General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Suffolk	Named exit award: Diploma of Higher Education in Dental Hygiene

Outcome of Inspection	Recommended that the qualification is approved (DCP) for the two graduating students exiting the programme to register as a Dental Hygienist.

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

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a Dental Hygienist**
Learning Outcomes:	**Preparing for Practice Dental Hygienist.**
Programme inspection dates:	**14th and 15th October 2025 14th November 2025**
Examination inspection dates:	**29th January 2026 4th February 2026**
Inspection team:	**Gillian Mawdsley (Chair and non-registrant member) Joanne Brindley (DCP member) Linda Gunn DCP member Angela Watkins GDC Quality Assurance Manager**
Report Produced by:	**Angela Watkins GDC Quality Assurance Manager**

This is a new programme inspection of the Diploma of Higher Education in Dental Hygiene, which is a year 2 exit award that forms part of the new Bachelor of Science with Honours in Dental Hygiene and Dental Therapy programme at University of Suffolk which was provisionally approval in November 2023.

The programme is taught over a three-year period with an exit point at year two for students wishing to complete the programme with a Diploma of Higher Education in Dental Hygiene qualification. Students who do not pass the year 3 Therapist element will have the opportunity to leave with the Hygiene qualification providing they have met the necessary learning outcomes.

This is the first dental programme that the University is offering, and they have faced several local challenges including recruiting and retaining staff and engaging with placement providers.

The number of placements is slowly increasing, and this is giving students additional access to live clinical placements. However, there is a clear inconsistency with the experiences that students are getting across the placements, and this needs to be better managed by the university to ensure there is calibration across the various placements and supervisors.

During the inspection, the panel met with students who praised the support that the university had given them. There were clear examples of how the provider had supported

them throughout the course individually and as a cohort. Students feel both valued and heard meaning that they very much enjoy the blocks of training and blended approach to learning.

During the inspection in October 2025, the panel identified some serious concerns that needed addressing before approval was considered. As a result, the provider was given a list of actions, and an additional Inspection was carried out in November 2025. The panel returned in November and acknowledged the work and candour displayed by the team however there remained a requirement to embed the changes made.

The provider introduced an Objective Structured Clinical Examination (OSCE) as part of the gateway / exit point for year 2. The panel had been informed that there were two students who wished to exit the programme at the end of year 2 to register. So, when the panel returned to observe the OSCE in January 2026, they observed the two students completing their OSCE and reviewed the latest clinical experience data showing their progress.

Following the visit in January 2026, further clinical experience was required for the two students exiting, which was completed and the evidence reviewed by the panel ahead of the examination board assessment in February 2026. As a result, the panel agreed the following outcome:

Regarding the two students exiting the programme

As a result of additional inspection activity and focused scrutiny on the two students exiting the programme the panel are assured that these two students exiting the programme are fit to practise as a safe beginner and approval has been granted for these two students to register. Activity from the panel has included; review of progress against the actions set out October 2025, the introduction of the OSCE Examination Inspection, increased clinical activity, feedback received from the external examiner and the revised PAD documents. Therefore, the panel are assured to grant approval for these two students to register as a Dental Hygienist.

Regarding the rest of the students

The panel were content that the remaining students can progress to year 3 given their progress to date towards the actions set in October 2025 and given the additional time to obtain and record the breadth of necessary clinical experience that is required. However, the panel have not received adequate assurance of the competence as safe beginners for the remaining members of the cohort, which would allow any additional students to leave the programme and to join the register as a Dental Hygienist.

The panel acknowledged that this is a new programme, in a new sector for the university and have been encouraged by the team's willingness to learn, seek to improve and respond to various requests for information throughout this inspection.

The GDC wants to thank the staff, students, and external stakeholders involved with the Bachelor of Science with Honours in Dental Hygiene and Dental Therapy for their co-operation and assistance with the inspection.

Background and overview of qualification

Annual intake	24 students
Programme duration	37 weeks per year weeks over 2/3 years
Format of programme	**Modules in each year:** **Year 1** Introduction to Professional Practice Pre-clinical Sciences Clinical Skills Development 1 Clinical Practice **Year 2** Dental Sciences Clinical Skills Development 2 Dentistry in Society 1 Research Skills for Oral Health **Year 3** Dentistry in Society 2 Oral Health Dissertation Integrated Clinical Practice Preparing for Professional Practice
Number of providers delivering the programme	One

Outcome of relevant Requirements[1]

Standard One	
1	Not Met
2	Met
3	Met
4	Not Met
5	Partly Met
6	Met
7	Partly Met
8	Partly Met
Standard Two	
9	Partly Met
10	Partly Met
11	Partly Met
12	Not Met
Standard Three	
13	Not Met
14	Not Met
15	Not Met
16	Partly Met
17	Partly Met
18	Partly Met
19	Partly Met
20	Partly Met
21	Not Met

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

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

Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients. *(Not Met)*

Student's complete skills in labs prior to providing patient care. The lab technician will give access to students outside of their timetable if they require additional support.

