

**Education Quality Assurance Inspection Report**

|  |  |
| --- | --- |
| Education Provider/Awarding Body | Programme/Award |
| University of Manchester | BSc Oral Health Science |

|  |  |
| --- | --- |
| Outcome of Inspection | Recommended that the BSc Oral Health Science continues to be approved for the graduating cohort to register as a dental hygienist and a dental therapist.  14 Actions have been identified for the provider to address. |

**\*Full details of the inspection process can be found in Annex 1\***

**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 dental hygienist and dental therapist.**  **Risk based inspection focused on Requirements 2, 4, 5, 9, 10, 11, 12, 13, 14, 15, 19 and 20.** |
| **Learning Outcomes:** | **Preparing for Practice (dental hygiene; dental therapy)** |
| **Programme inspection dates:** | **14 & 15 February 2024** |
| **BSc Sign Up Meeting:** | **10 April 2024** |
| **Inspection team:** | **Kim Tolley (Chair and non-registrant member)**  **Joanne Brindley (DCP member)**  **Kathryn Fox (Dentist member)**  **Martin McElvanna (GDC Education Quality Assurance Officer)** |
| **Report Produced by:** | **Martin McElvanna (GDC Education Quality Assurance Officer)** |

This was a follow-up joint inspection of both the BDS and BSc Oral Health Science following an Urgent Inspection on 3 April 2023. The risk-based inspection focused on Requirements 2, 4, 5, 9, 10, 11, 12, 13, 14, 15, 19 and 20. This report relates to the BSc programme.

The programme inspection was conducted on site at the Division of Dentistry (‘the Division’) at the University of Manchester.

The inspection panel was comprised of GDC education associates (‘the panel’, ‘we’). The panel were grateful for the documents received in advance of the inspection and some further documents that were made available on site during the inspection.

Of the 12 Requirements being considered, four were considered to be ‘Met’. The remaining eight Requirements were considered to be ‘Partly Met’.

14 actions have been identified in total for the Division to address. 12 to be addressed by the end of quarter 4 of 2024. Action 3 should be addressed by 10 May 2024 as part of transition planning to the new GDC Safe Practitioner Framework. Action 11 should be addressed by August 2024 for the final sign-off meeting.

The panel noted the progress made against the recommendations following the Urgent Inspection in 2023 and the Division are to be commended for this. In particular, several staff vacancies had been filled and internal promotions had taken place.

The panel noted that there is good team and student interaction between the BDS and BSc programmes.

Overall, the panel had no major concerns about the BSc programme and agree that it should continue to be ‘approved’ for graduates to register with the GDC as a dental therapist and a dental hygienist.

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

**Background and overview of BSc Oral Health Sciences programme**

|  |  |
| --- | --- |
| Annual intake | X students |
| Programme duration | X weeks over x months/years |
| Format of programme | e.g:  Year  1: basic knowledge, clinic attendance, shadowing  2: knowledge and simulated clinical experience  3: direct patient treatment  4-5: direct patient treatment, clinic attendance, outreach, placements |
| Number of providers delivering the programme | (1) |

**Outcome of relevant Requirements[[1]](#footnote-1)**

|  |  |
| --- | --- |
| **Standard One** | |
| 2 | Met |
| 4 | Partly Met |
| 5 | Partly Met |
| **Standard Two** | |
| 9 | Partly Met |
| 10 | Partly Met |
| 11 | Met |
| 12 | Partly Met |
| **Standard Three** | |
| 13 | Partly Met |
| 14 | Partly Met |
| 15 | Met |
| 19 | Partly Met |
| 20 | Met |

