General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
Eastman Dental Hospital Education centre (EDHEC) awarded by London South Bank University (LSBU)	BSc Dental Therapy

Outcome of Inspection	Recommended that the BSc Dental Therapy is approved for the **graduating cohort only** to register as dental therapists with a re-inspection in 2024.

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

Inspection summary

Remit and purpose of inspection:	Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dental therapist.
Learning Outcomes:	Preparing for Practice- Dental Therapist
Programme inspection date:	4-5 July 2023 25h October 2023 (Remote)
Examination inspection date: **Exam Board date:** **Verification meeting:**	11 (On-site) and 12 (Remote) October 2023 29 November 2023 11 December 2023
Inspection team:	Amanda Orchard (Chair and non-registrant member) Joanne Brindley (DCP member) Beverley Bishop (Dentist member) Natalie Watson (GDC Education Quality Assurance Officer)
Report Produced by:	Natalie Watson (GDC Education Quality Assurance Officer)

Executive summary

An inspection was conducted in July 2023 of both the dental hygiene and therapy programmes undertaken at Eastman Dental Hospital Education Centre (EDHEC) awarded by London South Bank University (LSBU). The inspection was combined, however separate reports are published for each of the programmes.

The programmes were both new, therefore this inspection took place in the year of the first graduating cohort, to determine if full approval could be granted.

As part of the inspection, the panel undertook a 2-day on-site inspection, observed exams, conducted a remote follow up inspection and attended an exam board meeting. Following this meeting the panel also attended a final remote verification meeting.

The panel agreed that out of the 21 requirements, 8 were “Met” and 13 were “Partly Met”. EDHEC have been given 10 actions to address. Full approval was not agreed following this inspection and a re-inspection in 2024 will determine if full approval can be granted if the actions have been addressed. The current cohort was approved for graduation, as the panel were assured, they were at the level of a safe beginner.

The relationship between EDHEC and LSBU was good, however the panel are concerned that EDHEC are restricted by LSBU policies and this at times holds the programme back. This relationship would benefit from being strengthened and policies to be reviewed to enable EDHEC to work more effectively.

The staff at EDHEC are committed to improving the programme and work hard to support their students. Students spoke highly of programme staff and enjoyed their learning experience.

The panel identified some concerns within this programme which included:

- Lack of adherence to policies or timeframes outlined within policies
- Monitoring of clinical data and LO mapping
- Exam inconsistences
- Exam board arrangements and confirmation of student data
- SFtP investigations
- Experience of Amalgam restorations, pulpotomies and impressions

All concerns will be addressed in the actions outlined in this report and will be reviewed in 2024.

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

Background and overview of qualification

Annual intake	10 students
Programme duration	3 years
Format of programme	Year 1: **4 modules** Foundations in Clinical Skills and Practice Biomedical Science Oral and Dental Sciences Personal & Profession Practice 1 2: **3 modules** Applied Clinical Practice Dental Therapy Dental Specialities Personal & Profession Practice 2 3: **3 modules** Consolidated Clinical Practice Dental Therapy Research and Dissertation Personal & Profession Practice 3 Exit to Registration
Number of providers delivering the programme	2

Outcome of relevant Requirements[1]

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

The panel was provided with evidence of processes utilised by EDHEC to capture and monitor pre-clinical student activity.

Both hygiene and therapy students complete a Foundation in Clinical Skills and Practice (FCSP) Module. Therapy students also complete an Applied Clinical Practice Dental Therapy Module (ACPDT) in Year 2. This includes theoretical education and practical training in the simulated setting and is assessed using longitudinal formative assessments. A monitoring spreadsheet allows staff to identify those that are failing to meet the required standards early and put necessary support mechanisms in place.

The simulation practice-based learning record (PBLR) for the FCSP and ACPDT module includes pre-clinical Direct Observational Procedures (PC DOPS) as well as simulated clinical activities in the skills lab. All simulated PC DOPS require satisfactory completion to be successful in the assessment. Any aspects that have not been completed, or where a student has been unsuccessful, is repeated. Students are supervised at a ratio of 1:4 in skills labs.

Students also complete summative assessments at the end of the module which includes a Periodontal instrumentation exam, an Observed Structured Clinical Exam (OSCE) and a Restorative Practical Assessment. The module lead and the staff teaching within the module, monitor all students. The panel had sight of a terms of reference and meeting minutes for the Student Progress Committee. Students are RAG rated monthly, which reflects their progress on the programme. Students also attend monthly meetings with their personal tutor to discuss progress.

Students are also required to successfully complete all components of UCLH mandatory training and records of this is monitored centrally.

The panel had difficulties in interpreting the student data presented, due to the change from paper based to electronic monitoring. The panel did not have assurance at the initial inspection and have had to seek further clarification. The panel would encourage the EDH team to ensure that where there are mixed methods of recording, that there is a clear audit trail of student experience.

The panel consider this 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)*

Within the pre inspection documentation, the panel was provided with evidence that confirmed agreement and consent to treatment by a student takes place, across all clinical locations and that it is recorded appropriately.

There are opportunities for patients to consent and decline treatment with a student at EDHEC, both informally and formally.

Patients are referred and triaged by a consultant from the relevant departments this is then sent to the EDHEC staff team to ensure suitability and categorise for the appropriate clinical remit and suitability of student year level.. When a referral is accepted, and an appointment is made, patients receive an information leaflet informing them Eastman is a teaching hospital, and that their care may be provided by students under the supervision of qualified staff. This information is also included on the consent form.

At the first student appointment, the patient is given an information leaflet which highlights that their treatment is undertaken by students. Once signed, this form is inputted into the patient's electronic clinical record.

