General Dental Council

protecting patients,
regulating the dental team

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
University of Bristol	Bachelor of Dental Surgery (BDS)	30 and 31 January 2019

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

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

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dentist.** **Specific Requirements for review following risk assessment: 4, 8, 9, 11, 13, 15 and 19.**
Inspection dates (programme):	**30 and 31 January 2019 (1.5-day inspection)**
Learning Outcomes:	***Preparing for Practice (dentistry)***
Inspection panel:	**Eileen Skinner (Chair and Non-registrant Member)** **Thomas Addison (Dentist Member)** **Stuart Boomer (Dentist Member)** **Carolyn Inman (Dentist Member)** **Kathryn Counsell-Hubbard (Quality Assurance Manager)** **Martin McElvanna (Education and Quality Assurance Officer)**

The BDS programme at the University of Bristol is an established and respected programme that utilises the full range of facilities at its disposal. Students attend a range of clinics in order to gain the requisite skills to progress towards being safe beginners.

The school is responsive to the needs of its students, from whom the feedback on the programme was excellent. Evidence of changes to the programme, as a result of student feedback, was readily available. This has culminated in the new BDS programme that will be introduced for current year 4 students progressing to year 5, as well as new year 1 students, in September 2019.

The programme, along with many other programmes of this kind, struggles to recruit and retain an effective mix of patients in order to address the students' needs. Coupled with this is the compartmentalisation of the programme resulting in the staffing requirements for each clinic (to supervise students) being devolved to the Element Leads. This has led to situations when the supervision of students has been disjointed and therefore monitoring can be fractured. Two students were able to undertake clinical work for a term without logging their activities on the clinical recording system, CAFS, which gave the panel great cause for concern. Cohesive monitoring of the student experience together with a higher level, scrutiny-based approach to arranging supervisors are two of the areas in which the programme can improve in order to transition from adequate to exemplary.

This inspection was a focused inspection based on specific Requirements from the *Standards for Education* identified as part the risk assessment of the programme's annual monitoring[1] return from 2018. All other requirements are considered to be met.

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

[1] Annual monitoring is the regular review process used to monitor programmes and determine inspection activity.

Background and overview of Qualification

Annual intake	71 HEFCE-capped home and overseas students. Up to 8 non-HEFCE overseas students
Programme duration	187 weeks over 5 years
Format of programme	Current curriculum consists of 23 units within the themes of Biomedical sciences, Dental skills, Primary care dentistry, Advanced care dentistry, Human disease, Personal and Professional Development. Students must pass all units within a year to progress to the next year. Year 1: 4 units delivering underpinning scientific knowledge, professionalism and communication skills Year 2: 7 units delivering underpinning scientific knowledge, simulated clinical experience, professionalism and communication skills. Direct patient treatment from Term 3. Year 3: 5 units delivering simulated clinical experience, direct patient treatment, human disease including hospital placement, professionalism and communication skills. Years 4-5: 7 further units delivering advanced simulated clinical experience, direct patient treatment, consultant clinic attendance, outreach placements. BDS Finals incorporates Gateway to Finals assessments and is delivered in three parts. A new curriculum from 2019-20 has a revised structure and a new Finals format.
Number of providers delivering the programme	Two: Educational Provider: University of Bristol Placement Provider: University Hospitals Bristol NHS Foundation Trust.

Outcome of relevant Requirements[2]

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	**Partly Met**
12	Met
Standard Three	
13	**Partly Met**
14	Met
15	**Partly Met**
16	Met
17	Met
18	Met
19	**Partly Met**
20	Met
21	Met

[2] All Requirements within the *Standards for Education* are applicable for all programmes. Specific Requirements will be examined during inspection activity through risk analysis processes or due to current thematic reviews.

Standard 1 – Protecting patients
Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.

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

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

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

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

The programme is divided on a modular basis in which broad areas of study are termed as 'elements', with each element having its own lead. The Element Lead is responsible for ensuring the supervision of students on clinics and outreach placements appropriate to that element. Details of the supervision ratios, which differ depending on the particular area of dentistry being practised, were provided to the panel and found to be sufficient.

Students reported to the panel that they were satisfied with the level of supervision given. In most clinics and outreach placements, students work in pairs and/or are paired with a dental nurse so that even when the supervisor is not present, they are not unsupervised.

