

INSPECTION REPORT

Education provider:	Bristol Dental School
Programme/Award:	Diploma in Orthodontic Therapy
Remit and purpose:	Full inspection referencing the <i>Standards for Education</i> to determine approval of the award for the purpose of registration with the GDC as an orthodontic therapist
Learning Outcomes:	<i>Preparing for Practice (orthodontic therapy)</i>
Programme inspection dates:	27 & 28 October 2014
Examination inspection dates:	4 & 5 December 2014
Inspection panel:	Julie Stone (Chair and Lay Member) Rosemarie Khan (DCP Member) David Young (Dentist Member)
GDC Staff:	Kathryn Counsell-Hubbard (Lead) Krutika Patel
Previous inspection:	April & September 2008
Outcome:	Recommended that the diploma continues to be approved for the graduating cohort to register as orthodontic therapists

Inspection summary

This report details the inspection of the Diploma in Orthodontic Therapy programme (hereafter referred to as the 'programme') delivered at University of Bristol Dental Hospital (UBDH, also referred to as the 'provider'). The final examinations for the qualification are provided by the Royal College of Surgeons of Edinburgh (RCSEd).

There were many positive aspects of the programme, most notably the close relationship between the programme team and the students. The students' enthusiasm for the programme was evident, as was the commitment of the programme leads. The programme team is small; the regular members comprise a consultant orthodontist and orthodontic therapy tutor. Coupled with the current small cohort of nine students, an intensive, but supportive learning environment has been created.

The programme commenced in 2008 and is held in high regard by the workplace supervisors the panel spoke with. The programme team is experienced at running training events for the workplace supervisors and confident in delivering a programme that produces well trained orthodontic therapists. Teaching is delivered at the UBDH and the University of Bristol Dental Care Professional (DCP) School. This means that the students have access to excellent facilities and a range of clinical teachers and lecturers.

The positive attributes are undermined by some significant issues with record-keeping and the formal quality assurance procedures. Unannounced visits to training practices are a key method of quality assuring the work placements, but these are neither logged nor documented. Any issues that are found at these visits are neither recorded nor formally discussed amongst the programme leads. A similar absence of recording exists for the work undertaken to map the curriculum onto the GDC's Preparing for Practice learning outcomes. This also applies to the discussions and outcomes of meetings to modify the programme to meet the specific needs of the cohort. It is not possible to track in detail what changes have been made year-on-year and of equal importance, why such changes have been made.

The internal policy layer that governs the programme was poorly evidenced and seems to comprise a range of policies from different areas, including the University of Bristol Dental Hospital (UBDH), the Trust and the individual work placements. The majority of the policies seen that are deemed to be specific to the programme are out of date, contain conflicting information, and make mention of approaches and methods of completing tasks that were not reported during the inspection. While a student handbook is being introduced for the next cohort (commencing January 2015), one has not been produced for previous years and it was therefore difficult for the panel to be assured that students are aware of the procedures that govern their learning and practice at UBDH while on the programme.

Many areas of the programme require attention and work, including the differing approaches to grading students, the support of students who may encounter difficulties in practice and formalising the assessment strategy. To deliver the changes that the panel believes should be made will present a challenge to the small team at Bristol, but their commitment to delivering the programme was evident. For this reason, it is believed that the programme leads can incorporate the required changes.

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

Inspection process and purpose of Inspection

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 and new qualifications where it is intended that the qualification will lead to registration.
2. The aim of this quality assurance activity is to ensure that these institutions produce a new registrant who has demonstrated, on graduation, that he or she has met the outcomes required for registration with the GDC. This is to ensure that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.
3. The inspection focuses on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education*.
4. The purpose of this inspection was to make a recommendation to the GDC to determine whether the programme delivered at UBDH should continue to be approved as a route for registration as an orthodontic therapist. The GDC's powers are derived under the Dentists Act 1984 (as amended) under The General Dental Council (Professions Complementary to Dentistry) (Qualifications and Supervision of Dental Work) [DCP] Rules Order of Council 2006.
5. Inspection reports may 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 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 be approved 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 approval, the report and observations would be presented to the Council of the GDC for consideration.

The Inspection

7. This report sets out the findings of an inspection of the Diploma in Orthodontic Therapy at UBDH. The final examination provided by the Royal College of Surgeons of Edinburgh (RCSEd) was also inspected. The GDC publication *Standards for Education* (version 1.0 November 2012) was used as a framework for the inspection.
8. The inspection comprised of two parts. The first visit to the school was carried out on 27 and 28 October 2014 and involved meetings with staff involved in the management, delivery and assessment of the programme, all students enrolled on the programme, and separate videoconference meetings with two of the workplace trainers. These meetings formed the first part of the inspection and are collectively referred to as the “programme inspection”. The second part was also at the School to observe the final clinical examination run by the RCSEd on 4 and 5 December 2014.
9. The report contains the findings of the inspection panel across the two visits, together with consideration of the supporting documentation prepared by the School to demonstrate and evidence how the individual Requirements under the *Standards for Education* have been met.

Overview of Qualification

10. The Diploma in Orthodontic Therapy is delivered within the University of Bristol Dental Hospital. The programme leads hold honorary contracts with UBDH but the programme itself is not part of the University. Information about the programme can be found online via the University website and governance is provided by the NHS Trust. The programme has been offered since 2008 and takes an average of eight students per year although there is capacity for more. The current cohort comprises nine students.
11. The programme is 52 weeks in duration, commencing in January. Students undertake a core course of four weeks of full-time training, delivered at the DCP School and UBDH, at the beginning of the programme with a further 12-15 days being taught over 44 weeks, dependent on the needs of the cohort. The timetable is flexible and time for revision sessions of the students’ choosing are included. Outside of the training days, students are at their work placements treating patients, learning and consolidating skills. Students must complete a minimum of 23.5 hours of orthodontic therapy work per week and these hours are monitored by the provider. The workplace trainers are aware of the programme timetable and are required to provide weekly tutorials. The content of these tutorials is agreed between the supervisor and student; the provider does not prescribe what topics should be covered.
12. Core skills are taught and assessed during the core course with these being consolidated and built upon at the work placements. Summative assessment takes place both internally, using written examinations and Objective Structured Clinical Examinations (OSCEs), and externally with the RCSEd written papers, case presentation and structured oral examination.
13. The course team comprises a consultant orthodontist who is also the Programme Director, and the OT Tutor. The team is supported by the Head of the DCP School and by clinical teachers. Ongoing monitoring and assessment of students, pastoral care, liaison with the workplace trainers, and formal reviews of the logbooks are completed solely by the course team. The team have the power to agree and implement changes although this will often take place in with the agreement of the Head of the DCP School.

Evaluation of Qualification against the *Standards for Education*

14. As stated above, the *Standards for Education* were used as a framework for this inspection. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement is met, partly met or not met and to provide evidence in support of their evaluation. The inspection panel examined this evidence, requested further documentary evidence and gathered additional evidence from discussions with staff and students.
15. The inspection panel used the following descriptors to reach a decision on the extent to which the Bristol Dental Hospital Diploma meets each Requirement:

A Requirement is **met** if:

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

A Requirement is **partly met** if:

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

A Requirement is **not met** if:

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

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

Requirements	Met	Partly met	Not met
1. Students will 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients must be made aware that they are being treated by students and give consent	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Should a patient safety issue arise, appropriate action must be taken by the provider	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

GDC comments

Requirement 1: Students will 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*)

The assessment of students' knowledge and skills starts before the commencement of the programme. At the interview stage, the students' previous dental knowledge and experience is

assessed by the programme leads, who then modify the programme to meet the needs of the cohort. The panel felt this was an example of good practice.

A full range of clinical subjects are covered during the four week core course. These include oral examination, radiography, and sterilisation, as well as other key subjects such as law, ethics, professionalism and consent. Core competencies are delivered and assessed during the core course: bonds, bands, impressions and arch-wires. This consolidated teaching prepares the students for entering the clinical environment as a student orthodontic therapist, with the expectation that competencies will be built upon and improved during their time on placement. The students are also able to participate in new patient assessment clinics at UBDH during the core course. This not only exposes students to the clinical environment but allows for communication skills to be developed and formatively assessed by the supervising consultant.

The core course culminates in a pre-clinical Objective Structured Clinical Examination (OSCE) which must be passed before students are allowed to commence their work placements. All core competencies are tested during the OSCE and the programme leads participate within the exam so that students must complete or replicate procedures on a mock patient rather than a phantom head.

The panel were satisfied that students are adequately and appropriately trained and assessed prior to treating patients.

Requirement 2: Patients must be made aware that they are being treated by students and give consent (*Requirement Partly Met*)

Obtaining consent is covered during the pre-clinical core course. Students receive lectures on the subject and are made aware of their obligations under the relevant guidelines. The consent procedure and policy at the work placements is checked by the OT Tutor for the programme during their pre-programme inspections.

The method, by which students are expected to obtain and check that consent has been given for treatment, can differ between placements. The provider does not prescribe or provide guidelines on how consent should be obtained and recorded by students. Similarly, there is no model for the identification of students on placement. The use of particular uniforms, badges, or patient-focussed signage is not required by the provider, so it is up to the individual supervisor and student to decide how patients will be informed that a student orthodontic therapist is undertaking their treatment. The students are given an ID badge from the Trust with student orthodontic therapist and their name written on that can be used on placement. However the panel felt it would be helpful if the student handbook was updated to make clear that ID badges should be worn in any clinical situation,

While the panel recognised that the enforcement of standardised uniforms, badges and/or signage across a range of placements would be difficult to enforce, it was felt that more could be done on the part of the programme leads to assure themselves that patients are adequately informed and are able to make a decision whether they want to be treated by a student and know the implications of this.

