General Dental Council

protecting patients, regulating the dental team

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Annual Review of Education

2014-16

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Section A: Introduction

Executive summary

1. This is the third Annual Review of Education, analysing the General Dental Council's (GDC) quality assurance activity for the academic years 2014/15 and 2015/16.
2. In the 2014/15 academic year, we undertook inspections of 14 programmes, which comprised 33 individual inspection visits. In the 2015/16 academic year we inspected 12 programmes, comprising 30 visits. Across both academic years, the majority of inspections were of DCP programmes, with two BDS re-inspections in 2014/15 and one in 2015/16.
3. In these years, dentistry (BDS) and dental hygiene and dental therapy programmes have tended to meet more of the requirements of the *Standards for Education* than programmes offering qualifications for other dental care professional (DCP) groups.
4. Programmes in general have found it particularly challenging to meet Requirement 17 of the Standards, which requires that assessment utilises feedback from a variety of sources, including patients and customers. Whilst many programmes have mechanisms in place to collect feedback, getting meaningful feedback and using it to inform student development has proved difficult.
5. Requirements relating to patient protection matters were more likely to be met than other requirements across the Standards. It is reassuring to see that patient protection issues are a focus for providers, and our inspections highlighted many instances of good practice.
6. There is wide variation in the rigour of arrangements for the quality management of programmes. Many providers have only informal procedures in place, and some DCP programmes tend to rely on their small student and staff size being conducive to trusting relationships.
7. Many providers continue to have major issues with ensuring students have access to an adequate number of patients of different ages and backgrounds, and with different treatment needs.
8. As has been noted in previous annual reviews, many providers are not presenting a full and coherent mapping of the programme against the GDC's learning outcomes and, coupled with this, there is evidence of the need for more detailed and thorough blueprinting of assessments for many providers.
9. Over the past four years, 21% of programmes inspected have required a re-inspection. Following a re-inspection, programmes have demonstrated significant improvement: on average improving in 50% of requirements.
10. This report also covers the results of our annual monitoring exercise, which provides a formal mechanism between inspections for training providers to report on progress against the *Standards for Education* and early identification of issues that may impact on the delivery of their qualifications.
11. The quality of annual monitoring responses from providers was varied, and often no information was reported in response to some of the questions asked. The GDC will

need to consider this result and what further actions and guidance might be required for the next annual monitoring exercise.

12. Finally, it should be noted that the GDC's approach to quality assurance activity will be reviewed as part of the development of a risk-based quality assurance process. This is part of our plans as set out in our publication *Shifting the Balance*.

Background

13. 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.[1]

14. The GDC published the *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.

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

16. Both the *Standards for Education* and *Preparing for Practice* were revised in June 2015 and these revised versions were used in our quality assurance activity from the beginning of the 2015/16 academic year. Information on these revisions can be found in the 2013/14 Annual Review of Education.

17. Previous versions of the *Standards for Education* and the learning outcomes for registration are available on the GDC's website.

18. The third Annual Review of Education comes at a time when the GDC is questioning more broadly how it can better regulate the dental profession, both for patients and registrants, in our recent publication *Shifting the Balance:* a better, fairer system of dental regulation.

19. *Shifting the Balance* highlights the importance of ensuring that dental professionals are equipped with the knowledge and skills to enable them to provide excellent patient-focused care. Pre-registration education and training clearly plays a major role in this. Within this document, we have aimed to identify, using evidence collected over the 2014/15 and 2015/16 academic years, where we can best apply our efforts within our regulatory remit, being particularly mindful of the direction and aims of *Shifting the Balance*.

20. This report follows a similar structure to the previous two annual reviews, but offers an opportunity to look at inspection and monitoring data over a longer period of two academic years. We have also begun to look at trends via the registration category of the training programme. These developments are intended to improve our ability to:

    - offer helpful feedback to providers;
    - enhance our guidance, engagement work and policies; and
    - better target our quality assurance activity.

[1] For more information, please refer to the GDC's corporate strategy for 2016-19.

21. Looking to the future, we expect this analysis to help us to develop and implement a risk-based quality assurance approach, which we are seeking to introduce from the 2018/19 academic year.

22. We have outlined progress against the recommendations from the 2014 annual review. This progress includes the piloting of a training provider workshop to explore issues with our *Standards* that many providers find difficult to meet. We have set up a working group which has been looking at the specific challenges dental nursing awarding bodies face in meeting our requirements. We have also introduced a dedicated student professionalism resource on our website which will be further developed over time.

23. It should be noted that there is a change in reporting period for this review from the calendar year to the academic year to fit better with the majority of programmes we regulate. This means the report covers a longer period than the previous reviews.

Our process

24. The GDC's Quality Assurance (QA) process includes:

- reviewing proposals for new programmes and qualifications from providers and awarding bodies;
- inspecting course providers and awarding bodies; and
- annual monitoring (paper-based).

25. GDC QA inspectors undertake inspections of programmes leading to registration, working in panels of three or four, supported by a member of the GDC's QA 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 exam inspection. Providers must submit evidence in advance of the inspection to demonstrate whether programmes meet our requirements.

26. Inspectors make a recommendation to the Council of the GDC as to whether a programme is sufficient' or should be 'approved' for registration.[2] The 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 decision is made, inspection reports are published on the GDC's website. Reports may require a provider to take certain actions and/or make improvements, and/or recommend a re-inspection to check that the necessary improvements have been made. The GDC does not rank or grade programmes.

27. The GDC would like to thank the providers and students who contributed to inspections. We hope the information and recommendations will be useful for providers in particular. An engagement plan for sharing the findings is in place and we welcome feedback on the content of this report. Our contact information can be found on page 44.

[2] 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.

Section B: Inspections

28. In the 2014/15 academic year, we undertook inspections of 14 programmes, which comprised 33 individual inspection visits. In the 2015/16 academic year we inspected 12 programmes, comprising 30 visits. Further details of the types of programmes inspected can be found at **Annex 1.**

29. Across both academic years, most inspections were of DCP programmes, with two BDS re-inspections in 2014/15 and one in 2015/16. We also inspected three dental technology programmes offering the same award, and for the purposes of analysis in this report we have counted this as one programme.

30. Programmes inspected in the first three years since the *Standards for Education* were introduced (2012-2015) were assessed against 29 requirements. For the 2015/16 academic year, the Standards were revised to 21 requirements. For comparative purposes within this report, we have reviewed previous reports and amended the judgements to reflect the change to 21 requirements. This allows for easier identification of trends and other findings over time.

31. From analysing the outcomes of inspections over four academic years, we have found that dentistry (BDS) programmes and dental hygiene and dental therapy programmes have, on average, met a higher proportion of requirements within the *Standards for Education* than programmes offering qualifications for the other DCP groups.

32. Although we would have hoped to see the achievement of the Standards improving over time, this did not happen. One significant reason for this is that the first two years of inspections largely comprised BDS inspections, which met more requirements on average than DCP programmes.

33. The first of the following three tables illustrates the combined outcomes for all 53 education programmes against the *Standards for Education.* The next two tables illustrate the outcomes within the individual academic years 2014/15 and 2015/16. **Annex 2** contains the overall outcomes for 2012 -16 by individual requirement.

	Met	Partly Met	Not Met
Standard 1 – Protecting Patients	70%	26%	4%
Standard 2 – Quality Evaluation and Review	52%	33%	15%
Standard 3 - Assessment	47%	46%	7%
Overall	57%	36%	7%

Table 1: Overall achievement of Standards for Education*, 2012-16*

	Met	Partly Met	Not Met
Standard 1 – Protecting Patients	62%	35%	4%
Standard 2 – Quality Evaluation and Review	43%	32%	25%
Standard 3 - Assessment	37%	56%	7%
Overall	47%	44%	9%

Table 2: Inspections 2014/15

	Met	Partly Met	Not Met
Standard 1	73%	20%	7%
Standard 2	44%	42%	15%
Standard 3	51%	40%	9%
Overall	58%	33%	10%

Table 3: Inspections 2015/16

Findings of inspections in the 2014/15 and 2015/16 academic years

34. The requirements under Standard 1, relating to patient protection matters, are generally met to a greater extent than those across Standard 2 and Standard 3. This remains true for the two academic years evaluated within this report. Throughout the 53 inspections against the *Standards for Education*, 70% of the assessments of requirements in Standard 1 were met, compared to 52% of Standard 2 (governance) and 47% of Standard 3 (assessment). Whilst this provides assurance that patient protection issues are a focus for providers, it also indicates that there are areas to be addressed for many programmes.

35. A summary of achievement across each requirement of the *Standards for Education* can be found at Annex 2.

Standard 1 – Protecting patients

	Met	Partly Met	Not Met
All inspections 2012-2016	70%	26%	4%
Inspections 2014/15	62%	35%	4%
Inspections 2015/16	73%	20%	7%

Table 4: Standard 1

36. This standard requires education providers to maintain an awareness of their duty to protect the public and to ensure that any potential risks to the safety of patients are minimised during treatment by students.

37. It is encouraging that our inspections highlighted many instances of good practice for this standard. There was evidence of a strong emphasis on providing regular training for staff in a variety of ways such as peer review, mentoring and shadowing.

38. Many providers demonstrated thorough pre-clinical training for students often with a robust approach to professionalism. Giving students the opportunity to begin treating patients at an early stage in the programme also proved to be a benefit for some programmes. Our panels saw evidence of how this boosted confidence in students and gave them a better understanding of their professional responsibilities – especially when this was backed up by observing more senior peers.

39. Reports drew attention to constraints impacting on student experience arising from tight timeframes for the delivery of some of the shorter DCP programmes. Some programmes require pre-clinical training to be strengthened.

40. It was clear that most providers are handling student professionalism and fitness to practise requirements well. Our reports noted some positive approaches such as a 'yellow card' system to assess students' professionalism. This scheme allows all staff – not just those involved in clinical training – who encounter students to issue a yellow card should they spot anything untoward happening. Another provider makes good use of role play workshops to explore how to apply the GDC *Standards for the Dental Team* in a 'safe' environment, using actors to play the part of patients. This allows students to reflect on difficult situations as a group.

