

# General Dental Council

## Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
Queen Mary University of London	BDS

Outcome of Inspection	Recommended that the BDS qualification continues to be sufficient for the graduating cohort to register as a dentist.
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\*Full details of the inspection process can be found in Annex 1\*

## Inspection summary

<b>Remit and purpose of inspection:</b>	<b>Inspection referencing the Standards for Education to determine sufficiency of the award for the purpose of registration with the GDC as a dentist.</b>  <b>Time-elapsed inspection: focused on Requirements 1, 4, 7, 9, 13 and 15.</b>
<b>Learning Outcomes:</b>	<b>Safe Practitioner Framework and Preparing for Practice (details in report)</b>
<b>Programme inspection date:</b>	<b>10 March 2026</b>
<b>Inspection team:</b>	<b>Michael Rivelin (Chair and non-registrant member) Barbara Chadwick (Dentist member) James Ashworth-Holland (Dentist member) Martin McElvanna (GDC Education Quality Assurance Officer)</b>
<b>Report Produced by:</b>	<b>Martin McElvanna, GDC Education Quality Assurance Officer</b>

The inspection of the Bachelor of Dental Surgery (BDS) (hereafter referred to as “BDS” or “the programme”) is awarded and delivered by Queen Mary University of London (hereafter referred to as “the Institute”).

The programme was inspected as part of the “time elapsed” risk-based inspection process due to the length of time that had elapsed since the programme was last inspected in 2019. No particular risks had been identified through the General Dental Council’s (GDC) regular monitoring exercises and so a standardised list of six Requirements for “time elapsed” inspections from the Standards for Education were considered in this inspection.

The Institute of Dentistry sits within the Faculty of Medicine and Dentistry in the University structure and is well integrated within the wider University, with a range of resources available for the programme and for the students.

The inspection panel identified some areas of good practice. We concurred with the Institute that one of the strengths of the BDS programme is that students have access to a good breadth of clinical experience at both The Royal London Dental Hospital and at the three additional outreach placement centres (hereafter referred to as “the centres or “outreach”) across East London.

We noted that there are strong and effective support systems for students with a variety of support pathways including the Student Support Office. At the inspection we learnt that an increasing number of students on the programme are believed to work part-time and are from a widening participation background as a result of QMUL’s strong widening participation initiatives.

We suggest that the Institute consider identifying these students earlier in the programme in the interests of patient safety and to ensure these students continue to be well supported.

The School makes effective use of the “LiftUp” system for longitudinal monitoring of student development over a range of clinical and non-clinical metrics.

The Inspection panel (hereafter referred to as “the panel”) was pleased to receive a well-presented and complete set of evidence prior to the inspection. The panel was provided with clear and informed responses during discussions. The Programme team also demonstrated positive leadership and team working, which was evidenced throughout.

The panel consider that all six of the Requirements being considered are “Met”. Consequently, the panel agreed that it did not need to observe the BDS finals exams or examination board meetings. Although there are a couple of suggestions in this report, no formal inspection actions have been identified.

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

## Background and overview of BDS qualification

Current annual intake	Year 1: 79 Year 2: 76 Year 3: 79 Year 4: 71 Year 5: 100
Programme duration in weeks	Year 1: 35 Year 2: 44 Year 3: 44 Year 4: 44 Year 5: 43
Format of programme	<p><b>Year 1</b> Basic and life sciences teaching and learning, project work, Population Oral Health and Evidence Based Dentistry teaching and learning Clinical Practice – peer learning, simulation, observation and project work. Simulated practice, observation and clinic attendance to deliver preventative advice to patients. Project work and observation.</p> <p><b>Year 2</b> Applied sciences teaching and learning. Human Health and Disease teaching and learning. Clinical practice attendance, observation and project work. Simulated practice in Basic Clinical Skills, observation and clinic attendance.</p> <p><b>Year 3</b> Applied Clinical Sciences Teaching and Learning. Simulated practice in advanced clinical skills. Clinical practice observation, Clinical Treatment of Paediatric and Adult patients.</p> <p><b>Year 4</b> Applied Clinical Sciences teaching and learning Simulated practice in advanced clinical skills. Clinical practice observation and Clinical treatment of Paediatric and Adult patients.</p> <p><b>Year 5</b> Consolidation of learning Case-based discussions Clinical Practice observation and Clinical treatment of Paediatric and Adult patients.</p>
Number of providers delivering the programme	One

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

<b>Standard One</b>	
<b>1</b>	<b>Met</b>
2	Met
3	Met
<b>4</b>	<b>Met</b>
5	Met
6	Met
<b>7</b>	<b>Met</b>
8	Met
<b>Standard Two</b>	
<b>9</b>	<b>Met</b>
10	Met
11	Met
12	Met
<b>Standard Three</b>	
<b>13</b>	<b>Met</b>
14	Met
<b>15</b>	<b>Met</b>
16	Met
17	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)**

The panel received comprehensive documents and commentary ahead of the inspection against this Requirement.

