INSPECTION REPORT

Education Provider / Awarding Body:	**Queen Mary University of London (QMUL)**
Programme / Award / Qualification:	**Bachelor of Dental Surgery (BDS)**
Remit and purpose:	**Full inspection referencing the *Standards for Education* to determine the continuing sufficiency of the award for the purpose of registration with the General Dental Council (GDC) as a dentist**
Learning Outcomes:	***The First Five Years***
Programme inspection dates:	**21 & 22 October 2013**
Examination inspection dates:	**19-22 May 2014**
Inspection panel:	**Alan Kershaw (Chair and Lay Member)** **Trevor Burke (Dentist Member)** **Daryll Jagger (Dentist Member)** **Fizan Tahir (Dentist Member)**
GDC staff:	**Kathryn Counsell-Hubbard (Lead)** **Luke Melia**
Outcome:	**Recommended that the BDS remains sufficient for registration as a dentist**

Inspection summary

The BDS at QMUL is an established programme which has faced a number of challenges in recent years. The move to the newly developed Dental Hospital of Barts Health NHS Trust required considerable planning and consultation with staff and students alike, and presented an obstacle to staff to ensure that the student experience was not compromised. The panel was impressed by the enthusiasm displayed by students before the change and further impressed with the flexibility of staff in adapting to the new environment.

The structure of the School of Medicine & Dentistry (SMD) has changed and a new Dean was appointed for the Institute of Dentistry in August 2013. This change has had a positive impact on the administration and direction of the programme. The Dean works with excellent support from the programme leads, who welcomed the inspection as an opportunity to examine the programme in full and implement changes.

The programme has also had to adapt to internal changes, being the new 2012 curriculum and adopting the Longitudinal Integrative Foundation Training Undergraduate Postgraduate Pathway (LIFTUPP) system for clinical recording, feedback and reflection. Both initiatives have meant significant changes for the programme but have generated excellent feedback from students.

The panel was impressed with the programme overall and in particular with the support mechanisms for students. The use of allocated pairs for clinical experience had a positive impact on the student enjoyment of the programme, and also allowed for continuous peer review. The ‘open door’ policy adopted by staff was appreciated by students. Electives and self-selected study modules also contribute to the student experience.

Despite multiple areas of good practice, the inspectors noted some areas where improvements should be made. Most notably, this includes the quality assurance of outreach placements and gathering patient feedback. These areas were identified as problematic by the programme leads and this insight has given the panel some assurance that policies and procedures will be put into place as required to address the deficiencies.

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

Inspection Process and Purpose of Inspection

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 and new qualifications where it is intended that the qualification will lead to registration.

2. The aim of this quality assurance activity is to ensure that these institutions produce a new registrant who has demonstrated, on graduation, that he or she has met the outcomes required for registration with the GDC. This is to ensure that students who obtain a qualification are fit to practise at the level of a safe beginner.

3. The inspection focuses on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education*.

4. The purpose of this inspection was to make a recommendation to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist in the UK. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended) to determine sufficiency of the programme.

5. Inspection reports may 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 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, the report and observations would be presented to the Council of the GDC for consideration.

The inspection

7. This report sets out the findings of an inspection of the BDS awarded by QMUL. The GDC publication *Standards for Education (version 1.0 November 2012)* was used as a framework for the inspection.

8. The programme inspection took place on 21 and 22 October 2013. During the inspection, the inspectors met staff involved with the management and delivery of the BDS programme. The inspection team also met with clinical teaching staff, outreach tutors, and students on the BDS programme.

9. On 19 to 21 May 2014 the inspectors attended the practical elements of the final examination. These were the Case Presentations and the Unseen Case Presentations.

10. The inspectors also attended on 22 May 2014 for the Final Examination Board meeting.

Overview of qualification

11. The five year BDS programme is delivered primarily at the Dental Hospital of Barts Health NHS Trust. The BDS sits in the Institute of Dentistry (hereafter referred to as the 'School') which is part of the School of Medicine & Dentistry (SMD) part of QMUL. Each cohort is approximately 75 students strong. The programme aims to build up the knowledge, skills and attitudes required to enter dental practice as a safe beginner. A particular goal of the new Dean is for the School to be recognised as a world class institution for research as well as training. A good relationship is enjoyed between the Institute for Dentistry and the Barts Health NHS Trust where the transparency of logistical operations has had a direct impact on students by resolving a previously long-

standing issue with instruments. Students experience a range of placements starting in Year 3, the majority of these being directly under the governance of Barts Health NHS Trust.