41. In relation to raising concerns, one provider required students to complete a report when a clinical incident occurred. They then present this report to their peers. Students see this as a form of 'therapy' and our inspectors were impressed that this scheme encouraged honesty and candour.

42. Raising concerns was, however, an aspect of inspections where panels noted room for improvement, especially around the need to implement formal procedures for dealing with issues when they are raised. Many DCP programmes rely on small cohort numbers and close relationships between staff and students to handle concerns.

43. There is a distinct need for providers to ensure they have clear and consistent procedures in place and that incidents are recorded and monitored carefully.

44. There appears to be scope, too, for achieving greater consistency in the approaches to obtaining consent across the various locations where students work with patients. Where students undertake much of their training in the workplace, there is a need to improve checks on the suitability of the working environment.

No	Owner	Action
1	GDC	Issues relating to the recording of clinical incidents and obtaining consent to be covered at future training provider workshop events.

No	Owner	Recommendation
A	Providers	Ensure that clear and consistent procedures are in place for concerns to be raised, with incidents monitored and recorded thoroughly and carefully

Standard 2 – Quality evaluation and review of the programme

	Met	Partly Met	Not Met
All inspections 2012-2016	52%	33%	15%
Inspections 2014/15	43%	32%	25%
Inspections 2015/16	44%	42%	15%

Table 5: Standard 2

45. Providers need to have effective policies and procedures in place to monitor and review their programmes.

46. The inspections in 2014/15 and 2015/16 demonstrated that there is wide variation in the rigour of arrangements for the quality management of programmes. Many providers have very informal procedures in place and, in very few cases, no discernible procedures established at all.

47. Panels continued to find that some smaller DCP programmes tend to rely on the fact that since they have a low number of students, issues are rare and easier to deal with on an ad-hoc basis. Given small student groups, it is common for strong relationships to form between students and staff and there can be a reliance on this relationship being strong enough for students to feel comfortable in coming forward with issues. However, the opposite could be equally as likely, with some students not wishing to harm these relationships by raising a potentially contentious issue or problem.

48. One school described their intention to try and collate information related to handling incidents and concerns from other local providers. Inspectors agreed that this would inform decision-making and develop learning potential.

49. The handling of serious threats to programmes was highlighted for several providers as requiring improvement, particularly in establishing when the GDC needs to be informed of serious risks.

50. Where feedback from students or from external sources has suggested changes must be made, our panels found that there was poor recording of these issues and, consequently, the ability to track and monitor actions undertaken to resolve problems had been undermined.

51. Inspection panels found that there was often a deficiency in the external scrutiny of programmes with the role of the external examiner lacking clear definition. Some external examiners were still being used to examine students rather than fulfilling a more high-level QA function, which means that these programmes are not receiving valuable external scrutiny.[3] There was also evidence of limited responses to the recommendations made by external examiners.

52. In contrast to this, several providers have strong frameworks in place. For example, we saw evidence of external verifiers being utilised to ensure consistency of standards across multiple locations.

[3] Requirement 11 of the *Standards for Education* states that Quality Assurance Agency (QAA) guidelines on the use of external examiners should be followed where applicable.

53. Where qualifications are awarded by a body separate to that delivering the programme, panels found there was often a need to increase contact and communication between the two parties.

54. Our reports reveal some inconsistency when it comes to quality assuring work placements and outreach. Some providers need to formalise their approach, including developing more rigorous processes for pre-course checks and recording students' clinical data. Other providers were found to have strong, established processes including placement inspections based on risk, using feedback to drive change and ensuring outreach and workplace trainers have full access to staff training packages.

No	Owner	Action
2	GDC	Additional guidance on recording and reporting threats to programmes to be produced

No	Owner	Recommendation
B	Providers	Ensure careful and thorough recording of feedback from students and external sources
C	Providers	Ensure formal, thorough and well-documented processes are in place for the quality assuring of work placements

Standard 3 – Student assessment

	Met	Partly Met	Not Met
All inspections 2012-2016	47%	46%	7%
Inspections 2014/15	37%	56%	7%
Inspections 2015/16	51%	40%	9%

Table 6: Standard 3

55. Assessments must be appropriate, valid and reliable to demonstrate achievement of the GDC learning outcomes.

56. As previous annual reviews have highlighted, many providers experience a significant challenge in ensuring students have access to an adequate number of patients of different ages and backgrounds, requiring a range of treatments. There is a clear need to continue to seek out methods to resolve the shortfalls they are facing.

57. For some programmes, there were inequalities of experience between students within that programme. To address this, some providers give outreach tutors access to overall clinical data so they can allocate patients to address gaps in experience while others are developing patient recruitment campaigns and strategies. Inspectors noted that issues arising that related to clinical experience were sometimes exacerbated by poor record keeping.

58. Some providers collect clinical data in a variety of formats rather than using one, consistent approach. This makes gaining an overall 'snapshot' of students' experience and ability difficult to achieve. In such cases, it was difficult for panels to be assured that students were at the level of a safe beginner at the end of their course of study. In more

than one case, students appeared to be finding themselves in the less than ideal position of completing clinical work right at the very end of the programme, or even after final examinations had taken place.

59. As noted in previous annual reviews, many providers are not presenting a full and coherent mapping of the programme against the GDC's learning outcomes and, coupled with this, there is evidence of the need for more detailed and thorough blueprinting of assessments for many providers. However, inspectors could find examples of collaborative approaches to assessment strategies utilising the experience and skills available via the staff team. There were some good examples, too, of team working opportunities via joint lectures/tutorials and 'practice teams' where student dentists work in collaboration with student hygienists, therapists and dental nurses.

60. Feedback and reflection also remain a focus for inspection reports, since many providers are still trying to find a way forward with many aspects of this Requirement. The workshops we are arranging with providers will help us work together on this issue.

61. There is scope for many programmes to expand opportunities for students to reflect on their own performance and to provide guidance on how to reflect usefully. Gathering patient feedback can be sporadic and work therefore needs to continue to address the need for feedback to form part of overall assessment strategies.

62. Some providers are, however, handling the use of feedback and reflection well and in these cases, they appear well embedded within the programme. Some providers ensure that reflective learning is used for both academic and clinical aspects of the programme and encourage students to think critically throughout their training. Others make a point of giving feedback on good, as well as less good, performance and have instigated methods to ensure that students are not able to 'cherry pick' the patients they receive feedback from.

63. Inspectors found that the majority of assessments were well run with robust procedures in place, while regular module and assessment reviews allowed providers to monitor and evaluate examinations.

64. Several inspection reports noted that marking and grading schemes were unclear and in need of review to improve the integrity of assessment outcomes as well as students' understanding of what they need to demonstrate.

65. Additional input from external examiners would also assist with this, especially where reports noted that external examiner feedback is limited or missing entirely.

66. Although inspectors found that there were several programmes where the input from external examiners needs to be far more rigorous and wide-ranging, there are also programmes which use external examiners well. For instance, at one programme they attend progress decision meetings where the overall performance of students is evaluated; another will have external examiners in attendance at re-sit 'gateway' examinations while another ensures that the package of documentation shared with external examiners is clear and comprehensive meaning they can provide a meaningful level of scrutiny.

67. Inspectors found on more than one occasion that assessments were not providing the opportunity for students to fully demonstrate the depth of their knowledge or the range of the abilities across the skills tested.

No	Owner	Action
3	GDC	The GDC will evaluate the approach to quality assuring Requirement 13, which relates to achievement of the learning outcomes. This will be considered in developing the approach to updating *Preparing for Practice.*

No	Owner	Recommendation
D	Providers	Identify methods to resolve shortfalls in student experience with patients of a variety of ages and backgrounds, with a range of treatment needs.
E	Providers	Consider how to demonstrate a full and coherent mapping of assessments against the GDC's learning outcomes.
F	Providers	Ensure that methods are in place to obtain feedback from patients and other parties to inform student development and assist with reflection.
G	Providers	Demonstrate a clear process for determining what students need to know and do — and to what level — to pass assessments, alongside marking systems that reflects this.

Observations on patterns by programme type

	Number of inspections	Met	Partly Met	Not Met
Dentistry	20	68%	29%	3%
Hygiene and Therapy	14	67%	32%	2%
CDT	3	22%	44%	33%
Orthodontic Therapy	5	30%	60%	10%
Dental Nursing	7	52%	36%	12%
Dental Technology	4	33%	46%	20%

Table 7: Performance of all programmes against the Standards for Education *by profession*

68. As described above, BDS programmes and dental hygiene and dental therapy meet more requirements on average than the other professions. Dental technology and clinical dental technology (CDT) programmes have found it more challenging to meet the Standards.

69. The reasons for these difficulties may include that these programmes are often delivered outside higher education environments and do not have the resources, for example, of dentistry programmes. For dental technology, there is more limited patient interaction, and although the Standards were applied with knowledge of this, it may account for some of the issues in meeting them.

70. Inspections of the five orthodontic therapy programmes has resulted in a high number of partially met requirements, but none of these programmes have required re-inspection. The structure of these programmes means that the governance arrangements can be less than optimal and this is reflected in poor achievement of the requirements under Standard 2. Although there may be several areas that require attention, these

programmes are ensuring patient safety risks are minimised and are producing safe beginners.

71. It should be noted that we have not yet inspected all programmes against the *Standards for Education*, and we do not know if the findings for individual professions will apply when we have information about all programmes leading to registration.

72. BDS programmes in general, alongside many DCP programmes, have found Requirement 17 harder to meet than all others. This requires that assessment utilises feedback from a variety of sources, including patients/customers and peers. Whilst many programmes have mechanisms in place to collect feedback, gathering and using this in an effective way is challenging. The reasons for this are multiple and include that patient feedback is normally overwhelmingly positive. A key may be to harness the feedback that is not so positive compared to others within a cohort and using this for reflection and development.

