General Dental Council | protecting patients, regulating the dental team

INSPECTION REPORT

Education provider:	**Edinburgh Dental Institute**
Programme/Award:	**BSc Oral Health Science**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dental hygienist and dental therapist**
Learning Outcomes:	***Developing the Dental Team (Dental Hygiene and Dental Therapy)***
Programme inspection dates:	**27 & 28 March 2013**
Examination inspection dates:	**20 – 22 May 2013 (Exam Board meeting 22 May)**
Inspection panel:	**Philip Brown (Chair and Lay Member)** **Maxine Kane (DCP Member)** **Elizabeth Watts (Dentist Member)**
GDC Staff:	**Kathryn Counsell-Hubbard (Lead)** **Ross Scales**
Previous inspection:	**First inspection**
Outcome:	**Recommended that the BSc is approved for the graduating cohort to register as a dental hygienist and a dental therapist and approval of future cohorts is subject to a re-inspection.**

Inspection summary

This report follows the first inspection of the BSc Oral Health Science programme (hereafter referred to as the 'programme'). Within this report, commentary is provided on areas of good practice and areas where action is required. Detailed explanations of how the programme has met, part met or not met the General Dental Council's (GDC) *Standards for Education* are contained within the main body of the report. Areas where improvement is required are listed as each standard is discussed and also summarised at the end of this report.

The *Standards for Education* are the framework against which the programme was compared. Consideration must be given to the fact that the *Standards for Education* were published after the programme commenced and have therefore been applied retrospectively.

The BSc Oral Health Science programme is the first four year dental hygiene and therapy programme in the UK. The majority of students reported that the additional year gives them what they feel to be 'an edge' over other dental hygiene and therapy graduates, although some students are still interested in pursuing foundation training. The graduating cohort are skilled practitioners who are fit to practise at the level of safe beginner, and risks to patients treated by students on the programme are minimised. Enthusiasm across all cohorts is high.

The programme has several areas of notable and good practice: student reflection is encouraged and built into the timetable from the beginning of the programme; students are exposed to a large amount of outreach experience; external examiners provide overarching quality assurance of 'gateway' assessments early in the programme. Additionally, the high level of commitment of the staff to the programme was notable. Many members of staff take on multiple roles with supervision, tutoring and assessment, and the close relationship this creates between students and staff is an attribute that will hopefully continue as the programme matures.

There are, however, significant aspects of the programme which require action. The overall impression of the panel was that there is a lack of formalisation of policies and procedures, including the production of relevant policies, mapping assessments to GDC learning outcomes, the recording of discussions and decisions surrounding standard setting, incident reporting, and the quality management framework.

The relatively small cohort size appears to be the reason why policies and procedures have not been formalised. The inspectors understood that this may also be why the central recording of students' clinical experience and clinical performance and mapping of the programme against the GDC learning outcomes is limited. The programme leads rely on the close relationship with students to identify real or potential issues. The panel noted that the cohort size may mitigate the need for some detail to be recorded, but policies, procedures and adequate reporting must still be in place to ensure consistency and for internal quality assurance.

There was very limited documentary evidence provided by the School to demonstrate that the Requirements under the *Standards for Education* had been met. The inspectors had to rely heavily on explanation from programme staff to fully understand programme structure, assessment methodology and the quality framework that the programme sat within.

The panel were surprised that, despite being part of the institution, the programme did not receive much support from the University of Edinburgh, particularly in the formalisation of

policies and processes. The programme leads may wish to utilise the University's resources in meeting the actions required in this report.

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

Inspection process and purpose of Inspection

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC and new qualifications where it is intended that the qualification will lead to registration.

2. The aim of this quality assurance activity is to ensure that these institutions produce a new registrant who has demonstrated, on graduation, that he or she has met the outcomes required for registration with the GDC. This is to ensure that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

3. The inspection focuses on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education*.

4. The purpose of this inspection was to make a recommendation to the GDC to determine whether the programme should be approved as a route for registration as a dental hygienist and dental therapist. The GDC's powers are derived under the Dentists Act 1984 (as amended) under The General Dental Council (Professions Complementary to Dentistry) (Qualifications and Supervision of Dental Work) [DCP] Rules Order of Council 2006.

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

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

The Inspection

7. This report sets out the findings of an inspection of the BSc Oral Health Sciences (OHS) at Edinburgh Dental Institute (EDI). EDI is part of the University of Edinburgh, which awards the qualification. The GDC publication *Standards for Education* (version 1.0 November 2012) was used as a framework for the inspection.

8. The inspection comprised of two inspection visits. The first was carried out on 27 and 28 March 2013 and involved meetings with staff involved in the management, delivery and assessment of the programme, and with all students enrolled on the programme. This is referred to as the programme inspection. The second visit took place between 20 and 22 May 2013 and is referred to as the examination/student sign-off inspection.

9. The report contains the findings of the inspection panel across the two visits and with consideration to the supporting documentation prepared by the School to demonstrate and evidence how the individual Requirements under the *Standards for Education* have been met.

Overview of Qualification

10. The BSc in OHS programme is a dental hygiene and dental therapy qualification that sits within the College for Medicine and Veterinary Medicine (hereafter referred to as the 'School') at the University of Edinburgh (hereafter referred to as the 'University'). The programme started in 2009 with an intake of 9 students recruited through UCAS. The programme was initially due to run every other year but an annual intake was introduced from 2011. The programme is a four year Honours programme, as opposed to the usual three years for other degree level dental hygiene and dental therapy programmes and is currently the only hygiene and therapy programme of this length within the UK. The programme does not have a current Year 3 due to there having been no intake in 2010. The maximum cohort number is 10 students which is defined by capacity at EDI and also agreed with NHS Education for Scotland (NES), who are partners in the programme and provide funding for the first three years. One student from the 2009 cohort has left since the start of the programme and therefore the 2013 graduating cohort numbers eight.

