

Education Quality Assurance Inspection Report

Awarding Body/Education Provider	Programme/Award
University of West Scotland in conjunction with New College Lanarkshire	Certificate of Higher Education in Dental Nursing (as part of the BSc Dental Nursing programme)

Outcome of Inspection	Recommended that the Certificate of Higher Education in Dental Nursing is approved for the graduating cohort only to register as a Dental Nurse.
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Full details of the inspection process can be found in Annex 1

Inspection summary

Remit and purpose of inspection:	Inspection referencing the <i>Standards for Education</i> to determine approval of the award for the purpose of registration with the GDC as a Dental Nurse.
Learning Outcomes:	Preparing for Practice: Dental Nurse.
Programme inspection date:	First visit: 10 th -11 th February 2026 Portfolio visit: 20 th May 2026

Examination inspection date:	OSCE visit: 19th February 2026 Assessment Board: 28th May 2026 School Board of Examiners: 8th June 2026 Term 3 School Board of Examiners (Re-sits): 26th August 2026
Inspection team:	Jenny McKibben (Chair and non-registrant member) Anna Lown (DCP member) Fiona Ellwood (DCP member) Angela Watkins (GDC Education Quality Assurance Manager) Natalie Watson (GDC Education Quality Assurance Manager)
Report Produced by:	Angela Watkins Natalie Watson

Inspection Summary

The inspection was undertaken as a new programme inspection reviewing all 21 requirements within the Standards for Education, to determine whether the programme could be recommended for full approval. Of the 21 requirements reviewed, 5 were met and 16 were partly met.

The panel would like to acknowledge the significant amount of work undertaken by the provider in preparation for the inspection. A wide range of documentation was submitted, which was clearly organised and well presented, and this was appreciated by the panel. The provider also accommodated the panel well throughout the inspection process and demonstrated openness and engagement during discussions.

The panel identified several areas of good practice and strengths within the programme. In particular, the programme demonstrated a strong approach to feedback and reflection, with evidence of responsiveness to student experience and a commitment to continuous improvement. The programme also offers students valuable social impact opportunities and experiences that they may not ordinarily encounter, which was viewed positively by the panel.

A strong partnership between the university and college was evident, with collaborative working relationships supporting programme delivery. In addition, the panel recognised staff commitment to development and noted improvements between the first and second inspection visits.

The panel identified areas requiring further development in order to strengthen the programme and support full compliance with the standards. This includes the need to evidence the student journey across the programme, alongside the formalisation of documentation, processes, and to improve audit trails to ensure consistency and

transparency. Further work is required to strengthen supervisor calibration and training arrangements.

A programme-specific risk register is required. In addition, systems should be developed to effectively monitor actions and progress arising from quality assurance activities.

The External Examiner should have greater input into the design of assessments that are being undertaken, to establish if they are fit for purpose. An assessment that requires review is the OSCE Assessment observed by the panel.

The programme requires a centralised tracking system for monitoring clinical experience to provide clearer oversight of student learning opportunities and achievement.

Overall, the panel recognised that the provider is making considerable efforts to develop a strong and effective programme. The provider demonstrated a willingness to engage with feedback, reflect on areas for development, and implement improvements. While there are several aspects that require further strengthening and tightening of processes, the panel is confident that the provider has the commitment and capacity to continue improving the programme moving forward. The provider has advised that some changes cannot take place until the next academic year and therefore this will be reviewed at a follow up inspection in 2027.

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

Background and overview of qualification

Annual intake	25 students (minimum)
Programme duration	36 weeks over one year
Format of programme	2 SCQF Level 7 modules delivered over Term One (September – December) 2 SCQF Level 7 Modules delivered over Term Two (January – April) 2 SCQF Level 7 Modules delivered over Terms One and Two (long thin Modules)
Number of providers delivering the programme	This is a Franchise programme – New College Lanarkshire delivers the programme, University of the West of Scotland provides quality assurance and award.

Outcome of relevant Requirements ¹

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

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 programme includes an *Introduction programme* which is delivered at both the UWS Lanarkshire Campus and the Coatbridge Campus onsite dental clinical simulation facility. During the inspection the panel met with the students who reiterated that this introduction programme had given them confidence to be in a academic environment. A student articulated that by the end of the introduction programme they moved into the practice placement with full confidence in their ability, this was echoed by other students who had the same experience. The panel noted that the introduction programme is good and enabled students to gain the confidence and competence to enter the clinical environment fit to practice. However, the provider must formalise the assessment process and the handover of students to the placement, to ensure continuation of the ongoing training and progression.

During the Introduction programme students undertake a formative assessment on mandatory training and relevant skills to demonstrate competence before moving into clinic. The Work Based Assessors (WBA) sign off the competency level to allow students to move to clinic and work with patients. During a follow up visit to review student portfolios, mandatory training completion was documented.

This Requirement is **Partly Met**.

Action: Formalise a handover process to clinical placements which evidence training and ongoing progression opportunities.