|  |
| --- |
| **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 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)***  At the inspection, we learnt about the success of the BUPA pilot with the commissioning of two new outreach centres.  Ahead of the inspection, we had been provided with evidence of the patient consent form used at Manchester Dental Hospital on the Consultant and triage clinics, which the patient physically signs. We have also been given details of the electronic consent forms used for patient treatment.  We heard about the implementation of a new database (HIVE) which contains electronic patient consent forms that were previously paper based.  If a patient declined to be treated by a student at BUPA, they would be directed to general practice instead.  Students wear badges and identifiable uniforms at the Manchester Dental Hospital.  We considered this Requirement was 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 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student’s stage of development. *(Requirement Partly Met)***  The panel received a staff-student supervision policy dated 7 February 2024. However we noted it didn’t contain reference to supervision for paediatric patients and outreach clinics.  During the inspection we were assured that in the absence of allocated supervisors or a risk of low staff: student ratio, other tutors would be sourced and failing that, a clinic would be cancelled. The ongoing recruitment of new tutors should help especially as they can work between zones at the Dental Hospital.  At the inspection, we also heard from clinical tutors at the BUPA practices, who explained the student supervision arrangements. There was a commitment by BUPA to recruit supervisors to undertake this role.  The panel considered the Division should continue to work on the development and implementation of the new staff to student supervision policy, covering all areas of clinical work and the various outreach centres.  This Requirement is considered to be Partly Met.  **Requirement 5: Supervisors must be appropriately qualified and trained. This should include training in equality and diversity legislation relevant for the role. Clinical supervisors must have appropriate general or specialist registration with a UK regulatory body. *(Requirement Partly Met)***  At the inspection we heard that all Trust staff must undergo annual Mandatory Training which includes equality, diversity and inclusion. This is reviewed during the annual performance and development review process.  All supervisors must have registration with the GDC and this is checked during the appointment process and evidence of registration must be provided at the beginning of each year.  By way of induction, all new University staff must complete several mandatory training courses including health and safety, data protection, cyber security, diversity in the workplace, unconscious bias and disability equity.  The panel noted that monitoring of staff training appeared to be reliant on the centres and on assurance from the NHS and CQC reports for staff compliance, and that the Division didn’t appear to have a central staff monitoring system.  The panel consider that the Division should consider a central tracking and monitoring system to monitor staff training including EDI training and GDC registration.  This Requirement is considered to be Partly 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 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 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.** |
| **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 Partly Met)**  The Division has an Assessment and Examination Group (AEG) which is chaired by the Programme's Assessment Lead, a newly formed Curriculum Development Committee (CDC) and a Staff Student Liaison Committee (SSLC).  The provider explained that the UG Programme Committee (UPC) and Dental Leadership Team (DLT) meet monthly to discuss issues or proposed changes relating to the curriculum.  Prior to the inspection, the panel had sight of minutes from the SSLC, AEG and SSLC.  At the inspection, we met theCurriculum Review and Development Lead who explained the mapping work that had been recently undertaken to ensure coverage and assessment of the current GDC learning outcomes. We noted there is a second phase of this work which will be completed over the next few months. It was also noted that the GDC has published a new Safe Practitioner framework and that work will be required to transfer mapping to this document.  The Division should provide an update to the ongoing curriculum mapping work to the GDC learning outcomes and preparation to move to the new Safe Practitioner Framework.  This Requirement is considered to be Partly Met.  **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 Partly Met)***  The Division explained that any reports and concerns which relate to the programme are dealt with as a matter of urgency via the UPC, AEG, or DLT. The Division also has strong lines of communication with the School of Medical Sciences Board, the Faculty of Biology, Medicine and Health’s Teaching and Learning Committees and the University’s Teaching and Learning Strategy Group.  The Division explained that it has a Risk Register for both programmes which is reviewed at the UPC. This is supported by an internal quality assessment process that was piloted in 2023 and is being rolled out in 2024. The panel noted that the Risk Register appeared to have only two items on it: patients complaints and low staff morale. We learnt that there is a separate Trust Risk Register which includes risks to clinical governance and patient safety.  The panel recognise that the Division are awaiting clear guidance on developing a Risk Register within the Division. We recommend that work continue on the development of a more comprehensive risk register.  The panel was aware that student representatives had reported problems with administrative support in the SSLC minutes. These issues are being addressed at the SSLC and escalated to Division staff, but improvements had been noted. Quite a few of the problems were related to the roll-out of the new HIVE system and patient allocation.  