainees that alternative positions would be found for them, should this prove necessary. In addition, it is beneficial for training providers and outreach and work placements to have programme-specific policies on raising concerns, rather than rely on generic NHS or university policies, which may not be as relevant as they could be.

In practice, it can be difficult to have insight as to when it is appropriate to raise concerns. Inspectors reported the use of situational judgment tests in the training of students as a way of helping to determine whether or not a matter should be taken forward.

Three of the reports in this review relate to re-inspections of programmes where this requirement was previously only partially met. In two cases, this requirement is now fully met, since clear pathways for raising concerns have been introduced and for the third programme, which was no longer being offered after the inspection, a clear procedure must be provided as part of any new programme submission made.

Standard Two: Quality evaluation & review of the programme

Standard 2: The provider must have in place effective policy and procedures for the monitoring and review of the programme

Table 3: Number of programmes meeting Standard Two requirements based on 2013/14 inspections

Requirement		Met	Partly Met	Not Met[6]	Total
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 learning outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.	9	6	1	16
10	The provider must have systems in place to quality assure placements.	9	6	1	16
11	Any problems identified through the operation of the quality management framework must be addressed as soon as possible.	9	6	1	16
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 immediately. (NB where there is geographical variation in oral health needs, providers must inform the GDC of the issues and action to be taken to demonstrate that the outcomes have been met).	12	3	1	16
13	Programmes must be subject to rigorous internal and external quality assurance procedures.	12	3	1	16
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.	13	3	0	16
15	Providers must consider and, where appropriate, act upon all concerns raised, or formal reports on the quality of education and assessment.	12	3	1	16

[6] Where a requirement has been found to be “not met”, this means that the inspection panel were not provided with sufficient evidence to demonstrate compliance with that requirement during the inspection. Inspection panels make a recommendation on whether a programme is sufficient/approved for the purposes of registration based on consideration of each programme as a whole and with particular regard to patient and public safety. Full descriptors of ‘met’ ‘partly met’ and ‘not met’ can be found at the end of this document.

The requirements under this standard cover both quality management and quality assurance of programmes. The area in which training providers were strongest was external input into quality assurance processes, in particular the use of external examiners. Robust quality management and strategic oversight of programmes, as well as the quality assurance of work placements and outreach, proved more challenging.

There were good examples of training providers involving students, mentors, trainers and other staff in their quality assurance processes. Some difficulties arose at the strategic and quality management levels. Training providers should guard against: leaders and directors being spread too thinly and/or having insufficient back-up; strategic committees being overly focused on operational matters; confusion regarding committees' remits and reporting structures. In a few cases, training providers needed to provide better evidence of how actions were taken forward and whether mechanisms existed to raise (and address) issues quickly enough. It is also important for the GDC and training providers to have a shared understanding of what constitutes a major or minor change to a programme.

There were examples of good practice in the quality assurance of work placements and outreach, despite this area proving more of a challenge (seven of the training providers either partially met or did not meet this requirement). These examples include: designating a lead or supervisor for work placements and outreach; making regular contact with, or visits to, training sites; enabling workplace trainers to spend time at schools and moving trainers between practices; producing audit documents for placements; holding debriefing sessions after placements; making training of workplace trainers mandatory. There were instances of low uptake of centralised training by workplace trainers. On the other hand, some providers made it mandatory for workplace trainers to attend specific training and we would expect this to be standard across all providers.

In some cases, training providers need to ensure that: there are formal reporting mechanisms between the training provider and training sites (with clear guidelines and processes defined) and that any issues can be taken forward quickly (rather than waiting for end-of-year meetings, for example); there is clarity on assessment and logging of clinical experience; learning agreements are in place between the training provider and work placements and outreach to help standardise the experience for students (for example, time spent at tutorials, breadth of experience gained). Effective communication plans between training providers and work placements and outreach and ways of tracking progress on any actions required were also needed, in some instances.

Student feedback on work placements and outreach was routinely collected and its value to the quality assurance process would be further enhanced if all training providers took steps to improve response rates to their questionnaires or made it mandatory to provide feedback.

There was some overlap in the findings from the three most challenging requirements under this standard (Requirements 9, 10 and 11). Further to a review of the Standards for Education in 2015 as outlined on page 32, we have consolidated a number of requirements in this section to address this duplication.

Recommendations

Training providers need to ensure that staff on work placements receive the same training provided to staff at the central site, including on equality and diversity.

Standard Three: Student assessments must be reliable and valid

Standard 3: Assessment must be reliable, valid and fair to all students. 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

Table 4: Number of programmes meeting Standard Three requirements based on 2013/14 inspections

Requirement		Met	Partly Met	Not Met[7]	Total
16	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. 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.	9	7	0	16
17	The provider must have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes.	8	7	1	16
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.	10	6	0	16
19	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.	8	7	1	16
20	The provider should seek to improve student performance by encouraging reflection and by providing feedback.	14	2	0	16
21	Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a regulatory body.	9	7	0	16
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.	13	3	0	16
23	Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments.	7	9	0	16
24	Where appropriate, patient/peer/customer feedback should contribute to the assessment process.	4	10	2	16

[7] Where a requirement has been found to be “not met”, this means that the inspection panel were not provided with sufficient evidence to demonstrate compliance with that requirement during the inspection. Inspection panels make a recommendation on whether a programme is sufficient/approved for the purposes of registration based on consideration of each programme as a whole and with particular regard to patient and public safety. Full descriptors of ‘met’ ‘partly met’ and ‘not met’ can be found at the end of this document.

25	Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion.	10	6	0	16
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.	9	7	0	16

This proved to be the most challenging of the four standards, with an average incidence of requirements that are fully met of 9.2 (it was 12.4 for Standard 1 on patient protection). With the exceptions of Requirements 20 and 22 (see table above), six or more of the training providers partially met or did not meet the remaining requirements under this standard.

Fourteen of the training providers fully met Requirement 20, to seek to improve student performance through encouraging reflection and providing feedback. It is positive that providers are strong on this, because the willingness to receive feedback in a positive way and reflect on your own performance is key to professionalism.

Key challenges for a number of training providers included: carrying out robust standard setting; blue-printing of assessments against the learning outcomes; tracking of assessment in the workplace or in outreach; and having a structured approach to summative assessment of communication skills and professionalism. There were also difficulties in sourcing appropriate patients for learning and continuous assessment of students.

We received examples of ways in which some training providers were addressing these challenges. Where appropriate, approaches to standard-setting, such as Angoff and Hofstee[8] were used. In other cases, structured mark sheets with clear descriptors for grading assisted in standardising assessment. Such mark sheets and descriptors also extended to covering communication skills and professionalism at a number of training providers. The training of examiners is important to ensuring consistency of standards, particularly in high-stakes assessments; an example of notable practice was case presentation videos, whereby examiners could practise assessing the clinical abilities of students.

We require training providers to show in detail when and how each learning outcome is assessed. It is important that training providers map their assessments against the learning outcomes before the programme begins, rather than retrospectively. We received good examples of this exercise, which mapped each learning outcome to the relevant year and term of the programme / title of the module, name of the exam / summative assessment (for example, 'Final clinical exam, module 1, year 4', Satisfactory completion of clinical targets, module 1, year 4) and the type of assessment used (for example, OSCE, SAQ, SBA). This level of detail helps to demonstrate that learning outcomes are assessed on more than one occasion and by different assessment methods.

In order to log formative and summative assessments in the various clinical environments, a number of training providers are, or will be, using electronic portfolios (such as the Longitudinal Integrative Foundation Training Undergraduate to Postgraduate Pathway (LIFTUPP) and the Clinical Assessment and Feedback System (CAFS)). Regular review of these portfolios allows training providers and students to anticipate potential gaps in experience (both for cohorts and individual students), as well as logging the outcomes of

[8] In the Angoff Standard Setting Procedure, for example, experienced judges "estimate the proportion of the group of minimally competent candidates who would respond correctly for each item, then record, repeat, and cumulate for the test as a whole." In the Hofstee Compromise Method, judges are asked the minimum and maximum acceptable cut scores and the minimum and maximum acceptable fail rates. These values are averaged and "the cumulative sum of candidate scores is plotted" and compared against the judge-determined limits. (Source: General Medical Council)

assessments in a robust, systematic and detailed way (for example, including all of the various skills and areas of knowledge covered by one particular assessment).

A further challenge was for training providers to source sufficient numbers of appropriate patients. For those inspected in the academic year 2013/14, methods used to address this included: use of flyers to recruit patients; adjusting clinic times to improve access for patients; appointing a consultant in a specialty where patient supply was low (this facilitates referral of, for example, paediatric cases to a training provider and a robust triage mechanism). In addition, careful logging of students' clinical experience through electronic means enables dental schools / training providers to anticipate, and plan for, potential shortfalls.

Ten training providers only partially met Requirement 24 ('Where appropriate, patient / peer / customer feedback should contribute to the assessment process.'). A further two did not meet the requirement at all. This was the highest incidence of training providers partially or not meeting a requirement. Clinics tended to seek patient feedback on their overall experience of treatment, rather than focus on the performance of a specific practitioner / student. In one case where this requirement was met, students give their patients a survey form to complete. These forms are reviewed by the training provider on a monthly basis and the comments fed back to students, both to inform their development and as part of their continual assessment. Another example of good practice was assessment of students' portfolios which include feedback from patients and peers. Where this requirement was partially met, it appeared feedback from patients did still occur. However, this might be verbal (for example, from patient to supervisor of student), only when volunteered by patients or where comments came from simulated patients / actors. One institution used 'patient educators' in the assessment process; patient educators have a formal role and work directly with students to support them in learning.

