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General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
Glasgow Caledonian University	BSc Oral Health Sciences	3 & 4 December 2019; 22 June 2020

Outcome of Inspection	Recommended that the BSc Oral Health Sciences continues to be approved for students to register as a dental hygienist and a dental therapist.

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

Inspection summary

Remit and purpose of inspection:	Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dental hygienist and a dental therapist
Learning Outcomes:	Preparing for Practice (dental hygienist and dental therapist)
Programme inspection dates:	3 & 4 December 2019
Examination inspection dates:	22 June 2020 (Exam Board)
Inspection team:	Benjamin Walsh: Chair and Non-registrant Member Carolyn Inman: Dentist Member Clare McIlwaine: DCP Member Marlene Ledgister: Education & QA Officer James Marshall: Education & QA Manager

The BSc Oral Health Sciences (BSc OHS) programme delivered at Glasgow Caledonian University (GCU) was last inspected in 2013. Following a review of evidence submitted through the GDC monitoring process, the decision was made to carry out a full inspection of the programme during the 2019-2020 academic year.

The School reported that since the last inspection there has been a restructure at the university that has led to the creation of several smaller departments. The BSc OHS programme is now grouped with radiography and podiatry, which has enabled a greater level of support for the School. There have been changes to senior management within the School since the last inspection, including both the School Director and Programme Lead. Both of these roles were filled by existing programme team members. There is no longer a School Director, the new post of Programme Lead has been filled by the existing Programme Director.

The programme team were very positive about the practical elements of the course, highlighting the School's focus on ensuring student access to a broad range of patient treatment types. The panel was also pleased to note the following:

- Continued funding and positive working relationship between the School and NHS Education for Scotland (NES)
- Innovative use of simulation, in cases where students have limited access to particular treatment types.
- Continuing efforts to maintain patient numbers following the success of previous initiatives to engage stakeholders and increase patient numbers; this included close collaboration with the Public Dental Service which resulted in an improved referral route for patients.

The panel was informed that the acceptance criteria for treatment by students was revised in 2018. The programme team reported that the new referrals system enables general dental practices to refer patients directly to the undergraduate programme for treatment.

Student groups were generally positive about their learning experiences and reported that they have grown in confidence as the course has progressed.

The Programme team explained that staff shortages within the programme have been mitigated by using BDS and PDS staff and added that two outreach posts were filled in April and September 2019.

The GDC wishes to thank the staff, students, and external stakeholders involved with the BSc Oral Health Sciences programme for their co-operation and assistance with the inspection.

Background and overview of qualification

Annual intake	14 students
Programme duration	109 weeks over 3 academic years
Format of programme	**Year 1** Clinical skills training Periodontal clinics Modules: • Restorative Dentistry • Biomedical Science & Oral Biology • Plaque Related Disease • Clinical Practice I • FIPP **Year 2** Adult and paediatric restorative clinical skills training Periodontal and adult restorative clinics Modules: • Dental Biomaterial Sciences • Dental Radiography & Imaging • Paediatric Dentistry • Clinical Practice II • Comprehensive Oral Care • WIT **Year 3** Periodontal, adult and paediatric restorative clinics Outreach clinics Placements Modules: • Dental Research • Clinical Practice III • Oral Disease • Integrated Patient Care • TIIP
Number of providers delivering the programme	Glasgow Caledonian University and Glasgow Dental Hospital & School (NHS GG&C)

Outcome of relevant Requirements[1]

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

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

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

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

The panel was told that students are given a timescale and completion date by which competencies should be taken. Students must complete and demonstrate competence in carrying out clinical treatment in a simulated environment prior to treating patients. For clinical treatments, students must complete required competencies by the end of each trimester. Student logbooks are regularly cross-checked to ensure compliance. However, on viewing the clinical experience data, the panel identified that there were a number of discrepancies with the figures. These were raised with the Programme Lead, cross-checked with the logbooks and amended. The School explained that the discrepancies were due to staff changes and the use of both paper based and electronic recording systems.

The School stated that extra sessions are arranged in the event that a student is unable to complete their required clinical experience targets. Despite the issues referenced in the paragraph above, the panel noted that progress had been made with the recording of clinical experience with reduced reliance on paper logbooks. During the inspection students told the panel that if they felt they were not getting enough clinical experience they would approach the clinic supervisor to request support.

