

## Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Date
Queen Mary University of London	Bachelor of Dental Surgery (BDS)	23 May 2019

Outcome of Inspection	Recommended that the BDS continues to be sufficient for the graduating cohort to register as dentist.
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**\*Full details of the inspection process can be found in the annex\***

## Inspection summary

<b>Remit and purpose of inspection:</b>	<p>Inspection referencing the <i>Standards for Education</i> to determine approval of the award for the purpose of registration with the GDC as a dentist.</p> <p><b>Risk based: focused on Requirements 4, 6, 9, 11, 12, 13, 14, 15, 17 and 19</b></p>
<b>Learning Outcomes:</b>	<i>Preparing for Practice (Dentist)</i>
<b>Programme inspection date:</b>	23 May 2019
<b>Inspection team:</b>	<p><b>Amanda Wells (Chair and Non-registrant Member)</b>  <b>Jo-Anne Taylor (Dentist Member)</b>  <b>Timothy O'Brien (Dentist Member)</b></p> <p><b>Martin McElvanna (GDC Education &amp; Quality Assurance Officer)</b>  <b>Krutika Patel (GDC Quality Assurance Officer)</b>  <b>Hermione Brown (GDC Quality Assurance Manager)</b></p>

The BDS inspection undertaken at Queen Mary University of London (QMUL) was a risk-based inspection looking at specific areas of focus identified by the GDC's Education & Quality Assurance team in 2018. Information considered when identifying potential or actual risks included annual monitoring returns, previous inspection reports (and progress against any actions) and responses to wider recommendations in the GDC Annual Review of Education.

The inspection focused on Requirements 4, 6, 9, 11, 12, 13, 14, 15, 17 and 19 and some additional specific areas within those Requirements which are detailed below. Of these, five are considered to be met and five are partly met. The rationale for this is explained in the commentary under the Respective requirement.

The education associates comprising the inspection panel were grateful for the documentation received in advance of the inspection. Having reviewed this, the panel sought further documents and a supplementary set was provided. Requests for additional information during the inspection were provided quickly. Following the inspection, we had further questions around the student sign-up process and we received a timely and comprehensive response to these.

The panel was impressed by the dedication of senior staff involved in the delivery of the learning outcomes, assessment and administration of the programme. We were pleased to have met the Institute of Dentistry's (Institute) new permanent Dean who has been in post since January 2019 following an extended period of interim appointments. We met students

who were enthusiastic and positive about both the BDS programme and the relationship with staff involved in its delivery.

The team acknowledge that since the last GDC inspection in 2013 and 2014, the Institute has been through a period of significant change and experienced major challenges, particularly at one outreach centre. We recognised multiple areas of good practice and initiatives that have been developed. However, we noted some areas where improvements should be made. Most notably, the quality assurance of outreach placements, the gathering and use of patient feedback and the monitoring of students' clinical experience in final year. As a result, several recommendations have been made which are listed in the Summary of Action under page 20. We will monitor progress against these during the next GDC Annual Monitoring exercise in 2020.

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

## Background and overview of qualification

Annual intake	72 students
Programme duration	218 weeks over 5 years
Format of programme	e.g.: Year 1: basic knowledge, clinic attendance, shadowing 2: knowledge and simulated clinical experience 3: direct patient treatment 4-5: direct patient treatment, clinic attendance, outreach, placements
Number of providers delivering the programme	1

## Outcome of relevant Requirements<sup>1</sup>

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

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<sup>1</sup> 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*)**

**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*)**

Under this Requirement, the panel was tasked with also looking at staffing levels and whether this has any impact on how this Requirement is met.

At the inspection, we heard evidence about staffing at the Institute. The senior team indicated that they do not have difficulties with recruitment and that they do not have any current vacancies requiring urgent appointment. In the event of vacancies, there are developmental opportunities for existing staff already at the Institute. We heard that eight new clinical supervisors have recently been employed, most of whom have teaching qualifications or relevant experience.

The Institute explained that they support staff to acquire the Fellow of the Higher Education Academy (HEA) status. The Panel saw comments in the Institute of Dentistry Periodic Review Report from June 2018 (June 2018 report). In it, they commended the Institute for the high number of Senior Fellows and encouraged it to continue to engage relevant staff to participate in the teaching recognition programme.

Clinical supervisors have an induction afternoon as well as on-line training sessions. They are allocated a mentor for three years by way of a formal agreement and are paired with experienced staff at clinics. We heard however that calibration of staff is a challenge as there are some 90 clinical staff members. We were informed that a new post of clinical governance lead has been filled. We commend the creation of this new post which should help to overcome some of the practice management and communication issues occurring at outreach which we were informed of.