Generally, there were more opportunities for peer, rather than patient, feedback at a number of the programmes inspected. Students provided this through role play with fellow students or in paired clinical settings. There was still scope for formalising the feedback process, clarifying its role in student assessment and including the views of other members of the dental team (practice receptionists, dental nurses and supervisors in outreach could all comment on a student's performance, including their professionalism and communication skills). It is important that all dental professionals seek feedback from a variety of sources, which may include, in the case of non-clinicians, those who refer work to them.

Standard Four: Equality and Diversity

Standard 4: The provider must comply with equality and diversity legislation and practice. They must also advocate this practice to students.

Table 5: Number of programmes meeting Standard Four requirements based on 2013/14 inspections

Requirement		Met	Partly Met	Not Met[9]	Total
27	Providers must adhere to current legislation and best practice guidance relating to equality and diversity.	15	1	0	16
28	Staff must receive training on equality and diversity, development and appraisal mechanisms will include this.	9	7	0	16
29	Providers must 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.	13	2	1	16

Of the four standards, this one has the second highest average incidence of requirements that are fully met (12.3). The average for Standard 1 (protecting patients) is 12.4, Standard 2 (quality management) - 10.7, Standard 3 (assessment) – 9.2.

15 out of the 16 providers inspected demonstrated full adherence to current legislation and best practice guidance (Requirement 27 above). Under this requirement, examples of good practice were given in the recruitment of students. One school, for example, provides experience and support for students wanting to apply to dentistry from groups under-represented in higher education. Some training providers also reported that their training of recruiters covers awareness of unconscious bias and that multiple mini-interviews are used to help ensure objectivity in the recruitment process.

Requirement 28 proved more challenging; seven of the 16 providers partially met the requirement (nine fully met the requirement). In a number of cases, this was because providers couldn't produce evidence of equality and diversity training for those staff working away from the school / central location. Other reasons providers only partially met this requirement included: failure to enforce attendance at initial or top-up training and to monitor training undertaken through the appraisal process; no training on equality and diversity offered that was specific to the role. From the point of view of work placements, inspectors

[9] Where a requirement has been found to be "not met", this means that the inspection panel were not provided with sufficient evidence to demonstrate compliance with that requirement during the inspection. Inspection panels make a recommendation on whether a programme is sufficient/approved for the purposes of registration based on consideration of each programme as a whole and with particular regard to patient and public safety. Full descriptors of 'met' 'partly met' and 'not met' can be found at the end of this document.

recognised that trainers (and sometimes trainees) are registrants and, therefore, required to adhere to equality and diversity standards. One training provider reported that, to extend training to the workplace, its e-learning module on equality and diversity is available in outreach locations.

The findings under Requirement 29 were positive. A number of providers reported that students were not simply taught about compliance with the law; in addition, they were encouraged to reflect on the impact a chronic illness, for example, may have on an individual's dental health. Two training providers reported that their students sign agreements to abide by equality and diversity principles, which extend to other areas that may not be protected characteristics.

Another example of good practice was one school's work with a community engagement team. This enabled students to interact with disadvantaged and marginalised groups from the start of their training. Another training provider explained how their e-portfolio would provide an opportunity to reflect on equality and diversity in practice. One school reported that examples such as the relationship between the Mental Capacity Act 2005 (which applies to England and Wales) and the Adults with Incapacity (Scotland) Act 2008 are used to highlight the differences in legislation between the four UK nations.

Five training providers reported that they had received a bronze or silver Athena Swan award; this recognises commitment to advancing women's careers in the sector. Other providers are applying for the award.

As outlined elsewhere in this report, the Standards for Education have been refined and reduced from four standards to three. Requirement 29 under Standard 4 has been integrated into a revised learning outcome in the updated version of Preparing for Practice. Requirements 27 and 28 are integrated into requirements 3, 5 and 19 of the revised Standards for Education.

Our inspectors

The GDC's inspections of dental education programmes are carried out by external quality assurance (QA) inspectors.

Our inspectors include dentists, dental care professionals and lay members from legal, education and healthcare backgrounds. The GDC's QA Team recruited a new panel of QA inspectors in the summer of 2012. All inspectors were appointed through an open and competitive recruitment process and are subject to the conditions set out in the GDC's Governance Manual for Associates of the GDC, which includes confidentiality, declaring conflicts of interest, anti-fraud and whistleblowing. A list of our inspectors is provided at **Annex 3.**

All inspectors are subject to ongoing training. Two whole day training events were held in Autumn 2012, the first was specific to the role of the lay chair, which included some background to dentistry and the dental sector. A second, larger event brought the registrant inspectors and lay chairs together, and focused on the practicalities of inspecting against the then newly published *Standards for Education*. Members of the QA advisory panel who had helped develop the Standards were invited to speak, and a number of evidence-based exercises were undertaken in preparation for the 2012-14 BDS inspection round. A further training event was held in January 2013 for a small group of inspectors that could not attend the autumn sessions. Feedback on the content of the training was positive.

Following the first year of inspecting against the *Standards for Education*, a further training event took place in March 2014. Once again, this event brought together the registrant inspectors and lay chairs with a view to building on the experience gained from completing the first set of new style inspections against the Standards. The agenda included speakers covering several aspects of the QA process, including a director of a training programme that had recently been inspected. The QA team also developed two evidence-based scenarios for the day, exploring evidence evaluation and decision-making under the Standards; a second exercise focused on the impact of the Francis Report on the healthcare sector, particularly in respect of 'whistle-blowing' and professional responsibilities within dental education.

A further training day will take place in November 2015. This training session will include a focus on equality and diversity issues that are specific to the role of QA Inspector, the revisions to the Standards for Education, as well as a calibration exercise to ensure that inspectors are applying inspection judgements consistently.

In early 2015 the QA team invited inspectors to provide feedback on the quality assurance process and the performance of the QA team. A number of actions were identified through this process and will be addressed via team discussions and with inspectors during annual training days. Refining certain aspects of the inspection process, developing the approach to assessing new course submissions and providing feedback to inspectors on their performance will be key areas of focus during the coming year.

Annual Monitoring Exercise 2014

A. Background

The GDC annual monitoring exercise process covering the 2014 calendar year was designed to build upon the knowledge from the first inspections that took place using the *Standards for Education*. It is a development of the GDC's previous approach, pending further development that will be implemented in the 2015 exercise.

The annual monitoring exercise provides a formal mechanism between each inspection to share information on programme delivery and facilitate reporting, and early identification of any new risks or issues, both for individual training providers and the wider sector.

To avoid duplication and reduce the burden on providers, programmes inspected in the 2013/14 or 2014/15 academic years were not required to complete this exercise[10]. 37 training programmes took part in the 2014 annual monitoring exercise. All training providers were required to provide a response to the question asking them about their annual student fitness to practise data.

Type of Education programme.	**Number of providers responding to 2014 annual monitoring exercise.**
Dentistry	6
Hygiene/Therapy	15
Orthodontic Therapy	2
Dental Nursing	9
Dental Technology	5
Clinical Dental Technology	0

A copy of the annual monitoring questionnaire is attached at **Annex 7** and comprises a number of quantitative questions to gather information about programmes alongside some thematic questions to explore specific issues in more depth, including student fitness to practise, patient safety and clinical experience. In addition, we asked about progress in implementing the actions identified in the previous inspection to check that providers are on track.

B. Changes to programmes

Significant changes to an approved programme or those which impact more widely across the sector can be indicative of potential risks, and in some cases may indicate the need for further quality assurance activity or changes to GDC policy.

Providers reported a number of changes to their programmes including changes to assessments (including, for example, changes in weighting of multiple choice questions); implementation of electronic recording systems; and the introduction of additional modules (including, for example, on professionalism). In a few cases, we have taken follow-up action to ask for further information about these changes to provide assurance that the GDC's Standards for Education are being adequately met.

Dental schools informed us that the Government's ten percent reduction in dental student numbers had come into effect. On the whole, dental schools reported that they are currently managing the associated reduction in income without impacting on the quality of training. Developing postgraduate provision, or training for overseas students and DCP groups, were cited as ways of limiting the effects of reduced

[10] These providers were required to submit information in relation to student fitness to practise cases only.

funding. This will need to be monitored closely going forward to ensure that there is not a negative impact on the quality of provision and new graduates' ability to practise as safe beginners.

Recommendations
The GDC will continue to monitor potential impact on quality of programmes arising from economic factors

C. Patient safety

The GDC's primary purpose is to protect patients. Providers must be aware of their duty to protect the public and ensure that patient safety is paramount and that patients receive good quality care. Dental professional students are learning important skills which they will use and develop throughout their professional careers. However, any risks to patient safety must be minimised: for example, by ensuring students provide patient care only when they have demonstrated adequate knowledge and skills and by providing appropriate supervision.

Even with effective mitigations in place, things sometimes do go wrong and, unfortunately, a small number of patients are subject to harm. In these cases it is essential that there are effective processes in place for raising and managing concerns in a candid and transparent manner that support individual and organisational-wide learning about how to prevent future occurrences. Providers must inform the GDC if a significant patient safety issue arises.

With regard to patient safety issues occurring on their programmes only 13 providers (some offering more than one programme) reported that there had been any instances of harm to patients (whether major or minor). The frequency of those 2014 incidents ranged from as many as 15-25 (on three programmes) and, more commonly, three or fewer (on seven programmes).

In almost every case the harm caused to patients was minor. The most common cause of injury – occurring 44 times – was minor laceration to the mouth, lip or nose with the tip of a dental bur, or, less often, minor laceration to the skin with sharp instruments. On seven occasions, the treatment caused the patient minor chemical burns, and in six cases a dental bur came loose while inside a patient's mouth; again no serious injury followed. In at least 24 cases, a student caused injury to themselves from laceration with a dental bur, scaler, needle or other sharp instrument.