11. The programme operates under a tripartite agreement: it is part of the University of Edinburgh but run on NHS premises with some NHS or NHS Education Scotland (NES) staff. The new Director of the Institute has been in post since 1 January 2013. A closer working agreement between NHS Lothian and the University has allowed for resources to be pooled and enabled six senior posts across all disciplines to be created at EDI. Funding has been made available by NES due to its service level agreement with EDI, meaning that the programme is well-resourced. Students do not have honorary contracts with NHS Lothian but some members of staff do.

12. The programme is taught with a mix of lectures, practical, and clinical sessions. Both formative and summative assessments are employed including case presentations, pre-clinical Objective Structured Clinical Examinations (OSCEs), case-based learning, written papers, and literature reviews. Students commence treating patients from Semester 2 of Year 1 and continue to see patients at EDI throughout the programme. Outreach placements take place at four facilities across three health boards. Students

are rotated through each placement allowing them to practise and develop skills with a broad range of patients.

Evaluation of Qualification against the *Standards for Education*

13. As stated above, the *Standards for Education* were used as a framework for this inspection. Consideration was given to the fact that the *Standards for Education* were approved in late 2012 and that it may take time for providers to make amendments to programmes to fully meet all of the Requirements under the Standards and to gather the evidence to demonstrate that each Requirement is being met. The inspection panel were fully aware of this and the findings of this report should be read with this in mind.

14. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement is met, partly met or not met and to provide evidence in support of their evaluation. The inspection panel examined this evidence, requested further documentary evidence and gathered further evidence from discussions with staff and students.

15. The inspection panel used the following descriptors to reach a decision on the extent to which the BSc in OHS at EDI meets each Requirement:

A Requirement is **met** if:

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

A Requirement is **partly met** if:

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

A Requirement is **not met** if:

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

Standard 1 – Protecting patients **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised**			
Requirements	**Met**	**Partly met**	**Not met**
1. Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients	✓		
2. Patients must be made aware that they are being treated by students and give consent	✓		
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care	✓		
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development.	✓		
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body.		✓	
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety		✓	
7. Should a patient safety issue arise, appropriate action must be taken by the provider		✓	
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.		✓	
GDC comments			
Requirement 1: Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients *(Requirement Met)*			

Before proceeding to patient clinics, students are assessed in periodontal procedures in Year 1 and restorative procedures in Year 2 in the clinical skills laboratory. Students also see paediatric patients to deliver oral hygiene instruction to gain patient management experience before commencing clinical operative work on paediatric patients. There is a pre-clinical OSCE in periodontal skills that students must pass before they are permitted to treat patients, which the panel was pleased to see is externally examined. Students reported that they felt confident and ready after completing Semester One of the first year to progress to treating patients. One issue raised by students was that there was a gap between experience in the clinical skills laboratory and starting on clinic (due to the winter break) which they felt lessened their confidence to a small degree. This does not appear to have been fed back to staff.

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

The inspectors were told that consent is verbally given on clinic. In addition, blank patient consent forms were made available to the panel and these clearly indicated that the treatment was to be completed by a student. The consent forms have not been fully implemented across all outreach placements and a working party is looking at how full implementation may be achieved. Plans to send consent forms to the parents of paediatric patients were also noted and welcomed.

Supervising staff reported some occasional difficulty in determining parental responsibility for paediatric patients, but incidents involving consent or the lack thereof were not reported in the information from the incident reporting system.

The panel noted plans by supervisors at EDI to provide written treatment plans to patients to further aid informed consent, and agreed that this would be desirable.

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

The programme is subject to NHS Education for Scotland (NES) and NHS Lothian health and safety policies, and complies with the requirements of these. Safety briefings are held with staff and students each morning at EDI. Outreach placements are subject to the health and safety policies of their relevant NHS board.

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

Clinical supervision levels are at four to five students to one supervisor. The panel felt that this level was appropriate. Numbers of supervisors per cohort do not appear to vary according to the available documentary or oral evidence. Effective communication exists between EDI and outreach placements, which allows for any potential issues to be raised and for supervision levels to remain consistent. The panel noted comments from students who stated that they felt that supervisor levels were not as high as they would wish, however, the panel felt that the supervision ratio compared favourably to many other programmes and was acceptable.

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

The panel were satisfied that appropriate registration is held by all supervisors. Some staff CVs were available and showed appropriate qualifications.

EDI does not require supervisors to hold any formal supervisory or teaching qualification. Staff inductions do not include training on supervisory skills and supervisors at EDI are not required to attend a formal training course. Outreach supervisors informed the panel that some teaching courses are available to NHS staff.

The panel requires that training in supervisory skills be introduced at a level appropriate for the individual staff member. It may be appropriate to cover this through an induction or training days.

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

The panel noted that there is a University-wide whistle blowing policy, although this is not tailored to clinical subjects. The inspectors were also advised of the role of support staff on clinic who can report any issues or concerns. Dental nurses are actively involved in patient safety and a monthly hand hygiene audit is conducted which assists in reducing risks to patient health.

Staff and students were all aware of the need to raise concerns and felt that they knew to whom they would report those concerns. The panel were concerned that a formal policy on raising concerns relating to patient safety does not exist for the programme. There is also no documented procedure in the student handbooks or any other documentation about how a concern should be reported and how it would be handled. Without a policy the panel could not be assured that this Requirement was met. The panel were not confident that students were explicitly aware of their obligation to raise a concern, as students reported "picking up" how to raise a concern while on clinic rather than being told what the correct procedure was. This heightens the risk of students adapting to a culture on clinic that may not be conducive to a patient's best interests and does not provide them with assurance that they would not be penalised for raising a concern in good faith.

A formal policy and procedure on raising concerns must be created and this should be included in student-focused material as well as being enforced in the learning environment.