Equally, the panel felt that a policy must be developed to clarify how consent for treatment by a student should be obtained to ensure that there is a standard against which the processes in place in the placements may be measured. This would ensure that a baseline is achieved, which would give greater scope to the programme leads to request a change in a placement policy should their approach to consent not be considered to be robust or good practice.

Requirement 3: Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care (*Requirement Met*)

The experience that students receive during the core course is subject to NHS health and safety policies. University Hospitals Bristol (UHB) policies and those specifically from the DCP School come into effect where teaching takes place in the clinical skills laboratories and in UBDH.

All work placements are required to have been inspected by the Care Quality Commission (CQC). The placements are further subject to a pre-clinical inspection by the programme's OT Tutor to further determine their suitability. A checklist of policies and facilities is used to ensure that all areas are checked, including staff ratios, health and safety equipment, and numbers of instruments. All areas of the checklist are numerically weighted so that potential placement must attain a minimum score to be considered suitable. Any placement that does not meet the checklist criteria would be deemed to be unsuitable and the student would therefore not be offered a place on the programme.

The checklist criteria was felt to be stringent and the requirement for all placements to have been CQC inspected gave further assurance to the panel that the placements are safe and appropriate. However, the inspectors agreed that the internal policy governing placement inspections could be strengthened. For example, the policy in place does not define what action the programme leads would or could take if problems arose at a placement. A policy describing actions that would be taken to resolve any issues, as well as related recording systems to track the resolution of the issues, could be introduced to strengthen the process and provide an audit trail.

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

The supervision levels on placement can vary, with a sliding scale of supervision employed. Supervisors are expected to oversee an entire procedure at the beginning of the placement with this reducing to a check at the beginning and end of a procedure as the student progresses. The time at which the supervision levels reduce is up to the individual supervisors to determine.

Should a supervisor be away from the practice then the student can only be supervised by another specialist-registered orthodontist. This is a condition of the indemnity insurance obtained by the programme leads for the students. If an orthodontist is not available then the student must stop all orthodontic therapy duties.

Supervision is checked during unannounced visits from the OT Tutor. Such visits ensure that the students are not participating in dental nursing duties during their required weekly 23.5 orthodontic therapy hours, and also that both student and supervisor are adhering to their learning agreement.

Students reported that they were happy with the level of supervision received, and the supervisors spoken to by the panel also felt confident that the level of supervision was right. Several supervisors have been responsible for past students and felt they could decrease, or increase, the amount of supervision as the student required.

Students receive weekly tutorials at their placements which are delivered by their supervisors. These tutorials underpin the learning students receive from the provider as well as further enhancing the supervisors' understanding of the student's skills and abilities. Added to this is

the fact that all of the current cohort was working at their work placements, with their supervisors, before commencing their training. These established relationships provide further assurance that supervisors are aware of the support their students need and can therefore deliver the requisite level of supervision.

This confidence combined with the sliding scale approach to supervision, and the conditions of the indemnity insurance, assured the panel that students are being supervised appropriately. The unannounced visits give further assurance, but these are seriously undermined by the fact that the findings of such visits are unrecorded. The panel was very disappointed by this, as the purpose of such visits is important and could uncover patient safety issues as well as issues relating to student safety and welfare. The panel accepted that visits are taking place, but agreed that the implementation of a formal recording system for these is a priority for the programme leads (unannounced visits are addressed further under Requirement 10).

Requirement 5: Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body (*Requirement Met*)

Registration details were provided for all the workplace supervisors and their specialist registration was confirmed to the panel by GDC staff. It was confirmed that students were always supervised by specialists in orthodontics, but previous experience in teaching and/or supervising trainee orthodontic therapists is not a prerequisite for potential supervisors. To mitigate this, the provider holds two Train the Trainer days to prepare supervisors for the programme.

The first Train the Trainer day takes place during the core course, before students enter their work placements, and the second occurs halfway through the programme. Subjects covered during the first training day include the marking schemes available to the supervisors, completing the logbooks, giving feedback and calibration. The second day is targeted at assisting the supervisors to prepare students for final exams and in selecting suitable case presentations.

The panel was pleased that training is regularly given to supervisors and that this is still the case even if a supervisor has been involved with the programme previously. Both of the supervisors the panel spoke with had had students in previous cohorts and were familiar with the expectations of the provider.

Requirement 6: Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety (*Requirement Partly Met*)

The programme uses the whistleblowing policy of the relevant Trust regarding raising concerns. Students hold honorary contracts with the relevant NHS Trust for their work at the DCP School and UBDH. Individual work policies coming into force when at their placements. The programme leads operate an open door policy to students to encourage issues and concerns to be shared. Time is also allowed during the study days for general discussion on 'patient journeys' and treatments, giving students the opportunity to discuss any issues they have encountered in practice. All students are required to keep their registration with the GDC while on the programme so are subject to the GDC's Standards for the Dental Team and the prescribed duty to raise a patient safety concern where appropriate. Registration is not only a requirement for the programme but also for entry to the RCSEd final exams.

While the relevant Trust whistleblowing policy is in force at times, the absence of a programme-specific policy has implications in terms of the protection and support students can expect to receive, if they need to raise a concern about their employer/work placement. The

lack of guidance describing how students would be supported or how the programme leads would address any issues with the supervisor highlights potential conflicts of interest as students may put at risk their ability to continue at their place of employment through raising a legitimate concern.

The programme leads advised the panel that they would write to or email a placement if a student had a concern. The programme leads informed the panel that the student may seek advice from programme leads and they programme leads would liaise with the student and the training orthodontist and offer assistance. However, the panel felt this needed to be firm up by the School and documented in the student handbook or the 'Whistleblowing Policy' so that it is clear what the policy is to all involved. The inspectors felt that the School needed to take greater ownership of this issue, rather than relying on the policies in place in relation to placements.

The panel could not consider the Requirement to be met because of the lack of documentation providing detail of the support that would be offered to a student who raised a concern about a placement. The registrant status of the students, and the fact that there had not been an incident requiring a student to leave a placement due to a patient safety issue in previous years, was taken into account, and the Requirement is therefore considered to be partly met. The programme leads must introduce formal guidance for their students about raising concerns. Additional guidance describing the support offered in the event of a concern being raised should also be produced and implemented. This guidance should also be in the student handbook as one of the policies that must be read.

Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider (*Requirement Partly Met*)

Students' practice at the DCP School and UBDH is governed by the policies of the relevant Trust, which cover a full range of areas including incident reporting, protecting patient information and staff conduct. Work placements are checked to ensure that the requisite patient safety policies are in place and that there are appropriate health and safety procedures.

There is no written requirement for the supervisor to inform the provider of a patient safety incident involving a student. However, even within the DCP School and Bristol Dental Hospital there was no documentary evidence that demonstrated how the programme leads would be involved should an issue arise. Being Trust employees, the members of the programme team are subject to Trust policies although there was no evidence of participation with the governance meetings or health and safety boards of either the School or Hospital.

The panel was particularly concerned that the remit and responsibility of the programme leads in regard to any issues at the work placements was not defined. Learning and education agreements are in place between the supervisors and students but there are no such formal agreements between the provider and the supervisors. The panel felt that introducing an agreement that relates directly to the relationship between the workplace supervisor and the provider was integral to ensuring that patient safety is assured and that students are adequately supported. Should an issue arise in practice, the programme leads do not have any defined powers to intercede should they feel that this is warranted for the safety of the student as well as that of the patient.

This Requirement is partly met because there was limited evidence provided that demonstrated the programme leads would take action in the event of a patient safety issue occurring at a placement. The provider must create and implement a policy or guidance document that defines when they would be informed and when they can intercede on a patient safety issue involving a student. Such guidance or policy must be shared with workplace supervisors.

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 (*Requirement Partly Met*)

At the commencement of the programme, students are required to sign a declaration that confirms their understanding of fitness to practise. The programme has not had any student fitness to practise issues to date. The declaration is underpinned by the students' registrant status, as they are subject to GDC Standards for the Dental Team. Student attendance at study days and at their work placements is closely monitored. Professionalism is covered in a formal lecture that references the GDC's Standards for the Dental Team. Students are bound to NHS proceedings while at the DCP School and University Hospitals Bristol due to their honorary contracts with the Trust.

However, the programme does not have its' own student fitness to practise policy. It is unclear whether the Trust policy could be invoked if a student fitness to practise issue were identified at a work placement and the policy also does not describe the action the programme leads would take.

A programme-level policy must be introduced to describe what action would be taken should a student be subject to fitness to practise proceedings at a local level, before NHS procedures apply, and also in regards to any fitness to practise issue arising from an incident at a work placement. Students and supervisors alike must be made aware of the policy.