73. Several programmes across the professions did not meet, or only partly met Requirement 14, which relates to having systems in place to plan, monitor and record assessment, including continuous clinical and technical assessment, against the GDC learning outcomes. Programmes with limited resources found this Requirement harder to meet, though many large, well-established programmes within universities also did not meet this Requirement.

74. Another requirement that has proved challenging to meet for many providers relates to standard setting assessments. Inspection panels continue to see summative assessments[4] being assigned an arbitrary pass mark, frequently 50%, without any rationale as to why other than university regulations. We recognise that smaller cohorts present problems in carrying out formal standard-setting procedures and panels accept this. For Requirement 21, which includes standard setting, to be considered met, panels expect to see a clear process for determining what students need to know and do – and to what level – in order to pass the assessment, and alongside this a marking system that reflects this.

Training provider workshops

75. On 6 December 2016, the Quality Assurance team delivered a workshop to providers of dental hygiene and dental therapy qualifications to help them develop aspects of their programmes to better meet the GDC's *Standards for Education*; in particular, Requirements 14, 17 and 21.

76. The QA team identified three academics who had the relevant expertise to lead interactive sessions with set objectives related to the Requirements listed above. Sessions on blueprinting, the use of multisource feedback and standard setting methods were held. 34 delegates from 21 of the 22 hygiene and therapy providers attended.

77. We hope that this and future workshops with providers will offer the opportunity for us to give greater clarity and guidance to providers. A series of workshops to address specific needs of different professional groups is planned.

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[4] Summative assessment refers to the assessment where the focus is on the outcome of a programme, or part of a programme. This contrasts with formative assessment, which summarises the individuals' performance for their own development.

78. As part of the *Shifting the Balance* work programme, the GDC intends to have greater interaction with providers outside inspection activity. These events will enable us to work more closely with training providers to improve compliance across the *Standards for Education* and help increase patient safety assurance. We hope that the workshops will help programmes and reduce the need for re-inspections and lead to a reduction in costs.

79. Future workshops may focus on learning from the GDC fitness to practise process, how this can influence the GDC learning outcomes and how providers could address these issues within their programme structure and content.

80. The agenda for future workshops has not been finalised, however it is envisaged some elements of this workshop will be incorporated alongside the issues identified in this report, including more detailed information from annual monitoring. If useful learning has been gained from the evaluation of fitness to practise cases in time for the BDS providers' workshop, it is planned that a session at this event would be devoted to how this could influence the GDC learning outcomes and undergraduate programmes.

No	Owner	Action
4	GDC	Further workshops with the remaining education providers will be held to address issues highlighted in this report. These should include a session focusing on developments relating to risk-based QA activity as outlined in *Shifting the Balance*.

Effect of re-inspections

81. Over the past four years, 21% of programmes inspected have required a re-inspection. As the education providers become better at meeting our Standards and embedding the learning outcomes, we expect this figure to decrease. It is, however, pleasing to see the results of re-inspections. Of the seven first time re-inspections that have been undertaken (excluding the second re-inspection of one programme), the average programme had 50% of the requirements improved from either not met to partly met or partly met to met, or not met to met.

82. For one programme, which was poor at an inspection, the provider withdrew the programme and provided a new course submission. When the new programme was inspected, a total of 17 of 21 requirements improved their assessment ratings.

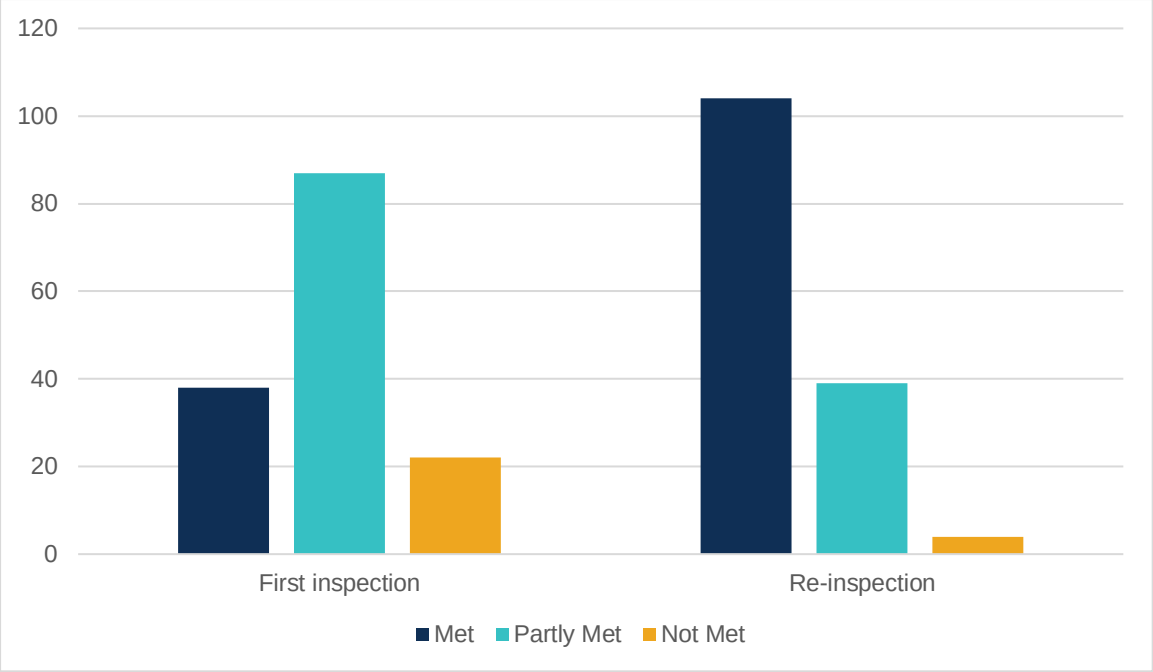

Figure 1: Average observed changes in Standards for Education *programmes inspected and re-inspected in 2012-16*

Section C: Monitoring

83. The GDC annual monitoring exercise provides a formal mechanism between inspections for training providers to report on progress against the *Standards for Education* and early identification of issues that may impact on the delivery of their qualifications.

84. In response to feedback received last year from training providers, the GDC committed to changing the feedback period from a calendar year to an academic year to better fit with existing reporting structures. Consequently, over this transitional period, the last annual monitoring exercise covers a slightly longer period of 19 months, January 2015 to August 2016. Programmes inspected during the 2015/16 academic year were not required to complete the exercise, apart from responding to a question on student fitness to practise data.

85. It should be noted that as part of our plans set out in *Shifting the Balance,* the GDC's approach to quality assurance activity will be reviewed as we develop a risk-based quality assurance process. Further information can be found in Section E.

86. For this annual review, we have looked at information longitudinally, where possible. To provide context for identifying patterns in the responses over time, the table below sets out the number of providers who were requested to return an annual monitoring form. Although the duration of the 2015-16 annual monitoring reporting period was longer, the total number of programmes involved is similar.

	Number of programmes responding to 2013 annual monitoring exercise	Number of programmes responding to 2014 annual monitoring exercise	Number of programmes responding to 2015-2016 annual monitoring exercise
Dentistry	0	6	16
Hygiene and Therapy	19	15	9(10)[5]
Orthodontic Therapy	1	2	5
Dental Nursing	6	9[6]	2
Dental Technology	10	5	8
Clinical Dental Technology	1	0	0
Total	**37**	**37**	**40(41)**

Table 8: Programmes participating in annual monitoring exercises, 2013-16

[5] One provider returned information for two programmes on the same form so data cannot be separated.
[6] SQA Dental Nurse programmes are reported on individually.

Differences between the 2015-16, 2014 and 2013 exercises

87. The 2013/14 Annual Review of Education recommended that the GDC reduce the number of thematic questions in future annual monitoring exercises, to reduce the volume of information providers had to return and enhance the suitability of annual monitoring as a vehicle for capturing and comparing certain information. This was particularly in relation to reporting students' clinical experience.

88. To address the time it took to analyse information from the last annual monitoring exercise the format was altered to require providers to submit their responses in a spreadsheet.

89. Questions were asked about:

- progress on action plans;
- risks and issues identified in relation to meeting the *Standards for Education*;
- student fitness to practise data;
- compliance with learning outcomes in *Preparing for Practice*;
- programme details, to identify any changes that might impact meeting the *Standards for Education*; and
- training and assessment of the learning outcome in relation to complaints handling.

90. There was also an opportunity to provide further information including sectoral or wider education issues, feedback on the annual monitoring process and GDC quality assurance processes.

Overall assessment of the quality of responses

91. The quality of responses varied greatly and for some programmes only a limited picture was obtained. Possible reasons for this and associated recommendations are outlined later in this report

92. Although there is no text limit in the spreadsheet format it could be concluded that the appearance and design may have impacted on the quality and amount of information some providers returned.

93. As we progress with the work on developing a risk-based approach to quality assurance activity, including the criteria for establishing risk profiles, we will look in detail at the quality of responses given by providers.

No	Owner	Action
5	GDC	Review use of spreadsheet format and design of the monitoring form
6	GDC	Provide guidance intended to improve the quality of responses and use the information received, or lack thereof, to build the risk profiles for training programmes

Question 1 – Complaints handling – teaching and assessment

94. *Shifting the Balance* proposes a number of measures aimed at ensuring that complaints are properly handled and that they dealt with by the right organisation. One of the 'upstream', or possible preventative, factors being considered is how complaints

handling is taught during pre-registration training and this was probed in the annual monitoring exercise this year.

95. The QA team wanted to establish what is happening across qualification and registrant categories and whether there is need for providers to improve their training and assessment of students in this area.

96. All programmes leading to registration with the GDC are required to cover the following learning outcome:

> Recognise and demonstrate the procedures for handling of complaints as described in *Standards for the Dental Team, Principle 5: Have a clear and effective complaints procedure*[7]

97. Students are required to have **knowledge** of the requirements regarding complaints handling **and** have developed their **skills** in handling complaints (indicated by the terms 'Recognise' and 'Demonstrate').