With regard to part time staff, the Institute explained the rationale for only appointing part-time staff who can commit to a minimum of two days per week. All outreach staff at Barkantine and Sir Ludwig Guttman Centre (Guttman) work with staff who attend at both the QMUL base and outreach. Both of these factors help to ensure the standardisation of teaching, training and calibration.

When hearing evidence about staffing, we considered that there appeared to be a lack of contingency plan for potential staffing shortages. We suggest that the Institute consider staff succession planning, particularly for key members of staff.

The panel saw various documents to illustrate the induction process for new staff. We also saw a list of staff confirming appropriate GDC registration, including staff on the GDC's Specialist List. All staff are expected to undergo training in equality, diversity and inclusion as well as unconscious bias. The Institute has a suite of online courses and a centre for academic professional development at Mile End. A central record is kept on training that staff have undertaken. Mandatory training is checked on a yearly basis. There are termly staff development days which take into consideration training needs which are identified in advance. Staff have an annual appraisal to discuss and reflect on their development needs. Clinical leads at each of the outreach centres are responsible for the appraisal of staff assigned to their centre and their monitoring generally.

Regarding the supervision of students, we were provided with documents ahead of the inspection such as weekly timetables and rotas demonstrating staff to student supervision ratios. The Institute explained that students are fully supervised on clinic (base and outreach centres), in the Clinical Skills Lab (CSL) and Prosthetics Laboratory by suitably trained staff members. These include various dental care professionals who have appropriate GDC registration. Students are supervised according to the procedures they are undertaking. They aim to have a ratio of one staff member to seven students for the majority of routine clinics but aim for a ratio of one to five or six where this is practical. Nursing support is also usually provided at a ratio of one to four or five, but we were informed that in the Southend centre, this was one nurse to two students. In high stress areas such as Oral Surgery, the Institute aims for a ratio of one to three. We consider there is wide disparity in staff to student ratios between outreach sites. The team suggest the Institute should endeavour to standardise these if possible. However, students did indicate that staff were always available if required.

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

**Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so. (Requirement Met)**

Under this Requirement, the panel was tasked with also looking closer at online raising concerns and whether this has any impact on how this Requirement is met.

The panel had sight of the Whistle blowing Policy (Raising Concerns in the Workplace) which contained useful flow charts. This was recently re-written to make it clearer and we agreed that it was more accessible to students. This is available on the policy page of the Institute's online portal 'QMPlus' which is a resource suite for staff and students. Raising concerns is also embedded within the programme. This is undertaken in the Professionalism, Teamwork and Social Responsibility module where ethics and professionalism is taught from Year 2 prior to patient contact. We also saw the Dignity at work: Tackling Bullying and Harassment in the Workplace document.

The Institute encourages an open-door policy so that students and staff can approach various members of staff and the senior academic team should they need support or to raise a concern.

Incidents and clinical alerts are logged in the Institute's Longitudinal Integrative Foundation Training Undergraduate to Postgraduate Pathway database (LIFTUPP) and the panel had sight of a redacted list of these. This includes students' absence from clinic, incidents involving actual or potential harm to patients, staff or students. Alerts are then forwarded to the Head of Undergraduate Programmes, Head of Student Support and Year Leads. Repeat incidents or incidents of concern are reviewed by the Head of Undergraduate Programmes and Head of Student Support.

Incidents such as needle stick injuries, wrong tooth extractions and hydrochloride incidents are recorded on the DATIX system and the panel had sight of a redacted list of these. These are reported to the Student Support Office by the Head of Nursing at Barts Heath in order to ensure pastoral support is given. Students involved are given management advice to prevent this from happening again. DATIX incidents are also forwarded as reports to the clinical governance team for review once a month to discuss issues and lessons to be learned. The panel noted that there had been several of such incidents between September 2017 and September 2018. This resulted in an overhaul of safety procedures and new measures being put in place, such as a new surgical safety checklist. These procedures are also monitored by the Institute's undergraduate nursing team.

Concerns raised by students go through the Staff Student Liaison Committees (SSLC). The panel saw minutes of these and evidence that concerns were being addressed. There is further discussion about the SSLC at Requirement 9.

Although we saw policies for recording incidents, the panel considered that the levels of harm were not clearly defined and that this was often down to the subjective judgment of staff. We recommend clearer criteria to define these levels and when clinical alerts should be escalated. When DATIX issues are logged, we suggest that there should be a clearer audit of specific actions and action plans to close the audit loop. We therefore concluded that the reporting and escalation of incidents should be more formalised, particularly for low level alerts.

