General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Glasgow	BDS

Outcome of Inspection	Recommended that the BDS qualification continues to be sufficient for the graduating cohort to register as a dentist.

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

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine sufficiency of the award for the purpose of registration with the GDC as a dentist.** **Time-elapsed inspection: focused on Requirements 1, 4, 7, 9, 13 and 15.**
Learning Outcomes:	**Safe Practitioner Framework**
Programme inspection date:	**11 February 2026**
Inspection team:	**Cindy Mackie (Chair and non-registrant member)** **Cathy Bryant (Dentist member)** **David Young (Dentist member)** **Martin McElvanna (GDC Education Quality Assurance Officer)** **James Marshall (GDC Quality Assurance Manager)**
Report produced by:	**Martin McElvanna, GDC Education Quality Assurance Officer**

The inspection of the Bachelor of Dental Surgery (BDS) (hereafter referred to as “BDS” or “the programme”) is awarded and delivered by the University of Glasgow (hereafter referred to as “the University” or “the School”).

The programme was inspected as part of the “time elapsed” risk-based inspection process due to the length of time that had elapsed since the programme was last inspected in 2019. No particular risks had been identified through the General Dental Council’s (GDC) regular monitoring exercises and a standardised list of six Requirements for “time elapsed” inspections from the Standards for Education were considered in this inspection.

The Glasgow Dental Hospital and School sits within the School of Medicine, Dentistry and Nursing within the University structure and is well integrated within the wider University, with good resources available for the programme and for the students.

The inspection panel identified some areas of good practice. We concurred with the School that one of the strengths of the BDS programme is that students have access to a good breadth of clinical experience at both the Dental Hospital and at the seven outreach placement centres (hereafter referred to as “the centres or “outreach”).

The School makes full and effective use of the “LiftUpp/Develop©” system (“LiftUpp”) for longitudinal monitoring of competence. It is also used in the assessment of Safe Practitioner Framework (SPF) behaviours which has been comprehensively implemented into the

system. We also noted a strong and effective culture of pastoral and wellbeing support for students was evident.

The Inspection Panel (hereafter referred to as “the panel”) was pleased to receive well-presented and complete evidence prior to the inspection and discussions during the inspection provided further assurance to the quality of the programme. The panel was provided with clear and informed responses during discussions. The Programme team also demonstrated positive leadership and team working, which was evidenced throughout.

The panel consider that five of the Requirements being considered are “Met” and one Requirement is “Partly Met”. This report includes Inspection recommendations for this particular Requirement.

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

Background and overview of BDS qualification

Annual intake	80 students
Programme duration	Year 1: 22 weeks Year 2: 35 weeks Year 3: 42 weeks Year 4: 42 weeks Year 5: 37 weeks
Format of programme	**Year 1** Introduction to aspects of clinical dentistry, supported by the teaching of clinical medicine, patient management and health promotion and biomedical sciences such as anatomy, physiology and microbiology, clinical observation. **Year 2** Introduction to the theory and practice of the subjects that form the clinical basis of dentistry: operative dentistry, prosthodontics and periodontics. As part of the introduction to operative dentistry students learn about the treatment of dental caries, carried out in a simulated clinical setting. Knowledge from year 1 is built upon by further study of biomedical sciences, clinical medical sciences and patient management and health promotion. Students also begin the management and treatment of patients and continue clinical observation. **Year 3** Skills expanded in all aspects of restorative dentistry and carry out first extraction and take first radiographs. Students attend outreach placements in paediatric dentistry. Other teaching includes a comprehensive head and neck anatomy course, the dentist's role in providing smoking and alcohol advice, initial preparation for the provision of sedation, and self-directed work within various subject areas. During year 3, students undertake a period of elective study, with a dedicated period of time, situated after year 3 exams to finalise and present a project. This is an opportunity for personal and professional development. Possible elective study options include: an audit project, an educational comparison, involvement in ongoing research projects (quantitative or qualitative), a healthcare project in a remote or low-income country. **Year 4** Students continue to work in the Dental School and in the community and have an opportunity to develop clinical skills through exposure to patients in all the dental disciplines. Teaching includes oral medicine, sedation, orthodontics, and further aspects of patient management and health promotion. **Year 5** Students spend half the time in the Dental School and half working in outreach centres which are based in Public Dental Service locations. Students are allocated to one residential and one non-residential Outreach centre. There will be a small number of lectures. Students attend sessions in each of the following core units: restorative dentistry – crown and bridge, minor oral surgery, endodontics, paediatric dentistry, periodontics, consultant clinics (1 and 2).
Number of providers delivering the programme	One