The benefits of the Element Leads having ownership of the supervision arrangements were evidenced in discussions with outreach supervisors, who reported close working relationships with the Element Leads. However, this division in the administration of supervision means that essential critical overarching oversight is absent. In some areas, such as paediatrics, there are a small number of supervisors so consistency is easier to achieve. However, in some elements of adult dentistry, the numbers of supervisors required, coupled with a timetable that involves constant rotation across clinical sites, means that the student experience is less consistent.

The rotational pattern of student clinic placements resulted in a large number of different tutors, with a corresponding lack of consistency. This also led to a significant clinical recording issue (detailed further under Requirement 8). The programme leads are aware of the implications of this issue as was evidenced during extensive questioning by the panel. However, on the basis of the rest of the supervision data, student feedback to the panel, and the level of insight exhibited by the programme leads and staff, the panel find this Requirement to be met. The panel would strongly recommend, however, that the programme leads continue to consider and investigate issues which could arise from the lack of consistency between supervisors on clinic and are proactive in evaluating their processes.

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

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

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

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

A new process for dealing with student fitness to practice issues has been introduced. Multiple pieces of evidence about the process were provided to the panel who deemed the process to be robust. When triangulated, students reported that they have enjoyed the pastoral element introduced into the new process. The students also clearly understood the remit and purpose of the student referral system, which is part of the new process. This allows anyone who comes into contact with students, including peers and patients, to raise a concern. The process is used by staff within the programme to better formalise the escalation of concerns regarding student performance.

There were some elements of the new process that the panel found warranted further attention. Case Investigators (CIs) have responsibility for meeting with students when an issue arises and deciding what action should follow, such as escalation to the formal University mechanisms or issuing a formal warning. However, having only one CI making such a decision, particularly as part of a new process, caused the panel concern regarding the consistency of approach. The panel felt that a decision agreed by at least two of the three available CIs may be more robust and less open to challenge. The panel was also concerned that there is no published standard stating how many formal warnings may be issued before a student is referred to formal fitness to practice proceedings. The panel would recommend that a threshold is considered and introduced to ensure that cases are appropriately escalated, when appropriate.

The panel found this Requirement to be met. The panel would encourage further development of the process so that decision making is seen to be fully reasoned and consistent, and that everyone involved understands and follows the process. However, the panel also wished to commend the provider for the insight shown during the inspection. The provider informed the panel that it will better publicise the student fitness to practice process, based on information from meetings with students, and will also increase its review of the clinical recording system, CAFS, to identify potential fitness to practice issues earlier.

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 was provided with evidence of a comprehensive committee structure involving various groups at University, Faculty, and School level. Chief amongst these is the Dental Education Committee (DEC), a School-level group that is concerned with the overall delivery and quality achieved by all dental programmes at the University. The DEC undertakes an Annual Programme Review (APR) which is a paper-based exercise drawing together various pieces of information and feedback to appraise the units that comprise the BDS programme. This process also utilises peer review which is undertaken by the Unit Leads.

An impressive aspect of the DEC is its inclusion of student representatives. The provider uses a University-level Education Action Plan (EAP) that defines the strategic aims and objectives of the programme along with the actions to be completed to achieve them. The EAP is presented at DEC meetings and students may review and feedback on the plans at that time.

The panel was unclear as to the scope of the EAP as the document appeared not to utilise timescales. Some items were ticked off as being completed with little explanation. The panel would, therefore, also urge the provider to introduce additional detail to this document. Expanding on what has been done, how and when would allow for easier review and give the provider a record that actions have been completed. The use of deadlines would also help the EAP evolve from guidance to a living document that determines the work that must be done to ensure the ongoing quality of the programme.

The School sits within a faculty comprising three schools of health science namely medicine, veterinary medicine and dentistry. The programme leads for the BDS sit on the Faculty level committees that report directly to the University Academic Quality and Standards Committee.

The programme leads informed the panel that the structure will be changing in 2019/20 as the University imposes a higher-level quality process. It was not clear what the outcome of this change will be and the panel would urge the provider to inform the GDC on how these changes will impact the management structure within the School and quality assurance process for the programme.

The panel found that this Requirement was 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)*

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development. *(Requirement Partly Met)*

Comprehensive evidence was provided to demonstrate that the provider is meeting the first part of this Requirement. The direct line of communication between the provider and the University, as well as the constant oversight provided by such clear reporting lines, gave the panel reassurance not only of a comprehensive quality assurance structure but also of external oversight.

Further externality is provided via the use of external examiners who comment on the content of the units as well as on final assessments. The panel saw evidence which showed that, in most cases, external examiners' suggestions were acted upon. The appointment and use of external examiners is governed by University policy. Patient feedback is also collected from the adult dental health clinics, and while this primarily feeds into progression meetings, such feedback can be escalated and considered by the programme leads.

