

General Dental Council

Education Quality Assurance Targeted Inspection 2021 Report

Education Provider/Awarding Body	Programme/Award
Kings College London	Bachelor of Dental Surgery

Outcome of Inspection
The Bachelor of Dental Surgery programme does assure us that students will be safe beginners (ongoing targeted monitoring during June and July 2021).

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

Inspection summary

Remit and purpose of inspection:	A 2021 Targeted Inspection focusing on Requirements 13 and 15 in the <i>Standards for Education</i> to determine ongoing sufficiency of the award for the purpose of GDC registration as a dentist. The inspection is to seek assurance that that all GDC Learning Outcomes have been achieved and that all students have satisfied the criteria of safe beginner, paying particular attention to an appropriate level of clinical experience.
Learning Outcomes:	Preparing for Practice (Dentist)
Programme inspection date:	Monday 24 May 2021
Inspection team:	Katie Carter (Chair and non-registrant member) Gill Jones (Dentist member) David Young (Dentist member) Marlene Ledgister (GDC Education Quality Assurance Officer) Martin McElvanna (GDC Education Quality Assurance Officer)

Executive Summary

The purpose of this targeted inspection was to decide if the current graduating cohort of students will, at the point of graduation, meet the required standards expected of a safe beginner for registration with the GDC. The impetus for this targeted inspection was the COVID-19 pandemic and the effect it has had on the ability of education programmes to provide the requisite level of experience to their students both in terms of clinical and non-clinical skills.

The BDS programme (“the programme”) at Kings College London (“the School”) was inspected because the evidence gathered prior to the inspection did not assure the GDC that the current final year students would meet the standard of a safe beginner. The inspection sought to verify and clarify evidence provided, to gather new information and to recommend next steps.

Following the inspection, we determined that Requirements 13 and 15 were met. We concluded that the processes assured us that the graduating cohort of students in 2021 would be safe beginners.

The main areas of assurance were:

1. evidence presented that the School has a variety of interventions in place to ensure students can obtain the necessary clinical experience.
2. evidence of an effective approach to student feedback, reflection, and review to support achievement of the expected competencies.
3. receipt of further data to illustrate the process for sign-up.

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

Background and overview of qualification

Annual intake	143 students
Programme duration	5 years
Format of programme	e.g: Year 1: basic knowledge, clinic attendance, shadowing 2: knowledge and simulated clinical experience 3: direct patient treatment 4-5: direct patient treatment, clinic attendance, outreach, placements
Number of providers delivering the programme.	One

Outcome of Requirements

Standard Three	
13	Met
15	Met

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)*

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)*

Assessment of non-clinical skills

1. Assurance that students have attained the necessary level of Leadership, Communication and Professionalism Skills (Requirement 13).

Prior to the inspection, the School submitted documentary evidence to demonstrate student attainment of the requisite non-clinical skills. The panel were able to see a range of paperwork including student reflective logs and observation reports.

The School told the panel that central to assessment and sign-off are the competence-based Tutor Marked Assessments (TMAs). Examples of these had been submitted to the panel demonstrating evidence of student attainment in communication, management and leadership and professionalism. TMA documentation recorded that students must obtain a satisfactory or outstanding rating to pass the TMA. Feedback on these skills was also evidenced on sample clinical feedback forms. Once completed, these are uploaded onto the School's e-learning platform, KEATS.

The panel also had sight of examples of the School's Competence Assessment Form (CAF) showing evidence of student self-reflection, peer assessment, ratings for communication, management and leadership and professionalism, which are signed off by the tutor. This evidence was supported by the detailed CAF reflection and assessment criteria. The School demonstrated a holistic approach to student development covering clinical and non-clinical skills.

2. Assurance that students have worked with a satisfactory range of patients to ensure they have necessary patient management skills (Requirement 13).

We learnt that one of the tools to monitor student progression is the use of "faculty norms", which were explained by staff as average numbers of patients being seen at key progress points, based on previous cohort data. We were told, however, that these are used more as a guide to identify how much experience students are getting and to target support where experience is low. The School added that it employs a more holistic case-based approach to the attainment of clinical experience rather than relying on counting up single treatments as evidence to determine achievement.

The panel were told that these "faculty norms" look at pure clinical activity for each discipline providing a way of comparing if the range and breadth of clinical experience could be considered at a sufficient level for every student before they were signed up for finals. The School added that faculty norms were reviewed taking into consideration social distancing.

Staff and students said that the students' return to outreach had been positive, with a proactive targeted approach to ensure students are getting the best possible opportunities to achieve the requisite competencies. Prior to going back to clinics, extensive treatment planning learning opportunities were undertaken. Although the return to clinics was affected by the pandemic, the School confirmed that there was an adequate number of chairs in each of the four outreach clinics and sufficient patients to allow students to complete the required minimum number of TMAs expected to be undertaken.

