General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Central Lancashire	Bachelor of Dental Surgery – international route (BDSi)

Outcome of Inspection	Recommended that the BDSi is sufficient for the graduating cohort to register as dentist.

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

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine sufficiency of the award for the purpose of registration with the GDC as a dentist.**
Learning Outcomes:	**Preparing for Practice (dentist).**
Programme inspection dates:	**24, 25 and 26 July 2023**
Inspection team:	**Jenny McKibben (Chair and non-registrant member)** **Rita Bagga (Dentist member)** **Heidi Bateman (Dentist member)** **Andrew Buddle (Dentist member)** **Angela Watkins (Quality Assurance Manager, GDC)** **Kathryn Counsell-Hubbard (Quality Assurance Manager, GDC)**
Report Produced by:	**Kathryn Counsell-Hubbard (Quality Assurance Manager, GDC)**

The international route BDS offered by the University of Central Lancashire (hereafter referred to as "UCLan", "the School" or "the provider") is an innovative programme that demonstrates the changing needs of dental education. The programme seeks to actively address the national deficiency in qualified dentists by using students' prior qualifications and experience to enter them onto a training course that mirrors the final two years of a standard BDS programme.

The students undertaking this programme have qualified and worked as dentists, occasionally as specialists, outside of the UK. A minimum period of clinical experience is required as well as a pre-course assessment. Out of 50 candidates sitting the first pre-course assessment, 16 passed and subsequently seven were able to take up their offers and commence the programme. UCLan brings a wealth of experience in working with, effectively, post-graduate and international students which allows for support mechanisms to be in place that might not traditionally be available at other institutions.

As the programme is innovative, it presents certain risks and required a level of scrutiny above that of the UK student based BDS inspections. The panel were at UCLan for three days and checked the assessment and clinical practice data for all students. As much of the programme as possible is mapped to the existing BDS but key structural differences are evident, such as when the students begin their clinical practice and where this experience is gained. The existing BDS offers clinical experience at dental education centres and extended training practices but the international students are placed at one of two sites operated by the corporate dentist organisation {my}dentist.

These placements benefit from giving students immediate ‘real world’ experience and serves the local communities by increasing the number of dentists available to patients. One of the panel’s initial concerns was the potentially small patient pool given that {my}dentist is a private dental provider; however, this was mitigated by verbal evidence of the payment options available which allow for treatment to be at a level more commensurate with NHS prices. The concern was further not borne out through a review of the students’ attainment, as all students were achieving their clinical requirements.

The programme was scrutinised to a high degree because of its innovative format. The panel were aware that a programme of this kind may be open to replication given that it can ‘fast track’ individuals into general dentistry which faces a workforce crisis. A number of concerns were identified prior to the inspection but the panel were pleased to find that many of these concerns were unfounded and that the programme has achieved a lot in a short amount of time.

The programme will be subject to regular and vigorous review, but this is to reflect the changes the provider plans to make to the programme as opposed to being a reflection of its’ quality.

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

Background and overview of qualification

Annual intake	34 students
Programme duration	Year 4 (number of weeks) 32 weeks, full time Year 5 (number of weeks) 46 weeks, full time 78 weeks over 18 months
Format of programme	e.g: Year 4: basic knowledge, clinic attendance, shadowing and simulated clinical experience 5: direct patient treatment, clinic attendance, outreach, placements
Number of providers delivering the programme	1 (UCLan)

Outcome of relevant Requirements[1]

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

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

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

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

Before students are recruited onto the programme, they must demonstrate registration and good standing in their last country of practice as well as a minimum of 600 postgraduate clinical hours. The panel are assured that all checks are carried out robustly, however, the school should consider keeping a central, auditable record, of all these entry requirements checks that have been carried out on students. Students must meet these criteria before being invited to the School to undertake the pre-admission written examination paper and observed structured clinical examination (OSCE). The OSCE examines potential students in the skills that would be expected after the first three years of a dental surgery qualification.

