

**Education Quality Assurance Inspection Report**

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| Education Provider/Awarding Body | Programme/Award |
| University of Portsmouth | BSc (Hons) in Dental Hygiene and Dental Therapy |

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| Outcome of Inspection | Recommended that the BSc (Hons) in Dental Hygiene and Dental Therapy continues to be approved for the graduating cohort to register as a dental hygienist and therapist. |

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

**Inspection summary**

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| **Remit and purpose of inspection:** | **Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dental hygienist and dental therapist** |
| **Learning Outcomes:** | **Preparing for Practice for dental hygienists and dental therapists** |
| **Programme inspection date:** | **23 and 24 April 2024** |
| **Examination inspection date:** | **N/A** |
| **Inspection team:** | **Jim Hurden (Chair and non-registrant member)**  **Clare McIlwaine (DCP member)**  **Kevin Seymour (Dentist member)**  **Kathryn Counsell-Hubbard (GDC Quality Assurance Manager)**  **Toni Wood (GDC Education Quality Assurance Officer)** |
| **Report Produced by:** | **Kathryn Counsell-Hubbard & Toni Wood** |

The BSc (Hons) in Dental Hygiene and Dental Therapy programme (hereafter referred to as “the programme”) delivered by the University of Portsmouth (hereafter referred to as “the School” or “the provider”) is a well-resourced programme that offers students the opportunity to get ‘real world’ experience at its own Dental Academy. The Academy benefits from one of the clinical areas mimicking a general dental practice and thereby gives students the essential insight into work, post-registration.

Students also benefit from a small but supportive programme team who work hard to provide students with the support they need to complete their studies. Having managed to continue running the programme through the COVID-19 pandemic, the programme team may face additional challenges due to a University-wide restructure. The Dental Academy currently comprises its own school within the Faculty of Science and Health, but the number of schools will be consolidated to increase efficiency of resource. The Dental Academy will combine with the School of Health Care Professions to become the School of Dental, Health and Care Professions, which is likely to include a future expansion to the dental education already offered.

While this is an exciting opportunity for the programme team, the potential for additional duties as a result of the expansion, along with increased stress, is considerable. Such changes may also impact on the clinical agreement with King’s College London, whereby BDS students attend the Dental Academy for a period of outreach. This allows the hygiene and therapy students the opportunity to work with BDS students.

The panel were impressed by a number of processes in place, as well as with the commitment of the programme team and the facilities on offer. The ability for the current programme to operate in the same way following the restructure is uncertain, and the panel would like to revisit the School after the restructure has taken place and the changes have been embedded. Until that time, the programme team should be assured that their hard work has been noted and that the programme on offer is exemplary.

The GDC wishes to thank the staff, students, and external stakeholders involved with the BSc (Hons) in Dental Hygiene and Dental Therapy programme for their co-operation and assistance with the inspection.

**Background and overview of qualification:**

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| Annual intake | 36 students |
| Programme duration | X 36 weeks over 3 years |
| Format of programme | Year  1: Fundamental scientific knowledge, pre-clinical simulated skills, introduction to clinic, foundations of evidence-based practice  2: Applied scientific knowledge including dental radiography, direct patient treatment, introduction to research skills, paediatric pre-clinical skills  3: Direct patient treatment, collaborative care outreach, applied research skills, leadership and management skills. |
| Number of providers delivering the programme | 1 – University of Portsmouth |