Students undergo a robust induction programme covering a variety of key areas. This is supported with a variety of comprehensive handbooks covering assessment, clinical practice and expectations on professionalism, record-keeping, attendance and reflection.

Students attend the Institute of Dentistry clinical skills simulation lab and attend regular mandatory sessions in the simulated learning environment, working with state-of-the-art simulators and dental haptics.

The *Handbook for Student Clinical Practice* is comprehensive and includes clear guidance on all gateway assessments and minimal standards professional and clinical for all years of programme.

Students progress through the Dental Clinical Skills module in anticipation of a clinical gateway assessment to ensure they are safe to provide treatment to patients. They may only provide a treatment to patients once they have successfully passed the relevant clinical gateway. Students failing the gateway are subject to remediation plans which are recorded in the student's portfolio with a suggested date for a resit.

The panel saw robust use of these gateways and effective controls in place to prevent students from providing clinical treatment beyond their authorised scope.

The panel heard that students who have not successfully completed the relevant clinical gateway assessments are aware that they must not undertake procedures for which they have not been formally signed off as competent.

The panel also heard that students who have not successfully completed the relevant clinical gateway assessments are subject to alerts that are applied on LiftUpp. These are visible in real-time to clinical supervisors to enable them to restrict students from treating patients for a particular procedure. This was corroborated by outreach staff during the inspection who also considered that the gateways were effective. We were told that patients are offered care with an appropriate, alternative student when this situation arose to ensure their ongoing safety whilst under care at the outreach facility.

Students who struggle in the clinical environment are subject to a remediation plan which is developed by the appropriate year, and programme leads and in conjunction with the clinical lead. Additional slots are made available for students to attend additional supervised sessions if they wish to have additional time to practice techniques or are required to undertake remediation actions by clinical skills supervisors.

Clinical simulation skills logbooks remain an important part of the formative process and contain staff feedback and student reflection.

The panel considered that this Requirement was 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)**

In the clinical environment, students are supervised by clinical lecturers, readers, professors or clinical supervisors who are general dental practitioners. They have experience in undergraduate clinical education. Clinical supervisors are scheduled to attend regular training sessions for calibration and benchmarking.

All teaching staff are expected to complete the Certificate in Learning and Teaching (CILT), or an equivalent qualification, within three years of appointment. At the inspection, the rationale for this, as well as the process of CILTs checks was clearly explained.

Newly appointed staff undertake induction, training and a period of shadowing prior to independently supervising students. This ensures consistency of supervision standards across the programme.

Clinical supervisors and clinical faculty staff hold current GDC registration which is verified annually.

Clinical supervisors are present at all clinical facilities to observe student procedures, monitor professional behaviour and intervene where necessary to ensure patient and student safety and appropriate standards of care are being maintained.

Supervision is supported through defined staff-to-student ratios. The expectation is for a maximum ratio of 1:8 in the clinical skills laboratory and 1:6 in patient clinics. We saw comprehensive timetables and at the inspection, we heard more details on group sizes and supervision ratios.

The panel considered that this Requirement was Met.

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

**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)**

**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)**

Prior to the inspection, the panel was provided with various documents including *Incident Policy and Procedures*, *Risk Management Handbook*, *Patient Safety Incident Response Framework (PSIRF) Handbook*, sharps injury and splash contamination policies and *Datix User Guide*. These illustrate that the Institute has established and robust systems to identify, record, investigate and respond to patient safety incidents which are in line with Queen Mary University of London and Barts Health NHS Trust policies.

There is a clear process for reporting, triaging and investigating incidents in accordance with the *PSIRF Framework*. Specific incident types are detailed, such as clinical incidents, sharps injuries and occupational exposures and these managed in accordance with specific, clearly defined protocols.