Outcome of relevant Requirements[1]

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

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

Standard 1 – Protecting patients **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.**
Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients. *(Requirement Met).* Students on the programme are introduced to the clinical environment by way of observation of undergraduate teaching clinics in year one. There is a gradual increase in complexity of treatment from years two to five. BDS2 (year two) consists of continuing observation and assisting to facilitate further familiarisation with clinical procedures and the clinical environment. The BDS2 summative assessments include written exams and OSCEs, where knowledge of biomedical and dental science is examined. There are a number of clinically focused teaching blocks such as local anaesthesia (LA) symposia and block teaching to prepare students for the clinical environment and treating patients. There is simulated practice such as phantom heads available in all clinics including outreach facilities for the preparation of specific procedures, consolidation of skills and targeted training where required. This is available on an ongoing basis for all year students. Students receive inductions on areas such as patient safety, infection control and consent before engaging in clinical practice. In year two, preclinical students are taught the techniques of clinical skills in preparation for a “technical gateway”’ called “Pre-Clinical Skills Assessment (PCSA)” from the preclinical environment in BDS2 into the clinical environment in BDS3 (year three). We had sight of the School’s PCSA document which clearly outlines expectations and the assessment process. The PCSA covers five areas: periodontics instrumentation, cavity preparation and restoration, splinting technique for dental trauma and aspects of oral surgery. All areas must be passed to progress to clinical care. Passing the PCSA exempts successful students from a later part B professional examination in May. If a student is unsuccessful in the May diet, they have targeted training in preparation for an August resit diet of the PCSA. If a student is unsuccessful after three attempts, they are excluded from programme. The Progress Committee then considers if a resit of the year should be permitted. The panel was assured that this Requirement is 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)*** **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)***

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

Student supervision is a patient safety priority across Glasgow Dental School and outreach clinics governed by policy and operational procedures. We learned that safety huddles take place at the beginning of clinical sessions and checks by tutors on clinical work.

Clinical sessions are supervised by appropriately qualified staff who are trained in both clinical oversight and educational best practice. Supervisors have direct responsibility for patient care and intervene where necessary to ensure treatment provided meets professional standards of appropriate quality. At the inspection, we heard evidence that supervisors are effective in identifying clinical issues which require attention when supervising.

In the pre-inspection documentation, staff: student supervision ratios were clearly explained; these are procedure dependent and we consider them to be reasonable and in line with other providers. This was demonstrated in the departmental timetables provided.

Teacher education sessions are mandatory and attendance is compulsory. There are opportunities to attend education days and outreach staff development. At the inspection, we heard from outreach staff that there is good communication between outreach centre staff, and the centres discuss consistency and best practice between them.

We saw evidence of staff and outreach staff training information which demonstrated consistency in planning, delivery and content. It targets key component subject matter and relates to specific staff member roles. We saw minutes of relevant meetings and reference to training and educational videos used to promote consistency in assessment and feedback.

We noted that some previous issues with cancellations and reduction in clinics had been actively addressed.

The panel was assured that this Requirement is Met.

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

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)*

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).*

Prior to the inspection, the panel saw evidence of a comprehensive incident management framework within the clinical governance structure. Known as "Datix" for NHS Greater Glasgow and Clyde and "InPhase" for outreach, it is used to record adverse incidents across NHS, School and outreach services.

We commended a dedicated University NHS liaison manager and dental nurse tutor responsible for handling patient safety matters for the programme.

All outreach centres operate under NHS protocols for incident reporting to ensure alignment with national patient safety standards. Serious incidents are also recorded on the LiftUpp system.

When an adverse incident is flagged, an appropriately trained staff member is identified as the lead investigator. There is immediate escalation of the event to senior clinical leads and to dedicated staff members dealing with all reporting and student outcomes. We saw evidence of this taking place in practice in the pre-inspection documents and at the inspection.