The Institute confirmed that they are continuing to work with colleagues in the Medical School and IHSE (Institute of Health Science Education) to develop an online portal. This will allow students to anonymously raise concerns that will be reviewed by the Institute's Head of Governance. We encourage the Institute to continue to develop this.

**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)**

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



## Standard 2 – Quality evaluation and review of the programme

The provider must have in place effective policy and procedures for the monitoring and review of the programme.

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

Under this Requirement, the panel was also tasked with looking at the BDS integration with the BSc in Oral and Dental Health Sciences (Dental Hygiene and Therapy) and staff turnover and stability and whether these have any impact on how this Requirement is met.

Before the inspection, the panel was provided with a range of documents to illustrate the complex quality assurance framework within which QMUL and the Institute operate. There are a variety of mechanisms, processes and committees that underpin the operation of the framework and these are explained in the Educational Manual (Quality) 2016-17 QMUL. These ensure that the quality of the programme is being monitored and improved. At the inspection, the Institute's senior team comprehensively explained this framework further.

We were informed that the Dean has delegated responsibility for the Institute and is supported by an executive group who interact with the Institute and programme staff. Within the Institute, the main decision-making committee is the Dental Education Committee (DEC). It has oversight of the management and delivery of all programmes delivered. The Dental Quality & Assessment Committee (DQAC) meets every month and leads on the oversight of quality and assessment matters. The panel had sight of various minutes from these committees to illustrate this.

The team reviewed the contents of the Institute's June 2018 report which covered a range of areas such as staffing and Institute management and Taught Programmes. The report also included an evaluation of programmes including a review of learning outcomes, the curriculum, assessment methods and use of feedback. We noted the commendations listed in the summary and in particular the recommendations, particularly in relation to outreach. This is discussed further at Requirement 12.

We also noted the minutes from Annual Programme Reviews led by the QMUL ARCS(Academic Registry and Council Secretariat).

The management of academic quality and standards in teaching and learning is placed on individuals rather than committees. This is detailed in the Strategic Plan 2014-2019 and the Learning, Teaching and Assessment Strategy 2017-18. We also had sight of the QMUL Academic Regulations 2018-19 and QMUL Assessment Handbook 2017-18.

Students are also involved in the quality assurance framework by participating in the SLCC which meets every second month. They are joined by staff representatives to discuss matters related to the delivery of the programme, report concerns and provide feedback. Students informed us that they felt confident to raise concerns. In the Institute's June 2018 Report, it was noted that student representation was strong on DEC and DQAC. It was also noted that SSLC meetings were co-chaired with both a student and academic Chair.

The panel saw evidence of changes to the current 2012 curriculum which resulted in a comprehensive mapping exercise to the Preparing for Practice learning outcomes. It now addresses the four main areas of the learning outcomes. It resulted in the introduction of new themes which included:

- Professionalism
- Teamwork
- Social Responsibility
- Public Health
- Evidence Based Dentistry

These new themes will facilitate enhanced coverage of the communication, professionalism and management and leadership learning outcomes. The mapping of learning outcomes remains under review by DQAC and DEC with input from the SSLC and module conveners.

Staff at the Institute explained that the BDS is fully integrated with the BSc Oral and Dental Health Sciences (Dental Hygiene and Therapy). This is being converted from a diploma programme beginning in September 2019. We were informed that its management will not have any impact on staffing levels for the BDS given the extent to which the two programmes are integrated.

The team considered that there is a robust and complex quality assurance framework within which the Institute operates, both at Institute and University level. This is underpinned by detailed processes and a clear committee structure to monitor the quality of the programme and implement changes. Documents provided to us clearly illustrated that the Institute efficiently manages any issues relating to the quality of the programme and that programme changes are adopted following the correct processes.

**Requirement 10: Any concerns identified through the Quality Management framework, including internal and external reports relating to quality, must be addressed as soon as possible and the GDC notified of serious threats to students achieving the learning outcomes. The provider will have systems in place to quality assure placements. (Requirement Met)**

**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)**

Under this Requirement, the panel was also tasked with looking at the collection and use of student feedback to inform programme development and whether this has any impact on how this Requirement is met.

The rigorous internal quality assurance framework within which the Institute operates has been discussed in detail under Requirement 9. This illustrates the various internal processes and committees that underpin the framework.