98. To support this the following questions were asked in the annual monitoring exercise:

- Do you provide students with formal training on handling complaints from patients?
- If yes, please provide a brief outline of the training given, including its duration.
- Are students formally assessed in their ability to handle patient complaints?
- If yes, please provide a summary of these assessments.

99. As the first question asks about 'formal training' it may not be reliable in terms of eliciting information on how complaints handling skills are embedded in clinical work.

100. The results were as follows:

	Number of programmes	No formal training	No formal assessment
Dentist	16	2[8]	6
Hygiene and Therapy	9 (10)	0	3
Dental Nurse	2	One awarding body has not confirmed as states is training provider responsibility	One awarding body has not confirmed as states is training provider responsibility
Dental technology	8	3	3
Orthodontic therapy[9]	5	0	1

Table 9: Programmes providing formal training and/or assessment on handling complaints from patients

101. A wide range of delivery in terms of time and approach is evident. Some providers (two BDS programmes and three dental technology programmes) offer no formal training and no assessment of complaints handling. This is of concern particularly as the same

[7] *Preparing for Practice* – Dental Team Learning Outcomes GDC 2015
[8] The LDS does not provide training so just the two BDS programmes are included in these figures
[9] Also note no data for the Royal College of Surgeons as they are the awarding and examining body and do not provide training

providers asserted that their programmes delivered assessment across all learning outcomes.

Formal training

102. Across the registrant categories, where training is delivered, the qualitative responses indicate that this is generally in a lecture format at different stages of programmes and with varying frequency. Ideally the training should be embedded and developed throughout the programme as part of a student's progression to becoming a professional.

103. Some programmes do not appear to offer the opportunity to develop skills in this area:

- 'One lecture within the professionalism teaching deals specifically with complaints.' (Dental Hygiene and Therapy programme)
- 'A Trust e-learning package is completed by all students on customer service 20 minutes' duration in which handling complaints from patients is covered.' (Orthodontic Therapy programme)
  'Theory is covered in two separate presentations covering both the professional and patient aspect. This is supported by online learning activities developed for the student to engage with. Group based discussions are further facilitated around actual reported scenarios to support the learning.' (Dental Nurse programme)

104. Other programmes described how the training is embedded throughout the programme outside 'formal' teaching mechanisms:

'This is included in case-based learning sessions where different scenarios are presented to the students. These sessions are timetabled once a month throughout Years 1 - 4 of the programme.' (Dental Hygiene and Therapy Programme)

Assessment

105. Where assessment occurs in BDS programmes, students are typically assessed more than once:

'Students are formatively and summatively assessed on their ability to handle complaints…. After every patient contact, students and supervisory staff complete an on-line reflective report on professionalism and any issues are noted, including any patient comments.'

'During every enquiry based learning(EBL)/DayBook session students discuss issues raised within the scenarios and are signposted by the facilitators where appropriate. Complaints issues are included in several EBL cases in Years 1-3 for BDS and several complaints scenarios are included in the DayBooks in BDS Year 4 and 5. After every EBL or DayBook session, students complete a reflective report on the sessions and are assessed formatively on the Form B EBL judgement form by the facilitator. For example, in BDS Year 4 as well as discussing learning outcomes in relation to complaints management at the Daybook presentation days where appropriate, students develop and post a written complaints policy on their Discussion Forum.'

(BDS programme – also similar for the Hygiene and Therapy run by the same provider)

106. DCP providers who assess in this area tend to use a variety of assessment methods, some requiring a student to pass this learning outcome to move forward to the next stage of the programme. Some programmes rely exclusively on written assessments, which are not likely to be the most valid format of assessment for the 'demonstrate' part of this learning outcome, particularly for assessing how a student deals with communication challenges.

Recommendations

107. As the approaches are varied, the implementation of the complaints handling learning outcome should be looked at further. We propose to repeat this question in the next annual monitoring exercise. The question should be designed to see how the training is embedded more broadly and to gain a more in-depth picture of training, assessment and, just as importantly, experience and opportunity to practise and develop skills over time in this area.

108. How this can be looked at through other quality assurance activity will also be considered. Newly qualified registrants will be surveyed in 2017 on how well they felt their training prepared them for practice across the skills, behaviours and knowledge areas. A question on complaints handling will be included in this survey.

No	Owner	Action
7	GDC	Complaints handling will be a specific area of focus as part of the *Shifting the Balance* consultation follow up work.
8	GDC	Follow up non-compliance with complaints handling learning outcomes with individual providers and promote the Dental Complaints statement.
9	GDC	A redesigned question on complaints handling will be included in the next annual monitoring exercise. Findings will be compared with responses from the planned new registrant survey on pre-registration training.

No	Owner	Recommendation
H	Providers	Consider how best to develop training and assessment in complaints handling to instil the resilience, communication skills and attitude required to prepare students for professional practice

Question 2 – Issues and concerns

109. We asked providers about risks to the successful delivery of their programme. Most programmes might be expected to report something in at least one of these areas as part of their overall management systems and processes. This year 16 programmes did not complete this question or stated there were no issues or concerns (in comparison to 10 and 9 out of 37 programmes in the previous two annual monitoring exercises):

	Number of programmes	Number of programmes reporting no issues, concerns or changes
Dentistry	16	3
Dental Hygiene and Therapy	9(10)	3
Orthodontic therapy	5	4
Dental nurse	2	2
Dental technology	8	4
Total	**40(41)**	**16**

Table 10: Programmes reporting no issues or concerns

110. The number of programmes identifying no issues may be for one or more of the following reasons:

- there genuinely are no issues or concerns;
- there is improved handling of serious threats to programmes - this was picked up as an area of improvement in inspection reports (See pages 10-11);
- there is a reluctance to report these to the GDC:
- there is a lack of robust internal management processes on the programmes to identify and track their management – this is backed up by inspection findings for smaller DCP programmes;
- there is a lack of understanding about the information required.

111. Questions relating to the raising of concerns about patient safety, actual patient safety issues and the management of such concerns and issues were asked in a different format this year which makes comparisons difficult with previous years' data.

112. Only two BDS programmes and one dental hygiene and therapy programme reported any patient safety issues. Information on raising concerns was received from just three providers. Whilst on the face of it, this could be a good indicator, we know from our inspections that more issues and concerns are likely to have arisen.

No	Owner	Action
10	GDC	Take steps to improve the collection of patient safety and raising concerns information in the next annual monitoring exercise.

Patterns in this year's data

Patient supply and student clinical experience

113. The most frequently raised concerns by providers related to patient supply and student clinical experience. These are interdependent. Ten providers reported problems in these areas and they were mainly in respect of dentistry and hygiene and therapy programmes. The most commonly occurring shortfall was in the supply of paediatric patients.

114. Overall, the responses relating to patient supply were consistent with those raised in the previous annual monitoring exercise. The reasons for these challenges varied. One provider told us that they held extra evening clinics to mitigate the shortfall.

	Dentist programmes No of issues reported	Hygiene and Therapy programmes No of issues reported
Simple extraction	1	-
Simple restorations	1	-
General supply	3	-
Complete denture case	1	-
Indirect restorations	1	-
Paediatric dentistry	2	2
Patients with implants	-	1
Pulpotomy treatment	-	1
Amalgam	-	1

Table 11: Patient supply issues raised through annual monitoring

	Dentist programmes No of issues reported	Hygiene and Therapy programmes No of issues reported	Dental technology programmes No of issues reported	Orthodontic Therapy programmes No of issues reported
General practical experience	2	-	1	1
Paediatric dentistry	3	2	-	-
Oral medicine	1	-	-	-
Electronic patient management systems causing an issue with general patient supply	1	-	-	-
Multiple software systems	1	-	-	-

Table 12: Student clinical experience issues raised through annual monitoring

115. In terms of observing changes to practice, providers commented on several developments, which will be considered when the learning outcomes are reviewed:

- 'Fixed bridges are now less frequently prescribed and so only simple bridgework is expected of our students.' (BDS Programme)
- 'There is an emerging trend that pulpotomy treatments are diminishing. This is likely in part due to the evidence base for their use' (Hygiene and Therapy Programme)
- 'There is a possible trend that amalgam as a dental material may be phased out, which may be imposed by an EU directive. There is also an evidence debate that suggests the reduced use of amalgam in the primary dentition.' (Hygiene and Therapy Programme)

Recruitment and staffing/staff turnover

116. Recruitment and staffing/staff turnover was the next most frequent concern and this was reported mainly by BDS programmes.

117. Recruitment issues were described both in terms of student recruitment to programmes and staff recruitment. Finding candidates with the appropriate experience for academic and/or clinical posts was raised by three providers. One BDS programme had found difficulty recruiting to an oral radiology post as there are no new professionals due to exit specialist training soon.

118. Other staffing issues were described as being due to 'business as usual' reasons and were being managed, for example, by external recruitment.

119. Student recruitment was challenging for one hygiene and therapy programme which was struggling to find candidates that met their entry criteria.

'Introduction of patient representatives to their recruitment process as part of the Value Based Recruitment agenda to provide more patient involvement. Health Education England have introduced the Value Based Recruitment agenda to be implemented from September 2015.' (BDS Programme)

Funding and resources

120. This was commented on by five BDS providers. Two BDS providers mentioned the 2% reduction in funding due to the review of the student tariff by the Department of Health introduced in 2014/15 academic year. One of these reported that the reduction had had a significant impact on recurrent funding and that it was putting the viability of the programme at risk. Two further BDS providers also highlighted this under the category 'Changes in student numbers'.

121. The responses in this annual monitoring exercise suggest that the impact is being managed by most. It is recommended that the GDC maintains a watching brief in case provision is affected.

122. BDS providers noted the following:

- ‘Minimal teaching support in Restorative Areas from substantive NHS staff - places strain on academic staff to cover. Through NHS staff becoming unavailable to teach due to service pressures and vacant NHS posts.’

  This type of issue may become more prevalent depending on future NHS pressures.

- ‘Changes to (local) commissioning of Salaried Dental Services outreach have altered students' exposure to Community Dental Services outreach. This now encompasses a broader range of environments, but with no direct clinical care provided by the students.’
- ‘The 'Business/Gap Module' delivered by NHS Education for Scotland will no longer be supported by NES.’ This covers business aspects of general dental practice and affects year five students.