The panel was aware that there had been issues regarding timetables. We learnt that this been caused due to a transfer between teams and there were some difficulties with the handover which led to timetabling clashes. Some staff were new to dentistry and have had to learn the basics for clinic scheduling requirements and the variability between clinics. New staff have also been recruited. As a result, timetabling has much improved.  The panel learnt about the high numbers of patient complaints in 2023. This related to student treatment, excessive patient expectations of treatment and a significant number of lost appointments. We were assured that this was largely because of a challenging transfer to the HIVE system and issues with patient lists. These issues have now been rectified with extensive student training and there had been no patient complaints in the month of January 2024. The Division has indicated that a service evaluation is being conducted and we would like to see this in due course.  The Division explained that the Programme Team completes an annual Student Experience Action Plan (SEAP) following continuous monitoring, reflection on the previous academic year and planning for the forthcoming academic year. It takes into account student feedback. The SEAP is faculty-driven and the Division indicated that it needs to complete one specifically for dentistry. The panel recommends that this is completed as suggested.  At the inspection, the panel noted the positive staff developments with vacancies being filled and several staff members taking on new and existing leadership positions. This has made programme support more stable and has alleviated the workload on the senior programme team. The panel recommends that the Division should continue to work on staff recruitment, development and succession planning.  This Requirement is considered to be Partly 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)***  The Division explained that the University uses an annual meeting of the Teaching and Learning Strategy Group (TLSG) to review teaching and learning. This Group oversees development of policies, procedures and structures for teaching and learning.  The Division explained that the programmes have both a programme External Examiner (EE) and a number of subject EEs. They provide an annual report which is considered by the Programme Assessment Lead and a formal response given.  The Division explained thatthe University is currently reviewing and developing its processes for periodic review. Whilst this is under review and development, the University has adopted a risk-based approach and will undertake a review on request by a programme area. It is expected that that a new process will be approved and implemented for the start of the next academic year (2024/25).  There is further discussion regarding EEs at Requirement 20.    The panel heard examples of when student feedback led to changes in assessments and systems. We also heard about patient feedback. Patient complaints were largely due to administrative issues, but otherwise feedback on students was good.  This Requirement is considered to be Met.  **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 Partly Met)***  The Division confirmed the appointment of a new Lead for Outreach. It has developed a standard proforma for outreach audits. Although the panel had sight of a template outreach evaluation form, we didn’t see a completed one. The Division should provide examples of completed evaluation forms following the expansion of placement provision.  There is also a standard memorandum of understanding for all future placements, which includes roles and responsibilities for both the University and the placement partner. Placement providers are given a contextualised handbook which includes their roles and responsibilities, and the expectations of Manchester and their students.  At the inspection we learnt that the BUPA pilot has proven to be highly successful, with an initial two centres being used. They are currently in the recruitment phase for additional clinical supervisors. BUPA is actively engaging with Manchester. The expansion involves onboarding five practices in phased intervals during 2024, each of which will be equipped with two dental chairs.  The Division meets BUPA regularly and the panel noted they have a good relationship.  The panel had concerns that the new Lead for Outreach is employed on 0.1 fte basis, particularly given the broad coverage of the role, ongoing developments and prospective expansion to placements. We recommend the Division consider expanding the employment basis for the Outreach Lead.  We noted an apparent lack of formal training to outreach supervisors or induction. In addition we note that the staff away day agenda didn’t have any content regarding calibration and training. The panel recommend that the Division consider the standardisation of induction and training for placement supervisors.  This Requirement is considered to be Partly 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 Partly Met)***  Prior to the inspection we had received the handbook of Milestones and Gateways which outlines the information gathered for clinical progression, including gateways, procedural targets and written and observed milestones.  Students also have a range of clinical milestones to complete which assess their competency in different procedures. Procedures usually completed in one appointment are completed as observed milestones, where their tutor grades the encounter on a range of criteria.  Milestone data is currently recorded on paper, handed into the office, and then uploaded. There are plans to do this electronically.  The panel were grateful to observe the first sign-up meeting on 14 February 2024. We noted the discussion across a range of criteria, such as absences, professionalism rating cards, milestones and gateway data, and direct and indirect clinical procedures. We also observed the range of outcomes being issued. Some outcomes were issued with conditions for students to undertake further specific clinical activities.  