Actions

No	Actions for the Provider	Due date
2	The provider must introduce a policy regarding students obtaining and checking consent while at their work placements. The provider should also consider introducing standardised badges or signage across all placements to ensure that patients are better informed that a student orthodontic therapist is providing treatment at that placement.	Targeted Annual Monitoring 2015/16
3	The provider should consider introducing a policy to govern the inspection of potential student work placements. This policy should describe the process for resolving any issues with related recording of the identification and resolution of such issues.	N/A
6	A programme-specific policy about raising concerns must be introduced. The provider must also define what support students will receive in the event of raising a concern to further encourage students in their duty of candour.	Targeted Annual Monitoring 2015/16
7	The provider must implement guidance and/or a policy to define when they will be involved in the resolution of a patient safety issue involving a student. Such guidance or policy must be shared with workplace supervisors.	Targeted Annual Monitoring 2015/16
8	The provider must implement a student fitness to practise policy and make students and supervisors aware of its contents.	Targeted Annual Monitoring 2015/16

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

Requirements	Met	Partly met	Not met
9. The provider will 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. The provider will have systems in place to quality assure placements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Any problems identified through the operation of the quality management framework must be addressed as soon as possible	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Programmes must be subject to rigorous internal and external quality assurance procedures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow the Quality Assurance Agency (QAA) guidelines on external examining where applicable	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
15. Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

GDC comments

Requirement 9: The provider will have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function (*Requirement Partly Met*)

The quality management for the programme operates on an informal basis. The programme leads hold the responsibility for modifying the programme based on student experience and feedback, mapping the curriculum to the learning outcomes, and completing the newly introduced 'Annual Review'. Much of this work is reported to the Head of the DCP School of the University of Bristol.

The policy content for the OT programme comes either from the Trust, who have ownership of the programme, or from the University of Bristol via the Dental Hospital or DCP School. The programme therefore benefits from being able to utilise an in-built policy layer, which is an

advantage considering that the administration of the programme is solely the responsibility of the small programme team. The small team allows for a close relationship with the students, who will meet with the Programme Director and OT Tutor throughout the core course and at every study day. Having autonomy to modify the curriculum also allows for revision sessions to be decided upon and built into the programme at short notice.

While elements of the current management framework are to be admired, the panel felt that they could not consider there to be a formal, effective framework in place. This is because the process overall lacks definition, structure and there is an absence of formal recording.

Meetings between the programme leads are not documented, meaning that there was no evidence available that demonstrated how the programme had been modified over time or how any issues identified by students or other teaching staff had been considered and resolved. Timetables were provided to evidence changes to the programme based on the experience of the cohort but these lacked detail. Meeting minutes for 2012, 2013 and 2014 were provided in the documentation.

The mapping of the programme to GDC learning outcomes was not comprehensive or evidenced in any great detail. A 'Blueprint Assessment' was provided that demonstrated the matching of final exam assessment types (the written, case presentation or oral exam components) to the programme's learning outcomes along with a further mapping document that matched assessment types throughout the programme to the RCSEd learning outcomes.

There was no link between the mapping documents in place and the timetable, so it was not possible to see when a particular learning outcome had been assessed and the type of assessment used. The programme leads advised that the programme has been mapped to the GDC's learning outcomes in Preparing for Practice, but could provide no documentary evidence of this other than that produced for this inspection. The panel could not find evidence that all the domains defined in Preparing for Practice were being addressed by sessions noted on the timetables

Reviewing student logbooks is one way in which the programme leads can be assured that all GDC learning outcomes are being met by the students, but the review of these is not formally recorded. The OT Tutor stated that they made notes after reviewing each logbook and also that the Programme Director knows where the notes are physically kept so they can review them if they so wished, also any problems are highlighted to the programme director. The panel agreed that that this system was not sufficient and did not constitute effective recording or information sharing. There was no documentary evidence provided that the programme leads met regularly to discuss the programme, although assurance was given that this does happen. The need for a central recording system was highlighted after the first inspection of the programme in 2008 and the inspectors were disappointed that this has not been implemented.

The notion of an Annual Review was welcomed by the panel and evidence of the first review, completed for the 2013 cohort, was provided. The Annual Review is intended to be the formal process for analysing all aspects of the programme and making determinations as to what can be changed or improved for the next cohort. The panel were hopeful that this process will 'bed in' and improve, as the Review that had been completed did not appear to be as comprehensive and wide-ranging as it could be. The panel noted that the process was introduced by the current Programme Director who was appointed in 2012.

Despite the number of policies available to the programme leads to adapt and apply to the programme, a number of policies provided to the panel were out of date or factually incorrect. Four policies were provided that were labelled as being specifically for the orthodontic therapy programme, and were all dated 2014. However, the timeframes for completion of key events

within these policies were not dated past 2007, indicating that the policies have not been updated since that time. These dates were left as this was the original time that these were completed. All four codes of practice are updated yearly and the new date placed on the front cover for each new intake. The information contained within at least one of the policies was contradictory.

The lack of contemporaneous and factually correct programme-specific policies must be addressed. The panel appreciated that the programme is designed for a small cohort of students who will receive the vast majority of their experience away from the provider, meaning that the numbers of formal meetings, committees and quality assurance required may be fewer than for a larger programme. However, the lack of a basic quality management framework in regards to record keeping and effective policies means that this Requirement cannot be fully met.

Further to this, should a programme lead be unexpectedly away then there is no contingency as to how the programme would function. As stated above, the quality management of the programme is the responsibility of the programme team who are also responsible for the pastoral care of students and administration of assessments. Without up-to-date policies and key documents being held centrally, the panel could not determine how cover for one of the programme leads could step in and be effective in the role.

For this Requirement to be met, the provider must formalise their approach to mapping, modification of the programme year-on-year, staff meetings and recording. A basic quality management structure must be implemented, underpinned by thorough recording that defines how often programme leads will formally meet and what areas will be discussed at each meeting. Staff meetings, particularly when decisions are being made, must be minuted and those minutes held centrally and securely. Review of student attainment via the logbooks must also be held in the same manner to allow the Programme Director and Head of the DCP School to review as necessary.

A detailed mapping exercise demonstrating how the GDC learning outcomes are delivered and assessed must be completed as soon as possible. Such documentation must detail where in the timetable the outcome is covered, how it will be assessed and when. A subsequent exercise to bring all internal policy up to date must be implemented.

**Requirement 10: The provider will have systems in place to quality assure placements
(Requirement Partly Met)**

The quality assurance of work placements consist of three main elements: inspections prior to the programme commencing, unannounced visits during the programme, and learning agreements between the student and their placement supervisor.

The first element is completed by the OT Tutor and consists of a visit to the placement to ensure that set criteria are present, such as relevant patient safety policies, suitable equipment for treatment and an area where students may have tutorials with their supervisor. An unannounced visit is also completed by the OT Tutor and can either be an entirely random visit or triggered by a concern raised by either the student or the supervisor.

The learning agreement comprises two different written agreements, one called the Training Education Agreement and the second being the Training Agreement. The first contains expectations for the student and the supervisor which have been set by the provider, and include the need for independent study, self-evaluation, and the requirement for a suitable learning environment. The student and supervisor need to complete a form to signal their intention to adhere to the expectations, while the second agreement must be jointly completed

with the student and supervisors' specific and individual values, obligations, and expectations of each other.

The panel found that all placements have been visited and the requisite paperwork completed. Potential students will not be offered a place on the programme until a satisfactory pre-programme inspection has been completed. The programme leads further evaluate the ongoing quality of placements through informal feedback obtained during study days and the second Train the Trainer day.

The panel found much to praise about the quality assurance systems of placements but were disappointed that these were undermined by two main issues. First, the unannounced visits are not documented or recorded in any way. When questioned, the panel were informed that it is possible that some hand-written notes of the visit had been kept but there are no formal mechanisms that record when the visit took place – the dates are in the tutors diary which can be accessed by the DCP director, the reason for the visit, what was found at the visit, and whether any further action was required. The lack of recording was felt to be a serious and significant gap in the quality assurance process and one that must be remedied immediately.

Secondly, formal agreements between the provider and the supervisor regarding learning and teaching were not in place. The panel felt that this presented a gap in the action that a provider could reasonably take if an issue were to arise. The obligations and expectations of the supervisor to the provider, and vice versa, were not defined. Without a direct agreement, the panel were concerned that a supervisor could argue against the provider's attempts to intercede on specific matters because the supervisor's agreement is with the student, not the provider.

To fully meet this Requirement, the provider must implement formal recording of unannounced visits. Such recording must be thorough and include the outcome of the visit, including any contact with the supervisor following the visit to resolve an issue. The provider must also implement an agreement between itself and the supervisors to ensure that the supervisors understand that the programme leads may act on a student's behalf if necessary.

Requirement 11: Any problems identified through the operation of the quality management framework must be addressed as soon as possible (*Requirement Partly Met*)

The principal method for programme leads to identify problems is by direct feedback from students. Students meet with the Programme Director for a 1:1 meeting in Month One and Month Five of the programme. The programme leads advised the panel that students are encouraged to raise any issues they may have with any aspect of the programme at that time. There is also the opportunity for informal feedback during the study days. The OT Tutor may identify an issue via the review of the logbooks and feed this back to the Programme Director. Due to the small cohort and size of the programme team, it is assumed that issues can be identified and discussed quickly, as both of the programme leads are based at the DCP School.

Supervisors have the opportunity to provide feedback at the second Train the Trainer day and also have contact details for the programme leads, so may raise an issue at any time. The supervisors that spoke with the panel advised that they felt comfortable speaking with the programme leads and would not hesitate to do so if they needed to consult with them.

The lack of recording identified for other Requirements was also in evidence here, as documentary evidence of the 1:1 meetings or any other student feedback was not provided. The time allowed for the review of the logbooks during 1:1 meetings also appeared to be limited as there was no allocated time for this activity in the timetables. Contact with the

supervisors also did not appear to be logged, so the panel had only oral evidence that issues can and would be identified.

The informal nature of the quality management framework (discussed under Requirement 9) meant that there are no set timeframes within which problems must be resolved or a formal process for managing them. The programme leads may consult with the Head of the DCP School if required but as the programme is an NHS one it is difficult to ascertain exactly what support would be offered by the DCP School in resolving problems.