DATIX is risk management reporting system used to manage incidents. We learnt that investigations focus on identifying contributory factors and system issues, rather than apportioning individual blame.

Where appropriate, serious concerns may be managed under the Institute of Dentistry Professional Capability and Fitness to Practise procedures.

We learnt that staff and students are encouraged and actively supported to report patient safety incidents, near misses and any other patient safety concerns through the Trust's DATIX system.

The Institute works closely with Barts Health NHS Trust clinical governance teams. Monthly reports are produced to report incidents involving students and these are shared with the Institute to inform future preventative actions, targeted staff and student training and general service improvement.

The panel considered that this Requirement was 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)**

The Institute has a comprehensive quality management framework within which the BDS programme operates. We saw helpful documents detailing an overview of the quality assurance structures. It is clear that overall quality of the programme lies with the Dean.

Oversight of the BDS programme and quality assurance is managed through the *Dental Quality Assurance Committee (DQAC)*. The *Organisational Governance and Quality Assurance Framework* structure is clear and there is a wide range of policies and procedures included to illustrate an effective quality assurance framework.

The DQAC Action plan demonstrates how quality data is reviewed to improve the programme. Agenda and minutes of relevant meetings were provided which illustrated well-presented minutes, traceable actions and information.

An annual curriculum review of all modules and the overall programme is undertaken through the QMUL programme review process. We saw programme review reports which demonstrated this and areas of risk and good practice were clearly identified.

Following publication of the *GDC's Safe Practitioner Framework* in 2023, a comprehensive curriculum review and mapping exercise was completed by the Institute, which was supported by a *GDC Transition Action Plan*. This resulted in the *BDS Assessment Mapping - BDS Year 1 New Curriculum 2025*.

The existing 2012 curriculum aligns with the *Preparing for Practice* framework up to 2025. From the 2025/26 academic year, Year 1 is delivered in alignment with the new 2025 Safe Practitioner curriculum, whilst Years 2 to 5 remain aligned with *Preparing for Practice* for existing cohorts. This phased approach ensures continuity and compliance with the GDC learning outcomes for all students.

The panel considered that this Requirement was Met.

**Requirement 10: Any concerns identified through the operation of 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. (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 Met)**

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

### Standard 3 – Student assessment

Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.

**Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. (Requirement Met)**

As described at Requirement 9, the Institute has embedded a phased approach to the move from Preparing for Practice to the Safe Practitioner Framework.

There are clear minimum standards for all years of the programme. There are several handbooks detailing expectations for student clinical practice and professionalism.

For each of the five BDS years, Progress Review Panel meetings are scheduled three times each year. Minutes and data from Sign-Up and Sign-Off meetings were presented and the sign-up to final examinations was clearly explained. This illustrated minimum clinical activity required and modules that must be passed before entering final examination phase of the programme. The panel saw a wealth of student data reviewed at these meetings, including the dynamic and evidence-based approach taken to defining minimum clinical activity.

For BDS Years 1–4, students who have not achieved the required level of engagement or experience are allocated additional time for clinical treatment, simulated clinical skills and targeted support, detailed in remediation action plans.

Prior to the inspection, the panel had concerns that some student attendance was poor for non-clinical activities. At the inspection, staff explained how this matter is being actively managed and that attendance had notably improved. There is a robust system for logging student attendance, including lectures. Students are reminded of their obligation to attend, and that attendance and professionalism records are monitored from the beginning of the programme. This is monitored in line with the BDS Attendance and Engagement Policy. Poor attendance or professionalism concerns can result in an escalation process involving senior staff and referrals to internal fitness to practise via the *Clinical Academic and Professionalism Concerns Policy*.

All BDS examiners and assessors are trained and calibrated. Assessments are standard set, appropriate psychometric testing is undertaken, double marking is applied to specific assessments and standards are reviewed. We saw evidence of benchmarking to other UK dental schools. Annual revalidation and reskilling of endodontics and fixed prosthodontics skills in the Clinical Skills Laboratory was introduced in 2025. Prosthodontics skills revalidation is covered under reskilling in BDS Year 5.

The panel would encourage the Institute to continue to employ a variety of mechanisms to ensure assessor and tutor calibration takes place.

There is good oversight from external examiners and they are invited to attend Sign-Up meetings. At the inspection we heard that their recommendations are acted upon, and we saw evidence of this.