Recording of incidents feeds into the Significant Adverse Event Review (SAER) meetings. These are conducted for all significant events, with findings reviewed by the Hospital Clinical Governance Committee. Action plans are then developed collaboratively and monitored for implementation. Any lessons learned are disseminated through staff development sessions and student briefings.

At the inspection we heard that the School strives to embed candour principles with a culture of transparency and no blame, and that targeted training or refresher sessions are conducted with staff and/or students where required. Clinical, academic and pastoral support is given to those students involved, and students are encouraged to produce a written reflective piece on the incident.

Prior to the inspection, we learnt about three adverse incidents in 2024, October 2025 and December 2025, all involving cases of wrong tooth extractions. Two of these occurred at the same outreach placement centre within some months.

At the inspection, the panel heard more detail about the circumstances of the incidents. We learnt that although on the first two incidents, the Oral Surgery Protocol for extractions was not followed, it was when the third incident occurred. Whilst it is common practice and the practice within the Glasgow Dental School to use a clinical whiteboard to visually display the extractions to be carried out for a patient, there is some difference in approach to this practice at some outreach centres. At the inspection, we were informed that on the third occasion, communication between the student and the tutor could have been clearer and has since been recognised and acted upon.

The panel considered that documentation of the planned clinical procedure on both the whiteboard and a written consent form in the outreach centre would have provided an opportunity for the supervisor and student to ensure that they both understood what treatment was to be undertaken. It appears that there was a failure in this understanding and communication which contributed to both incidents. We consider that the more consistent the patient safety measures and student experience is between centres, the less risk there is of clinical incidents occurring due to a lack of familiarity and consistency.

The School explained, that subsequent to the third wrong tooth extraction they intended to create an area within the VLE as described. The panel understand this has now been actioned.

The panel also understand that actions are in place to ensure returning BDS4 students will complete this on return from the exam period in late May, before the summer break. All other students will complete prior to the start of the new academic session, at the induction in July /August after they return from the summer break.

The School also met staff at placement centres regarding the third incident to go over the Protocol again. Further training days have also followed. Pastoral support has been given to students.

The School are still engaged in the final investigative process regarding the significant incident from 2025 in keeping with the protocol. A further meeting with the centre has been offered and to meet staff there. The panel recognised through inspection documentation and discussion that in the main, adverse incidents are being reported quickly, investigated comprehensively, and escalated where appropriate.

The panel have made some recommendations to the School regarding the consistency in student supervision, management and supervision of tooth extractions, the implementation of the Surgical Pause, or "Time Out" protocol, the use of clinical whiteboards, the identification and marking of teeth and the use of clinical pauses.

We recommend that the School promptly complete the final part of the ongoing investigation into the third wrong tooth extraction from 2025 and consider how to prevent or minimise the incidence of wrong tooth extractions in future and to standardise protocols for all centres. Once this is complete, we recommend that the School meet all centres as a matter of urgency to cascade the findings on this 2025 investigation and conduct additional or refresher training to staff and students. The School should also notify the GDC when this has been done.

The panel noted that the SAER Datix report in December 2025 following an incident from August 2024 related to LA took a considerable length of time. At the inspection we learnt that the "commissioning" of an incident to completion of a SAER report should usually be no more than 140 days. We recommend that this period should be shortened if possible and entered into protocol at the earliest opportunity.

The panel considered more generally that there was some inconsistency between the placement centres in terms of supervision and management of students' clinical practice. There was some inconsistency between the centres with the means of obtaining patient consent, either verbal or written. The allocation and ratio of dental nurse support is variable on occasion. The panel also make recommendations in relation to these.

The panel considered that that this Requirement is Partly Met. Recommendations are detailed in full at the Summary of Actions section of this report.

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)*

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 University has a comprehensive quality management framework within which the BDS programme operates. The University team provided us with helpful flowcharts detailing an overview of the quality assurance structures. Overall quality of the programme lies with the Director of Dental Education, supported by lead staff members and a quality assurance officer.

The framework includes annual course monitoring, which results in an annual report submitted to the University which is a key component of academic quality. The reports we saw were comprehensive and holistic, indicating what went well, areas for development and future innovation. In addition, reflective analysis and periodic subject reviews complement this.

The framework also facilitates collaboration with NHS Education for Scotland, and we saw evidence of regular, formal review and feedback with NHS and Vocational Training (VT) service providers. There is also an annual review of outreach facilities.