In most cases of patient injury (or student self-injury), staff and students generally responded immediately to assist the patient, with an apology if appropriate, followed by reminders to students of proper and existing procedures: for example, the application of local anaesthetic or handling of dental drills. In some cases, patient safety issues prompted additional supervision of undergraduate clinics. In cases of equipment failure, students were reminded to notify the appropriate staff member so that the manufacturer could be informed. Providers confirmed that staff would work with individual students if problems were recurring.

The quality of evidence given to the GDC by providers varied significantly. At the more thorough end, some providers supplied the actual internal issue logs in the form of spreadsheets exported from a Datix or LIFTUPP system, as well as flow charts or summaries of the institutional process for issue reporting and escalation. Other providers supplied only short, written summaries to the question without documentary evidence, and in some cases without elaboration on what patient safety or student self-injury incidents had occurred. It was surprising that some providers reported no patient safety incidents at all. Where a course has few students or there is little clinical activity this may be possible but some of the programmes reporting no issues didn't fall into this category. Processes in place for recording patient safety issues will need to be

investigated further with these providers. This includes further work looking at what processes are in place to check what patient safety issues are recorded for programmes where a substantial amount of clinical training is carried out in the workplace.

Recommendations
The GDC will continue to collect patient safety data through the annual monitoring and to provide guidance on the threshold for incident reporting.

D. Clinical Experience

Gaining clinical or technical experience is an essential part of every dental professional's training. We noted in last year's report that students in some programmes now begin treating patients at an earlier stage in their training than has traditionally been the case.

The GDC does not set targets or minimum levels of treatment that students must undertake to be considered as a 'safe beginner'. We know that this can vary from student to student and from programme to programme. However, providers must produce evidence of a clear and reasoned approach to determining that each student has reached the required level across the clinical and technical areas prior to qualification.

In the Annual Review of Education 2012/13, we identified that a number of providers found some difficulty in demonstrating that they fully met our requirements relating to student clinical experience. Although these difficulties primarily related to the availability and recruitment of patients, monitoring and recording of continuous clinical assessment is also a contributing factor. We therefore asked for detailed information about clinical experience as part of the 2014 annual monitoring exercise.

How clinical assessment data is collected and recorded

Providers use both student log books/sheets/portfolios and electronic recording systems. In some programmes there is more than one method of collecting and recording data: for example, paper-based records being used for outreach and electronic recording on clinic. However data is collected and stored, it is essential that all programmes can provide evidence that students have the appropriate breadth of clinical experience to meet the learning outcomes as set out in *Preparing for Practice***.**

There are a variety of approaches to recording and categorising clinical experience across dental and DCP programmes, making direct comparison between experiences gained by students at different providers difficult. In some programmes, a treatment does not have to be carried out independently in order to count toward clinical experience, and students' grades are based on the level of support/intervention needed. In others, students need to have carried out the majority of the work independently.

> "*… treatments… must be carried out independently and to a level judged as competent by a trained witness. The level of competence is deemed to be that of a safe beginner ready to begin practice*". [Dental nursing programme]

A number of providers told us that they do not require all recorded treatments to be at a certain standard in order to count towards overall clinical experience, noting that each student will progress throughout their clinical training.

Observing or acting as an assistant can provide a valuable learning experience, but this does not generally count towards a student's clinical experience. However, in some programmes this may be taken into account when considering a student's overall experience.

Similarly, there are a variety of approaches as to what constitutes a "unit" of clinical experience. In dentistry, endodontics is sometimes recorded per tooth or per canal. Likewise, root surface debridement could be recorded in terms of sessions of treatment, individual quadrants, sextants or a patient's full mouth: for example, one hygiene and therapy programme requires each student to have carried out ten full mouth root surface debridements that involves treating all four quadrants of the mouth, and is normally delivered over four separate patient appointments. In another (dentistry) programme the mean number of quadrants treated was 15.

Evidencing decisions to sign off students as a safe beginner

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. We asked providers about how they make evidence-based decisions to sign off qualifying students as safe beginners.

A number of programmes highlighted the importance of professionalism in evidencing that students are working at the level of a safe beginner. For example, one programme told us that in order to sit final examinations students must have a satisfactory attendance and timekeeping record, no outstanding fitness to practise or professionalism issues, and all NHS Trust mandatory training must be up to date.

In terms of clinical experience, some programmes require students to have undertaken a specific number of procedures as a pre-requisite to sitting final examinations/graduation. In some cases, if students have not completed as many treatments as would be expected, their experience of procedures carried out independently is taken into account. One programme highlighted that:

> "…*guidelines have to be flexible enough to accommodate the varying care needs of the patients the students are treating. Therefore, decisions are made on performance patterns and not numbers*".

Some programmes do not require students to perform a specific number of procedures, but successfully to complete a series of in-course clinical assessments and/or written examination papers in order to sit their final examinations.

One hygiene and therapy programme reported that:

> "*The school does not believe in setting numbers in the form of requirements as it precipitates non holistic treatment of patients which is detrimental to learning and provides poor patient care. We also do not believe that a limited number of competency assessments demonstrate a safe beginner as it only establishes that students can do a procedure on a specific day, under a specific clinical situation, on a specific patient. It doesn't necessarily transfer to other clinical situations. Therefore the school believes that a breadth of clinical experience must be demonstrated for sign up and that all clinical procedures are longitudinally assessed for competency against the safe beginner level*".

Some dental technology programmes require a certain number of hours of practical/technical work to have been completed and others require specific number of each type of device to have been made to a satisfactory standard.

Procedures/treatments where it may be challenging to ensure that all students gain the required amount of clinical experience

All programmes reported that they were currently able to provide appropriate patients across all areas, but there are a small number where a continuing effort is required, and these are in line with overall changes to oral health in the UK population. The GDC's learning outcomes described in *Preparing for Practice* are designed to meet both current and future oral health needs. However, it is important that the GDC maintains a dialogue with the sector and wider profession to monitor whether any changes are required.

> *"As dentistry changes due to improved knowledge and evidence base we modify our expectations of student experience preparing students for the future of dentistry, not just the traditional past."* [dentistry programme]

Dentistry

Dentistry programmes identified a number of areas as presenting a challenge, including endodontics and complete denture prosthodontics. Providers reported that they were successfully employing a range of strategies to identify sufficient patients requiring crowns (for example advertising and working with general dental practitioners to identify potential patients).

> *"We prescribe fewer crowns now than ever before, but we believe our expectations are achievable and so have stuck to our expectation."* [dentistry programme]

> *"We have noted a decrease in the number of root canal procedures undertaken by the graduating cohort of 2014 and have put in place additional recruitment strategies to identify suitable patient cases for undergraduate treatment. On review of the current stage 5 students output at January 2015 we can identify that the current student cohort have already attained a greater experience in this skill with current measures being a mean of 6.2 canals."* [dentistry programme]

Some programmes allow students to count large partial denture cases and/or do additional work in the clinical skills lab to practise their skills.

> *"Complete denture prosthodontics is challenging. We allow students to count large partial denture cases where there is no occlusal vertical dimension of occlusion determined by tooth contact. The principles are therefore as if the patient had no teeth. We also now have very good clinical skills facility models for students to work with on this topic."* [dentistry programme]

Data relating to students' actual clinical experience are categorised and collected in different ways and this makes direct comparison difficult. However, the data we were able to collect suggest student's experience of root canal treatments and crowns is often fairly low. The number of roots treated by students varies, with the mean ranging from five to 12.

Schools do use more formal clinical assessments to evidence students' competence in areas where experience is low: For example, in cutting a crown preparation, making a provisional restoration, taking an impression and fitting the completed crown.

In addition, some programmes have more access to patients requiring full dentures than others, reflecting improvements in the UK population's oral health. As a result, some programmes do count partial denture cases towards the total clinical experience in prosthetics and use clinical skills assessments to ensure that students have the necessary knowledge and skills to treat patients requiring full dentures. One programme, however, required students to have completed four partial and six complete dentures before graduation.

Dental Hygiene and Dental Therapy:

Providers were confident that students could demonstrate the necessary behaviour, skills and knowledge upon graduation.

Hygiene and therapy programmes reported that whilst all students are clinically competent 'safe beginners' at qualification, there are some particular challenges including amalgam restorations (some providers noted an increase in the use of Hall crowns for treatment of deciduous teeth), paediatric extractions and pulpotomies.

As with dentistry, direct comparison of the data is difficult because it is collected in different ways (e.g. different classification of treatments and different ways of counting, which might be per tooth, treatment episode/session, quadrant etc.) but the data we have collected does suggest a varied amount of experience – for example, the number of adult amalgam restorations ranged on average from 10 to 34 per student (providers classify these in slightly different ways). Extractions of deciduous teeth ranged from four to 17 per student.

Students' experience of pulp therapy in particular was low. Typically, students performed fewer than three treatments, and in some cases none at all. Providers told us that the use of pulpotomies has declined in the UK, with alternative treatments such as Hall crowns or extraction being more appropriate. However, it is important that providers can demonstrate students' competence in this area. One provider reported that students gain additional practice in the clinical skills laboratory using extracted natural teeth.

Orthodontic Therapy

For orthodontic therapy programmes, the data we collected suggests that students gain a broad range of clinical experience during their training. However, students' clinical experience is primarily gained in practice settings and these settings affect the numbers and types of treatment they are able to undertake. (For example, in one programme the numbers of orthodontic emergency cases ranged from 38 to 151.) Similarly there are challenges for some students in fitting head gear which takes place primarily in a hospital setting.

Dental Nursing

Two dental nursing providers noted that in specialist practices, student dental nurses may not always have sufficient training opportunities and chair-side experience. For example, those working in orthodontic practices may have limited opportunities to assist with restorations or root canal treatments. Providers manage this by providing students in these practices with the opportunities to attend a general dental practice to gain the necessary additional experience.

Dental Technology

One dental technology programme identified challenges finding work experience for students in orthodontics.

