General Dental Council | protecting patients, regulating the dental team

INSPECTION REPORT

Education provider/ Awarding Body:	**University of Bristol**
Programme/Award:	**Diploma in Hygiene** **Diploma in Therapy**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a *Dental Hygienist or a Dental Therapist***
Learning Outcomes:	***Preparing for Practice (Dental Hygiene or Dental Therapy)***
Programme inspection dates:	**24 – 25 January 2017**
Examination inspection dates:	**15 March 2017 – Therapy Exam** **14 June 2017 – Hygiene Exam**
Inspection panel:	**Michael Yates (Chair and Lay Member)** **Joanne Brindley (DCP Member)** **Christine Cotton (DCP Member)** **Barbara Chadwick (Dentist Member)**
GDC Staff:	**Rachael Mendel** **James Marshall (Programme only)** **Krutika Patel (Therapy Exam only)**
Outcome:	**Recommended that the Diploma in Therapy remain sufficient for registration as a dental therapist.** **Recommended that the Diploma in Hygiene remain sufficient for registration as a dental hygienist.**

Full details of the inspection process can be found in the annex

Inspection summary

The inspection team was pleased with the documentation received for both programmes in advance of the inspection and during the inspection. The documentation received was filed in a logical order so the panel were able to find the evidence demonstrating how each requirement was met. Any documentation requested during the inspection was provided in a timely manner.

It was evident that both programmes had small dedicated teams who provided support to all the students. The students were extremely positive about the staff on the programme and noted how approachable and willing they were to go beyond what would be expected of them in order to assist a student. It was clear that the small cohorts allowed the programmes to address any concerns or issues that arose with individual students or with the programme overall quickly. However, the small cohort and close working relationships within the programme led to issues being dealt with informally and often without an evidence trail. The use of formal policies and procedures should be used to ensure all students are treated equitably and in order to keep accurate records of all incidents, issues or concerns.

The small cohort and infrequent collation of students' clinical data from across all sites compromised the hygiene programme by making it difficult to monitor student progression. While the panel were confident that upon graduation, students on both programmes were fit to practise as safe beginners, the recording processes for hygiene students clinical work was not robust and it was noted that these processes need to be improved.

The inspectors noted that the staff were working in a challenging environment, with specific regard to funding issues, the cessation of the therapy programme and the uncertainty of how the programmes will move forward in the future. However, it was clear to that the programme staff worked well as a team and were passionate about the programme and education of the students.

Background and overview of Qualification

Annual intake Hygiene Annual intake Therapy	8 students 6 students
Programme duration Hygiene Programme duration Therapy	X weeks over x months/years Dental Hygiene – Full time 91 weeks over 21 months Dental Therapy – Part time 2 days per week over 24 months
Format of programme Hygiene Format of programme Therapy	: Year One Basic principles; system based learning; simulated learning Preclinical competencies completed; Transition to clinics Year Two Develop competences; expanded clinical attachments; Preparing for Practice Year One Basic principles; system based learning; simulated learning; (preclinical adult restorative) Transition to clinics; Preclinical paediatric Year Two Develop competences; Paediatric clinical sessions; expanded clinical attachments Preparing for Practice

The panel wishes to thank the staff, students, and external stakeholders involved with the Diploma in Hygiene and Diploma in Therapy programmes for their co-operation and assistance with the inspection.

Standard 1 – Protecting patients **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.**			
Requirements	**Met**	**Partly met**	**Not met**
1. Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients.	✓		
2. Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing.	✓		
3. Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place.	✓		
4. When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development.	✓		
5. Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body.	✓		
6. Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parities how concerns will be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so.	✓		
7. Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified.		✓	
8. Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance.	✓		

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

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

A range of evidence was provided to demonstrate that students only provided patient care when they had adequate knowledge and skills. The School makes use of gateway assessments that need to be passed before students can progress to working on clinic. Both programmes start pre-clinical work in week two of the programme while therapy students are all registered dental hygienists and are expected to already have a certain level of dexterity and clinical knowledge when commencing the programme.