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

The panel was told that the option of receiving treatment from a student is offered to patients during their initial assessment and this is reiterated in the patient information pack. Prior to any treatment taking place, students will introduce themselves to the patient, stating that they are a student, and a consent form clearly marked with 'student' will be signed. In outreach settings, the consent forms indicate that the patient will be treated by students. The School stated that signage is present on all clinics informing patients that it is a teaching clinic.

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

The School reported that all staff teaching on the BSc OHS programme are employed by Greater Glasgow and Clyde Health Board and as such are subject to statutory and mandatory training. Equality and Diversity training is one of these elements and training is provided via "learnPro", an online learning platform. The module introduces staff to equality legislation (Equality Act 2010 & Human Rights Act 1998) and contextualises this within a health and social care setting.

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

The panel noted that the staff student ratio is between 1:4 and 1:5 in the hospital clinic. The School added that staffing levels are rarely insufficient – there had been only one incident in the last two years where additional supervision cover was needed. The School also reported high levels of nursing support - sometimes at a ratio of 1:1. The panel was pleased to note that nursing staff provide feedback on students and their performance, for example about the use of equipment.

The panel was told that students are supported via a personal tutor who would identify performance issues including low grades, which might be an indicator of well-being issues. Issues can also be identified via the weekly returns from logbook submissions. Students experiencing pastoral issues can access the university support system, Living Well. This service can provide counselling or academic support for students. Students meet with their tutor at least once per trimester and additional sessions can be arranged, should further support be required.

The School stated that if a problem was identified, a Cause for Concern document would be completed and an action plan drafted with the student, outlining the support and actions agreed to resolve the issue. This would be reviewed after one month and extended if necessary.

Integrated teaching in the outreach centres enables enhanced support and learning opportunities for teaching staff. There is a high level of support between the School and the outreach supervising teams. Regular meetings take place between outreach staff and hospital staff to monitor and review student progress.

The School maintains good relationships with consultants, enabling discussion about patients and treatments. There is also a University Liaison Group that meets on a monthly basis, engaging in supportive discussion around processes common to both Glasgow Caledonian University and Glasgow University.

Staff Student Liaison meetings take place a week before the Programme Board Meeting. Students stated that their Personal Tutor remains assigned to them throughout the course. They said they receive good support and guidance and that when staff absences occur, these are managed well by the School.

The panel was told that NHS Education for Scotland (NES) funding had enabled the appointment of an additional member of staff who undertakes all administration including timetabling, absence recording and the monitoring of module completion.

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

The panel was informed that recruitment to a teaching post requires four years' clinical experience and a recognised teaching qualification. Staff receive an induction and are trained on all university and hospital processes. They must complete all statutory and mandatory training (learnPro) units. There are also a range of optional training opportunities available for staff. The induction for new members includes shadowing of more experienced clinicians to develop familiarity with student grading criteria. New staff members are also given the opportunity to shadow other lecturers within the School.

There was evidence of a strong focus on staff development and training. The panel considered, however, that the School would benefit from formalising the newly introduced peer review process. The panel was told that staff are given support to achieve a teaching qualification. Moderator supported calibration takes place for hospital clinical teaching staff, as well as moderation exercises around marking for outreach staff. Training is monitored through a dashboard which is overseen by the Local Governance Manager.

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 Partly Met)***

The panel was told that the Preparation for Practice module, which is delivered at the beginning of the course, covers law, ethics and professionalism. The panel was pleased to note that all healthcare profession students are taught together. Students are also required to read key university and GDC policies and sign to confirm they have read the Raising Concerns Policy at the beginning of each year. Students are told they can speak to any tutor if they want to raise a concern. Students are unable to progress to the clinical environment unless competence has been demonstrated.

The School added that in Year 2 there is a heavy focus on raising concerns, with the use of GDC scenarios; in Year 3 students compile a Preparing for Practise portfolio. The School provided evidence of a significant focus on this topic and confirmed that students know what process to follow to raise a concern including adverse incident reporting. However, students meeting with the panel did not demonstrate full confidence with regard to raising concerns during their time on the programme; it was felt that this should be more clearly embedded into Year 1 teaching.

In the event of any patient complaints, these would be reported to the Head of School who would respond accordingly. Learning from any patient incident would also be shared with the student concerned. Learning from complaints is shared via the Intranet and discussed during the Clinical Governance Days.