We understand that there are further sign-up meetings and we wish to observe the final sign-off meeting in August 2024.  At the inspection, we were taken through a helpful demonstration of student monitoring and recording systems.  However, the panel had some concerns about the robustness of clinical data capture. It was also evident that the visibility of overall student progress, with respect to longitudinal clinical assessment of students, was not possible.  The panel noted that although single and multi-surface restorations were captured on the master spreadsheet, this was not discussed or viewed when the data was presented at the Sign-up panel. Only overall totals were reviewed. The panel considered that without knowing how many complex procedures have been undertaken and at what grade (bearing in mind that the SP (procedural intervention) grade was deemed to be acceptable as a threshold for passing a milestone), the Sign-up panel does not have full insight into each student’s clinical experience. The Division should ensure that an appropriate breadth of treatment has been met at an appropriate skill level.  The range of clinical activities undertaken within Paediatrics was also not visible. However, the panel did note that the Division are looking at new software and would encourage this development.  The panel also had concerns over the robustness of the use of thresholds during assessments, required for clinical progression. For example, we noted there was no differentiation between the threshold levels, that student were expected to achieve, for both basic or more complex procedures. As an example relating to dentistry milestones, a student can pass a programme based on a series of novice level grades, but according to the rubric this indicates that they would still require additional training. Essentially this means that students can graduate by completing all their milestones, both basic (e.g. direct restorations) and complex (e.g. molar endodontics) at “Sp” level, and even though deemed “satisfactory”, procedural tutor assistance is still required.  Additionally, we considered that there was the potential for students to be strategic in choosing simpler procedures in order to meet their clinical targets.  The Division should consider more explicit presentation of clinical data as described above and consider capturing the students’ longitudinal development and the complexity of their clinical experience.  The Division should address the apparent lack of differentiation in the threshold levels between basic and complex procedures.  This Requirement is considered to be Partly Met.  **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)***  As detailed at Requirement 13, the panel were grateful for a student progression demonstration meeting which illustrated the current systems in place for monitoring student data and progression.  The Division should continue to work on student monitoring systems which are in development.  This Requirement is considered to be Partly 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)***  Prior to the inspection, we had been provided with the Handbook to gateways and milestones and the School Programme Handbook, both of which have been significantly updated.   As discussed earlier, there had been an issue with shortage of patients due to the implementation a new database (HIVE) which has now been resolved.  BSc students go to other placements than the BDS students including a new practice in Oldham (replacing Bateman and Best in Liverpool), the ICE implant centre and Trafford Hospital.  At the inspection, students indicated that they see a good range of patients, particularly from some deprived areas and are able to acquire broad experience as required but would be grateful for greater patient numbers.  We learnt that some patients have been accessed through a government initiative focused on returning people back to work. This is a commendable initiative.  As discussed earlier, the BUPA pilot has been a success and is being rolled out across additional placements during 2024.  This Requirement is considered to be Met.  **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 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 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice.**  **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 Partly Met)***  The panel learnt that all staff undertaking clinical assessments for the Division are GDC-registered. Staff undertaking non-clinical assessments of undergraduate students are experienced members of the research and teaching team.  The Division explained some of the processes in place for calibration of assessments.  The panel noted that some EEs had remaining concerns about standardisation and calibration of examiners. There was a recommendation that consideration should be given to the calibration of the assessment team given that they come from differing roles. The Division has agreed to consider this. We noted that the Division has already made some progress in this with the production of online calibration training videos. The panel recommend that they develop this further by considering in-person calibration of both examiners and actors used in OSCEs.  This Requirement is considered to be Partly Met.  **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).***  The Division explained that the University’s Taught Programme Enhancement team in the central Teaching and Learning Delivery office (TLD) oversees the processes for nominating, appointing, and circulating EE reports. The programme team considers and acts on any EE comments formally responds to them.  The panel had sight of a good range of EE reports. The reports were generally positive and we saw evidence of improvements as a result of these in the assessment systems and professional services team.  We consider that the EEs should have full access to the papers prior to the exam and that an EE should be present at sign-up and sign-off meetings. At the sign up meeting we observed the EE was unable to attend and a recording of the meeting was being sent to them to review.  This Requirement is considered to be 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.** |