The implementation of a more formalised quality management framework together with a mechanism to record and follow up on any problems reported to the programme leads would assist this Requirement to become met. Meetings between the programme leads to discuss and resolve problems must also be introduced to provide an audit trail and assurance that problems will be addressed.

Requirement 12: Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity (*Requirement Partly Met*)

The programme leads are aware of the educational climate in regards to orthodontic therapy programmes in the UK and are aware of the numbers needed to allow their programme to continue to run. Up to 12 students can be recruited for each cohort but the programme could continue to run if the cohort reduced to six students. This is not envisaged to be an issue at the present time, as the number of suitable applications exceed the number of places available every year.

The panel felt that a risk to students achieving the required outcomes on the programme would be if they experienced difficulties at their work placements. As mentioned under Requirement 6, work placements are the students' places of employment and this presents a conflict in regards to raising concerns as this could lead to employment difficulties. The panel accept that students are registrants and therefore are obliged to report concerns about patient safety if they arise, but felt that further support should be available for students in this situation. This is particularly important considering the clinical responsibilities that orthodontic therapists have in addition to those that dental nurses have.

Students are also at risk from having to discontinue a placement should their supervisor be unexpectedly away from work and another specialist orthodontist being unavailable. Such a situation would invalidate the student's indemnity insurance and render them unable to practise as a student orthodontic therapist. Whatever the potential reason for losing a placement, it is entirely the responsibility of the student to find a new supervisor. Two weeks are allowed for a student to find a new supervisor. The panel understood that the programme leads would not offer any practical support and there is no arrangement with UBDH to provide temporary placements to students.

The panel felt that a student losing a placement is a possible risk to the programme and the programme leads could do more to assist students should this situation arise. The programme leads must explore how they would be able to support students in such a situation and communicate this.

The panel also noted there was no process for notifying the GDC if there were any issues identified within the quality management framework governing this programme. The panel would like to see such a process implemented. This should include which stakeholders would be informed, who among the programme staff would notify the GDC, and how quickly the GDC would be informed.

Requirement 13: Programmes must be subject to rigorous internal and external quality assurance procedures (*Requirement Partly Met*)

Internal quality assurance is provided by the two programme leads, as discussed above. Quality assurance is not provided by the external stakeholders, such as the NHS or RCSEd, so the programme leads have developed relationships with the programme directors of other orthodontic therapy programmes in order to provide externality. The programme director for the South Wales Orthodontic Therapy programme quality assures the Bristol programme every year by meeting with students, gathering their feedback and providing recommendations to the programme leads. The programme also has links with the programme in Leeds. The panel recognised the proactivity on the part of the programme leads in developing these relationships and introducing externality in this way, and felt that the programme leads should be commended for this.

Documentary evidence of these visits and any student feedback obtained was provided for the panel during the inspection. The appraisal carried out for each student by the external appraiser is in their student file. The inspectors agreed that the process would be strengthened if the work completed by the external programme director was recorded. The panel were told of an example when students were unhappy with a consultant that provided a lecture during the programme and fed this back to the South Wales programme director. The programme leads were subsequently notified and the consultant was replaced with a more engaging clinical teacher. The example highlighted the programme leads' ability to make autonomous decisions and modify the programme to make it engaging and effective for students, but recording of such changes would be beneficial.

In-programme assessments are not subject to any form of external quality assurance and the curriculum is not ratified or overseen by any of the external stakeholders. Recording of the interaction with the South Wales programme director is an important step and the panel would also support any move to extend the external programme director's role to provide oversight of the curriculum and assessments. This would benefit the programme especially where improved mapping to the GDC learning outcomes is required and provide assurance that assessments are commensurate with current educational practices.

Requirement 14: External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow the Quality Assurance Agency (QAA) guidelines on external examining where applicable (*Requirement Partly Met*)

External examiners are not used throughout the delivery of the programme. In-programme assessments are set, marked and administered by the provider.

External examiners are used for the RCSEd final exams. These include the programme leads, who are considered to be 'external' because they are examining within their role as RCSEd examiners and are not present to provide an internal examiner role. All of the examiners used for the final exam are trained by the RCSEd and familiar with the learning outcomes for, and scope of, an orthodontic therapist.

All external examiners were used in examining students, meaning that no examiners were free to provide overarching quality assurance of the process. The objectivity of examiners asking to quality assure an exam that they have been directly involved with is compromised and feedback received after the exams could be considered to be of limited value.

To meet the Requirement, the provider must introduce the use of an external examiner(s) during the programme. The close relationship between the programme leads and the students

calls into question the objectivity of the in-programme assessments and some externality would help to ensure that the assessments are robust and adequately testing students. The RCSEd must also introduce a method of providing overarching quality assurance when examining students. A recommendation of the panel would be to utilise a selection of examiners to examine students leaving one or two free to observe the examiner pairs and provide feedback. The provider could utilise their own external examiner, once engaged, to provide overarching quality assurance of the final exam for the provider's own purposes.

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment (*Requirement Not Met*)

The Annual Review is the only formal report that the provider completes. The impact of the Review is not known because of its recent implementation. As mentioned previously, any concerns raised by students have not been recorded and there was no documentary evidence provided to the panel that concerns are acted upon. Additionally, there was no formal feedback received at the RCSEd examiners meeting.

While the Annual Review may become more detailed and provide a formal basis for the quality of the programme to be monitored, maintained and/or improved, this is currently not the case. The panel considered that this Requirement is not met on that basis. Formal reporting from external examiners, the South Wales programme lead or exit questionnaires from graduating students would all provide sources from which the quality of education and assessment could be determined.

Actions

No	Actions for the Provider	Due date
9	The provider must introduce a quality management framework. This must define when areas of the programme will be discussed, require thorough recording of all meetings, central recording, focussed and detailed mapping of the programme to GDC learning outcomes, and an exercise to bring all policies up-to-date and keep them up-to-date in future.	Targeted Annual Monitoring 2015/16
10	The recording of the findings of unannounced visits must be introduced immediately. The provider must also create and implement a formal agreement between itself and the supervisors to define what the obligations and expectations are of each party.	Targeted Annual Monitoring 2015/16
11	The provider must record feedback received from students and supervisors thoroughly, notifying them of problems with the programme. Recording of meetings to discuss such problems and their resolution must be implemented.	Targeted Annual Monitoring 2015/16
12	Support for students losing a placement must be defined and communicated to students.	Targeted Annual Monitoring 2015/16
12	The provider must also define, within the quality management framework, the escalation process for serious threats to the programme, who will notify the GDC of such uses and the timeframe within which notification will take place.	Targeted Annual Monitoring 2015/16

13	The provider must record the external quality assurance provided by the external programme director. The provider should also consider whether the role of the external programme director can be extended to provide external quality assurance of the assessment strategy and the curriculum.	Targeted Annual Monitoring 2015/16
14	The provider must introduce the use of external examiners throughout the programme, particularly in regard to the clinical exams. The RCSEd must introduce a method of ensuring that an external examiner can provide overarching quality assurance of the final exams. The provider should consider whether their own external examiner could be involved in that process to provide feedback on the final exams to the provider itself.	Targeted Annual Monitoring 2015/16
15	The provider must develop the Annual Review into an effective means of reviewing the quality of the programme. Additional sources for formal reporting must be considered and implemented.	Targeted Annual Monitoring 2015/16

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

Requirements	Met	Partly met	Not met
16. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
17. The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18. Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
19. Students will have exposure to an appropriate breadth of patients/procedures and will 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. The provider should seek to improve student performance by encouraging reflection and by providing feedback ¹	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
22. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
23. Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
24. Where appropriate, patient/peer/customer feedback should contribute to the assessment process	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
25. Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

¹ Reflective practice should not be part of the assessment process in a way that risks effective student use

26. 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

GDC comments

Requirement 16: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards (*Requirement Partly Met*)

Attainment throughout the programme is measured through in-course assessments and by reviewing the logbooks to ensure that all clinical competencies are being undertaken and assessed. Students obtain the skills necessary to commence safe treatment of patients during the core course, and must pass a pre-clinical OSCE before they are permitted to progress onto their work placements.

The work placements are used to improve clinical and communication skills and to obtain additional training through tutorials with their supervisors. There are no prescribed numbers or benchmarks for treatments completed at the work placements, although students must complete every required procedure at least once in the first six months of practice and once more in the second six months. This is in place to keep students' skills up-to-date in each procedure.

The logbooks are reviewed during the study days at the School and the OT Tutor will speak with students directly if they appear not to be performing well or if they are not practising all of the competencies required. The provider has mapped the RCSEd learning outcomes to the assessment used during the programme, and every outcome is assessed at least once before the final exams and in at least one component of the final exams. The GDC learning outcomes are also mapped to the final exam.

The internal sign-up process consists of an OSCE that takes place approximately two months before the RCSEd finals. The OSCE takes place after the deadline for entry onto the final exams so the programme leads sign-up all students and make the decision to either withdraw or defer those who fail to perform to the required standard.

The Assessment Policy makes mention of a Board of Examiners meeting to be held after final exams and also the use of internal examiners. Neither process was observed. An overall assessment strategy containing details of each assessment type and the relevant pass marks was not provided.