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

There is an incident reporting and risk management system called DATIX in place. Two members of staff are responsible for inputting information on a student's behalf should a patient safety incident occur, although the panel were informed that any professional on clinic can report an incident. Recorded incidents are investigated by the principal dental nurse in the first instance and then discussed at the Quality Improvement Team (QIT) meeting run by and for NHS Lothian employees. The Programme Director is also invited to attend and is therefore responsible for feeding back incidents and the associated learning to staff and students.

The panel were briefed on the operation of DATIX and were presented with examples of minutes from the QIT meeting, wherein issues were identified and discussed. The panel recognised that while all clinical areas will experience incidents, the records of how incidents were disseminated back to staff and students, and how any learning from these was taught and/or communicated, was inadequate. According to documentary evidence received in advance of the inspection, as well as oral information given at the inspection, the main method by which information is disseminated to staff is via the weekly team debrief which is an informal meeting that is not recorded or minuted. The evidence did not contain any examples of how teaching has been adapted or additional teaching arranged for students to cover

learning that may have come from a patient safety issue. The panel therefore found no evidence to assure them that appropriate action had been taken where patient safety issues had arisen. The absence of any framework or policy meant that this Requirement was not fully demonstrated.

The panel therefore require that robust recording procedures are introduced for actions, discussion and learning following a patient safety incident.

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance *(Requirement Partly Met)*

The student fitness to practise (FTP) policy for the School was made available to the panel but this, while covering the BSc in OHS, only specifies formal procedures at College level after a concern has been referred to the Fitness to Practise Committee. The panel were told that there were no other documented procedures or guidance dealing with how fitness to practise issues would be handled within the BSc programme.

Staff and students informed the panel that the concept of and need for student FTP was discussed during the induction week. The students were aware of the need for professionalism and that their behaviour outside of the workplace could impact on their good-standing as a member of the dental profession. Some students told the inspectors that they found this immediate need to behave in a professional manner (in comparison to students on other programmes), just as a registrant would, to be a challenge. This was especially felt by those students who entered the programme directly from a school environment. Explicit teaching on this area was included within the programme's themes and staff were confident in reporting any contraventions in the expected standard of behaviour. However, in the absence of any written policy or guidance, the mechanism as to how an issue would be addressed was not understood by students although there was a general impression that the Programme Director would be involved in any proceedings.

No student FTP issues were reported or evidenced.

The GDC student FTP guidance was quoted as evidence that this Requirement had been met. This is a guidance document and cannot replace the need for a specific policy for the programme.

The panel require that a School or programme level student FTP policy must be put in place which details how concerns would be identified, handled and referred to the College Fitness to Practise Committee. This must be made available to staff and students alike.

Actions

No	Actions for the Provider	Due date
5	Training for all staff in supervisory skills must be introduced. Training may differ between different members of staff dependent on their previous experience of supervising students. Training should incorporate the policies and procedures in place.	Re-inspection in 2015
6	A formalised process for the reporting of concerns must be devised, to ensure consistency and to encourage and foster the practice of raising concerns that may affect patient safety.	Re-inspection in 2015

7	Any action arising from a DATIX report must be evidenced thoroughly from discussion at the committee to resolution, dissemination and teaching (when appropriate) at a programme level.	Re-inspection in 2015
8	A student fitness to practice (FTP) policy that details how concerns would be identified, handled and referred to the College Fitness to Practise Committee must be introduced at School or programme level. The operation of the policy should be made explicit to staff and students, and must also be included in student literature.	Re-inspection in 2015

Standard 2 – Quality evaluation and review of the programme **The provider must have in place effective policy and procedures for the monitoring and review of the programme**			
Requirements	**Met**	**Partly met**	**Not met**
9. The provider will have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function.		✓	
10. The provider will have systems in place to quality assure placements	✓		
11. Any problems identified through the operation of the quality management framework must be addressed as soon as possible		✓	
12. Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity		✓	
13. Programmes must be subject to rigorous internal and external quality assurance procedures		✓	
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow the Quality Assurance Agency (QAA) guidelines on external examining where applicable		✓	
15. Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment		✓	
GDC comments			
Requirement 9: The provider will have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the			

curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function *(Requirement Partly Met)*

The quality management framework for the programme comprises the School committee structure, with different elements of the programme being divided under various committee remits. The awarding institution, the University of Edinburgh, has devolved all management of the programme to the School including implementing minor and major programme changes. The panel noted that a successful change has been made to the programme's curriculum in regards to when restorative training takes place. Based on feedback received from staff and students, this training has been transferred to Semester One of Year 2 instead of commencing in Year 1. Staff and students reported to the panel that this change had been beneficial.

The evidence provided to the panel about the committee structure was not clear: the structure for the committees and how they interact with one another was confusing. No guidance describing the relationships and responsibilities of each committee was not available nor was it clear how committees communicate with each other to ensure joined-up working and that the quality of the programme is effectively managed.

Additional changes that have been made to the programme were not fully evidenced. The inspectors were told that legislative changes are discussed informally at the weekly team debrief meeting. The inspectors were informed that mapping of the programme to the GDC learning outcomes in the new curriculum document, *Preparing for Practice*, has been undertaken for Year 1 and is being taught to the cohort who will graduate in 2016.Evidence of this mapping exercise was not provided to or requested by the panel.

The panel could not be wholly satisfied that this Requirement had been met because detail as to how the committees manage the quality of the programme, as well as where the responsibility for this function lies within the School structure, was not available. A statement detailing how the structure works and which committee holds responsibility for each area of the programme must be created for the panel to fully consider the effectiveness of the quality management framework.

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

Outreach placements are facilitated by NES and built into the service level agreement with EDI. Two tutors from EDI are responsible for overseeing outreach and they meet regularly with outreach supervisors and clinical directors from the relevant health boards. Outreach supervisors attended a briefing day where the marking scheme was explained and logbooks for each student reviewed. Supervisors and students are encouraged to feedback any comments or suggestions for improvements to the tutors at EDI.

The criteria that a potential placement should meet have not been defined in the documentation. A statement of this kind would be useful for the programme providers in future should a new outreach placement be required.