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 Partly Met)***

The panel was told that students are not allowed on clinic until they have demonstrated competence in the simulated environment. Professionalism grades are logged and raised with the programme team. If issues were identified, treatment would be stopped immediately. The School added that DATIX incidents are monitored at each Programme Board meeting.

During the meeting with the programme outreach team, the panel was informed of an incident that had been logged on Datix; however as this had taken place in outreach rather than the dental hospital setting, the learning had not been shared widely following the incident.

The panel agreed that regardless of the location of potential patient safety issues, these should be shared with the programme team and used as learning opportunities, where appropriate.

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 was told that students take part in Fitness to Practise (Ftp) policy learning sessions during their induction and again at the beginning of each academic year. The School outlined the process for managing FtP concerns. The panel was provided with an example of the School investigating a potential concern and consulting with the university, which provided advice on how to proceed and ensure both staff and students were supported. The Year 1 students who met with the panel had only recently started the programme. They stated that whilst they had not yet received any teaching on FtP procedures, they had read and signed the policy.

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 School explained that a tripartite arrangement exists between NHS Education Scotland, GCU and the NHS. The Head of Department, Oral Health Directorate General Manager and Dental Undergraduate Manager form part of this strategic board. There is a Memorandum of Understanding between the three organisations which meet regularly to discuss programme issues. There is also a Programme Board that meets three times per year and Assessment Boards meet twice per year.

The panel had been provided with documentation and processes evidencing implementation of the School's Quality Assurance Framework. The School further explained that action plans, module improvement plans, and student feedback were used to address any performance issues identified. An example given was that more group meetings have now been timetabled following feedback and a module improvement plan. The panel was also told that GCU will be holding a 'closing the feedback loop' session, to ensure students are notified of how GCU is addressing concerns raised.

The programme enhancement plan is also used for making changes to course content during the year. For example, this was used following the introduction of changes to periodontal guidelines and in relation to amalgam restoration changes in paediatric treatment. This plan is completed and shared by the University Board.

The panel was told that module improvement plans are created taking account of feedback from students at the end of each module. Evidence presented to the panel gave assurance that the Quality Assurance processes in place are understood at all levels of the delivery team. The team demonstrated effective collaboration and understanding of recording and communication structures. The panel noted that outreach is well supported and incorporated into the quality assurance processes of the programme.

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

The panel noted from information provided that there had been a decline in NSS scores with regards to student feedback, in particular in the area of receiving feedback about assessment performance. The School stated that they are making students aware of feedback mechanisms. Structured action planning is also taking place to address these issues and the School gave examples of some changes that have been made in response to previous NSS results. This included, for example, action planning to address previous NSS feedback which had identified a need for greater integration with the wider university to ensure students felt they were fully part of GCU.

The panel was satisfied that there are effective, coordinated communication structures in place to help identify and address quality issues, including the Programme Board, Staff Student Consultative Group and the Academic Policy and Practice Committee.

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

The panel was satisfied that information provided evidenced the effective use of External Examiners in the quality assurance of the programme.

The School informed the panel that work had been undertaken with a patient focus group to create new patient feedback forms. The aim of this is to better support programme development as previous forms had been deemed too simplistic. The panel was told that the new forms, in place since the start of the 2019-20 academic year, had not yet been formally collated and summarised but indicated that the feedback to date has been positive.

The panel was informed that outreach specific feedback forms were being implemented. The new forms are mirrored on the BDS patient feedback forms and carry the student number so that students can be identified in the event of an issue being raised. The School noted that patients provide a great deal of positive verbal feedback and attempts have been made to ensure anonymity and therefore improve the variety of feedback. The School stated that this information is used to inform programme development, but it does not contribute towards assessment or alter any grade given. However, any feedback about professionalism could potentially be used and in this instance feedback on the grade would be given to the student.

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 Partly Met)***

The panel was informed that funding to support outreach placements is provided by NES and the Scottish government. Prior to a quality assurance visit being undertaken at a placement, a pre-visit questionnaire is completed. A module monitoring report is completed and disseminated to all departments. In addition, a formal inspection of outreach centres by NES is scheduled to take place every three years.

The outreach team reported that inductions take place at the start of each student placement including all mandatory training. The panel was told that the calibration of staff has been a key focus in recent years. Staff and students representing a range of stakeholders meet to hold calibration workshops. The Outreach Committee meets regularly after each rotation of students.