Competence is assessed in several ways for both programmes, including through the use of pre-clinical logs that are monitored by staff on a regular basis, formative assessments are used throughout pre-clinical training to ensure students are progressing appropriately. A gateway assessment as well as a summative online assessment must be passed before students can progress onto clinic to ensure the students have the appropriate level of skill and knowledge.

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

Patients are informed in numerous ways that they may be treated by students. The Bristol Dental Hospital website states that it is a teaching hospital and explains that they will be treated by students under supervision. When patients are referred to the hospital, and assessed by the relevant consultant, patients are again told that they will be treated by students and verbal consent is received.

New patients receive a welcome letter from the hospital which outlines treatment may take longer than usual to complete because a student will be undertaking the treatment under the supervision of qualified staff. Posters are displayed in the waiting rooms to inform patients that it is a teaching hospital. The students are also required to wear scrubs that state that they are either student hygienists or student therapists.

All patients who attend a student dental hygienist or therapist clinic have their proposed treatment reiterated to them under the supervision of a tutor. Verbal and written consent is obtained for each course of treatment and consent is gained again for specific procedures such as dental extractions.

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

During the inspection, the panel were satisfied that the school complied with all relevant legislation and requirements regarding patient care. Bristol Dental Hospital is a registered organisation with Care Quality Commission (CQC) to be a provider of dental services. The Dental School has also been awarded an Athena SWAN silver award. As students undertake all their clinical activity at the Bristol Dental Hospital facilities, the clinical governance frameworks for the students falls under the auspices of UHBristol and they therefore have to undertake the statutory and mandatory hospital training.

UHBristol NHS foundation Trust is an authorised Public Benefit Corporation and is therefore required to comply with governance standards set out by the NHS Act; students are subject to all Trust protocols for ensuring a safe and appropriate working environment.

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

Both the hygiene and therapy programmes have small cohorts and are therefore closely supervised by the staff when on clinic, especially during the first year of training and when students initially start treating patients. Students provide direct clinical care according to their stage of training and development. The timetable is structured to allow teaching and learning to be appropriate to the student stage of development. The feedback from students of both programmes was overwhelmingly positive and they felt that the staff were supportive and approachable if they needed assistance.

The panel noted that the small teams on both programmes ensured that there was a high level of communication between staff and that all students were closely monitored and supervised by dedicated staff; any issues or concerns could be picked up quickly and dealt with efficiently.

The Diploma in Dental Therapy lead supervised all paediatric treatments plans and was therefore aware of how well the therapy students were progressing throughout the programme. Issues were picked up immediately rather than at an end-of-term formal meeting.

These small teams allowed any progression issues to be dealt with quickly, and staff could provide extra support and remediation to students without delay to ensure students were not falling behind.

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

All staff involved in teaching students are appropriately qualified and registered with the GDC and hold a clinical contract with UHBristol NHS Trust together with having honorary clinical status with the University of Bristol. All staff have attended the UHBristol clinical induction course which includes equality and diversity training, training regarding conditions such as dementia and learning disabilities as well as the Mental Health Capacity Act (2005). A 'Living the Value' session is covered which includes communication and behaviour, describes the Trusts' culture and values and outlines the expected behaviours of staff.

The panel saw evidence of the mandatory training logs during the inspection, highlighting training the staff had completed and when their certifications need to be repeated. All staff training was completed and up to date. The panel noted that not all staff had a teaching qualification and while the panel were assured that all staff were appropriately qualified, it

would be beneficial to the programme and the staff if their professional development was supported.

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

The panel saw evidence that the School had policies and procedures in place for students to raise any concerns and these procedures had been provided to students, however, these policies had not been utilised since no formal concerns had been raised. A raising concerns policy is in place and both students and all those involved in in the delivery of education and training are aware of their obligation to raise concerns and the procedures in place to do this.

Students were aware of their options for raising a concern; by talking to a supervisor or tutor, or by using the student concern form if they had concerns about patient safety relating to other students or other staff members. Once a concern has been raised, a formal procedure is followed either through the Trust or University policies depending on the nature of the concern.

The University and the Trust both had whistleblowing policies in place and students were aware of these and what they needed to do if they had any concerns.