Where a patient requires interpretation for consent, the EDHEC utilise a 'Language Line' translation service which can also be accessed via an iPad.

During a tour of the clinical facilities, the panel had sight of the posters on display, informing patients that they may be treated by a student. Students also wear name badges, which highlight their student status.

For some formative assessments, students undertake clinical treatment on their peers. This includes treatment such as BPE scoring, bleeding scores, impressions, and local anaesthesia administration. Medical history and consent are gained appropriately for this activity. Students commented that this enabled them to practice their skills, as well as being able to empathise with a patient and what they may experience during treatment.

The panel consider this Requirement to be **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 patient care primarily at Eastman Dental Hospital (EDH) clinics as part of the ULCH Trust and undertake placements in community clinics. Students are inducted into clinical areas appropriately and are supported by EDH supervising staff at all locations.

EDH is governed by the UCLH Trust governance framework, which ensures a safe and appropriate environment for patient care, including staff and students. The dental division has local processes and policies to support this.

The Trust is registered with the Care Quality Commission and is compliant with their requirements.

All staff and students are expected to complete mandatory training, which ensures those working in the Trust follow the protocols. The panel were assured that the training completed provides a safe environment for students.

Students are expected to adhere to the Trust process for completing a WHO safe surgery checklist for irreversible clinical procedures.

The hospital has a dedicated security team, who manage entry and exit to the building. A senior nurse is dedicated to lead and manage each floor and ensures that the safety requirements are observed, by all those working in clinical areas. Students are supported by 1:1 or 1:2 dental nursing chairside support. Students are supervised on clinics at a ratio of 1:4.

The Health and Safety Committee addresses any issues relating to health and safety of patients treated within the hospital. Minutes of these meetings were provided to the panel.

Divisional clinical governance meetings are attended quarterly by all staff and students working clinically. Topics include patient safety, audits, consent, infection control, diversity training, Datix reports and training updates. Minutes of these meetings were also provided to the panel.

Students are invited to attend the Improvement Experience Group and present recommendations for making the hospital more accessible to groups of diverse patients. Themes of incidences are presented to staff via the Clinical Review Committee at termly staff meetings.

The Clinical Review Committee provides an opportunity to review Datix incident reports and for improvements in clinical service delivery and patient experience to be discussed.

The panel was assured that placement sites are assessed to make sure that they are compliant with the health and safety requirements of a learning and clinical environment. A placement link tutor undertakes practice placement risk assessments. Close relationships are maintained with the placement staff, student, and link tutor to identify issues and evidence good practice.

The panel consider this Requirement 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 Partly Met)***

As mentioned under Requirement 3, students are supervised at a ratio of 1:4. Staff leave is managed carefully to guarantee that appropriate numbers of supervisors are available to maintain the staff student ratio. Students advised that they felt suitably supervised on clinics.

Students are provided with nursing support both in EDH and community placements. When nursing support is not available, students will nurse for each other, or staff will step in to avoid patient cancellations. EDHEC have expressed the challenges with dental nurse support; however, there is a standard to ensure students always have access to a nurse, and that they do not normalise working alone. The Nursing Team plan rotas for clinics and this is confirmed two weeks prior to the clinics taking place. The Nursing Team are currently recruiting, to expand the pool of nurses within EDH.

When students have passed the FCSP module, their clinical sessions commence. EDHEC have introduced the 'Getting over your firsts' period and students have more support and time which offers a positive experience when they may be feeling anxious.

Students commented that they felt very supported.

Within community clinics, students are supervised by a member of staff from the Eastman education team.

The panel was made aware of an incident in which a student let a patient leave the clinic without being checked by a supervisor at EDH. This also happened on a further separate occasion. The student involved in this incident was subject to SFtP proceedings and it was managed appropriately by the programme team.

This was explored during our inspection visit. EDHEC staff advised the panel that this was remediated by introducing whiteboards in each dental bay to ensure a checklist is completed by students for each patient. Although the panel accepted this could ensure all stages to the process are undertaken, some personal information was visible to patients passing by and during our tour of the facilities, we did not see that check in and check out had been recorded. The whiteboards were utilised for documenting medical history and key stages in treatment. There were confidentiality concerns with this method.

Due to the concerns around the possibility of patients leaving without being checked by a supervisor and patient confidentiality issues the panel consider this Requirement to be **Partly 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)*

EDHEC advised that recruitment, induction and appraisal processes all contribute to ensuring that staff supervisors are appropriately qualified and trained.

UCLH completes a Trust induction day for staff and outlines the mandatory training required for completion, which includes training in equality and diversity. An induction to the Dental Education Centre is also mandatory. Adherence is confirmed in the appraisal process.

All staff supervisors are encouraged to hold a formal educational qualification. Any new staff who do not hold this qualification are supported to obtain this within three years of commencing their post. GDC registration and significant experience in clinical dentistry are essential requirements during recruitment and consideration of applicants.

Supervisors participate in peer reviews, which provides a method of evaluation and constructive feedback on teaching practice.

LSBU also offers a range of supervisor training opportunities.

Calibration exercises take place to support supervisors in preparing for assessments. This is an opportunity to grade individually and then review as a group and identify anomalies.

The panel consider that this Requirement is **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 Partly Met)*

There are good examples of policies and learning activities which allow staff and students the opportunity to raise concerns.

Staff and students are expected to be familiar with the Trust's policies on Raising Concerns, Whistleblowing, Duty of Candour and Safeguarding. These policies are accessible on the trust computers or can be found on a remote log in off site. The staff and student handbooks also outline the process to follow should a concern need to be raised.

LSBU also have a 'Speak up' policy which is available for staff and students to utilise if a matter cannot be dealt with in line with the Trust and EDHEC policies.