12. The programme is split into three stages over five years, with five main themes running longitudinally throughout. Placements include dedicated paediatrics clinics and this combined with the diversity of patients at both the School and outreach means that students are prepared for a range of patients in whichever sphere of dentistry they pursue post-graduation.

Evaluation of Qualification against the *Standards for Education*

13. The provider was requested to undertake a self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement was met, partly met or not met and to provide evidence in support of their evaluation. The inspection panel examined this evidence, requested further documentary evidence and gathered further evidence from discussions with staff and students.

14. The inspection panel used the following descriptors to reach a decision on the extent to which the BDS of QMUL meets each Requirement:

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.

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**			
Requirements	**Met**	**Partly met**	**Not met**
1. Students will 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	✓		
2. Patients must be made aware that they are being treated by students and give consent	✓		
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care	✓		
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development.	✓		
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body	✓		
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety	✓		
7. Should a patient safety issue arise, appropriate action must be taken by the provider		✓	
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	✓		

GDC comments

Requirement 1: Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients *(Requirement Met)*

Students receive teaching on bio-science before the training in practical skills begins. Patient safety is taught and underpinned by the environment in the clinical skills lab which reflects what would be expected if the student were in clinic seeing patients. Requirements for behaviour and professionalism must be met and are tested in the gateway assessments that are completed before patient contact.

Gateway assessments take place throughout the first three years of the programme, with specific clinical assessments during Year Two before the students progress to treating

patients. The assessment methods range from Single best answer tests, projects and written assignments to clinical assessments and case presentations.

The summative assessments are underpinned by formative assessments to ensure that student behaviour and communication skills are appropriate to allow them to work on clinic. Working in pairs allows students to develop the 'softer' skills while gaining competence and confidence clinically. Students also have the opportunity to re-take a summative assessment if they fail in their first attempt.

Requirement 2: Patients must be made aware that they are being treated by students and give consent *(Requirement Met)*

The teaching of consent involves simulated scenarios to inform and test students. Patients are informed that students will deliver their treatment when they first attend an appointment at either the School or outreach. Consent will be obtained on multiple occasions as the treatment plan evolves, and students are involved at each stage. Written information on student treatment is provided to patients and is written to the 'plain English' standard. Students are identifiable by their uniforms and badges to further inform patients.

A specific patient leaflet is utilised for those who participate in the clinical exams. This leaflet clearly informs patients of what to expect during the process and further contributes to their awareness and ability to consent to student treatment. Signage was seen in the clinical areas further informing patients that they may be treated by a student.

Requirement 3: Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care *(Requirement Met)*

The improved governance position of Barts Health NHS Trust has allowed increased monitoring to ensure the full complement of instruments is maintained. This has been a serious issue for the School in recent years but has been resolved for at least one calendar year to date.

Relevant health and safety policies are held for clinics at the School with the outreach placements also being at NHS facilities. No current issues or complaints were evidenced either in the minutes of relevant committees or via meetings with staff and students. There was no explicit requirement for placements to have been inspected by the Care Quality Commission (CQC) evidenced in the documentation provided to the panel. The School was preparing for its own CQC inspection at the time of the GDC's inspection.

The panel was satisfied that the environments for patient care are safe and appropriate.

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

The levels of supervision demonstrated in the documentary evidence were deemed to be sufficient by the panel. This information was triangulated with students who were satisfied with the supervision they received. Students also reported that the level of supervision was continuous at the outreach placements, demonstrating that supervision is sufficient across all sites.

Requirement 5: Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body *(Requirement Met)*

All full time academic staff at the School must undertake compulsory training in education, and it was further reported that many honorary staff will also complete a teaching qualification while at the School. Teaching skills are further underpinned by regular peer review.

General dental practitioners come into the School prior to supervising on outreach to hone their skills in the clinical skills laboratory and also to learn what is expected once they start to supervise.

The panel was confident that clinical supervisors are appropriately qualified and trained. The GDC registration of clinical supervisors within the School was confirmed by GDC staff.

Requirement 6: Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety *(Requirement Met)*

The programme leads reported that raising concerns is 'embedded' within the programme. This was evidenced by the introduction of the Professionalism, Teamwork, and Social Responsibility (PTSR) strand within the 2012 curriculum within which ethics and professionalism is taught from Year 2, prior to patient contact.