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 Partly Met)

The students are all provided with uniforms that have their names embroidered and clearly identify them as a student in the practice. Most students wear these uniforms within their practice placement. However, in some practices the students have to wear the same

uniform as the other employees. UWS supplies name badges which clearly identify their name and that they are a student.

The panel reviewed the *UWS Placement Provider Tripartite Agreement 2025* which states that the placement provider should support students to ensure service users are aware of the student's status as a learner and obtain verbal consent to observe and participate in care and treatment. However, the provider must ensure that consent is recorded prior to treatment commencing to ensure there is an audit trail of consent given.

During a follow up meeting with placement supervisors, this was reiterated and although verbal consent is gained, typically from the dentist treating the patient regarding assistance of a student, there needs to be documented written evidence that consent has been gained.

The panel therefore deem this Requirement to be **Partly Met**.

Action: The provider must ensure there is evidence that consent is gained for the patient to be treated by a student.

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

Prior to the student commencing a placement the provider carries out a Health & Safety compliance check to ensure that the placement has all key policies, indemnity and insurance in place.

The panel reviewed a completed *NCL UWS Collaborative Franchise Agreement* which is signed by both parties detailing responsibility and expectations.

Students all confirmed that they received an Induction when they first attended placement which included Health & Safety. The panel reviewed the *Induction Checklist* which is signed by both the student and supervisor.

The provider rates all dental placements as a medium risk and therefore carries out a formal monitoring as a minimum every two years. The Work Based Assessors confirmed that each time they carry out a student observation on site, they include visual checks key safety aspects which are captured in the student portfolio.

The provider gave a demonstration of their In Place system which captures all the information regarding the vetting process and health & Safety checks carried out. Following an additional follow up visit, it was evident that the In Place system will prompt staff when expiry dates are approaching which provides assurance that this will remain on track.

This requirement is **Met**.

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

Each student is allocated a Work Based Assessor (WBA) and a personal tutor, who is their main point of contact with the college. The WBA is a GDC Registrant and carries out observations of students in placements and ultimately signs off the student as competent.

During the inspection in February, it was unclear if students were allocated a placement supervisor or a placement mentor. This was also unclear amongst students. We gave an action and asked for this to be explained. During an additional follow up visit. It was apparent that progress had been made and an information session had been delivered to supervisors and a placement handbook had been created that gave guidance on the role of the placement supervisor and the mentor role was removed which brought clarity. This will be formally implemented with training for all placement supervisors starting in the next academic year. It was confirmed during the inspection that placement supervisors are GDC Registered.

There is no calibration or formal training across the placements. Although supervisors do not confirm overall competence, they do observe students which confirms experience and

whether they require additional support in those areas. As students work across various placements, the panel would expect to see that training and calibration is taking place to ensure the supervisors understand what level of experience is appropriate for progression. The provider must give training and calibration to be assured that students are assessed fairly and consistently.

During the first visit, the panel spoke to a supervisor who was a named signatory, however it was identified that the supervisor was no longer a GDC registrant. Following this visit an action was given and the panel requested that the provider must carry out regular checks of current GDC registration of all supervisors, also cross referencing to InPlace to ensure accurate records are maintained. At the follow up visit the panel saw evidence of this and progress had been made. The panel had sight of the signatory list and GDC evidence within the portfolio and were made aware that records had been updated on In Place. We also spoke with placement supervisors who confirmed they were GDC Registrants.

The panel deem this Requirement **Partly Met**.

Action: The provider must ensure that placement supervisors are provided with training and calibration which incorporates standardisation in competency sign off and understanding of pass/fail of clinical experience.

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 Partly Met)

All WBA and placement supervisors are checked to ensure that they are on the General Dental Council (GDC) Register. The panel reviewed the *Component 2 – Clinical Dental Skills 2025 Portfolio* which includes a record of signatories who can sign off the students work. The document includes the supervisor's GDC registration number and signature. The WBA check the signatures when they review the student portfolio. As outlined under requirement 4, there has been progress since the first visit, and this is captured on the In Place system. Longstanding supervisors' GDC registration should be regularly reviewed.

The WBA confirmed that they completed their required CPD, and also essential training as required by the provider.

The WBA recognised upskilling in their own academic knowledge and understanding since working with the university.

As outlined under requirement 4, there is no ongoing training or calibration taking place for workplace supervisors. However, this is planned to be undertaken in the next academic year.

This Requirement is **Partly Met**.

Action: The provider must regularly review longstanding supervisor GDC Registration status. Also linked to Requirement 4 actions.

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 university utilise the *A National Approach to Raising Concerns in Practice*, however the document reviewed was a draft version and related to Nursing and Midwifery Students. This includes a Raising and Escalating Concerns in Practice Template. The provider must adapt this document to make it relevant to this programme.

The panel reviewed the *UWS Placement Provider Tripartite Agreement 2025* which states that the placement provider should notify the Module Coordinator as soon as practicable of any material changes in circumstances which might affect the student's placement or of any significant concerns about student performance. The document is signed by the placement provider at the point of agreement.