Raising Concerns and Duty of Candour are embedded into programme delivery and are introduced during an induction and repeated in each year group. The panel was however concerned that a summative assessment does not take place for raising concerns.

EDHEC develop students' reflection skills throughout the programme which allows for identification of responsibilities and concerns about their own health, behaviour and professional performance.

EDHEC have an open-door policy and students always have access to staff in an open plan office with closed safe spaces (if needed), should a student require immediate assistance. Students can contact personal tutors, year leads, module leads and programme directs at any time to discuss any arising matters.

The panel was provided with evidence of a concern being raised by a student and was dealt with appropriately. The panel noted the response time was not in line with the policy; however, this was delayed due to the Easter break and an initial attempt for the student to discuss with the peer before intervention took place. The panel would advise that policy timeframes are adhered to, or if unachievable, the policy should be reviewed.

During the inspection, staff, students, external examiners and outreach staff all confirmed they were aware of how to raise a concern or where to access the policy. Students were also aware of the Datix Incident reporting system utilised by EDHEC.

Staff were aware of the tiered reporting structure and explained the escalation process if they needed to raise a concern about the programme director. Students were also aware of the action to take if their first point of contact was not available.

Due to the lack of summative assessment for raising concerns and the policy timeframes not being adhered to, the panel consider this Requirement to be **Partly 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)***

Pre-inspection documentation outlined the process for patient safety incident reporting. These are collated centrally and reported via the Trust's Datix reporting system and then allocated to the appropriate team for management. Supervisors support students in completing these where required to ensure accuracy. The programme director is made aware of all Datix reports via an automated system. Patient safety clinical incidences that involve students are also reported to the Clinical Review Committee and personal tutor/year lead for action at the Student Progress Committee.

Patient complaints, both informal and formal, are manged as per the Trust protocols of which are managed by the Patient Advice and Liaisons Service (PALS).

Any concerns identified in clinic by a supervising tutor are graded as a cause for concern grade C. This is then discussed with the personal tutor, year lead and programme director. The student is offered an opportunity to reflect following the incident.

The LSBU Student Fitness to Practise (SFtP) process is followed if required and if an incident requires further escalation, EDHEC would inform the GDC.

The panel was provided with evidence of incidents being identified and managed.

The risk register was provided within the evidence.

The panel was assured that there are various opportunities for patient safety issues to be identified. Some uncertainty arose around a patient being able to leave without being checked by a supervisor. The panel did not see evidence that there is robust remediation in place to prevent this from reoccurring.

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

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

The panel had sight of the LBSU SFtP procedure and were assured the policy was in place.

Both staff and students confirmed they were aware of this process and where to find further information.

Students are introduced to SFtP in the induction to the programme and it is embedded throughout.

Students sign a declaration at the beginning of each year of study which informs the department of any development or changes which may affect their fitness to practice as a student. Students also contractually commit to their obligations and expectations required of them by attending a training programme, which has an end result of registering to a regulatory body.

The Student Progress Committee allows staff to identify students that require intervention.

EDHEC provided information of one student undergoing SFtP proceedings. The panel was concerned that the policy was not adhered to, in terms of providing a timely response to the student. The welfare of the student during this time was a concern; however, EDHEC advised the panel that there were various levels of support available, and that the individual was heavily supported by the personal tutor and year lead. The student did have access to LSBU student support services. The student was not removed from clinics during this time as it was risk assessed and staff felt it was not a risk to patient safety.

During the exam inspection, the panel was informed that there were two additional SFtP cases. Programme staff provided information regarding timelines for both cases and it was clear that LSBU processes delayed the investigations and again the timelines set out with the policy were not adhered to.

Due to the policy timeframes not being adhered to, the panel consider this Requirement to be **Partly Met.**

Standard 2 – Quality evaluation and review of the programme
The provider must have in place effective policy and procedures for the monitoring and review of the programme.

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

Within the pre-inspection documentation, EDHEC provided assurance that there is a clear framework in place to demonstrate how the quality of the programme is managed. EDHEC and LSBU work in partnership to deliver the programme and they maintain a positive relationship which allows for development of the programme. LSBU is responsible for the academic standards of awards made in its name and for ensuring the quality of learning experiences is appropriate, to enable students to achieve those standards.

The EDHEC team design, deliver and provide the academic and clinical training, whilst adhering to the quality assurance framework set out by LSBU. EDHEC also works within the UCLH Trust infrastructure.

Community care placements were introduced, and students attend once a week with a supervisor from EDH. As student numbers are small, the students have been able to have equal opportunities and access to patients. Supervisors grade students on CAFS as they are familiar with this platform due to use whilst supervising as part of EDHEC.

EDHEC have developed the programme as a result of feedback provided from staff, students and the external examiner. The relevant committees also provide assurance that there are various opportunities for the quality of the programme to be appropriately managed.

EDHEC provided blueprinting to the GDC learning outcomes. The panel noted there were some gaps and that some learning outcomes were not summatively assessed, as expected. Following an additional submission of mapping of the learning outcomes and review by the panel, there were some LOs that did not have a summative assessment and it was unclear how some aspects were summatively assessed within the programme. EAs were provided with data which outlined that although one example of a learning outcome was mapped to formative assessment on three occasions, this formative activity was a class based discussion and it was unclear how that would be achieved if a student was absent. The other two aspects of formative assessment for this outcome were clinical activity and did not provide assurance to the panel that students are able to translate their theoretical knowledge into practice at threshold level.

The panel consider this Requirement to be **Partly 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 panel was assured that the external examiner has various opportunities to identify concerns and that the issues raised are actioned in a timely manner.

