General Dental Council

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Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Date
Newcastle University	Bachelor of Dental Surgery (BDS)	9 May 2019

Outcome of Inspection	Recommended that the BDS continues to be sufficient for the graduating cohort to register as dentist.

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

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dentist.** **Risk based: focused on Requirements 4, 9, 11, 13, 15 and 19**
Learning Outcomes:	***Preparing for Practice (Dentist)***
Programme inspection date:	**9 May 2019**
Inspection team:	**Gail Mortimer (Chair and Non-registrant Member)** **Sarah Balian (DCP Member)** **Thomas Addison (Dentist Member)** **Martin McElvanna (GDC Education & Quality Assurance Officer)** **Krutika Patel (GDC Quality Assurance Officer)** **Amy Mullins-Downes (GDC Quality Assurance Manager)**

The BDS inspection undertaken at Newcastle University was a risk-based inspection looking at specific areas of focus identified by the GDC's Education & Quality Assurance team in 2018. Information considered when identifying potential or actual risks included annual monitoring returns, previous inspection reports (and progress against any actions) and responses to wider recommendations in the GDC Annual Review of Education.

The inspection focused on Requirements 4, 9, 11, 13, 15 and 19 and specific areas within those Requirements which are detailed below.

The inspection panel, comprising of GDC education associates, were grateful for the documentation received in advance of the inspection. Having reviewed this, the panel sought further documents and an additional comprehensive set was provided. Requests for additional information during the inspection were provided quickly.

The panel was impressed by the robust management structure evident within the School, together with a cohesive team approach amongst all of the staff involved in the delivery of the learning outcomes, assessment and administration of the programme. The School has a culture of developing staff from within.

The team considered that the management of outreach was good and that outreach placements allowed students to gain a broad range of experience in a number of clinical settings.

The associates were impressed with the pastoral care of students. We noted positive feedback from student representatives in terms of support, supervision and action. Students were also positive about staff, indicating there is a good relationship with them.

The panel considered the School's approach to assessment as both innovative and progressive. As students move through the programme stages their progression can be clearly seen and the team was satisfied that the students were fit to practise as safe beginners upon graduation.

The School is also to be commended for having an open dialogue with external partners and the Health Education England working across the North East and Cumbria.

Overall, the team had no major concerns with the programme and agreed it was well organised and ensures a thorough assessment of students across the learning outcomes contained within the GDC publication 'Preparing for Practice'.

The panel wishes to thank the staff, students, and external stakeholders involved with the BDS programme for their co-operation and assistance with the inspection.

Background and overview of Qualification

Annual intake	71 students
Programme duration	188 weeks over 5 years
Format of programme	**Stage 1** Orientation and Study Skills Anatomy of the Head and Neck Cell Biology Interpersonal Skills and Shadowing Introduction to Dentistry Neurobiology Dental Physiology Metabolism & Homeostasis **Stage 2** Craniofacial and Tooth Biology Behavioural and Social Science for Dentists Basic Pharmacology Dental Materials Science Microbiology for Dentistry Immunology and Healthcare Nutrition and Diet Oral Environment Key Clinical Skills **Stage 3** Clinical Introduction Course Applied Anatomy Dental Materials Science Dental Public Health Human Diseases Oral Diseases Clinical Skills courses in Restorative Dentistry, and Orthodontics Clinical attachments with associated lectures and seminars in Restorative Dentistry, Paediatric Dentistry, Primary Care Outreach (Oral Health Education), Oral Surgery, Dental Emergency Clinic and Radiology **Stage 4** Dental Public Health Dental Sedation Human Diseases Oral Diseases Clinical Skills courses in Restorative Dentistry and Oral Surgery Clinical attachments with associated lectures and seminars in Restorative Dentistry (including Interprofessional Clinic), Paediatric Dentistry, Primary Care Outreach, and Oral Surgery **Stage 5** Current Opinion in Dentistry

	Dental Public Health Gerodontology Oral Diseases Clinical attachments with associated lectures and seminars in Restorative Dentistry, Paediatric Dentistry, Primary Care Outreach, Dental Emergency Clinic and Oral and Maxillofacial Surgery **Stages 1- 5** A vertically integrated course on Professionalism and Personal & Professional Development runs through all stages of the programme.
Number of providers delivering the programme	1 – Newcastle University

Outcome of relevant Requirements[1]

Standard One	
1	Met
2	Met
3	Met
4	Met
5	Met
6	Met
7	Met
8	Met
Standard Two	
9	Met
10	Met
11	Met
12	Met
Standard Three	
13	Met
14	Met
15	Met
16	Met
17	Met
18	Met
19	Met
20	Met
21	Met

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

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.