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

The Datix reporting system that manages and logs all clinical incidents using an online form is in place across all clinical sites that the students attend. A manager is required to review any incidents within 72 hours so the incident can be escalated and managed appropriately. There is a clear procedure in place for reviewing each incident and actions are put in place to minimise the risk or re-occurrence. Staff all complete clinical incident training and all clinical incidents are reported and discussed at the quarterly clinical governance meetings. A staff member from the DCP school is a member of the committee so this information can then be disseminated back to the rest of the school.

It was noted that the systems and policies were in place to manage clinical incidents, however, they did not demonstrate how these policies are put into action when an incident occurs and no audit trail was available to demonstrate how the information is logged and disseminated throughout the school. The panel recommends that formal processes are put in place to ensure that all incidents are logged, actioned and disseminated appropriately. Issues should be discussed at team meetings and noted in the minutes. Communication with students about safely issues on clinic must also be formally recorded with clear feedback mechanisms in place.

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

The Director of DCP training is a member of the Faculty's Fitness to Practise panel while another member of staff is a fitness to practise case investigator. The school has fitness to practise policies in place and staff and students can complete a student concern form to be considered by the Faculty within Fitness to Practise procedures.

Students are required to read the GDC Student Fitness to Practise documentation and students are provided with advice to familiarise them with examples, in the documentation, of behaviours that may cause concerns. Students are also required to sign and return a document confirming that they have read and understood the Fitness to Practise information within their first month of training. Information about professional behaviour expectations is also presented to students during the induction week.

The panel noted that all policies were in place, students were aware of these policies and how to address any concerns they may have. It was also noted that because the cohorts for both programmes were small, any issues were picked up immediately which has resulted in no Student Fitness to Practise cases being brought through.

While the panel note that a small cohort means that any Student Fitness to Practise concerns can be managed quickly and sometimes fairly informally, the school should not become complacent regarding the need to adhere to policies and procedures.

Actions

No	Actions for the Provider	Due date
7	Formal processes must be put in place to ensure that all incidents are logged, actioned and disseminated appropriately.	Annual Monitoring 2017/2018

Standard 2 – Quality evaluation and review of the programme **The provider must have in place effective policy and procedures for the monitoring and review of the programme.**			
Requirements	**Met**	**Partly met**	**Not met**
9. The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.		✓	
10. Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes.	✓		
11. Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development.		✓	
12. The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements.	✓		

GDC comments

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

The awarding body for both programmes is the University of Bristol, the programmes are therefore accountable to the University policies and procedures. The programmes make use of two frameworks to manage the quality assurance of the programmes, a local and direct framework specific to the diploma and the University of Bristol framework.

The Dental Education Committee (DEC) has the remit to deliver and quality assure both programmes. Under the DEC there are a number of sub-committees which include the Dental Teaching Committee and the Dental Assessment Committee, where any programme issues can be referred.

Both programmes are fully evaluated each year via the Annual Programme Review (APR). The programmes rely heavily on this process for quality assurance purposes and paperwork was presented at the time of the inspection to verify this. Additionally the programme have a DCP standing item at DTC and DEC to ensure representation at these meetings and validity of the programme.

The panel saw clear evidence of how both programme curricula were mapped to the latest GDC learning outcomes, however they did not see a clear audit trail of how any changes to the curricula were passed through the Committees and they felt that there was an over reliance of programme staff taking on this responsibility without any support from the University as several committees had a heavy BDS focus. The panel recommends the University Committees seek to make them less BDS focussed and use them as a way to work across all dental programmes.

Any changes to the Diploma programmes have a clear process which they must follow. Any changes are discussed initially at APR, then DEC and DTC. The actions are then followed through with the Academic Quality and Policy Office (AQPO). Depending on the nature of the changes, approval is then sought via the Faculty Undergraduate Studies Committee and finally the Undergraduate Education Committee.

