General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Central Lancashire	Diploma in Orthodontic Therapy (Apprenticeship)

Outcome of Inspection	Recommended that the Diploma in Orthodontic Therapy is approved for the graduating cohort to register as Orthodontic Therapists.

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 an Orthodontic Therapist.**
Learning Outcomes:	**Preparing for Practice Orthodontic Therapy**
Programme inspection dates:	**23/24 April 2024**
Examination inspection dates:	**Final Assessments: 8/9 October 2024** **Assessment Board Meeting: 4 November 2024**
Inspection team:	**Helen Poole (Chair and non-registrant member)** **Elizabeth Ikuesan (DCP member)** **David Young (Dentist member)** **Scott Wollaston GDC Staff member (Quality Assurance Manager)**
Report Produced by:	**Scott Wollaston GDC Staff member (Quality Assurance Manager)**

The University of Central Lancashire (UCLan) ('the university') delivers the Diploma in Orthodontic Therapy (Orthodontic Therapist Apprenticeship) within its School of Medicine and Dentistry ('the school'). For several years the school has delivered an Orthodontic Therapy Diploma which was awarded by the Royal College of Surgeons of Edinburgh, then in 2022 the university made a submission for this self-awarded apprenticeship model. As this is a new programme, the course has received a full inspection of all 21 requirements within the Standards for Education.

The school has longstanding experience of delivering the Orthodontic Therapy course and this has transitioned well into the self-awarded apprenticeship. The school submitted comprehensive documentation and provided a thorough narrative as part of the pre-inspection process and have met all 21 requirements.

The GDC thanks the staff, learners, and external stakeholders involved with the Diploma in Orthodontic Therapy for their co-operation and assistance with the inspection.

Background and overview of qualification

Annual intake	30
Programme duration	13 months plus 1 month for EPA
Format of programme	Lectures, Phantom head Practical, one to one Teams teaching, small group seminars, Clinical placements in primary or secondary care Orthodontics, with specialist Orthodontist, clinical presentations
Number of providers delivering the programme	1

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	Partly Met
17	Met
18	Met
19	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 Met)***

In order to sign up to the course, learners have to be a GDC registrant. Given the diverse backgrounds and experience of the learners, the School of Medicine and Dentistry ('the school') dedicates the first four weeks of the course to aligning the cohort.

Throughout this period, learners are thoroughly equipped for the practical aspects of patient care through a combination of lectures and hands-on training within the university and the simulated clinical environments. Learners receive continuous guidance and feedback from tutors as their skills progress.

At the end of the first four week-long learning block, learners undertake a pre-clinical summative assessment. If a learner does not pass, they receive constructive feedback and

[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.

have the opportunity for a retake. In accordance with university regulations, learners have two attempts. Under specific circumstances, the board may permit learners to re-sit either individual assessments or the entire module. This pre-clinical phase ensures learners' readiness to transition to treating real patients.

The Specialist Orthodontic Clinical Mentors ('mentors') participate in a compulsory training session. During this, they receive comprehensive information regarding the course requirements, procedures for assessing clinical readiness, and for documenting and evaluating learner advancement. Additionally, mentors are obliged to engage in the 12 weekly progress review meetings, known as tripartite meetings, alongside the learners and their tutor.

Any learner failing to meet the stipulated requirements will be provided with supplementary support or remedial sessions facilitated by the school.

The panel consider this requirement to be 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)***

The school stated during the inspection that in all the learners' clinical settings, notices are displayed regarding the potential involvement of learners in treatment procedures. Mentors are requested to inform patients verbally and obtain written consent prior to any treatment starting. Patients can refuse treatment by learners if they wish to. Learners are also identifiable by their name badge.

The panel consider this requirement to be 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)***

The learners' workplaces maintain registration with the Care Quality Commission (CQC) and adhere to standards governing patient care. Mentors and staff all undertake Equality, Diversity, and Inclusion (EDI) training. The school also conducts audits of each practice where a learner will be working, to ensure they comply with relevant health and safety legislation and university policies. The school provided the panel with copies of their audit of placements template, as well as their audit policy and process. They undertake audits annually, whether the practice has had learners with the school previously or not.