Students are informed about Raising Concerns in their CertHE Level 7 Programme Handbook and are required to sign the *UWS Conduct, competence & fitness to practice procedure* to acknowledge accountability and understanding of the process.

During the initial inspection the panel found that staff and students were unclear on the criteria and process for raising concerns, therefore the provider must ensure that students and staff are applying the universities high level policies and procedure continually throughout the programme to refresh knowledge.

Since the first visit, the supervisor handbook now has a clear raising concerns policy. This has also been added to the student portfolio. The panel also spoke with placement supervisors who were aware of the raising concerns process.

This requirement is **Partly Met**.

Action: The provider must adapt the National Approach to Raising Concerns in Practice document to ensure it is relevant to this programme.

The provider must implement the raising concerns process with all supervisors and students.

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 UWS Placement Provider Tripartite Agreement requires the placement provider/practice to provide a robust induction for the student which will address the 9 GDC Principles. This must include student access to practice policies and an induction to the clinical setting that students will be using to provide support during clinical procedures. Evidence of protection of vulnerable groups, occupational health screening and immunisations are in place prior to students accessing practice placement. Should a student wish to raise concerns, the initial point of contact will be the personal tutor assigned by UWS and NCL staff. The personal tutor would escalate to the Programme Lead (UWS) and Senior Registrant (NCL). If necessary, this may include advising the GDC as the regulator.

There have been no patient safety incidents and therefore the panel did not see the process being utilised. The panel was advised during the inspection that there is an incident reporting form and that the induction covers the process of reporting incidents. The programme handbook outlines this process.

Incident forms are reviewed and managed by the University

Practice supervisors are aware of the raising concerns process.

As outlined under requirement 6, the National Approach to Raising Concerns in Practice document should be relevant to the programme.

Action: Same as Requirement 6.

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 reviewed the *Student Code of Conduct and Procedures for Student Discipline 2025/2026* which details the process for student fitness to practice. There has been no student fitness to practice cases to date, so the provider was unable to demonstrate how they apply the process.

The CertHE Level 7 Programme Handbook highlights the fitness to practice expectations and include links to the UWS Conduct, Competence and Fitness to Practise Procedure which describes the process in more detail.

Students complete a signed declaration at the beginning of the programme in relation to Fitness to Practice Guidance and consideration for a student's fitness to practice is made throughout the programme which could impact a student's eligibility for completion of the programme.

Student Fitness to Practice is embedded throughout the programme within various modules.

Staff are GDC registered and aware of the Student Fitness to Practice policy.

This Requirement is **Met**.

Standard 2 – Quality evaluation and review of the programme

The provider must have in place effective policy and procedures for the monitoring and review of the programme.

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

The programme team and Senior Registrant take responsibility for ensuring that the curriculum remains mapped to the GDC learning outcomes. They are currently mapping their programme to the GDC LOs and behaviours which is the basis for the development of the programme.

The panel reviewed the *UWS Academic Quality Framework* which the panel found to be structured and robust. The quality framework is underpinned by the *Scotland's Tertiary Quality Enhancement Framework (TQEF)* which enhances the overall quality assurance of the programme.

The use of module review forms enables opportunities for module and programme enhancement.

An independent External Examiner is appointed, and roles and responsibilities are outlined in the External Examiner Handbook.

The provider made changes to the provisionally approved submission without notifying the GDC. In future the provider must inform the GDC of any changes to the programme through the GDC [Programme modifications](#) process.

This Requirement is **Met**.

Requirement 10: Any concerns identified through the operation of 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. (Requirement Partly Met)

There is a clear process for managing concerns identified through the quality framework. There is a process in place for a nominated person from UWS and NCL who are responsible for reporting to the School of Health and Life Science School Board.

Programme changes are approved at the Adult Nursing, Community Health Division Programme Board which takes place quarterly.

The External Examiner informed the panel that she had raised concerns through her reporting process and noted that the provider is responsive to suggestions and that they show a keen willingness to improve.

The staff explained that the overarching risk register for the provider does not include any risks identified to the Dental Programme. The panel viewed the new risk register system *Ideagen* which is an online system currently being implemented. The provider assured the panel that risks will evolve and develop as the system is fully implemented. Any high risks must feed into the overall risk register for the university.

The panel deem this Requirement to be **Partly Met**.

Action: The provider must have a programme specific risk register which is regularly reviewed and actioned and there should be an audit trail of this.

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 programme is subject to quality assurance both internally and externally. The internal process is clearly set out in the *UWS Academic Quality Framework* which the panel reviewed.

Supported by the Quality Enhancement Support Team, there are mechanisms for internal review of all aspects of the programme.

The Divisional Programme Board, has the responsibility for the quality management of the programme.

Externality is conducted by an External Examiner, who is a GDC registrant and an Independent Dental Advisor.

During the visits, the panel were assured that both internal and external quality assurance is undertaken. The internal moderator was present at the OSCE exams and the panel had sight of moderator reports following this, as well as an EE report which included a review of recorded exams following this assessment.

