General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Date(s)
Edinburgh Dental Institute, University of Edinburgh	BSc (Hons) Oral Health Sciences	29-30 January 2020

Outcome of Inspection	Recommended that the BSc (Hons) Oral Health Sciences continues to be approved for the graduating cohort to register as a dental hygienist and a dental therapist.

Full details of the inspection process can be found in the annex

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 and a dental therapist. **Risk based: focussed on Requirements:** **1, 4, 5, 7, 8, 10, 11, 12, 13, 14, 15, 17, 18, 20 and 21**
Learning Outcomes:	**Preparing for Practice (dental hygienist and dental therapist)**
Programme inspection date(s):	**29-30 January 2020**
Inspection team:	**Jane Jones - Chair and Non-registrant Member** **Shazad Malik - Dentist Member** **Sarah Balian - DCP Member** **Amy Mullins-Downes - Quality Assurance Manager** **Kathryn Counsell-Hubbard - Quality Assurance Manager**

The inspection undertaken at the Edinburgh Dental Institute (hereafter referred to as "the Institute") was risk-based focusing on specific areas of their BSc Oral Health Sciences programme ("the programme"). The GDC's Education and Quality Assurance (EQA) team and a panel of Education Associates (hereafter referred to as "the panel", "the team" or "associates") undertook an independent evaluation of information available to determine the content of the inspection. The information considered included annual monitoring returns, previous inspection reports (including progress against actions), responses to wider recommendations in the GDC Annual Review of Education, and Fitness to Practise data
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Following this assessment, we de, 11termined that the inspection panel would focus on Requirements 1, 4, 5, 7, 8, 10, 11, 14, 15, 17, 18, 20 and 21.

The purpose of this inspection was for the panel to assess whether this programme continues to meet the Requirements for the purposes of GDC registration as a dental hygienist and dental therapist.

Of the 21 Requirements, 14 were considered to be Met and 7 were considered to be Partly Met. The rationale for this is explained in the commentary under the respective Requirement. The inspection took place during the academic year and was carried out in line with the GDC's risk-based approach.

The education associates comprising the inspection received various documentary evidence in advance of the inspection and were able to review this prior to the inspection taking place.

The GDC made additional requests for further documentation which was subsequently provided in a timely manner.

The panel was impressed by the active leadership skills evident within the Institute, particularly with the effective changes made by Programme Director of Oral Health Sciences, to the delivery and quality of the programme. It was clear that the Programme Director works hard to ensure a cohesive team approach amongst all of the staff involved in the delivery of the learning outcomes, assessment and administration of the programme. However, whilst the improvements made to date were positive and well received by the staff and students, the continuity and maintenance of these improvements relies heavily on the Programme Director, and some further succession planning and resource is needed for this improvement to continue. The panel acknowledge that the students, overall, appeared motivated and happy in their studies and the teaching they receive.

The panel agreed that the curricula ensures good, thorough assessment of students across the learning outcomes contained within the GDC publication 'Preparing for Practice', however following the inspection, several actions and matters for consideration have been requested.

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

Background and overview of qualifcation

Annual intake	10 students
Programme duration	133 weeks over 4 academic years
Format of programme	**Year 1** • Basic knowledge • Clinical shadowing • Periodontal clinical skills course • Medical emergency training • Clinical inductions • Infection Control • Periodontal/prevention patient treatment clinics (semester 2) **Year 2** • Expand on knowledge gained in year 1 • Introduction to statistics/research methods • Restorative clinical skills course • Paediatric prevention treatment sessions (semester one) • Paediatric restorative treatment sessions (semester two) • Continuation of periodontal and prevention treatment clinics • Restorative patient treatment sessions in semester 2 • Paediatric General Anaesthesia Sessions **Year 3 (Junior Honours Year)** • Students are introduced to oral medicine, special care dentistry and clinical imaging • Continuation of patient clinical treatment sessions (whole mouth care) • New patient screening clinics • Paediatric general anaesthesia sessions • Oral Health Improvement Team and Public Dental Service observational visits • Opportunity for an Erasmus exchange (semester 2) **Year 4** • Students focus on a literature-based dissertation • Continue to develop clinical skills both within the Edinburgh Dental Institute and outreach placements • Seminars focusing on Preparation for Practice aspects

Outcome of relevant Requirements

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

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)*

There have been some changes to the structure of the curriculum since the last inspection (2013) and these include a periodontics programme for the first-year students. Improvements have been introduced that allow students to demonstrate their competencies and the timings around when learners do this is more student led. Prior to these changes there was a focus on being exam ready for the pre-Christmas examinations rather than being competent. Staff stated that this methodology allows them to identify where support is required, and this enables them to plan resources to provide additional support. Any areas of additional student support that are identified are discussed within the staff team regularly.