The panel spoke with some of the clinical mentors, who ratified that audits take place via video call. From the evidence provided by the school and the details above, the panel consider this requirement to be 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)***

The school has a Clinical Supervision of Students Policy in place, of which the panel were provided a copy, to ensure learners receive appropriate supervision commensurate with the activity and their developmental stage. The school have a maximum supervision ratio of 1:2.

The school also provided the panel with a copy of a detailed mentor handbook, which is sent to all mentors and outlines their responsibilities. The 12-weekly tripartite meetings are mandatory for mentors and learners to attend. When speaking with the mentors during the inspection, they commented on the benefit of these meetings. Furthermore, mentors are referred to the guidelines by the British Orthodontic Society (BOS) on the supervision of orthodontic therapists.

Learner progress is monitored through the tripartite reviews. Each learner has an Individual Learning Plan (ILP), and this is followed up in the tripartite meetings. If there were any issues from any party, these could also be raised during these meetings.

The school told the panel during the inspection that learners could raise any issues with their mentor at any point throughout the course. This has not happened to date, and is deemed unlikely, as the mentor is the learners' employer who put them forward for the course. If any issues were to occur however, the school assured the panel that they would work with the learner and help them to move to a different practice, pending an audit and approval.

Considering the evidence provided by the school and the details above the panel consider this requirement to be 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 Met)***

All mentors are reviewed during the application process to ensure they are registered as specialist orthodontists with the GDC, and this is checked every year, irrespective if the mentor has worked with the school before. During the induction week, all mentors attend the mandatory clinical mentor training day. This training is tailored to the specific requirements of learner supervision.

All mentors are required to undertake EDI training as part of their regulatory requirements. Confirmation that the staff in practices have undertaken this training, along with their CPD requirements, is requested in the initial audit of the practices.

The panel consider this requirement to be 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)***

During the inspection, the school provided the panel with their Policy for Raising Concerns. This document ensures all are aware of how to raise concerns and what issues they should raise. The panel met with the learners during the inspection, and they all confirmed they have read the policy. The document also references the GDC Standards for the Dental Team and assures that no one will be penalised for raising a concern.

The school also state that the practices the learners work in all have clear policies for raising concerns. The panel have not seen any evidence of this, and the practice audit template

does not ask for confirmation that they have a raising concerns policy. The panel would suggest this is added to the audit template.

The school state that all teaching staff and mentors have undertaken training on how to deal with patient safety issues. Copies of the training material are made available on Blackboard, the school's virtual learning environment, which the mentors have access to.

The university's Safety, Health & Environment (SHE) team centrally record all clinical incidents reported to the school. Serious concerns are raised to the Rapid Response Dentistry (RRD), a team who meet weekly, to take any necessary action, such as raising with the head of school or reporting to the GDC. Speaking with the mentors during the inspection, they were all aware of this process and how to raise any concerns.

The school also have a Structured Event Reporting Forms (SERF) process in place for professionalism issues. The panel were provided with a copy of this policy. Anonymised SERFs feature as a recurring agenda item in the school's Quality Assurance and Evaluation Sub-Committee meetings, facilitating trend analysis and targeted interventions.

In cases of significant events, such as clinical incidents or breaches of professionalism, the Fitness to Practise (FtP) process is invoked. The university's casework team manages this process to uphold standards of professional conduct and safeguard the integrity of clinical practice.

The panel consider this requirement to be 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)***

The school told the panel that all the specialist orthodontic practices the learners work at are registered with the Care Quality Commission (CQC) and adhere to all requirements concerning patient care.

As noted previously, the school have a Clinical Placement Audit Policy is in place. Any identified concerns or potential gaps are addressed at that point.

All clinical incidents are documented following the guidelines stipulated in the school's Clinical Incidents Policy. These incidents are then reported to the school via the Safety, Health & Environment (SHE) team within the university. Practices also report any incidents locally, following their own protocols. In cases where a serious concern is raised, immediate action is taken, and the university's Rapid Response Dentistry (RRD) is notified to implement any immediate actions.