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

As highlighted under Requirement 9, a quality management framework has not been fully evidenced, which has a consequential impact on this Requirement.

A Teachers' Group committee and Curriculum Executive committee meet at programme level to discuss student progression and programme themes. It is expected that quality management issues would be discussed at these meetings, and while oral assurance was given that this does happen, the documentary evidence was not clear or explicit in this regard. Discussions from both committees may be escalated to the Board of Studies meetings, which are at School level but it is not clear or defined when escalation is appropriate. Up-to-date minutes for these committee meetings were not available to the panel. It was therefore not possible to see the full framework 'in action' or to determine whether issues are actually escalated and dealt with effectively.

The panel felt that problems identified through the committee structure would be dealt with as soon as possible but there was no documentary evidence to support this. Definition and guidance on the quality management framework would assist the programme leads in meeting this Requirement.

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

The programme does not have a high number of students, and it is reasonable to expect that serious threats would be identified and acted upon by senior staff. The panel received oral assurance that the GDC would be notified if a threat arose. The programme uses the University-wide Code of Practice on whistleblowing, which would be of assistance in evaluating the programme and possibly allowing for relevant issues to be reported to the GDC. The programme has not reported any incidents where the whistleblowing policy has had to be used.

It was difficult to determine by which committee other serious threats that would compromise the running of the programme, such as funding issues or problems with patient supply, would be identified or how quickly this would happen, especially as the frequency that the various committees meet is not defined. The panel could not be assured that the GDC would be notified at the earliest opportunity as no information about the committee structure was presented. It is assumed that the Programme Director would take responsibility for notifying the GDC of a serious threat although no explanation was given to the panel to confirm this.

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

The programme has not been subject to any formal review or scrutiny by the University of Edinburgh, since it first recruited students in 2009, although a review is due to take place in the 2014/15 academic year.

The panel found that internal quality assurance procedures were not clearly defined. The panel were not clear whether there was a process for an internal cyclical review of the programme. Students are able to provide feedback into the programme development, though some students told the inspectors that this was not acted on and that the feedback provided had been turned around and used as a criticism of the students that provided it.

Internal quality assurance was evidenced by the major change successfully made to the programme regarding the move of teaching on Restorative skills to Year 2 from Year 1.

External quality assurance has not been undertaken by any organisation although external examiners are utilised. External examiner reports were available for the panel's review and feedback on the quality of the programme was seen at the Board of Examiners meeting.

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

The panel met with both of the external examiners and were satisfied that they understood the learning outcomes and their context. Both examiners are involved with DCP education programmes at other institutions. One examiner has been utilised for practical clinical examinations and both have been used for final year case presentations. They also review the dissertation and degree classifications.

As both examiners were directly involved in assessing students in the final exams, they were not able to provide overarching quality assurance of this process. The inspectors felt that the programme assessment would benefit if the School followed QAA guidance, and that at least one of the external examiners must have oversight of the entire assessment process especially in Year 4 for the final exams.

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *(Requirement Partly Met)*

The panel felt that it was likely that any concerns and/or formal reports would be acted upon but the evidence to explain where this would happen is not definitive. External examiner reports are discussed at a programme level and recommendations provided were taken into consideration if felt necessary by the programme leads. One external examiner report questioned whether students had learned model answers as a way of completing an examination as the answers given were uniform in their style and content. This concern was discussed but the assessment process was not altered as the programme leads felt that the subject being examined lent itself towards uniform answers similar to what a model answer may be.

However, as outlined for previous Requirements, evidence demonstrating the management of quality improvement was not provided by the School. Meetings of the Curriculum Executive and Board of Studies are opportunities where such concerns could be raised although it is not evident that such issues have been raised from the minutes of these committees. Minutes from the School's Undergraduate Studies committee were not provided to the inspectors. A clear committee structure, with details of remits of each committee and how committees interacted with each other would inform and help to assure the panel that this Requirement is met.

Actions

No	Actions for the Provider	Due date
9, 11, 12, 15	The quality management framework must be documented and guidance produced to explain the responsibility and remit of each committee. An indication of how often each committee convenes and the membership of each would also be of use, as well as details on how any issue that needs to be reported to the GDC would be handled and by whom.	Re-inspection in 2015
10	The programme should develop and submit a statement on what criteria a potential outreach placement should meet. This is for the programme's own future use should new outreach placements be required.	n/a

13	Evidence of quality assurance external to the programme and any changes to be made as a result of this must be provided and will need to be reviewed by the GDC inspection panel.	Re-inspection in 2015
14	The School must ensure that there is scrutiny by external examiners of the entire assessment process, in line with QAA guidance	Re-inspection in 2015

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

Requirements	Met	Partly met	Not met
16. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards.		✓	
17. The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes		✓	
18. Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed		✓	
19. Students will have exposure to an appropriate breadth of patients/procedures and will undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes	✓		
20. The provider should seek to improve student performance by encouraging reflection and by providing feedback[1]	✓		
21. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body		✓	
22. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted	✓		

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

23. Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments		✓	
24. Where appropriate, patient/peer/customer feedback should contribute to the assessment process		✓	
25. Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion		✓	
26. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard		✓	

GDC comments

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

The evidence provided indicated that students had gained a sufficient level of knowledge and skills throughout the four years of the programme to be considered at a level sufficient for them to begin practice as a safe beginner. The logging of clinical procedures in practice allows for staff to monitor a student's progress through individual student logbooks. Assessment takes place via a variety of methods throughout each academic year and gateway assessments must be passed for students to progress onto clinic, then onto outreach and onto their finals.

Numbers of clinical procedures completed by students are collated and results of summative assessments are recorded centrally. Central recording of this data allows broad gaps in achievement of learning outcomes to be identified and monitored. As the summative assessments are not clearly mapped to the learning outcomes, it is difficult for the School to identify gaps in individual student's achievement of these.