The recruitment process not only determines which students have the skills to undertake this short programme but acts as a gateway, ensuring minimum levels of skill and competency before students undertake a consolidated period of clinical practice at the School. During this block of practice, the individual skills of each student can be assessed to enable teaching to specifically target any areas of weakness before the students commence placements at a {my}dentist practice. Additionally, given the small size of the first cohort, the provider is able to monitor students closely and establish close relationships with students, which also helps with their acclimation to the UK.

The panel examined the assessment blueprint and reviewed minutes from the appropriate board meetings where progression is discussed.

The Requirement was found to be met.

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

Consent is taught and assessed within the Integrated Clinical Knowledge module. Signs are utilised in the {my}dentist practices to advise of student treatment and students wear the UCLan scrubs to delineate themselves from staff. A leaflet is also handed to patients to inform them that their practitioner is a student, and this is included within the student's own introduction to the patient.

The panel are content with the measures described but identified an issue with the consent form. Until the time of the inspection, the provider had been utilising a general consent form that patients sign to give their consent to the treatment. Students noted their student status on the form. However, the provider needs to introduce a form that allows the patient to give explicit consent to treatment being provided by a student. This is an important distinction and one that will indicate that the practitioner, in this case a student, may give the treatment as opposed to the current process where the patient gives generic consent to the treatment, irrespective of the practitioner.

The provider responded to the concerns raised by the panel and immediately took action to change the consent form. The panel recognise these efforts and urge the provider to ensure that future patients consent to both treatment in general and treatment specifically by a student.

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

The provider works closely with their clinical partner, {my}dentist, to ensure that the placements are effective and support students. Mandatory staff training includes the placement supervisors and communication between them and the programme lead is regular. Supervisors reported feeling supported by the programme lead and praised their ability to respond to their questions within a short time frame. All placements are subject to review by the Care Quality Commission and those reports are checked by the provider.

The placements are subject to the same processes utilised by the existing BDS programme, and action sheets from the Quality Assurance committee and quality assurance documents were reviewed and found to be robust. The provider utilises a Structured Event Reporting Form, or SERF, that allows for any issues to be highlighted and reported back to the programme lead in short order. The panel reviewed examples of SERFs and saw how issues are identified and dealt with.

The programme team advised that one of the placements will be changing, and that others may be introduced or changed in the future. For the first cohort, the placements have either been in Thetford or Clacton-on-Sea but the Thetford practice will soon stop hosting students, and a new site in Falmouth will open. Despite this change and any in the future, the panel are assured by the processes demonstrated and found the Requirement to be met.

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

The School utilises enhanced training practices (ETPs) for the training of their BDS students. Due to having a full cohort for the standard UK BDS, students on the BDSi attend different ETPs that are owned and run by the corporate dental organisation {my}dentist. The practices used are ones situated in areas with low levels of available NHS dentistry, and students working at such placements are intended to help support the community.

The students undergo a School-based skills practice period but are not supervised in an open plan dental hospital clinic which would give opportunities for supervisors to easily supervise multiple students at once. Supervisors within the School also do not have the opportunity to observe the students over an extended period in the clinical skills laboratory because this element of the programme is short. To counteract this, while ensuring patient safety, a strict supervision ratio is maintained of no more than one supervisor to four students These ratios allow not only for close supervision but mean that the students can develop and improve in a shorter time frame.

Students enter the programme at a stage equivalent to a UK year four student and are expected to have the relevant skills of a year four student. This is the baseline from which

students are supervised. Supervision is supported by regular calibration and weekly meetings with the Programme Lead.

Practices are subject to quality assurance audits. They must meet the criteria imposed on the UK BDS ETP sites and reports from the Care Quality Commission are reviewed as part of the programme team's consideration as to the suitability of a placement. All ETPs must be approved by the Programme Lead and they have recently observed the interviews for potential staff for the new site in Falmouth.

The panel were impressed by the close working relationships between the ETPs and the central programme team which is often difficult to achieve. The supervisors from those sites spoke positively of the programme and the students, and those at the Clacton-on-Sea ETP were excited to continue to supervise students. The Requirement is considered to be met.