Additionally, the Institute was able to demonstrate that they provided bespoke training for students that had extenuating circumstances causing unavoidable absence.

There was positive feedback from students that they receive sufficient hours in the skills laboratory before beginning clinical work but also that the Institute would allow them to have more if they felt that this was required, and students indicated that they felt comfortable asking for this additional preparation. Nursing staff are very involved in preparing students before they start to attend clinic. The Periodontal Clinical Skills Handbook is very clear and explains expectations well.

The Institute was able to demonstrate that the pre-clinical process is clear and merges the NHS guidance and University competence of clinical skills well. The panel was satisfied to see NHS training for cross infection had been mapped to GDC Learning outcomes.

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)*

Clinical supervision levels are five students to one supervisor. When treating paediatric patients, this increases to five students to two supervisors. It was the panel's view that this ratio is appropriate, however the Institute did not provide a formalised rationale regarding the chosen ratios.

Supervision at outreach appears very good at present. The student will always have a dedicated dental nurse and as a result of the current small number of learners in the final year, the ratio is 1:1. A secondary centre is opening in Fife in line with previous years to accommodate an increase in student numbers.

Students wanting to complete a competency assessment whilst on clinic will require a supervisor dedicated to them to carry out the assessment. This means that only one student at a time can carry out a competency so that an appropriate level of supervision can be maintained for the other students. This has caused issues previously and as a result, the Institute is seeking to provide additional staff cover.

The Institute provides good opportunity for students to give continuity of care to patients. A system was developed based on student feedback and students are able to work on specific modules such as radiology or paediatrics for six weeks at a time and create and complete a whole treatment plan.

At the time of the inspection the panel was advised that the Institute was undertaking an audit in the restorative department (NHS Lothian) that was scrutinising various factors including supervisor ratios. The audit is being conducted over two academic years to ensure sufficient data is collected, with the first interim review being carried out in May 2020. The Institute reported that initial findings are showing that clinics are running well with appropriate supervisor cover. The audit is just taking place in the restorative clinic at present; however, the panel was advised that there are plans to extend this to paediatrics and outreach.

Going forward, it is recommended that the Institute introduces a specific policy around student/supervisor ratios. There is no policy in place that is specific to clinical cover and staff sickness or other absence. A specific policy that has a robust mechanism on ratios would benefit the Institute and provide a framework for ongoing succession planning activity as well as ensuring adequate cover when students require a competency assessment.

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

The panel was satisfied that all clinical teaching staff and supervisors hold the appropriate registration. Evidence was provided that all staff undertake training in Equality, Diversity and Inclusion and that this is part of the induction process. This is completed and recorded on the Institutes' 'LearnPro' system. The panel observed that newly recruited members of staff reported that they were satisfied with the induction process. The Institute use an induction handbook that is clear and provides good detail around the required levels of attainment that should be achieved in each year.

The panel recognised that at the time of inspection, there was no formalised induction process that has a specific focus on calibration. We recognised, however, that the Institute is taking steps to redress this and develop a process. Priority should be given to this and consideration of remote calibration should be given. However, staff do receive two inductions: aN Institute and a NHS induction to ensure that they are able to work within both settings.

At the time of the visit, the panel considered that gathering evidence on qualifications of outreach staff, e.g. training certificates and information on the sites themselves, needs to be a formalised and embedded into the usual outreach process.

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

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 Institute was able to demonstrate that they have appropriate systems in place designed to identify and record issues. The panel was shown the reporting and risk management system DATIX which is an NHS reporting system. The system is being used by the NHS Quality Improvement Group with relevant issues being reported from the group to the Institute . The Institute use DATIX alongside another system: iDentity. A prominent feature of iDentity is that it can be used to record student performance concerns. Alongside this, significant issues are recorded on a central NHS risk register and this is held by West Lothian Community Health and Care Partnership.