Other issues

123. One BDS programme recorded the impact of the introduction of Direct Access and changes required to their course. Another BDS programme reported an increased use of patients in their assessment process. They are working with students from across the School and faculty to develop an awareness of, and address the needs, of the community they serve in response to the University's Learning and Teaching strategy. This strategy requires all departments to improve their social accountability and breakdown barriers between the university and the surrounding area.

No	Owner	Action
11	GDC	Maintain a watching brief on cuts in funding to BDS (and other) programmes in case provision, and/or the quality of this provision, is affected.

Question 3 – Student professionalism and fitness to practise

124. Student professionalism and student fitness to practise is an important part of preparing students for practice and ensuring patient safety. The new student professionalism and fitness to practise guidance emphasises the importance of professionalism for patients and promotes the embedding of the *Standards for the Dental Team* in training from the outset.

125. It sets out clearly what is expected from student dental professionals, enables appropriate support to be provided for students where issues are identified, recognises the fact students are learning and mistakes may happen and, if necessary (rarely), provides a fair and transparent process for ensuring students who are still unable to meet appropriate requirements to exit a training programme.

126. This question focuses on the requirement for providers to have a student fitness to practise policy which covers professionalism, clinical/academic work and health.

127. The GDC collects data from all education and training providers on student fitness to practise cases annually, including information on the cases reaching the threshold of student fitness to practise procedures.

128. The detail included in responses varied by provider. Just under half of the programmes reported no student fitness to practise cases. Whilst it would not be unusual for a programme with low student numbers to have no fitness to practise issues raised, it is surprising for programmes with larger numbers. We have identified that further guidance should be produced to better inform providers about the stage and level of fitness to practise issues we want to receive.

	Number of programmes reporting cases	No of programmes reporting no cases
Dentistry	14	1[10]
Dental nurse	1	4
Orthodontic therapy	1	5
Dental technology	0	11
Clinical dental technology	0	1
Hygiene and therapy	9	1
Total	**25**	**22**

Table 13: Student fitness to practise cases reported by programmes

129. There were 12 programmes reporting cases in the last annual monitoring exercise which might suggest an improvement in the embedding of the student fitness to practise requirements. It should be noted that during the development of the updated student professionalism and fitness to practise guidance, which was published in October 2016, DCP providers that were not part of a university reported they had more challenges in implementing policy and processes in this area.

130. The decisions made about cases appeared sound and the information provides a helpful insight into the range of professionalism and other fitness to practise issues experienced by students. Appropriate support and extra training for students was in evidence and most students continued training with no further issues. Where a problem could not be resolved, studies were terminated (in a small number of cases).

131. The highest proportion of student fitness to practise cases were categorised under professionalism. This was followed by health. Clinical issues were much fewer in number. However, many issues covered more than one area. For example, some professionalism issues were found to have a health issue as a contributory factor following investigation.

[10] The LDS does not provide training so does not report on student fitness to practise cases.

Direct patient safety issues	Other
• Student extracting wrong tooth • Student treating and discharging patient without agreement from the clinical tutor • Administering wrong side dental block to a patient then providing block to the correct side without informing tutor	• Attendance • Student taking patient records home – patient confidentiality • Cheating and plagiarism • Persistent failure to respond to feedback • Assault • Low level and serious drug issue • Alcohol related damage to property • Range of health issues • Communication issues with staff • Inappropriate use of social media • Police caution undisclosed and criminal conviction • Alcohol abuse and failure to attend blood alcohol test • Inappropriate conduct outside of training environment • Unprofessional behaviour • Failure to disclose clinical incident and inappropriate behaviour towards another student

Table 14: Examples of student fitness to practise issues reported through annual monitoring

132. This body of information will feed into the development of extra cases studies on the new student professionalism area of the GDC website.

133. We routinely look at student fitness to practise information during inspections and the data provided thus far has demonstrated that most providers have implemented the guidance soundly.

134. To improve the quality of the information returned through annual monitoring it is recommended that, since the launch of the new student professionalism and fitness to practise guidance and resources, we draft a communication strategy that:

- reminds providers of their responsibilities;
- explains the reasons why this is important; and
- provides examples to help.

135. The new guidance was covered at the inspector training event.

No	Owner	Action
12	GDC	Develop communication with providers on embedding student fitness to practise policy and processes.
13	GDC	Review approach to quality assuring the requirement relating to student fitness to practise.
14	GDC	Consider providing further guidance addressing the information we wish to receive, including an example of a completed student fitness to practise annual monitoring response.

Question 4 – Delivering the learning outcomes in *Preparing for Practice*

136. *Preparing for Practice* was published in 2011 and some minor revisions to the learning outcomes were made in 2015. Since 2011 we have sought information from training providers about the progress they have made in updating their programmes so they map to the learning outcomes in *Preparing for Practice*. In this year's annual monitoring returns, seven providers stated they are still not fully compliant with the *Preparing for Practice* learning outcomes:

	Number of programmes	Number of programmes reporting non-compliance
Dentist	16	5
Dental Hygiene and Therapy	9(10)	1
Orthodontic therapy	5	1
Dental nurse	2	0
Dental technology	8	
Total	**40(41)**	**7**

Table 15: Providers reporting non-compliance with Preparing for Practice

137. However, three of the providers who confirmed they were compliant with *Preparing for Practice*, told us that they were not teaching or assessing complaints handling. A further six stated they were training but not formally assessing complaints handling. Therefore, 16 respondents are unable to demonstrate full compliance with the *Preparing for* Practice learning outcomes.

138. Some of these providers offered an action plan and date by which they are working towards compliance. Others gave no information so there was no indication if the impact is substantial or not and which skills and knowledge areas are affected. This may impact on their students' ability to qualify and register if the non-compliance is found to be significant.

No	Owner	Action
15	GDC	Follow up non-compliance with *Preparing for Practice* with specific training providers to ensure there are no significant gaps in students' training. Feed into work developing risk profiles for programmes.

Question 5 – Monitoring actions from inspections

139. Monitoring progress against actions from inspection reports worked well in the new format of the annual monitoring questionnaire and made tracking action plans easier. Overall, providers had made good progress in addressing actions arising from previous inspections. Depending on the length of time since the last GDC inspection, some programmes had active action logs and others were closed. Where there are concerns relating to a provider's failure to adequately address inspection-related requirements, these are being followed up on by the quality assurance team.

Question 6 – Further information

140. Half of the programmes completed this section. They used it to report on a range of matters, some of which related to the question about issues and concerns and in other cases, to highlight good practice and programme development. Several programmes informed us of awards or other forms of recognition they had gained.

141. Examples of positive developments include:

- improving student support, including for professionalism
- targeted development of educational expertise in the form of a research group and scholarship to provide support and structure to staff with roles focussed on teaching and education.

142. One BDS provider has developed a "Graduate Passport" based on their student dataset to enable BDS graduates to demonstrate certificated undergraduate quantitative experience to dental foundation trainers. This has been demonstrated to Health Education England (HEE) representatives in pilot form and the provider reports that HEE have indicated a desire to pursue this as a basis for a national model. However, we understand that this innovation appears to have stalled and we will monitor future progress closely.

143. Another BDS programme informed us that consideration is being given to revise the BDS and BSc in Dental Hygiene and Therapy curricula to have a 'common' first 3 years, with the intention that any students who successfully complete this period could leave with a BSc in Dental Hygiene and Therapy. This is an interesting development, which the GDC will consider when a new programme submission is received.

144. Patient safety issues were also reported. On two separate occasions BDS students had extracted the wrong tooth from a patient. This resulted in the provider introducing mandatory seminars on consent; a new oral surgery gateway for Year 3 students introduced for 2016/17; and revision of their Safety Check list for surgical extractions.

145. There was a reference to the regulatory burden and a request for regulators to work together where possible:

> 'There is an increase in regulatory pressures. As well as inspections from the GDC and CQC, we are now taking part in a HEE-led Multi Professional Visit in November 2016. This will include meetings with groups of BDS and Hygiene and Therapy students as well as dental nurses, StRs, and core trainees. We are concerned that this is introducing areas of duplication and would suggest that it would be more cost effective for the various organisations to work more closely together to avoid duplication of effort.'

Section D: Engagement and Policy Development

Engaging with Partners and Professionals

146. Reflecting the objectives in our corporate strategy, particularly those relating to professionals and partners, we are focused on building and maintaining strong relations with our key stakeholders. Through our interactions with stakeholders in 2016 we have aimed to better understand the challenges faced by those we work with as well as recognise what is working well.

147. We recognise the value of the views of students and new registrants and that these must be form a bigger input to developments within education. It is important that we understand how well new registrants feel they have been prepared for their professional life through their primary training and that their feedback informs developments across education and training.

148. Building stronger relationships with future and new registrants is an area we will focus on over the coming years. Students have fed into the student professionalism materials we have developed and work has started implementing the student engagement strategy in the form of GDC staff meeting new registrants.

149. Improving engagement with stakeholders has also enabled us have a closer understanding of sectoral and educational issues and pressures. All of this is critical to development of our education policy and quality assurance work.

150. We have done this through increasing face to face engagement with pre- and post-registration education stakeholders and through the attendance of meetings of formal groups such as the Hygiene and Therapy Directors' Group, the Dental Schools Council (DSC), the Committee of Postgraduate Deans and Directors (COPDEND) and specialty groups.

151. We have also created a Dental Nurse Working Group which has a programme of work exploring specific provider issues in this registrant category and aiming to facilitate work to address them.

152. In late 2016 we held a training provider workshop designed to provide an opportunity for dental hygiene and therapy providers to share good practice and discuss solutions to some of their training and assessment challenges.

153. We have actively engaged with the Faculties and Specialty Advisory Committees (SACs) through attendance and contributions towards meetings of the Joint Colleges Postgraduate Training in Dentistry (JCPTD), Advisory Board of Specialty Training in Dentistry (ABSTD). We attended the Advisory Board for Foundation Training in Dentistry (ABFTD).