The panel noted that the DCP programmes were reliant on addressing concerns within the team and that quality mechanisms at a programme level were informal. Programme staff regularly discuss the programme and student performance but this is on an ad-hoc basis. An internal risk register noted the significant risk to the programme due to changes in funding and how this could impact on the type of qualification offered. The programme should formalise the quality assurance mechanisms at the programme level to ensure that a clear process is followed.

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

As both programmes are small, any concerns that are identified are dealt with quickly and efficiently. The Annual Programme Review (APR), Faculty Quality Team (FQT) and External Examiners' reports are all used as part of the quality management framework. The programmes indicated that if any concerns arose, they were dealt with as quickly as possible and where appropriate, dealt with at a local level so as to ensure a speedy resolution to any issues. As noted in Requirement 4, it is important that policies and procedures are still followed and the correct committees are involved in any quality assurance concerns, even when the cohort is small.

Evidence of this taking place was highlighted via the External Examiner reports, where suggestions were made and the programme were receptive to these suggestions and addressed their concerns quickly.

The programme did notify the GDC prior to changes in funding to the programme that were likely to affect how the programme would continue in the future. The panel urge the programme leads to continue to notify the GDC of any changes to the programme that may occur due to funding changes.

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer

feedback must be collected and used to inform programme development. ***(Requirement Partly Met)***

Both programmes are subject to external quality assurance and have External Examiners in place who are involved with dental education at other institutions, are GDC registered and therefore familiar with GDC learning outcomes. The role of the external examiners is clearly defined in the 'Policy for External Examining of Taught Programmes at the University of Bristol', with duties that include providing comment and advice on curriculum content, reviewing draft assessments and to submit an annual report of their finding to the School. The External Examiners felt that their reports and feedback was used to develop the programme and they had seen some of their suggestions implemented into the programme.

Feedback is collected from patients but this is done on an ad-hoc basis, rather than formally. There was no evidence of how this feedback was used to inform and develop the programme. The provider must implement a system to capture patients' feedback on their treatment which is then be used for programme development.

Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. ***(Requirement Met)***

All the sites that both hygiene and therapy students work at are part of the University Hospital and therefore fall under the governance structures, policies and procedures of UHBristol NHS Foundation Trust. All sites are set up in a similar way to ensure students are receiving the same educational experience across all sites albeit with distinct types of patients being seen across locations.

All staff and students working at placements undertake the hospital induction and the dental clinical induction and training courses. The DCP staff attend the outreach placements with the students, so all assessments undertaken at these sites are being marked by the same staff. This ensures that there is calibration among all sites.

Actions

No	Actions for the Provider	Due date
9	The provider must formalise the quality assurance mechanisms at a programme level.	Annual Monitoring 2017/2018
11	The provider must ensure that there are mechanisms in place to allow feedback being collected from patients to be used to inform and develop the programme.	Annual Monitoring 2017/2018

Standard 3– Student assessment **Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.**			
Requirements	**Met**	**Partly met**	**Not met**
13. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards.	☐	✓	☐
14. The provider must have in place management systems to plan, monitor and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes.	☐	✓	☐
15. Students must have exposure to an appropriate breadth of patients and procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant learning outcomes.	☐	✓	☐
16. Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed.	☐	✓	☐
17. Assessment must utilise feedback collected from a variety of sources, which should include other members of the dental team, peers, patients and/or customers.	☐	✓	☐
18. The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.	✓	☐	☐
19. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/assessors should have received training in equality and diversity relevant for their role.	✓	☐	☐
20. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented.	✓	☐	☐
21. Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area	☐	✓	☐

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

GDC comments

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

Assessment information for both programmes was set out for each module, this included learning outcomes for each module, assessment criteria and types of assessment used to determine competence in any given area. The panel saw evidence of the GDC learning outcomes being mapped against both the modules and assessments for both programmes. At the programme inspection, the panel saw that frameworks were in place for all formative and summative assessments to be logged. There was also evidence that all students are assessed in an appropriate manner to ensure that they are fit to practise at the level of a safe beginner.