During a visit to review portfolios, the panel was assured that internal moderation had taken place following the submission of the completed portfolios and that this would also be completed by the external examiner.

The panel noted that the external examiner feedback requires a standardised template which will encourage detailed constructive feedback. We did not see expected areas of improvements identified by the EE.

Within the portfolio, there was evidence that students are gaining patient feedback and reflecting upon this which is also signed off by a WBA. There were no examples of how the programme had been developed following this feedback; however the feedback did not include programme specific suggestions.

There was evidence of programme development following student feedback.

This Requirement is **Partly Met**.

Action: The provider must encourage the EE to provide constructive feedback which will enable enhancement to the programme or assessment. The form should be developed to encourage this and there should also be an opportunity for staff to acknowledge the feedback and what action may be taken as a result of this.

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 received a demonstration of the UWS InPlace system which captures details of placements and the students in them. The system integrates with BANNER which holds all the student data and feeds fields through to InPlace. The external examiner noted that the Aula system was the most efficient system she has ever used to carry out her role. Unfortunately, during our initial visit InPlace was not working for the NCL staff and so a workaround tracker was in place. There were plans to rectify this and ensure that all staff are able to use the system and record the information centrally to mitigate risk of errors and efficiency. At the follow up visit, the panel were informed that the access issue had been resolved and staff now have access to the system.

All new placements are vetted, and the panel reviewed the *External Workplace/Placement Premises Checklist*. All placements are deemed medium risk to start, and a visit is arranged before the placement commences and the remainder of the checklist is done onsite.

The panel is assured that the system is good, however, the provider must further develop the system to capture information regarding feedback, concerns, actions and placement risk ratings as well as monitoring of the placement QA. Once these developments are implemented this will make the process and system more robust.

The panel has had sight of feedback from students and patients. The panel acknowledge that students are reflecting on the patient feedback received and this is reviewed by the WBA. There was evidence that student feedback has informed programme development.

This Requirement is **Partly Met**.

Action: The provider must further develop the use of In Place to monitor actions and progress for placements.

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 provider has a documented structure in place mapping the GDC Learning Outcomes against the qualification modules, which confirms full learning outcome coverage for a dental nursing programme. However, the individual module descriptors for the programme set out the learning outcomes for the module and how these maps against the SCQF7 (Scottish Credit and Qualifications Framework Level 7), however it is not clear on the descriptors how this is mapped to the GDC Learning Outcomes. For transparency the provider should make it clear on the descriptors which GDC Learning Outcome the module maps to.

The panel reviewed the *UWS Assessment Handbook* which clearly defines the process and sets out the grading criteria. Some assessments are marked based on the pass/fail grade descriptor held in the assessment handbook (*Appendix 1: Marking and Grading Scheme*). During the inspection the panel reviewed assessment paperwork and spoke to supervisors who confirmed that they do not receive calibration or training on the use of the pass / fail grade to prepare for carrying out observations of students within the workplace. Although this pass/fail mark does not contribute to the overall assessment decision of competence, as this is done by the WBA, the provider must offer training and regular formal calibration to ensure a consistent approach is applied to all students by supervisors across placements.

Students are assessed at the end of each module throughout the programme and the outcomes are recorded on Banner once moderation has taken place and a quality check of marks is conducted by UWS.

The panel returned to review a sample of student portfolios. The assessors have signed off all GDC LO and Behaviours, however the progress and full learner journey was not demonstrated within the portfolio or online systems. The provider must ensure that there is a clear audit trail of student progression and attainment.

Within the portfolio's, observations did not include a date and were not detailed in some instances. It was clear from the mapping of LOs that students are not longitudinally assessed. The observation reports within the portfolios require further detail and must be improved to include the date of assessment, consistency across WBA reports and improved mapping which demonstrates longitudinal assessment.

Assurance for this requirement is based upon, the WBA involvement and observations that are undertaken as we didn't get assurance from the OSCE assessment. WBAs have provided detailed constructive feedback to students and ultimately sign off the students clinical competence. The panel were shown the BANNER system during the follow up visit which demonstrated achievement of assessments and gradings for each student.

The panel were assured that students would not progress if they had not achieved all LOs.

This Requirement is **Partly Met**.

Action: The provider must implement supervisor training and calibration and clearly define a pass/fail assessment decision which is clear in supervisor/programme handbooks.
The provider must develop a process to capture the full learner journey which demonstrates a students progress throughout the programme.
The Provider must improve the portfolio to ensure there is audit trail of when observations take place and when LOs are achieved.

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 provider uses a system called *Banner* to capture formative and summative assessments and grading. The panel received a demonstration of the system and saw how it integrates with other systems across the UWS. During the initial inspection, the system was not currently accessible by NCL therefore a spreadsheet workaround is in place until the system is compatible. UWS are currently in the process of inputting the information. The panel was assured that assessment records are appropriate.

Alongside Aula the provider uses a system called Moodle which captures resources for students including assessment related documents.