A vital aspect of external quality assurance of the programme is the use of external examiners (EE). The Institute confirmed that EEs play a role in ensuring that the Institute adheres to the guidelines of the QAA Quality Code for Higher Education. The panel had sight of the Guide for External Examiners which details their responsibilities and function. EEs are appointed by the Director for Taught Programmes and then approved by the Institute and QMUL's central committee. EEs undertake a variety of functions. At a general level, they compare the QMUL BDS programme against other UK providers for consistency and contemporaneousness. They monitor the standard of the programme against the QAA Quality Code. They are expected to highlight areas of excellence in provision. They attend examiner training and calibration sessions. They are required to report on key issues affecting delivery of the programme and

provide feedback on the appropriateness of course aims and learning outcomes. EEs report on whether the Institute's assessment methods measure student achievement rigorously and fairly.

Concerning exams, EEs review and approve all exam questions. They review the standards of marking, scrutinising a sample of assessed work. EEs observe oral exams but are not directly involved in examining students. They are required to attend Subject Exam Board meetings to endorse, where appropriate, results and progression decisions. They can choose to attend Degree Examination Boards.

EEs are required to provide oral and written reports. Oral reports are made after the exam board has completed its deliberations. They can comment on the assessment process, academic quality of the cohort, make recommendations for improvements to teaching or assessment and check whether recommendations from previous years have been properly followed up. Full annual written reports form an essential part of QMUL's quality assurance framework. These are a major source of information for the annual review of taught programmes and for the Institute's periodic reviews. They are reviewed by the Assistant Academic Registrar before being forwarded to the exam boards. The chair of the exam board will report back to EEs comments with any follow up actions to be taken. The panel had sight of various EE written reports ahead of the inspection.

Regarding student feedback, students are able to contribute to course development through representation on SSLC, DQAC and DEC, as well as through QMUL Module Evaluation and in course evaluations and focus groups. The panel saw evidence of student involvement in various committee minutes. An example of feedback from students was the desire to feel more confident prior to treating patients. As a result, the Institute now has drop in sessions in the CSL for year 3. Regarding the issues at Southend outreach centre, it was evident that feedback was correctly fed through the SSLC. However, the panel considered that the Institute should make greater use of student feedback as a means of informing improvements to facilities at outreach. We recognise that the Institute is working on student feedback generally and commend them on some impressive initiatives to gather it, particularly the frequency of data collection. We recommend that the Institute considers how to capitalise on feedback and we encourage further development in this area.

The Institute confirmed that a number of senior staff have roles as external examiners in other UK dental institutes. They use this experience and note any good practice to feed into improvements at QMUL.

Full commentary regarding the collection and use of patient feedback is discussed at Requirement 17. Although the use of student feedback is well developed, the use of patient feedback is one area of external feedback still requiring development, the team therefore considered that this Requirement is 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 Partly Met)**

Under this Requirement, the panel was also tasked with looking at the management and quality assurance of placements and outreach locations and whether this has any impact on how this Requirement is met.

Students at QMUL attend four outreach sites at various stages of their BDS programme in rotation. The Guttman centre delivers general restorative teaching and paediatric patient care.

Attendance at Newham General Hospital allows students to gain experience in Medicine, Surgery and Accident & Emergency in years 2 and 3. Students attend Barkantine in years 3 and 4 for local primary dental care provision. In year 4, students also attend the Southend Academic Centre to gain distant primary dental care (GDP) experience. We heard from students that they received a thorough induction at each of these placements and felt supported at outreach as much as at the Institute.

The panel heard that there were several serious issues at outreach which had a negative impact on students' clinical experience. This also had an impact on student progression through the final stages of year 5 which is discussed further at Requirement 13. The first major issue was the failure of suction equipment at Southend which directly caused a reduction in patient access for students. We heard that the incident took quite a few months to resolve and did not appear to have been managed in a timely manner, albeit due to external factors beyond their control. A further technical issue caused disruptions to the service provided at the Guttman centre in October 2018. This resulted in a rescheduling of services at Whitechapel (hub) to maintain continuity of service and clinical teaching.

A new role of Head of Outreach was created to address the issues related to outreach with the goal of improving the teaching and learning environment for students. In addition, the role is intended to improve communication between the academic hub and outreach and between outreach centres. Since appointment, outreach leads have met on a monthly basis and there is a clear willingness to improve relationships, share information and good practice between the centres. The Head of Outreach has also identified and reported risks to the DEC with action plans. A risk assessment was carried out to ensure funding was made available for a replacement suction unit at Southend. A new Service Level Agreement is being agreed. The team acknowledge that the creation of this new post should enhance the quality assurance of outreach sites. We noted the recommendation in the Institute's June 2018 Report to upgrade deteriorating equipment as soon as possible to minimise risks to students' clinical experience and patient safety. The team appreciated the candour of staff in explaining the circumstances which they had identified as causative to the issues. We considered that the Institute should consider more immediate contingency plans should a major incident happen again.

