General Dental Council

protecting patients, regulating the dental team

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Date
King's College Hospital NHS Foundation Trust	Diploma in Dental Hygiene & Therapy	6 & 7 November 2019

Outcome of Inspection	Recommended that the Diploma in Dental Hygiene & Therapy continues to be approved for the graduating cohort to register as a dental hygienist and a dental therapist.

Full details of the inspection process can be found in the annex

Inspection summary

Remit and purpose of inspection:	**Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the General Dental Council (GDC) as a dental hygienist and a dental therapist.** **Risk-based inspection focused on Requirements 1, 3, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17 and 21**
Learning Outcomes:	**Preparing for Practice (dental hygienist and dental therapist)**
Programme inspection date:	**6 & 7 November 2019**
Inspection team:	**John Vaughan (Chair and Non-registrant Member)** **Aradhna Tugnait (Dentist Member)** **Bal Chana (DCP Member)** **Martin McElvanna (GDC Education & Quality Assurance Officer)** **Marlene Ledgister (GDC Education & Quality Assurance Officer)**

The Diploma in Dental Hygiene & Therapy programme (hereafter referred to as 'the Diploma' and 'the programme') is delivered King's College Hospital NHS Foundation Trust (hereafter referred to as 'the School', 'the Trust' and 'the provider') and funded by Health Education England. We learnt that the programme is coming to an end in June 2021 when the last cohort graduate. Funding is secure until then.

Final examinations are provided by the Royal College of Surgeons of England ('RCSEng'). The qualification is awarded by RCSEng following successful completion of its examinations at the end of 2.5 years of full-time study.

The inspection of the programme was risk-based looking at specific areas of focus identified by the GDC's Education & Quality Assurance team during 2019. Information considered when identifying potential or actual risks included annual monitoring returns, previous inspection reports (and progress against any actions) and responses to wider recommendations in the GDC Annual Review of Education.

The inspection focused on Requirements 1, 3, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17 and 21 and specific areas within each which are detailed under the respective Requirement below. Of the 14 Requirements being looked at, we considered that 6 were met, 4 were partly met and 4 were not met.

The inspection panel comprised of education associates ('the panel', 'the team', 'we') identified three key challenges for the programme that require action.

The first is staffing issues. The School lost key staff members within a short period of time in summer 2019. The School is receiving ongoing distance support from the former Deputy Head of Dental Hygiene & Therapy on an honorary contract basis. Senior vacancies remain unfilled and we were advised during the inspection that there were no plans to fill them given that the programme is finishing in 2021. Instead, responsibilities have been re-distributed to existing staff whose roles have been enhanced. These staffing challenges have had an impact on how some Requirements were being met, which is discussed in detail later in this report.

Secondly, there are major weaknesses in the quality assurance framework which is largely informal and ad hoc. The governance arrangements are inadequate. This is discussed in more detail at Standard Two.

Thirdly, data reporting continues to be a weakness. Further commentary on this can be found later in the report.

We considered that there are some areas of good practice, particularly with patient access and elements of student assessment.

We were disappointed that we did not have the opportunity at the inspection to meet some key staff from the Trust such as the Clinical Director and the Associate Divisional Manager of the Dental Hospital to whom the Acting Deputy Head reports.

We were informed that a new BSc in Dental Therapy and Hygiene to be run by King's College London is currently being planned. We indicated that the proposed programme lead should contact the GDC urgently to discuss the process for seeking provisional approval of this programme before any students are accepted.

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

Background and overview of qualification

Annual intake	30 students
Programme duration	2.5 years
Format of programme	Year 1: basic knowledge, clinic attendance, shadowing, simulated clinical experience 2: knowledge and simulated clinical experience, direct patient treatment, outreach placements, literature, research project 3: direct patient treatment, outreach placements
Number of providers delivering the programme	1 provider delivering the programme: King's College Hospital 1 provider delivering the final exams and awarding the qualification: RCSEng

Outcome of relevant Requirements[1]

Standard One	
1	Met
2	Met
3	Partly Met
4	Met
5	Met
6	Not Met
7	Met
8	Met
Standard Two	
9	Not Met
10	Partly Met
11	Not Met
12	Partly Met
Standard Three	
13	Met
14	Not Met
15	Met
16	Met
17	Met
18	Met
19	Met
20	Met
21	Partly Met

[1] All Requirements within the *Standards for Education* are applicable for all programmes unless otherwise stated. Specific requirements will be examined through inspection activity and will be identified via risk analysis processes or due to current thematic reviews.