Following publication of the GDC's Safe Practitioner Framework in 2023, a comprehensive curriculum review and mapping exercise was completed by the University, which was supported by a GDC Transition Action Plan, implementation timeline and a full update of programme information documents and mapping for implementation in 2025.

The BDS programme now has a spiral curriculum mapped against SPF learning outcomes and behaviours. The panel had sight of mapping documents which illustrate that the BDS is mapped to both Preparing for Practice and SPF.

The University's current BDS5 (year five) cohort have completed years one to four under the Preparing for Practice learning outcomes and were also provided with SPF catchup training at the end of BDS4. This effectively means that they have the added enhancements of SPF in addition to Preparing for Practice outcomes. For their final year, the current BDS5 have also been undergoing formal behaviour monitoring which is evidenced within LiftUpp.

Several sources of feedback are used to inform programme development, including students, patients, nurses, peers and tutors alongside National Student Surveys and internal surveys. The panel observed the use of such feedback in the programme.

Student feedback highlighted issues of variable operation of outreach clinics, patient availability and the impact of dental nurse shortages. We noted the efforts made by various means to capture SMART annual feedback and a "you said, we noted" approach. We saw examples of changes and a positive response resulting from student feedback.

External examiner feedback is a key part of external quality assurance. We noted that the latest feedback for BDS across all years 1-5 is universally positive.

The panel was assured that 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 Met)***

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

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

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

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

Prior to the inspection, the panel saw a mapping document which illustrate alignment of the BDS programme to the learning outcomes and behavioural expectations to SPF.

Students have access to a helpful document outlining assessments in the BDS programme and provides a clear guide to the various assessments, standard setting and pass marks that they will encounter during the BDS programme. BDS5 have had training to include SPF and have also been undergoing formal behaviour monitoring which is evidenced clearly within LiftUpp.

The School utilise a variety of formative and summative assessments. The assessment framework includes written examinations, oral presentations, OSCEs, structured clinical reasoning oral exams, simulated clinical assessments and clinical snapshot competency assessments.

The 2020-2026 SPF outcome blueprint is a new BDS assessment blueprint. Each assessment is mapped to specific learning outcomes, ensuring comprehensive coverage and transparency. It is fully integrated and consolidated within the programme assessments.

The School uses the longitudinal continuous assessment digital platform, LiftUpp and bespoke University IT systems to track and assess student progression.

At the inspection, University staff delivered a comprehensive introduction to the LiftUpp system which is used to track student activity and progress. We saw lists and numbers of procedures and clinical progression. The monitoring of SPF behaviours is fully embedded in LiftUpp. We saw a breakdown of clinical-, interpersonal-, professional- and self-behaviours, supported by 34 descriptors and we commended this. We heard that the means of assessment of behaviours has been made clear to students, with a clear rationale why they are now being assessed.

LiftUpp can also be used to place alerts on student performance, professional concerns, and flag adverse incidents, including to outreach. Feedback is also monitored via LiftUpp.

The Longitudinal Clinical Development Panel (LCDP) looks at clinical progression and feeds into the exam board system. This panel reviews similar areas that a sign up / sign off meeting would do at other Schools. At the meetings, clinical competency achievement, longitudinal progression, breadth of experience and mentoring engagement are reviewed, and the

implementation of targeted training can be made. The LCDP makes recommendations to a Pre-Board Scrutiny panel with comprehensive information on students' clinical ability, numbers of procedures, consistency of performance, safety and behaviour monitoring.

The School employs modified Angoff and borderline regression in order to standard-set written assessments, OSCEs and case presentations.

The BDS5 Course Information Document 2025-26 indicates all of the elements that students must pass. This includes the OSCE, satisfactory attendance, completion of the Mentorship Programme, passes in satisfactory clinical performance as evidenced in LiftUpp. It is clear that all domains in SPF are being reviewed: clinical knowledge and skills, interpersonal skills, professionalism and self-management.

The panel was assured that this Requirement is Met.

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

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

In the pre-inspection documents, we read that students have comprehensive exposure to a wide and diverse range of patients and clinical procedures across all major disciplines of dentistry. This is key to the development of practical skills and students undertake patient care activities on sufficient occasions leading to competence in the relevant learning outcomes and to independent practice.