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)***

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)***

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)***

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)***

Under this Requirement, the panel was tasked with also looking at staffing levels and the supervision of students and whether this has any impact on how this Requirement is met.

The School indicated that there are always challenges with staffing and in particular with recruitment of clinical academics. However, they explained that in the event of School vacancies at lecturer level, it is usually possible to recruit from within the Clinical Fellow cohort. The senior academic team is composed of a high number of Newcastle graduates promoting the ethos of the school and the number of Clinical Fellows trained and retained is highly commendable. The School is confident of their solid network involving all teams with a strong ethos of multi-disciplinary collaboration. The panel considered that there were good communication streams within the School.

The School explained that students undertake clinical activity in their respective year cohorts, with suitably allocated supervisors who have appropriate experience. The team acknowledged that there are good supervision levels within clinics. Continuity of staffing is maintained to ensure a consistent teaching experience. The School explained that when determining the appropriate staff to student ratio, they are mindful of the student's stage of development and area of clinical discipline. However, their main focus is to ensure the ratios allow for high quality teaching and tailored feedback. For example, at the start of clinical placement in stage 3, students are supervised in a 1:4 ratio in the paediatric, conservation, periodontology and prosthodontics clinics. In oral surgery, sedation and dental emergencies clinics, students are supervised on a 1:1 ratio for exodontia.

In the event of staff shortages, the panel noted there are strong contingency plans in place to relocate staff from other clinics if possible so that these ratios are maintained. As a last resort, if ratios cannot be maintained, clinics are cancelled in the interests of patient safety. Clinical Teaching Leads arrange staff rotas and in the event of absence, have the responsibility to maintain patient safety and student educational experience in line with the School's guidance documents.

Regarding succession planning, the responsibility lies with the School's Senior Management Team consisting of the Head of School, the Director of Dental Education, the Director of Research and the School Manager. This is outlined in the School's Strategic Review document which also details objectives that were created and specific actions to be taken.

Finally, the associates noted that nursing support was good. Qualified nurses have access to the School's electronic database called 'iDentity' where they can provide feedback on students. There are two or three chairs per nurse so students know who they will be working with. Cross-infection teaching and assessment at outreach is also delivered by nurses.

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)***

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)***

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 Met)***

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)***

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.

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 Met)***

Under this Requirement, the panel was also tasked with looking at staffing levels and whether this has any impact on how this Requirement is met.

Before the inspection, the panel were furnished with a range of documents to illustrate the complex quality assurance framework within which the School operates. There are a variety of mechanisms, processes and committees that underpin the operation of the framework and these are explained in the University's Quality and Standards Handbook. These ensure that the quality of the programme is being monitored and improved at various levels, such as School, Faculty and University level. At the inspection, the School's senior team

comprehensively explained this framework further. Overall responsibility for the School's framework lies with the Head of School, supported by the School of Dental Sciences Executive committee. However, in terms of day to day management of the framework, that responsibility is delegated to the Director of Dental Education. Responsibility for longer term succession planning falls to the School's Senior Management Team and is recorded in the School's comprehensive annual Strategic Review.

The team learnt that the responsibility for quality assuring academic standards and teaching lies initially with the University Education Committee (UEC), which develops and oversees the policies and procedures to underpin these. At Faculty level, the Faculty Education Committee (FEC) ensures that the UEC's University's policies and procedures are effectively implemented.

The panel also heard about the operation of the Board of Studies (BoS) and how it plays a vital role in overseeing and monitoring the quality evaluation and assurance processes. Chaired by the Director of Dental Education, the BoS meets once a month to review various reports from the Directors of Examinations and Assessment, Progression and Student Support, Academic Studies and Clinical Studies. It also receives reports from the Student Staff Committee (SSC) and student representatives are members of and attend the Board of Studies. Reports include suggestions for changes and external examiner feedback reports. The outcome of the BoS meetings are reported to the School Executive who may request that the BoS take follow-up actions. Although the School does not have a risk register as such, the BoS identifies and flags up any risks to the programme, such as the retirement of key staff members. The team had sight of the BoS Action Minutes and agendas to illustrate its operational role.