The panel identified that effective collection and use of patient feedback is an issue. Currently, feedback is not routinely gathered from all clinics which prevents a proportion of the patient base from being able to comment on their treatment. The use of comment cards was found to be useful and an excellent method of gathering contemporaneous feedback. However, there was not a standardised process in place to obtain feedback from all clinics.

Implementation of an effective method of gathering patient feedback from across all clinics, underpinned by a formal process for reviewing that feedback, would allow this Requirement to be met. Until that time, the panel find the Requirement to be partly 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)*

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)*

The programme benefits from a coherent "sign-up" procedure involving external examiners. The process is structured and inclusive with various meetings involving students and non-students. A student's progression to final assessments, or not, is based on a range of information. While there are 'totals' in place which guide clinical achievement, this information is considered in conjunction with the student's overall performance.

A full and varied range of assessments are utilised throughout the programme and are governed by relevant university policies. However, the panel did find the programme to be very assessment focussed. In particular, fifth year students currently undergo various assessments within a short time frame as well as working full time in clinics. The provider is introducing an updated curriculum for the 2019/20 programme, and while the structure of the assessment timetable has been broadened, the burden of the number of assessments still appeared to be significant.

Despite an appropriate "sign-up" process, the panel was concerned by the apparent conflict between a holistic assessment of student attainment and the use of "totals". These appeared to vary significantly among students for a variety of reasons including availability of patients. The panel accepted that "totals" were not strictly adhered to but the online recording system, CAFS, is based on those "totals". Numbers of procedures undertaken, which feed into "totals," were of primary concern to the students interviewed. In recent years, all students have progressed to finals despite the disparity in the numbers of procedures undertaken and even when students have lacked the required number of procedures which go towards their "totals". This information led the panel to question the provider's rationale for having "totals" at all and whether a different system might be more in keeping with the provider's holistic approach to student progression.

The panel was also concerned by the "totals" examined for the current fifth year students, shown on CAFS. These numbers showed a disparity in the amount of experience between students, with some students achieving double the number of procedures compared with their peers. Updated numbers were provided to the panel following the inspection but the concern remains that the student experience is not consistent and equitable. In addition, neither the programme leads nor other programme staff were able to describe the process for identifying and monitoring struggling students outside of the monthly progression meetings. How one supervisor would communicate his/her concerns to another supervisor, and how this would be subsequently recorded, monitored and escalated, was not clear. The panel was concerned that students failing to meet their "totals" would not be identified in sufficient time to enable them to gain the requisite amount of clinical experience.

To meet this Requirement, the provider must implement a formalised process for identifying and monitoring struggling students with current progression procedures. The student experience must be reviewed to ensure that it is as consistent and equitable as possible. The provider should also review its use of "totals" and should continue to review and refine the new curriculum to ensure the assessment schedule is not unduly burdensome.

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

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

The panel was largely satisfied as to the student experience based on the evidence provided. Of particular note were the effective use of Structured Clinical Observed Tasks (SCOTs) to judge progression in earlier years of the programme and the use of pre-general anaesthetic assessment clinics for paediatric experience. The panel was also pleased with the evidence provided regarding human disease experience which is integrated with basic science and pathology.

Of concern was the management and allocation of patients to students. Students may refer between year groups but this is not a formal process. The formal allocation of patients is done by a non-clinician and it is the students' responsibility to obtain the patients they need. The provider aims to treat patients holistically. This means that patients won't be transferred to students for different parts of their treatment based on the clinical experience which the students need. The panel fully support the concept of holistic patient care being delivered by the students. However, given the disparity in student experience, and the lack of clinician involvement in the process of patient allocation to students, there was no clear process for ensuring that students were being provided with appropriate patients to meet their needs. Alongside this, the absence of a clear pathway for students to pass on the care of patients to their fellow students appeared to result in some students not being assigned patients that would address the student's clinical experience requirements at that time. The panel felt that the process for allocation of patients to students was in need of revision and would benefit from a clinician's input.

The panel recognised the efforts of the provider to recruit more patients and noted that there is a waiting list of patients. However, the panel would recommend a review of the waiting list to ensure that the correct patient profile is available for students. Often, students are completing multiple procedures before being able to practice the procedure that they need to count as part of their "totals". This means that there can be significant repetition of simpler, common skills and less opportunity for students to work on complex procedures which are rarer. Refining the selection criteria may go some way to improving the student experience. Equally, the provider could consider teaming senior students with junior students to share the holistic treatment plan or else incorporate dental hygiene and therapy students in order to promote team working.