Students' clinical logs were stored across several different sites, in a paper format, this meant that the collation and monitoring of this information was poor. The panel were provided with data relating to the student's clinical experience from across a range of sites, however this data was not up to date at the time of the examinations and had not be collated into one document. It therefore made it difficult for the panel to determine what experience each student had gained without cross-refencing a number of sources. Although there are clear criteria students must achieve to sign up for the final examination, a finalised list of total clinical procedures each student has attained was not available at the time of the examinations and evidence of the examination sign up procedure was not clear. The programme stated that given the size of the programme the tutors could pick up any concerns quickly, while on clinic. However, there was no documentation providing any evidence discussing when tutors felt a student may need more experience in a specific area and how the issues were addressed or discuss across the programme. There was also no evidence or minutes detailing how decisions were made regarding a student's eligibility to sit the final examination. Meetings did take place between staff and students prior to sign up for the exam, but the minutes of these meetings focused on student performance on assessments, rather than eligibility to sit the exam.

With regards to Dip Dent Therapy the programme director has confirmed that there was evidence of this within the Dental Therapy staff meeting minutes.

The panel understood that, given the small cohorts, those experiencing difficulty or failing assessments could easily be identified and provided with the necessary remediation. However, to ensure each student is being properly monitored throughout the course, the programme must implement a process which enables all students' clinical data to be recorded in one place and updated frequently. This would reduce the risk of the School being challenged by a student, as they would have accurate data to evidence decisions made in allowing students not to sit the final exams or progress through the programme. For the same reason, the sign-up procedure for exams must be formal with an agenda and be minuted showing that all student data was reviewed in deciding which students could progress to sitting the final examinations.

The programme must implement more rigorous recording and monitoring procedures by the start of the new academic year to ensure that better records of student clinical logs are kept.

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

Students' clinical activity is monitored continuously, with staff members signing off and assessing every patient they see. This ensured that any issues with a student's clinical proficiencies could be picked up quickly and the student given the opportunity to take part in remediation activities promptly. This was due to the small teams, rather than the processes involved for monitoring clinical activity.

As stated in Requirement 13, the monitoring and collation of clinical data needs to be more robust, most specifically at the outreach sites which needs to be addressed for future cohorts, to ensure that students are receiving a full range and breadth of patients. It was not clear whether clinical logs were kept for specialist clinics.

A complete log of all clinical activity had not been produced prior to the hygienist examination. The logbooks that the panel saw for the hygienist students raised concerns that the student data was not being collated or monitored regularly. There was a heavy reliance on informal processes that work because the cohort is small and the tutors know the individual students' and not because a robust data collection process was in place.

The panel felt that data was collected in silos and that the programmes lacked a central recording system. A more robust system for collating this data needs to be put in place so that student progression can be monitored more closely and any issues with experience being gained can be formally picked up and recorded at a much earlier stage.

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

For both courses, a programme handbook lists all modules and describes what areas of study will take place under each module and how they will be assessed. A clinical rotation is in place, providing students with an extensive referral base of patients, which includes patients from Oral Medicine, Orthodontics, Paediatrics, Special Care Dentistry and Restorative Dentistry providing students with appropriate breadth of patients.

Throughout the course, nominated tasks in the form of OSCES, nominated must-pass competencies, case presentations, clinical tasks and reflections must be undertaken to a satisfactory level for progression. The tasks identified are considered as important skills for the level of safe beginner at qualification.

The panel were satisfied that the therapy students were exposed to an appropriate breadth of patients and were competent in achieving the relevant learning outcomes. The documentation relating to the hygiene students' progress was not up to date at the time of the examination, however a log of final clinical totals was provided to the panel after the examination which they were satisfied with. It was noted that clinical numbers for some of the extended skills procedures were low and that without a more robust monitoring system this could be overlooked by the programme. The programme staff said that although there were shortfalls in some clinical procedures, the students had gained experience in the clinical skills laboratory. However, this was not evident in the pre-clinical logs.

Whilst the panel were confident that students had achieved an appropriate range and breadth of patients based on the up to date clinical logs that were provided after the hygienist examinations they were not confident that the clinical logs had been monitored and used in a formal sign-up process. There is an over reliance on the cohort being small and the staff knowing how the students are progressing on an individual basis, rather than tracking and monitoring clinical logs.