Regarding assessment mapping to the latest GDC outcomes, the panel heard that the School uses a red, amber and green rating system, presenting as a minimum of three opportunities for mapping attainment against each of the learning outcomes. The team also heard that the BoS has an added responsibility for ensuring that all assessments within the programme are mapped against the learning outcomes. We saw evidence that proposed changes to the Gerodontology course had been documented and the potential impact of such changes on the attainment of the learning outcomes clearly outlined. At the inspection, the School confirmed that they are currently mapping learning outcomes to the level of exam questions.

Regarding changes to the programme, the panel observed that recommendations for changes are initially considered by the relevant School committee before being referred to BoS for initial approval. Major changes must be escalated to Faculty level for final approval. The panel saw several examples of major changes made to the programme since the last GDC inspection, resulting from a widescale review of processes. Following external consultation, there have been changes to the sign-up process which now takes into account both knowledge and clinical skills based assessments: 23 defined In-Course Clinical Competency Assessments (INCCA), Restorative and Paediatric Case Portfolios, Medical Emergencies training, Dental Public Heath Assessment, Professionalism (In-course) essay, Radiology (IRMER) and Oral Diseases Clinical Slides assessments. This process also considers any outstanding Fitness to Practise cases. The School also reviewed methodology around finals, adopting a more contemporary method of assessment to ensure students are better prepared to sit the final exams. This has resulted in revised exam regulations for the finals exam and the panel saw several documents illustrating this.

Other changes include a move from using case-based discussions to using Modified Objective Structured Long Examination Records (MOSLER) as an assessment tool. There has also been development with the 'iDentity' system in the monitoring of students. Pastoral support is overseen by the School Progress and Support Committee, while decisions on disciplinary and Fitness to Practise / Fitness to Study processes have recently been devolved to an independent Professional Standards Review committee in order to ensure objectivity of

decision making and consistent ongoing pastoral support for students in difficulty. These processes continue to evolve.

Finally, the panel were informed of the School's Annual Monitoring and Review (AMR) and Learning & Teaching Review (LTR) processes, also overseen by the BoS. The AMR is an annual exercise to review the operation of the programme over the previous academic year and to develop an action plan for the next year. The LTR takes place for all taught programmes on a six-yearly cycle which is linked with the AMR process. The LTR is led by internal and external peers and a student representative. It is tasked with reviewing and reporting on the security of standards and the quality of learning. Both reports are considered by the BoS and an action plan drawn up if there are any areas identified for improvement.

The team considered that there is a robust and complex quality assurance framework in operation at University, Faculty and School level. This is underpinned by detailed processes and a clear committee structure to monitor the quality of the programme and implement changes. Documents provided to the panel clearly illustrated that the School manages any issues relating to the quality of the programme efficiently and that programme changes are adopted following the correct processes.

The associates also considered that there is a strong and established leadership team and management structure within the School. The senior team have clearly defined responsibilities and there is a collegiate sense of working together.

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

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 Met)***

Under this Requirement, the panel was tasked additionally with looking at how student feedback is used to inform development of the programme.

The rigorous quality assurance framework within which the School operates has been discussed in detail under Requirement 9. This illustrates the various internal processes and committees that underpin the framework which operates at School, Faculty and University level. The School consulted externally when reviewing their sign-up process to finals exams. They confirmed that they adhere to the guidelines of the QAA Quality Code for Higher Education which includes the QAA's Framework for Higher Education Qualifications.

A vital aspect of external quality assurance of the programme is the use of external examiners (EE). The team was impressed with the number of EEs being used. Various documents outlining their function, responsibilities and training such as the External Examiner Policy and External Examiner Handbook were available to the panel. There is a formal recruitment and induction process and EEs are appointed centrally for four years initially. Nominated appointees are initially recommended to the Board of Studies by the Chair of the relevant Exam Board. The University's central Learning & Teaching Development Service then oversees the appointment criteria after receiving the School's nomination. When appointed,

EEs receive a wealth of web-based resources to access plus the University's Quality and Standards Handbook with evidence seen of engagement.