From the evidence provided, the panel could not be satisfied that this Requirement had been fully met. The assessments were not closely mapped to the learning outcomes in either the pre-inspection mapping table provided or in the Central Registry (the University's central recording database) where assessment marks are logged. Clinical competencies are logged but are not mapped to the outcomes to ensure coverage of all competency-based outcomes. The overarching strategy for the assessments used was not documented and several of the documents listed in the GDC mapping template provided did not address the Requirement indicated. Consequently, the approach ensuring curriculum coverage of all learning outcomes was not coherent.

The panel considered the University marking scheme, which uses grades A-F, and how this is used in regards to clinical skills. The inspectors were told that a grade D was a satisfactory or pass grade and the baseline level. The mark scheme description states that this grade indicates satisfactory performance. Students are marked according to the expectation for a student at their stage of development: there are different expectations to achieve a D grade for a Year 1 student than for a Year 3 or 4 student. Comparatively, grades for students increased on average from C and D grades in earlier years to A and B grades in the later years. There was very limited use of the bare pass grade or below on clinic, which was felt to be unusual as

students are likely to perform at a 'just satisfactory' or even unsatisfactory level on occasion while they are acquiring and refining skills. It appeared to the inspectors that a student could still achieve an above satisfactory or 'good' grade or better even if they had received help and advice from a supervisor while completing the procedure. Some students told the panel that they did not always understand the grading they received and that they felt grades could be randomly applied and not helpful. In addition, some staff were critical of the grading scheme and told the inspectors that it needed to contain clearer marking criteria. These issues indicated to the inspectors that the grading scheme needs to be evaluated to ensure that it is appropriate for the grading of clinical skills.

For the Requirement to be fully met, the panel requires an assessment strategy to be introduced which fully explains how each process works. There must be clear descriptors for the marking scheme and comprehensive mapping of the assessments to the learning outcomes so that coherent analysis of the achievement of the learning outcomes can take place. In lieu of a new or amended marking scheme, guidance on the current marking scheme should be introduced so that staff are confident to award the appropriate grade based on clear criteria that differentiate one grade from another.

The programme has a potential exit strategy for any student who passes all of their assessments in Year 3 but who do not want, or are not felt able, to complete the research component in Year 4. Any student of this kind would progress until May in Year 4 to gain further clinical experience for their case presentation assessments. The student would then leave the programme with a BSc in Dental Science but would be required to complete the Diploma in Dental Hygiene and Dental Therapy examination with the Royal College of Surgeons of Edinburgh in order to gain a qualification with which to register with the GDC. The programme leads must contact the GDC before using this exit strategy.

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes *(Requirement Partly Met)*

Student records and assessment data were made available to the panel and showed that a record of every clinical procedure is logged in a paper file for each student, kept by that student. The programme providers use the University's Central Registry to keep track of summative assessments which assists tutors to identify any failing students, although there is no cross-referencing to the learning outcomes within this system.

Based on the evidence provided, the mapping of GDC learning outcomes to assessments was not comprehensive. The mapping originally completed for the submission and again for the inspection was quoted as being the programme's mapping documents. Within these, there was no explanation as to how various methods of assessment are used and terms such as 'continuous assessment' were not defined, and therefore unhelpful in assuring the panel that the programme is sufficiently mapped and aligned to the learning outcomes.

The panel felt that improved mapping of the learning outcomes to the assessments, including mapping within the Central Registry itself, if possible, must be completed and evidenced before this Requirement can be considered as met. The programme providers must ensure that they monitor achievement of the learning outcomes via assessments. This will provide assurance that all of the outcomes have been met.

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

The panel reviewed evidence which confirmed that a range of assessment methods are utilised. A written examination on professionalism along with three case studies and a dissertation comprise the final year assessments. Copies of the dissertations and answer sheets from the exam were available for review. The panel observed the assessment of the case studies. Documentary evidence showed that earlier in the programme students undertake OSCEs, Structured Clinical Operative Tests, written examinations and a literature review.

The panel agreed that the range of assessment methods used were generally appropriate to the learning outcomes. There was some concern that some areas, such as professionalism, are assessed in a written format where an alternative assessment may be better suited. An assessment strategy was not defined or explained to the panel. The panel were therefore not assured that the performance of the assessment methods is monitored, quality assured or developed in any structured way. The documentary and oral evidence showed that the assessments had not been clearly mapped against the learning outcomes, and there was no sign-posting on where a particular learning outcome had been taught and assessed during the programme.

The panel felt that it would be very helpful for the programme leads to observe the case studies to ensure that the assessment method was meeting the objectives of the exam. There was a lack of clarity in the available documentation and between staff and external examiners as to what the purpose of the case studies were and what line and type of questioning should be employed. The time allowed for calibration and co-ordination between the internal and external examiners was brief, and the external examiners had no formal written or oral briefing.

In order to meet this Requirement, the programme leads must introduce steps to provide greater focus and structure to the assessments. This would normally include more detailed examiner guidance and briefing, including defining what is being assessed (knowledge, applied knowledge, understanding) and also greater clarity and description within the mark scheme used. Any form of development of the assessment processes must be recorded and a rationale for the assessment methods employed would be useful in further aiding quality assurance.

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes *(Requirement Met)*

Student portfolios were available for review by the panel and showed a satisfactory level of clinical experience and exposure to a range of procedures. A range of patients are seen at the EDI clinic and across the four different outreach sites, attended by all students in turn. Students in the current Year 4 cohort started outreach in Year 3 but all intakes following the 2011 cohort will undertake outreach in Year 4 only. This is not expected to impair the amount of clinical experience gained. The panel felt this change was not likely to have a negative impact on student experience or achievement of the learning outcomes. The panel were impressed overall with the level of outreach experience of the graduating cohort. A very good range of patients were seen across the different outreach sites, as well as at EDI.

