General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
Birmingham School of Dental Hygiene and Therapy awarded by the university of Birmingham	**BSc Dental Hygiene and Therapy**

Outcome of Inspection	Recommended that the BSc Dental Hygiene and Therapy continues to be approved (DCP) for the graduating cohort to register as dental hygienist and dental therapist.

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.**
Learning Outcomes:	**Preparing for Practice Dental Hygienist & Therapist**
Programme inspection date:	**24 November 2021**
Examination inspection date(s):	**Not applicable**
Inspection team:	**Ruth James - Chair and non-registrant member** **Clare Mcilwaine - DCP member** **Richard Jones - Dentist member** **James Marshall – Quality Assurance Manager** **Angela Watkins – Quality Assurance Manager**

The inspection of the programme was risk-based looking at specific areas of focus identified by the GDC's Education & Quality Assurance team during 2019. 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 panel comprised of education associates ('the panel', 'the team', 'we') identified three key challenges for the programme that require action.

This inspection was delayed activity from the 2019-20 monitoring due to the recent pandemic in 2020-21. Whilst this was formed as part of the risk-based monitoring, due to the pandemic and the length of time since all evidence was received a fuller inspection covering all 21 requirements was carried out.

The panel noted several areas of good practice. Since the last inspection in 2016 the school have made a significant move from paper-based portfolios to the Clinical Assessment Framework (CAF) system, a student monitoring system. The panel were pleased that the system runs across outreach centre's too which streamlines the process. Further developments of the system are in the schools plans for 2022-23.

During the inspection the school noted that straightforward restorative cases were a challenge to source however, the programme team are working closely with the BDS programme lead to ensure collaborative working between BDS and BSc students. A further benefit to this is supporting the BSc students to develop their direct access knowledge and skills.

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

Background and overview of qualification

Annual intake	**Annual intake:** 28 students year one 28 students year two 28 students year three
Programme duration	126 weeks over 3 years
Format of programme	**Year 1** Basic knowledge and application of knowledge, clinic attendance, observation, clinical simulation periodontology and adult restorative dentistry, direct patient care periodontology **Year 2** Knowledge and application of knowledge, simulated clinical experience adult restorative care and paediatric dentistry, direct patient care periodontology **Year 3** Knowledge and application of knowledge, direct patient treatment periodontology, adult and paediatric comprehensive patient care, outreach placement adult and paediatric comprehensive patient care
Number of providers delivering the programme	**1 plus 5 outreach clinics**

Outcome of relevant Requirements[1]

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

During the inspection the panel reviewed evidence of the assessment strategy and were satisfied that a robust gateway assessment process was in place to ensure students had obtained the necessary competence in clinical procedures prior to treating patients.

The panel interviewed students during the inspection and were pleased to note positive feedback on their experience in the pre-clinical laboratory environment.

The school deliver a modular programme that requires students to pass each module prior to the next, it was clear that this ensures ongoing competency prior to treating patients.

Students reported that there was an in-depth Induction, both online and face to face which ensured they were fully prepared at the beginning of the programme despite the challenges of starting the BSc during the COVID-19 pandemic.

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)*

It was clear that consent was taught during Induction week and focused on professionalism. This was further enhanced during the pre-clinical environment where students were taught about the different types of consent.

The panel was shown the documentation that is provided to patients to ensure they are aware that their treatment may be provided by a student. In addition to this at the start of the patient treatment students are required to gain consent from the patient and this is observed by the supervisor. The panel was informed that all verbal consent is recorded on the patient's CareStream Clinical Record.

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 school clearly described the resilience framework which has been put in place as a result of the pandemic. Students reported that as a result of this they felt safe to attend both the dental hospital and the outreach clinics.

The university is in the process of analysing Equality, Diversity and Inclusion (EDI) data for all students in order to ensure appropriate support mechanisms are in place.

The school carries out regular site visits to all outreach placements to ensure students are in a safe environment, the panel was satisfied assured that this was a robust and effective process.

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 panel was informed that the pre-clinical laboratory has a 1:9 staff to student ratio. In addition to this, in patient clinics including the dental hospital and outreach sites there is a maximum ratio of staff to students of 1:5.

At the beginning of each clinic session, supervisor and students have a "huddle" meeting to discuss and plan the treatments being carried out during that day to ensure students have sufficient support to carry out the work.

The associates were informed that each student is allocated a personal supervisor who supports a small number of students, the personal supervisor carries out 1-2-1 sessions with each student as well as group sessions for peer discussions.