There are a range of committees which are part of the quality assurance framework, of which issues and concerns can be identified and discussed. This includes:
- Clinical Review Committee
- Module Review Committee
- Assessment Board
- Student Progress Committee
- Staff Student Liaison Committee
- Operations Committee
- Annual Review Board

There are also two new committees being introduced which are:
- Audit and Risk committee
- Recruitment and Admissions Committee

The SSLC and student progress meetings provide an opportunity to discuss arising issues and address these, and students commented that they felt any concerns are actioned in a timely manner.

There was assurance that concerns are raised and discussed and actioned within these groups and committees.

Supervising staff grade students following clinical interactions and there is a mechanism to identify any areas where there is a cause for concern. There is a formalised process for managing students who are graded in this way. Although verbal feedback is provided at the time of the clinical session and students complete their self-assessment within 24 hours, the panel was concerned that supervisors are required to complete their online gradings within five days, and this was not considered contemporaneous. There was a concern that with a number of students to support, it may be difficult to provide accurate gradings and feedback. This highlighted that concerns may not be identified in a timely manner.

Community care placements are quality assured via the placement link tutor.

Although there are various measures in place internally, the panel was concerned that policies and timeframes have not been adhered to by EDHEC and LSBU. There were instances in which concerns had not been responded to or resolved in a timely manner and the timeframes outlined in policies were exceeded by months in some instances.

The panel therefore consider this requirement to be **Partly Met.**

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

EDHEC informed the panel that they manage the day-to-day monitoring of teaching and any changes to the learning content follow a structured process and approval from LSBU. The panel was provided with various documents which evidenced the internal quality assurance procedures.

There is an external examiner appointed who has been involved in shaping the programme. The panel had sight of a range of evidence that confirms that the external examiner has multiple opportunities to feed into and make suggestions for programme improvements. The external examiner provides a good level of support and has been integral to improving quality in the programme.

Students are encouraged to feedback to both programme staff and LSBU. There are various routes in which they can do so.

Staff also have the opportunity to feedback during one-to-one meetings or appraisals. The NHS staff survey also allows identification of the EDHEC staff team and is reviewed by the programme director and the senior management team.

The panel was assured that changes had been made because of staff and student feedback.

Patients are asked to provide feedback at the end of a treatment session, which is anonymous and individualised for each student. Within a particular assessment, students are asked to consider how feedback has led to their quality improvement practices.

Feedback from the range of sources is relayed back to the wider UCLH Trust and Improvement Experience Group.

During the exam inspection visit, the panel had sight of the external examiner observing the exams remotely. They were also in attendance at the examiner briefing and provided feedback following the exams.

Moderators were present and completed proformas to record their feedback. The panel had sight of these following our visit. Although the internal and external QA took place, there was concerns that the forms were not consistently completed and that some elements of the document were not completed.

The panel was assured that feedback is collected following exams from examiners, moderators, the external examiner and students and will be used to develop the assessment for the future cohorts.

The panel noted that an additional External examiner would be beneficial to the programme. This would ensure that there are contingency arrangements should the appointed external examiner not be available and allow for more in depth review of the programme.

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

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

EDHEC utilises community care placements for Therapy students who are supervised by EDHEC staff. Any placement utilised is appropriately risk assessed and an induction for students is conducted in that environment. The quality assurance and monitoring of these placements is led by the placement link tutor.

Whilst at the community care placement, students are supported and have access to a supervisor from EDH. The students have an opportunity to provide feedback regarding their placement via their supervisor or the link tutor.

Community care placement supervisors provide feedback and grade students in alignment with EDHEC processes and record this on CAFS.

Students have access to The Eastman Dental Hospital where they have opportunities to gain a wide range of experience. This includes:
- Special care clinics
- Oral medicine clinics
- Inter-professional learning periodontal clinic
- Inter-professional learning paediatric clinic
- Radiography
- Treatment planning clinic- Restorative 1
- Staff treatment planning clinic
- Treatment planning clinic- periodontist 2
- Paediatric New patient assessment

Student feedback regarding these placements is gained through the EDHEC student evaluation. The panel had sight of the feedback report produced.

Supporting staff provide verbal and written feedback following completion of treatment.

EDHEC have a Staff Student Liaison Committee (SSLC) which enables students to feedback each month. Students felt that they are listened to and that actions are followed up where possible in a timely manner.

Patients feedback is collected which allows the anonymous feedback to be linked to the student treating the patient. Feedback is recorded on the CAFS recording system and is linked to a clinical session. Students feedback in released in bulk periodically, to ensure the feedback is anonymous and cannot be identified as being a particular patient.

The University College London Hospital (UCLH) Trust has strong relationships with patient groups to gain feedback which feeds into the Improvement Experience Group.

The panel consider this Requirement to be **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 Partly Met)*

The summative assessment mapping document provided to the panel, did not map all learning outcomes to assessment. The panel requested additional mapping, and this was reviewed in

October. There are some areas not summatively assessed in the programme which was of concern to the panel.

Student progress meetings provide the opportunity to discuss progress on the programme. Students are RAG rated to identify the progress made and this is also discussed during personal tutor meetings if necessary.

EDHEC utilised paper-based portfolios but have recently introduced the CAFS monitoring system. As cohorts were small, the team advised it was manageable during the data transfer. Audits were conducted to ensure the data transfer was successful.

The modular structure of this programme ensures that students are successful in all aspects of the summative assessments of the module. Upon completion of all examinations, results are moderated and taken through the LSBU Examination Boards which ensure students have met the standards required within that year. Students who have not been successful are not able to progress into the following year.

The programme does not have a sign-up process into final assessments, due to its modular structure. To ensure students have met the requirements and learning outcomes, there is an Exit to Registration module. All modules are presented to the LSBU examination board.