We learnt that case presentations are submitted which show the management of patient care over a one to two year period and the OSCE examination has been replaced with clinical reasoning VIVAs. The School stressed that the case presentations must relate to real patients.

The panel were told that VIVAs are used for assessment, similar to an unseen case presentation. These are particularly useful in assessing a deeper knowledge, understanding and tests students' reasoning skills.

Assessment of clinical skills

3. Assurance of clear delineation between simulated and patient-based procedures (Requirements 13 and 15).

The panel were told that students have been working in pairs on simulated activity, with one in each pair taking on the nursing role. Students used haptics to support with hand-eye coordination prior to going back to treating patients. The School explained that the emphasis has been on ensuring that students have experience with a range of treatments. Simulation is utilised as a backup and marked to the same standard. The increase in simulation opportunities had been a key tool to keep students from deskilling and maintain their confidence and competence.

Documentary evidence provided by the School highlighted that the new CAF has been adopted across simulated practice and is marked to the same standard and criteria.

We were told that TMAs cover the assessment of competency and there are a couple of competencies that can be achieved with simulation, for example, crown and bridge. The School emphasised that where there are any TMAs signed off with simulation, the student will have previously completed the activity with a patient.

Students who met with the panel were positive about simulation stating that they had found it very useful and there is a clear line between simulation and clinic, with demonstration that this is being used to good effect and as a reflective tool. Students added that they can sit with their tutor afterwards to talk through treatments and find the use of reflection beneficial. The panel were assured that simulation is not wholly relied upon and instead has supported the students to maintain skills as they return to treating patients and move towards the safe beginner level.

The School have a total of 12 haptics with six more on the way.

4. Assurance that students have gained clinical experience around a full range of clinical procedures (Requirements 13 and 15).

The School uses a variety of mechanisms for recording clinical data. At present, for BDS5, data is recorded on paper forms which are collected and collated by staff at each site where

clinical activity takes place. This system will be replaced by an ePortfolio which is in the process of being implemented across all years.

The School explained that students with low levels of clinical experience are discussed at Progress Committee meetings, support needs are identified and communicated to tutors who agree, with students, plans for obtaining the necessary clinical experience. Student Liaison Officers at each site assist in ensuring that patients/treatments are channelled to those students who need them.

Due to the pandemic, there has been a reduction in clinical experience, but this is being managed well by the School. The School explained the reference made to 'Hurdles' in the documentation. We learned that these are used to establish students' breadth of clinical experience and range of patients seen. There has been a decrease in some of the 'Hurdles' expected previously, but the School gave a good explanation why this was the case and citing again that the programme is competency-led.

At the inspection, the senior team explained to us that Progress Committee meetings essentially acted as sign-up meetings and are attended by all team leads who give individual feedback on students' clinical progress. The key approach at these meeting is to triangulate student data from a range of sources, starting with the progression of those students who were identified as needing support early on. TMAs and Reflective Practice Reviews must be completed and passed by all students to complete sign up.

The three indicators in this process are signed up, signed up with support, or not signed up. The School added that the next meeting in June 2021 will provide an update and recommendations on whether the majority of students can be signed up. The panel noted that the data showed some students with an amber rating, but the School provided assurance that these students should obtain the necessary clinical experience. The School confirmed that most students will be in clinics until the end of June 2021 with the Progress Lite Committee meeting scheduled for mid-June to review students' action plans, review progress, and make any further recommendations.

The School explained that the sourcing of micromotors has mitigated the need for AGP, but with some limitations on their usage, for example ultrasonic scaling. It added that students had rotations through outreach, with half of them attending Portsmouth and half attending West Norwood, supported by seminars and tutorial preparation.

Students explained to us the benefits of receiving feedback on clinical performance at the end of every session and that this helped with their confidence. They added that there has been much more focus on reflection and improvement this year and they are being encouraged by tutors to carry out more procedures. Extra clinics at Queen Mary's Sidcup have been useful and students reported working on busy clinics. We heard that the School would actively check whether students felt able to progress and hand over patients to other students to allow them to gain experience.

5. Assurance that students have received sufficient access to clinical experience to ensure a safe level of clinical competence (Requirements 13 and 15).

The panel considered that access to outreach has been important. The panel was given evidence that a variety of outreach centres are being used with a good system of rotations. The panel sought verification of the numbers of chairs available at each centre. There are 3 at Sidcup, 18 at Denmark Hill (not all are being used), 3-4 at Guys (oral surgery), 20 at Portsmouth (10 not used), 10 at West Norwood (5 not used). Of the 30 available Guy's chairs, 24 were used for UG patient treatment on the Guys rotas (6 dedicated to endodontics, 6 not

used due to social distancing). Students told the panel that they had experienced busy clinics at Sidcup with up to 12 patients per day.