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)***

The panel was provided with clear evidence demonstrating the appropriateness of supervisors which included registration status, qualification/s attained and ongoing training requirements.

The associates were pleased to note the effective training and support on offer for new staff which included calibration and a buddying system. The panel was confident that the support system in place would ensure new starters have a solid foundation to become effective educators.

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. ***(Partly Met)***

Students informed the panel that they are taught about raising concerns and the need to report patient safety issues within the first term. However, whilst there did appear to be an understanding amongst staff and students of the need to raise concerns, the panel were concerned that the structure for escalating issues was unclear.

The panel agreed that the school must develop and document a clear raising concerns process that identifies a clear pathway and contact point for raising concerns.

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

The associates were informed that the Datix patient safety reporting system is used within the NHS settings. All Datix issues and near misses are discussed and shared on a monthly basis, including sharing with the students for learning. The school gave an example of this process in action and the learning that was cascaded following the incident.

The panel was also informed that should an immediate issue arise on clinic the student would be removed to minimise the risk to patient safety.

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)*

During the inspection the Programme Lead gave an overview of the Fitness to Practise process in place which mirror the General Dental Council (GDC) student fitness to practise guidance.

The panel was provided with an example of the Fitness to Practise (FtP) process in practice and the panel were satisfied with this process.

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)*

The panel accepted that there was a multi-layered and comprehensive quality framework in place across the partnership. Several sources and mechanisms are used to collate feedback and used to develop the programme. A collaborative agreement is in place across the partnership with clear KPIs, which are reviewed externally every five years.

The school demonstrated an agile approach to making changes to programme delivery during the pandemic. The school developed a resilience framework in line with government and Health Education England guidelines, which enabled the programme to continue to function despite the challenges faced.

As part of the resilience framework the school moved to online delivery of lectures during the pandemic. Whilst the students were broadly supportive of this some reported that some enhanced interactivity would be beneficial if online learning was to continue as a permanent delivery model. Further staff training on the use of online teaching delivery may be of benefit to the programme.

The panel agreed that the programme was very well supported by the Programme Lead. However, they were conscious that a lot of responsibility sits with the individual. There is a risk that over reliance on one individual could result in failures in the programme should the individual be unavailable. The panel also noted there has been a recent long-term absence of a senior member of the team which highlighted the need for succession planning. The panel

agreed that the school should consider support or succession planning for the programme lead.

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)***

During the inspection the school gave an example of students in earlier years struggling with the timetabling of the programme. The programme lead used a collaborative method of engaging early year students with later year students in order to explain the benefits of the current timetabling system. Bringing in peer confirmation resulted in a satisfactory outcome for the year one students.

The panel was pleased to note that the school's response to the pandemic, including adaptions to the building and additional clinical training sessions available to students, which maintained students clinical experience against learning outcomes.

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. ***(Partly Met)***

The school use the University of Birmingham policy quality framework which is disseminated throughout all programmes delivered in the university. Annual reports are produced by the Programme Lead which captures all outcomes from various external stakeholders including the GDC and external examiners.

The panel was informed that patient feedback is obtained in various ways; however, they were concerned that students directly asking the patient for feedback may not always provide an unbiased view of the patient experience. The panel agreed that the school must seek additional or alternative options for gaining unbiased patient feedback.

It was clear during the inspection that the school encourages open discussion between the students and the external examiner. The school uses the University of Birmingham External Examiner appointment process to ensure a consistent approach with appointments and to minimise reciprocal relationships.

During the inspection the panel spoke with the external examiner who confirmed there was a robust induction process at the beginning of their tenure and that they were provided with all the necessary information to carry out their role.

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)***

The associates noted that all outreach centres have full access to the Clinical Assessment Framework (CAF) system which allows them to record issues contemporaneously.

Periodically supervisors obtain patient feedback on an adhoc basis. The findings of this feedback are shared with stakeholders.

During the inspection the panel interviewed supervisors in the outreach settings who confirmed that the Quality Lead for Dentistry carries out annual inspections of all outreach centres.

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)*

During the inspection the panel was given a demonstration of the Clinical Assessment Framework (CAF) system which is used to record all clinical experience that students gain in the dental hospital and outreach centres.

The panel was informed that student progression is monitored on a regular basis with particular emphasis during the pre-entry to finals meeting in February of the academic year. During this meeting any shortfalls of clinical experience are identified and supporting guidance is provided to the students. There is a subsequent progression meeting prior to finals at which point all student experience is reviewed and any students who hasn't demonstrated competency in all clinical areas will not be put forward for final exams.

The panel reviewed GDC learning outcome blue printing against the programme and was satisfied that at the end of the course students would graduate as safe beginners.