During the Inspection dated 14 and 15 October 2025, the panel saw *9_A07 Quota Data and Competencies* which identified the lack of complexity of student progression statistics being captured. This raised a concern on how the academic team can measure the students' competency levels that are required prior to treating patients with limited data the provider holds. The provider was told that they must develop the progression statistics to capture the breadth of procedures being undertaken and to clearly demonstrate the students' progression through grading.

The panel reviewed the *9_A07 Quota Data and Competencies* during the inspection visit on 14 November 2025 and noted the improvement on the data being used for student progression, however, there remains room for improvement. The provider must compare and be able to demonstrate the clinical data capture system with the learning outcomes for each registrant group.

The panel reviewed *A24 Student Course Handbook* which clearly documents that summative assessments are carried out as a gateway between Year 1, 2 and 3. However, the provider acknowledged that the Year 1 gateway had not been completed at the end of the first year and had been completed in the first two weeks of Year 2 which was prior to the students moving into clinic. Due to University policy regarding changes to curriculum, this is currently deemed as voluntary, although there is assurance that all students have attended the assessment. The provider must align policy with practice and ensure that Year 1 gateway forms a mandatory part of the course and that is what is communicated and documented to students.

The panel is assured that progress has been made against this requirement and a work-around has been implemented to ensure students do not provide patient care until they are assessed as being at a competent level. However, the provider must formalise this process with recording of clear auditable student progression and assessment completion. Therefore, the requirement is not met.

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

Students are taught about obtaining patient consent to treatment in the *Introduction to Professional Practice* module, as part of the provider's Law and Ethics teaching.

Patients are made aware that by attending placements a BSc student will treat them. Consent will be obtained by the practice supervisor, and patients are required to confirm this at every follow up appointment to gain revalidation of consent. The panel reviewed examples of patient templated consent form which are required to be completed and added to the patients' file

Appendices A11Student Treatment Consent and Medhx Form and *A12 Student Treatment Refusal Form*. As the student gains experience, they will seek verbal consent from the patient, overseen by the practice supervisor. This consent is scanned onto the patient records if taken in writing, and if verbally obtained is added into the treatment notes.

All staff and students wear visible name badges denoting their role and status in the placements. Students and Staff Uniforms have distinct colours to make it easier to identify. The panel attended the CIC Placement and observed clear delineation of these roles displayed on the walls and there are posters informing the patients that students are working in the premises. The panel reviewed *Appendix A13 Patient Flyer* which is an example of a flyer given to recruit patients to the student clinic.

The panel is assured that this Requirement is met.

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)*

All patient care is conducted on placement, and an audit is undertaken either on-site or remotely, which includes obtaining information about the placement staff, clinical educators and their policies and procedures.

Prior to students attending placements, the University of Suffolk placement team conducts an on-site inspection to ensure that each placement is complying with the University's requirements. This includes Health and Safety, Equality, Diversion and Inclusion and Review of their latest Care Quality Commissioner (CQC) Report.

The panel reviewed *Appendix A15 Practice Learning Environment Audit* which the panel is assured is a robust audit record of the placements and includes an action plan where areas for improvement are identified and monitored. The provider confirmed that the Placement Team are responsible for monitoring responses to audits.

Audits are then carried out annually with ad-hoc inspections conducted if required.

The panel is assured that 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. *(Not Met)*

The panel reviewed *1_A01 DHT Programme Organogram &Staff* and during the inspection the provider explained the course management structure within the School of Health, Sciences and Society had changed following a recent restructure. BSc (Hons) Dental Hygiene and Therapy now sit under the Head of Allied Health Professions from the academic year 2025/26. The panel is assured that these changes are having a positive impact on the structure of the programme.

At the time of our visit in October 2025 there were 4 teaching staff members who are responsible for the academic (core) delivery of the programme, all student clinical activities are supervised as part of the placement provision. The panel acknowledge that there had been recent stability within the programme structure and as a result the panel could see that there is a drive to improve and develop the programme and achieve success. There is however inexperience across the workforce in delivering GDC regulated programmes, and the

programme would benefit with some subject expert guidance either internally or externally sourced.

Placement supervision is inconsistent and does not always align in breadth or exposure necessary to achieve the learning outcomes. The provider must develop a consistent approach to placement supervision including development and implementation of relevant Policies and Procedures.

The provider and a placement supervisor informed the panel that the first placement calibration workshop had taken place, and the panel reviewed the A33 Calibration Workshop Calendar and A34 Workshop Details 2025-26 noting the planned activity. During the inspection, the panel met with several placement supervisors from across the placement locations. The panel observed an inconsistency with the students' experience and training across the placements. To address this the provider must ensure that all supervisors take part in formal training and calibration. This will ensure that a level of standardisation occurs across the placement providers, allowing all students to have an equitable experience. All placement supervisor standardisation training should be tracked and monitored by the school.