The Institute reported that there had been no significant patient safety incidents in the eighteen months prior to the inspection. For the last incident, DATIX was used to report the adverse event on clinic and a Significant Event Report was completed. At the time, the student's Personal Tutor met with the student to discuss the issue and support their learning. The Institute reported that reflective sessions are held with students and discussion takes place around learning and resolution. Reflective portfolio sessions are held on a monthly basis and these involve safety briefings and de-briefings.

Students reported that they were aware that they needed to raise concerns, should an issue arise. They were confident of where they should go to do so and appeared to understand what might amount to a concern.

The panel was not entirely assured that, despite these structures and the evidence provided prior to the inspection taking place, there was a robust system for recording learning following adverse events, and what procedures would be put in place to avoid a repetition of the issue. It is recommended that the Institute design and implement a system that tracks and evaluates negative events, records lessons learned from any adverse incident, and tracks improvement.

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

The Institute has undergone a significant number of changes, and they have now implemented a specific dental Fitness to Practise policy, as opposed to being previously reliant on a generic college level policy. However, this policy was only given to students two weeks prior to the inspection taking place. The Institute was able to demonstrate that they have a code of ethics, but it was unclear how much the students engaged with educating themselves around this and how much the Institute promotes it. The code of ethics was embedded into the programme two years ago, so the current Years 1 and 2 have had exposure since the start of the course, however the same could not be demonstrated in the two final year groups. The panel

discussed the introduction of the Code of Ethics with the students and they were very positive and encouraging of this as this change given that it was as a result of their feedback.

The Institute use a system called EUCLID to formally record concerns after being flagged on iDentity and the panel received a demonstration of the system. The system highlights and flags issues early so that action of a preventative approach can be taken and stop issues escalating. The Institute reported relatively low numbers of concerns that have been raised and these tended to be as a result of student absence. Where clinical concerns are raised, the Institute reviews these and focuses on any wider implications for patient safety.

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)*

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 Partly Met)*

The programme uses two quality management frameworks: the NHS framework that relates to operations and management, and the University framework that informs the various internal committee structures, including the Board of Examiners, Student Feedback Committee, Learning and Teaching Committee and Programme Directors Meeting. Whilst most of the structure is well-defined, the panel found that the terms of reference for the Programme Directors Meeting need improvement and clarity.

Whilst the Institute does not have a timetable for the committee meetings and each has its own schedule, it was able to clearly demonstrate the interdependencies of the committees and that the content of one influences another. They are embedded within the Trust and the University and this allows for external feedback and the sharing of good practice in an appropriate and prominent way.

Despite the numerous committees, there was no clear strategy in terms of succession planning. The panel was concerned that much relied upon the Programme Director. The panel consider that the lack of clear succession planning is a risk. There is a high workload across all the staff and an additional vulnerability is the lack of administrative support. The whole team work in an incredibly cohesive way and their determination and clear commitment is commendable. However, it was unclear how there would be continuation in terms of key staff absence.

The Student Handbook is updated annually and at present a hard copy is given to the student which will be removed in due course and the content and updates moved to the Learn System.

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)*

It was demonstrated that patient feedback is obtained at periodontics, restorative and outreach clinics. This feedback is gathered at programme level. There is a general comments box in patient waiting area, with comments being traceable back to individual students. The method of collection is questionable – the students themselves ask the patient if they are willing to give feedback and the patient then completes a feedback form and gives the completed form back to reception*.* This method may impact on patients who want to feedback negatively and who may not feel they can do so. The panel could not understand the rationale for the fixed times and very limited periods of collection of patient feedback.

It is recommended that the Institute improves the collection and use of patient feedback and could consider new ways of gathering the feedback. The creation of a Patient Liaison Group and becoming involved with the NHS Patient Experience Service are examples. The use of systems, such as GREATIX, within the NHS are positive, however the Institute must take steps to aggregate the feedback they collect and use it to inform continuous improvement.

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

The panel observed that documentation is in place to quality assure the student placements. These documents include essential measures such as a patient data, health and safety checklists and supervisor ratios. Placements are visited twice a year and these visits include a specific focus in patient numbers, feedback, patient demographics, actions from previous meetings and CPD.