Recommendations
The GDC will explore with the Dental Schools Council and Directors of Hygiene and Therapy how to identify and disseminate good practice in treatment areas where patient supply is low.
The GDC will undertake further work to gather data relating to student clinical and technical experience.

Commissioners of training programmes should ensure that students are able to access a sufficient number of patients, requiring a range of treatments that will allow them to demonstrate achievement of the GDC learning outcomes and be fit to practise as a safe beginner.

E. Professionalism

Training as a dental professional marks the beginning of a professional's career throughout which they will be expected to meet the GDC's professional standards, demonstrate a commitment to continuing professional development, and respond to changes to technology, oral health and treatments. Training and education therefore provides an essential opportunity to lay strong foundations for the future dental workforce.

We asked providers about how they ensure students are familiar with the GDC's professional standards. (*Standards for the Dental Team* was published in 2013 and replaced *Standards for Dental Professionals.*)

Almost all providers told us that they felt the *Standards for the Dental Team* were embedded well within their programme(s) and that students were regularly signposted to the GDC document throughout their studies. A number of providers stated that they directly linked professionalism modules or units to these standards. For example, a dental hygiene programme includes a foundation course during the first year where all lectures have been mapped to the GDC *Standards*, and individual learning aims within these are used as introductions so that students understand the relevance of the document.

There were various examples cited for how the GDC *Standards* were embedded within programmes and many were common across different programmes and different registrant types. In some cases, students are tested on their understanding of the importance of the *Standards* before they even commence their programme of study through the admissions process. A dental nursing programme expects prospective students to have familiarised themselves with the *Standards* and demonstrate their understanding of these via their personal statement and interview questions. Similarly, students applying to a hygiene and therapy programme take part in exercises as part of the recruitment process which test their knowledge and understanding of the *Standards*. Providers stated these methods gave a clear and early indication of how seriously they treat the content of *Standards for the Dental Team*.

Some education providers said they signal to students the importance of the *Standards* by providing them with a paper and/or electronic copy of the document. Other programmes went further by requiring their students to sign up to a Code of Conduct, Memorandum of Understanding or student agreement to show they are willing to use the *Standards* at the centre of their activity. The GDC has recently distributed over 10,000 paper copies of the *Standards* across providers to ensure that all students have easy access to this key document.

Many providers are able to offer joint teaching across the dental team regarding the *Standards.* Other providers cited a multi-faceted approach to teaching as being particularly successful within their institutions. One provider suggested that their staff reinforce the *Standards* by acting as role models, displaying the right characteristics and behaviours required of dental professionals. We would encourage all providers to ensure that programme staff act as exemplars of the *Standards.* It was disappointing that very few providers told us that student reflection was used as a means of embedding the *Standards* throughout their programmes.

Recommendations
The GDC will investigate methods of encouraging greater emphasis on professionalism during pre-registration training, for example, through new guidance.
Training providers should ensure that professionalism is a focus throughout education and training programmes and that all students understand their responsibilities to raise concerns and understand how their concerns will be dealt with and acted upon.

F. Raising concerns

Generally, providers acknowledged that there can be challenges in encouraging students to raise concerns when things go wrong or when patient safety may be at risk. These challenges are shared by the wider health and social care sector. Lord Francis' report into the Mid Staffordshire NHS Foundation Trust highlighted the critical significance that individuals failing to raise concerns, or those in positions of responsibility failing to act on them, can have for patient safety. The GDC has strengthened this area in *Standards for Education* and the learning outcomes contained in *Preparing for Practice*. These changes will come into effect from the start of the 2015/16 academic year.

Typically, students are provided with the necessary information about the procedures they need to follow should they need to raise a concern. This is normally through student handbooks or literature available in Virtual Learning Environments. Examples of ways in which providers are able to make the process of raising concerns easier range from providing anonymous reporting books to getting students to sign-up to a Code of Conduct.

Many smaller DCP providers appear to rely heavily on having an open-door policy where students can approach any member of staff with particular issues or concerns. Similarly, many providers reported that they employ a "no-blame" policy when investigating issues around patient safety.

Responses from providers seemed less clear about how they ensure students understand the need to raise concerns when confronted with an issue or when things do not go to plan. Some schools, such as the University of Northampton Foundation Degree in Dental Nursing, use case studies. Others, like the Lambeth College BTEC Extended Diploma in Dental Technology, use role play, and some programmes, such as the Newcastle University Diploma in Hygiene and Therapy and the Eastman Dental Hospital Diplomas in Dental Hygiene and Therapy, employ mandatory lectures. There was much less emphasis on discussion, debate and reflection across all responses.

We have noted a possible confusion between "raising concerns" and student fitness to practise (covered below). We would encourage providers to ensure that they understand fully the differences in purpose of these areas. Based on the responses provided, we believe that this is an area that providers should consider how to further develop within their programmes.

Recommendations
The GDC will monitor the impact of revised *Standards for Education* which includes a greater emphasis on raising concerns.

G. Student fitness to practise

The *Standards for Education* requires providers to have a student fitness to practise policy and apply it as required. (Standard 1, Requirement 8).

Typically, the first stage in the student fitness to practise process involves local investigation and management, involving, for example, the tutor system or head of school. The vast majority of issues are resolved at this level. However, some cases are often escalated to an internal fitness to practise panel or committee ahead of using a formal university (or equivalent) system.

12 programmes reported specific cases where concerns had been raised about students' fitness to practise. In each case, this related to a very small number of students. In the majority of cases, these concerns did not include direct or immediate risks to patient safety, and were managed locally. A small number of cases were escalated to student fitness to practise committees. Common concerns raised included student attendance and the falsification of lecture attendance registers. One case related to social media and another to an undisclosed police caution. In the majority of cases, students received a warning and were able to continue their studies subject to an action plan and/or further monitoring.

A small number of more serious concerns (relating to communication skills, theft and contacting a patient inappropriately) involved underlying medical conditions which required treatment and on-going monitoring.

Three cases involved unprofessional behaviour and falsifying records of clinical experience which led to termination of studies.

Providers' feedback in relation to student fitness to practise will feed into the work to revise the GDC's student fitness to practise guidance. This is due to be published in early 2016. We have analysed the self-declarations on registration applications over the annual monitoring period to look at whether patterns broadly reflected what has been reported by providers. Where a significant mismatch of reporting between providers and registrant applications has been identified, the information will be used to strengthen the updated student fitness to practise guidance we are developing, and shared with providers in that registrant category. We plan to do further work with providers to look at where their policies and systems can be improved.

Recommendations
The GDC will publish revised Student Fitness to Practise Guidance, including guidance on the threshold for reporting to the GDC.

H. Feedback on the GDC's Quality Assurance Function

The GDC welcomes providers' views on any aspect of the GDC's quality assurance function and how thes responsibilities are carried out. This includes honest feedback about what works well or not so well. 19 providers fed back their experiences of the GDC's quality assurance process through the annual monitoring exercise and this feedback is summarised below**.**

What works well

Eight providers told us that their experience of the GDC's Quality Assurance was a positive one:

> "*Our experience, both during the GDC visitation in 2013 and subsequently, has been positive. The work that we have been undertaking since 2013 to assess our curriculum against the Preparing for Practice ILOs has provided reassurance about the breadth of our programme, but has also identified some valuable enhancements that we are now enacting" [*BDS programme]

> "*…very happy with the process for the visitation and report that was part of the recent quality assurance process. The visitors were a delight to work with and the process took place in a spirit of*

formality but with an overall acceptance that it was for the good of patients and the development of a training programme." [BDS programme]

***"**We are happy with the GDC quality assurance function and feel the guidance given is comprehensive and relevant."* [Dental nursing programme]

What providers told us we could do better

Four providers reported concerns that the annual monitoring exercise was time consuming to complete; though one of these felt that completing it was nonetheless a useful process.

"The annual monitoring questionnaire required a lot of additional work to locate data much of which is held by the Trusts not the School. Some of the data is very context specific and requires careful interpretation before it should be used in a widespread manner, in particular relating to Adverse Incidents. Fitness to Practise data is thankfully rare on an annual basis as it is again very context specific. The process itself can be protracted due to the regulations of the University, over which the Dental School cannot supersede". [BDS programme]

"This document has been easier to complete than the previous one, being more specific in guidance as to the breadth and depth of information which is required. I believe it gives us a better opportunity to explain our teaching, assessment and quality assurance processes and our planned programme for improvement. The only drawback has been asking us to report on what happened in 2014. This is out of date information on our curriculum, in view of the continual programme of changes we have made since September 2011 and is not representative of the cohort due to qualify in 2015 and our current practices." [Hygiene/Therapy Programme]

In light of the above feedback, we intend to adjust the annual monitoring cycle so that it applies to academic, rather than calendar years from now on.

We are grateful for this feedback and will consider whether we can reduce the number of thematic questions in future annual monitoring exercises. We will also provide additional guidance on the amount of information/evidence required.

Two providers suggested greater interaction between the GDC's Quality Assurance function and providers: for example, holding an annual workshop to update providers on the latest developments and discuss future plans.

"*Annual workshop- invites to all involved in teaching/mentoring to be invited to workshops, where we can have the latest up-to-date information and possible future plans discussed with us. These could be arranged throughout the UK and will be welcomed*". [Dental Technology programme]

We will give this further consideration as we develop the 2016 business plan.

Recommendations
The GDC will consider reducing the number of thematic questions in future annual monitoring exercises and provide additional guidance.
The GDC will amend the annual monitoring cycle to reflect academic rather than calendar years.
The GDC will consider how to work more closely with providers to share information and best practice and develop a strategy to do this.

Revised Standards for Education and Preparing for Practice

In June 2015, the GDC published revised versions of *Standards for Education* and *Preparing for Practice*. Together, these documents are the framework for the GDC's quality assurance of dental education in the United Kingdom. Both are designed to ensure that risks to patients in the training environment are minimised and that new registrants begin their professional careers with the appropriate skills, knowledge and behaviours to practise independently as safe beginners.