To fully meet this Requirement, the provider must review and improve its categorisation of patients and the way in which patients are allocated to students. A formal process for students to share patients based on their own clinical competence needs must be considered and implemented with cohesive staff support.

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/Partly Met/Not Met)*

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

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

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

The panel received evidence regarding staff training and staff retention. Some processes were found to be appropriate: there is effective logging of staff training, including equality and diversity training. Staff involved in examining students must observe an entire diet of examinations before examining students, at which point the provider ensures that they are paired with an experienced examiner. The panel was originally concerned that the withdrawal of NHS staff from University processes, such as examining students, might have had a detrimental effect on the programme but the evidence confirmed that this was not the case. However, the panel would support the provider's efforts to re-engage NHS staff as part of the NHS contract.

The provider advised that assessments are videoed but these are not routinely used in either calibration or in the training of new supervisors or examiners. The panel recommended that such a resource should be fully exploited.

However, the panel did have concerns in other areas. Due to the delegation of key areas of governance to the individual Element Leads, the calibration of supervisors differs depending on the element in question. For example, calibration exercises were evidenced for the Restorative and Adult Dental Health areas. The panel was concerned that there is not a consistent approach, defined by policy, as to how and when, calibration should take place. It is entirely within the remit of the individual Element Lead as to how supervisors are trained and calibrated.

The training and calibration of supervisors must be revised and standardised across the programme, incorporating areas of good practice into every clinical area. The provider should also consider using all types of technology at their disposal, such as videoed assessments, to better enable such training and calibration to take place.

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

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

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
4	The provider should investigate what issues could arise from the current method of organising supervision for students and evaluate what can be done to prevent issues arising.	A key driver of students' variation in supervision is the existing timetable. We continue to work on our clinical student timetables for our new BDS Curriculum. From September 2019 will move to a new and consistent clinical rotation for students in Year 5. We will continue to roll out new clinical timetables for the other years of the programme in line with the introduction of each new academic year. In addition, the School has recently appointed 3.6FTE (5 Headcount) senior clinical academic staff, joining the School in Autumn 2019. Further appointments are anticipated this calendar year for 2FTE 50:50 funded posts (with UHBristol) at a senior level in Oral Surgery. We are starting to implement a new workload planning model into the School; this along with the new appointments will provide more consistency of supervision on clinic. This will be supported by the introduction of e-rostering software which will be utilised to timetable supervisors and manage annual leave. In addition, we have already held a calibration session for staff and are calibrating their grading behaviour via feedback from our CAFS system.	Annual Monitoring 2020/21
9	The provider should contact the GDC as soon as any significant issues are identified as a result of the change to quality management structures.	We continue to evaluate and develop our quality management structures. During 2019/20 we anticipate further work at a School and Faculty level to enhance quality assurance structures with our placement provider. Naturally we would contact the GDC were any issues identified.	Annual Monitoring 2020/21
9	The provider should consider expanding the use of the EAP.	The EAP will outline delivery of SMART objectives and closely monitor and report timings of completed actions.	Annual Monitoring 2020/21

		From 2019 the EAP will be scrutinised by a new University Quality Team (UQT), which will further improve this process. The School's Director of Education will be a member of the UQT.	
11	The provider must introduce a method of gathering patient feedback across all clinics. A policy should be put in place that outlines how such feedback should be considered and fed into programme review.	Following several pilots of methods to collect patient feedback, we have developed the functionality within our ePortfolio (CAFS). Following a successful pilot on the largest student department in the Hospital, we will roll out patient feedback collection across all other areas in 2019/20.	Annual Monitoring 2020/21
13	The provider must implement a formalised process for identifying and monitoring struggling students outside of progression procedures.	We have raised this topic as a factual correction. Students have an individual review of their progress towards Totals with their Element Lead at the start and end of Year-4 and at the start of Year-5. Students also have regular meetings with their Clinical Group Mentor. Furthermore, the Year-5 Lead also meets with students individually to assess progress. All these meetings derive an 'action plan' to support the student's attainment. Any student who appears to require support is flagged and a further review meeting arranged to ensure that progress has been made. The effectiveness of our processes is evidenced by the observation that all our students have been supported to gain the required levels of experience and skill for the last 4 years. Repeated meetings with the last student not to have gained the necessary experience found that student to be disengaged for non-academic reasons. The student was barred from sitting finals, but with further support was able to achieve his totals and pass finals six months later. In addition, we have robust formal processes for identifying and monitoring students struggling with pastoral issues or with fitness to practice that	Annual Monitoring 2020/21