154. We think it very important to keep these channels of engagement open, so that we can hear from these key stakeholders, update on developments and work more closely together to take forward education and training for the benefit of students, and trainee registrants with the ultimate aim to drive up the quality of care of our patients.

GDC Student and Trainee Engagement Strategy

155. The GDC has developed an engagement strategy for students and registrant trainees across all registrant categories, to commence in early 2017. This will be a phased

approach over three years and aims to set sustainable foundations for our longer-term engagement with these groups. It will include a range of key activities through a range of channels, which have and will continue to be informed by feedback from students and trainees.

156. This engagement will support the initiatives reflected in the *Shifting the Balance* consultation, published in January 2017.

157. In 2016 we undertook extensive external research to inform engagement strategy, seeking feedback from students, registrants, other regulators and key stakeholders including education and training providers. This helped us develop the strategy with appropriate content and channels.

Objective	Description of success	How success will be measured
Contribute to harm reduction and improving safety by supporting students to improve their understanding of their responsibilities regarding professionalism	Students will use and engage in the GDC's guidance on student professionalism and standards to inform their treatment of patients and general approach to preparing to be registered professionals.	The GDC will seek feedback from students, registrants and education providers on the efficacy of our student professionalism guidance.
Improve their understanding of the role of the GDC, which will contribute to improving the GDC's relationship with registrants overall.	Students will have an understanding of the GDC's statutory functions and key organisational priorities. The dental professions' understanding of the use of the ARF will improve.	The GDC will test awareness and understanding of our work with students and new registrants, through face to face interactions and surveys. Analysis of reporting from CAIT regarding the differences of the types and frequency of queries being received from students and trainee registrants.
Achieve engagement from students and trainee registrants in the GDC's policy development and operational improvement work.	Students and registrant trainees will be stakeholders that the GDC engages on a regular basis.	Students and trainee registrants will provide input to GDC developments. The GDC will proactively seek the input of students and trainees during major consultations, such as on regulatory reform.

Table 16: Aims of the student and trainee engagement activity

158. The student and trainee engagement strategy reflects the three objectives in the broader communication and engagement strategy, which was approved in January 2016.

159. The strategy also takes on board the GDC's strategic objective to put patient safety at the heart of what we do. This involves shifting the balance in favour of doing more to prevent harm and away from responding to harm once it has occurred.

160. There is an opportunity for the GDC to improve how we share existing content with students, tailor existing and develop new content for students' needs. It will enable us

to build more meaningful relationships with dental professionals, and gain information that will inform future policy development work.

Evaluation

161. We will seek feedback and evaluate the activities each year, to inform developments for the coming year and longer term business and policy planning.

Student Professionalism and Fitness to Practise Guidance

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

163. The guidance needed to be updated to reflect the GDC's *Standards for the Dental Team* and *Standards for Education* and be presented in a more suitable format for each user group: students, patients and education providers.

164. In spring 2015 we asked students and providers what was helpful in the old guidance and what they would want to see in new resources. We also asked questions about how best to engage with students. Patients were asked about their expectations when being treated by students in the GDC Annual Patient and Public Survey 2015. We took this feedback on board and proposed a suite of products for each user group and web based resources. We consulted students and providers on the draft student and provider guidance in autumn 2015.

165. The feedback resulted in:

- the addition of introductory guidance that was more accessible for all students as well as the full guidance document;
- increased emphasis on professionalism and what it means to be part of a regulated profession;
- clarification of what is expected by the time students reach the point of registration and how their application could be affected in different scenarios; and
- ensuring the range of students and training provision across the registrant categories was better taken into account.

166. We also aimed to ensure that there is a good balance between setting out the responsibilities of the student with the recognition of their trainee status and being supportive. The importance of insight and reflection when mistakes are made is also highlighted. The guidance clearly links to the *Standards for the Dental Team, Standards for Education* and current GDC policy and guidance. The responsibility of training providers and students throughout the training process is explained.

167. The guidance was launched in October 2016 along with online supportive materials. All of the information can be found on our new Student Professionalism web pages. These include case studies on meeting the *Standards for the Dental Team* in training and FAQs. The publications include:

    - student guidance, comprising two booklets:
        1 an introduction explaining what student professionalism and fitness to practise are; and
        2 full guidance for students;
    - training provider guidance; and
    - information for patients which can be made available before they receive any care/treatment from students.

168. These materials feed in to the current work on looking at how we can improve professional regulation, specifically placing greater emphasis on supporting and empowering the profession to focus on prevention during their pre-registration training and preparation for life as a dental professional.

Feedback and review of the resources

169. Next year we will ask students and providers for feedback on the resources during the annual monitoring process so there will be an opportunity to suggest further improvements. The web resources will be expanded over time and new case studies will be developed to reflect themes in the student fitness to practise annual monitoring data.

Dental Nurse Working Group (DNWG)

170. The DNWG was convened in December 2015 to explore the feasibility of a risk-based approach when quality assuring providers delivering dental nurse qualifications. The Group has met four times in 2016 and is made up of quality assurance inspectors: two dentists, two dental care professionals and a lay person. Following the first meeting, the Group agreed it would be valuable to have feedback from the Council Member, Kirstie Moons, who is also a registered dental nurse.

171. Outcomes of DNWG include:

    - discussion of the feasibility of a paper-based approach to quality assuring local providers;
    - what the GDC would want to know to ensure local providers are meeting our Standards;
    - what are the perceived risks and benefits of adopting such an approach for the following groups: providers, awarding bodies and the QA Team;
    - assessment of the approach taken by other regulators, including the General Pharmaceutical Council, Health and Care Professions Council, and the Scottish Social Services Council;
    - gathering a list of how many providers and students were involved with each of the awarding bodies; and
    - development of a questionnaire, used to collect information on the quality assurance processes in place for individual providers.

172. Feedback from the awarding bodies generally supported the approach, and the awarding bodies were happy to work with the GDC to ensure all providers would comply with our requirements.

173. However, one of the awarding bodies felt the questionnaire replicated the approach taken by their own Approval and Quality Assurance Advisors (AQAA) and it may be onerous for providers to then comply with GDC requirements. The Group noted these concerns but were of the view that the GDC questionnaire focussed on patient safety and student competence whilst the AQAA approach focused on the suitability of the provider to deliver the qualification.

174. The questionnaire is being piloted with a national provider in 2017. The QA Team is currently reviewing the information received from local providers. A meeting will be arranged for the DNWG to assess the information and determine which local providers should be visited as part of the 2017 inspection.

Quality assurance of specialty training

Introduction

175. Following our publication of the *Standards for Specialty Education*, we undertook a post-introduction review in Spring 2016.

176. The Council has recognised that the quality assurance of specialty training carried potential substantial resource implications. Piloting a quality assurance process and the post-introduction review were determined to be the means for the Council to take an informed view on a quality assurance process. We have been mindful that that our regulatory approach must not introduce disproportionate or unnecessary burdens on providers.

177. Following publication of the Standards, we continued an active programme of engagement with the specialist training sector from 2015 into 2016. We have promoted the Standards and our role in quality assuring specialty education to providers and speciality trainees.

The Pilot Process

178. Following discussions with COPDEND, we were very grateful that three programme providers covering five Local Education and Training Boards (LETBs) participated in the pilot process:

- London Dental Education and Training, Health Education England incorporating NE, NW and S London
- Health Education England - East Midlands (HEE EM)
- Health Education England - South West (HEE SW)

179. We circulated draft templates and guidance to the pilot sites in September 2015 and discussed them with the volunteers before their use. Based upon these discussions we refined the assessment tools and the three volunteers were asked to provide data against the final self-assessment tools in the first quarter of 2016.

180. We were also very grateful to receive agreement from two examination providers to participate in the pilot process, the Faculties of Dental Surgery from:

- the Royal College of Surgeons of England
- the Royal College of Surgeons of Edinburgh.

181. Following discussions, a redacted version of the *Standards for Specialty Education*, focussing only on those requirements relevant to examination providers was circulated and the two Royal College volunteers were asked to provide data in the first quarter of 2016.

Volunteer submissions and findings from the pilot

182. The pilot process was based upon moderated self-assessment including:

- a data set that profiled specialty trainees and scrutinised key data including information about the trainees' progression rate through programmes and exit examinations;
- a self-assessment questionnaire giving providers the opportunity to indicate how they meet the Standards; and
- the opportunity to provide illustrative and supporting evidence to underpin self-assessment.

183. All volunteers submitted information against requirements set out in the *Standards for Specialty Education* by March 2016. Whilst there were different approaches amongst volunteers to the submission of evidence and self-assessment, there was a predominant theme, when requirements were not met or partially met, that the volunteer acknowledged that meeting the requirement was the subject of ongoing project work.

184. Follow-up actions requested by the GDC ranged from requests to learn more about ongoing project work to sight of particular policies or outputs from committees that were cited in narrative but not presented as evidence.

185. We also asked for actions when a requirement was met, where we believed the combination of the narrative and evidence as presented demonstrated good practice and had the potential to be a "model" response or guidance for future providers.

Stakeholder meeting and feedback

186. In April 2016, we held a very successful stakeholder engagement meeting with all programme and examination providers who contributed to the pilots plus the chair of COPDEND and a representative from HEE Quality Team.

187. The workshop informed the discussion about a proportionate risk-based, process for future quality assurance for specialty training and education. There were also useful suggestions for the refinements of the Standards.

188. The volunteers fed back that the level of detail set out by us in the pilots to quality assure the process, was necessary, appropriate and of the right level.

189. The volunteers made valuable suggestions to improve the Standards and the proposed process as well as highlighting further areas for us to explore. There is a particular need to understand the examination providers' ability to supply evidence

which, whilst very useful to the quality assurance process, may possess significant data protection sensitivities.

190. It was evident from the feedback received that it would be right to have discrete standards for the LETBs/Deaneries and Royal Colleges, as they focus on different requirements.