The OHS outreach tutor teaches and also provides a level of support for the School, providing a link between outreach and the GCU team. The panel was told that any concerns would be raised via the tutor and if serious, the Dental Hospital would be contacted. The outreach team added that often staff would be working in both outreach centres and the Dental Hospital and this cross-over supports the raising of issues. The GCU Whistleblowing and Cause for Concern policies are in place, and students have access to the Whistleblowing Policy from the outset.

Outreach staff reported that they are invited to outreach training days and have the opportunity to share good practice. Visiting lecturers also attend these training days, which have been well received by the outreach team. The outreach tutors reported feeling well supported by the GCU programme team.

Supervisors who are new to the role attend the dental hospital and shadow more experienced members of staff. The panel was told that HT staff had been invited to a combined BDS and HT training day for the first time and it is hoped that this will continue going forward. The panel considered that this was good practice.

The outreach team reported that they have been developing a proforma for treatment planning to streamline the process and improve consistency. Students input weekly figures and are good at feeding back if numbers of procedures performed are low in certain areas.

Outreach staff explained that the cause for concern process is used to identify issues and gave an example of additional support being provided to a student enabling them to continue with the programme and graduate.

Outreach have their own process for monitoring student progression. While they do not set benchmark numbers, they work to an approximate number of procedures required at an expected level. In Lanarkshire Adult Outreach there are staff members available who can take over the monitoring of student progression in outreach.

The panel was told that there are a range of nursing support levels in outreach placements. There is a ratio of 1:1 nursing support in paediatric outreach. In other outreach settings this varies from 1:2 nursing to no nurses in one placement where students nurse for each other. The outreach staff reported that they feel very supported.

Outreach staff reported that two sets of patient feedback have been collected recently, including patient satisfaction surveys. However, as this is a new process for collecting patient satisfaction data, the information has not yet been formally analysed. The panel was informed that student numbers are on the forms, so they could obtain individual feedback on their performance.

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

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

The panel was informed that students must pass the gateway pre-clinical OSCE, prior to being allowed to treat patients. The pre-clinical OSCE includes medical emergencies, decontamination, hand hygiene, consent and communication skills.

Therapy students take a combined training programme with BDS for restorative components of the course, with specific pre-clinical assessments. Competency needs to be demonstrated in the use of each instrument. Students must also demonstrate pre-clinical competency in the use of amalgam. If students struggle with this aspect of the programme, extra tuition is given in restorative therapy at the Buchanan Centre in Coatbridge. Students elect when they are ready for assessment and there is a case presentation in January/February supported by a 'mock exam'. Summative assessment is in the form of written papers taken at the end of year 2 and year 3. Students also present three case presentations from a case they have worked on from start to finish. In addition to the case presentations, the restorative element of the programme is assessed via a portfolio presentation.

Competencies are completed by students at the end of each stage of the programme throughout the course. The panel were informed that the majority of paediatric competencies are achieved during year three.

The small cohort means that staff are more able to discuss students' progression and any professionalism concerns, such as attendance. The panel was informed that if students miss more than 20% of a module, they are not able to sit the exam.

The panel was told that there is no university wide sign up policy and queried whether currently students could take exams with inadequate clinical experience. Staff stated that they were confident that this would not happen. Students could not graduate in such instances as the Assessment Board review that takes place after the exams would identify a shortfall in clinical competency. However, the panel noted that based on information available, Assessment Board review meetings appear brief and more assurance is needed to confirm that this would not happen. The Panel considered that a more robust process is needed to scrutinise such a vital aspect of the programme.

The panel was informed that the pass mark for clinical modules is 40%. The panel was told that this is a GCU requirement. Further to this, students are only permitted two resit opportunities for clinical assessments. The School added that three attempts are allowed for theory modules and that students can carry one failed module over to the next year.

The panel was told that the School operates a number of assessment methods including open book, portfolio and a Team Observed Structured Professional Encounter (TOPSE). This is a multidisciplinary team meeting with students undertaking summative assessment on how they interact, which has received positive feedback from the students. The panel noted this as good practice.

Overall, however, the Panel were satisfied with evidence that the process and protocol for student progression are robust and implemented correctly.