When speaking to the placement supervisors, it was identified that communication between the placements and the Institute requires some improvement to ensure consistency and that when discussion is needed, better usage of technology is used to reduce a reliance on face to face meetings.

The Institute identified that clarity is necessary around expectations of students when they are on outreach placements. The panel was pleased to see that steps are being taken to address this.

Currently, the placement supervisors were not made aware of any pre-existing issues with students before their arrival on placement and the department view on this matter is that this was not necessary. The placement supervisors acting as accountable professionals, requested that relevant information to be disclosed, particularly if there is likely to be some impact on the placement. The Institute should consider seeking student consent and sharing this information where relevant.

In the last academic year there was 20% non-attendance at outreach placements. The Institute has recognised the significance of this and taken steps to address this by introducing

a low-level concern letter that is triggered and issued following two absences. They have also improved guidance around absence reporting with the outreach centres. It is recommended this guidance is written into the Student Fitness to Practise policy.

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)*

There has been significant progress since the last inspection. The panel was assured that the curricula, the teaching staff and clinical exposure would enable the students to gain a sufficient level of knowledge, experience and confidence to begin practice as a safe beginner.

The Institute was able to demonstrate that efforts had been made to map the curricula against the GDC learning outcomes and were continuing to map assessments across particular learning outcomes. The Deanery has had particular focus in recent years on learning outcomes and this is an area of continued development.

In terms of ensuring that sign up requirements are being met, this was previously not formalised but there now is a process and all students have an appropriately timed sign off meeting in March. This provides assurance that the requirements are being met and allows adequate time to remediate issues before the final summative exams take place in May. Feedback is given post assessment, and this is recorded at the Board of Examiner Meetings and communicated with all members of the Assessment Board.

The Institute has done a lot of work on the sign-up procedure and the panel recognised this positive progress.

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

The Institute reported that all students are encouraged to demonstrate their own competencies throughout the academic year when they feel ready, rather than do these at the end. Students are encouraged to reflect and identify areas where they require further support and discuss particular needs with their personal tutor. However, during the inspection, the panel was not sufficiently assured that the Institute's recording systems were recording student clinical experience to a degree that allows for effective and timely monitoring by personal tutors or the programme team.

Students must undertake Directly Observed Procedures (for example in the administration of local anaesthesia) which is is recorded on the Institutes' e-portfolio and iDentity. iDentity captures experiences for all clinical activity including clinical observations across all sites and is used to record the modular learning and this shows percentage scoring against work, commentary around items of note, absences, concerns and commendations. The students use

this system to record their reflective commentary which is then reviewed by the personal tutor and commented upon.

The Institute is using other methods as part of its teaching plans. Lectures can be uploaded onto an online teaching system, Learn, in advance of what is being taught and students are encouraged to view this. There are also both video and audio lectures stored on the system using MediaHopper.

The panel was informed by students of several instances where lectures were cancelled without adequate notice and whilst this teaching was generally rescheduled at a later date, the students found a lack of notice or prior contact frustrating. When questioned about this, the Institute advised that cancellation of classes is not a frequent occurrence and students are informed by email. The Institute uses an online timetable to plan lectures, and this is kept updated by the lecturers and administrative staff. We recommend that the Institute explores the option of providing more administrative support to the programme in order that planning and communication can be better facilitated.

Some students reported that there appeared to be an inconsistency in grading, technique and approach amongst the teaching staff, which can leave them feeling unsure of what is expected of them. We identified this as an area for improvement for the Institute and that calibration requires a formal process.

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

During the inspection, the numbers of each competency undertaken were unclear and further information was requested following the inspection taking place to gain clarity. Unfortunately, as a result of the impact of COVID-19 and the ensuing lockdown, there was an impact on what material could be provided which we accepted. The information that was provided appeared to show that some students had gaps in particular areas, namely Radiology Reporting and Amalgams. However, it was highlighted that there had been incidents where students had not recorded certain Oral Hygiene information correctly. The Institute stated that certain data relating to Radiology and Amalgams is recorded in student Restorative Handbooks. However, , at the time of this report being written and as a result of the COVID-19 restrictions was unavailable.