These revisions are the result of a post-implementation review of the *Standards*, which were originally adopted in September 2012. *Preparing for Practice*, first published in 2011, also required amendments to bring it up-to-date. Summaries of the changes to the *Standards* and *Preparing for Practice* are attached as Annexes 5 and 6, respectively.

We understand that these changes will have implications for training programmes and have sought to minimise the impact of these changes at this stage. With this in mind, we have reduced the number of requirements in the *Standards for Education* to increase their clarity and remove duplication, and changes to the learning outcomes as set out in *Preparing for Practice* have been kept to a minimum.

The changes to *Standards for Education* clarify and strengthen our requirements of education providers, encourage professionalism amongst students and therefore enhance public and patient protection. In particular, the three requirements relating to Equality and Diversity, which were formerly held under a single standard, are now embedded throughout the *Standards.* This will allow Equality and Diversity to be assessed more thoroughly and in depth in the quality assurance process.

The changes to *Preparing for Practice* reflect changes to the *Standards for the Dental Team* and the recommendations of the Francis Report. They ensure the learning outcomes for new registrants reflect the new focus on patient-centred care. Consultation on these changes was carried out last year.

The new *Standards for Education* and *Preparing for Practice* were published on the GDC's website in June 2015. These documents will be used for inspections in the 2015/16 academic year.

Student Fitness to Practise

The current Student Fitness to Practise Guidance was published in 2010. The aim of the guidance is to provide a framework to assist training providers in ensuring students on training programmes leading to registration as dental professionals understand and display the standards required of practising registrants. This is a key part of managing the risks to patient safety during training, and preparing the student with the professional attributes required for registration with the GDC.

The guidance sets out the standards expected from students during training, how a training provider may respond when students fail to meet these standards, and the policy and processes they should have in place.

Since publication of this guidance in 2010, data summarising student fitness to practise issues has been collected in the annual monitoring process to monitor issues across programmes. Initial feedback on the quality of the guidance gained in the 2010/11 annual monitoring process was positive. However, the guidance needs to be updated to reflect changes in GDC policy documents, for example, the new suite of guidance relating to the GDC quality assurance process and *Standards for the Dental Team.*

A two-stage development process has been designed to review and improve:

- the content of the guidance
- the quality of the student fitness to practise data collected from training providers during annual monitoring
- the format for the different audiences and engagement with patients and students.

Stage one will see guidance for training providers and students developed by the end of 2015. Stage two will see the development of support materials for the GDC website, patient research and development of patient information by summer 2016.

This will enable the GDC to develop a suite of products that will be much more helpful to key users. This includes creating some support materials that will help students apply GDC standards in their training and improve their awareness of the GDC and what we do. Improved ways for the GDC to communicate with students are also being addressed in the work. This is an important opportunity to engage with students in preparation for their future relationship with us once they become registrants. A better understanding of the expectations that patients have and the information they might need will also be gained.

Next steps

Development of student fitness to practise web-based support materials	Winter 2015/16
Final student and training provider publications to Council for noting and launch	January 2016
Student and patient engagement on student professionalism	First two quarters 2016
Development of materials for patients on what they should expect when they are receiving care from student dental professionals and what to do if they are unhappy with the care they receive	Summer 2016

Education policy development: an update

We are currently involved in a range of policy development activity in relation to education and quality assurance

Reviewing our approach to regulating the dental specialties

In 2014, we undertook a review of our role as regulator of the dental specialties to ensure we continue to operate as an effective and modern regulator with a primary focus on protecting patients and the public.

The review considered the fundamental issue of whether the GDC should regulate the specialties at all, and posed three more key questions:

- Does regulation of the specialties bring any benefits (potential and/or actual) in terms of patient and public protection?
- Is regulation of the specialties proportionate to the risks posed by those dentists providing more complex treatments?
- Are the specialist lists the appropriate mechanism for helping patients to make more informed choices about care not seen as falling within the remit of the general dental practitioner?

The Council concluded that the GDC should continue to regulate the specialties and not make significant policy changes. The Council agreed, however, to minor regulation and administration improvements, namely:

- rewriting and redesigning the specialist list content on the GDC website to ensure that it is in plain English and patient-friendly, and that searching the specialist lists is straightforward
- publishing online information for general dental practitioners about the use of the specialist lists
- producing guidance on applying to enter the specialist lists via mediated, or assessed, entry.

This work is underway in close consultation with our external stakeholders (including the Royal College of Surgeons, and the Committee of Postgraduate Dental Deans and Directors), and scheduled to be completed by the end of the year. Future plans for the quality assurance of specialty training is detailed below.

Quality assurance of specialty training

Developing *Standards for Specialty Education*

In 2014 we continued our development of *Standards for Education* into draft *Standards for Specialty Education.* Our draft was initially tested against the feedback received in early 2014 as part of the review of *Standards for Education.* Additionally, our drafting addressed a number of themes:

1) Ensuring that the draft Standards were proportionate. This resulted in different emphasis on
    a) Student Fitness to Practise (as speciality trainees are GDC registrants) and
    b) A focus upon patient safety at the point when the specialty trainee provides clinical procedures within their training.
2) Ensuring that the Standards reflected providers' responsibilities for the quality management of education.
3) Ensuring that the language of the Standards and the examples of evidence given in the document were appropriate to specialty training.

4) The definition of "provider" – acknowledging the postgraduate deanery[11] as a provider and also the role of the Royal Colleges as providers of the final examination as part of the quality assurance process.

5) Clarification that providers should map training programmes to the specialist curricula. This confirmed the GDC expectation that providers will be able to demonstrate how the approved curricula are delivered. Following implementation, such mapping will be central to compliance with the Standards.

Also in 2014 we consulted on changes to the *Standards for Education*. The Council considered the outcomes of this work at its October 2014 meeting. As outlined above, the proposed changes were designed to strengthen our approach, for example by providing an increased emphasis on raising concerns; reducing duplication; and improving clarity. These themes were also incorporated within the *Standards for Specialty Education* prior to its consultation. Similarly, the consultation on the *Standards for Specialty Education* sought views on the integration of the equality and diversity requirements across the whole document.

Consultation

We consulted for 12 weeks between 1 May and 24 July 2014. In addition to being available on the GDC website, the consultation was targeted at postgraduate deaneries, the Royal Colleges, other educational providers as well as specialty trainees.

With the agreement of the Chair of the UK Committee of Postgraduate Dental Deans and Directors (COPDEND), a presentation and detailed discussion of the draft Standards took place at a meeting of COPDEND in July 2014. At this meeting, postgraduate deans indicated their willingness to work collaboratively with the GDC and to contribute to further development of the Standards and also to participate in any pilot of quality assurance activity/process prior to formal implementation.

We received 36 responses to the consultation. Whilst this number is relatively small, we received representations from key stakeholders involved in specialty education including COPDEND, individual deaneries, Royal Colleges and professional associations. We were also pleased to receive responses from specialty trainers and trainees.

Respondents were widely supportive of the principle that the GDC should quality assure specialist education, and were generally in agreement with the standards and underlying requirements. However, respondents' detailed comments suggest that providers are not yet clear about how the *Standards for Specialty Education* would work in practice.

This confusion appears to have arisen from differences in perspective. The Standards used for pre-registration education were introduced to support and clarify a longstanding operational process of quality assurance and inspecting pre-registration providers. In contrast, the specialty standards will be followed by the introduction of an operational process that will be entirely new to the providers affected.

This, in addition to the need for full analysis of the information provided in consultation responses, led the Council of the GDC to conclude in October 2014 that there was a need for further engagement with the specialist education sector on the operational aspects of quality assurance activity ahead of implementation.

Specifically, the Council commissioned:

1) Further work prior to publication of the *Standards for Specialty Education* to ensure that they

   a) could be clearly understood by providers and specialty trainees; and

[11] In England, the deanery function sits within Health Education England (HEE).

b) reflect the initial steer from the Council and feedback from stakeholders about how the Standards would be operated.

2) A revised Standards document with detailed proposals will be presented to the Council in 2015.

Cardiff University - GDC registration of graduates from 2010 to 2014

In 2014, we identified an issue regarding the legal status of Cardiff University to award BDS qualifications from 2010 to 2014 and the consequences for registration of its graduates from those years.

The background

Dental authority status gives an undergraduate education institution the power to grant degrees, licences or other diplomas in dentistry. The holders of such qualifications are entitled to registration with the GDC and automatic recognition of their qualifications under European legislation. Undergraduate education programmes which lead to registration with the GDC are also subject to quality assurance by us to ensure that those who join the register are safe to practise.

Section 37 of the Dentists Act 1984 provides for recognition as a student by a dental authority as one of two conditions that need to be in place to legitimise the clinical activities of students of dentistry so that their clinical/practical work is not deemed the practice of dentistry. This permits undergraduate and postgraduate students to practise dentistry without being registered with the GDC and provides an exemption from committing an offence (illegal practice) under section 38.

The Privy Council is responsible for awarding dental authority status to institutions. Dental authority status was previously linked to medical authority status which lends to the complexity. The Privy Council does not hold or publish a definitive list of institutions holding dental authority status. Over time, a number of institutions have restructured or changed their name and, as dental authority status cannot automatically be transferred in these cases, a fresh application to the Privy Council is necessary.

For example, developments in the structure of the University of London have led to former constituent parts of that university, Kings College London and Queen Mary University of London, applying for and achieving dental authority status in their own right.

Cardiff

The possibility that Cardiff University lacked dental authority status came to our attention as a result of work we were doing in 2014 to assist a potential new undergraduate provider and as part of the research we undertook to inform the Law Commission’s work on the draft Bill to govern healthcare regulators.

We looked at all undergraduate providers against the legislative information available to check for dental authority status. We identified that Cardiff University appeared to lack dental authority status, following a restructuring (outlined below), and we wrote to the University to point out their potential need to acquire this legal status.