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

The school provided evidence that learning outcomes had been mapped to modules and assessments. The programmes use a combination of both formative and summative assessments to both drive student learning and ensure that students are progressing through the programme. Assessments methods used include written examination, clinical case presentations, practical examinations and clinical scenarios.

The blue printing documentation seen by the inspectors for the hygienist examinations was not up to date and some of the learning outcomes were not being assessed where they said they were. The programme should ensure that the blue-printing and mapping documentation is monitored and updated at each iteration of the examination to ensure the documentation remains up to date and relevant.

The panel felt that the assessments were appropriate, there was evidence of staff trying to standard set as best of possible but the staff did note that due to the small teams, the use of a formal standard setting process such as Angoff was not feasible. Where appropriate, the use of double blind marking took place.

The panel have suggested that the programmes further align with other university programmes in order to work together as a wider team so that standard setting could be used for assessments and the programme can make use of expertise from other programmes.

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

The programme provided evidence of feedback that is collected informally from patients through a patient satisfaction survey. Dental nurses are also asked to provide tutors with informal feedback about the students which is used to alert tutors of concerns about any students. The tutors also provide feedback to students in their clinical logbooks.

There are plans in place to develop a more formal method of patient feedback in relation to assessments and a new E-portfolio is being considered for BDS students for next year. It is thought that the dental hygiene and therapy students would make use of the same system, providing more opportunities to be linked to assessments.

Whilst the panel could see evidence of feedback being collected, and the desire to improve the feedback being collected, the way in which this feedback is currently utilised was not evidenced. It is collected in an informal manner and any subsequent discussions with students is not documented. The panel suggests that a more formal approach to collecting and utilising the feedback takes place.

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

Students are provided immediate feedback on clinic that includes reflecting on transferable skills such as professionalism and enabling students to reflect on their progress and personal development. They also have the opportunity to obtain feedback for both written and clinical assessments with their tutor.

The panel were provided evidence of reflection taking place in the clinical logs. When speaking with the students it was apparent to the inspection team that they understood the purpose and importance of reflection. They also stated that they were required to reflect throughout their pre-clinical and clinical training and how tutors then provided feedback on their reflections.

The students were positive about the process of reflection and found it to be a useful tool to identify what they had done well and what they could improve on next time. There was also evidence of students receiving feedback from their mock examinations when being told they can sign up for their finals, this feedback could have gone further and tutors could have provided feedback to the students about their clinical skills.

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

The panel were provided with evidence of the examiners and assessors mandatory training logs. The DCP staff have been involved in a series of workshops relating to assessment best practice and standard setting run both internally and externally.

The panel suggest that more formal methods of assessment are used to ensure calibration occurs across all clinical centres. The programme said they hoped that with the changes to commissioning and funding and the possible move to being a University programme in its entirety, a closer working relationship with the BDS programme would offer opportunities for more inter-professional learning within both programmes.

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

External Examiners provide written reports using the University pro-forma following each diet of the examination. The pro-forma asks them to comment on the process of the examination and other assessments, referencing fairness to students, rigour, benchmarking and programme specification.

There are clear guidelines set out by the University outlining the expectations of the External Examiner. There was also clear evidence that the reports were read by the programme leads, responded to and used to inform changes to the programmes.

External Examiners told the inspectors they were assured that the examinations were rigorous and met national standards. They considered that students were of a comparable level to other similar programmes available. They were also confident that the students had been treated equitably and fairly throughout the examination process.

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

The programme had clear guidance in terms of marking schemes and criteria. The examiners were provided with a standard set of questions that could be asked during the case presentations and a clear marking scheme with grade descriptors was used to determine marks. A pre-examination meeting took place and ensured that all examiners and external examiners were aware of their roles, the marking scheme was discussed and all examiners were aware of how they would deal with discrepancies in marks between the two examiners. Time was provided between each case presentation for the examiners to discuss their mark allocations and determine a final mark for each student.