The School demonstrated that student access to patients was being well managed. We particularly noted the good supervision levels, with student to supervisor ratios cited as 1:4 and 1:2 in some instances. We were told that the outreach 'sign out' process requires students to have completed competency assessments and the requisite clinical experience before leaving clinics.

The School evidenced good and effective communications with students regarding opportunities to book in patients at available clinics, which are being extended to the end of June 2021.

Students told the panel that increasing their restorative experience has been very positive. They pointed out that there will be a shorter gap between graduation and commencement of their dental foundation year, which will mean less opportunity for degrading of skills. Students also felt reassured they will be taking their transcripts with them.

6. Assurance that those students who have required remediation gain sufficient support to enable them to progress (Requirements 13 and 15).

We were informed that the current graduating cohort of students have been prioritised and are being closely supervised, meeting with their tutors every 6 weeks to review portfolios and undertake action planning. Students are matched with a tutor who is familiar with them and their work. The School explained that the mechanisms for monitoring and tracking of students' attendance, engagement and performance give early indication of students of concern and areas of challenge for them.

Thresholds for student attendance are included in the School's Attendance and Engagement Policy, and issues are picked up at Progress Committee meetings. Mechanisms have been put in place to ensure that time is made up. The panel were told that students with high absence rates have taken up additional sessions offered at evening clinics on 2 days per week and can join consultations and treatment planning sessions. Documentary evidence made available to the panel included an example Professional Development Planning record, charting completed extra catch-up sessions with student reflections recorded.

The panel were told that it plans to increase evening clinics to 3 days restorative activity per week in June.

The School demonstrated a proactive approach to identifying where extra student sessions are needed. The panel were told that timetabling has been very agile to meet individual student needs. The School added that Reflective Practice Reviews include development planning with weaker students to address shortfalls.

Students confirmed in discussion that whilst the timetable stays the same, there is tailoring for individual students. Students added that sessions are available to catch up on oral surgery, and they can organise time with consultants, including using their own time, if they so wish. Students were very positive about the role of Student Liaison Officers in supporting them to gain access to more treatments where necessary. Progress Committee meetings are also attended by the Student Welfare chair.

Summary of Action

Requirement number	No.	Action required	Observations & response from Provider	Due date
13/15	1	Evidence to be submitted showing that all TMAs have been completed and passed with the full cohort list giving assurance that the process is complete.		August 2021
13/15	2	Progress Committee meeting minutes for June 2021 evidencing the numbers of students going through to June 24 Sign Up.		August 2021
13/15	3	Progress Committee meeting minutes for July 2021 regarding the students who had been extended (beyond June 24)		August 2021

Observations from the provider on content of report

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Recommendations to the GDC

Education associates' recommendation	The BDS programme does assure us that students will be safe beginners upon graduation.
Date of next targeted monitoring exercise	August 2021

Annex 1

Targeted Inspections 2021 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.
2. The GDC has a statutory duty to ensure that only those students who have met the required learning outcomes as safe beginners can join the GDC Register.
3. The impact of the COVID-19 pandemic on primary dental education has been significant, particularly due to restrictions on patient access and clinical environments. As a result, the Education Quality Assurance team have developed a process to assure the Council and the public that we continue to only register individuals who are safe beginners.
4. During 2020 and 2021 we undertook a process of monitoring activity and meetings with providers of primary dental education. This included assurance of adequate provision of clinical experience for all students, particularly those expected to graduate in 2021.
5. Data gathered from this activity will inform decisions regarding the focus of education quality assurance inspection activity during 2021.
6. The targeted inspections in 2021 will focus on two Requirements from the GDC's Standards for Education: Requirements 13 and 15.
7. All providers of dental and dental care programmes with a final year cohort may be subject to an inspection if they do not provide evidence:
 - that satisfies the GDC that all Learning Outcomes have been achieved
 - that all students have satisfied the criteria of safe beginner, paying particular attention to an appropriate level of clinical experience.
8. Inspections will be focused on the assurance of the depth and breadth of experience of final year students. The decision to be made at the end of the inspection is whether students can be considered to have met the learning outcomes and have the requisite experience to be a safe beginner.
9. The education provider is requested to undertake a self-evaluation of against Requirements 13 and 15 under the Standards for Education 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. 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”.

10. 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 continue to recommend ‘sufficiency’ or ‘approval,’ the report and observations will be presented to the Council of the GDC for consideration.
11. The provider will be sent a written record of the inspection findings and next steps. There will be no opportunity for the provider to provide their observations or factual corrections as this inspection has been instigated under Section 11 of the Dentists Act 1984.