There is no formal process for sharing the student's stage of development across the placements. The panel was informed of a student attempting to deliver treatment which they were not supposed to. Fortunately, on this occasion, the students informed the supervisor that they were not allowed to conduct this treatment. To ensure patient safety, there must be a clear contemporaneous record of the student's stage of development so that the supervisor is fully aware of the student's competency level.

The provider must establish a centralised system to capture the students' progress and the stage of development which is shared and can be used by the placement supervisors.

The provider has increased the number of placements and placement supervisors. They have implemented a calibration process for all supervisors. The panel met with placement supervisors from across the placement providers and noted that there is informal communication regarding student progress, however, this must be formalised to demonstrate the students' current level of competence. They must be able to clearly record student progression throughout the programme.

The panel deem this Requirement to be not met.

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

Supervisors are given relevant training and are checked for regulatory registration.

The panel observed an inexperienced workforce. This included supervisors who are currently undertaking their PGCert. As a result, the programme would benefit with some subject expert guidance either internally or from an external source.

The panel is assured that this Requirement is partly met.

Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong.

Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so. *(Requirement Met)*

The panel is assured that the has robust policy and procedures in place for raising concerns.

The panel reviewed an anonymised *Appendix A35 Student monitoring document -Incident Log,* which is a process to record incidents, including instances of unprofessionalism. The student monitoring document included a log of a student who conducted a professional mechanical plaque removal (PMPR) on a patient without passing their OSCE. The panel is reassured that the incident was identified, logged and following the incident, the panel is assured that safeguards have been put into place to mitigate the risk of this happening again.

When on placement, students complete a Practice Assessment Document (PAD) which contains an area to capture cause for concerns.

During the inspection, the panel spoke to the students who confirmed that they knew how to raise a concern and that the relevant policies are available to them within the student hub area of the online learning environment (Brightspace). External stakeholders including placement can access the document via the Policies and Procedures page on the University's website.

The panel is assured that this Requirement is met.

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

The panel is assured that there is a patient safety system in place to capture and monitor patient safety issues.

The panel reviewed the *A35 Student Monitoring Document – Incident Log* which clearly lists all incidents raised, actions and progress. The panel asked the school to describe incident *2025_04* which involved a student providing treatment to a patient before passing the PMPR on the phantom head. The provider explained how the incident was identified, the additional training and actions given to the students and how this had identified an issue within the Year 1 gateway assessment. This assured the panel that the written process had worked, however, the lack of contemporaneous student competency data did not assure the panel that this incident was unlikely to happen again. Therefore, the provider must have a robust system in place for sharing and updating placement supervisors of the student's competency levels in a timely manner.

The panel deem this requirement to be partly met.

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

The provider uses Brightspace to outline the student's fitness to practice and the Standards for the Dental Team. The panel noted that this also is outlined in *A24 Student Course Handbook.*

The panel observed from the student handbook that student fitness to practice forms part of the teaching in Introduction to Professional Practice. The provider explained that this is underpinned with continued learning in Dentistry in Society 1 module in Year 2 and Preparing for Professional Practice module in the final year. The panel are assured through this process that this is not taught in isolation and that there is longitudinal learning in ensuring students fitness to practice and professionalism.

The provider has a clear flowchart in their *Fitness to Practise Procedure* which demonstrates processes are in place for recording student concerns. At the point of the Inspection, no student had completed the process for the panel to review.

The panel deem this Requirement to be partly 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. *(Partly Met)*

The provider has a documented framework which clear defines responsibility in relation to the management of the programme. The panel reviewed the *Framework and Regulations for Undergraduate Awards [30 credits]* and *Management of Academic Provision Framework*. However, during the inspection the panel identified that practical Restoration was being taught and assessed for Year 2 students. The programme allows for students to exit the programme at Year 2 with a Dental Hygienist registrable qualification. The provider must conduct a review of the curriculum to ensure that students are only assessed and qualified at the appropriate level of course in which they are going to register with the GDC.

The provider explained the process used for the implementation of the Year 1 and Year 2 gateway assessment which was evidenced in the *Approval of Changes to Existing Courses*. This process demonstrated how the provider considered amendment of elements of a course in between validation or re-approval periods to ensure that course content/structure can adapt and respond to changes in a timely manner.

The panel deem this Requirement to be partly 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.*(Partly Met)*

The panel reviewed the provider's risk register during the inspection and identified that the risk register contained high level risks. However, the inadequate articulation of operational risks and their assessment is a concern at a programme level and in relation to visibility at a higher governance level.

During the initial inspection, the panel identified that the programme was delivering restorative modules in Year 2 which meant anyone leaving the programme with a Hygiene qualification will have been assessed on learning outcomes out of what should comprise their Scope to Practice. The university was told that this must be removed from Year 2 and only delivered to

Year 3 Therapist students. During the follow up inspections in November 2025 and during the Exam Inspection in January 2026, the provider had removed Restoration from the Year 2 assessment. This had been done through the *Approval of Changes to Existing Courses* on a temporary basis. The provider must conduct a review of the curriculum to ensure that students are only assessed and qualified at the appropriate level of course in which they are going to register with the GDC.