The panel felt assured of the effectiveness of the placements from interviews with students and were pleased to learn of the current graduating cohort's paediatric experience at the Royal Hospital for Sick Children. Although this experience is not currently available for other cohorts due to staffing issues, the panel were supportive of the programme's plans to re-introduce this experience once resource issues have been resolved.

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

Students are required to keep reflective diaries which are then utilised in the teaching environment in sessions held once every three weeks. During these sessions the students use their diaries to facilitate discussion and to feed back to classmates about problems encountered in practice. These diaries also assist in selecting patients for final year case studies. The panel noted that some of the diaries seen did not appear to be fully reflective but more descriptive in outlining experiences in practice. The panel felt it would be useful for the programme leads to monitor the diaries and advise students on how these should be kept in order to be effective.

Feedback is encouraged in the clinical environment and evidenced by the marking sheets used for clinical assessments where the supervisor may note comments on the observed procedure. Students are also required to reflect on their performance and note this on the same marking sheets. The students told the inspectors that they felt that they received a good level of feedback and much of this was given orally, rather than written on the feedback sheets.

The ability to reflect effectively on patient care did not appear to be comprehensively assessed in the summative assessments. The panel felt that reflection should be further assessed within the Year 4 case presentations, and that feedback overall should continue to be encouraged throughout the programme.

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

The panel were satisfied that all examiners have appropriate registration with the GDC, and that external examiners have previous experience of examining similar programmes. However, both internal and external examiners were not offered any form of training or induction by the programme leads to orientate them to the programme and the assessments. A briefing was not provided prior to the case presentation assessments, so the examiners did not have the marking descriptors or a written description of how the exam should be conducted and in which areas students should be questioned. The panel felt that training in the expectations of these assessments was crucial for future examinations, of which a detailed pre-examination briefing should be a part.

The panel noted that inductions for new staff with supervision duties included shadowing other members of staff and the use of scenario-based discussions to help new starters become familiar with the marking scheme. The opportunity for formal training in education is available via NES; other than this, mandatory or routine training is not currently in place for staff to gain assessment skills. Some staff told the inspectors that they had very little briefing on their role and would have been better prepared for their role with a ‘training the trainers’ course.

The panel requires that the programme leads formalise the procedures currently in place to ensure that new supervisors and examiners have the requisite knowledge and skills relating to the assessment used on the programme. Routine training must be introduced for these skills to be obtained. External and internal examiners must receive full briefings on the aims of assessments, the learning outcomes to be covered, and the skills to be tested. The programme leads should also consider implementing training days or other opportunities to allow for calibration and briefing of internal and external examiners.

Requirement 22: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted *(Requirement Met)*

The external examiners are utilised on a number of occasions to contribute towards the assessment processes. Examination papers are sent to the external examiners for comment

and review, and the panel received oral assurances that the comments are taken into account. An external examiner is utilised for the pre-clinical OSCEs, and this was felt to be good practice.

External examiners are asked to comment on the standard set for non-written assessments. The panel did note that this feedback was gained informally by email and was not collated or centrally recorded.

The external examiners were able to report to the panel that the assessments appeared to be at the correct standard and they felt that these were also rigorous. Feedback from the external examiners was invited during the Board of Examiners and was minuted. Their opinion regarding degree classification was also requested for a student and was taken into account when the board agreed the classification.

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

The panel felt that the assessments were fair. Examples of standard setting were seen and documentation confirming standard setting for written papers was available. This showed the use of clear and appropriate model answers. The panel were informed that programme leads use the Modified Angoff scale to standard set pass marks for appropriate assessments. Evidence of standard setting of the pass and fail marks were seen at the Board of Examiners meeting and were in accordance with the University's Taught Assessment Regulations. Monitoring and quality assurance of this part of the assessment process was therefore evidenced.

The overall mechanism for standard setting, however, appeared to be an informal process including discussion between members of staff and emails to the external examiners. Neither the discussions nor emails are consolidated, centrally recorded or discussed at a committee level. Additionally, the marking criteria for both the case presentations and the dissertation were not documented. The percentage pass mark for clinical assessments was set at 50% as opposed to the University-standard 40% pass mark for written assessments. However, this appeared to be an arbitrary figure and the reasons for this pass mark were not explained or documented. The same marking scheme (alphabetical grades of A-F with D as the pass grade) is employed for clinical assessments although there are no clear grade descriptors. The panel were concerned that supervisors may struggle to award the correct grade without such guidance, especially as a grade of C is the traditional pass mark.

The panel felt that the information provided to students prior to the case presentation assessment was not comprehensive. The staff appeared to rely upon the students' experience of similar assessments earlier in the programme to inform them as to what would happen for the final assessments. The student handbooks did not include guidance as to how each assessment would be marked. In addition, there were no documented criteria available to inform the selection of appropriate patients for the case presentations.

For this Requirement to be met, standard-setting must be employed and evidenced across all types of assessment where it is appropriate to use it. Where standard-setting is not appropriate, clear grade criteria and description must be provided to examiners. A rationale must be introduced for the different percentage pass marks and the wider marking scheme. Furthermore, criteria should be set for the suitability of patients for case presentations and this should be communicated to students in writing, as well as orally. Guidance on all forms of assessment must be fully detailed in student handbooks or in briefing documents to ensure that students understand the criteria against which they will be tested and how the assessment will be conducted.

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

The panel accepted that some peer feedback is obtained and utilised during the reflective diary sessions. Evidence of patient feedback was not available as this is only collected orally on clinic. There was no policy on how such feedback would be used and what role it would play, if any, in informing formative assessment.

For this Requirement to be met patient feedback must be collected and collated as part of an overall policy. The use of both this and peer feedback should be considered as part of formative assessments. A clear policy as to the use of patient feedback should be instituted.

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

The panel noted that there are multiple assessments of many learning outcomes throughout the programme via in-clinic observations. The panel were not presented with evidence that demonstrated that assessments had been designed to ensure a sufficient sampling of student performance across all learning outcomes. The programme leads are therefore required to review how each learning outcome is assessed to ensure that all assessments are as reliable and valid as they can be.