A further verification meeting took place following Eastman programme staff raising concerns with LSBU regarding the exam board meeting. This verification meeting assured the panel that accurate student data was discussed, and overall outcomes were agreed.

The student clinical data provided to the panel, highlighted that there are some areas that were not captured within the breakdown reports. The panel was concerned with the students' clinical experience, specifically in relation to amalgam restorations, impressions and pulpotomies. Following a follow up inspection meeting, the panel was assured that students will have experience in these areas, although it is simulated and not necessarily summatively assessed. The panel would recommend that this is reviewed for future cohorts.

The panel consider this Requirement to be **Partly 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 Partly Met)*

EDHEC advised that assessments of students are carefully planned, monitored and centrally recorded across the Student Progress Committee, Assessment Board and LSBU systems.

Each student is monitored across 4 domains, which include:
- Conduct
- Academic
- Clinical
- Other

Each of the domains are RAG rated each month. These are made available to students monthly. The Student Progress Committee may suggest actions as a result of these ratings. Both staff and students confirmed during the inspection that this process is adhered to and useful to their progress.

Students' clinical experience is monitored monthly and is benchmarked against minimum expected clinical experience targets and across the cohort. DOPs are also monitored in line

with the domain criteria. Averages are shared and any concerns are escalated where appropriate.

PBLR reviews take place at the end of every term, and there are an additional step in monitoring each student and their progression.

Personal tutor meetings enable staff to monitor students' progress regularly and provide adequate support where required.

In March 2023, EDHEC purchased the Clinical Assessment Feedback System (CAFS), which has improved student monitoring.

During the remote inspection follow up meeting in October, the panel was introduced to CAFS and were able to see how clinical experience is captured and reported. CAFS has certainly improved the monitoring of clinical data for EDHEC; however, it was unclear why the reports do not capture the information that is being collected on the system. Specifically, the restoration type and tooth surface are not identifiable in the reported data. However, these are logged by students into the system, and it can be reviewed.

Due to this, it was difficult for the panel to assess the clinical experience data presented. The CAFS demo provided the assurance that the data is there; however, the panel would encourage EDHEC to review the reporting ability with CAFS.

We therefore consider this Requirement to be **Partly 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 Partly Met)***

Patients are referred from dental services within EDH and the internal staff self-referral service. Patients are triaged by the EDHEC staff team and are logged on a central system and categorised for the dental hygiene students which identifies the required treatment.

Students have access to a range of experience as they rotate around the different dental specialties within EDH. There is a system which the staff use to book students on each rotation equitably. Students also have access to patients at a primary care placement practice.

Students are required to pass all DOPs within a year, to progress into the following year.

The panel was concerned that the DOPs do not identify the complexity of the treatment completed, although, EDHEC staff advised this can be found on the CAFS system, and this was viewed by the panel during the demonstration in October. It was unclear what the process is if the DOPs are not achieved by a student and where a re-attempt is recorded. This was explored in an additional inspection meeting and it is clear that the CAFS system allows for improved recording of this.

The students are required to manage their own patient appointments. Although there is a benefit to ensuring these individuals are equipped for real world settings, the panel were concerned with the level of autonomy students have. Students stated that they manage their own patient base to meet their clinical need however, It was not clear if students are able to repeatedly select patients that do not challenge their skills in relation to complexity of treatment, tooth location or tooth surface. Staff informed the panel that the suitability of cases is decided by staff and is allocated in line with the student level and therefore to meet this

requirement it would be recommended that the students clinical data is reflective of the complexity of the treatment completed.

Students log their clinical sessions on CAFS which is signed off by the supervisor.

The panel was concerned with the clinical experience data during the inspection. EDHEC advised the panel that students will have opportunities to achieve this, and will be offered additional sessions throughout the summer, which will be suitably supported by staff. During the visit in October, the panel was presented with updated student clinical experience data. This had improved and there was a second opportunity for increasing experience by November, prior to the exam board. This was reviewed by the panel and assurance was provided that the clinical experience data was appropriate. There were concerns that the reporting of clinical data was difficult to interpret and should be reviewed by the EDH team.

EDHEC advised that student progress is tracked throughout the programme. The panel were assured that there are various opportunities to review student progress.

The panel consider this Requirement to be **Partly 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 Partly Met)*

The panel was provided with evidence of the summative assessment process within the evidence. There is a good range of assessment methodology utilised throughout the course.

EDHEC runs both academic and clinical assessments. Simulated assessments only occur for the FCSP module which is the first gateway to clinic. Each assessment undergoes a review following implementation and completion. Internal staff, the external examiner and students are involved in this process.

Post exam analysis is reviewed by the assessment board which includes feedback from a range of sources. EDHEC follows the LSBU Assessment and Examination procedures. Programme staff review assessments and if students do not achieve the expected score level, the question is reviewed, and appropriate action is taken.

During the inspection, the panel had sight of summative assessment data. There were concerns around the number of students failed attempts. As well as this, the learning outcomes not mapped to summative assessments, did not provide initial assurance that all learning outcomes are assessed and the panel was unable to determine if they are appropriate. The panel reviewed this in October and was assured that students were at the level of a safe beginner however some learning outcomes remained unmapped and would encourage this to be reviewed.

The Panel also reviewed student portfolios and it was not clear if the DOPs that were not passed were reattempted. This was explored further at a follow up inspection visit and this was explained to the panel. The CAFS system now allows for improved data collection in relation to reattempts.

The panel was provided with evidence of internal moderation and external examiner feedback which was responded to by the module lead.

During the exam inspection in October, the panel observed all of the seen case exams and a sample of the unseen case exams. The panel had sight of various evidence which included:

- Examiner briefings
- Examiner marking rubric/assessment questions
- Unseen/seen cases
- Internal Moderator proforma's
- External examiner feedback

The calibration that took place between the examiners was fair and gradings were thoroughly discussed.