At the inspection, Institute staff delivered a helpful demonstration of the LiftUpp system which is used to track student activity and progress longitudinally. It illustrated how students are monitored using a traffic-light system and the recording of an overall progress score following

Progress Review Panel meetings. As reported at Requirement 1, we also saw a system of real-time alerts against students who have not successfully completed the relevant clinical gateway assessments.

The panel considered that this Requirement was Met.

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

**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)**

In the pre-inspection documents, we read that students have comprehensive exposure to a wide and diverse range of patients and clinical procedures across all major disciplines of dentistry. At the inspection we heard more details about the patient case mix and patient access, as well as plans to open a new outreach centre in Barking in around two years' time. In January 2026, the GDC was kindly invited to reopening of the Barkentine outreach centre.

The Institute uses a system of comparing data for each BDS cohort's progress with those of previous BDS cohorts at the same stage of training. This is to monitor that students have comparable and appropriate exposure to a breadth of patients and procedures and have completed sufficient numbers of treatments at a competent level.

As referenced at Requirement 13, progress review panels monitor students' clinical experience according to the minimum requirements in the Handbook for Assessment of Clinical Practice 2025-26. We had sight of panel minutes that demonstrated that this process is followed. Students who have not achieved the required clinical experience will be given extra support by way of additional patient referrals and clinic sessions.

LiftUpp is used for recording activity, assessment and feedback in the clinical environment. From the demonstration we had during the inspection, it was clear that the use of LiftUpp ensures that students have access to an adequate range of patients and treatments.

The panel noted a process for the collection of patient feedback, but not all students receive such feedback. We suggest that the Institute consider mechanisms to share and improve individualised patient feedback directly with students.

The panel considered that students have good access to clinical experience opportunities and good access to outreach services which are supported by a strong administrative team.

The panel considered that this Requirement was Met.

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

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

**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)**

**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

Requirement number	Action	Observations & response from Provider	Due date
No actions identified.			

### Observations from the provider on content of report

All the team at the Institute of Dentistry, Queen Mary University of London would like to extend there thanks to the panel for the very positive inspection. We are delighted to see that all the inspected requirements were met. We were also delighted to see that several aspects of good practice were identified.

**Professor Christopher Tredwin**  
**Dean and Director, Institute of Dentistry, Queen Mary University of London**

### Recommendations to the GDC

<b>Education associates' recommendation</b>	The BDS continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council.
<b>Date of next regular monitoring exercise</b>	Academic year 2027 – 2028.

## 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 education associates with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is partly met if:

"Evidence derived from the inspection process is either incomplete or lacks detail and, as such, fails to convince the inspection panel that the provider fully demonstrates the Requirement. Information gathered through meetings with staff and students may not fully support the evidence submitted or there may be contradictory information in the evidence provided. There is, however, some evidence of compliance and it is likely that either (a) the appropriate evidence can be supplied in a short time frame, or, (b) any deficiencies identified can be addressed and evidenced in the annual monitoring process."

A Requirement is not met if:

“The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and students does not support the evidence provided or the evidence is inconsistent and/or incompatible with other findings. The deficiencies identified are such as to give rise to serious concern and will require an immediate action plan from the provider. The consequences of not meeting a Requirement in terms of the overall sufficiency of a programme will depend upon the compliance of the provider across the range of Requirements and the possible implications for public protection”

5. Inspection reports highlight areas of strength and draw attention to areas requiring improvement and development, including actions that are required to be undertaken by the provider. Where an action is needed for a Requirement to be met, the term ‘must’ is used to describe the obligation on the provider to undertake this action. For these actions the education associates must stipulate a specific timescale by which the action must be completed or when an update on progress must be provided. In their observations on the content of the report, the provider should confirm the anticipated date by which these actions will be completed. Where an action would improve how a Requirement is met, the term ‘should’ is used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

6. The Education Quality Assurance team aims to send an initial draft of the inspection report to the provider within two months of the conclusion of the inspection. The provider of the qualification has the opportunity to provide factual corrections on the draft report. Following the production of the final report the provider is asked to submit observations on, or objections to, the report and the actions listed. Where the inspection panel have recommended that the programme is sufficient for registration, the Council of the GDC have delegated responsibility to the GDC Registrar to consider the recommendations of the panel. Should an inspection panel not be able to recommend ‘sufficiency’ or ‘approval’, the report and observations would be presented to the Council of the GDC for consideration.

7. The final version of the report and the provider’s observations are published on the GDC website.