Written assessments are taken from an existing bank of examination questions, while new questions are standard set, using programme staff, by discussing relevancy and difficulty of the task/assessment. As mentioned in requirement 16, standard setting is limited due to the small staff numbers. The programme should integrate further with other programmes which would lead to more robust standard setting methods being used. The written assessments were all double blind marked.

The programme also makes use of the external examiners to assess the standard of the examination and are asked to provide feedback to the programme on the assessments in advance of the examination taking place.

Actions

No	Actions for the Provider	Due date
13, 14 & 15	The provider must put in place more rigorous recording at the start of the new academic year to ensure that better records of student clinical logs are kept.	Start of 2017 academic year
13, 14 & 15	The provider must provide the GDC with documentation that demonstrates evidence of the effective monitoring and individual student attainment of a full range of clinical experiences, alongside the clinical sign-up meeting minutes and assessment blueprinting and mapping documentation.	After sign-up meeting for the Hygiene Examination
13, 14 & 15	The provider must update the GDC on how the implementation of the new recording procedures have progressed.	Annual Monitoring 2017/2018
16	The provider must provide an update on how the update of the mapping documentation for the final hygiene examination is progressing.	Annual Monitoring 2017/2018
16 & 21	The programmes should try to associate more closely with other programmes in order to adopt more robust standard setting procedures as best practice.	Annual Monitoring 2017/2018
17	The provider must provide an update on how the plans/implementation of more formal patient feedback collection is progressing	Annual Monitoring 2017/2018

Summary of Actions

Req. number	Action	Observations Response from Provider	Due date
7	Formal processes must be put in place to ensure that all incidents are logged, actioned and disseminated appropriately.	All clinical incidents are logged and actioned on a Trust wide central database. The outcome from all clinical incidents are disseminated firstly to the person(s) who raised and logged the incident, and then at a quarterly governance committee meeting. The membership of this committee includes a Tutor Dental Hygienist from the DCP School. We will ensure that the pertinent issues from these meetings are discussed formally with all teaching staff, and then disseminated to all students with actions formally noted. Last term the Hospital introduced a clinical briefing session which takes place before the start of every clinical session. This briefing ensures all staff and students are aware of any relevant acute issues that have arisen together with feedback from any previous clinical incidences.	Annual Monitoring 2017/2018
9	The provider must formalise the quality assurance mechanisms at a programme level.	Risks and concerns to the programme are formally registered and logged through the University Annual Programme Review (APR) process. The programme director is also a member of the Schools Dental Education Committee where any concerns around QA can be discussed more widely with members of the Education Committee and Chair of Dental Education. In addition QA mechanisms are formally recorded at Faculty level by the Faculty Quality Teams.	Annual Monitoring 2017/2018

		The programme also submits a return to the GDC as part of their annual monitoring process.	
11	The provider must ensure that there are mechanisms in place to allow feedback being collected from patients to be used to inform and develop the programme.	The Dental School is looking at patient feedback across both the BDS and Hygiene and Therapy programmes. We are hoping to develop a patient participation group which will enable patients to provide direct feedback that can be used to enhance the programmes. We are also engaging with patients and seeking their feedback as part of the current BDS curriculum review, and the as part of the submission of a new BSc programme in Dental Hygiene and Therapy. We will ensure that the patient feedback we collect from student's clinical sessions is formally considered at the Tutors annual away day and used where appropriate to develop the programme.	Annual Monitoring 2017/2018
13, 14 & 15	The provider must put in place more rigorous recording at the start of the new academic year to ensure that better records of student clinical logs are kept.	We have a designated dental nurse who has been given protected time to undertake this duty. We are also briefing the students at the beginning of each term to remind them of their professional duty to acutely record all their clinical activity from all clinical sites. The log books will be closely scrutinised by the tutors at the student's termly progression meetings.	Start of 2017 academic year
13, 14 & 15	The provider must provide the GDC with documentation that demonstrates evidence of the effective monitoring and individual student attainment of a full range of clinical experiences, alongside the clinical sign-up meeting minutes and assessment blueprinting and mapping documentation.	The DCP school will ensure that all of the student's clinical experiences from across all sites are collated onto one document, and that this document is mapped to the sign up requirements for finals meeting. This meeting will be formally recorded with the students.	After sign-up meeting for the Hygiene Examination
13, 14 & 15	The provider must update the GDC on how the implementation of the new recording procedures have progressed.	We will update the GDC on the new electronic recording procedures as they come on board. The BDS programme has recently introduced a new clinical assessment feedback system (CAFS) which has been	Annual Monitoring 2017/2018