Moderators were present and completed proformas to record their feedback. The panel had sight of a sample of these following our visit. Although the internal and external QA took place, there was concerns that the forms were not consistently completed and that some areas had been missed.

The panel noted that there were some inconsistencies across the exams which included:

- Students being given an opportunity to answer additional questions at the end of the allotted time
- Students leaving earlier than the allotted time
- Technical difficulties in recorded grades on Moodle platform
- Incorrect candidate numbers

During the inspection follow up meeting in October, The EDHEC had reflected on the exams. It was clear that the marking rubric which is provided by LSBU was challenging and an agreement has now been made to adapt this so that it is more appropriate to a clinical programme.

The panel was in attendance at the exam board in November, as mentioned under Requirement 13, there were concerns that student data was not finalised prior to the Exam Board meeting taking place and the panel did not observe final decisions being made in relation to student outcomes. Eastman staff had to raise this with LSBU for a further verification meeting to take place. This meeting did provide assurance to the panel.

EDH have subsequently raised their own concerns with LSBU in relation to the management of the Exam Board meeting and have assured that panel that the intention to improve the organisation of this meeting for further cohorts.

The panel consider this Requirement to be **Partly 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)*

Prior to the inspection, the panel was provided with a range of evidence which confirmed that feedback is collected and considered at the Assessment Board and evaluated by the programme team.

EDHEC collect feedback from various sources which includes:

- Patient feedback
- Student feedback
- External examiner feedback
- Peer feedback

The panel had sight of evidence which confirmed that all sources of feedback are recorded and considered.

EDHEC have a student focus group and members are seen as extended members of staff and contribute to improving working relationships with students. Any requests or suggestions are raised in the group are discussed with other students and bought back to the group for discussion.

Students feedback on all assessments undertaken is reviewed by the programme team before discussion and assessment design decisions are made. There is also a SSLC which allows for further feedback opportunities.

The panel consider this Requirement to be **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)***

Prior to and during the inspection, the panel were assured that students are provided with regular feedback and encouraged reflection to improve their practice.

Reflection is presented early in the programme and reinforced throughout. The panel had sight of student portfolios during the inspection and reflection was documented.

The Personal and Professional Practice module is embedded across all years of the programme and includes reflective components.

EDHEC utilise a wheel of reflection where students complete and conduct a thorough reflection as they progress through the programme. This creates an opportunity to identify areas for personal growth and improvements in clinical performance.

Staff have attended a session on feedback/feedforward as well as the majority of staff having completed the Foundations In coaching Programmes offered by UCLH Trust.

Students are expected to reflect and self-assess after each clinical appointment. Students self-assess themselves in five domains of practice, which includes:
- Clinical skills
- Communication
- Professionalism
- Management and leadership
- Overall knowledge

Staff review this and provide feedback and grades across the same domain areas at every clinical session.

Each student is assigned a personal tutor who supports the students' progress and development.

During the inspection, students advised the panel that they felt they had adequate access to personal tutors, module leads and other staff involved in the programme. They felt that they were comfortable to contact staff via email or in person, outside of the planned meetings. Students were aware of how they were progressing and explained a RAG rating system which is discussed monthly in relation to progress.

The panel consider this Requirement to be **Met.**

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

EDHEC informed the panel that staff participation in marking assessments is only permitted when the staff member has had experience in an observatory or moderating role within their first assessment and is also supported by an established member of staff.

Recruitment of staff is structured and the person specification ensures that the appropriate skill mix is considered whilst also confirming suitable registration. Staff are inducted and complete the mandatory equality and diversity training. Appraisals ensure that staff are compliant with all training requirements.

Prior to assessments being undertaken by a staff member, those involved participate in a calibration exercise. The panel had sight of evidence which confirmed that this activity had taken place and that it was reviewed by the team. There is an opportunity to record assessments which can be reviewed by staff that miss calibration exercises and this provides an opportunity to conduct marking and calibration. The panel was assured any discrepancies in marking would be highlighted prior to assessments taking place.

All summative assessments follow LSBUs Examinations and Assessments policy of which is stated in the operations handbook which staff have access to.

The department offers in house training to new staff and updates to established staff in equality and diversity. LSBU and other stakeholders also provide training opportunities for staff to attend.

During the inspection, the panel spoke with the external examiner and community care placement staff who confirmed that they held current equality and diversity training.

The panel was concerned that the inconsistencies identified in the exam as stated under Requirement 16, were not recognised by the EDHEC team during the follow up inspection meeting.

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

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

EDHEC have one external examiner appointed to the role who maintains a good relationship with the staff and programme. The external examiner is provided with a handbook which outlines the role and responsibilities. External examiner training is also completed which emphasises the expectations.

The panel was provided evidence which confirmed that the external examiner had provided feedback both prior to and following assessments and that recommendations had been made for programme developments.

The external examiner produces annual reports which are scrutinised by senior programme staff and LSBU.

When speaking with the external examiner, it was clear they felt there were adequate opportunities to feedback and recommend areas for development within the programme. The external examiner advised the panel that feedback is acted upon in a timely manner.

The external examiner was aware of the raising concerns process and has utilised this previously.

The panel consider this Requirement to be **Met;** however, would like to recommend that consideration is made to increase the number of external examiners as mentioned under Requirement 11.

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

EDHEC programme staff have mapped assessments to learning outcomes across modules and the course as a whole. There are, however, some learning outcomes that are not assessed summatively.

The student handbook outlines the standard expected of students and provides assessment information.