Following a review, the Institute has made changes to the current competencies in order to widen the criteria and ensure that students have patient access, but also to include the requisite experience in rubber dams. The Institute reported that they have made some changes to the monitoring and assessments of Paediatrics to remain in line with national guidelines. However, students still report, and the Institute concurs, that access to patients and especially Paediatric patients is problematic and affected by patient flow. Some students reported that at times, access to patients was so limited that assessments were completed by carrying out certain competencies on each other and, in some cases, staff themselves.

It is advised that the Institute take demonstrable steps to develop a paediatric database and source this particular patient group much earlier on in the programme. Furthermore, it is recommended that the Institute take steps that would improve the efficiency and strengthen the accuracy of their central recording systems in order to be able to report quickly and correctly, up to date information of the work being undertaken by learners.

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. *(Partly Met)*

The Institute gather feedback using a review and feedback form that is completed alongside marking. This is the standard approach taken across all year groups. Feedback from peers and the wider dental team is recorded on iDentity, and the Institute state that this is then used to feed into the student assessments. Patient feedback is gathered twice a year at the end of semesters one and two, within the outreach clinics. The Institute rely on informal feedback given by all patients but there is no formal structure around this. Whilst there are plans to move to more multi-source feedback, this has not happened yet.

Students are given feedback by their clinical tutor if receiving an unsatisfactory grade, and a specific conversation with the learner takes place around this. However, this does not happen if students are given positive grades.

There needs to be clearer rationale for why patient feedback is only collected at limited times during the year and a better demonstration as to what impact this feedback has in terms of continual improvement. Furthermore, the Institute could consider formalising its process for the clinical tutors giving students feedback and increase this to ensure that feedback is given whatever the mark the student is receiving.

The panel noted and the Institute acknowledged that more work is needed to create a formalised process for gathering multisource feedback

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 Partly Met)*

The Institute was able to demonstrate to the panel that feedback is recorded on the system iDentity. Feedback is additionally given verbally at every clinic and students are asked to record this as part of their reflective practice, although there was no formal framework around this practice.

The university has a policy of holding bi-annual formal meetings with students to review feedback and ensure that appropriate reflection is taking place. Although the student cohort is small, and they can approach personal tutors outside of these meetings, the panel were not assured that just two formal meetings per year would be enough to ensure that reflective practice is firmly embedded.

The panel had apprehensions about the reflective diaries and that these were not based on any models or principles of reflective practice, the result being that these were reports rather than true reflections on practice and learning . The panel recommends that they provide formal models for use in reflective diaries and at the final meeting one of the colleagues from the medical Institute offered to share a model developed within Edinburgh University.

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***)**

During the inspection, the panel had sight of the External Examiner reports and these were very complimentary of the assessment process and the standard setting. Feedback is well documented and is taken on board, with the External Examiner comments adopted during the assessment development process.

Communication with the External Examiners is good, and they give a verbal report during the board of Examiners meeting which is followed through. Feedback is cascaded down, with all outcomes and actions discussed and recorded at successive meetings. Further to that, the External Examiners submit an Annual Report to which the Programme Lead then formally responds on the subject of any recommendations and commendations.

The panel was assured that this Requirement was being fully 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 University Standards Setting Panel set the standards of the assessment criteria and set the scores for the programme. They then convert these to the University's pass grade as these are different. Some of the students found this confusing, although the exam mark conversion is explained in pages 64 and 65 of the Handbook and the Institute state that this is communicated regularly with the students. Transposing the programme grade to the common marking scheme is not uncommon and the grades are required to be matched to the University guidelines.

All assessments and dissertations are double marked to ensure fairness, and this allows calibration between new and experienced assessors. It was clear that all the standard assessment procedures for summative assessments are undertaken.