At the inspection, senior programme staff indicated that one of the strengths of the BDS programme is the volume and breadth of clinical experience attained by students at both the Dental Hospital and at seven outreach placement centres.

We learnt about the snapshot competency assessments which are digitally recorded and reviewed, and which triangulate the longitudinal data to ensure that students are performing at the safe beginner level.

We saw detailed minutes of meetings with underperforming students which confirmed a collaborative evidenced approach and focus on support to achieve the range and number of treatments expected and prepare them for vocational training.

LCDP meetings occur at least three times a year and there is a list of recommended experience for restorative, oral surgery and paediatric dentistry. The breadth of clinical experience is assessed at these meetings and a recommendation is made, which is considered by the Pre-Board Panel and Board of Examiners.

As referenced at Requirement 13, the School uses LiftUpp for recording activity, assessment and feedback in the clinical environment. From the demonstration we had during the inspection, it was clear that the use of LiftUpp and longitudinal monitoring demonstrates a comprehensive and objective recording system, with evidence of student access to a range of patients and treatments.

Overall, the panel considered that the breadth of clinical experience is at an appropriate level and students have good clinical experience and access to outreach. The clinical numbers for BDS5 students are notably high. There are good efforts in place to access patients and problems can be identified and resolved early on.

The panel was assured that this Requirement is 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. (*Requirement Met)*

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)*

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)*

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

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

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

Summary of Action

Requirement	Action	Observations & response from Provider	Due date
7	1. The School should encourage consistency in the approach to patient safety between the outreach placement centres. In the management of tooth extractions, there should be consistency in: • supervision • the implementation of the Oral Surgery Protocol, Surgical Pause, or "Time Out" protocol • the use of clinical whiteboards • the identification and marking of teeth and the use of clinical pauses.	Since the GDC inspection, we have been working with the NHS Clinical Directors / Directors of Dentistry for the outreach centres to update the adult outreach extractions protocol and improve consistency. Advice in relation to the use of clinical whiteboards, written consent and reissue of the updated adult outreach extractions protocol has been shared. Examples of Dental School oral surgery checklists, and written consent proformas have been shared. We will continue to work with our outreach centres to improve consistency and ensure the oral surgery processes are being implemented. Staff and student refresher training will be standing items at induction sessions and education days. Surgical pause protocol is already an item at induction talks for new outreach tutors and these sessions will be updated to include the new protocols. The Dental School Undergraduate oral surgery teaching lead has already visited the centre where two adverse events occurred to speak with the team and will visit all centres during 2026 – 2027 academic year. Routine visits by the BDS5 outreach team will also assist in ensuring protocols are being followed.	+6 months (from date of report publication)
7	2. The School should promptly complete the ongoing investigation into the third wrong tooth extraction from 2025 and consider how to prevent or minimise the incidence of wrong tooth extractions in future. The	This investigation has now been concluded, confirmed in an online meeting with the Outreach Lead, Director of Dentistry and the Clinical Service Manager for the outreach centre involved. The implementation of the updated adult outreach extractions protocol, use of clinical whiteboards and	+6 months (from date of publication)

Requirement	Action	Observations & response from Provider	Due date
	protocols should then be standardised for all centres.	written consent aims to help minimise the chances of further adverse events in future, at this centre and across all other outreach centres. Further planned training events with staff and students are designed to aid in attaining consistency across centres. This will be monitored by the Outreach Lead.	
7	3. Following the outcome of this investigation, the School should meet all the outreach placement centres as a matter of urgency to cascade the findings and conduct additional or refresher training to staff and students.	On receipt of the draft inspection report and conclusion of the third wrong tooth extraction investigation, the updated adult outreach extractions protocol, and templates were sent to the NHS Clinical Directors and Directors of Dentistry. Further to the information being sent, the same information was then cascaded to all outreach staff, and virtual meetings were held with key outreach staff across all 7 outreach centres where learning from the adverse events was shared, and the updated adult outreach extractions protocol discussed. Refresher training is planned for students returning after the Exam diet (BDS4) before the summer break (late May). For all other clinical years, refresher training will be provided during the induction process, prior to the new academic year beginning for 2026 -2027 at induction in July /August after the summer break.	+6 months (from date of publication)
7	4. The School should also confirm to the GDC when these follow up actions have been completed.	We will keep the GDC informed of the progress of action implementation.	+6 months (from date of publication)