**Summary of Action**

|  |  |  |  |
| --- | --- | --- | --- |
| **Require-ment number** | **Action** | **Observations & response from Provider** | **Due date** |
| 4 | 1. The Division should continue to work on the development and implementation of the new staff to student supervision policy, covering all areas of clinical work and the various outreach centres. |  | End of Quarter 4 of 2024 |
| 5 | 2. The Division should consider a system to monitor mandatory staff training, including EDI and GDC registration. |  | End of Quarter 4 of 2024 |
| 9 | 3. The Division should provide an update to the ongoing curriculum mapping work to the GDC learning outcomes and preparation to move to the new Safe Practitioner Framework. |  | 10 May 2024 |
| 10 | 4. The Division should continue the development of a more comprehensive risk register.  5.The Division should forward the service evaluation report when available.  6. The Division should ensure that a Student Experience Action Plan is actioned for the Dentistry Division.  7. The Division should continue to work on staff recruitment, development and succession planning. |  | End of Quarter 4 of 2024  End of Quarter 4 of 2024  End of Quarter 4 of 2024  End of Quarter 4 of 2024 |
| 12 | 8. The Division should provide completed audit forms from January 2024 and those from the expansion of placement provision.  9. The Division should consider expanding the employment basis of the new Lead for Outreach position.  10. The panel recommend that the Division consider the standardisation of induction and training for placement supervisors. |  | End of Quarter 4 of 2024  End of Quarter 4 of 2024  End of Quarter 4 of 2024 |
| 13 | 11. The panel wish to observe the final sign-off meeting in August. The milestone master data spreadsheet and clinical totals spreadsheets for both programmes should be made available to the panel the day before.  The panel would also like to see a sample of a range of milestones for each cohort, which should also include coverage of communication skills and professionalism.  12. The Division should consider more explicit presentation of clinical data and give consideration to capturing the complexity of clinical experience.  13. The Division should address the apparent lack of differentiation in the threshold levels between basic and complex procedures. |  | Final Sign-off meeting in August (to be confirmed)  End of Quarter 4 of 2024  End of Quarter 4 of 2024 |
| 14 | 14. The Division should continue to work on student monitoring systems which are in development. |  | End of Quarter 4 of 2024 |
| 19 | 15. The panel recommend that the Division continue to embed the standardisation and calibration of examiners by considering in-person calibration of both examiners and actors used in OSCEs. |  | End of Quarter 4 of 2024 |

**Observations from the provider on content of report**

|  |
| --- |
|  |

**Recommendations to the GDC**

|  |  |
| --- | --- |
| **Education associates’ recommendation** | The BSc Oral Health Sciences continues to be approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council. |
| **Date of next regular monitoring exercise** | Progress Monitoring: due dates as indicated against the Actions above. |

**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 education associates 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 education associates must 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 monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The Education Quality Assurance 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.

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. [↑](#footnote-ref-1)