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

Placement supervisors are trained in-line with UCLan staff and subject to the same mandatory training requirements, such as equality and diversity. The CVs and confirmation of registration are reviewed by the programme lead before a potential supervisor is appointed and this is supported by a Clinical Supervisor Policy. The supervision ratio, both on placement and at the School, were found to be satisfactory.

The provider and {my}dentist actively try to pair students to supervisors with complementary backgrounds to better support the students. The panel found this aspect of the supervision process to be exemplary, as were the working relationships students forged with School-based clinical supervisors, with whom the students will correspond as required to treat their patients.

The Requirement is found to be met.

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

Placement supervisors are included within the mandatory induction and training that those employed by the School must complete, and hold the status of honorary university staff. This gave the panel assurance that all professionals with responsibilities for supervising the students had the knowledge and resources to raise a concern. Indeed, a concern was raised about a student and an incident was raised through the SERF system, additional training and support was given to both the student and their supervisor.

Despite the students' past professional experience, the fundamental elements of UK-based practice are covered within the initial learning block, and elements such as candour, whistleblowing and raising concerns are covered during this time. A specific whistleblowing policy is in place. Students also have access to online resources to further inform them how and when a concern should be reported. The University has a "report and support" procedure that acts to give the additional support required by those who need to raise a concern.

There are also multiple reporting lines to ensure that an issue is raised and acted upon. Students may raise such concerns with their supervisor, a member of University staff or the programme lead. Supervisors can report directly to the programme lead or Head of School, or can refer issues via their practice managers or the relevant clinical director at {my}dentist, who also maintains regular communication with the School.

These multiple strands of reporting mechanisms plus formalised policies and support initiatives allowed the panel to find the Requirement to be met.

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

The School has recently aligned with the medical school to create one new faculty. At the time of the inspection the formal merger of these two schools had not taken place but the programme leads had already aligned their processes with those of the medical school. A new quality management framework had therefore been introduced whereby the programme team now have access to multiple pieces of feedback about a student which are stored centrally. This allows the programme team to review their students 'in the round' and identify patterns of behaviour and highlight concerns.

The SERF system (discussed under Requirement 3) is effective in allowing for issues to be reported quickly. The system has a Designated Officer who is responsible for maintaining records and ensuring that relevant procedures are followed, such as referrals to fitness to practice processes. SERFs also feed in directly to the quality management system of the School as anonymised SERFs are discussed at the Quality Assurance and Evaluation Sub Committee, which further feeds into the Quality Assurance and Evaluation Committee and ultimately the Education Committee.

A risk register is held by the School but this is only updated on a quarterly basis. The panel felt that using the risk register, or a version of it, as a live document would benefit the programme team by enabling them to log and monitor contemporaneous risks as well as their resolution. The panel would strongly encourage the programme team to develop a more detailed such a living document, but ultimately found the Requirement to be met.

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

The panel examined documents and found fitness to practice and assessment 'fit to sit' procedures in place. These appeared to be robust and include the required characteristics of such policies. These are supported with targeted learning on professionalism and fitness to practice as well as a dedicated lecture on the SERF process.

One fitness to practice issue had been raised and dealt with. This involved a student prescribing an incorrect medication which was signed off by their supervisor. This issue was raised via a SERF and immediately identified for investigation by the designated officer. The student was interviewed by the Head of School and a clinical supervisor from UCLan

interviewed the {my}dentist supervisor. The reasons for the error were explored and the student supported with a structured programme of re-entry into the clinical area having been suspended during the investigation, as well as longer appointment times. A similar issue has not arisen.

The identification and resolution of the student's fitness to practice issue was in keeping with the standard process utilised by the programme. There have been no other student fitness to practise reports since the prescribing incident. The panel are content that the incident was effectively dealt with, and that the SERF process is robust. The Requirement was found to be met.

Standard 2 – Quality evaluation and review of the programme
The provider must have in place effective policy and procedures for the monitoring and review of the programme.

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

The programme makes use of the comprehensive committee structure already in place. An annual Course Review process is utilised by which programme leads review their programmes and compose action plans to address any issues or note changes to be implemented. Changes to the programme are escalated through the Curriculum Development subcommittee through to the Dental Academic Committee which provides oversight of all the dental programmes on offer. The Curriculum Development subcommittee holds responsibility for the mapping of GDC requirements to the programme. Outside of regular committee engagement, the programme is subject to scrutiny from the University's Periodic Review process.