Historically, the University of Wales possessed dental authority status but, following the Welsh Assembly Government's review of higher education in Wales, the then University College Cardiff and the University of Wales College of Medicine entered into a merger in August 2004. On this date Cardiff University ceased to be a constituent institution of the University of Wales and became an independent "link institution" affiliated to the federal University. The process of the merger was completed in December 2004 when the Privy Council granted university status to Cardiff, legally changing the name of the institution to Cardiff University.

Cardiff awarded University of Wales degrees to students admitted before 2005, but these were replaced by “Cardiff” degrees from 2010.

Whilst Cardiff University was awarded the power to award medical degrees in 2007, we were unable to confirm that the institution made an application for, or was granted, medical authority status for the purposes of the Dentists Act (dental authority status).

Following our identification of the issue with Cardiff University and clarification that they lacked the appropriate status, we supported their application for dental authority status to the Privy Council Office. The university was awarded dental authority status in July 2014.

The GDC has quality assured the undergraduate education programme offered by Cardiff University throughout the period in question (most recently in 2014 – discussed elsewhere in this report). As a result, we did not have any concerns about the quality of the programme or the ability of graduates to practise safely.

Therefore, whilst this transpired to be an issue of legal technicality rather than one of quality of education or of patient safety, the fact remained that only individuals who are graduates of a Dental Authority are entitled to be entered on the dentists register. As long as transitional arrangements resulted in Cardiff graduates being awarded University of Wales degrees (from 2004 to 2009), this entitlement was met. However, on reviewing the relevant pass lists and arising from discussions with the institution, we established that graduates were awarded Cardiff University degrees from 2010, resulting in a group of approximately 300 graduates having been entered on the register erroneously between 2010 and 2014.

As Cardiff University achieved dental authority status in July 2014, there are no implications for future graduates.

A plan to deal with the issues arising

We began working with Cardiff University, the Department of Health, the Chief Dental Officer for Wales, Welsh Government officials and the Privy Council Office to explore the implications of the irregularity at the end of 2014. The Registrar has a statutory duty to erase erroneous entries once it is clear that a registration has been made in error. However, we were, together with stakeholders, keen to regularise the position with minimal impact on the dentists concerned and their patients and developed a plan to achieve this.

We agreed with Cardiff University that they would issue a fresh award to the dentists concerned, based on their recently acquired dental authority status in 2014. A new award would enable the GDC to restore the individuals to the register immediately having first erased them. This meant that the dentists concerned would have a continuous period of registration on the GDC register.

Careful planning in partnership with the Department of Health and Cardiff University achieved this in the first half of 2015

GDC learning

We were surprised to discover that Cardiff University lacked dental authority status following our check of educational institutions. We have agreed a way forward with the Privy Council Office to manage future applications from institutions for dental authority status.

Recommendations and next steps

We welcome feedback on this report and its findings. We will seek opportunities to discuss these issues with our stakeholders in more detail. In addition, the **General Dental Council** will**:**

	Recommendations	Timescale/Review
1	**Work with training providers on promoting the importance of standard-setting for assessments, including for practical and clinical exams.**	Spring 2016
2	**Draw out good practice in the assessment and fostering of professionalism during future quality assurance activity, which would link with the policy work on professionalism and work with training providers on standard-setting for assessments.**	Spring 2016
3	**Continue to monitor the potential impact on quality of programmes arising from economic factors.**	Annual
4	**Continue to collect patient safety data through annual monitoring, and provide guidance on the threshold for incident reporting.**	Annual / Summer 2016
5	**Explore with the Dental Schools Council and Directors of Hygiene and Therapy how to identify and disseminate good practice in treatment areas where patient supply is low.**	Spring 2016
6	**Undertake further work to gather data relating to student clinical and technical experience.**	Autumn 2016
7	**Investigate methods of encouraging greater emphasis on professionalism during pre-registration training, for example, through new guidance.**	Summer 2016
8	**Monitor the impact of revised Standards for Education which includes a greater emphasis on raising concerns.**	Annual
9	**Publish revised Student Fitness to Practise Guidance, including guidance on the threshold for reporting to the GDC.**	Early 2016
10	**Consider reducing the number of thematic questions in future annual monitoring exercises and provide additional guidance.**	Summer 2016
11	**Amend the annual monitoring cycle to reflect academic rather than calendar years.**	Summer 2016
12	**Consider how to work more closely with providers to share information and best practice and develop a strategy to do this.**	Spring 2016

We recommend that providers of education and training:

	Recommendations	Timescale/Review
1	**Develop ways of obtaining feedback from patients for the purpose of student assessment, including how this could be more formal and structured than at present and specific to individual students.**	Next annual monitoring round and through inspections
2	**Ensure staff on work placements receive at the same training provided to staff at the central site, including on equality and diversity.**	Next annual monitoring round and through inspections
3	**Develop and improve programmes so that they fully meet the Standards for Education and so that qualifying students demonstrate the full breadth of learning outcomes set out in Preparing for Practice.**	Autumn 2016
4	**Ensure that professionalism is a focus throughout education and training programmes and that all students understand their responsibilities to raise concerns and understand how their concerns will be dealt with and acted upon.**	Autumn 2016
5	**Consider the findings of this report and work collaboratively with others to share effective practice and tackle common challenges.**	Summer 2016

We would welcome views from the Dentals Schools Council, COPDEND, the Dental Hygiene and Therapy Directors Group and other groups representing education providers in relation to:

Providing evidence of students' clinical and/or technical experience to provide assurance that qualifying students have achieved the full range of learning outcomes, whether common approaches could be developed and whether further GDC guidance is required.

We recommend that commissioners of education and training:

	Recommendations	Timescale/Review
1	**Ensure that students are able to access a sufficient number of patients, requiring a range of treatments that will allow them to demonstrate achievement of the GDC learning outcomes and be fit to practise as a safe beginner.**	Next annual monitoring round and through inspections

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If you are not sure who to direct your query to, please contact the general email inbox at qualityassurance@gdc-uk.org and we will ensure your email is directed to the relevant member of the team.

Annex 1: Education Programmes inspected in 2013/14

Scheduled inspections against the *Standards for Education*:

Dentistry programmes

- Queen Mary's School of Medicine and Dentistry BDS programme (*October 2013 and May 2014*)
- University of Birmingham BDS programme (*February and June 2014*)
- Bristol Dental School and Hospital BDS programme (*April and June 2014*)
- Cardiff University BDS programme (*March and June 2014*)
- University of Dundee BDS programme (*March, April and May 2014*)
- Queen's University Belfast Centre for Dentistry BDS programme (*April, May and June 2014*)
- Universities of Plymouth and Exeter BDS programme (*April, May and June 2014*)
- University of Sheffield BDS programme (*December 2013 and June 2014*)
- University of Central Lancashire (UCLan) BDS programme (*January, April and May 2014*)

DCP programmes

- King's Health Partners Diploma in Orthodontic Therapy (*December 2013 and May 2014*)
- University of Warwick Diploma in Orthodontic Therapy (*March and July 2014*)
- University of Portsmouth Certificate of Higher Education in Dental Nursing (*February, May and July 2014*)

Re-inspections against the *Standards for Education*

- Aberdeen University BDS programme *(April and June 2014*)
- University of Central Lancashire (UCLan) Diploma in Clinical Dental Technology (*September and October 2014*)
- University of Manchester BDS programme (*April 2014*)
- Teesside University BSc (Hons) Dental Hygiene and Dental Therapy (*May 2014*)

Follow up inspection using the previous inspection process:

- Belfast School of Dental Technology BTEC Extended Diploma in Dental Technology *(February 2014)*

Inspection reports are available on the GDC's website.[12]

[12] http://www.gdc-uk.org/Aboutus/education/Pages/Education-sector.aspx

Annex 2: Quality Assurance Team 2013/14 Activity – At a Glance

Total number of programmes inspected	17
Number of new programme submissions	2
Number of programmes submitting major revisions	0
Inspections by registrant category	
Number of BDS inspections	11
Total number of DCP inspections	6
Number of CDT inspections	1
Number of Hygiene and Therapy inspections	1
Number of Dental Nursing inspections	1
Number of Dental Technology inspections	1
Number of Orthodontic Therapy inspections	2
Inspections by type	
Number of new programmes inspected	1
Number of routine inspections	11
Number of re-inspections undertaken	5
Outcome of inspections	
Programme sufficient/approved for registration	13
Programme sufficient/approved for registration pending re-inspection	3
Graduating cohort only approved for registration	1
Programme not sufficient/approved for registration	0
Inspections by LOs/Standards	
Number of programmes inspected using the Standards for Education	16 (1 programme was inspected using previous inspection methodology)
Number of programmes inspected delivering Preparing for Practice learning outcomes	8 (9 programmes were inspected that delivered the learning outcomes from The First Five Years/Developing the Dental Team)
Other information *(2012/13 figures in brackets)*	
Average number of requirements met	19.5 (17.5)
Average number of requirements partly met	8.6 (8.8)
Average number of requirements not met	0.9 (2.7)

QA Team – Key Facts	
Budget (Policy and Operations) 2014	£1,121,719
Staff (Policy and Operations) 2014	11.6 FTE
Programmes subject to GDC QA	82 (78)
No of providers/awarding bodies we quality assure	49 (49)
Forthcoming operational activity – 2014/15	
Number of planned inspections	17 programmes

Annex 3: The GDC's Quality Assurance Inspectors

The General Dental Council's inspections of dental education programmes are carried out by external quality assurance inspectors. Inspectors will usually undertake inspections in teams of four, and each team is selected from a pool of experts recruited by the GDC.

Our inspectors include dentists, dental care professionals and lay members from legal, education and healthcare backgrounds.