The panel acknowledges the temporary changes made and the need to formalise these changes so deem this Requirement to be partly met.

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

The programme is subject to internal and external quality assurance. The panel met with the external examiner during the inspection who is a GDC registrant. The panel is concerned that important suggestion from the external examiner around Standard Setting had been acknowledged, however, the recommended changes have not been implemented in a timely manner. The provider must make key changes to the programme in a timely manner and with the support of experienced subject experts.

The panel acknowledge that there is limited experience in the team delivering dental programmes and the provider should consider obtaining external subject experts or critical friends to support the development of the programme.

The panel deem this Requirement to be partly met.

Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. *(Not Met)*

The university have a robust process in place for the setup of placements. The panel reviewed the *Student Workplace Health & Safety Checklist* which is specific for Dental Hygiene and Therapy students and is included in the *Placement Handbook.* All placement providers go through a site audit, and the panel reviewed the *Clinical Placement Agreement (CPA)* which covers placement specification, quality and monitoring requirements and financial arrangements. The University has a Placement Co-ordinator who has ultimate responsibility for organising and managing the placements to ensure they remain fit for purpose.

The panel saw a demonstration of the PamS system which is used to monitor students' attendance on placement which also captured student feedback on the placement.

However, the panel is not assured that the level of scrutiny of placements is consistent or documented. Quality assurance of placements is informal and inconsistent which could lead to ineffective identification of clinical concerns. The provider must develop a programme level framework to quality assure all placements and clinical scrutiny on an ongoing basis throughout the programme to ensure that students are gaining an equitable experience across all placements.

Due to the lack of documentation and consistent feedback, the panel deem this Requirement to be not met.

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

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. *(Not Met)*

The provider sets out the assessment strategy in the *A24 Student Course Handbook.* The panel reviewed the student handbook which clearly documents that summative assessments are carried out as a gateway and/or exit for year 1, 2 and 3. As part of the inspection in October 2025 it was identified that no summative clinical assessment was set for Year 2 and that there were students intending to exit the programme to join the register as Dental Hygienist who would not have been subject to a formal summative assessment at this point. This meant that the provider would be unable to provide evidence to demonstrate that these two students were fit to practice at the level of a safe beginner.

The provider does not have any formal process in place for Standard Setting and despite this being an earlier recommendation from the *External Examiner Report 2024-25* and follow up discussions between the provider and the external examiner that had taken place; this had not been initiated and was not implemented then. The external examiner did note that even though this was not in place he was assured, through other observation, that assessments and standards is being benchmarked at the same level as other institutions.

During the Inspection dated 14 and 15 October 2025, the panel saw *9_A07 Quota Data and Competencies* which identified a lack of detail including the complexity of student progression statistics being captured by the provider. This raised a concern as to how assessors would be able measure individual students' competency levels prior to treating patients with the limited data then being held. The provider was told that they must develop the progression statistics to capture the breadth and complexity of procedures and to clearly demonstrate how individual student progression was occurring through grading. Following the October inspection, the panel gave the provider a list of urgent actions they needed to address ahead of the intended graduation point for these two students intending to exit in February 2026 and included an additional Inspection date in November 2025 to review progress against the actions.

During the additional inspection visit on 14 November 2025, the panel reviewed the *9_A07 Quota Data and Competencies* and noted an improvement in the data being obtained and used for student progression, however, this still remained insufficient and the inspection team advised that the provider must compare the data capture system with the learning outcomes for each registrant group.

In response to these actions, the provider collated additional data which the panel scrutinised and noted specifically the progress recorded in the *9_A07 Quota Data and Competencies* of the two students who were exiting the programme to join the register as Dental Hygienists. This was to obtain assurance that they were leaving the programme as a safe beginner. However, there was still a shortfall in the breadth of clinical experience, so the provider was actioned to secure these clinical procedures for these two students before the examination board took place in February 2026. The panel reviewed the *9_A07 Quota Data and Competencies* again in February 2026 and was assured that the two students had received exposure to the breadth of clinical procedures to be a safe beginner.

As part of the gateway /exit point for year 2 the provider also introduced an Objective Structured Clinical Examination (OSCE) which the panel observed in January 2026 with a focus on the two students who would be exiting the programme to join the register as Dental Hygienist.

Regarding the two students exiting the programme
As a result of additional inspection activity and focused scrutiny on the two students exiting the programme the panel are assured that these two students exiting the programme are fit to practise as a safe beginner and approval has been granted for these two students to register. Activity from the panel has included; review of progress against the actions set out October 2025, the introduction of the OSCE Examination Inspection, increased clinical activity, feedback received from the external examiner and the revised PAD documents. Therefore, the panel are assured that for these two students this requirement is partly met.