The assessment question bank is in its infancy and growing. However, the panel was advised that when the questions are entered into the bank, they are standard set using the EBEL method. The panel was provided with evidence of this. When a student completes an assessment, the questions are reviewed. If there is a high fail rate amongst the cohort for particular questions, they will be highlighted and revised to ensure the assessment is valid. The bank of questions spreadsheet enables programme staff to identify how many easy, moderate or difficult questions are in the bank. EDHEC utilised the Moodle platform; however, this did not allow changes to be easily identifiable. The introduction of the Maxinity software will allow staff to review any changes made going forward.

Students have two opportunities to pass an assessment. If they fail the first attempt, they will be supported to prepare for the second attempt. If they fail at that stage, this will be discussed at the relevant Board. If the student is permitted to return, they may resit a module or a year. They are required to repeat the learning and will then be offered two attempts. This is in line with the LSBU assessment regulations.

During the Exam inspection, the inconsistences did not provide assurance to the panel that the assessment is undertaken fairly.

The panel did agree that the assessment is undertaken against clear criteria and students are aware of what is expected, however improvements can be made to ensure the assessments are fair and consistent.

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

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
4,7	The provider must develop a formal process to ensure there is no possibility of a patient leaving without being reviewed by a supervisor.	Within the three years of the programme, two incidents occurred in 2022 and Feb 2023, since then actions have been put in place: 1. After-Action-Reviews - and taking the students into a journey of understanding the reasons why patients needs to be checked out 2. Pre-clinical simulation activities/ role simulating checking in and checking out which includes staff lead and near peer teaching with senior cohorts. 3. Whiteboards are used to ensure that the student reminded 4. When these incidences occurred, the staff team did take action to ensure patient safety; patients were called by staff or asked to return immediately after the appointment. Laminated reminder ‘check out’signs have been put in each bay The whiteboards are a Trust wide process for clinicians who undertake the WHO checklist (however we adopted it for all students). The whiteboards and electronic patient records act as a reminder to the team supporting the patient. Information included on the whiteboards are: 1.) Student initials	Implemented

		2.) Nurse initials 3.) Patient 1 or patient 2 4.) Key medical history (and meds) – in case of medical emergency. 5.) Tx planned to be undertaken 6.) Check in 7.) Check out This is approved by our Health & Safety Governance team. Treatments are delivered in closed door bays (not open clinics) and the doors are frosted just under eye height level. There is not the opportunity of patients standing within the corridor due to the limited space and are escorted to reception by either the student or nurse to arrange the next appointments. No incidents have occurred since February 2023. Should this incident occur again, EDHEC will continue to be proactive in resolving any issues arising.	
6	The provider must adhere to policy timelines in relation to responding to concerns and ensure that raising concerns is summatively assessed in the programme.	EDHEC are keen to assure the panel that it is a priority to comply within policy timelines and on the occasion identified, the issue was addressed, the delay was due to the holiday period. Although no further concerns have been raised, EDHEC will ensure compliance of meeting all policy timelines. Raising concerns is delivered: 1. Didactically Year 1 with classroom activities 2. Formative assessment - Problem based learning in Year 2	Next inspection date To be confirmed following GDC response on position of all learning outcomes

		3. Formative assessment - Enquiry based learning Year 3 Both Year 2 and Year 3 require a written submission and class discussion and explore this subject several times in the same year. The complexity of formative assessments within the subject of raising concerns, within both year 2 and year 3, underscores the nuanced nature of gauging student understanding and skill development in this critical area. These activities embrace humanistic and challenging situations throughout the assessment process providing a richer scope for evaluation, recognising that ongoing engagement and reflection offer far more insight than a singular summative assessment. Raising concerns cannot be seen as a single process driven-issue but best explored by discussing and challenging all the facets that are associated with it. Raising concerns was mapped with in the formative assessment of Annex 2. When evaluating performance and achievement of learning outcomes, it is essential to adopt a global perspective that considers both formative and summative activities. While formative assessments provide ongoing feedback and opportunities for improvement throughout the learning process, summative assessments offer a comprehensive snapshot of overall attainment. By integrating both types of assessments, educators can gain a holistic understanding of student progress, ensuring a more accurate and meaningful evaluation of learning outcomes.	being assessed summatively.

		EDHEC plan to change one of the summative assessments in the Personal and Professional Practice 2 module to incorporate a summative assessment raising concerns/complaints handling The module lead is currently working on the assessment brief. . The final form of assessment has yet to be decided. Due to this needing to have module change approval from LSBU, we hope to implement this for the September 23 group of students	
8	The provider must review SFtP response timeframes and determine if they are achievable. The timeframes must be adhered to when utilising the process.	In view of the challenges encountered following a discussion with LSBU Fitness to Practice the following action has now been initiated to manage these cases in a timely manner: • Introduced a step prior to a referral being made to FtP • Called the 'Student Concern Pathway' • If the actions agreed within this pathway are not met by the student then the SFtP would be triggered LSBU Fitness to Practice process now also includes a triage stage from the point of referral to FtP that aligns with EDHEC's Student Concern Pathway. In this stage the referral will be considered and if appropriate, the student may be put on a remedial action plan for a period of time. Students who are not successful in completing the action plan will be referred to the FtP team for allocation to a local manager for investigation.	Ongoing – when next case arises