		supplement the informal processes that form part of our caring academic culture.	
13	The provider must audit student exposure to a variety of patients and identify areas where this can be improved.	We will audit student exposure to a variety of patients to identify areas where this can be improved. We will review our categorisation and allocation of patients as part of the work for our new curriculum, which emphasises greater clinical experience for students.	Annual Monitoring 2020/21
13	The provider should undertake a review of the use of totals in measuring student experience and competence.	We will review our use of Totals in measuring student experience and competence. In the interim, Totals are not an *absolute* requirement. The portfolio of work undertaken by each student is looked at holistically to ensure that they have covered a wide range of procedures and there will be a certain degree of compensation allowed depending upon individual student experience. The scope of Totals has increased for 2019/20 to include also simpler procedures. This will help to ensure that students view all patients as worthwhile within their education, and that as they progress through the programme they should not just be focusing on the more complex cases.	Annual Monitoring 2020/21
13	The provider should continue to review and refine the new curriculum to ensure that the assessment timetable is not unduly burdensome.	The structure within our new curriculum is streamlined and increasingly aligned for our summative assessments. There is also greater focus on student engagement to promote professionalism and the use of formative assessment to support students' learning. A principle of our new curriculum (BDS21) will be programme-based assessment, so that we will assess across the entire programme rather than having separate assessments for each unit, with the burden that creates. Thus, programmatic assessment in Year-	Annual Monitoring 2020/21

		1 BDS 21 will drastically reduce the number of Year-1 summative assessments. The number of assessments for Year-5 will be reduced by one third for the next academic year (18 assessments for Gateways/Finals 2018/29 down to 12 for Finals in 2019/20). We are also reducing assessments where we can ahead of rolling out BDS21. For example, following consultation with the External Examiner, the Unit of Dental Skills Year-3 for 2019/20 will have 3 fewer summative assessments. This will be achieved by a mixture of combining some assessment and by making others formative.	
15	The provider must review and improve its categorisation and allocation of patients to students. A formal process for students to share patients must be considered and implemented with cohesive staff support.	Patients are assessed by a clinician cognisant with student requirements, and are added to student waiting lists, categorised by procedure type. Students are allocated patients based on their requirements for a particular stage of learning. There is oversight provided by senior clinical academics and Element Leads. A mechanism exists that allows students to refer patients to other students. Students speak to the Student Clinic Coordinator and refer the patient back to the waiting list. The Student Clinic Coordinator will then allocate the patient to an appropriate student. However, we will review our categorisation and allocation of patients as part of the work for our new curriculum, which emphasises increased and enhanced clinical experience for students.	Annual Monitoring 2020/21
19	The provider must implement a process for the training and calibration of supervisors that must be adhered to across all elements of the programme.	An OSCE examiner training website has been developed and is available to all examiners from both the University and Trust. Access can be arranged for the GDC Inspectors if required.	Annual Monitoring 2020/21

		Staff calibration sessions have been held for Restorative and South Bristol staff, and further sessions are being planned for other departments. Our use of CAFS to monitor and feedback on staff grading behaviours was introduced to further support staff calibration. We are working with our Trust colleagues to ensure their support for greater staff calibration.	
19	The provider should consider using technology, where available, to assist in achieving consistency in the training and calibration of supervisors.	An OSCE examiner training website has been developed and is available to all examiners from both the University and Trust. Our use of CAFS to monitor and feedback on staff grading behaviours was introduced to further support staff calibration.	Annual Monitoring 2021/22

Observations from the provider on content of report

We were very grateful to the inspectors for their time and attention during the visit. We welcome their findings, many of which reflect our own observations and represent work in progress. Nevertheless, the inspection gave us cause to reflect and further impetus to enhance the programme and our students' experience.

Recommendations to the GDC

Education associates' recommendation	Qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council
Date of reinspection / next regular monitoring exercise	New BDS curriculum to be inspected in 2020

ANNEX ONE

Inspection purpose and process

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

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

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

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

A Requirement is **met** if:

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

A Requirement is **partly met** if:

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

A Requirement is **not met** if

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

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

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term 'must' is used to describe the obligation on the provider to undertake this action. For these actions the inspectors may stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term 'should' is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

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

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