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 school uses the CAF system which captures clinical attainment throughout the entire programme. In addition to clinical attainment CAF captures any professionalism concerns which are then flagged up with the programme team. The panel was pleased to note that regular performance meetings to interrogate the CAF data take place in order to monitor student progression.

The CAF system also provides students with the opportunity to reflect on their performance during each clinical activity and the feedback from supervisors. The associates were pleased to note that this takes place in a timely fashion.

The panel was informed that there will be further developments of the CAF system which will be implemented during the 2022-23 academic year. The panel supports the innovative developments that were proposed by the school.

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)*

During the inspection the panel saw evidence of the school's competency-based framework which is driven by experience rather than a numerical targeted system. All students who were interviewed were aware of their requirements for clinical activity.

The panel reviewed clinical activity undertaken and were satisfied that students were given the opportunity to undertake an appropriate breadth of procedures.

In the last 2016 report there was a recommendation to improve patient access. During the inspection the panel was pleased to be informed of an enhanced opportunity for students to gain paediatric experience.

During the inspection the school noted that straightforward restorative cases were a challenge to source. However, the programme team are working closely with the BDS programme lead to ensure collaborative working between BDS and BSc students. A further benefit to this is supporting the BSc students to develop their direct access knowledge and skills.

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)*

The panel were satisfied that a good range of assessment types were used during the programme. These included Structured Clinical Observed Test (SCOT), Observed Structured Clinical Examination (OSCE) and Extended Multiple-Choice Question (EMCQ).

The asscoiates were informed that the assessments are quality assured by the external examiner who provides feedback on any necessary changes. Each module has a staff team allocated and their responsibility is to quality assure the module and assessments.

In addition to this there are curriculum meetings for all programmes being delivered within the university in order to encourage best practice sharing.

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. *(Partly Met)*

Whilst the school did collect some patient feedback that was used to inform the assessment process the panel were concerned that the feedback collected face to face by the students was not anonymous. The panel felt that this could lead to an element of bias in the quality of the feedback provided. The associates agreed that the school must ensure any patient feedback that is used to inform the assessment process must be reliable and fit for use. In addition to this the school should consider using peer feedback to develop student performance

The qualified dental nurses who work with the students also oversee clinical set up procedures and cross infection control and give verbal feedback to individual students. Clinical assessment feedback is formative throughout the course, and is reviewed as part of the clinical progress meetings

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)*

The panel was informed that students are given verbal feedback at the end of each clinical session. Written feedback is captured on the CAF system and supervisors are required to

record their feedback within 24 hours. This was confirmed by students during the inspection. Students are asked to record their reflection on the CAF system and are also enabled to reflect on the feedback given by the supervisor.

Reflection is a central pillar within the BSc programme. Outreach supervisors informed the panel that they were provided with enhanced training on reflective practice this enabled them to share their knowledge skills and experience with the students.

During the inspection students shared their views on the good level of supervision, support and feedback they receive from the school.

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

The panel were assured that appropriate recruitment of assessors was applied. There is clear evidence of ED&I training which forms part of mandatory training within the Induction programme.

All new assessors have an initial period of mentorship when they shadow peers to learn the process of clinical teaching and assessment. The panel felt that the support for new staff was good.

New assessors are required to shadow an experienced examiner in order to gain an understanding of grading boundaries, assessors also undertake peer calibration to ensure a consistent approach is applied.

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 role and responsibilities of the external examiner are clearly set out in the External Examiners Handbook 2021-22. The panel met with one of the external examiners who assured the panel that he was clear on his role.

There is a clear structure for external examiners to review, test and report on assessments prior to the finals taking place. The external examiner is sent assessments at least 4 weeks in advance of students sitting, giving full opportunity to review and report on documents
The external examiner confirmed this by explaining the recent process which he had completed.

The external examiner explained to the panel how they are able to discuss any moderations with the internal examiners who will then follow the University policy to apply any changes.

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. (*Partly Met)*

During the inspection the panel observed a clear assessment strategy which detailed robust policies and procedures.

Assessments are marked anonymously and double marked by internal examiners and agree an overall mark. New staff are given sample assessments to mark and will also be given the opportunity to be a third person in the marking of assessments.