Standard 1 – Protecting patients
Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised.

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

Under this Requirement, the panel was tasked with looking closely at Gateway assessments.

The panel saw three documents detailing the "Gateway to Clinic" assessments across the disciplines of Hygiene, Adult Therapy and Child Therapy. These contained course aims, clinical skills criteria and examples of how to demonstrate skill and knowledge. These also explain how students must complete a variety of formative and summative assessments such as case scenarios, reflective logs, written papers, post-lecture tests and clinical tasks. The three documents also contain examples of unsafe practice particular to each discipline.

In addition, we had sight of the "Introduction to Clinic Handbook" which explains that this is a core compulsory module of the programme and an essential element to the Gateway to Clinic assessments. The subject matter contains areas such as medical emergencies, law and ethics, cross infection, history taking and patient assessment which students must pass in addition to Gateway assessments. The document also explains learning outcomes and assessment strategy for the module.

The panel considered that the Gateway to Clinic assessments were thorough and at an appropriate level. We were informed that students are not progressed until they had successfully navigated these Gateways. Furthermore, it is not physically possible to book patients until lists are formally opened only upon passing the Gateways.

We noted that since the last inspection, competencies have been reviewed to ensure they are at the right level and assess an appropriate level of skills.

The panel concluded that the students are appropriately trained, monitored and assessed throughout the programme and prior to treating patients.

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 Partly Met)*

Under this Requirement, the panel was also tasked with looking at staffing levels and whether this has any impact on meeting this Requirement, as well as monitoring progress against a previous GDC inspection action to implement plans for clinical audits or a similar plan to ensure that clinical areas are safe for students.

The panel heard that the supervision ratio on clinic is a minimum of five students to one supervisor. There is contingency if the ratio is compromised by asking additional staff to step in. If the ratio falls below this target, the clinic would be cancelled so as not to compromise patient safety.

Incidents are recorded on a mobile application called “Perfect Ward” which is the Trust’s new reporting system. Reports of incidents are issued at departmental level.

We had sight of the Local Safety Standards for Invasive Procedures (LocSSIP) which we considered to be a good initiative and which promoted patient safety. This was particularly notable in the area of paediatric practice where deciduous extractions must be done under one to one supervision and formal paperwork must be completed.

The panel saw the Trust’s corporate policies and documents, but we considered these were not sufficiently understood or applied within the School and appeared to be more appropriate for the undergraduate dental surgery programme.

Staff mandatory training is well organised and centrally recorded in the Trust database called ‘LEAP’. This system gives percentage scores of training that has been completed and gives early notice of forthcoming training sessions. We were informed that the department was largely compliant. We noted that staff training opportunities were plentiful and funded.

At the inspection we were advised that there is currently no audit lead in the hospital. The panel did not see evidence of clinical audits. The department does aim to follow the outcomes of audits in other departments and attempts to adopt any lessons learnt.

Given the staffing challenges and the lack of progress against the previous inspection action, we consider this Requirement to be partly met.

Actions	**Due date**
The provider should establish a clearer structure so that relevant issues identified at Trust level are appropriately implemented at School level.	Monitoring 2020
The provider should implement plans for clinical audits to ensure that clinical areas are safe for students.	Monitoring 2020

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)***

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 Not Met)***

Within this Requirement, the panel was also tasked with looking more closely at the duty of candour and students' ability to raise concerns.

Ahead of the inspection, the panel was provided with several documents including the Student Handbook 2019 which contains a Raising Concerns Policy ('the Policy') at Appendix 2, dated 'for review in August 2016'. It explains that students can raise concerns with their personal or clinical tutor. They can also raise concerns through student representatives. We noted that the Policy was due to have been reviewed in 2016 but this did not take place.

At the inspection we questioned staff about the Policy. They appeared initially to be somewhat unclear about its contents. They appeared to be unable to fully define and explain the implementation of the Policy at a local practical level. There also appeared to be some confusion as to what type of issues 'raising concerns' related to, with administrative and facilities issues at times being cited and not the key concerns definition that would be expected within the context of this Requirement.