**Outcome of relevant Requirements[[1]](#footnote-2)**

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| **Standard One** | |
| 1 | Met |
| 2 | Met |
| 3 | Met |
| 4 | Met |
| 5 | Met |
| 6 | Met |
| 7 | Met |
| 8 | Met |
| **Standard Two** | |
| 9 | Met |
| 10 | Met |
| 11 | Partly Met |
| 12 | Partly Met |
| **Standard Three** | |
| 13 | Met |
| 14 | Met |
| 15 | Met |
| 16 | Met |
| 17 | Partly Met |
| 18 | Met |
| 19 | Met |
| 20 | Met |
| 21 | Met |
| **Standard 1 – Protecting patients**  **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount, and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.** | | |
| **Requirement 1: Students must provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients. *(Requirement Met)***  Students undertake pre-clinical skills training on phantom heads before progressing to patients. An objective structured clinical examination must be passed prior to students coming out of pre-clinical skills training and receiving their passport to clinic. Regular phantom head work is supported by experience in the haptics laboratory. The pre-clinical skills element of the programme is supported by workbooks that students must complete and appropriate module guides.  The School utilises clear assessment strategies and every assessment has associated marking criteria. The panel found the Requirement to be 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)***  Patients are informed that their treatment will be provided by students prior to them attending the clinical environment. A consent form must be signed, and the student will discuss this with the patient before commencing treatment. The consent forms were reviewed and found to be appropriate. Signage and badges denoting the students’ status are also in use. Patients may rescind this consent at any time.  The consent process was well-articulated by both staff and students. The panel were content that the 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)***  Students provide the vast majority of care in the University-based dental clinics. These are operated and staffed by the University and have a Health & Safety Officer. A full range of clinical policies were evidenced, and a staff “huddle” was observed whereby key pieces of information about the clinic are imparted to students and staff alike. The Dental Academy holds its own incident database which is supported by a comprehensive governance framework. The full range of clinical policies were available and reviewed by the panel.  The Requirement was found to be 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)***  The standard staff-to-student ratio at the Dental Academy is 1:6, with less experienced students often working within a 1:4 ratio. Ratios are monitored at every clinical session with sessions being partially re-timetabled if the ratio cannot be maintained. Students described a sliding scale of supervision whereby they are supervised more at the beginning of the course than at the end.  Clinical module coordinators hold the responsibility of informing clinical supervisors of the progress of student groups and what expectations should be in place. This ensures that supervisors are aware of the level of supervision required at every session.  The programme benefits from utilising tailor-made clinics that are designed for the supervision of students. One clinic has walled in bays to mimic the experience of working in a practice, but the school have ensured that the walls include a large amount of glazing so that supervisors can see what students are doing at a glance.  The 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)***  All supervising staff members are registered with the GDC and have received appropriate training prior to undertaking supervisory duties with students. Upon commencement of employment, all staff members undergo an induction process that introduces them to the Dental Academy and the clinical environment. They are advised to collaborate with the module coordinator to ensure they provide supervision, guidance, and feedback appropriate to the students' stage of academic progress. Feedback to students is considered at multiple points through the operation of the quality management framework, not least at key progression points, so the quality of the feedback can be addressed if necessary. Additionally, the students reported feeling comfortable to speak to staff about their feedback should they not agree with this or require more detail.  Information regarding staff certifications and evidence of Continuing Professional Development (CPD) is collected annually and maintained in staff records.  After reviewing the evidence, the panel deem this Requirement to be 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 Dental Academy has established comprehensive Raising Concerns and Whistleblowing policies to guide staff and students in addressing any issues. During induction, line managers will direct staff to these policies and offer opportunities for discussion.  The Clinical Director and Associate Heads guide students to the virtual learning environment, Moodle, which hosts a folder containing all policies and guidance notes. Students must read and self-certify their understanding of these policies; this is monitored by the administration team. Non-compliance is reported to the Clinical Directors and/or Associate Heads for further investigation, with completion records maintained in the student file.  The panel found the Requirement to be 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 Met)***  The Raising Concerns at UPDA policy and the Incident Reporting Policy outlines procedures for reporting incidents, near misses, accidents, and serious or critical incidents related to patient safety. The University reviews all incidents, including trends during the departmental Health & Safety (H&S) and Clinical Governance meetings.  All reported incidents are directed by the department H&S Officer to the appropriate senior member for action. The H&S committee reports directly to the Clinical Committee and Departmental Executive Committee, where incidents and trends are analysed, and action plans are developed and disseminated.  Sufficient evidence has been presented to enable the panel to agree that this Requirement has been fully 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. *(Requirement Met)***  Concerns regarding a student's fitness to practice (FtP) may be raised by any staff member within the Dental Academy. Staff are encouraged to escalate concerns directly to a student's personal tutor, Module Coordinator, Clinical Director, Associate Head, or the Head of School (HoS) using the designated online form. Teaching staff are urged to document any student concerns, including those pertaining to FtP, utilising an online reporting mechanism. The Senior Tutor collates data related to these concerns to identify recurring issues or trends.  All reported concerns are deliberated upon by the Student Support Committee, comprising the Senior Tutor and Associate Heads, with actions disseminated accordingly. Should a concern pertain to an FtP issue, it is promptly relayed to the appropriate authority by the Senior Tutor, initiating adherence to the prescribed FtP process outlined in the policy.  The University has implemented an early intervention system designed to identify student behaviour patterns and communicate the potential repercussions akin to those in professional settings. Records of these interventions are centrally stored, facilitating accessibility for executive members and retention within student files. This initiative has notably mitigated instances of FtP within the university and was considered a very positive step in embedding reflective practise on professionalism by the Panel.  The Requirement is met. | | |