The level of support within the School allows students to approach various members of staff should they need to raise a concern. An 'open door' policy has been adopted and this was evidenced by the confidence the students exhibited when asked about the support they receive. The mechanisms for raising concerns are included in student-focussed material and all staff the panel met with appeared to be knowledgeable about, and comfortable with, the process. The students interviewed were able to demonstrate an understanding of their obligation to raise a concern if patient safety were at risk.

The embedded nature of raising concerns was further evidenced by a serious incident that was reported by students, which is detailed under Requirement 7.

Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider *(Requirement Partly Met)*

The serious incident reported by students was fully disclosed to the panel and felt to have been dealt with quickly and appropriately within the programme's guidelines. The panel was therefore confident that any future incidents would be dealt with in the same manner.

The DATIX incident reporting system is in use throughout the clinics, and reports are referred to the Clinical Director of Dentistry. Such reports are addressed within the Trust's management structure and where appropriate are actioned by both the Clinical Director and the Dean. Monthly governance meetings take place within the Trust to discuss issues and complaints, of which there were none outstanding at the time of the inspection.

Evidence of a prior ongoing issue with a shortage of instruments was provided and the panel noted that this has now been resolved. Since greater transparency in Trust procurement protocols were introduced this issue has not re-arisen. The panel were assured that patient safety issues are being dealt with appropriately.

However, the policies which define the process for dealing with patient safety issues are those of the Trust only. The School does not have its own policies in place that reflect the fact that issues may arise due to student treatment. The policies in use govern all relevant NHS staff, and it is felt that a School specific, student-centric policy needs to be introduced to underpin the process. This would make the process comparable with other schools and the

Requirement could then be considered to be 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 *(Requirement Met)*

The system in place at the time of the inspection was being reviewed with a view to reorganising the individuals involved with the process. No current student fitness to practise issues were reported at the time of the inspection. Students are aware of the process which is documented in the student-focussed handbooks. The principles of the GDC's guidance are present within the programme's policy, which is a School-level policy that then feeds into the wider QMUL procedures. The panel was pleased to see that the process for dealing with student fitness to practise issues started at a 'local' level where an understanding of the programme and the need for professionalism is particularly emphasised.

Actions

Req. Number	**Actions**	**Due date**
7	The provider must introduce a school-level policy for dealing with patient safety issues.	2015 Annual Monitoring

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**			
Requirements	**Met**	**Partly met**	**Not met**
9. The provider will 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	✓		
10. The provider will have systems in place to quality assure placements		✓	
11. Any problems identified through the operation of the quality management framework must be addressed as soon as possible	✓		
12. Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity	✓		
13. Programmes must be subject to rigorous internal and external quality assurance procedures	✓		
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow QAA guidelines on external examining where applicable	✓		
15. Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment	✓		

GDC comments

Requirement 9: The provider will 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)*

A coherent quality management structure was evidenced with a number of programme-level committees possessing decision-making capabilities. The Dean is supported by an executive group who act as a conduit between the SMD and programme staff. The decision-making capabilities of groups such as the Dental Education Committee (DEC) and the Dental Quality & Assessment Committee (DQAC) allow the quality of the programme to be managed effectively because issues can be dealt with quickly. The majority of committees convene each month, including the DEC which has overarching responsibility for the process.

The work of the various committees is informed and driven by the Learning, Teaching & Assessment Strategy 2010-15 which helps to formalise the processes. There is also effective student input via the Staff & Student Liaison Committee (SSLC). Students reported that they felt able to raise concerns and the year representatives are able to communicate with their entire cohort.

The creation of the 2012 curriculum involved a comprehensive mapping exercise to the Preparing for Practice learning outcomes. The layout of the new curriculum mirrors the four areas of the learning outcomes – clinical, management and leadership, professionalism, and communication – and has allowed the School to introduce areas that they felt to have been lacking in the previous curriculum. This includes a Global Epidemiology strand as well as the updated PTSR area.

One area of concern to the inspectors was the lack of recording of responses to reports from external examiners. Copies of responses were requested during the programme inspection but could not be located. Responses had not initially been provided to examiners in respect of reports received at the end of the previous academic year but the response for the current year was provided at the exam inspection.