		The FtP process applies to all students in Health & Social care and timelines over the past year were protracted as a consequence of the reorganisation of the professional service groups, including SFtP. FtP now sits within the LSBU Student Affairs team which comprises additional staff who are now able to process FtP referrals more quickly. The overall timeframe for completion of the whole process is influenced by the complexity of the case and the investigation process. LSBU review all policies and processes on an annual basis and any changes are taken through Quality and Standards committee and ultimately Academic Board for implementation in the following year.	
9,14,16,21	The provider must ensure that appropriate formative and summative assessments are undertaken and suitably mapped to the GDC Los and that reports are available via CAFS to monitor student progress.	The six learning outcomes that were identified of not being summatively assessed are included in repeated formative assessments which were mapped in the Annex 2 document. The learning outcomes in question were assessed between a range of 4 – 10 occasions within the training programme. See above comment re change to summative assessment in PPP2 module EDHEC will continue to work with the CAFS team to improve the functionality and data presentation of the software.	Summer 2024 and ongoing.
10	The provider must ensure that response to concerns is timely and in line with EDHEC and LSBU processes.	EDHEC are keen to assure the panel that it is a priority to comply within policy timelines and on the occasion identified, the issue was addressed, the delay was due to a holiday period. Although no further concerns have been raised, EDHEC will ensure compliance of meeting policy timelines. We have now following our	

		investigation established the reasons for the delays, EDHEC have worked closed with LSBU and both parties have recognised the need to ensure timely responses. To this end we have now implemented the following: LSBU Fitness to Practice process now also includes a triage stage from the point of referral to FtP that aligns with EDHEC's Student Concern Pathway. In this stage the referral will be considered and if appropriate, the student may be put on a remedial action plan for a period of time. Students who are not successful in completing the action plan will be referred to the FtP team for allocation to a local manager for investigation. The FtP process applies to all students in Health & Social care and timelines over the past year were protracted as a consequence of the reorganisation of the professional service groups, including SFtP. FtP now sits within the LSBU Student Affairs team which comprises additional staff who are now able to process FtP referrals more quickly. The overall timeframe for completion of the whole process is influenced by the complexity of the case and the investigation process. LSBU review all policies and processes on an annual basis and any changes are taken through Quality and Standards committee and ultimately Academic Board for implementation in the following year.	
11, 20	The provider should consider reviewing the internal moderation form with moderators to ensure appropriate completion.	The items noted by the panel, were identified during the examination process through the moderator reports. They will be used to frame and improve process for the	Summer 2024

	The provider should also consider appointing an additional external examiner.	next diet of assessments. EDHEC are happy to provide these reports as evidence, should it be required. EDHEC will review the moderator reports to ensure they serve their purpose and improve the standard of examinations.	
13,15	The provider must develop the reporting process from CAFS to ensure further detail is captured in student clinical data reports. The provider should review summative assessments for: -Amalgam fillings -Pulpotomies -Impressions -Raising concerns	The development and increasing functionality within CAFS is and will be an ongoing process. Amalgams, pulpotomies and impressions are included as part of a longitudinal assessment within the FCSP and ACPDT module, which is a summative requirement. For amalgam and pulpotomies, EDHEC is mindful, that these experiences will be limited in clinical practice due to alternative evidence-based treatment modalities and phasing out of amalgam. As such, students are presented with several simulation sessions in Year 3 which present various complexities of these procedures, although not categorised as a summative assessment, they are required to complete the portfolio successfully. When undertaking a review of assessments, EDHEC will consider if these should be adopted as summative. Raising concern has been responded to in requirement 6. EDHEC are exploring options for both dental hygiene and dental therapy groups to increase their experience of impression beyond undertaking peer activities.	Summer 2024 New academic year 2024.
15	The provider must implement a consistent approach to gaining clinical experience to	EHDEC would like to assure the panel that students do not have the autonomy to select their own patients. The staff manage all patients referred to EDHEC, where	Already implemented.

	ensure a broad range of experience which is complex and challenging to the student.	they are logged on; appropriate for year groups, clinical needs and complexity of treatment. Patients are allocated to students upon request or within the PBLR review. It is the responsibility of the staff team to monitor patient progression (as well as students) as they are receiving shared care with our speciality colleagues. EDHEC also has responsibility towards patient service and meeting Trust requirements on patient flows.	
16	EDHEC must work with LSBU to review marking rubrics which are appropriate to the programme and also improve preparation and management of exam board meetings.	LSBU has agreed that EDHEC can develop new marking rubrics which are more accessible and appropriate for students and staff on a clinical programme. Staff training took place in January 2024. Staff will continue to work on these, and pass through the necessary committees. EDHEC/LSBU are mindful that changes of rubrics need to be informed to students, the current summative assessments guidance and rubrics (May 2024) have been uploaded into Moodle (VLE) and students have been working towards the currently active rubrics. To adopt these changes a realistic timeline of implementation is the next academic year of September 2024, which would also allow time for testing of the new rubrics. EDHEC escalated their concerns immediately after the Exam Board meeting to the GDC and LSBU. An after-action review of the incident has identified areas which were escalated by the EDHEC team to both the GDC team and LSBU. Since this time, LSBU has proactively put in place the following mechanisms:	New academic year 2024 Implemented

		• Communication with the examination administrative team thus widening the pool of administrative support • A pre-subject area board (pSAB) and Award and Progression Board (APB) meeting takes place (when) which allows for any issues, inaccuracies and anomalies to be noted early so that they can be rectified before the formal SAB/ARB meetings • LSBU explained due to a restructure of their Professional Services Group, communication and processes were challenged and this was experienced for an acute period.	
19 and 21	The provider must ensure that exam inconsistencies are mitigated and if they do occur, are appropriately discussed at the Examination Board meeting. The provider must make improvements to improve fairness and consistency across exams.	EDHEC and LSBU will work together to ensure that reporting of any issues arising are presented appropriately in the Exam Board meeting.	Summer 2024

Observations from the provider on content of report

See response to actions above.

Recommendations to the GDC

Education associates' recommendation	Recommended that the BSc Dental Therapy is approved for the graduating cohort only to register as dental therapists.
Date of next QA activity	Re-Inspection 2024

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.