Regarding the rest of the students
The panel were content that the remaining students can progress to year 3 given their progress to date towards the actions set in October 2025 and given the additional time to obtain and record the breadth of necessary clinical experience that is required. However, the panel have not received adequate assurance of the competence as safe beginners for the remaining members of the cohort, which would allow any additional students to leave the programme and to join the register as a Dental Hygienist.

The provider still must embed the actions identified by the panel formally and be able to evidence clearly individual students' progress against all the learning outcomes. Therefore, the panel deem this requirement for the remainder of the cohort not met and the provider must communicate this effectively and transparently with all students. The provider must share that communication notifying the students of that proviso with the GDC for information and alert the GDC of any students wishing to leave the programme as hygienists to allow for progress to be reviewed in any individual case.

Conclusion
The panel through the additional inspection and scrutiny are assured that this requirement is partly met for these two students exiting the 0224 cohort in February 2026 to permit registration. However, for the remaining students this requirement is not met.

Requirement 14: The provider must have in place management systems to plan, monitor, and centrally record the assessment of students, including the monitoring of clinical and/or technical experience, throughout the programme against each of the learning outcomes. *(Not Met)*

During the Inspection dated 14 and 15 October 2025, the panel saw *9_A07 Quota Data and Competencies* which identified the lack of complexity of student progression statistics being captured. This raised a concern on how assessors can measure students' competent levels required prior to treating patients with limited data held by the provider. The provider was told that they must develop the progression statistics to capture the breadth of procedures and to clearly demonstrate progression through grading.

The panel reviewed the *9_A07 Quota Data and Competencies* during the inspection visit on 14 November 2025 and noted the improvement on the data being used for student progression, however, there remains room for improvement so the provider must compare the data capture system with the learning outcomes for each registrant group to ensure breadth and complexity are captured.

The Practice Assessment Documents is a paper-based system capturing students' progression and experience. This document forms part of the student's formative and

summative assessment. The panel reviewed samples of this document during the inspection in October 2025 and found that the document did not include a clear grading of students to be able to monitor progress. The provider was told to review the document and to demonstrate progression through clear grading.

The panel deem this Requirement is not met

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. *(Not Met)*

The provider captures student progress through the Practice Assessment Document (PAD). The panel reviewed a sample of PADs during the first inspection in October 2025. The panel were unable to clearly assess the PADs as the grading was unclear and did not capture longitudinal learning of the student to demonstrate the level of competency gained throughout the programme. The provider redesigned the PAD document, and the panel reviewed this in November 2025, this included clarity that the grading is pass/refer. The updated version of the PAD has improved the logging process which will enable the provider to clearly document student progress, which will enable the provider to identify and develop the students' skills to the level of competency required.

During the inspection, the panel spoke to students who felt supported by the provider and placement supervisors to obtain access to patients and procedures that they required to meet their "quotas."

In November 2025, the provider presented the panel with the revised Quota Data and Competencies data for all students. The provider acknowledge that the data still did not cover all the learning outcomes. The panel acknowledged the additional work that the provider had conducted to capture the data and is assured that continuing students will be demonstrate attainment against the learning outcomes. The provider was informed to provide the two students exiting the programme with additional clinical experience before the Examination Assessment Board in February 2026.

The panel reviewed the student portfolio and PAD for the two exiting students in January and February 2026 and identified clinical areas which were still outstanding. Following additional work between February 2026 and the final sign off meeting the panel reviewed evidence that these two students have received the necessary breadth of patients and procedures required to achieve the relevant learning outcomes.

The panel felt that the clinical "quotas" stipulated by the provider are low in some cases and high in others and the provider must therefore conduct sector research to benchmark against current quotas. The panel suggested that once meaningful data was available, internal benchmarking could also be applied. The provider must also compare "quotas" set against the learning outcomes for each registrant group.

The panel noted that a formal "sign up" and/or sign off process was not in place during the initial inspection in October 2025. Following a panel recommendation, the provider has subsequently put a process in place to address this which was reviewed in November 2025. However, due to the newness of this process, the inspection team have been unable to explore the effectiveness of this new process/panel fully. The provider must embed the formal "sign up" and/or sign off process to ensure an auditable record of decisions made for students' fitness to sit assessments.

Although the panel is assured that the two named individual students are fit to practise at the level of a safe beginner, the panel deem the Requirement not met.

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. (*Partly Met)*

The provider deploys a range of assessment approaches in line with the wider University policies. The module team and programme committee conducts annual monitoring and periodic reviews to ensure they remain fit for purpose and mapped to the current GDC learning outcomes.

The provider uses an external examiner to give independent oversight of assessment validity. The external examiner report stated that the programme would benefit from Standard Setting, and the provider has noted that this is in progress.

The panel deem this Requirement to be partly met.

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

The panel reviewed a range of positive multi-source feedback captured from across the programme.