Next steps

191. We have prepared a revised *Standards for Specialty Education and Training* and we propose consulting upon this amended document in early 2017 following the *Shifting the Balance* consultation.

192. In response to the feedback we have received, we have separated the Standards and requirements for programme and examination providers and have made the necessary housekeeping amendments to the language of the individual requirements.

193. We have retained the evidence suggestions but have edited them to reflect both evidence supplied in the pilot process and evidence we have requested to see following that process.

194. We are considering writing additional guidance based upon the examples of good practice we have identified during the pilot process.

195. The main learning point for GDC staff from the pilot exercise was the value of an evidence submission accompanying the completed self-assessment questionnaires. We consider that placing within the Standards an overarching requirement upon programme and examination providers to supply such evidence in a future quality assurance process would mitigate the need to develop a further level of assurance. We will consult in 2017 upon including such a requirement in the introduction to the revised Standards.

Revision of specialty curricula

196. The GDC is responsible for approving all curricula for education and training in specialist dentistry. The content of the curricula themselves is developed by Specialty Advisory Committees (SACs), who report to the relevant Dental Faculty. There are currently 13 curricula for training in specialist dentistry. 11

197. The GDC agreed in December 2015 to lead a review to revise all 13 curricula. A review is timely to ensure that the curricula reflect the GDC's *Standards for Specialty Education*, and as all but one of the current curricula are at least five years old.

198. To facilitate this process, and to establish consistency across the 13 curricula, over 2016 the GDC developed a new generic template to serve as the basis for each of the curricula. The template comprises 15 generic outcomes in the domains of: professional knowledge and management; leadership and team-working; patient safety, quality improvement and governance; and education and training, research and scholarship.

199. The purpose of the template is to identify and set out those aspects common to all curricula, regardless of specialty, and ensure consistency of language, definitions and

[11] Dental and Maxillofacial Radiology; Dental Public Health; Endodontics; Oral and Maxillofacial Pathology; Oral Medicine; Oral Microbiology; Oral Surgery; Orthodontics; Paediatric Dentistry; Periodontics; Prosthodontics; Restorative Dentistry; and Special Care Dentistry.

structure across the final publications. This was developed with extensive input from stakeholders, particularly the SACs, and including but not limited to COPDEND, NHS Employers, the Faculty of Medical Leadership and Management, and the General Medical Council, which has undertaken a similar project in the medical field.

200. The SACs have been asked to provide the specialty-specific content of their curricula or curriculum. This will entail:

- translating the curricula from its current format to the format of the new generic template; and
- bringing the curricula up-to-date with any professional or clinical developments in the specialty that have transpired since it was last approved.

201. We expect the curricula to be reviewed and approved by the end of 2018.

Education Inter-Regulatory Group

202. The GDC meets the education teams from other healthcare regulators biannually. The aim of these is to share our thinking on:

- education and other policy development work;
- operational education quality assurance issues; and
- horizon scanning.

203. Work of specific value from the last meeting has been sharing information about the strengths and weakness of our approaches to annual monitoring of our education programmes and student engagement. This will help inform the development of a risk-based quality assurance process. We have also started to identify where policy or guidance may be generic and could benefit from a joint approach in the future.

Section E: Development plans for 2017

Shifting the Balance: a better fairer system of dental regulation

204. Education is recognised in Shifting the Balance as a vital factor in preventing issues arising once a professional is registered. In this important piece of work examining how the GDC can regulate the profession more effectively and fairly we have looked closely at what we continue to do or do in the future in our education and quality assurance function to support this. The following pieces of work have been identified:

- Development of a risk based quality assurance system
- An approach to evolving *Preparing for Practice*
- Continue to monitor the transition to independent practice
- Look at how we can support registrants who have trained outside the UK when they start work here

Development of a risk based quality assurance system

205. This part of our work programme was proposed to be put in place once we had introduced and embedded the learning outcomes and *Standards for Education*.

206. Now that we have clear requirements for measuring providers against and these have been tested in a complete inspection cycle, we can move forward with building a system that is proportionate to the risks involved in a programme.

207. Currently we have an inspection cycle and monitoring process which is predominantly time based, i.e. there is a five- to six-year cycle of inspections for existing programmes and their assessments which works alongside a paper based annual monitoring process. The work to develop a risk-based quality assurance system will:

- Identify the areas that are a risk to the success of education and training and the factors that are likely to have the greatest impact on patient safety
- Develop a risk assessment approach for programmes
- Develop a system to determine the method, frequency and duration of quality assurance activity

208. We plan to survey UK qualified dentists who joined the register within the last two years to ask how well they felt their specific training programme prepared them for different aspects of their practice. This will help inform both a risk profile for training providers and potential areas for the focus of future quality assurance activity. It may also help identify areas for improving the pre-registration learning outcomes set out in *Preparing for Practice.*

209. In addition, we will begin using fitness to practise data to inform the development work and risk profiles we will build. We have specifically requested information by registrant category and UK training programme in the wider of body of work commissioned looking GDC fitness to practise data. This is with the recognition that recent information may only usefully inform risk profiles of individual programmes and that there are many other factors contributing to whether a registrant becomes subject to fitness to practise procedures.

210. Proposals will also consider other data and research held outside the GDC, and will be developed with stakeholder input and subject to public consultation. The aim is to migrate to the new system in the 2018/19 academic year.

An approach to evolving *Preparing for Practice*

211. *Preparing for Practice* was published in 2011 and was updated with minor amendments in 2015 following consultation with stakeholders. We need to ensure that these learning outcomes remain current and are reviewed in a way that is manageable for education providers. We have therefore committed to devise a process to ensure that the learning outcomes are agile and responsive and continue to be based on appropriate evidence.

212. The work will start this year. It will aim to create a process for updating the learning outcomes that is responsive and is based on the premise that an infrequent 'substantive' review is not required or desirable in practical terms. It will include:

- criteria/threshold for change – including evidence base;
- stakeholder engagement requirements;
- process for making changes, including approval; and
- implementation deadline for providers.

213. We will consult our education providers, along with other stakeholders.

Continue to monitor the transition to independent practice

214. Although the Transition to Independent Practice work we undertook in 2013 did not yield information pointing to an increased patient risk relating to newly qualified registrants we are continuing to look at ways to check that this remains the case. The survey of newly qualified dental registrants may provide some further insight.

Supporting registrants from overseas

215. New registrants who have undertaken their training outside the UK may face specific challenges in their transition to working here. These may include understanding the workings of the NHS and contracts, adapting to different patient expectations or different ways of working within a dental team. We are considering the role we should play in assisting these registrants in overcoming such challenges and helping to ensure that avoidable problems for patients or registrants do not arise.

Implications of the UK referendum on membership of the European Union

216. We will assess what impact this may have on registration and how this might put pressure on dental education provision to enable us to develop any mitigation plans.

217. Monitoring the developments of the training subjects in the European Directive on the Recognition of Professional Qualifications.

218. The list of subjects that dental qualifications are required to include is being updated. This will no longer affect what needs to be included in UK dental qualifications but the GDC will need to assess whether it is likely there will be any divergence from its pre-registration learning outcomes that may affect registrations from EU in the future.

Summary of Actions for the GDC

No	Action
1	Issues relating to the recording of clinical incidents and obtaining consent to be covered at future training provider workshop events.
2	Additional guidance on recording and reporting threats to programmes to be produced
3	The GDC will evaluate the approach to quality assuring Requirement 13, which relates to achievement of the learning outcomes. This will be considered in developing the approach to updating *Preparing for Practice.*
4	Further workshops with the remaining education providers will be held to address issues highlighted in this report. These should include a session focusing on developments relating to risk-based QA activity as outlined in *Shifting the Balance*.
5	Review use of spreadsheet format and design of the monitoring form
6	Provide guidance intended to improve the quality of responses and use the information received, or lack thereof, to build the risk profiles for training programmes
7	Complaints handling will be a specific area of focus as part of the *Shifting the Balance* consultation follow up work.
8	Follow up non-compliance with complaints handling learning outcomes with individual providers and promote the Dental Complaints statement.
9	A redesigned question on complaints handling will be included in the next annual monitoring exercise. Findings will be compared with responses from the planned new registrant survey on pre-registration training.
10	Take steps to improve the collection of patient safety and raising concerns information in the next annual monitoring exercise.
11	Maintain a watching brief on cuts in funding to BDS (and other) programmes in case provision, and/or the quality of this provision, is affected.
12	Develop communication with providers on embedding student fitness to practise policy and processes.
13	Review approach to quality assuring the requirement relating to student fitness to practise.
14	Consider providing further guidance addressing the information we wish to receive, including an example of a completed student fitness to practise annual monitoring response.
15	Follow up non-compliance with *Preparing for Practice* with specific training providers to ensure there are no significant gaps in students' training. Feed into work developing risk profiles for programmes.

Summary of Recommendations for Providers

No	Recommendation
A	Ensure that clear and consistent procedures are in place for concerns to be raised, with incidents monitored and recorded thoroughly and carefully
B	Ensure careful and thorough recording of feedback from students and external sources
C	Ensure formal, thorough and well-documented processes are in place for the quality assuring of work placements
D	Identify methods to resolve shortfalls in student experience with patients of a variety of ages and backgrounds, with a range of treatment needs.
E	Consider how to demonstrate a full and coherent mapping of assessments against the GDC's learning outcomes.
F	Ensure that methods are in place to obtain feedback from patients and other parties to inform student development and assist with reflection.
G	Demonstrate a clear process for determining what students need to know and do — and to what level — to pass assessments, alongside marking systems that reflects this.
H	Consider how best to develop training and assessment in complaints handling to instil the resilience, communication skills and attitude required to prepare students for professional practice

Update on Recommendations 2013-14

219. Good progress has been made responding to the recommendations set out in the last Annual Review. Where we have been unable to fully address an issue, we have proposed how we will take this work forward.