EEs undertake a variety of functions. They are required to report on the quality and academic standards of the University's awards. They report on whether the School's assessment methods measure student achievement rigorously and fairly and are conducted in line with relevant policies and regulations. They consider whether the standard of the programme meets the standards specified in external guidance documents. This includes the QAA Quality Code and the GDC's learning outcomes. They are expected to highlight areas of exemplary practice and innovation. They can also make recommendations for consideration by the Board of Examiners and subsequently the BoS. Concerning examinations, the EEs are invited to comment on draft exam papers, moderate exams and observe clinical exams. The EEs submit a report after each round of the exams. The School confirmed that EEs are not directly involved in examining students, consistent with the QAA Code of Practice. Reports from EEs are provided to the BoS who consider any recommendations made by them in accordance with the quality assurance framework for programme changes. The school cited the final examination changes as an example. EEs are also invited to attend Board of Examiner meetings.

The School has various methods for collecting patient feedback. These include a 'Just One Thing' card that can be completed at clinics after each treatment episode. Feedback from these cards is recorded in students' portfolios as patient feedback. Questionnaires are discussed between the student and the clinical supervisor at the time of completion. Further patient feedback is gathered in specific circumstances. For example, at stage 4 in term 1, students are asked to gather 10 detailed patient questionnaires on their interpersonal skills. The School indicated that they have completed an educational research project to develop a questionnaire specifically for collecting patient feedback. The panel suggests that the School continue to develop this work on adopting a single method of collecting feedback and making more effective use of patient feedback, not only as a method of informing student feedback, but also as a tool to inform programme development. With the use of iDentity integral to the course, it would make sense for patient feedback to be part of this system.

The panel considered how student feedback was being recorded and used to inform programme development. It was explained to us that the SSC plays a part in the School's quality assurance framework, as discussed under Requirement 9. Student representatives attend the BoS meetings. We noted students' comments being recorded in Course Review forms and students confirmed that programme changes were made as a result of their feedback to the School. One example was when students suggested that earlier patient access during the programme would be preferable. This was taken into consideration and resulted in a new course entitled Introduction to Clinical Practice.

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)*

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.

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

Under this Requirement, the panel was tasked additionally with looking at the sign-up process for final examinations and access to a range and number of patients and whether these have any impact on how this Requirement is met.

The panel reviewed the School's Assessment Strategy which outlines how assessments and examinations should be managed. This document indicates that students are encouraged not to compartmentalise learning within the various taught courses and Stages but to adopt a holistic approach to study. The School's Guide to Assessment 2018 gives an overview of the various assessment methods used, the grading system and criteria employed. The team reviewed the Assessment Blueprint BDS 2015- 2019 spreadsheets which set out how various assessments are blueprinted against the learning outcomes of the programme curriculum and we considered this to be very comprehensive.

The School explained that they use a 4-point grading scheme and a grading matrix for all examinations throughout the programme. In formative and summative clinical assessments the grade of 3 is aligned to the standard of a safe beginner. Formerly, this was a system including descriptors such as 'unsatisfactory'. However, following dialogue with supervisors and students it was considered these were too emotive and that a move to a numerical system was more sensitive to students. The panel acknowledge the benefit in making such a change. We noted that only grade levels 1, 3 and 4 are being used in INCCA's and we questioned why 2 wasn't being used. We also noted the description of each grade and considered that these could be more explicit, particularly grade 3 (the level of a safe beginner). The panel welcomed the changes currently being made to the grade descriptors for Radiology.

The panel noted the wide range of assessment methods being used. In-course assessments include essays, case reports and projects. For example, students undertake a Dental Public Health project (based in outreach). Summative assessments include Multiple Choice Questions, Modified Essay Questions, Short Answer Questions and Objective Structured Practical Examinations (OSPE). Clinical assessments take the form of Case Discussions and a variety of clinical exercises such as INCCAs, Objective Structured Clinical Examinations (OSCE), MOSLERs and Structured Clinical Operative Tests (SCOT).

The School explained that there are 23 wide-ranging INCCAs covering core skills and procedures in all clinical disciplines contributing to the Stage 5 final examination gateway. Students must demonstrate competency at the level of a safe beginner in all INCCAs in order to be eligible to sit finals. There is no compensation between the INCCAs. The School believes students should have sufficient transferable skills if they pass these assessments and the panel agreed with this rationale and commends this competency-based approach to assessments. In addition, the majority of in-course assessments are marked by two individual examiners.

The panel were given an explanation of the School's sign-up process. All candidates must successfully complete all the requirements of the Gateway before they are eligible to sit the Stage 5 finals exam. These include both in-course knowledge and in-course clinical assessments. There is no compensation between these two components. The sign-up process

involves a formal meeting whereby various School staff attend to review all the evidence compiled against each student individually. Students' personal circumstances can be taken into account at this meeting. The meeting is attended by representatives from the School, the Degree Programme Director, Stage 5 Examination Board Chair, Director of Student Progress and the School Manager. Students explained that they were clear on the expectations of them for sign-up, having received a lecture on the Gateway process which also covered assessments, exams and the system of portfolio reviews.