Students noted that they are given the opportunity to give feedback at the end of each module which they feel is considered by the programme team. The students also informed the panel that they have a "Student Voice Forum" twice a year.

The panel reviewed the *A43 Student Voice Forum Minute* which clearly demonstrated several examples of how students give feedback. This included a request for clearer, more detailed assessment criteria and a breakdown of module topics, with a "chapter page" for focused study and review. The minutes had been updated with the discussion, consideration and what changes had been made.

Feedback from the external examiner had been received and acknowledged but changes had not yet been made.

The panel deem this Requirement to be partly 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. *(Partly Met)*

There is a strong culture of reflection from both students and staff. The modules of study which deliver the theory of reflective practice is noted in the *A24 Student Course Handbook*, alongside mechanisms such as the PAD (for placement locations) and Personal Academic Coaches (PAC). The panel reviewed a sample of PADs during the inspection and saw some examples of reflection. However, there appeared limited use of the reflections in student development with no actions recorded to address thoughts.

The panel reviewed a sample of PADs which was contained within the document *A53 360 Feedback tool for placement.* Of those sampled, there were a number of documents that were not dated and placement supervisor feedback was not recorded. The panel noted that the feedback from placement supervisors did not always reflect the grade scoring and on several occasions recorded feedback as “I agree” which does not follow the cycle of reflection or provide adequate feedback.

The placement supervisors must receive training on how to complete documents fully and on how to give SMART contemporaneous feedback.

PAD grading calibration must be benchmarked and detailed for calibration and training of all supervisor and assessors. Grading across all areas should be reviewed to ensure all documents have consistent grading criteria.

The panel deem this Requirement to be partly 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. *(Partly Met)*

The panel noted an inexperienced dental teaching team and raised concerns that this had been evident in the lack of gateway and summative assessments at the start of this inspection.

The panel is assured that the move to the new School of Health, Sciences and Society and the head of Allied Health Professions (AHP) brings additional knowledge and experience which will support the development of this programme and creation and development of the relevant examinations and assessments. An example of this is the delivery of dental radiography which utilises staff from AHP for the practical and theoretical elements, in addition to the theoretical elements provided by the core teaching team

The panel deem this Requirement to be partly met.

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

The provider has an external examiner in place who noted in the *External Examiner Report 2024-25* that the assessment looks appropriate. During the inspection, the panel asked the EE if his recommendations had been considered and actioned. The EE noted that he had suggested that Standard Setting should be considered and implemented. The EE confirmed that discussion had taken place regarding appropriate Standard Setting, however, this was something still to be implemented.

Standard Setting must be employed for summative assessments, and the provider must be quicker to respond to suggestions from the external examiner which are fundamental to the programme.

The panel noted that EE suggestions from the *External Examiners Report 2024-25* were all relevant recommendations which had been identified by the panel during the inspection and must be considered and responded to in a timely manner.

The panel deem this Requirement to be partly met.

Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. (*Not Met)*

The provider must formalise its Standard Setting process so that there is a clear document demonstrating the method used.

During the inspection, the panel found that there was no summative clinical assessment at each gateway despite the provider stating there was a summative inspection *12_A10 Sign up and off document* as part of the sign up and sign off process. The provider had identified this themselves during the first cohort and has since set up a Year 1 summative assessment. For the current students, this was delivered at the start of Year 2 prior to students moving into the clinical placement. However, it was unclear amongst the team if this was a voluntary or mandatory assessment, and the provider must clearly follow its documented processes and demonstrate that students are competent to move through the programme, onto live patients and to exit the programme as a safe beginner.

The panel found inconsistencies across the supervision of students. This was across the different placements but is also noticeable with individual supervisors within the placement providers. The provider has set up regular placement meetings which is in its infancy and should be used to calibrate supervisors to ensure that students are getting a fair and equitable experience.

There were no examples of double marking observed to demonstrate consistency in marking, and there were no examples of moderation being undertaken. A review of the assessment strategy is required to ensure there is a fair and consistent approach.

During the inspection. the panel found that there was a good relationship built between staff and supervisors. However, the provider should consider if there may be some over familiarity with students as it was clear that having challenging conversations had become more difficult due to the closeness which had developed.

The panel deem this Requirement not met.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
1 & 21	Year 1 gateway must form a mandatory part of the course, and this must be what is communicated and documented to students.	The Year 1 gateway now forms a mandatory part of the course as an end of year assessment as part of the Clinical Practice Module. This has been communicated to the students and it is documented in the course handbook. University processes have been followed to make this change.	June 2026
1	The provider must develop the progression statistics to capture the breadth and complexity of procedures and to clearly demonstrate progression through grading.	The course team have developed a comprehensive record system using MS Excel in the short term which is being used for the 2025/26 academic year. In the long term, the University are procuring a software system to capture this data which should be in place for the start of the 2026/27 academic year.	June 2026
1, 13	The provider must compare the data capture system with the learning outcomes for each registrant group.	As above, the course team have developed a comprehensive record system using MS Excel in the short term which is being used for the 2025/26 academic year. In the long term, the University are procuring a software system to capture this data which should be in place for the start of the 2026/27 academic year. The data capture system that the course team have created compares the data with the learning outcomes for each student group and records both the numbers of examinations completed (the quota) and the complexity of these examinations.	June 2026