DCP	Dentist	Lay
Bal Chana	Alan Gilmour	Alan Kershaw
Caroline Logan	Alasdair Miller	Annie Turner
Chris Maryan	Alison Williams	Audrey Cowie
Chris Parker	Ann Shearer	Cindy Mackie
Christine Cotton	Barbara Chadwick	Gail Mortimer
Diane Hunter	Carolann Beck	Jeanne Goulding
Fiona Ellwood	Daryll Jagger	Julie Stone
Fiona Sandom	David Hussey	Katie Carter
Geraldine Birks	David Young	Kim Tolley
Hayley Lawrence	Edward Odell	Michael McCulley
Joanne Brindley	Elizabeth Watts	Michael Yates
Maxine Kane	Fizan Tahir	Philip Bunnell
Michael Reeson	Iain Mackie	Philip Brown
Robert Williams	Isobel Madden	Susan Morison
Rosemarie Khan	James Newton	
Sarah Murray	Janine Brooks	
	Kim Piper	
	Mike Mulcahy	
	Mohammed (Khalid) Mushtaq	
	Paul Howlett	
	Paul Wright	
	Peter Heasman	
	Raj Majithia	
	Samuel Cadden	
	Shazad Malik	
	Steven Farmer	
	Stuart Boomer	
	Suzanne Noble	
	Trevor Burke	

More information about each inspector is available on the GDC website.

Annex 4: The Standards for Education

Standard 1 – Protecting Patients **Providers and students 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.**	
Req 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 environment prior to treating patients.
Req 2	Patients must be made aware that they are being treated by students and give consent.
Req 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.
Req 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.
Req 5	Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body
Req 6	Students and those involved in the delivery of education and training must be made aware their obligation to raise concerns if they identify any risks to patient safety and should be supported to do so.
Req 7	Should a patient safety issue arise, appropriate action must be taken by the provider.
Req 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.
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.**	
Req 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 learning outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.
Req 10	The provider must have systems in place to quality assure placements.
Req 11	Any problems identified through the operation of the quality management framework must be addressed as soon as possible.
Req 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 immediately. (NB where there is geographical variation in oral health needs, providers must inform the GDC of the issues and action to be taken to demonstrate that the outcomes have been met).
Req 13	Programmes must be subject to rigorous internal and external quality assurance procedures.
Req 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
Req 15	Providers must consider and, where appropriate, act upon all concerns raised, or formal reports on the quality of education and assessment
Standard 3 – Student assessment **Assessment must be reliable, valid and fair to all students. 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.**	
Req 16	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. 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.
Req 17	The provider must have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes.
Req 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.
Req 19	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.
Req 20	The provider should seek to improve student performance by encouraging reflection and by providing feedback.
Req 21	Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a regulatory body.
Req 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.
Req 23	Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments.
Req 24	Where appropriate, patient/peer/customer feedback should contribute to the assessment process.
Req 25	Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion.
Req 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.

Standard 4 – Equality and diversity **The provider must comply with equality and diversity legislation and practice. They must also advocate this practice to students.**	
Req 27	Providers must adhere to current legislation and best practice guidance relating to equality and diversity.
Req 28	Staff must receive training on equality and diversity, development and appraisal mechanisms will include this.
Req 29	Providers must 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.

In order to find that an individual requirement has been **met** the inspection panel must agree that:

> "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."

The inspection panel will agree that an individual requirement has been **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."

The inspection panel will agree that an individual 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."

Annex 5: Summary of Changes to the Standards for Education

Standard 1: Protecting patients **Providers and students 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.**	
New Requirement	**Explanation of changes**
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 environment prior to treating patients.	Revised as a result of consultation feedback.
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.	Amendments to clarify that we require evidence of consent to treatment by a student. General recording of consent to treatment is a separate requirement for all registrants.
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.	Added “wherever treatment takes place”. The previous Requirement 27 has been integrated here to state that providers must comply with equality and diversity requirements.
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.	Additional emphasis placed on the role of the provider.
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.	The former Requirement 28 has been integrated here to state that training must include equality and diversity training specific for the role. The requirement now also clarifies that appropriate registration with a UK regulatory body is required.
6. Providers must ensure that students and all those involved in	Changes made to increase the focus on encouraging a duty of candour and ensure

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.	that providers have clearly documented and published policies and that those who raise concerns are not 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.	Additional clarifying requirement for systems to identify patient safety issues and to ensure that these are reported.
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 the GDC's Standards for the Dental Team are embedded within student training.	Reference to the GDC's Standards for the Dental Team has been added.

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.

New Requirement	Explanation of changes
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 learning outcomes and adapts to changing legislation and external guidance. There must be a clear	No change.

statement about where responsibility lies for this function.	
10. Any concerns identified through the operation of 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.	This is a new requirement that combines the previous Requirements 11, 12 and 15.
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.	This is a new requirement that combines the previous Requirements 13 and 14.
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.	Previous Requirement 10 was amended to clearly state that systems must be effective across all locations and that student and patient feedback should be collected as part of these systems. Inserted 'where students deliver treatment' to clarify this Requirement.

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.

New Requirement	Explanation of changes
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.	Reference to aggregation and triangulation removed, as this is now covered in the new Requirement 14. Inserted "Evidence must be provided that demonstrates this assurance".

14. The provider must have in place effective 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 revised to include reference to effective management systems and to specify that clinical and/or technical experience must be monitored.
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.	The requirement has been re-ordered as it is closely linked to the preceding 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.	Rewrite of Requirement 18 to include both best and current practice.
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.	Combined former Requirements 24 and 25, which were re-written to reduce overlap. Re-ordered the sentences in requirements 16 and 17.
18. The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.	Clarifying amendments.
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.	Integrated the former Requirements 21 and 28 to state that examiners and assessors must have received equality and diversity training relevant to their role, and specified registration with a UK body.
20. Providers must ask external examiners to report on the extent to which assessment processes are	Emphasised the need for responsibilities of external examiners to be documented is

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.	emphasised in response to feedback from QA team.
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.	Combined previous Requirements 23 and 26 with amendments to require 'appropriate' standard setting.

Annex 6: Summary of Changes to Preparing for Practice

Updated Learning Outcomes for All Registrants	Explanation for changes
6.5 **Recognise and respect the patient's perspective and expectations of dental care and the role of the dental team, taking into account current equality and diversity legislation, noting that this may differ in England, Scotland, Wales and Northern Ireland**	Further to consultation, reflects integration of Requirement 29 of Standards for Education into the learning outcomes. Amended to reference legislation in England, Scotland, Wales and Northern Ireland.
7.1 **Be familiar with and act within the GDC's standards and within other professionally relevant laws, ethical guidance and systems**	Revised as a result of consultation feedback
7.4 **Recognise the importance of candour and effective communication with patients when things go wrong, knowing how and where to report any patient safety issues which arise**	New requirement, agreed after consultation feedback.
11.5 (for all registrants other than Dentists and Dental Nurses) **11.6 (for Dentists), 11.4 (for Dental Nurses)** **Describe the impact of Direct Access on each registrant group's scope of practice and its effect on dental team working**	New requirement, agreed after consultation feedback.

Updated Learning Outcomes for Dentists	Explanation for changes
1.2.7 **Identify where medicines may cause adverse effects in patients and initiate action to manage and report**	New requirement, agreed after consultation feedback.

Updated Learning Outcomes for Dental Therapists and Dental Hygienists	Explanation for changes
1.2.5 **Undertake relevant special investigations and diagnostic procedures, including radiography**	Revised as a result of consultation feedback and the updated scope of practice guidance.

1.11.3 **Undertake non-surgical treatments, under prescription where appropriate, to remove hard and soft deposits and stains using a range of methods**	Revised as a result of consultation feedback

Updated Learning Outcomes for Orthodontic Therapists	**Explanation for changes**
1.2.5 **Contribute to relevant special investigations and diagnostic procedures, including radiography**	Revised as a result of consultation feedback and the updated scope of practice guidance.

Updated Learning Outcomes for Clinical Dental Technicians	**Explanation for changes**
1.2.4 **Undertake relevant special investigations and diagnostic procedures including radiography**	Revised as a result of consultation feedback and the updated scope of practice guidance.

Annex 7: BDS/ BChD Annual Monitoring 2014 Questionnaire

The 2014 GDC annual monitoring exercise process builds on the first inspections that have taken place using Standards for Education and the Quality Assurance Process. The main reason for carrying out the annual monitoring exercise is to provide a formal mechanism in between each inspection to share information on the delivery of programmes leading to registration with the GDC, to facilitate reporting of and early identification of any new risks or issues, both for individual training providers and more general ones that the sector may face. This exercise supports the regular communication that providers are encouraged to use to discuss risks and issues as they are happening and should assist with their successful management and mitigation. Providers are still expected to notify the GDC as risks and issues arise.

We are seeking information on risks and issues that may impact on the successful delivery of programmes, with particular emphasis on assessment, meeting the learning outcomes and patient safety. Updates on actions from previous inspection rounds are also requested. To help the provision of more consistent information brief guidance on relevant material/evidence is included. For each question please demonstrate how you have achieved or will deal with what is asked and include the appropriate evidence. We are asking for information for the period January – December 2014.

To avoid duplication with the inspection process, providers who have had a programme inspected in the 2013/14 academic year or who have an inspection planned in the current academic year do not need to complete this documentation for that programme. Information required for the Professional Standards Authority (PSA) on student fitness to practise will be requested separately for these programmes. The analysis will be shared in the Annual Review of Education 2013/14 which is planned to be published in 2015.

This year's annual monitoring exercise is designed to be a development of the previous approach pending further development of the process in 2015. The information is being gathered as part of the GDC quality assurance process and will be used to inform the focus of future quality assurance activity and risk management.

Please provide information for the programme/s offered at your institution and ensure that the evidence/material presented is relevant and concise. If more than one programme is delivered please complete the **separate form** provided for each one. You may wish to attach data or information in other formats for certain questions.