An additional group exists alongside the committee structure. The Rapid Response group is able to convene as required and in between when regularly scheduled committee meetings are due to take place. This group would react should any issues be reported about placements and be activated by the programme lead. The programme comprises a small team who work closely together, and are able to lead and take action should the programme lead be away.

The Requirement is met.

Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements. *(Requirement Partly Met)*

The programme utilises a clearly structured escalation process to reflect the severity of any issues reported or risks identified. The programme team deal with operational issues and can refer up to the School Executive Team. The appropriate University Service can be contacted directly if necessary. External examiner reports are considered centrally by the University.

As mentioned under Requirement 7, a risk register is used but this is only reviewed once every quarter. The document reviewed by the panel also did not include an adequate level of detail to fully explain why something has been identified as a risk, what any mitigation could be, and any reflections the School may wish to make on this or the action taken. During meetings with

the panel, programme staff were able to describe and explain those areas of the programme where risk was identified, such as the {my}dentist placements, but these were not recorded with the same level of depth on the risk register, if recorded at all.

The quality management process as a whole is undermined by the poor use of the risk register currently in use. A programme level risk register would be a more comprehensive measure in identifying and managing risk, particularly those that may not be identified through raising a concern, such as with a SERF. The programme has already accepted a larger intake for its' second cohort with one of the {my}dentist placements closing and a new one opening. Amidst such change, a live document to capture risks would give assurance that the programme will continue to be properly quality managed.

The Requirement is found to be partly met.

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

The programme uses two external examiners (EE) to provide external quality assurance. One EE is specifically engaged for the BDSi programme while the other oversees the final clinical examinations of both the BDSi and BDS programmes. The panel were able to meet with one of the EEs who reported that processes are adhered to and that assessments are commensurate with those used at other institutions.

The University has a central liaison who communicates with the EEs although contact is also maintained by the Head of School. EE reports are considered and responded to by the University and actions arising are fed through the Education Committee. An EE is also present at meetings to decide key progression points.

The patient feedback received to date has not had any impact on the design or delivery of the programme although this is reviewed by the Programme Lead so could be fed into the quality management system if necessary. Student feedback logs contain summaries of patient feedback as well as pieces of self-reflection so provide an excellent resource on which improvements could be based if required.

The Requirement is met.

Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. *(Requirement Met)*

The approach to placements is a contractual arrangement between the University and {my}dentist. As a dental corporate organisation, {my}dentist charges fees outside of the NHS payment bandings and all patients are therefore private. The panel are concerned that patients paying for private treatment may not all wish to be treated by students, and that this may impact on the range of experience students obtain at these placements. However, {my}dentist described their structure and the fact that they have payment plans closer to NHS costs, and they therefore do not restrict the patient groups. Furthermore, {my}dentist practices are

deliberately sited in areas where there is a lack of NHS dentistry so patient resource is not an issue.

Placements and the supervisors at them are subject to the same induction and training requirements as UCLan employed supervisors, and the panel were impressed with the integration of the {my}dentist supervisors with usual UCLan processes. Supervisors at these placements described a close and supportive relationship with the programme lead and extensive calibration. Evidence of calibration sessions was reviewed.

The same requirements of the enhanced training practices (ETPs) used for the standard BDS programme are imposed on the {my}dentist placements.

Patient feedback is obtained through the use of a QR code, although a paper version can be provided. These are specific to the student although are completed anonymously. The data from these are analysed by a named individual and the learning utilised by the programme team and shared with the student. At present the programme team have not had to implement any changes are a result of patient feedback. Student feedback logs are also reviewed although students can provide feedback to the programme lead or their supervisor at any time.

The Requirement was found to be met.

Standard 3– Student assessment
Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Requirement Met)*

The panel are assured that the international students undergo the same examination process, at the same time and location as the UK students. External Examiners assured the panel that when they review the students it was done “blind” so they were unable to differentiate between the UK and International students. It was confirmed in the panel meeting with the external examiners that when they attended their induction it was for Dentistry overall (UK and international).