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 Partly Met)*

The panel was informed that the School has been unable to procure student progression monitoring software, however, the programme team presented detailed information demonstrating how student clinical progression is monitored. The School identified that students had previously struggled to use the former logging sheets and so this was streamlined with a new spreadsheet for recording and submitting the data.

The panel was told that students submit information on a weekly basis which is centrally collated onto a spreadsheet by the Programme Coordinator. This must be done by 4pm each Friday. The School described this as a 'living document' which is analysed every other week by the programme managers. Attempts have been made to ensure that data is as clear and accurate as possible by ensuring that the (student) identity database information is included. The document is set up with 42 sheets for 42 weeks, which students complete and is totalled at the end. Outreach sites are also included in the recording. Going forwards the School will be considering how they can amend the recording system, for example, by expanding the restorative section. The School confirmed that students are sent this document at the beginning of term. As part of the process logbooks are first checked by tutors before students submit their data.

Students use this system to monitor their achievements, enabling them to identify gaps and ask for particular patients/treatment to undertake. The School added that students can also see each other's progress and negotiate treatments between them where possible thus supporting each other to achieve their targets. In addition, at the Buchanan Centre a wall chart is also completed. Tutors maintain insight into the figures and cross-reference information at regular intervals. A 3-4-week slot at the end of the year is kept for students to be able to address any shortfalls in clinical experience. To date, this has ensured all students have been deemed competent to sit the clinical skills exam.

Staff confirmed that safeguards are in place to prevent students from being able to graduate without meeting all of the required clinical competencies. Decisions are made regarding whether a student is fit to sit based on these records. Staff stated that students would not be able to sit the case presentations without having achieved adequate clinical skills experience and that students are aware of this requirement.

The School stated that it is considering making this system entirely live by way of central electronic access rather than being reliant on weekly spreadsheet entry, explaining that staff carry out audits of the student data being entered when time permits. The panel recommended that the audit should be a formal process and carried out at set regular intervals.

The panel was told that mitigating circumstances are considered both pre- assessment and retrospectively, when students are identified as needing extra support.

Students must complete competencies prior to graduation however the panel had some concerns that there is no formal 'fit to sit' process to formally identify students who are low on experience. The panel felt that the lack of clarity over where the cut off point for a student would be in order to prevent them from sitting finals / graduating should be addressed; the panel recommend that the School introduces guidance ensuring that all competencies are completed prior to the final assessment board and graduation board.

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

The panel was told that the School has access to a wide range of patient groups, including hospital and pre-surgery patients. Patients are triaged by staff before being allocated to students.

The success of the Child Smile oral health programme has added some additional challenges when sourcing paediatric patients, but the School noted that these were manageable. Most paediatric patients are treated in outreach; however, students have access to a small number of paediatric patients in the dental hospital. Outreach centres have different referral routes and requirements to ensure a wide variety of patient groups. The School added that referral criteria differs locally and there is a bespoke referral form for undergraduate students. Students are also taken around different centres to increase exposure to different clinics and this has received positive feedback.

The panel was told that while there are no set targets to achieve in outreach, clinical experience is closely monitored, and extra sessions are arranged if a student needs further support. Staffing issues are being mitigated. Additional dentists from the hospital have now been sourced and patients are being triaged specifically for the BSc students. The year three students interviewed by the panel felt that they currently have adequate clinical experience and that clinical progression logbooks worked well for them. They considered that undertaking theoretical and clinical work at the same time supports learning well.

Although staff and students had confidence that any students at risk of shortages in clinical experience would be identified and remediated in the necessary areas, this process is not adequately formalised through monitoring systems. The panel suggested that a final clinical meeting must be held to scrutinise and determine whether students have adequate clinical experience prior to taking exams.

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)*

A previous action plan indicated that question writing should be improved to avoid 'procedural' questions so that candidates were able to apply their knowledge. A review of assessment questions was undertaken with external examiners and a question bank has been developed to address this concern.

The panel noted that marking sheets have been reviewed and are now more user friendly. The panel were informed that university regulations do not require double marking however the team have continued with this, which the panel felt was a positive approach. The panel also saw evidence that blueprinting to the GDC Learning Outcomes had taken place.

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 Partly Met)*

Students are encouraged to seek guidance from the full range of the dental team members they work with. Vocational Trainee dentists are in clinic twice per week and able to contribute

towards assessment. In paediatric clinics students work with and are assessed by senior dentists who give feedback to students on clinical performance and professionalism.