From speaking with the clinical mentors, the panel were told that the school undertake a thorough audit prior to the course commencing. They stated they all had to submit written evidence and copies of any statutory documents and policies. For any professionalism issues, the mentors would follow the SERF process mentioned previously, and if deemed necessary, the school would apply the Fitness to Practise (FtP) process. All mentors were aware of the various processes to follow and commented that they had close contact with the school staff.

The panel consider this requirement to be 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)***

The school has an FtP policy, which is aligned to the GDC for Student FtP guidance. During the induction process, learners are made aware of the process, and there is a direct link to the policy within the Apprenticeship Handbook. FtP and the GDC Standards for the Dental Team are also covered with the learners in their Professionalism and Clinical Practice in Orthodontic Therapy module.
All staff members involved in program delivery possess a thorough understanding of the UCLan Regulations for the Conduct of Students, UCLan FtP Policy, GDC standards for the Dental Team, and GDC Student FtP guidance. The clinical mentors are also taken through the policy during their mentor training day.

UCLan also has a Support to Study policy in place. Staff members initiate this, where they consider that appropriate guidance and support for learners to enhance their overall well-being and academic success is required.

Considering the evidence provided and the details above, the panel consider this requirement to be 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)***

All activities within the school are governed by the university's regulations as outlined in their Academic Quality Assurance Manual.

The school has established a Quality Assurance Framework (QAF) that outlines the current management structure. As the Diploma in Orthodontic Therapy is part of the apprenticeship standard, the Academic Quality Unit (AQU) at UCLan also provides additional oversight to ensure compliance.

The Learning and Teaching Sub-Committee is responsible for programme quality and curriculum content, ensuring alignment with GDC learning outcomes and apprenticeship knowledge, skills and behaviours (KSBs). The programme lead is responsible for ensuring the curriculum continues to address all GDC learning outcomes in light of any changes and maintaining alignment with the apprenticeship standard to enable learners to meet the full range of KSBs.

The External Examiner (EE) is also involved with the course content and assessments, ensuring the programme maintains quality standards consistent with GDC learning outcomes and KSBs. The university also expects that any apprenticeships have an External Assessor (EA) to work alongside the EE, focusing on the end point assessment (EPA).

The panel consider this requirement to be 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 Met)***

Issues identified through the operation of the QAF are reported to the Quality Assurance and Evaluation Sub-Committee. Additionally, concerns can be raised through SERF. The Head of Dentistry is responsible for reporting any serious threats to learners achieving their learning outcomes to the GDC. These risks are also recorded on the Risk Register. The school told the panel during the inspection that medicine, dentistry and optometry course staff review active risks together.

Operational issues are expected to be resolved by the course team. School-level actions are addressed by the RRD or the school executive team, while broader actions are referred to the wider university.

EE reports are submitted to the AQU at UCLan for review and then forwarded to the school. The programme lead is responsible for addressing any essential actions identified.

As highlighted previously within this report, the school have a robust mechanism for auditing the learners' workplaces before they can commence the course. The tripartite meetings are also an avenue for any concerns to be identified.

The panel consider this requirement to be 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)***

As noted previously, the school use both an EE and an EA. Both are registered orthodontists on the GDC specialist register. Both are also involved with the Royal College of Surgeons of Edinburgh (RCSEd) orthodontic therapy assessments, and so are familiar with the GDC learning outcomes and their context for orthodontic therapists. They undertake induction training with the university before commencing duties. The EE attends programme and module boards throughout the year. The EA attends the assessment board during the EPA period.

Summative assessments are internally verified by teaching staff before being externally verified by the EE.

Patient feedback is collected by learners within their workplaces. Results are collated annually and submitted to the clinical education co-ordinator, who then feeds this into the relevant sub-committee to inform programme development, where necessary.

The panel consider this requirement 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 Met)***

As noted within this report so far, the school have a process in place to audit all workplaces before a learner commences the course. The mentors confirmed this when the panel met with a selection of them during the inspection. The panel have seen a copy of the audit template and consider it covers all necessary areas to ensure that patient care and learner assessment meets these standards.

Patient feedback is collated and submitted annually, as outlined above. Learners have regular contact with school staff and can feedback regarding their workplaces either informally, or formally within their tripartite meetings. The school also collect learner feedback via review meetings, which are scheduled three times a year. A representative attends these meetings on behalf of the whole cohort. There is also an end of module questionnaire which is sent to learners to complete.