At the inspection, the panel was presented with clinical data for year 5 students. The panel considered there was disparity between the expected level of clinical activity set by the School and the actual number of completed procedures achieved by students. From the data presented, it was apparent that some students had not completed the number of procedures specified by the School. For example, some skills hadn't been clearly demonstrated and students' experience in paediatric dentistry appeared to be particularly variable. This led the panel to have reservations as to whether all students were receiving a full breadth of experience. When questioned, the School explained they were aspirational clinical targets which students were encouraged to achieve in order to support and develop their skills and to compliment the use of INCCAs. The data was not in itself a sole way of determining competency and the School consider it preferable to look at the breadth and range of experience of students and the transferability of skills acquired. Following this explanation, we were reassured by the School that these aspirational targets complement the competency-based nature of the programme. We were assured that the data was not being used as a means of informing student assessment. However, given that the data is entered by students, we would encourage the School to develop a more rigorous auditing and monitoring system to ensure that any issues with non-recording or inaccuracies can be dealt with.

The panel considered that the range of procedures for Paediatric patients did not cover certain clinical procedures which were low when considering the clinical targets that were presented. The School may wish to consider expanding the INCCA to ensure that students are assessed in these areas, for example, preformed crowns, extractions, etc.

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 Met)***

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

Under this Requirement, the panel was tasked additionally with looking at access to a range and number of patients and whether this has any impact on how this Requirement is met.

There are two outreach centres to the north and west of Newcastle and two to the east. The locations represent a variety of patients and are all in high needs areas. All of the outreach locations are subject to CQC inspection which provides a good level of quality assurance. Students indicated that the outreach centres gave them good access to paediatric patients but that some cancellations of these appointments had somewhat of an adverse effect on limiting students' access to these patients. However, overall students felt they saw a good range of patients to gain the necessary clinical experience.

At the inspection, the School explained that patient recruitment can be challenging and are making efforts to address this, particularly for paediatric patients. We recognise the efforts the School are making to address this. The School explained that in order to ensure that students

have sufficient access to clinical cases, undergraduate patient waiting lists are structured to facilitate the availability of cases suitable for developing core clinical skills. The School indicated that they have processes in place to review and respond to any shortfall in waiting lists and to actively recruit patients when waiting lists become low. This included specific clinics to triage patients from the University web-based self-referral list. The panel had sight of this impressive portal where the vast majority of patients are sourced. A small number are referred from general dentists where appropriate and students are usually proactive in sourcing patients for themselves and indicated that staff are supportive in helping them gain patient access and give practical tips when patient numbers are low.

Students will treat the same patient until they qualify allowing continuity of care. The focus is on delivering oral health in a longitudinal and continuous manner without any swapping of patients where practical. The assumption is that patients will be treated for the full three clinical years by the same student. Students indicated this continuity in the management of their patient throughout this period was beneficial for their own development. The team agreed with the School that it is important for patients not to be reallocated between students and that this continuity of care to patients was good practice.

The monitoring of the range and number of clinical procedures undertaken by students is carried out at Periodic Portfolio review meetings between students and clinical teachers. These take place at four strategic times during clinical training. At these meetings, students' clinical experience is reviewed in each clinical area to check the appropriate breadth of patients and procedures. These Portfolio reviews are informed by data recorded in 'iDentity', which records productivity, quality of clinical care and any issues. Having had sight of this system, we saw how student clinical activity is constantly monitored and reviewed. Supervisors can easily review the breadth and depth of students' clinical experience. In the event that students' clinical experience was low, the School can easily put bespoke arrangements in place such as strategically booking patients. Students' progress towards the attainment of all GDC outcomes is reviewed at Stage 4 by the Stage 5 Board of Examiners. This is done taking into consideration of the learning outcomes that will be assessed in Stage 5. We had some concerns that the input of data is student led. Although more onus should be placed on students to ensure the data is accurate, the School might wish to consider a system of random audit checks to monitor this.

Although the panel identified some variability between students regarding access to patients, particularly paediatric patients, it was noted that by year 5 patient numbers between students were more balanced.

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 Met)*

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 Met)*

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)*

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)*

Under this Requirement, the panel was tasked additionally with looking at staffing levels and whether this has any impact on how this Requirement is met.