The panel was informed that the CAF system supports the calibration of standard setting by reporting on individual supervisor gradings. The associates noted the different methods of standard setting used however; this was not evidenced through recorded documentation. When standard setting is not in place standardised marking guides are used. The panel agreed that the school must be able to evidence decisions made during the standard setting process.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
6	The panel agreed that the school must develop and document a clear raising concerns process that identifies a clear pathway and contact point for raising concerns.	The School will ensure that the process in place for raising concerns will be fully documented and it is clear to all those involved within the programme. This will provide clear reporting lines for escalating concerns about staff or students. As part of the development of the updated Clinical Assessment and Feedback System (CAFS) system we plan to investigate the option of a raising concern alert within the programme which can be used to raise a concern about a student or staff member which will be escalated accordingly. Birmingham School of Dental Hygiene and Therapy is part of Birmingham Community Healthcare NHS Foundation Trust, who alongside its Speaking Up: Raising Concerns Policy, has dedicated Freedom to Speak Up Guardians who will link with the School to provide support.	An update to be provided in the annual monitoring report 2022-23.
11	The panel agreed that the school must seek additional or alternative options for gaining unbiased patient feedback.	Patient feedback within BSDHT will continue to be gained anonymously. Anonymous feedback is collected for each clinically active cohort on a termly basis with evidence (Evidence 87 & 88) provided in the submission of documents to the GDC QA Team prior to the inspection. Evidence 88 demonstrates examples of the reports generated from anonymous feedback for the clinically active cohorts for adult daytime and evening clinics and paediatric clinics. We plan to further develop electronic anonymous patient feedback through the updated Clinical Assessment and Feedback System (CAFS), which will allow patients to feedback electronically at a later time anonymously directly to the individual students reporting system.	An update to be provided in the annual monitoring report 2022-23.

		Birmingham School of Dental Hygiene and Therapy are working towards the introduction of the updated CAFS system for the next academic year, commencing September 2022.	
17	The associates agreed that the school must ensure any patient feedback that is used to inform the assessment process must be reliable and fit for use. In addition to this the school should consider using peer feedback to develop student performance	Feedback is collected from patients anonymously. Anonymous feedback is collected on a termly basis for all clinically active cohorts. Evidence 87 and 88 submitted within the original submission as part of the inspection process demonstrates examples of the reports generated from the anonymous feedback for adult daytime and evening clinics and paediatric clinics. We plan to further develop electronic anonymous patient feedback through the updated Clinical Assessment and Feedback System (CAFS), which will allow patients to feedback electronically at a later time anonymously directly to the individual students reporting system. Birmingham School of Dental Hygiene and Therapy are working towards the introduction of the updated CAFS system for the next academic year, commencing September 2022. Peer observation and peer feedback, currently undertaken by students in earlier years observing more experienced students, will be developed further into the new academic year and documented with the Professionalism Module (Year 1) and the Professionalism Required Element (Years 2 and 3). This will allow students of equivalent years to observe and feedback within their peer group and reflect on feedback received and will be evidenced within these modules.	An update to be provided in the annual monitoring report 2022-23.
21	The panel agreed that the school must be able to evidence decisions made during the standard setting process.	BSDHT submitted examples of evidence of standard setting in the initial submission of the inspection process. These demonstrated examples of standard	An update to be provided in the

		setting evidence for Year One DHCP OSCE and Year Two ARDTCP (Evidence 115) and the Assessment Strategy (Evidence 12) demonstrates the rationale behind the standard setting methodology (p10-11) and the standard setting/standardisation methods used in all modular assessments (p22-23). In additional information requested prior to the inspection evidence for standard setting decisions was provided for the Biomedical Science Module, DHCP OSCE, IARD Module and ARDTCP Module, along with signposting to the Assessment Strategy (p10-11) identifying the rationale for standard setting methodologies and (p22-23) identifying the standard setting/standardisation methods used for each modular assessment. BSDHT plan to develop this further, following the process of Standard Setting each assessment as described in the BSDHT Assessment Strategy, the rationale behind individual decision making for each standard set assessment will be recorded and stored within the BSDHT database. For those standard set through calculation using Modified Cohen, evidence of the calculation will be recorded within the database with reference to the individual cohort and the assessment set.	annual monitoring report 2022-23.

Observations from the provider on content of report

The Birmingham School of Dental Hygiene and Therapy thank the GDC Education Associates for their consideration of the BSc Programme and for providing a comprehensive report on the Schools' meeting of the GDC Standards for Education. This will enable us to further develop the programme and focus on areas where we can improve the educational experience and enhance the learning for our students.

Recommendations to the GDC

Education associates' recommendation	The **BSc Dental Hygiene and Therapy** continues to be approved for holders to apply for registration as a Hygiene & Therapist with the General Dental Council.
Date of next regular monitoring exercise [Delete as applicable]	2022-23

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.