Part A: Programme details

Name of institution:	Name and title of head of institution / department:	Contact details for head of institution (Address, phone and email)
Name of Department/School:	**Programme lead**	**Contact details for programme lead** (Address, phone and email)

Name of programme[13]:	Programme duration (contact weeks)	Date of last inspection	Awarding Body (if different from institution)	Number of students in each year of the programme	Please confirm that you hold Dental Authority status [14]

[13] Please only include programmes which lead to GDC registration.
[14] The GDC is required to keep up to date records.
Due to the GDC's historic relationship with the General Medical Council (GMC), dental authority status was linked to medical authority status. Thus Part II of the Act Dental Education defined a dental authority as a medical authority who grant(s) degrees, licences or other diplomas in dentistry and related medical authorities to bodies who were entitled to choose GMC Council members. The GMC's legislation moved away from the concept of medical authority and their constitution developed. In order to address developments, the Health Care and Associated Professions Order 2009 put in place transitional and saving measures relating to the GDC, including giving powers to the Privy Council to designate institutions as dental authorities.

Therefore: a list of institutions that hold dental authority status may be found in the schedule to the GMC (Constitution) Order 2002: http://www.legislation.gov.uk/uksi/2002/3136/contents/made and institutions designated as dental authorities since 2009 by the Privy Council Office may be searched for on http://www.legislation.gov.uk/

Part B: Questions about the programme

1. Please describe any risks, trends or changes, arising from both internal and external causes, which you identified in 2014 as having impacted on or that may impact on the successful delivery of the programme and how it meets the requirements set out in Standards for Education.

Please provide this information in the table below. You should address the following areas:

January – December 2014

a) whether there have been any significant changes to the programme in the curriculum design or assessment, or if there are any planned, which may affect its delivery and meeting of the standards and requirements set out in Standards for Education

b) whether there have been any issues with staffing in terms of recruitment, staffing levels, turnover, or management of staff

c) whether there have been any changes in funding levels/resources

d) whether there have been problems with patient supply in any areas

e) whether there have been any significant changes in student numbers

f) other

Category	Description of risk/trend/change	How it impacts on the programme – including impact on patient safety and assessment of the learning outcomes	How serious the impact would be/is	How it is being managed/mitigation plan
a) Changes to the programme	• Please list for each category •			
b) Staffing	•			
c) Funding/resources	•			
d) Patient supply	•			
e) Student numbers	•			
f) Other	•			

Patient safety

The GDC's primary role is to protect patients. The GDC is requesting information about how patient safety concerns and issues are monitored across the range of education and training programmes. We are asking providers how data is collected and how it is managed - including whether other bodies are involved e.g. the NHS.

2. Please provide summary information on the patient safety issues that occurred in relation to your programme in the period January – December 2014. This information should include how the issue was managed/resolved. Please present summary data showing: • **what information was recorded** • **types of incidents** • **seriousness** • **number of incidents** • **how they are managed/resolved** • **trends** **You may wish to provide summary data from incident logs and records of actions taken. Please ensure the information provided does not breach confidentiality requirements and does not include any details which may identify an individual. Documents may be attached in support of your response.**
Response

Student clinical experience

3. The GDC does not set targets or minimum levels of treatment that students must undertake to be considered as a 'safe beginner'. However, providers must produce evidence of a clear and reasoned approach to determining that a student has reached the required level across the clinical areas. In the Annual Review of Education 2012/13, we identified that a number of providers have found some difficulty in demonstrating that they fully meet our requirements relating to student clinical experience. Although these difficulties primarily relate to the availability and recruitment of patients, monitoring and recording of continuous clinical assessment is also a contributing factor.
We want to understand more about the approaches providers use to ensure that students have reached the level of competence required. This includes the policies for collecting data, the data collected and how that data is interpreted to make the decision to sign a student up to the final assessment or to sign the student off at the end of the programme.

The purpose of asking for this information is to inform our thinking on what we expect providers to routinely record to support their 'safe beginner' decision-making process. Once we have clarified our criteria/requirements, in consultation with providers, we aim to incorporate these requirements as part of an improved annual monitoring process. The information is also helpful in that it can provide an indication of the changing patterns of treatment need and may inform future changes to the learning outcomes. We acknowledge that it may take providers some time to provide this and we are happy to receive data in the format in which it is currently collected. Please contact us if you would like to discuss this further.

a) Please describe how you collect and record clinical assessment data.

Response

b) When clinical assessment results are recorded, please explain what counts as 'one' patient treatment or completed procedure. For example:

- **must the treatment be carried out independently**
- **what level of advice and assistance is permitted**
- **do observations of procedures count in any clinical area**
- **Additionally, does the treatment have to be carried out to a satisfactory or passing standard and are the assessment criteria relative to the student's stage of development or are they relative to the level of a safe beginner ready to begin practising independently?**

Response
c) Please describe the evidence that is required to make the decision to sign off a student as clinically fit to practise as a safe beginner. You should include the following in your response: whether students are required to complete a particular number of treatments at a certain level, what flexibility is there in the acknowledgement of transferable skills where there may be an issue with patient supply. We want to know how the decision that a student has reached the level of a safe beginner is determined and the evidence that this is based upon.[15]
Response
d) Please provide the summary data of clinical experience across all clinical areas that you hold for the cohort(s) of students who were awarded their qualification between January – December 2014. This should be accompanied by a narrative that explains what the figures represent. The data can be provided in the format that you already hold it in. You should provide the range across the cohort, as well as the average number for the cohort in each area. **We recognise that formats will vary across providers. Data should be provided in a format which can be compared annually. Please ensure the information provided does not breach confidentiality requirements and does not include any details which may identify an individual.**
Response

[15] It is recognised that dental nurses often assist with parts of clinical procedures. This question refers to the activity they have responsibility for carrying out, which may be part of assisting the dentist with a clinical procedure, and whether they are able to do this independently or need support

e) Please tell us about any areas, or specific procedures where it is particularly challenging to ensure that all students gain the required amount of clinical experience. For these areas, how do you intend to ensure students who are due to qualify in 2015 gain sufficient experience before they complete the programme?
Response

Transition to Preparing for Practice

4. Preparing for Practice was published in autumn 2011. Please confirm whether this programme is now fully compliant with the learning outcomes in the document i.e. when students who qualify have been assessed against the learning outcomes set out in Preparing for Practice[16]. If not, please provide details that outline why the programme is not yet compliant and the date when it will be.

- **Full compliance Yes/No**

If no:

- **Areas of non-compliance**

Response

- **Reasons**

Response

- **Date of full compliance (month/year)**

Response

[16] There have been some minor amendments to the learning outcomes in Preparing for Practice to reflect updates to GDC policy. These were approved by Council in October 2014. We will contact training providers with an updated publication in due course.

Professionalism

5. How are the GDC Standards embedded in the programme and how do you ensure students are familiar with them, and the behaviours required, from the beginning of the course? **(Standards for the Dental Team was published in 2013 and replaced Standards for Dental Professionals)**
Response

6. Lord Francis' report into the Mid Staffordshire NHS Foundation Trust highlighted the critical significance that individuals failing to raise concerns, or those in positions of responsibility failing to act on them, can have for patient safety. The GDC has strengthened this area in Standards for Education and the learning outcomes contained in Preparing for Practice (these changes will come into effect from the start of the 2015/16 academic year). Both the GDC's Annual Review of Education and GDC Annual Registrant Survey 2013 both indicated that student awareness of the requirements around Raising Concerns is varied. **a) How do you ensure you are confident that students will raise a concern appropriately when something has gone wrong?**
Response
b) Please provide information on any concerns raised regarding this programme in 2014 and how they were managed/resolved. NB Some of the information provided here may overlap with information in Question 2 which asks about

patient safety issues. Some patient safety issues may have been identified by an individual or group of people raising a concern. This question is broader. Please present summary data showing:

- **what information is recorded**
- **types of concerns**
- **seriousness**
- **how they are managed/resolved**
- **trends**

You may wish to provide summary data from a larger database. Again please ensure the information provided does not breach confidentiality requirements and does not include any details which may identify an individual. Documents may be attached.

Response

Student fitness to practise

The GDC is required to collect specific information on student fitness to practise by the Professional Standards Authority (PSA). The GDC Student Fitness to Practise guidance will be updated in 2015. We will contact stakeholders in the spring to ask for feedback on the guidance, to find out more about how providers apply the guidance, and any issues providers may face during proceedings.

7. Please provide information regarding all student to fitness practise cases which occurred in 2014. **Please note that we only require a summary of the issues raised and you should not include any details which may identify an individual. Information should include:** • **How many concerns have been raised about students' fitness to practise in the past year** • **Description of the concerns raised, including risk to patients** • **Number of cases that reached each stage of the process, the action/resolution and reasons** • **Outcome and decision** • **It may be helpful for you to provide a description of the stages within your process for background information** **NB Providers are reminded of their responsibilities should there be an issue with a student's fitness to practise and the registration process (see GDC Student Fitness to Practise Guidance 2010 and the current GDC registration forms).**
Response

Part C: Progress on implementing inspection actions

Summary of actions and observations in the 2013 inspection report. Please provide an update on any actions taken since.

No	Action	Observations Response from Provider	2014 Annual Monitoring Update

Part D: Feedback about the GDC Quality Assurance Function

8. The GDC would like to hear your views on your organisation's experience of any aspect of the GDC's quality assurance function and how these responsibilities are carried out. We welcome honest feedback about what works well or not so well. Information provided will be used to inform the development of our policies and processes. A summary of the feedback will be shared in the Annual Review of Education 2015, including our plans to respond. Please indicate whether or not your organisation is happy for the feedback to be shared – the source of the feedback will not be identified.

Response

Thank you for completing the 2014 annual monitoring questionnaire.