		rolled out to years 2, 3 and 4. It is anticipated CAFS will come online for the new Hygiene and Therapy programme in 2019.	
16	The provider must provide an update on how the update of the mapping documentation for the hygiene examination is progressing.	All assessments within the Diploma in Dental Hygiene where mapped to the Preparing for Practice document (all GDC LO). This was later updated when the programme was submitted to the University Programme Approval Group as a result of changes regarding University regulation and the evolution of South Bristol Community Hospital. We individually blueprinted the final examination for the Diploma, including all summative examinations in the programme. This paperwork was made available to the panel. The University also required an Intended Learning Outcomes document which also covered this programme. Could the panel kindly clarify the following statement: *'The blue printing documentation seen by the inspectors for the hygienist examinations was not up to date and some of the learning outcomes were not being assessed where they said they were.'* We are very keen to know what part of the documentation was not up to date and which learning outcomes where not being assessed where we said they were.	Annual Monitoring 2017/2018
16 & 21	The programmes should try to associate more closely with other programmes in order to adopt more robust standard setting procedures as best practice.	The DCP staff have attended School wide teaching meetings on standard setting, and as result of these meetings, and given the small number of students	Annual Monitoring 2017/2018

		attached to the programme it was deemed our standard setting was adequate for our examinations. The Dental Hygiene students currently sit some summative examinations alongside the dental undergraduates; however, as we move forward working on the new BSc programme together with the BDS curriculum review that is currently taking place we are looking at developing further joint assessments which should help with standard setting.	
17	The provider must provide an update on how the plans/implementation of more formal patient feedback collection is progressing	We will provide the GDC with this information as the work on this progresses.	Annual Monitoring 2017/2018

Observations from the provider on content of report

None provided

Recommendations to the GDC

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

The School must provide detailed information regarding how they have met, or are endeavouring to meet, the required actions set down in this report in 2018.

Annex 1

Inspection purpose and process

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC. It also quality assures new qualifications where it is intended that the qualification will lead to registration. The aim of this quality assurance activity is to ensure that institutions produce a new registrant who has demonstrated, on graduation, that they have met the learning outcomes required for registration with the GDC. This ensures that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).

3. The GDC document '*Standards for Education'* 2nd edition[1] is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is **met** if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the inspectors with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is **partly met** if:

"Evidence derived from the inspection process is either incomplete or lacks detail and, as such, fails to convince the inspection panel that the provider fully demonstrates the Requirement. Information gathered through meetings with staff and students may not fully support the evidence submitted or there may be contradictory information in the evidence provided. There is, however, some evidence of compliance and it is likely that either (a) the appropriate evidence can be supplied in a short time frame, or, (b) any deficiencies identified can be addressed and evidenced in the annual monitoring process."

A Requirement is **not met** if

"The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and students does not support the evidence provided or the evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to serious concern and will require an immediate action plan from the provider. The consequences of not meeting a Requirement in terms of the overall sufficiency of a programme will depend upon the compliance of the provider across the range of Requirements and the possible implications for public protection"

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term 'must' is used to describe the obligation on the provider to undertake this action. For these actions the inspectors may stipulate a specific timescale by which the

[1] http://www.gdc-uk.org/Aboutus/education/Documents/Standards%20for%20Education.pdf

action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term 'should' is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The QA team aims to send an initial draft of the inspection report to the provider within two months of the conclusion of the inspection. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme is sufficient for registration, the Council of the GDC have delegated responsibility to the GDC Registrar to consider the recommendations of the panel. Should an inspection panel not be able to recommend 'sufficiency' or 'approval', the report and observations would be presented to the Council of the GDC for consideration.

7. The final version of the report and the provider's observations are published on the GDC website.