Requirement 26: The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard *(Requirement Partly Met)*

The panel were satisfied that programme staff were aware of the expected standard of students. Student awareness of the expected standard was not evidenced in documentation as the information included in the student handbooks was brief. Assurances were accepted from staff that the students are made aware of assessment criteria orally.

Guidance regarding assessments must be formalised in writing and explicit teaching on this made clear in the timetables for this Requirement to be met.

Actions

No	Actions for the Provider	Due date
16 & 18	The methodology for aggregation, triangulation and standard-setting must be documented with the introduction of a rationale for the different pass marks and marking scheme. Clear grade descriptors must also be introduced.	Re-inspection in 2015
17 & 25	The range of assessments must be comprehensively mapped across all the learning outcomes for use by the programme tutors to ensure that all outcomes are appropriately assessed on multiple occasions.	Re-inspection in 2015
18 & 23	Instances of standard-setting with external examiners must be formalised and documented.	Re-inspection in 2015
20	The use of reflection in student development should continue to be encouraged.	n/a
21	Examiners must receive full briefings on the aims of assessments, the learning outcomes to be covered, and the	Re-inspection in 2015

	skills to be tested. The programme leads should also consider implementing training days or other opportunities to allow for calibration and briefing of examiners.	
21	Routine training must be introduced to ensure that new supervisors and examiners have the requisite knowledge and skills relating to the assessments used on the programme.	Re-inspection in 2015
24	Patient feedback must be collected formally and a policy introduced to describe why this feedback is sought and how it will be used to aid student development and assessment.	Re-inspection in 2015
26	Criteria must be provided that outlines the suitability of patients for case presentations and this should be communicated to students orally and in writing. Guidance on all forms of assessment must be fully detailed in student handbooks or in briefing documents to ensure that students understand the criteria against which they will be tested and how an assessment will be conducted.	Re-inspection in 2015

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

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

GDC comments

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

Relevant policies regarding disability, respect and dignity, and a student complaints procedure were all seen to be in place. The programme providers reported an active relationship with the offices within the School that assist students with a disability to enter the programme and for reasonable adjustments to be made. No incidents concerning an equality and/or diversity issue, either with staff or students, had been recorded, and the panel were orally informed that the student complaints procedure had not been invoked.

The programme leads held an instructional afternoon with a subject specialist following implementation of the Equality Act 2010 to ensure they were meeting the principles of this, which appeared to be the case. In addition to the University policies, the equality and diversity policies of the relevant NHS boards are in place on clinic and on outreach placements. The

policies of the relevant NHS boards in non-NHS Lothian placements come into force as appropriate.

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

Staff reported that there was mandatory equality and diversity training for all staff, including those acting as personal tutors. This is delivered in an online format or through a workshop. Evidence as to how often such training should be undertaken or whether this was part of the appraisal process was not available. It was also not clear what would happen if a member of staff failed to complete the mandatory training.

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

The panel found during interviews with students that their knowledge of equality and diversity legislation was present but not comprehensive. Students receive a lecture on the principles of equality and diversity in Year 1 and this is to be repeated in Year 4. There was no evidence of explicit teaching on the varying requirements according to geographical location but some assessment takes place in Year 4 on preparation for practice which reinforces the need for on-going compliance with relevant legislation.

The panel felt that the principles, and governing legislation, of equality and diversity must be integrated into the programme to give students specific knowledge in this area. A refresher of teaching delivered at the beginning of the programme should be provided earlier than Year 4 to help reinforce the integration of the subject into clinical practice.

Actions

No	Actions for the Provider	Due date
28	Equality and diversity training must become part of the staff review process.	Re-inspection in 2015
29	Equality and diversity training for students must be repeated earlier than Year 4.	Re-inspection in 2015

Summary of Actions

Req. number	Action	Observations Response from Provider	Due date
5	Training for staff in regards to supervisory skills must be introduced.	All staff will undertake clinical assessment training in conjunction with the University of Newcastle in January 2014. All new lecturing staff are required to undertake the Postgraduate Certificate in Academic Practice offered by the University of Edinburgh. All new clinical teaching staff will have a full induction programme about our assessment methods, and a period of mentored working when they first start to supervise trainees. There will be an annual training day for all educators involved in the programme to refresh and review assessment process as an additional QA measure.	Re-inspection in 2015
6	A formalised process for the reporting of concerns must be devised, to ensure consistency and to encourage and foster the practice of raising any concern that may be detrimental to patient safety.	The student handbook is being updated to include additional information and guidance in relation to raising concerns about risks to patient safety. The University of Edinburgh 'Raising Concerns' document utilised by the College of Medicine and Veterinary Medicine will be included. A link to the GDC website is already included, as is the policy adhered to within NHS Lothian.	Re-inspection in 2015
7	Any action arising from a DATIX report must be evidenced thoroughly from discussion at the committee to resolution, dissemination and teaching (when appropriate) at a programme level.	DATIX reporting is discussed at the Quality Improvement Team Committee (QIT) that meets usually on a monthly basis. The School of Dental Hygiene & Therapy is represented on this group,	Re-inspection in 2015

		and issues arising from these meetings are fed back to the permanent School staff at weekly team meetings. Outcomes from DATIX incidents are relayed between the QIT committee and clinical staff via the School representative. Any incidents that have implications across the programme will be communicated to all educators by email once they have been identified. Any changes in policy / procedures will be reinforced at the annual educators meeting.	
8	A student fitness to practice policy that is appropriate to medical and/or dental students must be introduced at School or programme level. The operation of the policy should be made explicit to staff and students, and must also be included in student literature.	The College of Medicine and Veterinary Medicine Fitness to Practice policy is adhered to within the BSc programme. http://docstore.mvm.ed.ac.uk/Committees/Fitness-to-Practise.pdf The content will be made more explicit to include additional information specifically in relation to Oral Health Sciences.	Re-inspection in 2015
9, 11, 12, 15	The quality management framework must be documented and guidance produced to explain the responsibility and remit of each committee. An indication of how often each committee convenes would be of use, as well as details on how any issue that needs to be reported to the GDC would be handled and by whom.	Internal Quality Assessment of the programme is undertaken by the College of Medicine and Veterinary Medicine. The five yearly External QA Review is scheduled for the academic year 2014-15. The OHS Board of Studies currently meets twice per year. Any issues arising from the Board of Studies are taken to the College Undergraduate Studies Committee (Medicine, Veterinary Medicine & Oral Health Sciences) which meets three times per year. Should there be any threats or concerns about	Re-inspection in 2015