4	The provider must develop a consistent approach to placement supervision including policies, procedures, and calibration.	We have set up monthly Dental Clinical Educator Forum meetings which the Head of Allied Health Professions chairs. Clinical Educators and Practice Managers are invited to attend these meetings. We share information about the course and give those attending the opportunity to share any concerns or issues they have about student experience and supervision. We have a Clinical Supervision Model – Placement Providers (UoS Dental Hygiene & Therapy Programme) document which provides information about the level of supervision that students need to have in different year groups on the programme. New Clinical Educators attend a training session which includes a calibration session. We are planning a one-day training day for Clinical Educators which will include annual updates, calibration training sessions and training on giving feedback to students for Clinical Educators. We are looking into GDC endorsement/accreditation for this training day.	September 2026
4 & 7	The provider must have a robust system in place for sharing and updating placement supervisors of the student's competency levels in a timely manner.	At the moment this information is shared with Clinical Educators via email and students are asked to let Clinical Educators know where they are on the programme. The new software system which will capture student completion of competencies and quota numbers will be shared with Clinical Educators and will be in place for the start of the 2026/27 academic year. This means that Clinical Educators will be able to access this information form the system 'live'.	September 2026

9 & 10	The provider must conduct a review of the curriculum to ensure that students are only assessed and qualified at the appropriate level of course in which they are seeking to register with the GDC.	As documented in the report we have removed the assessment of restoration from the year 2 assessment. This was done via the University processes. We are currently reviewing the curriculum and where content is delivered. However, our long-term plan is to remove the exit point for students at the end of year 2, so that all students will complete all three years of the programme and exit as Dental Therapists. This would provide more flexibility in how and when we deliver the course content.	June 2026
10	The provider needs to demonstrate that they have identified and articulated and assessed the key operational risks and steps to be taken for their mitigation accurately to ensure transparency at university governance level	We have reviewed and updated the course risk register which can be provided for the panel if required.	September 2026
11	The provider must make key changes to the programme in a timely manner and use the support of external and internal subject experts.	We had a training session for the course team on Standard Setting on 19/05/26, we will be piloting Standard Setting for the end of year 3 viva assessment for the Integrated Clinical Practice module in June 2026. Standard Setting will be used for clinical assessments from the start of the 2026/27 academic year for the following modules: Level 4 – Year 1 Clinical Skills Development 1 – OSCE and Unseen Written examination. Clinical Practice and Pre-Clinical Sciences – OSCE and Unseen Written examination. Dental Sciences – Unseen written examination. Level 5 – Year 2	September 2026

		Clinical Skills Development 2 – OSCE and unseen written examination Dental Sciences – unseen written examination and medical algorithm.	
11	The provider should consider obtaining external subject experts or critical friends to support the development of the programme	We have expert guidance within the University for curriculum development, assessment planning and course delivery. The course was written by an external expert. The external examiner is very experienced within the subject area and has provided extensive support and advice. We also had some advice before the GDC inspection from an external expert. Our course leader recently attended the Dental School Council meeting and is a part of the Directors Group and now has a buddy/mentor from the Eastman University. We will continue to seek advice about the course and curriculum from our external advisors.	September 2026
12	The provider must develop a programme level framework to quality assure placements and clinical scrutiny.	The university have a robust process in place for the setup of placements. All placement providers go through a site audit, and we have a Clinical Placement Agreement (CPA) which covers placement specification, quality and monitoring requirements and financial arrangements. The University has a Placement Co-ordinator who has ultimate responsibility for organising and managing the placements to ensure they remain fit for purpose. We also have the PamS system which is used to monitor students' attendance on placement which and capture student feedback about placements.	September 2026

		Quality assurance of placements is a continuous process. Student feedback via PamS and the Student Voice Forum, Clinical Educator feedback and feedback during the Dental Clinical Educator forum are triangulated and feed into our School Risk register. Any risks are triaged and acted upon. This assists in quality assurance of all placements and results in clinical scrutiny on an ongoing basis throughout the programme to ensure that students are gaining an equitable experience across all placements. The course practice placement lead regularly visits all placement sites. The Practice Education Forum has overall governance of the school placements risk register, collation of student placement feedback and audits. Practice Placement leads from all courses in the school attend this meeting. We have already submitted the school QA structure with our original evidence	
13	Year 2 summative assessment must form a mandatory part of the course if this is what is communicated and documented to students.	The Year 2 summative clinical assessment now forms a mandatory part of the course as an end of year assessment as part of the Clinical Skills Development 2 Module. This has been communicated to the students and it is documented in the course handbook. University processes have been followed to make this change.	June 2026
13	Summative assessment must demonstrate longitudinal and progressive learning to assure the provider that students are fit to practise at the level of a safe beginner.	There are summative clinical assessments at the end of each year of the programme which form the gateway to the next year of study and ensure that students at fit to practice the practical skills at the level of a safe beginner.	June 2026