The programme leads stated that any issues identified in the review of the logbooks by the OT Tutor will be brought to the attention of the Programme Director. The inspectors were unable to identify documentary evidence to support this statement. There was also no evidence that a review of the logbooks is completed with reference to summative assessment data held by the programme leads. Formal triangulation of student attainment was not evidenced anywhere in the programme. Neither the pre-clinical OSCE nor the sign-up OSCE are followed by a formal meeting to ratify results and confirm which students may progress. The provider's actions are weakened without formal recording.

The lack of central recording was a significant concern for the panel. This concern applies not only to in-course documentation, such as minutes of meetings and progression decisions, but

also to the logbooks themselves. Being paper-based, the risk of such documents being lost, accidentally destroyed, or potentially tampered with, is tangible. The logbooks are an important source of information, not only in tracking student attainment but in ensuring that students have met all of the entry criteria set by the RCSEd to enter the final exams. The RCSEd's Regulations Relating to the Diploma in Orthodontic Therapy state that students must have demonstrated "successful completion of a continuous assessment record". The programme leads stated that there had not been an issue with a student losing their logbook in the past but the panel still felt that this was a significant risk and that exploration of an online system, or at least a method to back up the data from the logbooks, should be considered.

Paper logbooks also prevent a review of a student's work without that student being present at a study day. This means that there is no opportunity for an ad hoc or particularly detailed review. The panel had difficulty in reviewing the logbooks while at the exam inspection because these had to be available for the RCSEd examiners and were then being returned to the students after their final case presentation, which emphasised this issue.

The final exam comprises three components: written papers, a structured oral exam and case presentations. Every component must be passed and a minimum mark achieved in each for the finals examination to be passed. There is no aggregation in place although different rules apply as to which components of the exam may be re-taken on their own by a student, depending on whether the two written papers have been passed. The written exams are set independently by the RCSEd and standard-set using the Angoff method by a team of examiners prior to the exams taking place. The RCSEd confers the qualification onto students. The assessments within the programme are used to ensure that students have the requisite skills and abilities for either entering the clinical area or to be admitted to the finals.

The incomplete mapping of the programme to the GDC learning outcomes, as mentioned under Requirement 9, gave rise to concerns as to how the programme leads could be assured that all the outcomes are met by students. The panel could not determine exactly which outcomes were being taught and assessed at particular times during the programme, and were unsure as to how the programme leads are assured of this when considering whether students are ready for the sign-up OSCE.

There is much that the provider needs to do in order to fully meet this Requirement. Holding formal progression meetings and recording these is of particular importance, as is the adoption of a central recording system. The panel recognise that introducing an e-logbook or online system will be a challenge, and while this may not be feasible, other options should be considered, such as asking students to submit scanned copies of logbook pages each week. Such regular information gathering would allow the programme leads to build their own internal logbook for each student and allow for a more detailed review of student attainment. Improved mapping of the programme, as required earlier in this report, will allow for further assurance that this Requirement is being met. .

The panel also had concerns about the in-course assessments and the final exams, which will be discussed further under Requirements 18, 21 and 23. Notwithstanding these concerns and the other flaws identified, the panel felt that the students observed during the exam inspection were safe and suitable for registration as safe beginners.

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes (*Requirement Not Met*)

There was no evidence provided that demonstrated the assessment of students throughout the programme is recorded or monitored against the GDC learning outcomes. The incomplete

mapping of the programme to the learning outcomes meant that programme leads cannot check individual student attainment across the range of outcomes.

The programme leads rely heavily upon their close relationship with students as a method of monitoring student attainment. A close relationship does not constitute a management system and the lack of formal review undermines any holistic knowledge the programme leads may have about their students. Such relationships with students also cannot be guaranteed for future cohorts.

The formalisation of processes and completion of mapping specified for earlier Requirements would assist the provider in meeting this Requirement.

Requirement 18: Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed (*Requirement Partly Met*)

The methods utilised for assessing students include practical and theoretical assessments, which can be summative or formative. As well as the OSCEs, students complete a mini multiple short answer question paper and clinical assessments in the core course, and mock written papers prior to the final exams.

The panel noted that there was no evidence provided that demonstrated the quality assurance of the internal assessments. Assessments did not appear to have been discussed within the Annual Review and there was no documentary evidence that the South Wales programme director considered assessments as part of their remit to provide feedback to the provider.

The questions for the OSCEs are set by the programme leads and other clinical teachers involved with the programme. All questions are logged on a spreadsheet and the performance of that item in the assessment is reviewed. The questions are chosen for each OSCE and if a question needs modification then the setter will be asked to alter the marking guide as well. The Programme Director has undertaken formal question-setting training.

Despite these measures, the panel felt improvements could be made as the OSCEs are run by the programme leads, who also take on the role of mock patients and are responsible for marking the students. As mentioned previously, the programme leads have fostered close relationships with the students, but such relationships are also a burden on the objectivity of the programme leads when dealing with high-stake assessments. Considering the lack of externality from an examiner at any time during the programme prior to the finals, the objectivity in running and marking these important assessments was felt to be lacking and not in line with current assessment practice for summative assessments.

There was an absence of documentary evidence concerning the quality management of the programme overall and the panel could not determine when or if assessments had been developed or changed since the start of the programme. Because of this, and the other concerns that have been raised above, the Requirement can only be considered to be partly met.

Recording decisions and changes regarding the assessments, potentially through the Annual Review, as well as introducing peer review via the external programme lead and utilising an external examiner, would help the provider to meet this Requirement.

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will 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*)

Students are exposed to a full breadth of procedures during the core course of the programme, including training on headgear which may not necessarily be covered at the work placements. The programme leads are aware of differences between work placements in terms of the patients treated by that placement, as the patient mix is assessed during the pre-programme interview process. The types of patients available and the procedures likely to be offered are checked during the pre-programme inspection of the placement.

Students are required to complete 23.5 hours of orthodontic therapy practice per week at their placements. The supervisors are made aware of the hours required during the first Train the Trainer day and are also given the programme timetable at this time, with details of what is taught during the core course and on the study days. In this way, supervisors can better ensure that students see the appropriate breadth of patients at the placements and contribute to their learning with the weekly tutorials.

The panel had the opportunity to review logbooks and meet with students during the programme inspection. They felt that the experience students gain from the provider and at their placements was sufficient to allow them to cover all of the GDC learning outcomes. However, the assurance of the panel, and indeed of the programme leads, would be strengthened with comprehensive mapping to the GDC learning outcomes so that the programme leads can check the programme against the outcomes to make sure that all areas are covered. Increased monitoring of the logbooks would also provide greater assurance because the review is currently informal.

Requirement 20: The provider should seek to improve student performance by encouraging reflection and by providing feedback (*Requirement Met*)

Reflection and feedback is built into the programme via patient contact sheets in the logbook and during the study days. Students reflect on each patient treatment they have provided and record their reflection in the logbook. The supervisor must then provide a note of their feedback to the student on their performance. Evidence of this process being followed was seen in the logbooks.

Evaluation and feedback on assessments was evidenced in the timetables. Students receive feedback on their performance during the core course and may also provide feedback to the programme leads to help with the quality assurance of the programme. The students stated in a meeting with the inspection panel that they were satisfied with the amount of feedback received and also felt that their feedback to the provider was taken into consideration. There are opportunities for students to be given formal feedback by the provider through the 1:1 meetings with the Programme Director.

In addition, students must complete two reflective journals throughout the programme and these are monitored by the programme leads. It was unclear, however, how these journals were used by the programme leads and there were no examples of what feedback has been given to students arising from these.

The Requirement is considered to be met based on the evidence reviewed although a clear definition as to the use of the reflective journals would provide greater assurance of this in future.

Requirement 21: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body (*Requirement Partly Met*)

All professionals involved with assessing students during the programme hold appropriate registration. The programme leads each hold registration as either an orthodontist or as an

orthodontic therapist and have been trained to examine students by the RCSEd. The supervisors are registered specialists and have been trained to assess students by the provider.

The external examiners from the RCSEd also hold the requisite specialist registration and have undergone the RCSEd's training. Many are involved with other training courses, both for orthodontic therapy and orthodontics, and have examined students on other courses. During the exams, the examiner pairs observed RCSEd protocol by each examiner within the pair keeping to the same set of questions for every student to ensure standardisation and by marking independently.

However, the panel observed several aspects of examination practice which did not constitute good practice. At least one member in each of the examiner pairs (2 of the 3 rooms were inspected) was seen to make comments to indicate their assent or dissent to what the student was saying and thus giving the student clues as to whether to continue with their answer or change it. Leading questions were also used and students were often rushed before they had the opportunity to answer a question fully or to elaborate.

Examiner pairs did not ascertain that they were examining the correct student before commencing the structured oral or case presentation exams. Each candidate wore a visible ID badge with their candidate number and photograph and there was extremely limited discussion regarding calibration observed at the pre-exam briefing. The pre-examination briefing started before the panel was present despite the programme leads being aware of the panel's wish to attend. It was stated that the examiners had already reviewed written papers and collated a set of questions to ensure that questions were not repeated during the clinical exams, but this happened before the panel were at the meeting and no evidence of this was seen.

Despite the issues described above, the panel did not feel that students were marked incorrectly, and felt that only safe beginners passed the final exam. However, the practice followed by the examiners could be improved to help ensure best practice is always observed, thereby strengthening the consistency, validity and reliability of the assessments.

As stated under Requirement 14, the panel would like to have seen some oversight of the exams by a member of RCSEd staff or another external examiner acting in a purely quality assurance capacity. The RCSEd must consider the implementation of further training especially in regards to the meetings held before and after the exams, which did not mirror the criteria given in the RCSEd's own regulations.