The panel consider this requirement to be 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)***

The school have provided the panel with evidence of the programme being mapped to the GDC learning outcomes, as well as the apprenticeship standard KSBs.

Before a learner is permitted to sit the final summative assessment, the school staff conduct a 'sign-up to finals' meeting, where each learner is reviewed to consider whether they have met all clinical requirements.

The panel observed the summative assessments on 8 and 9 October 2024. The learners conducted Vivas and case presentations over the two days. The panel considered that the Vivas appropriately covered a range of topics to assess the learners' knowledge. The assessments are internally verified and standard set before being sent to the EE for their review and comments.

The panel consider this requirement to be 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 Met)***

The learners' clinical performance is monitored longitudinally via Leopard and learners are required to complete and submit a clinical portfolio to demonstrate they have met the clinical requirements. The outcomes assessed by clinical procedures are mapped to the learning outcomes.

The learners' individual learning plan recorded on OneFile is also reviewed alongside Leopard at the tripartite meetings, to ensure they are on track to complete all learning outcomes. Leopard uses a traffic light system, so tutors can see any areas that learners need to work on. Tutors are also able to create actions that feed into the learner's dashboard, and dates for the actions to be completed can be set. This enables early intervention by the school, to ensure that the learners are on track.

The panel consider this requirement to be 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)***

The school told the panel that as some of the learners are in primary care practices, and others are in secondary care, there can be a difference in the exposure to treatment types that the learners get. The learners confirmed this when we spoke with them during the inspection. The school said that they will facilitate swapping the learners to sister practices if it is beneficial for their experience.

With the constant monitoring of the systems, and the traffic light system within Leopard, the school are easily able to identify and intervene appropriately where there are considerable experience gaps. As headgear is not a frequent practice now, but learners still need to learn the skill in case they do encounter it once qualified, the school run a phantom head clinic on this.

The panel consider this requirement 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 Partly Met)***

As the programme is an apprenticeship, it operates with an integrated end point assessment (EPA). There are also formative and summative assessments throughout the course, and before entering the EPA period, learners' progress is reviewed, and they are signed off as being able progress to the end point assessment stage. This includes maths and English, as a mandatory requirement. They also meet with the clinical mentors to ensure they are happy for their learner to enter the EPA period. Clinical mentors also undertake Direct Observation of Procedural Skills (DOPS) assessment on their own learners in practice, throughout the course. The mentors told the panel that they were advised on how to assess and grade learners during their induction and were calibrated well by the school. Mentors have 10 competencies on which they have to assess the learners and log their scores on Leopard and discuss this with the school during the tripartite meetings.

The panel observed the Vivas and case presentations on 8 and 9 October 2024. There were four examiners, who had split into two pairs of examiners, in separate rooms. The school told the panel that the learners would be seeing both pairs of examiners, apart from one learner who had a conflict with one examiner. On the second day, the panel noted that several learners were seen by the same examiners as the first day. From speaking with the learners at the assessments, some noted that they did see different examiners whilst others said they saw the same. The provider must ensure that candidates are exposed to as many of the examiners where possible, to ensure equity and fairness in the learner experience.

On the first morning, the examiners met with the EE to review the planned cases for the Vivas. There were eight cases to be presented to the learners in their 15-minute slot, with learners to get through as many of these as they can during their slot. The EE questioned whether there was an expected minimum number of cases for the learners to complete, and the programme lead stated they expected at least four cases to be answered by all learners. The panel considered this was not best practice, as some learners were graded against answering four cases, while others had covered more. The panel would suggest that the provider sets a more reasonable number of cases for the Viva assessments, to ensure all candidate answer the same number of questions. This would allow the more advanced learners to go back and answer some cases in more depth to obtain a higher mark.