We were informed that the Policy is available to staff and students on the intranet should they require it. Any changes to it are communicated by email or at clinical governance meetings. There are termly meetings to allow staff to raise concerns on any subject. We did not consider this approach was sufficiently proactive and robust. We were not assured that the Trust ensures that teaching staff are embedding awareness of how to raise concerns throughout the education they are delivering.

Similarly, students did not appear to be clear when we asked them at the inspection. Some cited examples which illustrated a misunderstanding of the meaning of raising concerns as would be expected under this Requirement. We noted that the Policy states that students can discuss a concern 'outside their department', but it does not sign-post to where or to whom. Again, the Policy indicates that students can approach 'any member of senior management of the Trust' but does not indicate exactly who.

We considered therefore that there was little evidence that students were aware of the range of mechanisms available to them to raise concerns, including external support. There is no clearly defined escalation process or alternative routes to raise concerns. Furthermore, it is not clear how compliance with this Policy is monitored in the School. We consider that the Policy is not widely known or understood by staff and students and as a result is not effective. As a result, we consider this Requirement is not met.

Actions	**Due date**
The provider must review the Raising Concerns Policy. This must include a detailed and formal mechanism for dealing with concerns when they arise with details of named staff roles and responsibilities and a clear escalation path. Staff must be fully aware how it is implemented.	Monitoring 2020
The provider must design a mechanism for reviewing policies and communicating at different levels how these impact across the programme. The School should ensure that the policy sets out clear communication structures and deadlines, who is responsible and the date for review.	Monitoring 2020

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)***

In the event of a patient safety issue arising, students must inform a member of staff or the head nurse allocated to the department. The current mechanism for recording incidents is DATIX. The panel saw evidence that issues have been recorded and dealt with using this system. Some incidents did also result in follow up actions and used as a learning opportunity.

The Deputy Director is notified immediately of incidents recorded who will either lead an investigation into it or delegate it to another staff member.

Issues recorded on DATIX are presented to the Quality & Risk Governance Committee for the purpose of shared learning. Details of the investigations and outcomes of these incidents are cascaded to the full staff team either at meetings or by email.

We also recognise the use of LocSSIPs which is discussed at Requirement 3.

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 Standards for the Dental Team are embedded within student training. *(Requirement Met)*

The panel had sight of the Student Fitness to Practice Policy ('the Policy') at Appendix 1 in the Student Handbook 2019. We were also notified of two matters in the 2019 Annual Monitoring return which related to a professionalism incident involving social media and a clinical matter. The team was assured that both matters had been managed appropriately in accordance with the Policy.

Students are also given an induction presentation on their first day as well as being made aware of the School's Code of Conduct.

At the inspection, the team explained that student fitness to practise matters are categorised into academic issues, clinical issues and isolated incidents. Each requires a different approach with the student. Incidents are also discussed at staff meetings.

Staff are also introduced to the Policy upon induction. They are also regularly reminded during plenary meetings to voice any concerns regarding a student's conduct or competence via the student's personal tutor.

The GDC's Standards for the Dental Team are embedded continually throughout the course which begins at 1st day presentations. They are also included in various modules such as Introduction to Clinic and Law & Ethics. They are included in student review meetings and help inform clinical grading criteria.

Given that the Policy dates to August 2016, the panel considered that it might be benefit from review.

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 Not Met)*

Under this Requirement, the panel looked at progress against a previous GDC inspection action to formalise the quality management of the programme and to improve recording.

Ahead of the inspection, the panel were provided with the Quality Assurance Policy 2018. We considered this two-page document to be a vague and aspirational statement of quality assurance intentions. There is no reference to any tangible quality assurance framework within which quality processes are monitored and implemented.

We heard about the existence of various meetings between programme leads and staff, team meetings, weekly and termly plenary meetings and an annual review of modules. These appeared to be the only forum for discussing quality assurance elements of the programme. They did not appear to be systematically discussed at such meetings, only when the need arose.

We considered minutes of various meetings. Some appeared to be missing standing agenda items and the terms of reference for meetings was not clear. It was difficult to see how items identified for action at one meeting are picked up at the next meeting or to ensure that the outcome of any changes is recorded and monitored. Minutes of meetings are lacking or not adequately structured. There are no specific recording documents that demonstrate what changes have been made to the programme and why. We therefore consider that recording continues to be a major weakness in the programme.