However, it was felt that the recording and speed with which the School communicates with its' external examiners needs to be reconsidered and developed. The panel did appreciate that University interaction is required before examiners can be responded to, and recognised that this can delay responses being collated and sent.

On the basis of the evidence received both prior to and at the inspection, the panel are assured that a comprehensive structure is in place. The student perception of the quality of the programme was high and the 2012 curriculum received great praise.

Requirement 10: The provider will have systems in place to quality assure placements *(Requirement Partly Met)*

The outreach placements are fully established and have been utilised by the School for a number of years. All placements received positive feedback from the students interviewed by the panel. The five placements comprise three nearby community centres, one specialising in paediatrics, one hospital placement for surgical and A&E experience, and one placement further afield in Essex. The three community dental placements in London already come under the auspices of QMUL with staff at the Essex placement receiving honorary contracts with QMUL soon. The level of formal, contractual interaction with the majority of the outreach placements give some assurances of informal quality assurance, as the staff at those placements must perform to the same standard as those within the School itself.

The School were open in their responses in the pre-inspection documentation that systems are not in place to quality assure placements. There is communication between the Dean and the leads in outreach but this is not regular or formalised. Some monitoring of outreach takes place when the modules within the curriculum are evaluated. The completed evaluations are analysed by the programme leads and the results discussed at DQAC where action points are identified. Such action points may not be specific for outreach but can still dictate what should happen at the placements.

However, the maintenance of teaching standards has no formal mechanism and the School is fortunate that there have not been any serious gaps in the teaching or overall experience at the placements. Student feedback on the placements is positive, but how any negative feedback would be utilised and acted upon is unclear.

The panel recognises that the School is planning to recruit an individual who will have

oversight of all the outreach placements. There are also plans to appoint clinical leads for all outreach placements who will work with the Head of Outreach to ensure overall consistency of all placements. These measures would help the School reach standardisation across all sites and will help to co-ordinate the training and calibration of outreach teachers. The opportunity for GDPs to come into the School before they supervise students does already contribute to calibration and standardisation but more could be done to formalise the arrangements.

The feedback received on outreach placements, along with the possibility of some quality assurance through the module evaluations, means that this Requirement can be considered to be partly met. However, the School must introduce the measures outlined to the panel as a matter of urgency to ensure that placements continue to offer experience to the required standard.

Requirement 11: Any problems identified through the operation of the quality management framework must be addressed as soon as possible *(Requirement Met)*

The regularity with which committees meet is monthly in most cases, and minutes show a closure of 'the loop' in regards to identification, discussion, and resolution of issues. Serious issues are discussed at the DEC and can be brought forward as a Chair's action if needs be. The process is further underpinned by the Dean sitting on a number of committees so he is involved at a 'grass roots' level and can bring issues to the attention of the School of Medicine & Dentistry or the University as and when required.

The panel was confident that issues would be identified and addressed in a timely manner within the quality management framework.

Requirement 12: Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity *(Requirement Met)*

Clear plans for escalation exist within the quality management framework, meaning that staff know how and to whom serious threats should be reported. There was a potential threat to the achievement of learning outcomes due to the move to the new building during the academic year. The School was aware of the potential difficulties and impact of the move. The contractors being used were specialised in re-developments of clinical premises and the timetable for the move was devised to coincide with the Easter break.

Further to this, the School maintained regular and effective communication with the contractors so that any issues were flagged immediately. It was found upon a tour of the new facilities that there was ample space for the move of phantom heads into the new building, and using existing equipment had the advantage of reducing the potential for procurement logistics to interrupt the move.

However, upon discussion with programme leads, the panel identified that there will be fewer treatment chairs in the new facility which may impact on students' clinical experience. The School stated that the Trust is aware of the School's student capacity and that plans were still being refined. Some of the clinical activity may need to be re-housed elsewhere but plans are ongoing and there was ample time between the programme inspection and the moving dates for a resolution to be found. There was no update on these plans during the exam inspection.

The School relocated to the new facility in April 2014. While this presented a significant challenge for staff and students, there was no evidence during the exam inspection (which took place in May 2014) that the move had adversely affected students and their ability to learn. It was observed, in fact, that the move had enhanced the student experience

particularly in regards to the clinical examinations as the new facility is spacious. Hospital and programme staff reported that the move had been handled efficiently and with relatively few disruptions to patients. The panel was able to observe how the increased space allowed for a smooth administration of the clinical examinations. Further information on the capacity for clinical activity, however, should be provided to the GDC once the move has been embedded.