We learnt that teaching staff based in Whitechapel also cover the clinics at two of the outreach sites (Barkentine and Guttman), which ensured consistency and a degree of quality assurance at these sites. However, this is not the case with Southend and the panel considered this could be detrimental to that centre. The Institute should consider how to ensure there is an inclusive and consistent management structure across all three sites. Regarding training, we heard that this is delivered for outreach staff across all sites. They attend regular staff development meetings and undergo same induction process. Staff also teach and learn from their peers in the CSL. Assessment training is completed at staff development days, training events and examiner training sessions. The team heard that there appeared to be an informal handover of student progression data between year leads. It appeared to be shared on email only when required. However, we are aware that these handovers are currently being developed and embedded and recommend that process continues. We suggest formal timetabling of handover meetings so that students learning needs are flagged and supported.

Regarding patient and student feedback, it was clear that some issues raised by students were being addressed but that there were still shortcomings in the collection and use of it. This is discussed further at Requirements 11 and 17.

Given the recommended areas for progress as explained above, the team considered that this Requirement was partly 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*)**

Under this Requirement, the panel was tasked with also looking at the sign-up procedures for final examinations and access to a range and number of patients and whether these have any impact on how this Requirement is met. Regarding access to patients, please see the commentary under Requirement 15.

Ahead of the inspection, we reviewed the Institute's 2017-18 Assessment Handbook which comprised details of the full range of formative and summative assessments, In Course Assessments (ICAs) and exams allocated to the individual BDS Part examinations. We also saw examples of assessment questions included in exam papers. Assessments are tailored to the stage of students' development so that knowledge, problem-solving and clinical competencies can be adequately assessed. A wide range of assessment types are used and include single best answer, extended matching answer, structured answer questions, short answer questions, case reports, clinical ICAs, work-based assessments, Objective Structured Clinical Examinations (OSCE), spotter examinations, problem enquiry-based learning reports, poster and oral presentations. These allow for tailored learning styles for different students and an appropriate means of testing different skills and knowledge. The Institute confirmed that candidates with specific learning needs are reviewed and appropriate modifications are made in line with the Institute's recommendations.

The final Part 5 exam consists of two written papers and two clinical elements. In order to be awarded the final degree by the degree board, students must pass finals as well as all in-course assessments. At this point, students are formally signed off by the Head of Undergraduate Programmes, including the GDC registration application.

The Institute has a process of standard setting for examinations. These are reviewed at each diet and the marking is set against specific criteria with the level of question set commensurate with the year. Either Modified Angoff or Ebel standard setting is carried out by a group of 6-8 examiners. All exam questions are subject to psychometric analysis by the exams office.

Ahead of the inspection, the panel reviewed details about the Institute's sign-up process for final exams. It involves a review of students' clinical experience in December and March in year 5. ICAs are reviewed ensuring that students have completed all required assessments and have demonstrated clinical competence across all areas. Students who receive outcomes 1 and 2 will be signed up. Those on an outcome 4 overall will not be signed up and require an

extension to training. Students who fall short in one or two areas may be signed up, provided they have suitable patients and completion of action plan is achievable.

For the 2019 cohort, the panel learnt that not all students met the required clinical requirements by the sign-up meeting for the Part 5 examination. This was also evident during the LIFTUPP session at the inspection. In addition, some students who had already passed the finals exams were required to complete additional procedures before they could be awarded the BDS. The Institute indicated challenges with this, citing various reasons including the issues previously mentioned at outreach, student management of patient booking, patients not attending and failure to complete treatments due to conflicts in teaching timetables. In addition, there was a change to the Health Education England deadline for Dental Foundation Trainee applications, which meant that in order for students to apply they needed to be signed up to finals at an earlier stage. It was also apparent to us that there was some degree of disruption whilst changes in leadership and clinic arrangements were being implemented. These circumstances meant that a deviation from the published sign-up process was unavoidable. Following the inspection, we had some enquiries such as the number of students affected, required actions, potential consequences and timeframes for students. We also sought details on any planning the Institute took to prevent this situation in the future.