There also appears to be a heavy reliance on informal patient, student and staff feedback as a means of discussing quality issues, such as feedback from students and what changes to the programme may be required.

At the inspection, the School was not able to clearly state where quality assurance responsibility lies, the timescales for processes and communication structures for escalation. Although several people are apparently involved in quality assurance of the programme, there appears to be an over-reliance on one key member of the team, the Acting Deputy Head.

At the inspection we learnt that the Acting Deputy Head reports to the Associate Divisional Manager of the Trust's Dental Hospital Unit. However, it is not clear what involvement they have in the quality assurance process, and there is no clear evidence of structured accountability between the School and the Trust. We therefore considered that governance arrangements are weak. We were not assured that the implementation and use of Trust policies was being monitored and applied adequately at local level. Furthermore, we considered that these policies may not always be directly relevant to the School.

We were informed at the inspection that blueprinting of the GDC's learning outcomes is carried out in August at annual module reviews. Any changes made are recorded in minutes to ensure there is transparency of changes made. The panel did not receive any evidence of this so could not be assured that this process was working.

We concluded that the use of various meetings and the over-reliance on informal feedback appeared to be the only quality management mechanisms in place. We therefore considered that the framework lacked the required rigour. Whilst we recognise the commitment of the senior team to ensure that the programme is of a high quality, this was undermined by gaps in the monitoring and recording process.

Given the findings discussed and the lack of progress against the previous 2016 GDC inspection action, we conclude that this Requirement is not met.

Actions	Due date
The provider must formalise the quality management of the programme which must be detailed in a comprehensive quality management document.	Monitoring 2020
The provider should consider establishing a dedicated quality assurance forum, with appropriate terms of reference and membership, ensuring a high level of scrutiny, monitoring and transparency.	Monitoring 2020
The provider must implement methods to improve recording. This includes clearer recording of mapping exercises against the learning outcomes when conducted and any changes made.	Monitoring 2020

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

Under this Requirement, the panel was also tasked with looking at progress against a previous GDC inspection action to establish a contingency plan to counter unexpected staff absence and to define this in writing.

As discussed at Requirement 9, we consider there is an absence of a comprehensive and formal Quality Management framework.

During the GDC's 2019 Annual Monitoring exercise, the School notified us of the serious challenges they faced with staffing. Both the Director of School and Deputy Head of Department left within a matter of weeks. Since August 2019, the School is receiving support from the former Deputy Head who is engaged on an Honorary Contract basis, providing distance support largely over the phone when required. We did not consider this to be a sustainable arrangement in the long term. However, we fully recognise the difficult position the School finds itself in given the staffing challenges and particularly considering that the programme will be ending in 18 months with no plans to fill the existing vacancies.

At the inspection, the senior team explained how workloads have been re-banded in an effort to support the Acting Deputy Head's workload and all staff tutor roles have been banded upwards to recognise this. We considered that there were good communication channels between the senior team. However, it was clear that the senior team undertake a large variety of tasks such as teaching, assessing, timetabling and administrative tasks. As such, there is the potential for adverse risk to programme delivery if one or more of the leads was absent or left the School. This is particularly of concern given the absence of effective recording.

We were advised that the Trust is aware of the issues and have indicated that they will offer support to the School as required. To date, the School has not taken up this offer. The panel considers that this should be reconsidered to ensure that the programme is supported with the necessary senior leadership and governance through to the conclusion of the programme in 2021. We also considered that the School should seek out opportunities for external support from the wider Trust for administrative and IT support.

The panel had sight of a departmental risk log dated July 2019. However, this did not contain timeframes, ownership and staff names. Therefore, we considered it not to be a coherent and effective Risk Register.

Despite the challenges described, we did not consider that there were serious threats to students achieving the learning outcomes, given that the senior team appear to be working very closely together and with notable commitment, and that concerns were widely communicated at various meetings or on email as appropriate. However, we did consider than even a small change to staffing arrangements could have a disproportionate effect on programme delivery.

For discussion around the use of external examiners, see the commentary at Requirement 11.