The panel wish to commend the programme leads and staff for their hard work in ensuring that students were not adversely affected during the move to the new building. Staff should also be commended for adapting to their new facility with such adeptness as to not compromise the final exams.

Requirement 13: Programmes must be subject to rigorous internal and external quality assurance procedures *(Requirement Met)*

The programme is subject to periodic review by the University, and dentistry was included in the last three reviews. The CQC was due to inspect shortly after the GDC's inspection, and a mock inspection was taking place at the time of the GDC's inspection. Internal quality assurance is regularly undertaken by the DQAC, and this work feeds into the wider work of the SMD.

Further external quality assurance is provided by the external examiners who review written exam papers and produce reports on the final clinical exams. A full range of reports from the different external examiners was presented at the programme inspection. The panel further observed direct, verbal feedback at the Board of Examiners meeting following the final clinical assessments.

The contemporaneous response to recent external examiner reports was seen at the exam inspection. However, the panel wishes to note that historical responses could not be provided at the programme inspection and the programme leads advised that the responses could not be located. This undermined the rigour of the external quality assurance because it could not be determined how stringently feedback from the examiners was considered by the School. The evidence of the current response does provide assurance for the process now and in moving forward.

Requirement 14: External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow Quality Assurance Agency (QAA) guidelines on external examining where applicable *(Requirement Met)*

External examiners work within QAA guidelines and do not directly examine students. The programme has a full complement of external examiners who are all from similar institutions, and are therefore familiar with the learning outcomes. All appointments are recommended by the Professor for Dental Education and agreed with Part PIEs prior to gaining approval from SMD and QMUL committees. The programme leads did acknowledge that there can be difficulties in recruiting new external examiners but this is not an issue at the present time.

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *(Requirement Met)*

Reports from external examiners are the most common form of external reporting that the School receive. A response to the external examiner reports was provided at the exam inspection but earlier responses could not be found during the programme inspection, and therefore evidence of such reports being acted upon was lacking. The panel were concerned that such evidence had not been held centrally and securely

However, having seen the response to the current reports, the panel was assured that the quality assurance 'loop' is being closed and that the School is considering formal reports. The external examiners were able to give further assurance during interview at the exam inspection by detailing areas of improvement they had previously suggested which were in evidence at the exams.

Evidence of responses to earlier formal reports would have given complete assurance that this Requirement had been met. However, the evidence seen in the form of the current response and the information from the external examiners, does demonstrate the collaboration between the School and those reporting on a regular basis. The panel recommends that future responses be stored centrally and securely but consider the Requirement to be met.

Actions

Req. Number	**Actions**	**Due date**
9, 13 & 15	Responses to external examiner reports must be recorded effectively and securely. The mechanism for creating and sending responses needs to be re-evaluated to ensure that responses are sent in a timely manner.	2015 Annual monitoring
10	Quality assurance of outreach placements must be introduced as a matter of urgency. Appropriate staff should be recruited into roles to have oversight of the process.	2015 Annual monitoring
12	An update on the capacity for clinical activity at the new hospital, and whether any of this activity has had to be relocated, should be provided to the GDC.	2015 Annual monitoring

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**			
Requirements	**Met**	**Partly met**	**Not met**
16. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards.	✓		
17. The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes	✓		
18. Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed	✓		
19. Students will have exposure to an appropriate breadth of patients/procedures and will 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	✓		
20. The provider should seek to improve student performance by encouraging reflection and by providing feedback.	✓		
21. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body	✓		
22. 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	✓		
23. Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments	✓		
24. Where appropriate, patient/peer/customer feedback should contribute to the assessment process		✓	
25. Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion	✓		

26. 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	✓		

GDC comments

Requirement 16: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards *(Requirement Met)*

Student attainment is closely monitored via the use of LIFTUPP and also through a thorough sign-up process for the final exams. The sign-up process consists of three meetings between students, the Student Support Manager and senior tutors to discuss performance, check achievement of the required competencies and to flag any competencies in which a student may be deficient. The last of the three meetings takes place at the end of March with the finals commencing in May, meaning that time is still allowed for students to rectify any deficiencies

The use of LIFTUPP allows for triangulation of student attainment and feedback from supervisors. The panel noted that this system is in use at outreach as well as at the School, leading to 'joined up' working. The data from the previous electronic recording system, ePortfolio, has been retained and is reviewed alongside the LIFTUPP data. Both systems were used while LIFTUPP was introduced to ensure that all patient contacts were recorded.