For the GDC

	Recommendations	Timescale/Review	Update
1	**Work with training providers on promoting the importance of standard-setting for assessments, including for practical and clinical exams.**	Spring 2016	First workshop completed December 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	There will be a focus on this during workshops with providers.
3	**Continue to monitor the potential impact on quality of programmes arising from economic factors.**	Annual	See annual monitoring section of report.
4	**Continue to collect patient safety data through annual monitoring, and provide guidance on the threshold for incident reporting.**	Annual / Summer 2016	The change in format limited the responses. This will be reviewed.

	Recommendations	Timescale/Review	Update
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	Following the positive response to the first provider workshop this will be explored as an item for future workshops.
6	**Undertake further work to gather data relating to student clinical and technical experience.**	Autumn 2016	New registrant survey planned October 2017.
7	**Investigate methods of encouraging greater emphasis on professionalism during pre-registration training, for example, through new guidance.**	Summer 2016	Student professionalism resources developed and published. Student engagement strategy also now in place.
8	**Monitor the impact of revised *Standards for Education* which includes a greater emphasis on raising concerns.**	Annual	In the previous exercise there was a specific question. As with patient safety it was incorporated into the issues and concerns question so had a low response rate. This will be reviewed. Raising concerns guidance is included in the new student professionalism guidance.
9	**Publish revised Student Fitness to Practise Guidance, including guidance on the threshold for reporting to the GDC.**	Early 2016	Published October 2016.
10	**Consider reducing the number of thematic questions in future annual monitoring exercises and provide additional guidance.**	Summer 2016	Completed.
11	**Amend the annual monitoring cycle to reflect academic rather than calendar years.**	Summer 2016	Completed.
12	**Consider how to work more closely with providers to share information and best practice and develop a strategy to do this.**	Spring 2016	Following the positive feedback for the first workshop future workshops are planned.

For providers of education and training

	Recommendations	Timescale/Review	Update
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	This remains a focus for inspections. It is a planned agenda item for future provider workshops.
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	Progress has been identified during inspections. Continue to monitor.
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	Some providers are reporting they have not yet achieved this. Programmes will be followed up individually. The development of a risk based quality assurance process and approach to updating the learning outcomes will address this.
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	Feedback will be sought on the implementation of student professionalism and fitness to practise guidance and resources.
5	**Consider the findings of this report and work collaboratively with others to share effective practice and tackle common challenges.**	Summer 2016	Formal education groups will be asked to put this on their agenda this year.

Commissioners of education and training

	Recommendations	Timescale/Review	Update
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	This remains a key challenge and historic issues may continue. Patient supply issues are detailed in the annual monitoring and inspection reports analysis

Section F: The Education and QA Team

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Manjula Das	Head of Education Policy and Quality Assurance (Currently on maternity leave)
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QA Operations Team

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Quality Assurance Team, General Dental Council, 37 Wimpole Street, London, W1G 8DQ.

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: Quality Assurance Team Activity 2014-16

Scheduled inspections against the *Standards for Education*:

2014/15

Cardiff University, BSc Dental Therapy and Hygiene and Higher Education Diploma in Dental Hygiene

Central Manchester Foundation Trust Diploma in Orthodontic Therapy, awarded by the Royal College of Surgeons of Edinburgh

City & Guilds, Level 3 Diploma in Dental Nursing (QCF)

Dental Team Qualifications, Advanced Diploma in Dental Nursing

University of Essex, BSC (Hons) Oral Health Science (Dental Therapy)

Heath Education Kent Surrey Sussex, Diploma in Clinical Dental Technology, awarded by the Faculty of General Dental Practice of the Royal College of Surgeons of England

Manchester Metropolitan University, BSc (Hons) Dental Technology

The City of Liverpool College, Foundation Degree in Dental Technology

Birmingham Metropolitan College, Foundation Degree in Dental Technology

The University of Manchester, BSc Oral Health Science (Dental Hygiene and Dental Therapy)

University of Portsmouth, BSc (Hons) Dental Hygiene and Dental Therapy

Yorkshire Orthodontic Therapy Course, awarded by the Royal College of Surgeons of England

2015/16

Birmingham Community Healthcare NHS Foundation Trust, BSc in Dental Hygiene and Therapy and Diploma in Dental Hygiene, awarded by the University of Birmingham

The Greater Manchester School for DCPs, Diploma in Dental Hygiene and Dental Therapy, awarded by the Royal College of Surgeons of England

Edinburgh College, Diploma in Dental Technology, awarded by the Scottish Qualifications Authority

Cardiff University, Certificate of Higher Education in Dental Nursing

Scottish Qualifications Authority, Scottish VQ 3 in Dental Nursing at SCQF Level 7

University of the Highlands and Islands, Higher Education Diploma in Dental Technology

Council for Awards in Care, Health and Education (CACHE), Level 3 Diploma in the Principles and Practice of Dental Nursing

King's College Hospital NHS Foundation Trust, Diploma in Dental Hygiene and Dental Therapy, awarded by the Royal College of Surgeons of Dentistry

Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, Diploma in Dental Hygiene and Therapy

Re-inspections against the *Standards for Education*

University of Aberdeen, Bachelor of Dental Surgery 2014/15 and 2015/16

University of Dundee, Bachelor of Dental Surgery 2014/15

University of Central Lancashire, Diploma in Clinical Dental Technology 2014/15

University of Edinburgh, BSc Oral Health Sciences (Dental Hygiene and Dental Therapy) 2014/15

Manchester Metropolitan University, BSc (Hons) Dental Technology 2015/16

Birmingham Metropolitan College, Foundation Degree in Dental Technology 2015/16

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

Key facts 2014/15 and 2015/16

	2014/15	2015/16
Total number of programmes inspected	14	12
Number of new programme submissions	6	6
Number of programmes submitting major revisions	1	0
Number of BDS inspections	2	1
Total number of DCP inspections	12	11
Number of CDT inspections	1	0
Number of Hygiene and Therapy inspections	5	5
Number of Dental Nursing inspections	2	3
Number of Dental Technology inspections	1	3
Number of Orthodontic Therapy inspections	3	0
Number of new programmes inspected	1	3
Number of routine inspections	9	7
Number of re-inspections undertaken	4	2
Programme sufficient/approved for registration on ongoing basis	10	8
Programme sufficient/approved for registration pending re-inspection	2	3
Graduating cohort only approved for registration, new programme submission required	2	0
Programme not sufficient/approved for registration	0	1

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

	2014/15	2015/16
Number of programmes inspected using the *Standards for Education*	14	12
Number of programmes inspected delivering *Preparing for Practice* learning outcomes	12	12
Percentage of requirements met	47%	58%
Percentage of requirements partly met	44%	33%
Percentage of requirements not met	9%	9%

QA Team – Key Facts	**2014**	**2015**	**2016**
Budget (Policy and Operations)	£1,020,304	£837,868	£867,045
Staff (Policy and Operations)	11.6 FTE	10.6 FTE	10.4 FTE
Programmes subject to GDC QA	82	82	85
No of providers/awarding bodies we quality assure	49	49	52

Forthcoming operational activity – 2016/17	
Number of programmes to be inspected	16

Annex 2: Summary of Programme Performance 2012-16

Breakdown of Programme Performance Against Requirements, 2012 – 2016			
Requirement	**Met**	**Partly Met**	**Not Met**
Standard 1 – Protecting Patients			
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.	**81%**	**17%**	**2%**
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.	**87%**	**11%**	**2%**
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.	**68%**	**26%**	**6%**
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.	**72%**	**21%**	**8%**
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.	**47%**	**49%**	**4%**
6. Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so.	**70%**	**28%**	**2%**
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.	**57%**	**40%**	**4%**
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.	**81%**	**13%**	**6%**

Standard 2 – Quality evaluation and review of the programme			
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.	**58%**	**26%**	**15%**
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.	**47%**	**36%**	**17%**
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.	**51%**	**34%**	**15%**
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.	**53%**	**34%**	**13%**
Standard 3 – Student assessment			
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.	**47%**	**49%**	**4%**
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.	**34%**	**51%**	**15%**
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.	**47%**	**45%**	**8%**
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.	**51%**	**49%**	**0%**

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.	15%	68%	17%
18. The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.	75%	21%	4%
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.	49%	51%	0%
20. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented.	72%	19%	9%
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.	32%	64%	4%
Overall Standard 1	70%	26%	4%
Overall Standard 2	52%	33%	15%
Overall Standard 3	47%	46%	7%
Overall achievement of requirements	57%	36%	7%

Annex 3: The GDC's Quality Assurance Inspectors, 2014-2016

The GDC'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 (until Sep. 2016)
Chris Parker	Ann Shearer	Cindy Mackie
Christine Cotton	Barbara Chadwick	Gail Mortimer
Diane Hunter	Carolann Beck	Jeanne Goulding (until Oct. 2016)
Fiona Ellwood	Daryll Jagger (until Dec. 2015)	Julie Stone
Fiona Sandom	David Hussey	Katie Carter
Geraldine Birks (until Jun. 2016)	David Young	Kim Tolley
Hayley Lawrence	Edward Odell	Michael McCulley
Joanne Brindley	Elizabeth Watts	Michael Yates
Maxine Kane (until Jul. 2016)	Fizan Tahir (until Jul. 2016)	Philip Bunnell
Michael Reeson	Iain Mackie (until Dec. 2016)	Philip Brown
Robert Williams	Isobel Madden	Susan Morison
Rosemarie Khan	James Newton (until Nov. 2014)	
Sarah Murray	Janine Brooks	
	Kim Piper	
	Mike Mulcahy	
	Mohammed (Khalid) Mushtaq	
	Paul Howlett	
	Paul Wright	
	Peter Heasman (until Jul. 2016)	
	Raj Majithia	
	Samuel Cadden (until Dec. 2015)	
	Shazad Malik	
	Steven Farmer (until Oct. 2016)	
	Stuart Boomer	
	Suzanne Noble	
	Trevor Burke	

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

Annex 4: *Standards for Education*

The *Standards for Education* can be found on our website:

- Current version (2015-present)
- Previous version (2012-2015).

A summary of changes to the *Standards for Education* can be found in the Council meeting papers for 30 October 2014, Annex 6b.