Actions	**Due date**
The provider should review the senior leadership support available and consider seeking administrative and IT support from the wider Trust so that the senior team can be relieved of administrative tasks.	Monitoring 2020
The Risk Register should be more comprehensive and include timeframes and roles and responsibilities. This should include a contingency plan to counter unexpected staff absence and to define this in writing.	Monitoring 2020
The provider must implement methods to improve recording. This must ensure that clearer recording of mapping exercises against the learning outcomes have been conducted and any changes made.	Monitoring 2020

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 Not Met)***

Within this Requirement, the panel was also tasked with looking at how student and patient feedback is used to inform development of the programme. We also looked at progress against a previous GDC inspection action to introduce a policy regarding the use of feedback to ensure that this information is formally considered and used to develop the programme.

Commentary around internal quality assurance procedures can be found at Requirement 9 and 10.

Ahead of the inspection, we had sight of external examiner (EE) reports from 2018 and some feedback they had provided regarding the overall state of the programme, marking inconsistences and comments about the Objective Structured Clinical Examination (OSCE).

We learnt that EEs review exam questions and are informed of any changes prior to exams. The presiding external examiner is involved in Year One OSCEs and end of Year One written papers and provides feedback on these and makes recommendations. This examiner also acts as a moderating marker for the internal blind markers of the written examination in the event of any discrepancies.

EE reports are sent to the Acting Deputy Head and considered at Plenary meetings.

We considered that the use of EEs is not adequately formalised. Although the ‘External Examiners role’ document describes some of their functions, it does not detail the process for submitting their feedback, the format it should take, how feedback is considered and acted upon and deadlines for submission of feedback and review of it by the School. Once again, we consider this to be an overall weakness in recording. We did not see any evidence that

external reports from EEs and their observations were formally discussed, acted upon and responded to.

We learnt about the collection of patient feedback via the PALS hospital system as well as an internal feedback system within the department. We learnt that most of the patient feedback relates to administrative issues such as booking errors at reception. Some feedback related to complaints which were brought to the Acting Deputy Head. The panel also saw evidence that feedback from patients was used to inform students' clinical practice. However, we did not see any examples of feedback that was used to inform programme development.

Although we heard that students can provide feedback via student representatives, tutors and directly with the senior team, we did not see any evidence of student feedback being formally used to inform changes to the programme.

We concluded that the collection of patient and student feedback to inform programme development is not supported by a detailed policy that describes how it will be used and when it should be discussed and acted upon. Such a policy would help the School to meet this Requirement.

As a result of this, the panel determined that this Requirement has not been met.

Actions	**Due date**
The provider must develop a policy regarding the use of patient and student feedback to ensure it is formally considered and used to develop the programme.	Monitoring 2020
The provider should consider reviewing questions on patient feedback forms so that such feedback can meaningfully help to inform developments to the programme.	Monitoring 2020
The provider must improve and formalise the use of external examiners. The process for collection, use and response to feedback should be clearer.	Monitoring 2020

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

Under this Requirement, the panel was also tasked with looking at progress against previous GDC inspection actions to introduce quality assurance measures for outreach and to roll out patient feedback methods across all sites.

The Trust offers facilities such as Community Clinics, Norwood Hall and the Dental Institute to enable students to attend a wide variety of clinics. Placements are subject to the same regulations as the main hospital training facility as well as the same patient safety monitoring and incident reporting systems.

The School explained that they carry out annual environment checks through the use of quality assurance forms. However, we did not see any evidence of actions taken as a result.

Regarding student and patient feedback, please see the commentary under Requirement 11.

At the inspection, we were only given the opportunity to speak to one member of outreach staff. In addition, there was limited evidence available for the panel to determine whether any

progress had been made against the previous GDC inspection action to introduce quality assurance measures for outreach. Given this lack of information, as well as the weaknesses identified with the collection and use of feedback, we concluded that this Requirement is partly met.