Formal calibration was not observed and the meeting held to discuss the student's marks did not follow the procedures set down in the RCSEd regulations. The provider must liaise with the RCSEd to ensure that the correct procedures are followed and best practice observed to ensure equity and fairness for their students.

Requirement 22: 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 (*Requirement Not Met*)

The programme does not utilise external examiners at any time other than the final exams, and therefore no reports are received. The lead examiner for the RCSEd finals will compile a report but this is not shared with the programme leads, unless there is a particular area of feedback relating to them directly.

The programme leads are utilised as RCSEd examiners during the final exams. Students are allocated randomly amongst the examiner pairs, and it is a matter of chance as to whether the programme leads will examine their own students.

The Requirement is not met as external examiners do not perform a quality assurance function during the programme and are not asked to report on the assessment process.

The RCSEd must take action to ensure that their own documented processes are followed during their exams. The format prescribed for the meeting concerning the validation of marks in their protocol document was not adhered to, despite two associate members from the RCSEd being present. There was limited opportunity within this meeting for all of the examiners to provide feedback, which was an issue because only the lead external examiner compiles a report on the examination. The panel felt that the RCSEd should invite written feedback from all examiners as this would be representative of the full examining team.

Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments (*Requirement Partly Met*)

The criteria for the final RCSEd exams were defined in the regulation and protocol documents. The standard setting methodology was named as being the Angoff method. Groups of examiners were used to standard set the pass marks for each component of the exam including the vivas and case presentations. The documentation states clearly what the pass mark is and the grading system to be used. Students cannot pass the final exams if they fail any one component. Failing the written exam will require the student to undertake all components again, while failing a clinical component, such as the structured oral, will require the student to retake the clinical components only. The scripts for the written component were reviewed by the panel during the exam inspection and observance of the marking guides was seen.

Standard setting for the in-course assessments was not documented although the process was described. The programme leads stated that they use a group of six trainee orthodontists to review questions and decide what would be a suitable pass mark. This process was not described in the assessment policy. The process for marking the in-course assessments was also not defined in any paperwork so the panel could not be fully assured that these are being marked fairly or against clear criteria.

In all, twenty one candidates sat the final examinations, including students from orthodontic programmes, run by different institutions. The panel found the results of the final exams to be representative of the performance of the Bristol students. However, the inspection panel felt that the examination process raised questions about fairness for two specific reasons:

First, students are allocated to the examiner pairs by the RCSEd and some Bristol students were examined by their own Programme Director. The panel were advised that this was a coincidence as students are randomly allocated by candidate number. The panel were concerned that some Bristol students were examined by their Programme Director, whilst others were not examined by anyone they knew. The panel felt that this could be seen as advantageous to some, considering the close relationship between students and the programme leads. The programme leads advised that they would be required to inform the RCSEd staff they examined one of their own students but whether such a declaration would change the running of the exam is not known.

Second, the panel did not observe any supervision of students waiting for their exams to begin or of those students waiting to be allowed to leave after their exams had finished. The panel observed both sets of students waiting in different areas alone and with full access to mobile devices, meaning that students examined early in the day could forewarn their colleagues as to the types of questions that were being asked. The programme leads stated that the supervision of students was a matter for the RCSEd staff to attend to, but the panel felt that

this was the responsibility of all parties as any allegation of cheating would affect the fairness of the exams for all students.

The panel was concerned to learn that programme leads may examine their own students after being told one had dined with their students the evening before the exams. In this instance, the programme lead who socialised with the students did not examine any of them and the panel do not suspect any impropriety, but both the RCSEd and provider must take steps in future to ensure that programme leads do not examine their own students in future. Guidance on appropriate tutor-student interaction prior to an exam should be introduced and implemented. Such steps would help ensure fairness and would contribute towards the Requirement being met.

The provider must implement an assessment policy that details the standard setting methodology and pass marks for all of the in-course assessments. Should final exams take place on the provider's premises in future then they must assist the RCSEd in ensuring that students are appropriately corralled before and after exams. All parties must ensure that this happens for future exams across locations.

The use of two separate internal marking schemes on placements was a concern to the panel. Supervisors may select either a five point alphabetical or a three point numerical scheme as a way of marking student competency while at the work placements. The programme leads presented no rationale for when either scheme should be used or why two schemes are in place. This led to questions amongst the panel as to how effective the standardisation of supervisors marking students can be when some will be using an entirely different scheme from others. The panel felt that standardising the supervisors was a key component in considering whether they are appropriately trained by the provider, and without assurance of such standardisation in assessment the Requirement can only be considered to be partly met.

The provider must review the use of the two internal marking schemes and, if two schemes are still be used, define when each one is to be used, i.e. the alphabetical scheme at the beginning of programme followed by the numerical scheme, or vice versa. This must then be communicated to supervisors and appropriate training given to ensure standardisation across all placements. Without this in place the panel could not be assured that supervisors were marking clinical work to the same standard.

Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process (*Requirement Partly Met*)

During the core course, students work in pairs on clinic at UBDH which gives the opportunity for peer feedback. Once at their work placements, feedback is gathered from their supervisor and from patients. Both types of feedback are reviewed by the programme leads. Feedback from students also feeds into the programme via meetings with the South Wales programme director (discussed under earlier Requirements).

However, the use of feedback provided by patients or peers is not defined in any policy. There was no evidence that feedback is collated and discussed with students formally, such as during the 1:1 meetings with the Programme Director. To meet the Requirement, the provider must define how feedback will be used to contribute to the assessment process (formative and/or summative) and how any negative feedback from patients would be addressed.

Requirement 25: Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion (*Requirement Partly Met*)

Core competencies are assessed on a number of occasions. The provider holds no formal guidance as to how many times a procedure should be completed other than the guideline to practise within the first and last six months of the programme. The programme leads are aware that a procedure such as fitting and adjusting head gear may be difficult to see in practice. In that instance, students are not expected to gain the competency regarding head gear in practice and are instead taught the theory during the core course and the skills in subsequent sessions at the DCP School.

The sign-up OSCE is a school-run exam, which must be passed in order for the student to progress to the RCSEd finals. There are no summative, clinical exams between the two OSCEs. While a clinical OSCE is an effective means of assessment in theory, the panel were concerned that an external examiner is not utilised to assure the reliability of the assessment. Considering the high stakes nature of the assessment, objectivity from an external examiner would aid the validity of the assessment conclusion.

The inspectors found that the review of student attainment needs to be strengthened. Time for the review of logbooks is not built into the timetable. On the timetable, a slot is factored in on some of the study days to review logbooks and for discussion with the students. The OT tutor is present on all study days, allowing opportunity to review logbooks while teaching is carried out by other members of staff. There is no formal progression meeting where discussion on continuous attainment is considered in conjunction with, or prior to, the sign-up OSCE, which leads the panel to question whether a student could pass the OSCE while having performed poorly in some areas at their placement. The review of the logbooks is not recorded, and while the OT Tutor stated that she keeps notes on each student, these are not routinely shared with the Programme Director nor are they held centrally.

Thorough recording across the above areas would help to evidence that this Requirement is being met, but without that in place the panel can only consider this Requirement to be partly met. The School must introduce recording systems to support the ongoing review of students and should also consider introducing an element of externality and /or greater structure to the sign-up requirements for the OSCE to strengthen the assessment.

Requirement 26: 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 (Requirement Partly Met)

Students told the inspectors that they were kept informed about assessments and the course in general. However, the inspectors noted that the information given to students specifically in relation to the assessments appeared unclear and no student handbook is utilised on the programme. Timetables and policy information are available on the electronic system, BlackBoard, which can be accessed from work placements, home computers and on mobile devices.

The panel could not be sure that the standard expected of students was adequately explained. The timetables clearly stated which assessments will happen and when, but any kind of preparatory lecture or tutorial was not evidenced. Coverage of the Requirement in regards to student awareness could not be triangulated.

During lectures students are informed of the aims and learning outcomes of each lecture, which, when assessed would be based on these expectations and outcomes.

Similarly, the information given to supervisors was not clear. The programme leads advised that assessments are discussed during the two training days but it was not clear from the PowerPoint printouts provided whether such discussions involve detailed guidance on the standard expected of students. The programme leads appear to rely heavily on supervisors'

past experience both in the orthodontic field and in supervising students. While both are valid sources upon which supervisors may draw, there is no guarantee that all supervisors will have the same level of experience, and therefore detailed guidance and teaching during the training days would help fill any gaps supervisors might have in recognising both failing and high achieving students.

The variation in marking schemes used in practice also raised some concerns, as not all students were being held to the same standard. Comparability across the whole cohort was difficult for the inspectors to judge because supervisors could choose which scheme they personally want to use. As stated previously, the panel were not made aware of any rationale - for allowing supervisors to use the different marking schemes.

To fully meet this Requirement, the programme leads must implement a formal guidance document that is student-focussed and provides detail about the standard expected of them via ongoing assessment and at the summative assessments. The panel is aware that the programme leads are planning to implement a handbook in the near future and feel that this is the ideal place for such formalised guidance to be introduced.

Equally, guidance should also be provided in a supervisor-focussed document that ensure all supervisors, irrespective of experience, are aware of the standard expected of students on this particular programme. The programme leads should also consider the ongoing use of two marking schemes for the work placements with a view to implementing just one to ensure standardisation across the cohort.