During the assessments, once the 15-minute time slot was up for the Vivas, there was a knock on the door to indicate this. For the case presentations on the second day, learners had two of their cases to present to the examiners, which were timed at 15 minutes each. There was a knock on the door to mark the 15-minute point and for learners to move on to their second case. The panel did note some inconsistencies in this aspect, with some learners spending either extra time over the 15-minute mark for their Vivas, or for their first case presentation, meaning they had less time to present their second case. In one instance, the panel noted one learner being allowed to present their first case for nearly 20

minutes, meaning they had less time for their second case. The provider must ensure a fair distribution of the time allotted to all candidates. The panel would suggest that the examiners may find it beneficial to make use of visible timers within the assessments. This way, both learners and examiners will have a better idea of time remaining.

The panel also identified a lack of consistency between examiners and the questions they asked the learners during the assessments. The Vivas had a set template of questions and success criteria for each case; the panel found that the examiners did not ask these questions consistently to each learner. The provider must ensure that questions posed for the assessments are used for all candidates, to ensure a fair experience. For the case presentations, this needed to be more subjective and focused on each individual case brought by the learners. There was still a guidance document provided to examiners, to outline the expected areas the learner should cover; this allowed the examiners to tailor questions to each learner.

Within some of the assessments, the panel also observed some of the examiners responding positively to the learners' answers, acknowledging their answers as correct, and in some instances even expanding on their answer further. There were differences noticed between both sets of examiners over both days, with some providing more prompts than others. In some instances, examiners commented on the treatment plan, which is set by the learner's clinical mentor and outside of their remit. The panel would suggest that examiners adopt more neutral responses to candidates within assessments.

For the Vivas, the answer sheets provided comprehensive answers for some questions, however for some cases the expected answers section noted that the learner is expected to talk about a certain treatment type, or list pros and cons, without providing specific criteria of what is expected. This ambiguity allows for subjectivity from examiners when there is not specific success criteria noted. The provider must ensure that answer sheets for examiners clearly outline the success criteria for all questions, to ensure a fair marking process.

The school utilised marking criteria and assessment rubrics for both the Vivas and case presentations. Once each learner had sat an assessment, both examiners would independently score the learner from one to four. One and two are a fail; three is a pass or merit, and a four is a distinction. The examiners would also give a percentage score out of 100 for each learner's assessment. It was not clear to the panel how this percentage score was calculated based on the learner's answers, as the success criteria listed in the answer sheets was not scored or weighted. Each learner had two percentage scores from the Viva and case presentations, this was then averaged for their final score. The percentage score was then translated to the assessment rubric which had five sections from outright fail to excellent: each section relating to various percentage scores. The percentage scores listed were binary and did not include a range of percents. For example, a 'fail' was 48%. A 'clear pass' was 52%, 55% and 58%. It is unclear what would happen if a learner scored between 48% and 52%. Each section has a narrative against it, which outlines which learners should fall into these categories, however it was not specific to the assessments the learners had just undertaken. The provider must ensure that the assessment rubrics are more detailed and specific to the assessments.

Overall, the panel considered that the learners were demonstrating the knowledge and skills expected and that they would qualify as safe beginners. The panel consider this requirement to be partly 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)***

The school collect feedback from the clinical mentors and patients. This feedback is then collated annually and fed into the QA data bank, which is managed by a clinical education co-ordinator. Any urgent action needed based on the feedback is reviewed by the programme lead and directed to the RRD team. If urgent action is not required, this is passed to the relevant sub-committee.

Multi-source feedback is collected from other members of the dental team within the clinical environment and fed back to the learners verbally.

All feedback contributes to the learners' longitudinal learning as it is recorded on Leopard and OneFile and used to evaluate their progress and any development areas to target. The panel consider this requirement to be 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)***

Reflection forms a big part of the programme. Each time a learner completes a DOP within practice, they are required to record their reflections on the record within Leopard. This is then reviewed at the tripartite meetings and discussed with the learner and their clinical mentor. The school also deliver a reflective practice lecture within their professionalism and clinical practice module.

The clinical mentors also provide feedback to their learners, and when speaking to the panel they confirmed that the school delivered a session during their induction on how to give feedback constructively. The clinical mentors also told the panel that the learners undertake a longer reflective practice, reviewing where they started and how they have developed since beginning the course.