The panel were informed that consultants assess the case presentations. Further to this, integration with the BDS programme enables feedback to be received from BDS staff. The panel noted that students also carry out peer assessments, which is undertaken in the year one communication module, taught with the BDS students. The panel was informed that while students receive feedback after every patient they see, they do not always recognise this as being part of formal feedback. As noted in Requirement 11, a new patient feedback process has been developed, however the data has not yet been analysed.

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)***

As noted in Requirement 10, the panel was provided with a copy of the School's latest NSS results, which showed students were least satisfied with the area of assessment. There was a 5% reduction in student satisfaction regarding timely feedback on assessments and 15% reduction regarding how beneficial students felt feedback was. The School stated that this is a misinterpretation from students as they have the opportunity to get additional feedback. The panel was informed that feedback is given to the group following assessments with tailored feedback given to those who need or request it. The School explained that students are not given a mark until feedback has been given and students will sign to agree the mark.

Graded feedback is given by staff who are following an assessment rubric, and this is being continually developed. However, the panel was informed that the programme team has an action plan in order to further develop the area of feedback.

Students interviewed by the panel said that feedback received this year was timely and supportive, but that the end of year feedback is not specific, which makes it difficult to prepare for exams. They added that CP1 and 2 grades are always lowest and feel they do not get enough advice or instruction on how to improve these. Students told the panel that the criteria for competencies, either pass or fail, is clear and feedback is given.

The students stated that if they pass a module, they do not receive feedback on how they could further improve, which they felt was detrimental to their progression. The final year students stated that they receive group feedback rather than individually.

The panel was told that feedback is also provided via class representatives and the programme team email students with responses. Students said that they were happy with how their feedback is responded to. They added that this feedback is supposed to be provided within three weeks, but sometimes takes longer.

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

The panel was satisfied with evidence presented that the External Examiner process was robust and appropriate. The School demonstrated good practice by allowing Examiner shadowing and enabling new examiners to visit other schools to share best practice in assessment.

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 use of External Examiners is well embedded with evidence of External Examiner report actions being addressed. The School provided evidence that following the External Examiner review, changes have been made to the written questions. Changes have also been made to the end of year one assessments, which resulted in the use of a clinical OSCE rather than using patients. Also, further changes in the restorative assessment have been made, moving from assessing a student treating a patient to a portfolio presentation.

The External Examiner reported quality and rigour of assessment had been maintained along with consistency across marking.

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 Partly Met)*

The School stated that the Modified Angoff method is used for standard setting written short answer assessments. Prior to standard setting activity questions are sent to the External Examiner for review. Standard setting is only applied for written exams. For other assessments two internal assessors and a QA member of staff review the assessments. Not all summative assessments are standard set; the process is only carried out for end of year exams and is not used for multiple choice answers. Standard setting needs to be expanded to cover all areas of summative assessment in order to fully meet this GDC requirement.

The School confirmed that post-test meetings take place to review the performance of the questions compared with the cohort average. If further question development is required, this will take place after the Assessment Board and prior to the next academic year commencing.

The panel was informed that in the event of a student failing an assessment a bespoke support package would be agreed by the programme team. As the School has a relatively small cohort size this means that dedicated student support is of a high level. Students can also apply for consideration of mitigating circumstances both prior to and two weeks after the results of the assessment.

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
1	The School must ensure that accurate and contemporaneous records of student competence are maintained. Formal audit of assessment data is needed at key points throughout the year.	All data is now collected electronically on a weekly basis and stored on Excel spreadsheet by University Programme Coordinator who is now an embedded member of the Programme Team. Students have ownership of logbooks and have individual responsibility to submit weekly returns to PC. In regard to assessment, completion of competencies is checked by Tutors who review on a twice monthly basis. An audit of assessment data will be undertaken prior to the end of each Trimester with an action plan created for those students who require additional clinical experience or refresher elements of pre- clinical skills.	2021
6	The School must embed teaching on the raising concerns process from the beginning of the course and throughout. The School must ensure students are confident//equipped to raise concerns at any point during the programme, for example by use of flowchart. This should bed clearly embedded into Year 1.	The teaching of raising concerns will be embedded in induction and at key points throughout Year 1. (a. prior to treating patients and b. prior to end of year exam). Year 1 Coordinator is responsible for overseeing that all elements of teaching are completed. A flowchart will be introduced to Year 1 students and reminders given to all years at induction sessions. The flowchart will be visible in teaching areas.	2021