Actions	Due date
The provider should introduce quality assurance measures for all outreach placements with clear reporting and audit trails on any actions being taken.	Monitoring 2020
The provider must develop a policy regarding the use of patient and student feedback to ensure it is that formally considered and used to develop the programme.	Monitoring 2020
The provider should consider reviewing questions on patient feedback forms so that such feedback can meaningfully help to inform developments to the programme.	Monitoring 2020

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)*

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 Not Met)*

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

At the inspection, the senior team talked us through their system for recording and monitoring student data, which could be described as semi-electronic given the heavy reliance on the use of paper as well as spreadsheets. Data covers a wide area such as results of competence tests, quotas of clinical experience, academic progress, assessment results and absenteeism.

The senior team explained that there are limitations to moving to an electronic system due to resourcing issues in the Trust. The administrative team support the collation of results and monthly reports regarding student clinical progress to relieve the senior management team from carrying out these tasks. Staff who deliver lectures also record the input of student data.

We had sight of student logbooks and considered these were being appropriately used to record student progress and demonstrate how they are meeting the required competencies.

The School acknowledges that administrative support is proving to be a challenge. At the inspection, we learnt that some data had not been updated for at least two months due to staff absence. We were therefore not assured that data was being reviewed frequently. We also saw some examples of data inputting errors. The senior team explained that is only discovered when the data identifies students affected as outliers, warranting closer analysis.

In addition, there had been some input errors which meant some of the information presented was incorrect. We considered that there is an over-reliance on students to submit the information correctly.

Given the shortcomings identified, we considered that staffing shortages and over-reliance on paper-based monitoring is having a major impact on meeting this Requirement and as a result we concluded that it is not met.

Actions	**Due date**
The provider must improve the system of checking and validating student data. A process must be implemented to mitigate against errors with the inputting of data and ensure that this data is reliable.	Monitoring 2020
The provider should consider seeking out administrative and IT support from the wider Trust so that the senior team can relieved of administrative tasks.	Monitoring 2020

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)*

The panel heard that students attend a wide variety of clinics across the disciplines of paediatrics, adult restorative and periodontics. This was confirmed when we looked at students' logbooks. The majority of clinics are located at the Dental Institute as well as four Community Clinics and one at Norwood Hall Academy. The split between paediatric and adult patients is roughly 80/20.

There are processes to ensure that students have adequate access to patients. Firstly, the number of procedures is itemised in the student logbook and identified by way of clinical targets. Students are advised on the number of times they must carry out each procedure. Secondly, there is meticulous timetabling of students' attendance at clinics taking into account students' experience to date and case complexity. This helps to ensure there is fairness across the cohort. Finally, in the interests of continuity of care, students are assigned named patients who they will manage throughout their treatment. The panel commend the Trust on these measures and consider these to be areas of good practice.

The panel considered that there is a strong element of treatment planning for new and suitable patients, with a review being conducted firstly by the student, then by the supervisor.

Students indicated that they gained good experience in a variety of disciplines, but some felt they did not see enough patients, particularly in adult restorative cases where they felt less confident. However, they indicated that community tutors are on hand to help address numbers and targets. They indicated that they felt they had good nursing support.

One issue that students raised was patient booking errors at reception, which sometimes resulted in patients not turning up for appointments. We also learnt about a major issue with patient bookings as a result of a delay in opening the patient management system by the waiting list manager. We heard that this issue took some time to resolve but would not cause any further problems to students. We were assured that this booking system is only available to those students who have passed the requisite modules.

In the event that students have low numbers or experience, the panel was assured that both outreach and Trust staff are supportive by liaising directly with students if they need any further

experience in order to try and accommodate their needs. Students can also easily go to alternative clinics if necessary. As a last resort, and if there are other competence issues, students can be held back for a further six months.

We were assured that students have access to a good range of patients and procedures which enables them to meet the GDC's learning outcomes and to qualify as safe beginners.

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)*

Under this Requirement, the panel was also tasked with looking at staffing levels and whether this has any impact on how this Requirement is met. In addition, the panel was tasked also with monitoring progress against a previous GDC inspection action that the examinations provider improve the depth of questioning employed to test students on all relevant learning outcomes and that the programme leads ensure that all assessments robustly test the outcomes they are designed to cover.

The panel was pleased that the School had made good progress against the previous inspection action and we noted considerable improvement in this area.

A widescale blueprinting exercise had also been successfully completed. The learning outcomes are now clearly tested in the assessments indicated in the mapping documents.

The School have introduced new in-course assessments which focus less on written assessments and more on verbal case presentations, both pre-read and unseen. We considered these demonstrated good depth and coverage.