13	The provider must communicate with all students on the status of the programme.	After the last inspection on 4th February, wording was agreed with the GDC that was shared with all students on the programme. This explained to the students the progress being made as part of the GDC inspection and also the option that they had to exit the course at the end of year 2 with a DipHE in Dental Hygiene.	September 2026
13	The provider must share the programme status communication with the GDC for information.	We will alert the GDC of any student wishing to exit the programme at the end of year 2 with a DipHE in Dental Hygiene. At the moment we have one student who has moved into the 0924 cohort, however, she is behind with her competencies and quota numbers, so she will not be ready to sit the end of year 2 exam in June 2026. There are no other students wishing to exit at the end of year 2.	June 2026
15	The provider must review “quotas” set against the learning outcomes for each registrant group.	The course team have conducted sector research to benchmark our quotas against quotas used in other universities. We have also applied internal benchmarking and students’ PADs have been taken in on a regular basis during the academic year to review their progress against the quotas. We have also compared the quotas that have been set against the learning outcomes for each year group.	June 2026
15	The provider must embed the formal “sign up” and/or sign off process.	The formal “sign up” and/or sign off process has been embedded with Clinical Assessment Boards meeting before the end of year clinical exams which are minuted. These provide an auditable record of decisions made for students’ fitness to sit assessments.	September 2026

18	The placement supervisors must receive training on how to complete documents fully and how to give SMART contemporaneous feedback.	We have set up monthly Dental Clinical Educator Forum meetings which the Head of Allied Health Professions chairs. Clinical Educators and Practice Managers are invited to attend these meetings. We share information about the course and give those attending the opportunity to share any concerns or issues they have about student experience and supervision. We have a Placement Providers (UoS Dental Hygiene & Therapy Programme) document which provides information about the level of supervision that students need to have in different year groups on the programme. New Clinical Educators attend a training session which includes a calibration session. We are planning an annual one-day training day for Clinical Educators which will include annual updates, calibration training sessions and training on giving feedback to students for Clinical Educators. We are looking into GDC endorsement/accreditation for this training day. We have incorporated how to provide SMART feedback into the Clinical Educators' training.	June 2026
18	PAD grading calibration must be bench marked and detailed for calibration and training of all supervisor and assessors.	As above, this will be part of new Clinical Educator training and the annual one-day training day. There will also be ongoing discussions during the monthly Dental Clinical Educator Forum meetings.	June 2026
18	Grading across all areas of the PAD should be reviewed to ensure all documents have a consistent grading criteria.	The grading of the PADs has been reviewed and will be implemented for the end of year 1 and end of year 2 PADs this summer.	June 2026

20 & 21	Formal Standard Setting must be developed for summative assessments.	We had a training session for the course team on Standard Setting on 19/05/26, we will be piloting Standard Setting for the end of year 3 viva assessment for the Integrated Clinical Practice module in June 2026. Standard Setting will be used for clinical assessments from the start of the 2026/27 academic year for the following modules: Level 4 – Year 1 Clinical Skills Development 1 – OSCE and Unseen Written examination. Clinical Practice and Pre-Clinical Sciences – OSCE and Unseen Written examination. Dental Sciences – Unseen written examination. Level 5 – Year 2 Clinical Skills Development 2 – OSCE and unseen written examination Dental Sciences – unseen written examination and medical algorithm.	June 2026
20	External Examiners' recommendations must be considered and responded to in a timely manner.	We have responded to all the External Examiner's recommendations and we are working on a plan for standard setting as above.	September 2026
21	A review of the assessment strategy is required to ensure there is a fair and consistent approach.	We have carried out a thorough review of the assessment strategy for the course and made changes to assessments where required using the university processes.	September 2026

Observations from the provider on content of report

Thank you for a fair and comprehensive review of the programme. The feedback is welcome and we are grateful for the supportive way that the inspections were undertaken. There was one area in the report that does not appear to be included in the Summary of action, this was for Standard 8, where the report requested a copy of the FTP process from start to finish for a student, we would be happy to provide a redacted copy of this for the panel.

Recommendations to the GDC

Education associates' recommendation	The Bachelor of Science with Honours in Dental Hygiene and Dental Therapy is not approved. However, given the additional scrutiny undertaken in relation to the two students exiting the programme at Year 2, approval has been awarded for the Diploma of Higher Education in Dental Hygiene for the two individuals named, who can therefore apply for registration as a Dental Hygienist with the General Dental Council.
Date of reinspection / next regular monitoring exercise	Progress Monitoring June 2026 for cohort 0924 Year 2 exits New Programme Inspection 2026-27 Monitoring of any exiting students on a case by case until full programme approval is given.

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.