Actions

No	Actions for the Provider	Due date
16, 17, 19	The process for assuring student attainment must be formalised and comprehensive recording introduced.	Targeted Annual Monitoring 2015/16
17	Systems for developing the logbook and allowing for continuous review must be introduced.	Targeted Annual Monitoring 2015/16
18	Changes and revisions to assessments must be recorded and reviewed under the Annual Review. Externality to the clinical exams must be introduced.	Targeted Annual Monitoring 2015/16
19	Mapping to the GDC learning outcomes must be completed and married with the assessment strategy and timetable.	Targeted Annual Monitoring 2015/16
20	The provider should define the purpose of the reflective journals and how these are used to provide feedback to students.	N/A
21	The provider must liaise with the RCSEd to ensure that all examiners are appropriately trained, and to provide feedback on exam performance. The provider must also work with the RCSEd to ensure that regulations are followed during the administration of the exams. The RCSEd must consider what additional training can be given to ensure that examiners act appropriately and should implement a process that enables them to have oversight of clinical exams as they are taking place.	Targeted Annual Monitoring 2015/16

22	The provider must introduce a method of receiving formal reports from external examiners on the quality of assessments. The RCSEd must ensure that exam protocols and regulations are followed.	Targeted Annual Monitoring 2015/16
23	The provider and RCSEd must ensure that students are not examined by their own programme leads. The provider must implement an assessment policy that defines the standard setting method and pass marks for all the in-course assessments. Students should be corralled before and after the final exams to negate any possibility of inappropriate interaction between examined and unexamined students.	Targeted Annual Monitoring 2015/16
23	The provider must specify which marking scheme is to be used and when, and communicate this to supervisors to ensure standardisation.	Targeted Annual Monitoring 2015/16
24	The provider must implement a policy describing how feedback will contribute to the assessment process. The policy must also detail what action the provider would take in the event that a patient provides negative feedback.	Targeted Annual Monitoring 2015/16
25	Thorough recording systems and a formal progression meeting must be introduced by the provider to ensure that multiple samples of performance are considered. The review of logbooks must also be recorded and student treatment numbers held centrally. The provider should also consider introducing an external element, such as an external examiner, to the sign-up OSCE.	Targeted Annual Monitoring 2015/16
26	Guidance given to students and supervisors on assessments and the standard expected must be formalised. The provider should also consider withdrawing one of the marking schemes used at work placements to ensure standardisation.	Targeted Annual Monitoring 2015/16

Standard 4 – Equality and diversity
The provider must comply with equal opportunities and discrimination legislation and practice. They must also advocate this practice to students

Requirements	Met	Partly met	Not met
27. Providers must adhere to current legislation and best practice guidance relating to equality and diversity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
28. Staff will receive training on equality and diversity, development and appraisal mechanisms will include this	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
29. Providers will convey to students the importance of compliance with equality and diversity law and principles of the four UK nations both during training and after they begin practice	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

GDC comments

Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity (*Requirement Partly Met*)

The programme is has access to several sources of equality and diversity policy, from the DCP School, the NHS and UBDH. The programme mirrors the equality and diversity polices of the DCP School and University Hospitals Bristol for student recruitment and assessment while utilising the NHS policy for patient-facing activity. This is underpinned by the honorary contracts students hold with the relevant NHS Trust for experience gained at University Hospitals Bristol.

Students are subject to occupational health screening by the DCP School in order to enter the programme and the provider has made reasonable adjustments in the past to support students with dyslexia and dyspraxia.

However, the provider does not have any programme-specific policy on equality and diversity. This means that there is no prescribed process on how an issue for a student would be dealt with. As the programme is independent from the DCP School, and indeed the University of Bristol, the processes contained within those documents are unlikely to apply.

The programme forms part of the DCP schools programme portfolio. As all students hold honorary contracts with the Trust, if an issue was to arise they would be subject to Trust HR protocols.

It was difficult for the panel to be assured that best practice and current legislation would be adhered to because there is no process in place. While a patient-facing issue would be dealt with either by the work placement or via the NHS policy, there is no policy that applies directly to students. Such a policy must be introduced and describe how issues would be addressed.

Requirement 28: Staff will receive training on equality and diversity, development and appraisal mechanisms will include this (*Requirement Partly Met*)

The programme leads and clinical teaching staff are all subject to NHS training protocols and undertake equality and diversity training regularly. Unfortunately, the training of the workplace supervisors is not checked or monitored by the programme leads. Equality and diversity training is not included within the Train the Trainer days.

The panel recognises that all of the workplace supervisors are registered orthodontists and work at practices that have been inspected by the CQC. However, monitoring of the supervisors' equality and diversity training needs to be introduced for the Requirement to be fully met.

Requirement 29: Providers will convey to students the importance of compliance with equality and diversity law and principles of the four UK nations both during training and after they begin practice (*Requirement Partly Met*)

Students receive a lecture on equality and diversity from the Programme Director but this is only received within the last three months of the programme, according to the timetable provided. There was no evidence of pre-clinical training on the laws governing equality and diversity or on the differences between legislation across different locations. The panel felt that the equality and diversity lecture is provided as revision rather than preparing students for encountering patients in practice. This is particularly important considering the increased clinical exposure, and potential difficulties that may arise, in the student's new clinical role as an orthodontic therapist and their previous role, usually as a dental nurse.

The provider must include teaching on the principles of equality and diversity before students enter the clinical area. Based on a printout of slides, the lecture itself looked to be wide-ranging and of a good quality and therefore including this at a pre-clinical stage would assist the Requirement in being met.

Actions

No	Actions for the Provider	Due date
27	A programme-specific policy regarding equality and diversity must be introduced.	Targeted Annual Monitoring 2015/16
28	The provider must check the ongoing training of workplace supervisors in equality and diversity.	Targeted Annual Monitoring 2015/16
29	Teaching on equality and diversity must be delivered to students pre-clinically.	Targeted Annual Monitoring 2015/16

Summary of Actions

Req. number	Action	Observations Response from Provider	Due date
2	The provider must have a policy on students obtaining and checking consent while at their work placements. This policy must be a benchmark against which individual practice policies are measured. The provider should also consider introducing standardised badges or signage across all placements to ensure that patients are adequately informed that a student orthodontic therapist is providing treatment at that placement.	Standardised identification badges have now been introduced clearly identifying the student and their status as a student orthodontic therapist. The badges are provided by the Bristol Orthodontic Therapy Programme. The updated learning agreement also outlines the need for a clear consent procedure to ensure that patients are adequately informed of the orthodontic therapist's student status. Obtaining and checking consent is discussed at the initial training day with trainers and trainees.	Targeted Annual Monitoring 2015/16
3	The provider should consider introducing a policy to govern the inspection of potential student work placements. This policy should describe the process for resolving any issues with related recording of the identification and resolution of such issues.	A flowchart has been introduced which must be used at each practice inspection. This describes the process for identifying issues and the direction for resolution.	N/A
6	A programme-specific policy about raising concerns must be introduced. The provider must also define what support students will receive in the event of raising a concern to further encourage students in their duty of candour.	A programme specific policy has been introduced. A flow chart has been introduced to define the mechanisms to deal with concerns and the support systems in place to support students raising concerns.	Targeted Annual Monitoring 2015/16
7	The provider must implement guidance and/or policy to define when they will be involved in the resolution of a patient safety issue involving a student. Such	Guidance is now in place. Issues surrounding patient safety will be brought to the attention of the Programme Directors in the first instance by the new Student Raising Concern Form. Evidence can	Targeted Annual Monitoring 2015/16

	guidance or policy must then be shared with workplace supervisors.	also be collated from reflective journals, logbook, and patient satisfaction questionnaires. These are discussed at regular meetings and actioned accordingly. This subject is also outlined at the initial training day under - Raising Concerns and Resolution of Patient Safety Issues.	
8	The provider must implement a student fitness to practise policy and make students and supervisors aware of its' contents.	The students are employees at their clinical placements and hold Honorary contracts with UH Bristol. As such, they are subject to UH Bristol staffing policies in addition to local placement staff conduct policies. Student Fitness to Practice is discussed at the initial training day where policy is disseminated. A new Code of Practice and Fitness to Practice Policy designed specifically for Orthodontic Therapists has been introduced. This is available in the student handbook and on Blackboard. The policy is discussed with the students so they are clear of the process.	Targeted Annual Monitoring 2015/16
9	The provider must introduce a thorough quality management framework. This must include definition as to when areas of the programme will be discussed, thorough recording of all meetings, central recording, focussed and detailed mapping of the programme to GDC learning outcomes, and an exercise to bring all policies up to date.	A quality management framework has been introduced. Each event and the associated "what, who and when" for each event is documented. A framework documenting agenda items for all meetings has been implemented and dates of each meeting set. The GDC learning outcomes have now been mapped with the learning and assessment of the course. Included in the agenda of meetings	Targeted Annual Monitoring 2015/16

		<p>throughout the year is the review of GDC learning outcomes and course mapping.</p> <p>All policies have now been reviewed, updated and added to. Review of policies has also been included as an agenda item to meetings throughout the year.</p> <p>The annual programme review process has been revised.</p> <p>All meetings are now documented and stored on a central system.</p>	
10	The recording of unannounced visits must be introduced immediately. The provider must also create and implement a formal agreement between them and the supervisors to define what the obligations and expectations are of each party.	<p>A formal agreement is now in place between the trainers, trainees and the Provider. This signed agreement is stored on the central system.</p> <p>Recording of unannounced visits has been introduced. A proforma is completed for each visit. These are discussed in a formal environment and stored on the central system.</p>	Targeted Annual Monitoring 2015/16
11	The provider must thoroughly record feedback received from students and supervisors notifying them of problems with the programme. Recording of meetings to discuss such problems and their resolution must be implemented.	<p>Appraisals are carried out at month 1 (internal) and month 6 (external) with the trainees. A meeting is also held with the trainers at month 6.</p> <p>Feedback is also recorded through the online logbook. Reflection sessions of logbooks have been timetabled into each study day.</p> <p>Findings are documented and discussed at the Programme Lead meetings. These minutes will be available on the central system.</p> <p>Feedback is incorporated within the Quality Management framework.</p>	Targeted Annual Monitoring 2015/16