| **Standard 2 – Quality evaluation and review of the programme**  **The provider must have in place effective policy and procedures for the monitoring and review of the programme.** | | |
| **Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function. *(Requirement Met)***  The programme is supported by a comprehensive committee structure that provides multiple opportunities for issues and suggestions for change to be raised and escalated to a final decision point. The School’s approach to quality management is set by the University and supported by the annual Excellence and Quality Improvement Plan (EQuIP). The HoS holds ultimate responsibility for the EQuIP and reviews a range of data to complete the plan including student feedback, external examiner reports and a range of qualitative and quantitative data.  The agendas for relevant committees, mainly being the Education Committee, have been amended to take into account the new GDC curriculum document. The responsibility for mapping across to the new learning outcomes and behaviours is clearly defined.  The panel found the Requirement to be met although were concerned that such a detailed and complex committee structure for a relatively small programme was excessive. However, the panel recognised that not only must certain groups be in place per instructions from the University but that this structure will serve the school well when plans to merge and expand the School come to fruition.  **Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements. *(Requirement Met)***  The School utilises a Department Executive team which deals with concerns raised by staff or students. The committees within the quality management framework all have terms of reference and it is clear where they would escalate issues that may affect the safe running of the programme.  Students obtain most of their experience at the Dental Academy and then complete five one day placements in different specialist areas. The placements in Community Dental Services and general anaesthetic involve clinical work, and while the other placements may involve some clinical work, students mainly shadow and observe. Due to the use of placements in this way, a separate quality assurance mechanism is not required. However, should the provision of placement change, the provider must ensure that an ongoing quality framework process is implemented to ensure appropriate monitoring, quality assurance and consistency for. student experience.  The Requirement is found to be 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 Partly Met)***  External examiners perform a key function as part of the quality assurance measures imposed by the University’s Quality Assurance Committee. External examiners provide scrutiny and feedback at multiple points in the programme, such as during moderation prior to assessment approval, and act in an advisory capacity to the Module Assessment Board. Their role is set centrally, and external examiner reports are considered as part of the annual EQuIP.  Feedback is a strong element of the programme (discussed in further detail under Requirement 17). Patient feedback is gathered as part of the mechanisms in place, but the panel found limited evidence that this feeds into programme development in a meaningful way. While there appear to be multiple groups that may discuss patient feedback, evidence was not seen that this had been done or was a standard discussion point for the appropriate committees.  The panel recognised the inherent difficulties with using patient feedback in this way particularly as such feedback must be of sufficient detail and value to be properly utilised. However, actors are used in some practical assessments and their feedback could be fed into the quality management framework, particularly if detailed patient feedback is not available.  The Requirement is currently considered to be partly met but the School should be commended for the excellence of the 360° feedback mechanism employed.  **Requirement 12: The provider must have effective systems in place to quality assure placements where students deliver treatment to ensure that patient care and student assessment across all locations meets these Standards. The quality assurance systems should include the regular collection of student and patient feedback relating to placements. *(Requirement Partly Met)***  The School has effective feedback mechanisms (discussed under Requirements 11 and 17) and assures the quality of its’ in-house clinics (discussed under Requirement 3). As the School does not use traditional outreach placements, a quality assurance process for such sites does not exist.  However, students do have the opportunity to gain clinical experience on the placements, and these experiences would be logged and counted within the student’s overall clinical experience when making key sign-up and sign-off decisions. The way in which such experience is noted, and feedback given to students is not standardised. The School is in good contact with the providers of the one-day placements, and the panel had no reason to doubt the appropriateness of the experience or supervision at these sites, but the inclusion of such experience without proper standardisation in place was a concern.  The panel did not find evidence to suggest that any site where students of the programme could gain clinical experience were of a low standard, but the mechanisms are not in place to detect this. The School must review their practice of allowing experience on placement to be counted within a students’ overall experience for the purposes of progression and introduce a process, if appropriate, to ensure that students are supervised and assessed to the same level offsite as at the Dental Academy. The panel found this requirement to be partly met. | | |