We were confident that assessment methods are appropriate. A variety of formative and summative methods are used. At the end of the academic year, assessments are discussed and changed if required.

Having sight of the logbooks, it was clear that clinical assessments are being completed by the supervisors on clinic.

We were assured that students are robustly assessed before they can proceed to the final RSCEng examinations.

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)*

Within this Requirement, the panel was also tasked with looking at the use of patient and student feedback in the assessment of students, as well as monitoring progress against a previous GDC inspection action to collect regular and comprehensive patient feedback across all clinical sites and that programme leads gather all relevant forms of feedback, including peer feedback and implement a mechanism to gather, record and act on this.

We considered that major progress has been made against the previous inspection action. Patient feedback, wherever obtained, is assessed by a staff member and logged. This feedback is then returned to the student to add to their personal development plan (PDP). We considered that this was very helpful in aiding students to reflect on their performance.

Staff often provide regular feedback to students, both before and after exams, albeit in a more informal manner. We heard that they have a staff training day which covers providing feedback to students.

Students indicated they felt they received regular feedback from various sources, including peers, tutors and supervisors at clinics. In particular, students felt that patient feedback forms were useful and informative and were a good accompaniment to their PDPs.

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 Partly Met)*

Under this Requirement, the panel was also tasked with looking at staffing levels and whether this has any impact on how this Requirement is met. In addition, we also looked at progress against two previous GDC inspection actions: 1) that the examinations provider must improve the depth of questioning employed to test students on all relevant learning outcomes and 2) that the programme leads must ensure that all assessments robustly test the outcomes they are designed to cover.

The panel considered that both previous inspection actions had been adequately addressed.

The format of RCSEng final examinations and in-programme assessments are clearly detailed. Compensation between different parts of the final examinations is not permitted. Written examinations are double blind marked by the external and internal examiners. The final exams are entirely standard set by RCSEng and the Angoff method is used by the College.

Students also have a handbook which sets out the assessment schedule. Students informed us they understood the expectations of them and were clear on the range and types of assessments they would take.

The School indicated that all examinations are subject to standard setting and are reviewed prior to each assessment should modifications be required. However, we considered that the description of the standard setting process for the OSCE, clinical and programme assessments was not clear. In addition, although the School also use the Angoff method, we noted the absence of the use of a statistician.

We did not consider there was a systematic process for the discussion of student assessment. Although we heard that this is discussed at Plenary meetings, we considered that such meetings should be held separately with a clear focus on student progression and monitoring.

The panel had sight of the grading criteria which we considered could be more clearly defined. The criteria did not indicate specifically what a range of marks look like or even define what constitutes a pass and fail. The list of criteria appeared to be a prompt for tasks that students should be able to perform and it was difficult to see how it could be used as effective marking criteria for assessment.

At the inspection, we saw an example of a student complaint about the fairness of assessment which didn't appear to be fully resolved or to have provided the student with alternative options to escalate. The student did not appear to be given any further recourse to escalate the matter beyond the immediate programme delivery team. The panel also noted the absence of evidence of a clear and robust process for students to appeal results.

In addition, although the School indicated that training takes place frequently to ensure all staff have calibration training, we could not find evidence of this and we did not believe there was sufficient opportunity to allow for effective calibration prior to exams. We also noted the absence of a formal confidential Exam Board meeting to finalise results.

Given the issues we identified, particularly around standard setting and grading criteria, we concluded this Requirement is partly met.

Actions	**Due date**
The provider must formally document the method by which of assessments and examinations are standard set. The provider should consider the use of external examiners.	Monitoring 2020
The provider must formally document the process used to ensure fairness of assessments so there is a clear audit trail and for the leads' own reference. This will ensure transparency should a student dispute the accuracy or fairness of their marks. The provider should also consider having a separate Exam Board meeting to finalise results.	Monitoring 2020
The provider should consider consulting a statistician for standard setting of the OSCE and other summative examinations.	Monitoring 2020