The School indicated that all internal examiners have a teaching qualification or some previous experience of examining. Examiners involved in the assessment of clinical skills require full registration with the GDC.

Chairs of Examination Boards attend specific training on this role and it is delivered by the University's central Organisational Development Unit.

The team heard that new examiners are required to shadow experienced examiners. Prior to the inspection, documentation provided by the School confirmed this, for example, in finals, new examiners usually also receive training during mock exams in January.

At the inspection, the panel heard about the use of regular lunchtime and evening training sessions in the form of various workshops which also included staff from outreach placements. Subjects covered in these sessions included skills development, difficult interactions and student support.

The School indicated that during OSCEs, all examiners are required to undertake a pre-examination briefing which includes the opportunity to seek clarification on marking schemes. It also allows role players to co-ordinate their scripts to ensure as much consistency between OSCE stations as possible. We had sight of the OSCE Examiner and role-player briefing note which confirmed this.

When new assessments and marking schemes are introduced, teams have the opportunity to mark them which allows for training and examiner alignment. The School also hosts an annual Educational Development Day in November where further training and alignment exercises are held.

Staff from outreach confirmed to us they received clinical inductions to the local community and induction with the School with whom they felt there were strong links. They indicated they also have full access to the virtual Blackboard learning environment which encourages inclusion in the team and consistent teaching on all sites.

The panel were given details of training provisions for equality, diversity and inclusion (EDI). At a general level, the University ensures compliance with the Equality Act 2010 in respect of employment procedures and student teaching, supported by central guidance. It is also referred to in the BDS and BSc Professional Conduct Guide and Agreement. Regarding training, all new staff undertake EDI training at induction and then every three years afterwards. EDI training is monitored centrally though the University's personal development review process as well as the Trust's Appraisal systems. Academic staff undertake EDI training through an on-line training portal in the University's central Learning Management System. NHS staff involved in teaching and assessment for the School undertake EDI training through their NHS electronic staff records (ESR). Prior to the inspection, the team saw PDR Forms for Clinical Academic staff, a Safety Training Matrix, Induction Checklist and Mandatory Training Checklist for Trust Grade Dentists confirming this. An EDI training record from May 2019 confirmed almost all staff had undertaken this training. Finally, we heard that EDI is frequently covered as a standing agenda item on all Student-Staff Committees.

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)*

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 Met)*

Summary of Action

Req. number	Action	Observations & response from Provider	Due date

Observations from the provider on content of report

We would like to thank the GDC inspection team for their report which recognises Newcastle University School of Dental Sciences robust management structure, and team approach to delivering the BDS programme. In addition, it is gratifying to note that the team were able to appreciate our success at not only developing our staff, but also providing excellent pastoral care and support for our student colleagues.
We are delighted that our innovative and progressive approach to assessment was recognised by the team, and that it was clear to the inspection team that students are supported in their progression to safe beginners at graduation, having gained a broad range of experience in a number of clinical settings (including outreach).

The panel suggest that the School continue to develop our work on collecting patient feedback by adopting a single method of collecting feedback and making more effective use of patient feedback. Having undertaken two robust and published educational research projects to develop targeted patient feedback on individual student and on the programme, we feel that trying to now combine these would potentially be counter-productive and lack a robust evidence base. Nonetheless we will continue to monitor patient feedback on the programme (specifically the reporting of outcomes through Board of Studies) and seek to modify process where indicated. Whilst patient feedback on individual students is currently recorded on iDentity we will explore the feasibility of increased use of technology to allow direct patient input.

The panel have encouraged the School to develop more rigorous auditing/monitoring of iDentity data input by students, and we plan to explore how this can be best achieved in order to deal with non-recording or inaccuracies in a timely fashion. The panel also suggested an expansion of the number of INCCA that are required to be undertaken. Following discussion of this suggestion the School will undertake a wholesale review of the learning outcomes assessed within the current range of INCCAs in order to ensure that assessment and transferability of clinical skills within and across different patient sub-population's remains appropriate.

Finally, we would like to thank the panel for commending the open dialogue with external partners such as Health Education England working across the North East and Cumbria. We would hope to continue to utilise that dialogue to externally validate ongoing programme developments.

Recommendations to the GDC

Education associates' recommendation	The BDS qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council.
Date of next regular monitoring exercise	Annual Monitoring review 2020/2021

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 edition1 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 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.