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
4	The Institute should design and introduce a policy that is specific to clinical cover and supervisor ratios that includes contingency planning around sickness and long-term absence cover.	We currently have an informal process to allow for clinical cover. With the move to hybrid teaching in 2020-21 this will allow staff to be more flexible for clinical cover. A formal policy will be devised to include supervisor rations and contingency planning.	Within 12 months
5	The Institute must continue to focus on the introduction of a formalised induction process that has a specific focus on calibration, with consideration given to remote calibration.	Steps are in place to continue with standardisation events within induction activity and for current staff.	Within 12 months
7	The Institute must take steps to plan and implement a system that tracks and evaluates negative events, records lessons learned from any adverse incidents and tracks improvement.	The DAXTIX and Significant Event Analysis reports are discussed at our monthly team meetings, the Institute will draft a clearer policy to link the chain events together.	Within 12 months
11	It is recommended that the Institute improves the collection and use of patient feedback and could consider new ways of gathering the feedback and take steps to aggregate the feedback that they collect and use this to inform continual improvement.	We will discuss this with the NHS Lothian patient experience team. Students usually treat the same patients for a course of treatment which can last 6 weeks. The reason for collecting patient feedback at the end of each semester is to avoid the same patients completing feedback every week.	Within 12 months
14	The Institute must improve recording systems for student clinical experience and gradings to a degree that allows for effective and timely monitoring by personal tutors or the programme team, and that improves the understanding of students of what is expected of them.	Verbal feedback is given to all students after any clinical skills or clinical procedure, a grade is then agreed with the supervisor and the student. The supervisor will not usually add any comments to the submissions as this is given verbally, this feedback can be added to their reflective log. If the student receives an unsatisfactory grade then the supervisor will add a written comment to the visit. This is to ensure that that personal tutors can give constructive feedback and	Within 12 months

		identify any remedial teaching, because of any repeated 'U' grades. The iDentity account is linked to the Personal Tutor, so they are able to monitor clinical performance and attendance. The students would like the staff to submit a written comment for all procedures but by asking the students to reflect on the appointment and add in the verbal feedback this is a way of assessing their professionalism. They are all made aware of this during the identity training in year 1. We will ensure this information is written into the student handbook rather than just the identity training manual.	
15	The Institute must take demonstrable steps to develop a paediatric database and source this particular patient group much earlier on in the programme. Furthermore, it is recommended that the Institute takes steps that would improve the efficiency and strengthen the accuracy of its central recording systems in order to be able to report quickly and correctly up to date information of the work being undertaken by learners.	This will be discussed with our paediatric teams in the Dental Institute.	Within 12 months
17	The Institute must progress and improve the method and frequency of which it collates patient and multisource feedback. A formal process should be established and implemented when personal tutors give students both positive and negative feedback.	Verbal feedback is given to all students after any clinical skills or clinical procedure, a grade is then agreed with the supervisor and the student. The supervisor will not usually add any comments to the submissions as this is given verbally, this feedback can be added to their reflective log. If the student receives an unsatisfactory grade then the supervisor will add a written comment to the visit. This is to ensure that that personal tutors can give constructive feedback and identify any remedial teaching, as a result of any	Within 12 months

		repeated 'U' grades. The iDentity account is linked to the Personal Tutor so they are able to monitor clinical performance and attendance.	
		The students would like the staff to submit a written comment for all procedures but by asking the students to reflect on the appointment and add in the verbal feedback this is a way of assessing their professionalism. They are all made aware of this during the identity training in year 1.	
		We will ensure this information is written into the student handbook rather than just the identity training manual.	
		Academic feedback is always given after each formative or summative assessment.	
		Plans are in place to gather formal multisource feedback (in addition to the daily clinical feedback) from clinical supervisors, dental nurse teams, patients, and academic staff. This additional feedback will be discussed at an annual clinical progression review meeting and with the students at their personal tutoring meetings.	
18	The Institute must consider formal models for use in reflective diaries that encourage true student reflection The Institute must also revise its policy that allows for just students to receive just two review sessions per academic year and increase these meetings to ensure that	The programme team agree that formal reflections models need to be identified. The team have now explored formal models of reflective practice through the UoE reflective toolkit. These models will be embedded into the reflective portfolio sessions and clinical reflections going forward.	Within 12 months

	reflective practice is firmly embedded within the students learning experience.	The University of Edinburgh has a personal tutoring policy which states that students must have two compulsory meetings per academic year with their personal tutor. Students are invited to ask for further meetings if required and personal tutors often meet with their tutees if there are any areas of concern. As clinical feedback is given on daily basis the two formal/compulsory meetings per year along with the group meetings (reflective portfolio and case based learning) and the feedback sessions with the dissertation supervisors seems to work well.	

Observations from the provider on content of report

The Institute would like to thank the GDC inspection panel for their positive report and feedback.

Recommendations to the GDC

Education associates' recommendation	The qualification continues to be approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council.
Date of next regular monitoring exercise	2022

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 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 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 annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The QA 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.