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| **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)***  The programme is fully mapped to the current GDC learning outcomes and will also map across to the new framework of learning outcomes and behaviours which comes into effect on 1 August 2025. The programme is divided into modules with a nominated coordinator for each who is responsible for the module guide and associated assessments. All Module Coordinators have access to LiftUpp and can monitor student progress at any time to track their progression.  Any concerns raised about students by either Module Coordinators or personal tutors can be referred to the Student Support Committee which is also attended by the Senior Tutor and Associate Heads. This allows for values-based concerns to be raised easily as these might not fulfil the criteria for the clinical alerting mechanism on the central clinical recording system; LiftUpp. Any remediation required following consideration by the group will be offered to students and recorded. All student clinical data is considered at the Clinical Development Monitoring Panel (CDMP) which meets three times each academic year, and for which the last meeting of each year acts as the sign-up to final assessments.  The quality management framework ensures that student attainment and progression is collated and discussed at several points prior to the final CDMP. This allows the programme team to identify anyone struggling at an early point and to offer an intervention at an appropriate stage. A standardised remediation template is utilised. All assessments must meet University criteria and resits are offered should a student fail at the first attempt.  Clinical progression data, assessment timetables, module guides and examples of student portfolios were available for review during the inspection. The panel were assured through the triangulation of evidence between staff and students as well as the documentary evidence that the 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)***  The programme utilises two main systems involving students: LiftUpp and Moodle. Moodle is the online virtual learning environment where educational resources and policies can be kept for reference at any time. LiftUpp records clinical experience including feedback and is one of the main components of the CDMPs. LiftUpp allows for reports to be run to identify specific trends or achievement for particular treatments. The system is also mapped to the learning outcomes and Module Coordinators are expected to check LiftUpp against their module-specific outcomes at least three times a year. All clinical staff have access to the system.  A separate system, SITS, is utilised for summative assessment data, which is gathered ahead of Module Assessment Board and Board of Examiner meetings.  The panel found the Requirement to be 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)***  Benchmarks were introduced as a response to COVID-19 to ensure that students achieved a proportionate amount of clinical activity based on what was available at that time. Since the end of the pandemic, the provider has continued to utilise benchmarks while they wait for a ‘stable’ year when the approximate patient flow is known, and more static clinical targets can be created. The benchmarks have changed since the pandemic, being updated year-on-year based on the average student experience for each activity type in the previous cohort.  Work is ongoing to increase patient flow through the student clinics. The School holds an NHS contract to provide dental services, and this has limited their ability to off-board patients that no longer require treatment at a level to further students’ learning. This work is ongoing as a larger patient flow project which is supported by monthly meetings. Module Coordinators are also responsible for identifying those students who are lacking in a particular activity type highlighting this with the administration team to ensure that those students get the experience they require. Those students with whom the panel met reported some mixed results in how easily they got the kinds of patients they needed but the student data reviewed showed a healthy completion of the benchmarks to date.  The panel recognised that patient flow is an issue for all providers but found that the School was doing what it could to ease the situation. The 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)***  Assessments must progress through a number of steps before being used for students. Module Coordinators must conduct a peer review and submit a module assessment along with supporting documentation to the Assessment Panel. Here, the assessments are checked, and the methods of standard setting are discussed. An Assessment Artefact Moderation Form is used to track the assessment through the approval process. Module Coordinators are encouraged to seek and use feedback from external examiners to inform and support the proposed assessments.  The School is actively building a data set of how specific questions in assessments perform and hope to use that information moving forward. Currently, there are moderation processes and the use of marking criteria and schemes to bring consistency to assessments. Feedback from external examiners is also used where appropriate.  The Requirement is 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 Partly Met)***  The provider has several exceptional feedback mechanisms in place. Module Coordinators are responsible for gathering and utilising feedback to improve their modules, and clinical feedback for students is added directly onto LiftUpp and considered at key progression points. Students receive 360° feedback in practice from peers, supervisors and patients. Obtaining such feedback is a requirement of their summative portfolios. Meetings have been convened with external stakeholders, including a Community Conversation event where the public could come into the dental academy and speak to staff. The panel found that all these mechanisms are to be commended, especially the use of peer feedback.  As with the majority of schools, the provider does struggle with using patient feedback in a meaningful way. Patient feedback did not appear to be detailed or used by the programme team as a quality assurance tool. The panel recognised the difficulties with achieving this element of the Requirement but ultimately had to find the 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. *(Requirement Met)***  Reflection is embedded throughout the programme and is a part of the 360° feedback tool. Students’ reflections also form part of any action plans required. Clinical SWOT analysis is required at the beginning, mid-point and end of an academic year to develop their skills in this area.  A sample of student portfolios was reviewed. Students also described a culture of openness in that staff can always be approached for additional feedback and support to further their clinical practice. Feedback is an integral part of the central recording system and forms part of the sign-up to final assessments. A personal tutor system is also in use and tutors are encouraged to formulate action plans for their tutees based on the feedback seen on LiftUpp.  Overall, the panel found the support offered to students to be excellent and that feedback is a well-covered element of the programme. The Requirement is met.  **Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. *(Requirement Met)***  Part of the induction for new staff is an introduction to assessments. Staff calibration also occurs each year, for which evidence was reviewed by the panel. These are supported through the use of marking schemes and criteria. Equality, diversity and inclusion training is required by the University and a master spreadsheet is kept logging completion of this and other pieces of training. Each member of staff has a line manager who will check the spreadsheet and highlight what needs to be completed. Further personal development is available to all academic staff in the form of the Academic Professional Apprenticeship or the Academic Professional Excellence programme, both of which are supported by the School.  Students are only assessed within the School clinics as the outreach placements are only five days in total and mainly provide shadowing opportunities. This means that the School have greater ability to calibrate and ensure consistency across the assessment of students because all assessors are ‘in-house’.  The panel found the induction to be thorough and were content that all assessors hold the requisite professional registration. The Requirement is found to be 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)***  The external examiner reports reviewed were clear. Opportunities for these to be formally incorporated into the quality management of the programme was well demonstrated. The panel were able to speak with one of the external examiners who was clear on the rationale for their post and was comfortable to raise any concerns as necessary with the programme team. No concerns have been raised to date. The role of the external examiner is set centrally by the University and is set down in a job description.  The panel met with one of the external examiners utilised who reported a positive relationship with the School. They have the opportunity to highlight areas they feel could be improved but also advised that the assessments have always been of a high standard with no need for critical feedback.  The Requirement was found to be 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)***  The programme utilises Angoff and standard deviation when setting assessments and clinical benchmarks respectively. Special dispensation has been granted by the University to allow Angoff to be used. The assessments are taken through a robust procedure to assure their effectiveness and the School continues to build its’ data set to allow for more statistical analysis.  Evidence was seen of staff calibration and the panel were pleased to learn that recordings of student assessments are used for such activity and staff training generally. The students with which the panel spoke did not raise any issues or concerns with the assessment, and comprehensive module guides are in place. An issue involving some confusion about an exam manuscript was mentioned by students which the panel highlighted to the School for their consideration. Despite this, the panel were content that the Requirement is met. |