When speaking with the learners during the inspection, they told the panel that the university have valuable resources to support them with many aspects, including reflection. They stated that the learner hub, Starfish, enables them to request meetings with their tutors, as well as providing sessions on reflective writing. Learners commented on how much reflection they do, but all indicated that it was beneficial and makes sense to them. Learners had previously asked the school to provide a further session on reflective practice, which was arranged and delivered.

The panel consider this requirement to be 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)***

The school told the panel that they have a list of essential and desirable qualifications and training when reviewing clinical mentors. During the practice audits before a learner commences the course, the school checks that the mentor is registered with the GDC as a specialist orthodontist, as well as checking they have undertaken training on assessing and calibrating and equality and diversity.

Clinical mentors assess learners during their DOPS, scoring them between one and five. From speaking with the mentors at the inspection, it was clear that all mentors understood

how to utilise this grading system and when a learner was considered competent. They also were aware of how to support a struggling learner and what pathway they needed to refer to.

All examiners at the final exams were GDC registered specialist orthodontists or orthodontic therapists. All staff within the school must undergo equality and diversity training as part of their induction and ongoing mandatory training. The school also told the panel that all internal examiners and assessors are required to have or be working towards fellowship (Descriptor 2) to the UK Professional Standards Framework. The panel consider this requirement to be 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 university have an EE system policy which the school utilises. This includes a person specification for the role and the responsibilities of the EE, as well outlining who is able to take on the role. The policy outlines that the EEs are required to report on actions and the school must consider and act upon these where required.

During the inspection, the school explained the recruitment process to the panel and that they are in post for four years, or five if a transition is required. They stated that all assessments undergo internal verification and standard setting by internal staff before being sent for external verification by the EE. The EE is asked to comment on the content, range and level of all exam material, using as their comparators assessments undertaken in other education establishments and relevant benchmarking standards.

The EE is also given a range of exam results for their scrutiny. They are invited to attend module and course boards to observe the conduct of these meetings and comment on the assessments, its conduct, marking and the performance of the learners. The EE submits a report per cohort and the panel spoke with the EE during the final exams who confirmed they will do this.

As the course is an integrated apprenticeship, the university requires the school to also have an EA, focussing mainly on the EPA and submit a report per cohort. The panel attended the sign up to finals meeting, the final exams and the assessment board. Both the EE and EA were not able to attend the board meeting. The provider clarified at the assessment board that there was a separate meeting held with the EA prior to gateway, where they confirmed all gateway requirements for all learners was complete.

The panel consider this requirement is 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)***

From speaking with the learners at the inspection, the panel were assured that all learners were aware of the grade descriptors for their assessments, and the level expected of them. As previously highlighted within this report, the clinical mentors are also educated on how to grade learners during their DOPS and all mentors considered they were calibrated well on the scoring system.

The school use a modified Angoff standard setting procedure for summative assessments during their internal verification and an appropriate standard pass mark is agreed upon for each question. The panel consider this requirement to be met.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
16	The provider must ensure that candidates are exposed to as many of the examiners as possible, to ensure equity and fairness in the learner experience.	The final assessments will be updated to ensure consistency, equity and fairness. This will include standardisation in delivery and clearer marking criteria	October 2025
16	The provider must ensure a fair distribution of the time allotted to all candidates.	This will be updated for 2025	October 2025
16	The provider must ensure that questions posed for the assessments are utilised for all candidates, to ensure a fair experience.	All final assessments will be standardised to ensure equity of experience for each candidate	October 2025
16	The provider must ensure that answer sheets for examiners clearly outline the success criteria for all questions, to ensure a fair marking process.	This will be updated for 2025	October 2025
16	The provider must ensure that the assessment rubrics are more detailed and specific to the assessments.	This will be updated for 2025	October 2025

Observations from the provider on content of report

The School would like to thank the panel for their observations and feedback. We have taken on board your feedback and will implement suggestions in relation to the final assessments to ensure greater standardisation and ensure a robust process is in place. We are pleased that the panel observed students achieving a safe beginner standard and we are grateful for the observations that will strengthen this provision within the school.

Recommendations to the GDC

Education associates' recommendation	The Diploma in Orthodontic Therapy is approved for holders to apply for registration as an Orthodontic Therapist with the General Dental Council.
Date of reinspection next regular monitoring exercise	Monitoring 2025/26

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.