The provider currently uses paper-based student portfolios, there is no central system tracking recording and monitoring student progression against clinical experience. The provider must develop a central system to capture this detail and it should be shared or communicated contemporaneously with placement supervisors to ensure students are obtaining a full breadth of patients and procedures.

The provider is currently using its GDC LO mapping as a mechanism to monitor and track student progress. However, during students' clinical experience, this approach adds complexity to the monitoring of required clinical exposure. For example, an extraction procedure may address multiple learning outcomes; however, by assessing learning outcomes individually, the provider is unable to effectively identify gaps in clinical experience. As a result, opportunities to evidence experience across other learning outcomes may at times be overlooked.

This Requirement is **Partly Met**.

Action: The provider must develop a central tracking system which allows for planning, recording and monitoring of student clinical experience

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)

Students are gaining experience across a breadth of patients and procedures through a blend of 2 days a week out on placement and 2 days a week in the college. If students are struggling to have exposure to any type of patients or procedures, the WBA will source an interim placement from the bank of placements already vetted to give the student the opportunity to carry out the required procedure.

The panel is impressed by the simulation and learning environment within NCL, allowing students to gain confidence and skills prior to moving into placement. Once in placement the 2 days a week at college underpins continued learning and gives additional experience throughout the programme.

The student portfolio captures details of assessments and grading, however, the provider does not have a system which captures student progress against the clinical experience and breadth of procedures and patients. The provider must develop a central system to capture this detail and this must be shared or communicated contemporaneously with placement supervisors to ensure students are obtaining a full breadth of patients and procedures.

During a follow up visit, placement supervisors discussed how they support students to achieve experience and competence with particular LOs. They advised that students typically identify when they feel ready to be assessed as competent or where further experience is required and they work together to ensure this is appropriate.

This Requirement is **Partly Met**.

Action: Same action as Requirement 14.

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 Partly Met)

The UWS has a process in place, with a clear timetable and lines of responsibility, for developing and monitoring assessments. These processes are subject to scrutiny by the Internal Moderation, an External Examiner (who is GDC registered) and an Independent Dental Advisor.

Assessments are monitored via the Banner system and this outlines students' assessment grades for each module, as well as capturing assessment attempts. Grades are not uploaded into the Banner system until this has been moderated and grades finalised.

UWS conduct an assessment board meeting which enables staff to review students' grades and determine their eligibility to progress and complete their qualification following successful attainment of all required modules. The assessment board was observed by the panel, and it was clear that students who had not completed all modules were identified and would be given re-sit attempts. A student has a maximum of three attempts at each module to gain a pass mark. Four attempts will be considered where a student has submitted a claim for extenuating circumstances. There are specific timeframes set by the university for the additional attempts. The School Board of Examiners meeting records progression decisions.

The panel did not see evidence of the EE providing scrutiny regarding if assessments are fit for purpose prior to being undertaken as outlined under requirement 20. This would provide assurance that the validity and reliability have been considered.

As outlined under Requirement 21, the OSCE assessment requires review.

This Requirement is **Partly Met**.

Action: Same as Requirement 20 and 21.

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

The provider has a robust process in place to capture multi source feedback from across all stakeholders of the programme. WBA capture feedback from across the placement supervisors and students have several portals including a *Student Voice* and at the end of each module students are encouraged to feedback on the module content and assessment. This is reported via Divisional Programme Boards and Programme Monitoring Reviews.

The panel heard that students had given feedback that they were struggling to grasp academic writing skills so early in the programme, particularly given that the majority have no higher education experience. The university deliver a module called ASPIRE which addresses the progression from further education to higher education and following the feedback have changed the structure so that this is taught before students have to complete any written modules. This change also allows the programme team to give constructive feedback to help them write their first written essay. This module now spans two terms. There are alternative routes for support available to students.

The panel noted good practice within the portfolios as there was evidence of patient feedback regarding the students and students had reflected upon each comment. This was also signed by a WBA.

This Requirement is **Met**.

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

Students are supported on reflective practices throughout the programme. The panel reviewed the *UWS Level 7 Aspire Module Descriptor* which clearly details how reflection is taught and assessed as part of a 20-credit module. The panel had sight of evidence of student reflection during the inspection.

There is a continual communication of feedback from the supervisors, assessors and students and this was clear during the inspection when the panel met several students who all agreed that the provider has a clear open-door policy and they feel they are given constructive feedback and are supported in implementing that feedback and improving.

Feedback is captured in the student portfolios which was detailed and included areas for development. The panel saw examples of this during the inspection and the follow up portfolio visit.

Feedback is also provided to the students at the interim and summative review meetings by the WBA. Documentation demonstrated there is detailed feedback for the student, which is reflected upon.

Patient feedback is also gathered, and students reflect on this which is then reviewed by a WBA. The reflections included how students would continue or improve their practice based upon the feedback.

This Requirement is **Met**.

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

All staff within UWS and NCL have appropriate training to carry their roles and during the inspection the panel met with college staff who all echoed that they had enhanced their skills and knowledge of higher education since working with UWS.