The Institute provided a comprehensive response. They explained that this affected 54 students who had still to complete clinical experience at the sign-up meeting. They were required to continue treating patients and to provide evidence that they have addressed the identified shortfalls to be verified by subject leads. In exceptional cases, students may be offered the opportunity to demonstrate competency using a laboratory-based assessment. The team suggest this approach should be phased out as we do not consider this measures competency in the same way that work-based assessment of clinical procedures do. Failing that, the Institute should create a clear policy document setting out a decision-making process and explaining the circumstances when this would be acceptable.

Regarding future planning for sign-off, the Institute anticipates continuing with this approach, highlighting that it enables students to maintain their clinical skills until the end of the course and that students are registered at the Institute until mid-July. The Institute explained that they have introduced a review meeting in January of the final year. At this meeting, students' clinical experience is reviewed and targets are set for the sign-up meeting in March. The panel consider that this new sign-up process appears to be more pragmatic and flexible and it was apparent that it results in three different outcomes. Firstly, students who meet their targets can proceed. Secondly, students may proceed provided they continue their clinical work to achieve the agreed targets, otherwise the BDS award and GDC registration form would be withheld. Thirdly, in the event of an irretrievable shortfall, students would revert to year 4 for additional training or exit the BDS with an award of BSc in Dental Science, rather than failing year 5. The Institute explained that students with major concerns will be taken through the Professional Capability and Fitness to Practise process. The panel saw an example of a student who reverted to year 4 and was given good pastoral support.

We consider this approach to be acceptable, provided the outcomes are clearly published for students and staff and that accurate records are kept in order to track students through the sign-up process leading to final award and GDC registration. The Institute should record this process formally in a written, published policy document for the benefit of students and staff.

The Institute confirmed that all students in the 2019 cohort had successfully completed their clinical experience, in-course assessments and exams by the deadline set. Subject leads were confident that students had been treating an appropriate number of patients to achieve the clinical experience required for the sign-off and GDC registration.

At the inspection we had sight of a draft document on the new LIFTUPP protocol which outlines the expected targets students need to attain. We recommend that the Institute continue development on this as an important tool in the sign-up process. The document should be transparent and detail the purpose of the review meetings in January of the final year, explaining that attainment against targets is reviewed and action plans are agreed to address shortfalls ahead of the March sign-up meeting.

Given the recommended areas for progress as explained above, the team considered that this Requirement was 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)**

Under this Requirement, the panel was also tasked with looking at access to a range and number of patients and whether this has any impact on how this Requirement is met. Please see the commentary under Requirement 15.

The Institute explained that they have separate systems for the management of students at a pastoral and academic level. The Student Support Office (SSO) is where students' records are kept, including attendance and records of meetings. Academic progression is managed separately by a dedicated examination team which collects student assessment data, monitors student clinical records and student progression more generally. This data is stored electronically and access is restricted. This team also co-ordinate assessments and exams and is managed by the year assessment leads and Director for Taught Programmes.

The panel received a demonstration of the LIFTUPP system which the Institute uses as an essential tool to frequently monitor students' progression. Students are monitored to ensure that all of the GDC's learning outcomes have been assessed and they are continuing to demonstrate that they are a safe beginner.

The course leads review the number of procedures and the competencies achieved in each of the clinical skills. They will then attribute a score of 1, 2, 3 or 4, which is explained in letters sent to students. This data is then reviewed in its entirety by the Head of Undergraduate Programmes and a final outcome is determined. Should a student receive a score of 3 or 4 representing concerns, a one to one meeting is held with Head of Undergraduate Programmes and an appropriate action plan agreed to support the student.

When students transition from CSL to treating patients on clinic in year 3, they must complete a clinical transitions course at clinic where they use phantom heads. During the exercises, they are paired as operator the nurse and will complete clinical procedures in a simulated clinical scenario. All students must successfully complete this course before being allowed to undertake the Gateway exam to ensure that they are demonstrating safety prior to being permitted to treat patients on the clinic.

Student attainment is reviewed at progression meetings to monitor longitudinal progress. The main review points for monitoring clinical progression are as follows:

- 3<sup>rd</sup> year: August
- 4<sup>th</sup> Year: February and July
- 5<sup>th</sup> Year: December and March for sign-up to final exams and June for final sign-off

Although we saw evidence that students were being monitored, we considered this should take place more frequently. We saw imbalances in patient access between students. Some students far exceed the recommended numbers whilst others fell well short. We suggest earlier

intervention for those students falling short. Overall, we considered that greater use could be made of the data in LIFTUPP.