The programme has been fully mapped to the learning outcomes. Blueprinting links the outcomes to the assessments in each year, meaning that to pass the assessments is to have achieved the learning outcomes. Tutors check students' performance in assessments regularly throughout the programme, including a formal review at progression meetings.

The final exams comprise a written examination, and two practical elements. Students must present a case and will also undertake a viva on a previously unseen patient whom they have the opportunity to examine. The written paper, practical exams and continuous assessments are the four elements that are used to determine a students' overall mark for the Part 5 BDS examination and whether they have achieved Distinction, Merit or Pass.

The method for the use of the four elements was clear in the Schools' documentation and was adhered to during the Board of Examiners meeting. Each element of the final assessment process must be passed and there is no compensation between the elements. The panel was satisfied that School processes were being observed and that the final qualification conclusion was valid.

The panel did note the concerns of external examiners in that the inclusion of continuous assessment in the final marks does appear to increase the number of Merit and Distinction students. However, it was felt that, although the School may wish to consider such feedback for their own purposes, this does not adversely affect the assessment conclusion: only safe students are being passed.

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes *(Requirement Met)*

The Student Support Office (SSO) plays a major role in the monitoring of students. The office has an Assessment & Feedback Officer who collects and records the clinical competency units and other associated course units completed by students, and logs these. Tutors and students may review this data at any time. The Assessment & Feedback Officer will also contact students if they appear to be falling behind so students will be made aware of gaps before end of year reviews

LIFTUPP also plays a significant role within student monitoring and this system has been rolled out across all outreach placements. This joined-up working promotes consistency and allows easier student reflection. The system in place prior to LIFTUPP is no longer used but all the information has been retained centrally within the SSO.

Regular meetings with students also allow programme staff to monitor student progress effectively. Mapping has been completed so that unit competencies can be tracked against the learning outcomes.

Competencies can be formally achieved only once a minimum number of each specified procedure has been completed. While this ensures a certain amount of exposure, the lack of actual numbers to indicate how many times a student has undertaken a certain procedure means that their individual experience is not monitored. Such monitoring may be useful in the future to identify areas of difficulty and gain a broader picture of the student experience. The programme leads stated at the exam inspection that it would be possible to gather such numbers from LIFTUPP but this is not routinely collated.

Requirement 18: Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed *(Requirement Met)*

The assessment methods have been recently evaluated in line with the exercise to introduce the 2012 curriculum. The range appeared to be effective and wide-ranging. Assessments are discussed at the DQAC and issues can then be referred to DEC for changes to be agreed if required. When asked by the panel, students were satisfied with the assessment methods.

The panel was impressed by the extensive blueprinting that shows the assessment process in detail. Having reviewed such blueprints and observed the final clinical examinations, the panel was satisfied that the range of assessment methods employed were appropriate.

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will 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)*

The programme has a consultant who is in charge of patients. Students may feed back to the consultant if they are lacking in a particular patient type, allowing for that gap to be filled and patients reallocated effectively.

The patient variations in each outreach placement allows for an appropriate breadth of exposure for the students. The patient mix at the School is extremely varied due to its' central London location. Steele's Lane placement gives concentrated paediatric experience and Southend gives a more continuous patient experience with longitudinal care. Every patient contact is logged on LIFTUPP with competencies being signed off in hard copy and collated at the School.

A review of student progression is completed early in Year 5 so that students who have a deficit then have the opportunity to achieve any missing competencies. If the student is still

lacking closer to the final exams then deadlines will be set. Missing competencies may not impede a student from completing their finals but will mean that they are not signed off at the end of the programme and therefore would not be able to apply for registration with the GDC. Upon review at the exam inspection, it was seen that all final year students have achieved the requisite competencies in order to be awarded the BDS qualification.

Requirement 20: The provider should seek to improve student performance by encouraging reflection and by providing feedback *(Requirement Met)*

LIFTUPP has played a large part in making the reflection process easier as students may reflect immediately after a patient contact. Unit competency forms will not be accepted by SSO if the student reflection section has not been completed.