The school utilises an online assessment platform (Maxinity) for the planning and delivery of written and summative practical examinations. This system holds question banks, supports the internal and external verification process and allows assessments to be generated to an existing blueprint to ensure the appropriate learning outcomes are assessed.

The school currently use a system called Leopard, which records all clinical assessments and the outcomes performance of the student. The system also records clinical skills, knowledge and understanding, management, communication, and professionalism. The panel were able to review this system during the inspection. The panel were informed that the school will be moving to another system in due course.

A clinical assessment panel (CAP) consider the progress of each student towards clinical requirements set for the year. The CAP results are reported at the Module board for the

clinical skills modules in each year as part of the progression requirements. Final year students have to reach the clinical requirements in order to be "signed-up" for consideration at the final module board.

The Requirement was found to be met.

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

The School currently use a system called Leopard to centrally record clinical experience data. This system requires a number of workarounds to ensure that data is appropriately recorded and avoid issues. For example, a workaround exists to ensure that simulated experience data does not get counted as part of a student's patient experience data, which is counted towards their clinical requirements. The School will be transitioning to LiftUpp within the next 12 months and are confident that this will prove to be more robust.

Full evidence of the mapping of the programme to the relevant learning outcomes was provided and reviewed by the panel.

The Requirement is found to be met although the transition to LiftUpp will be monitored as part of future GDC activity.

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

Students have access to a range of patients at their ETP placements, which was reflected in the data reviewed by the panel. All clinical requirements had been achieved. The ETPs do not offer specific clinics aimed at certain modalities, such as have been seen at dental hospitals, but a range of secondary care placements were attended by the students to give them insight into specialist areas of practice.

Access to patients has been identified as an issue at the Thetford ETP and therefore a new site in Falmouth will be utilised by students from October 2023.

The nature of the clinical experience also means that students do not have the exposure to working with other members of the dental team. This has also been identified as an issue, especially considering the assimilation these students require to working in the UK. The programme team will review where additional team working can take place.

The changes to the ETPs and the integration of dental team working are both important areas which the GDC will continue to monitor. The Requirement is found to be met but ensuring that the new placement performs as predicted will be vital to the continued sufficiency of the programme.

Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed. (*Requirement Met)*

Assessments undergo a process of internal and external verification prior to students being tested. The external verification involves the external examiner. All assessments are overseen by the Assessment Lead and considered by the assessment subcommittee. The same final assessments are used for the programme as for the UK BDS course and are both governed by the same policies. An assessment handbook was reviewed as part of the inspection as well as student data and videos of their final clinical assessments, none of which caused the panel any concern.

The results from assessments are considered at various points in the committee structure. Two such meetings, being the Finalist Course Board and Clinical Assessment Panel (CAP), were observed remotely by part of the panel. These followed the processes set down in the policy documents but were short in duration and did not appear to examine each student in detail. The overall outcome proposed for each student was stated and the external examiner given an opportunity to raise any concerns, but the wider elements of progression, such as professionalism and the meeting of clinical targets, was not examined within the meeting.Consideration of such elements informed the decision of the programme lead when recommending which students should or should not progress, but it would have been useful for the panel to see those discussions and be assured that students are being considered holistically.

The Requirement is found to be met based on the evidence presented. However, future inspection panels will need to observe the meeting where the recommendations to the Finalist Course Board and CAP are formulated to see the process in action.

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

Feedback is gathered from multiple sources. A QR code or paper questionnaire is available for patient use while feedback is given to students by their supervisors after every patient interaction. Students must present a case study to other students in the Year Four element of the programme which allows for peer-to-peer feedback. The programme lead meets with the ETP supervisors weekly so can gather feedback about the performance of students at that time.

Actors are utilised for observed structured clinical examinations (OSCE) and and that actor is able to give feedback that is noted by the examiners. Formal written feedback is provided following summative assessments. In this way, student assessment is considered both summatively and formatively allowing for students to grow insight and improve their practice. The Requirement is therefore found to be met.