Work Based Assessors carry out informal calibration, however, the WBA must carry out formal recalibration training as part of ongoing development to ensure equity of assessment.

Practice supervisors' training and calibration requires implementation, which is now planned for the next cohort.

This Requirement is **Partly Met**.

Action: WBA and placement supervisors must undertake formal calibration

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 Partly Met)

During the inspection the panel received a demonstration of the *Aula* system which is the UWS central learning environment. The External Examiner (EE) uses Aula to review assessments, students marking and moderation virtually. The systems include the moderation form for the EE to complete and capture actions and updates on actions. The EE told the panel that they could not speak highly enough of the system as in their 20+ years' experience it is the most efficient system they have used in their role.

The panel met with the programme EE who complimented the UWS and NCL collaborative working with partners. The EE confirmed that assessments are shared prior to going live as well as internal moderator feedback.

The EE feels that the team is good at notifying them of any changes, for example the Divisional Coordinator will communicate in advance which modules are coming up for review and share a link to module via the AULA system. The EE also noted that they feel comments and reports are considered and a majority of the time accepted, with changes made in a timely manner.

Due to the modular structure to the programme the EE is required to complete a report at the end of each module and an annual report at the end of the academic year.

During the OSCE assessment, the students were recorded and these were shared with the EE. The panel was provided with an EE report following the OSCEs. It was noted that the detail was limited in relation to enhancement of the programme and assessment. This was also the case with other end of module external reports.

We did not see evidence of the EE's input and recommendations regarding the suitability of the assessments prior to them being undertaken.

The EE conducted a review following completion of all modules for the graduating cohort.

The panel would have expected areas to be identified and raised by the EE that were not, that would have improved aspects of the programme.

Requirement **Partly Met.**

Action: Same as Requirement 11.

The provider must ensure the EE is more involved at the design stage of assessment which creates an opportunity to identify any areas for improvement.

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)

During the inspection the panel reviewed assessment paperwork and spoke to supervisors who do not receive documented calibration or training on the use of the pass / fail grade for workplace observations. The provider must offer training and regular formal calibration to ensure that a consistent approach is applied to all students from all supervisors / assessors.

Expected standards are clearly defined in the *CerTHE Level 7 Programme Handbook* and also held within the Moodle system, however staff must be trained and undertake calibration to ensure that equity is applied to assessments.

The panel returned to observe the OSCE assessment. We were provided with a marking rubric, however, did not see this in use during the assessment gradings and identified that the grading criteria descriptors were incorrect. There was limited time for examiners to review the marking and feedback for students following each assessment and this was not ratified with a second examiner. The panel was made aware, following the inspection visits, that the programme lead was present and undertook second marking alongside the Senior Registrant as well as there being an internal moderator present. There was a large

number of students conducting this assessment in one day, and this was also highlighted on the internal moderation form. This is something that the moderator has advised should be reviewed prior to the next cohort's completion. The OSCE is embedded at an early stage in the programme, which does not allow for longitudinal assessment. The provider must consider if this timing allows for longitudinal assessment of students' progress which demonstrates experience against the learning outcomes.

During a follow up visit, the panel had sight of a revised marking rubric which has clearly defined descriptors for each grading outcome.

The programme records assessment data on the Banner system of which students have access to. This system clearly captures assessment results and attempts which is reviewed by the programme staff, School Assessment Board and the School Board of Examiners. This enables students who require additional attempts to be identified.

Although there is assurance that the student portfolio is assessed and determines the student's clinical competence, the portfolio requires further evidence to capture the full student journey for future cohorts.

The panel were assured that assessment data is recorded on Banner and that the clinical portfolio aspect of the programme is achieved.

There is added complexity in reviewing assessment criteria due to the way in which the learning outcomes are mapped to the programme. The provider must review the way in which they capture the student journey when gaining clinical experience. When this is undertaken, WBAs will be more effective in planning for observations and predetermine the learning outcomes that an observation is likely to include. This will provide a greater understanding for the students.

This Requirement is **Partly Met**.

Action:

Same as Requirement 4, 13, 14 and 15.

The provider must review the OSCE assessment process

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
1	The provider must formalise a handover process for clinical placements which evidences training and ongoing progression opportunities.	A standardised handover template has been developed to evidence all Preparation for Practice competencies which have been completed by students prior to commencing placement, this activity is undertaken within the skills labs at NCL. Competencies are signed off by Recognised Teachers of the University (RTU) and recorded within the Clinical Dental Skills (CDS) Portfolio. An updated CDS portfolio has been attached to the provider email response of 07.08.2026. Students are required to share the CDS Portfolio with their Practice Supervisor at the outset of placement to ensure supervisors are aware of the student's prior training, achievements and developmental needs. The standardised handover template will also be uploaded to InPlace to provide a centralised and auditable record. Students will have opportunities to progress within the first summative attempt-this will be evidenced within the portfolio which is shared with practice supervisor. Progression and achievement of competence is	

Requirement number	Action	Observations & response from Provider	Due date
		confirmed by the RTU and Work Based Assessor (WBA). Academic progression and achievement across all programme modules are recorded within the University Banner system. Students must successfully complete all six modules and associated module assessments to be eligible for professional registration. This equates to achievement of six SCQF Level 7 20 credit modules meeting the requirement of achievement of Certificate of Higher Education (120 credits).	