The supervisor provides feedback on LIFTUPP also and students like the immediacy of the system. Further formal feedback is provided after assessments. The SSLC allows for formal student feedback on the programme.

Students reported to the panel that they were happy with the level of feedback they receive and the amount of reflection they are required to do. The School allocates all students into pairs when they commence the programme for clinical skills training and practice. This allows for additional peer feedback to be given informally between students, providing further opportunity to improve student performance. The fact that students are paired also means that students are required to work together, providing an introduction to the team working they will encounter in their future professional lives. In this way the ability to give constructive critique is also taught.

Requirement 21: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body *(Requirement Met)*

Training for internal examiners and assessors appeared to be comprehensive. There are several opportunities for academic staff to undertake further training and there is specialist training for the Principal Internal Examiners (PIEs) and the Senior Internal Examiners (SIEs). The majority of examiners observed during the final clinical examinations marked to a similar standard and were confident in their role. The panel observed some disparity in the individual marks awarded, which suggests that further calibration is required. The examiners who found themselves in that situation were able to collaborate and agree a joint mark, sometimes after starting with a wide disparity. Newer examiners were able to observe some of the exams themselves in order to further their learning.

The outreach placements will soon come under the QMUL ‘umbrella’, meaning that the same training requirements will be applied to assessors outside the School. However, it is not clear whether such training has taken place yet. Introducing a Head of Outreach, as intended by the School, is one measure by which the training of outreach staff should be assured.

The panel did note, however, that there were no reported issues with the consistency of assessment across sites from either staff, outreach supervisors or students. The panel therefore feel that the Requirement is met although further action would improve and reinforce the ability for all assessors to mark consistently. Comprehensive monitoring of marks from across outreach and increased opportunities for calibration may be useful.

Requirement 22: 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 *(Requirement Met)*

External examiners review written examination papers and observe the final clinical exams. The external examiners do not mark or participate in the clinical exams but observe both the student and the discussion afterwards between the internal examiners to ensure that students are being marked accurately and consistently.

Following the clinical exams, the external examiners provide an oral report on their observations at the Board of Examiners meeting. These observations are minuted and the examiners also provide a written report setting down the changes they would like to see in future years.

Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments *(Requirement Met)*

The assessment strategy for the programme was clearly demonstrated in blueprints, handbooks, and policy documentation. The Angoff Standard Setting method is utilised for the 2012 curriculum. The processes for standard setting, while present, are still being embedded but there is opportunity for staff to be trained in assessment criteria during development days and training with the module conveners.

Examiners have the opportunity to calibrate before the exams and the PIE holds a briefing on each day of the clinical exams. The briefing covers the format and structure of the exams, how the mark sheets work and also a list of structured questions to aid the examiners in achieving consistency across all candidates. While the panel observed that some of the structured questions were not relevant in every exam, the majority appeared to aid examiners and ensure that students were asked similar questions throughout.

The mark sheets utilised included descriptors for the grade scale and the overall mark was achieved via an accumulation of agreed marks. The use of cumulative marks and clear grade descriptors further help to achieve fairness in the assessments.

Analysis of the student results is undertaken prior to the Board of Examiners meeting and the method for assuring the validity of these is explained at the meeting itself. Marks are double-checked so that staff were assured that marks had not been inappropriately rounded up or down by the formatting of the results spreadsheet. Fairness and adherence to assessment criteria is considered at many stages, and with the standard-setting methodology, the Requirement is considered to have been met.

Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process *(Requirement Partly Met)*

Peer feedback is possible via the pairing of students through a large portion of the programme. Patient feedback has not been introduced yet and the programme leads will consider how best to implement this now that the move into the new hospital facility has been achieved. The programme leads are going to consider whether LIFTUPP may play a role in obtaining and capturing patient feedback.

It was observed during the case presentation exams that patients were keen to convey their thoughts on their treatment by the student to the examiners. Some patients are clearly keen to provide feedback and the School may wish to capitalise on this.

In the absence of patient feedback, the Requirement can only be considered to be partly met. The programme leads should consider and implement a method for capturing feedback at the earliest opportunity. The use of such feedback within the assessment process must be fully explored and formalised into policy.

Requirement 25: Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion *(Requirement Met)*

LIFTUPP is the tool with which the School can analyse individual student performance in conjunction with summative assessment data. The performance of all students is reviewed as part of the sign-up process for the final exams in Year 5. The Assessment & Feedback Officer in the SSO is responsible for ensuring that assessment data is correct and up to date.