		being unable to achieve learning outcomes, then the Board of studies would prepare an action plan and alert the GDC should the need arise. The Curriculum Executive meets twice per annum and reports back to the Board of Studies Committee. All documentation pertaining to these committees will be available at re-inspection, along with processes for identifying concerns to the GDC.	
10	The programme should develop and submit a statement on what criteria a potential outreach placement should meet. This is for the programme's own future use should new outreach placements be required.	A statement of clinical and educational outcomes for outreach placements is being developed. This will describe how each outcome will be attained and assessed.	n/a
13	Evidence of quality assurance external to the programme and any changes to be made as a result of this must be provided and will need to be reviewed by the GDC inspection panel.	External quality assurance is provided by our external examiners and by a 5-yearly programme review led by University of Edinburgh. All of our external examiners provide reports on the basis of their observations about every diet of assessment. Actions arising from External Examiner reports are discussed at Board of Studies Committee and any resultant change instigated at the next diet of examinations. The University of Edinburgh 5-yearly review will take place during the academic year 2014-5. Evidence from both processes will be available at re-inspection.	Re-inspection in 2015
14	The School must ensure that there is scrutiny by external examiners of the entire assessment process, in line with QAA guidance.	We are in the process of modifying our assessment processes. From Semester 2, 2014 our External Examiners will moderate the examination process, but not be	Re-inspection in 2015

		directly involved in examining students. Two internal examiners from appropriate disciplines will be appointed for each examination.	
16 & 18	The methodology for aggregation, triangulation and standard-setting must be documented with the introduction of a rationale for the different pass marks and marking scheme. Clear grade descriptors must also be introduced.	We are seeking advice from the University regarding the validity of our assessment processes. We currently employ the modified Angoff technique for standard setting. Our documentation will be modified to give greater clarity to grade descriptors. All information pertaining to this, and grade descriptors, will be available at re-inspection.	Re-inspection in 2015
17 & 25	The range of assessments must be comprehensively mapped across all the learning outcomes for use by the programme tutors to ensure that all outcomes are appropriately assessed on multiple occasions.	We employ a broad range of assessments ie written, OSCEs, DOPs, (SCOTs), short answer questions and multiple choice questions which are mapped across the learning outcomes. We are in the process of re-mapping the programme to the new learning outcomes contained in 'Preparing for Practice'. We will ensure that multiple assessments are in place at re-inspection.	Re-inspection in 2015
18 & 23	Instances of standard-setting with external examiners must be formalised and documented.	Standard setting is currently agreed by the External Examiners when reviewing the proposed examination questions each semester. This is usually undertaken via email or by telephone. In future, this will be formalised and documented.	Re-inspection in 2015

20	Student feedback and reflection to continue to be encouraged.	This process will continue to be encouraged and developed, in conjunction with feedback mechanisms.	n/a
21	Routine training must be introduced to ensure that new supervisors and examiners have the requisite knowledge and skills relating to the assessments used on the programme.	All staff will attend the Assessment Training day in January 2014. All new clinical teaching staff will have a full induction programme about our assessment methods and a period of mentored working when they first start to supervise trainees. There will be an annual training day for all educators involved in the programme to refresh and review assessment process as an additional QA measure. (See Req 5)	Re-inspection in 2015
21	External examiners must receive full briefings on the aims of assessments, the learning outcomes to be covered, and the skills to be tested. The programme leads should also consider implementing training days or other opportunities to allow for calibration and briefing of internal and external examiners.	Full briefings will be scheduled prior to all examinations to ensure the purpose and function of each assessment procedure is understood by all examiners.	Re-inspection in 2015
24	Patient feedback must be collected formally and a policy introduced to describe why this feedback is sought and how it will be used to aid student development and assessment.	Patient feedback is already collected via questionnaire in some Outreach Centres. We will introduce this more formally across all clinical teaching domains, and create a policy outlining the purpose of the exercise. Verbal feedback is already sought from patients, with significant comments recorded in the student reflective portfolio.	Re-inspection in 2015

26	Criteria to be set for the suitability of patients for case presentations and for this to be communicated to students orally and in writing. Guidance on all forms of assessment must be fully detailed in student handbooks or in briefing documents to ensure that students understand the criteria against which they will be tested and how an assessment will be conducted.	Written criteria for patient selection and guidance on assessment will be incorporated into the student handbook, which is currently under revision. This will support the oral guidance already given to students. All documentation will be available to the inspection panel in 2015.	Re-inspection in 2015
28	Equality and diversity training must become part of the staff review process.	This is undertaken by all staff as part of a 5-yearly CPD cycle and currency of training is reviewed on an annual basis during staff appraisals. E&D training is delivered through either the NHSL or the University of Edinburgh eLearning portals.	Re-inspection in 2015
29	Training for students in equality and diversity must be repeated earlier than Year 4.	An Equality & Diversity workshop will be incorporated into the timetable at the end of second year and repeated in fourth year. Annual seminars will be made available to all students.	Re-inspection in 2015

Observations from the provider on content of report

Recommendations to the GDC

The inspectors recommend that this qualification is approved for holders to apply for registration as a dental hygienist and dental therapist with the General Dental Council

There should be a re-inspection of the next fourth year cohort in 2015.