12	Support for students losing a placement must be defined and communicated to students.	<p>The provider's policy with regards to losing a placement is documented in the learning agreement and in the student handbook. A clear process has been documented in the event of placement being lost which outlines where the responsibility lies to find alternative arrangements, and how this must be communicated.</p> <p>Issues and responsibilities relating to Placements are also communicated to students and trainers at the beginning of the course.</p>	Targeted Annual Monitoring 2015/16
12	The provider must also define, within the quality management framework, the escalation process for serious threats to the programme, who will notify the GDC of such issues and the timeframe within which notification will take place.	The process for dealing with serious threats to the programme is defined in the Quality Management Framework and in the Learning Agreement, including notification to the GDC.	Targeted Annual Monitoring 2015/16
13	The provider must record the external quality assurance provided by the external programme director. The provider must also consider whether the role of the external programme director can be extended to provide external quality assurance of the assessment strategy and the curriculum.	<p>The external assessor is provided with a proforma which is completed and stored. The external appraiser also writes a report, which is stored centrally. This is currently in place.</p> <p>From 2016, the role of the external appraiser will be extended and will also appraise the timetable and assessment process (linked to GDC learning outcomes) for quality assurance of the course. Leeds Orthodontic Therapy programme have confirmed they will act as external appraisers for 2016.</p>	Targeted Annual Monitoring 2015/16
14	The provider must introduce the use of external examiners throughout the programme, particularly in regard to the clinical exams. The RCSEd must introduce a method of ensuring that an external examiner can provide overarching quality assurance of the final exams. The provider should consider	The use of external examiners has been introduced. A representative from UCLAN Orthodontic Therapy Programme has confirmed as external examiner. Both written and oral Gateway	Targeted Annual Monitoring 2015/16

	whether their own external examiner could be involved in that process to provide feedback on the final exams to the provider itself.	examinations will be overseen by the external examiner and a report will be completed. The GDC recommendations have been relayed to the RCS Edinburgh regarding involvement of our external examiner at the final RCS examinations.	
15	The provider must develop the Annual Review into an effective means of reviewing the quality of the programme. Additional sources for formal reporting must be considered and implemented.	The Annual Programme Review has been revised. This is now a more comprehensive document, covering a review of mapping of GDC learning outcomes, teaching, assessment, appraisal, feedback and policy updating. This document will be held centrally.	Targeted Annual Monitoring 2015/16
16, 17, 19	The process for assuring student attainment must be formalised and thorough recording introduced.	GDC learning outcomes have been mapped to the teaching timetable and to the assessment process to ensure all areas of the curriculum are covered. Assessments, including formative assessments, are now standard set to ensure students are competent across all areas. Standard setting is recorded on the central system. Assessment results are recorded on Blackboard as well as centrally.	Targeted Annual Monitoring 2015/16
17	Systems for developing the logbook and allowing for continuous review must be introduced also.	An on line logbook has now been introduced. The logbook is reviewed at each study day and 3 monthly meetings include "review of logbook" on the agenda. The logbook will also be reviewed within the Annual Programme Review.	Targeted Annual Monitoring 2015/16
18	Changes and revisions to assessments must be recorded and reviewed under the Annual Review. Externality to the clinical exams must be introduced.	An external examiner has been introduced (2016 intake).	Targeted Annual Monitoring 2015/16

		The Annual Programme review has been revised from 2015 to include more thorough recording of any changes to the assessment process and the introduction of standard setting to all assessments.	
19	Mapping to the GDC learning outcomes must be completed and married with the assessment strategy and timetable.	Mapping of the GDC learning outcomes to the teaching timetable and assessment process has been completed. This will be reviewed annually.	Targeted Annual Monitoring 2015/16
20	The provider should define the purpose of the reflective journals and how these are used to provide feedback to students.	<p>The purpose of the reflective journals has been added to the student handbook.</p> <p>A seminar on reflection will be introduced to the trainers and trainees on the initial training day (January 2017).</p> <p>An explanation of the importance of clinical reflection and examples are provided in the student handbook.</p> <p>Opportunities to discuss and feedback from these reflections is built into the timetable – on a 1:1 and group basis.</p> <p>If issues arise from reflections or feedback then the appropriate escalation policy would be instigated.</p>	N/A
21	The provider must liaise with the RCSEd to ensure that all examiners are appropriately trained, and to provide feedback on exam performance should examples of poor examination practice be seen. The provider must also work with the RCSEd to ensure that regulations are followed during the administration of the exams. The RCSEd must consider what additional training can be given to ensure that examiners act appropriately and should also	<p>The provider has been in contact with RCS Edinburgh. It is a requirement that all examiners must complete an examiners training course and also attend refresher courses.</p> <p>The provider has been in contact with RCS regarding adherence to exam regulations. At the 2015 sitting, written copies of the regulations were given to all examiners. A lead examiner was</p>	Targeted Annual Monitoring 2015/16

	implement a process that enables them to have oversight of clinical exams as they are taking place.	appointed who also adhered to all guidance. The examiners' meeting was per the RCS protocol. Provider has been in contact with the RCS with regards to the GDC's recommendations.	
22	The provider must introduce a method of receiving formal reports from external examiners on the quality of assessments. The RCSEd must ensure that exam protocols and regulations are followed.	The provider has been in contact with the RCS Edinburgh with regards to the GDC recommendations. The external examiner for the provider is also required to complete a written observation and recommendations.	Targeted Annual Monitoring 2015/16
23	The provider and RCSEd must ensure that students are not examined by their own programme leads. The provider must implement an assessment policy that defines the standard setting method and pass marks for all the in-course assessments. The provider must also, when feasible, assist the RCSEd in supervising students before and after the final exams to negate any possibility of inappropriate interaction between examined and unexamined students. The RCSEd must also make sure such students are adequately supervised.	In place. This has been fed back to RCS. At the 2015 sitting, it was ensured that no student was examined by their Programme Leads. Any conflict of interest was declared prior to the exams. The provider has carried out standard setting of all assessments, as per own policy and the RCS methods. The provider has ensured that additional staff are present to facilitate supervision of students on assessment dates. This was in place for RCS sitting 2015.	Targeted Annual Monitoring 2015/16
23	The provider must specify which marking scheme is to be used and when, and communicate this to supervisors to ensure standardisation.	The marking scheme has been revised with the introduction of the online logbook. One marking scheme will be used. This will be the traffic light system of "red, amber, green". This is discussed at the initial training day to trainers and trainees. Calibration exercises are carried out to ensure standardisation.	Targeted Annual Monitoring 2015/16

24	The provider must implement a policy describing how feedback will contribute to the assessment process. The policy must also detail what action the provider would take in the event that a patient provides negative feedback.	A policy has now been introduced to deal with any negative feedback received from patients either through patient satisfaction survey or the Raising Concerns Form. Actions to be taken are clearly documented in flow chart form.	Targeted Annual Monitoring 2015/16
25	Thorough recording systems and a formal progression meeting must be introduced by the provider to ensure that multiple samples of performance are considered. The review of logbooks must also be recorded and student treatment numbers held centrally. The provider should also consider introducing an external element, such as an external examiner, to the sign-up OSCE.	Performance is monitored in several different ways to ensure multiple samples of performance are considered prior to progressing to the Final exam. Records of all assessments, appraisals, feedback are held centrally. The logbook is reviewed at each study day. A meeting to assess suitability to progress to Final examination has been formally timetabled.	Targeted Annual Monitoring 2015/16
26	Guidance given to students and supervisors on assessments and the standard expected must be formalised. The provider should also consider withdrawing one of the marking schemes used at work placements to ensure standardisation.	Only one marking system is now being used (traffic light system) to improve standardisation. Written guidance on assessments has been drawn up in the form of a table (including when carried out, reason for assessment, formative/summative and standard set) and has been included in the student handbook and on Blackboard (on line system available to trainers and students).	Targeted Annual Monitoring 2015/16
27	A programme-specific policy regarding equality and diversity must be introduced.	A programme specific Equality and Diversity Policy has now been introduced. This is available through Blackboard, has been discussed with the students and will be included in the student handbook from January 2017.	Targeted Annual Monitoring 2015/16
28	The provider must check the ongoing training of workplace supervisors in equality and diversity.	Equality and diversity has been added to the initial training day timetable. This presentation has also been added to Blackboard.	Targeted Annual Monitoring 2015/16

		Prior to course acceptance, the workplace is inspected. Training on equality and diversity as well as workplace policies are checked.	
29	Teaching on equality and diversity must be delivered to students pre-clinically.	<p>Equality and Diversity has been added to the initial training day timetable where both trainees and trainers are present. It is also available on Blackboard.</p> <p>The students also have further equality and diversity training within the first month of their training (preclinical), prior to returning to their workplaces.</p>	Targeted Annual Monitoring 2015/16

Observations from the provider on content of report

--

Recommendations to the GDC

The inspectors recommend that this qualification continues to be approved for holders to apply for registration as an orthodontic therapist with the General Dental Council.

The School must provide detailed information regarding how they have met, or are endeavouring to meet, the required actions set down in this report in 2015/16.