Prior to the final exams, student performance is examined at the Student Progress Review at the end of each academic year. This allows for a review of formative as well as summative data.

The panel was satisfied that the assessment conclusion is reliable and valid due to the processes throughout the programme that allow for full student review.

Requirement 26: 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 *(Requirement Met)*

The standards for the programme are clearly communicated to students in various handbooks. Each Year has a joining or a re-joining handbook, and attention is further drawn to relevant information during teaching sessions. New students complete a formal induction week which alerts them to the expected standard. In interviews with the panel, students reported that they understood what was expected from them.

Staff also have handbooks as a source of policy information as well as development days where student assessment is discussed. Exam preparation focuses on the credit levels of the programme which serves to inform and also remind staff of the required standard.

During the final exams, the panel observed that all staff and students appeared to be familiar with the exam process. Examiners showed a clear understanding of the level expected of students and were confident in using the marking criteria. The panel was satisfied that the Requirement had been met.

Actions

Req. Number	Actions	Due date
24	The programme leads must implement a method by which patient feedback can be recorded. A policy must then be created and instituted as to how the feedback will contribute to the assessment process.	2015 Annual monitoring

Standard 4 – Equality and diversity **The provider must comply with equal opportunities and discrimination legislation and practice. They must also advocate this practice to students**			
Requirements	**Met**	**Partly met**	**Not met**
27. Providers must adhere to current legislation and best practice guidance relating to equality and diversity	✓		
28. Staff will receive training on equality and diversity, development and appraisal mechanisms will include this	✓		
29. Providers will convey to students the importance of compliance with equality and diversity law and principles both during training and after they begin practice	✓		

GDC comments

Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity *(Requirement Met)*

Equality and diversity policies exist within the School and on outreach. Both QMUL and NHS policies exist in all locations. The enthusiasm for, and commitment to, the principles of equality and diversity were evident from meeting with programme staff and the panel was satisfied that legislation and best practice guidance are being followed.

Requirement 28: Staff will receive training on equality and diversity, development and appraisal mechanisms will include this *(Requirement Met)*

All staff are under the mandatory requirement to complete QMUL training and completion is recorded. Those with NHS contracts will also complete Trust training. Staff at Southend will be given honorary contracts with QMUL, as staff at the other outreach placements already have. All staff on outreach will therefore be subject to the mandatory training requirements of QMUL as well.

Requirement 29: Providers will convey to students the importance of compliance with equality and diversity law and principles both during training and after they begin practice *(Requirement Met)*

While the formal terminology of “equality and diversity” was not clearly understood by all the students interviewed by the panel, the need for professionalism and to abandon any form of prejudice while with patients was clearly articulated by all the student groups. There was a good understanding of ethics. Equality and diversity was shown by the documentary evidence to be interwoven throughout the PTSR strand. The potential differences in governing legislation between the four UK nations are addressed in the course that prepares students for vocational training.

Actions

Req. Number	**Actions**	**Due date**
	N/A	

Summary of Actions

Req. Number	Actions	Observations Response from Provider	Due date
7	The provider must introduce a school-level policy for dealing with patient safety issues.		2015 Annual Monitoring
9, 13 & 15	Responses to external examiner reports must be recorded effectively and securely. The mechanism for creating and sending responses needs to be re-evaluated to ensure that responses are sent in a timely manner.		2015 Annual Monitoring
10	Quality assurance of outreach placements must be introduced. Appropriate staff should be recruited into roles to have oversight of the process.		2015 Annual Monitoring
12	An update on the capacity for clinical activity at the new hospital, and whether any of this activity has had to be relocated, should be provided to the GDC.		2015 Annual Monitoring
24	The programme leads must implement a method by which patient feedback can be recorded. A policy must then be created and instituted as to how the feedback will contribute to the assessment process.		2015 Annual Monitoring

Observations from the provider on the content of the report

We very much appreciate the efforts of the inspection team during their visits to the Institute of Dentistry at Barts and The London QMUL and for this report. We feel the content and recommendations of this report are entirely fair and reasonable. We are confident that we will be able to address all of the recommendations before the 2015 Annual Monitoring.

Recommendation to the GDC

The inspectors recommend that this qualification is sufficient for holders to apply for registration as a dentist with the General Dental Council.