We also considered that the handover of students to clinics should be undertaken on a more formal basis where students' developmental needs are fully discussed. We heard that some placement providers were not always clear on the student's journey to date before arriving at clinic.

The panel commended the revalidation exercises available to students. There is further discussion about this at Requirement 15. We also note the use of formal records detailing the extent of clinical procedures. We encourage the Institute to review these as it was not easy to identify which procedures were being undertaken.

Given the recommended areas for progress as explained above, the team considered that this Requirement was 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 Met)**

Under this Requirement, the panel was also tasked with looking at access to a range and number of patients and whether this has any impact on how this Requirement is met.

The panel considered that the variation of patients in each outreach placement allows for an appropriate breadth of clinical exposure for students, particularly given the central London location of the Institute. Students expressed how they valued the cultural and economic diversity of the area and that this enriched their patient experience.

Patients are seen by students on a holistic basis and the new 2012 BDS curriculum ensures that patient care is delivered longitudinally. All patient contact and each clinical episode is logged on the LIFTUPP system so that each student's competencies can be tracked. This allows subject leads and supervisors to monitor how well students are performing individual procedures and their level of independence as they develop. This data is also reviewed by the Head of Undergraduate Programmes in years 3, 4 and 5. If shortfalls are identified, students develop their own action plans to target these. Should any weaker competencies be identified, this may lead to an extension of training time. All students in year 5 must demonstrate they have developed the required skills and competency at a Gateway examination before being signed-off.

Restorative patients are referred by general dental practitioners to the consultant clinic where they are reviewed and a decision is made whether they are suitable for undergraduate training. There is also a screening clinic where patients are booked directly into screening sessions undertaken by students. Treatment plans are then formulated, usually by the student who performed the initial screen.

The Institute explained that one major challenge with patient access was obtaining an appropriate number of endodontics patients. However, a new referral pathway in the form of a student dental emergency clinic has been developed which is a telephone triage system. This allows students to obtain slots in the clinic to allow them to source an appropriate breadth of patients and treatments.

The panel learnt about the Institute's use of revalidation exercises which is a notable feature of the programme. It allows students to maintain their competency in clinical skills by practising on phantom heads at the laboratory when required. Students championed this feature of their



training and indicated that access to the laboratory was good. This panel commended the use of this revalidation practice.

**Requirement 16: Providers must demonstrate that assessments are fit for purpose and deliver results which are valid and reliable. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed. (*Requirement Met*)**

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

Under this Requirement, the panel was also tasked with looking at the utilisation of feedback in assessment and whether this has any impact on how this Requirement is met.

Regarding the collection and use of patient feedback, the Institute confirmed that they recognised its importance and acknowledged the challenges in gathering it. A pilot was described but the team did not have sight of any evidence of the pilot. The team understood from the discussion that the pilot had not yet been evaluated or rolled out universally.

The team were informed that students routinely receive feedback from staff on clinic. However, no evidence of students routinely receiving feedback from patients on clinics was provided. Based on evidence provided, the team believed that at the time of the inspection, patient feedback was not part of student assessment.

Currently informal feedback is gathered during interactions between students and patients in the clinical environment.

The Institute has developed and piloted its own patient assessment form on iPads. This is already being used for the LIFTUPP system where feedback is provided to individual students. They are working with the LIFTUPP team to develop this feedback further so that it can be used as a tool to inform programme development and also as a means of informing student assessment. The Institute explained they are consulting with another BDS provider to attempt to overcome some of the logistical challenges with collecting and using patient feedback and work on ways how to develop it. At the inspection the senior team explained that they see patients having a role as educators but we did not see any evidence of this in practice. We recommend that the Institute continues to develop the use of feedback to ensure a quality service to patients and to inform programme development.

Peer feedback is given on an informal basis. Given that BDS students are well integrated with students on the DipHE Dental Hygiene and Dental Therapy programme, students often share patients and as a result there is a great deal of informal student to student feedback.

Feedback from nurses is still being explored and ways to formally recorded it in LIFTUPP. At the moment, nurses raise feedback informally, raising matters with supervisors and staff when appropriate.

The Institute have acknowledged continuing challenges with the use of feedback in student assessment. Although students receive feedback from members of the dental team and peers, feedback on professionalism is generally given informally. There are particular challenges with calibration between supervisors given that providing feedback on professionalism could be dependent on subjective judgment. The Institute explained that given the close interaction of staff and the dental team, there is an open culture of providing feedback to students and there is frequent communication between staff, often on email.