**Summary of Action**

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| **Requirement number** | **Action** | **Observations & response from Provider** | **Due date** |
| 11 & 17 | The provider must consider how patient feedback can be gathered in a way that allows for its’ inclusion in quality management of the programme. | The Dental Academy recognises the challenges of integrating patient feedback in a meaningful way. We now have a patient representative member on the EDI Committee and will consider including ‘patient voice’ as a standing agenda item at the Clinical Committee meetings.  The Dental Academy will host further ‘Community Conversation’ events to engage patients as key stakeholders in the quality management and development of the Dental Academy. | Monitoring 2025 |
| 12 | The provider must review the inclusion of one-day placement experience when considering a student’s total experience against benchmarks or clinical targets and introduce a process to ensure that such experience is at the same standard as that gained within the Dental Academy. | ‘Mentor Evenings’ take place on an annual basis and allow for opportunities for standardisation and calibration of outreach staff. The focus has historically been developmental for our outreach mentors, but an intentional shift towards assessment of students, expectations of outreach mentors and standardisation and calibration of mentors will feature heavily moving forward. The success of using pre-recorded student experiences as part of the calibration exercises will be further developed so that online resources can be delivered to external outreach supervisors and mentors to underpin and support the face to face Mentors Evenings. | Monitoring 2025 |

**Observations from the provider on content of report**

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| **The report has been compiled carefully considering the evidence provided and feedback from students, faculty staff, external examiners and placement providers.**  **Valid points have been raised and the panel’s understanding of current challenges faced across the UK, such as patient involvement in quality mechanisms is appreciated. The Dental Academy are keen to deliver the best possible patient and student experience and the positive validation for the majority of systems and processes in place at the Dental Academy is highly regarded and valued.** |

**Recommendations to the GDC**

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| **Education associates’ recommendation** | The BSc (Hons) in Dental Hygiene and Dental Therapy continues to be approved for holders to apply for registration as a dental hygienist and therapist with the General Dental Council. |
| **Date of next regular monitoring exercise** | October 2025 |

**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.

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. [↑](#footnote-ref-2)