Requirement number	Action	Observations & response from Provider	Due date
2	The provider must ensure there is documented evidence that consent is gained for the patient to be treated by a student.	Patient consent requirements are now explicitly outlined within the CDS Portfolio and reinforced during Preparation for Practice sessions. Practice Supervisors are responsible for ensuring that patients are informed when care is being delivered by a student and that valid verbal consent has been obtained. Supervisors are required to confirm adherence to this process through a declaration within the CDS Portfolio. Practice supervisors are also responsible for recording consent discussions within patient notes. Patient information posters will be distributed to all placement providers to support transparency and informed consent. Compliance will be monitored by the Programme Lead through portfolio auditing processes. Practice Supervisor declarations will be uploaded to InPlace by Work-based assessors.	

Requirement number	Action	Observations & response from Provider	Due date
4	The provider must ensure that placement supervisors are provided with training and calibration which incorporates standardisation of competency sign off and understanding of pass/fail gradings. See Req 5 for other action.	Placement supervisors are GDC Registrants who are required by the GDC to maintain professional competence through Continuing Professional Development (CPD). Supervisor training has now been implemented and will be updated annually. A Practice Supervisor Guide has also been developed to support consistency and standardisation. Examples of these can be shared on request. The revised CDS Portfolio and associated training materials clearly define supervisory responsibilities and the assessment process. Practice Supervisors support students in developing clinical competencies but do not make final competency decisions. Formal assessment and competency sign-off remain the responsibility of qualified Compleaetes, supported by robust internal verification processes. Evidence of these enhancements were submitted to the GDC as part of the previous monitoring process and the provider considers this requirement fully addressed.	

Requirement number	Action	Observations & response from Provider	Due date
5	The provider should ensure that documents used across programmes should clearly state the correct details relating to the programme the student is undertaking.	Programme documentation has been reviewed to ensure that students undertaking the BSc Dental Nursing programme receive documentation specific to their programme of study and relevant professional requirements. All placement supervisors are required to provide their GDC registration number prior to student placement commencement. Registration status is verified before placement allocation and monitored by WBAs and Recognised Teachers of the University (RTUs). An annual review of WBA and RTU GDC registration status is undertaken by the Programme Leader as part of the annual collaborative review process, records are maintained and reported through the University's quality assurance processes.	
	The provider must regularly review longstanding supervisors' GDC Registration status. See Req 4 for other action.		

Requirement number	Action	Observations & response from Provider	Due date
6 & 7	The provider must ensure that students and staff are applying the university's high level policies and procedures regarding raising concerns continually throughout the programme to refresh knowledge. The provider must adapt the <i>National approach to raising concerns in practice</i> document to ensure it is relevant to this programme. The dental nurse work based learning guide should be relevant to the registerable programme.	A programme-specific Raising Concerns document has been developed and aligned to the University's policies and procedures. This is also highlighted within the CDS Portfolio. This been attached to the provider email response of 07.08.2026 The process is reinforced through student preparation for practice activities, placement supervisor training and inclusion within the BSc Dental Nursing Programme VLE site, programme and module handbooks. This ensures students, practice supervisors and staff are aware of reporting routes, escalation procedures and professional responsibilities throughout the programme.	

Requirement number	Action	Observations & response from Provider	Due date
9	The provider must inform the GDC of any changes to the programme through the GDC Programme modifications process.	The programme team will continue to adhere to the GDC Programme Modifications process should any programme changes be required. Programme modification requests to GDC would be made for the Cert HE L7 component of the programme only. UWS have annual programme Enhancement and Annual Monitoring (EAM) processes in place to provide systematic assurance that the programme remains effective, meets academic standards, delivers a highquality student experience and has clear actions for continuous enhancement. There is also oversight of the programme at a Divisional and School Board level, these terms will change to Departmental and Faculty now the new University structure has been launched.	

10	The provider must have a programme specific risk register which is regularly reviewed and actioned and there should be an audit trail of this.	The programme is now governed through the Adult Nursing Community Health Department governance structure, which includes regular review of programme risks and mitigation actions. A programme-specific risk register will be maintained and reviewed routinely, with records retained to provide an auditable trail of decisions and actions taken. This is monitored by the University Placement Manager	
		Placement concerns and risks will be recorded within InPlace to provide transparency, monitoring and evidence of ongoing risk management. Enhancement and feedback loops will be closed by the PL and University Placement Manager. The University will continue to complete and submit annual risk monitoring documentation required by the GDC.	