Ahead of the inspection, the panel reviewed the Institute's June 2018 report. This acknowledged difficulties about students' awareness when they were receiving feedback on assessment and made a recommendation to act on this, particularly in relation to clinical and lab-based sessions. The report also indicated that students reported some issues related to feedback, such as the absence of clear timeframes for providing feedback on assessments, the variability in the amount of feedback provided and some deadlines for the return of feedback not being met. We noted in the report the recommendation that the Institute should develop a feedback policy which provides a clear timeframe for returning feedback. This should also detail the minimum level of feedback required to ensure consistency in the feedback being provided to students.

Given the recommended areas for progress as explained above and the apparent lack of progress against this Requirement since the last GDC inspection, the panel considered that this Requirement was partly met.

**Requirement 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice. (Requirement Met)**

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

Under this Requirement, the panel was also tasked with looking at staffing levels and whether this has any impact on how this Requirement is met.

The panel heard evidence that a significant number of people are involved in assessment and had appropriate registration and qualifications. The team saw various records confirming that new members of staff undertake a mandatory induction and comprehensive training programme which includes the supervision and assessment of students. The Institute indicated that all internal examiners and assessors have, or are expected to complete, a teaching qualification. Internal examiners are actively encouraged and supported by the Institute to become a fellow of the HEA. We saw a redacted list of staff confirming this.

The panel saw agendas for Staff Development Days hosted by the Institute where further training, calibration and standard-setting exercises are held. These sessions also included question-writing sessions to facilitate the development of new exam questions. Staff who act as assessment leads also have the opportunity to undertake further training in assessment. The QMUL Assessment Handbook outlines the preparation and calibration that takes place before exams. New examiners undertake examiner calibration are also required to shadow and observe with senior examiners during their induction period. Examiners undertake training prior to clinical examinations which also involves a period of calibration. Mark sheets include descriptors for grading of clinical assessments. Descriptors are also included in the Institute's LIFTUPP system and training is given on this.

New examiners are paired with experienced examiners when double-marking. They are reminded of the expectations of double-blind marking and agree a mark for each written question. Calibration also takes place for the Structured Clinical Reasoning (SCR) exam and the finals unseen cases. These examinations are independently double-marked and then agreed. In-course assessments are partly double-marked with agreed criterion referenced mark sheets. Regarding OCSEs, there is no double-marking but exam preparation and calibration takes place prior to them when examiners and simulated patient actors are briefed.

The panel were given details of training provisions for equality, diversity and inclusion (EDI) which is compulsory. All staff must also undertake mandatory unconscious bias training.

The use of external examiners has previously been discussed at Requirement 11.

The panel concluded that staffing levels were appropriate and there were effective systems in place to monitor the training of new and existing staff, examiners and supervisors.

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

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

## Summary of Action

Req. number	Action	Observations & response from Provider	Due date
11, 17	<p>The programme leads must implement a method by which patient feedback can be recorded and utilised. The collection and use of student feedback should be developed and expanded.</p> <p>A policy should be created detailing how this feedback will contribute to the assessment process.</p>		Annual Monitoring 2020/2021
12	The provider must continue to develop the management of outreach centres. This should include clear contingency planning.		Annual Monitoring 2020/2021
13	<p>Regarding the new sign-up arrangements, the Institute should formalise a new written, published policy document for the benefit of students and staff.</p> <p>The draft document on the new LIFTUPP protocol should be developed as an important tool in the sign-up process.</p>		Annual Monitoring 2020/2021
14	<p>The Institute should develop systems to ensure more frequent monitoring of students. Imbalances in patient access between students should be addressed earlier and the Institute should consider making greater use of the data in LIFTUPP.</p> <p>Handover of students to clinics should be formalised.</p>		Annual Monitoring 2020/2021
17	The Institute should develop a feedback policy which provides a clear timeframe for returning feedback. This should also detail the minimum level of feedback		Annual Monitoring 2020/2021

	required to ensure consistency in the feedback being provided to students.		
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### Observations from the provider on content of report

The institute of Dentistry welcome the comments in the report and thank the inspection team. The areas identified by the inspection team were also identified by the educational lead team. The majority of the action points are already in the process of being actioned. This inspection has given us the time to review, reflect and enhance our programme.

### Recommendations to the GDC

<b>Education associates' recommendation</b>	The BDS qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council
<b>Next regular monitoring exercise</b>	Annual Monitoring 2020/2021

## **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 edition<sup>1</sup> 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 inspectors 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 inspectors may 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.