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

The panel were able to meet with the entire graduating cohort who presented as an experienced and engaged group. Students reported feeling supported from the first day of the programme particularly in comparison to the other route to registration available which would be the Overseas Registration Exam. The School and {my}dentist have provided assistance with housing and acclimatising to the UK which has allowed the students to commence their studies.

Feedback was reported as being provided contemporaneously by supervisors as well as students attending weekly peer meetings and 1-2-1 meetings with their tutor. The panel reviewed the reflection logs and could see that these were being used to good effect.

The Requirement is met.

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

Summative assessments are carried out by UCLan staff who are all required to have or be working towards D2 which is aligned to the UK Professional Standards Framework. In additional all clinical ETP supervisors are required to have a clinical teaching qualification or be enrolled on a suitable training course.

The panel were informed that the school provide calibration for all supervisors and during the panel meeting with the supervisors, this was confirmed. The calibration process brings together colleagues across all ETPs as well as practice colleagues.

The Requirement is met.

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

The panel reviewed document "*Information on the External Examiner System"* which gave a comprehensive overview on the system in place at the University of Central Lancashire to recruit external examiners.

The school uses a system called Maxinity to capture curriculum mapping, written examinations, and summative practical examinations. External examiners have access to all online comments which are logged through the Maxinity system.

The panel were informed that students can request a copy of any comments made on their scripts or any reports made by external examiners on their work. If a request is received, the University will provide this information, to date no requests have been made.

An external examiner confirmed that they had made some suggestions to modify questions which had been considered and changes made.

The Requirement is met.

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

The panel reviewed the "UCLan Assessment Handbook" which contain the criteria for all assessments. When the panel met with the current graduating students, they confirmed that they were fully aware of the criteria and standards expected for each assessment.

The panel are assured that module verification is carried out through an internal verification process which is carried out by a minimum of two academic staff, ensuring that fair marking is applied across all students.

The external examiners confirmed that examination results for all students (UK and International) are integrated, which assured the panel that results were fair and consistent.

The Requirement is met.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
1	The school should keep auditable records of all entry requirements checks that have been carried out on students, such as police checks and checks against standards.	Records are kept by the university admissions team, but we will audit these to ensure both the accuracy and predictive validity going forwards	May 2024
1	School should continually review that 600 hour of clinical post clinical hours is adequate as part of the APL.	This will be reviewed on a regular basis to ensure that it meets the standard required to enter at BDS4. To date we have not had any concerns in relation to the clinical ability of the two cohorts we have admitted on these clinical hours, but we acknowledge the benefit of keeping this under constant review and making changes of necessary	May 2024
2	The provider must ensure that all patients are explicitly consenting to treatment by a student.	All consent forms were updated during the visit and continue to be used. We plan to audit the use of these and will provide examples during the visit in May.	May 2024
10	The programme must utilise a method of logging and tracking risks that is more contemporaneous and allows for an adequate level of detail to be recorded.	A live risk register has been implemented and we can give the panel access to this in May.	May 2024
14	The programme should update the GDC as to their progress in transitioning to the new central recording system.	The transition to LiftUpp should take place over the summer period in 2024. There have been hold-ups surrounding data sharing agreements and a transfer to new dental software happening in some of the trusts our other programmes work in. We will keep the panel updated with progress.	Ongoing

Observations from the provider on content of report

Thank you for this report and your observations. We are grateful for the positive outcome and areas of good practice you have highlighted. We appreciate the actions suggested and will be able to demonstrate the progress made towards these when the

panel visits in May 2024. We are grateful for the feedback on our processes and think the suggestions made have strengthen our provision and ultimately ensure the ongoing success of this innovative programme.

Recommendations to the GDC

Education associates' recommendation	The Bachelor of Dental Surgery – international route (BDSi) is sufficient to allow the graduating cohort of 2023 to apply for registration as a Dentist with the General Dental Council. This will be reviewed again in 2024.
Date of reinspection	Risk-based Inspection 2023-24, including inspection of examinations and review of actions.

Annex 1

Inspection purpose and process

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

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

3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

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

A Requirement is met if:

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

A Requirement is partly met if:

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

A Requirement is not met if:

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

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

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

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