11	The provider must encourage the EE to provide constructive feedback which will enable enhancement to the programme or assessment. The form should be developed to encourage this and there should also be an opportunity for staff to acknowledge the feedback and what action may be taken as a result of this.	The University operates a comprehensive quality assurance framework for both module and programme approval. External Examiners (EEs) are provided with access to module materials and Virtual Learning Environments and are invited to review assessments before release to students. EEs review samples of assessed work, approve module results and provide feedback through formal moderation processes and School Assessment Boards. In addition, EEs participate in meetings relating to module delivery and programme quality. All External Examiners submit annual reports and receive formal responses from the Programme Leader detailing actions taken. Feedback is systematically reviewed at module, programme, School and University levels through the	
		Academic Quality Committee (AQC), Institution Led Quality Review (ILQR) and externally via Tertiary Quality Enhancement Review (TQER).	

12	The provider must further develop the In Place system to capture information regarding feedback, concerns and placement risk ratings and ongoing monitoring.	The InPlace system will be utilised to detail placement allocations, record and monitor placement feedback, concerns and risk ratings. Feedback is provided by WBA and PL. Placement risks and concerns will be logged, reviewed and escalated as required in accordance with University policy. This will provide a transparent audit trail and support ongoing placement quality monitoring.	
13	The provider must implement supervisor training and calibration and clearly define a pass/fail assessment decision which is clear in supervisor/programme handbooks. The provider must develop a process to capture the full learner journey which demonstrates a students progress throughout the programme. The Provider must improve the portfolio to ensure there is an audit trail of when observations take place and when LOs are achieved. For transparency the provider should make it clear on the descriptors which GDC Learning Outcome the module maps too.	The CDS Portfolio has been substantially revised to improve transparency, governance and auditability. The portfolio now clearly maps activities and competencies against the General Dental Council Safe Practitioner Framework and identifies programmespecific learning outcomes relevant to the Clinical Dental Skills module. Enhanced preliminary, interim and final review sections have been introduced alongside structured reflective activities for students, Practice Supervisors, RTUs and WBAs. The revised documentation provides a clear record of observations, developmental progress and achievement of learning outcomes. Assessment decisions remain the responsibility of appropriately qualified WBAs and RTAs. Academic	

		results across all programme modules continue to be maintained within the University's Banner system. GDC learning outcomes are mapped to each module and are also mapped within the CDS portfolio.	
14 & 15	The provider must develop a central tracking system which allows for planning, recording and monitoring of student clinical experience. This should be shared or communicated contemporaneously with placement supervisors to ensure students are obtaining a full breadth of patients and procedures.	Students undertake mandatory Preparation for Practice training during programme induction. Completion is verified and signed off by RTUs prior to placement commencement. Evidence of training completion is recorded within the CDS Portfolio and uploaded to InPlace to provide an auditable record. Students will not be permitted to attend placement until all mandatory preparation requirements have been successfully completed. The use of InPlace and the revised portfolio supports improved monitoring of student progression and clinical exposure across placement settings.	

19	WBA must carry out formal calibration and recalibration training as part of ongoing development and to ensure equity of assessment.	Calibration and standardisation activities form part of the annual Professional Development Discussion process for all WBAs. This is documented by the Programme Lead and Senior Registrant. Many WBAs maintain active clinical practice, ensuring contemporary professional knowledge and skills. In addition, WBAs participate in Communities of Practice, facilitating the sharing of best practice, benchmarking and professional development.	
		Internal verification processes provide ongoing standardisation and quality assurance of assessment decisions. WBAs are also required to maintain annual CPD records evidencing continuing professional development and calibration activities. Annual monitoring of this is part of the UWS Collaborative Review process.	

20	The provider must ensure the EE is more involved at the design stage of assessment which creates an opportunity to identify any areas for improvement. See Req 11 for other action.	Assessment design and programme approval processes already involve both internal and external academic expertise. External Examiners review assessment materials prior to release to students and provide feedback on assessment appropriateness, alignment with learning outcomes and opportunities for enhancement. Any proposed changes to assessment strategies are discussed with External Examiners as part of the University's quality assurance framework. Evidence of ongoing dialogue between module teams and External Examiners is available to demonstrate compliance.	
21	The provider must review the OSCE assessment process. See Reqs 4,13,14 &15 for other actions	The OSCE assessment process has been formally reviewed following internal moderation, external moderation and GDC feedback, enhancements such as exam scheduling and documentation review have been implemented. Details of the review outcomes and resulting actions were presented during the previous GDC monitoring	
		meeting. The provider considers this requirement addressed and evidence has previously been supplied to the GDC.	

Observations from the provider on content of report

Comments made above against report actions by UWS.

Recommendations to the GDC

Education associates' recommendation	The Certificate of Higher Education in Dental Nursing is approved for the graduating cohort only to apply for registration as a Dental Nurse with the General Dental Council. Full approval will be considered at a re-inspection in the 2026/27 academic year.
Date of reinspection	2026/27 academic year (December and February).

Annex 1

Inspection purpose and process

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

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

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

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

A Requirement is met if:

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

A Requirement is partly met if:

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

A Requirement is not met if:

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

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

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

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