7	The School must present learning from recorded Datix incidents.	Each recorded DATIX incident will be shared with the entire Team at Teaching meetings. Outreach Supervisors must forward details of any incident to the Programme Leader at the time it occurs and update on any actions or learning opportunities that may arise. This learning will be shared with appropriate persons- Supervisors and Students and an element of reflection recorded and shared. A flowchart will be created for a DATIX reporting structure (similar to Raising Concerns Flowcart) and be visible in teaching areas including outreach clinics, which will act as a reminder to staff and students. The University will also be made aware of any incident involving a student.	2021
11/ 12 / 17	The School must ensure that the new patient feedback forms process is completed, and effectiveness measured.	Feedback forms will be collated and summarised to share information with staff and students. A review of these forms will take place once a significant number for each year of students have been collected. Following review, any relevant changes will be made to the form and this will be a continually developing process.	2021
12	The School must ensure completion of the patient feedback process in outreach placements.	As above with individual students being given feedback (whilst we ensure anonymity, Matriculation numbers are on the forms) to allow them to reflect and develop clinically.	2021.
13 /15	The School must implement a structured 'Fit to sit' process.	Fitness to study policy: https://www.gcu.ac.uk/media/gcalwebv2/student2/Fitness%20to%20Study%20Policy.pdf Each February, the Programme Team have meetings to discuss the progress of each student. Action plans are created as per Learning Contracts to support students in regard to clinical and theoretical needs. There have been no Final year students where this was applicable. There have been students in Years 1 & 2 where these action plans have been implemented. GCU hold pre-assessment board meetings in advance of Assessment Boards. These meetings include members from each module, the Programme Lead and the Head of School. The Pre board demonstrates that all student profiles are complete with regard to	2021.

		modules undertaken and progression codes achieved. The PB takes a significant time to complete, it does provide a detailed and accurate structure to the actual Assessment Board where a member from Academic Registry will oversee outcomes for those at final exam stage ensuring a robust process.	
14	The School must carry out a formal audit of assessment data. The School must ensure there is robust scrutiny of clinical achievement.	Stated in Requirement 1 Year coordinators will scrutinised clinical log books and match with electronic submissions of weekly returns. Any underachieving student will meet with Personal Tutor to address areas of poor performance and identify where further clinical experience is required. This will take place in line with Teaching meetings which takes place every two weeks.	June 2021 As soon as clinical activity resumes (COVID-19 19)
14/15	The School should implement a formal process to record remedial actions to address shortages in clinical procedures when these are identified. The School must present clinical progression data to the GDC prior to the examination board.	The School of Health & Life Sciences have an "Academic Cause for Concern" designed to support students in the academic environment. Each February, the Programme Team have meetings to discuss the progress of each student following which an action plan is created if deemed necessary for those requiring support both in clinical and theoretical domains. Review meetings are scheduled where students meet with Personal Tutors and record where actions have been met or detail where further support is necessary. These templates documents and meetings have been applied to students in Years 1 & 2 where action plans have been implemented and progression to exams has taken place. We have not had cause to create a Cause for Concern document or action plan for any student in Year 3. I believe this was superseded by the Covid-10 pandemic. Clinical experience statistics were forwarded via the GDC quality assurance provider update in April 2020. The Team will be happy to forward details of clinical activity once it resumes.	September 2020

21	The School must implement appropriate standard setting methods for all summative assessments.	All summative assessments are standard set in order to meet this requirement.	Completed for Trimester 1 2020-21. Ongoing process for all summative assessments

Observations from the provider on content of report

It should be noted that much of the activity noted in the observations and responses above was implemented prior to Covid-19. All Year 1 and 2 assessments were suspended and changes made to minimum thresholds in line with Glasgow Caledonian University no detriment guidance. Our Programme Team requested that our minimum threshold of 40% be maintained as per programme specific regulations. This was approved and students were sent a statement detailing this prior to Assessment Boards taking place.

Recommendations to the GDC

Education associates' recommendation	Qualification continues to be approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council.
Next regular monitoring exercise	2021 Monitoring

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 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”

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’ be 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’ be used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

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

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