Requirement	Action	Observations & response from Provider	Due date
7	5. The School should encourage consistency in the process of obtaining patient consent (ideally, written consent) between the outreach placement centres.	We will continue to work with our outreach providers to improve consistency in obtaining consent. We will continue to encourage sharing of best practise between centres and to use our dedicated outreach training days to provide updates on processes and policies. Written consent will be obtained for extractions. Written consent is already obtained from all patients in outreach centres at the start of their treatment to ensure that they are informed that they will be treated by undergraduate dental students under the supervision of a qualified dentist.	+6 months (from date of publication)
7	6. More generally, the School should encourage consistency in supervision and managing students' clinical practice between the placements, with the implementation of the same policies and protocols across the placements.	We will continue to work with our outreach providers to improve consistency in supervision and clinical practice. We will continue to make use of the dedicated outreach training days, the MS teams outreach site and the Virtual Learning Environment to inform outreach staff of relevant policies and protocols. Specific treatment protocols are contained within the Virtual Learning Environment, for example in the Restorative Dentistry teaching synopsis, and all outreach staff have access to this. Consistency in supervision and managing students' clinical practice will be monitored by the Outreach Lead during their ongoing regular visits to the centres and via student feedback (Staff Student Liaison meetings with class representatives and the outreach student feedback surveys). Each NHS board has specific policies they must adhere to, for example health and safety: management of needlestick injuries. Whilst generally similar some local variations do exist	+6 months (from date of publication)

Requirement	Action	Observations & response from Provider	Due date
		between the 6 affiliated Health Boards that accommodate the outreach centres. However, where possible we will encourage as consistent approach as possible to applying these policies.	
7	7. The allocation and ratio of dental nurse support should be further considered to maximise consistency between the centres.	The nursing staffing ratios are funded via a tripartite Service Level Agreement, between NHS Education Scotland, the partner health board and the University. The nursing ratio is 1 nurse to 2 students. This is identical across all 7 outreach centres. On occasion, a small number of our centres may allocate an additional nurse, if available. This has the benefit of training nurses to work with students which we consider as a strength. The agreed nursing arrangements in all our centres, which is 1 nurse: 2 students, generally works well. On rare occasions of short notice / acute absence of nurses a risk assessment will occur locally, and measures taken to ensure safe and appropriate supervision ratios are maintained. We will continue to work with the NHS boards, and NHS Education for Scotland to monitor and ensure staffing ratios and funding are maintained.	+6 months (from date of publication)
7	8. The School should ensure shortening the maximum period of investigating serious incidents, currently 140 days to an earlier timeline.	Any adverse incident that is reported by Inphase / Datix, in any of the affiliated health boards should be investigated within 10 days. If the decision is taken to escalate this to a Significant Adverse Event Analysis or Significant Event Analysis, then all NHS boards work to national policies which are	+6 months (from date of publication)

Requirement	Action	Observations & response from Provider	Due date
		governed by Healthcare Improvement Scotland (HIS). The timeframe varies depending on the level of incident, however, for SEA /SAER it is 140 days. This is set nationally and is not in our control. However, in the majority of cases the NHS team work to conclude the investigation as quickly as possible and well within this timeframe. As we have good reporting mechanisms for Datix and Inphase, and via the Liftupp system, we are able to provide academic, clinical or pastoral support for any student or staff member involved in an adverse incident within the 10 day period of the incident being logged. We will work with NHS colleagues to share this action from our inspection report to try and expediate the investigation and conclusion of any SAER/SEA involving dental students, where appropriate/possible.	

Observations from the provider on content of report

We would like to extend our thanks to the GDC inspection panel for their thorough and considered report. The recommendations and constructive feedback given will assist us in further strengthening the program.

We are very reassured that the Panel commended the BDS program in a number of areas, including the breadth and amount of clinical activity, the pastoral support provided to students, and how we have embedded SPF behaviours into the program. This is testament to the hard work and dedication of our staff.

Recommendations to the GDC

Education associates' recommendation	The BDS continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council.
Date of next regular monitoring exercise	Progress Monitoring on the actions in this inspection report: +6 months from date of report publication. Regular Programme Monitoring in the academic year 2027 – 2028.

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.