Summary of Actions

Action No.	Action	Req. No.	Observations & response from Provider	Due date
1	The provider should establish a clearer structure so that relevant issues identified at Trust level are appropriately implemented at School level.	3	We are not completely certain of the intent of this statement. We believe that it is instructing us to improve the structure, so that for *future* issues that are identified at Trust level, there is an effective mechanism to establish appropriate related and relevant implementation at School level. However, because of the immediate context where this statement appeared in the earlier document inviting factual corrections, we are unsure whether this is also referring to specific issues that the panel had already identified and are requiring to be addressed. If this is the case, then we are unsure what those issues are, and would ask for clarification on this, so that we can take the appropriate corrective action.	Monitoring 2020
2	The provider should implement plans for clinical audits to ensure that clinical areas are safe for students.	3	Our understanding of this is that it reflects the issue of an audit lead not being in place for much of the time since the last GDC inspection, and that the local audits that had been taking place were not therefore sufficiently formal as part of a hospital wide process. We therefore understand that the action required is to have an audit lead resolved for the hospital, and then link the local audits in as an integral part of the overall hospital audit. Local audits were submitted as part of the additional evidence, and are ongoing. Two Hospital audits leads have been appointed as of Tuesday 25th February 2020.	Monitoring 2020
3	The provider must review the Raising Concerns Policy. This must include a detailed and formal mechanism for dealing with concerns when they arise with details of named staff roles and responsibilities and a	6	In relation to the Requirement, it was our understanding that staff (and students) must be aware of obligations about raising concerns, and that they must be aware of where to reference details of the policy for raising concerns when required, but not that they should necessarily know from recall all the specifics of	Monitoring 2020

	clear escalation path. Staff must be fully aware how it is implemented.		the policy nor even that they should necessarily have an accurate recall, provided that they do know when to refer to the policy document. The staff and students are aware both of obligations about raising concerns, and of the policy, and therefore on that level we would have expected to have met the Requirement. This statement in the report therefore suggests to us that the panel's concern is about the level of knowledge that staff (and students) had from memory about the internal details of the Policy document, which in turn means that in order to remedy the situation we would need help to clarify what details are expected to be known at all times from memory by staff and students. The statement in the report regarding the panel not being assured that the Trust ensures that teaching staff are embedding awareness of how to raise concerns throughout the education they are delivering, does not seem to reflect the current CPD process for staff, which includes duty of candour training incorporating how to raise concerns. We would ask the GDC to clarify the meaning and scope of the statement that staff must be fully aware of how it is implemented. The student raising concerns policy has now been reviewed.	
4	The provider must design a mechanism for reviewing policies and communicating at different levels how these impact across the programme. The School should ensure that the policy sets out clear communication structures and deadlines, who is responsible and the date for review.	6	A title sheet has been added to all department policies clearly stating when the policy was last reviewed and when it is scheduled to be reviewed. It also includes naming the reviewing officer. A master data sheet has been compiled listing all policies and the review date. This is checked on a monthly basis to see what policies are due for review.	Monitoring 2020
5	The provider must formalise the quality management of the programme which must be detailed in a comprehensive quality management document.	9	The diploma programme is ending in June 2021. As a result, all of the first year modules and exams and many of the second year modules and exams have been run for the last time. We would like to ask for clarification for whether the document needs to cover management of any issues specific to course elements that	Monitoring 2020

			will no longer be run. Quality assurance of the BSc programme will come under the umbrella of Kings College London policies.	
6	The provider should consider establishing a dedicated quality assurance forum, with appropriate terms of reference and membership, ensuring a high level of scrutiny, monitoring and transparency.	9	Quality assurance and review from student and staff feedback following each module and assessment is carried out and used to develop the module/assessment as necessary. See earlier comment about the ongoing process of quality assurance in relation to the diploma and BSc programme.	Monitoring 2020
7	The provider must implement methods to improve recording. This must ensure that clearer recording of mapping exercises against the learning outcomes have been conducted and any changes made.	9, 10	At the time of the inspection the department were waiting for the Trust IT to provide a shared drive. This was ordered in July 2019. The panel were informed of this. The shared drive was available to all staff in January 2020. This now gives us the facility to upload all modules with the mapping to the GDC learning outcomes. It also gives us the ability to upload any changes, and all staff have access to this drive. All student monitoring has now been uploaded to the shared drive. This gives all staff access to student attendance, numbers of clinical procedures carried out and performance in all exams and modules. It was not possible to demonstrate this level of monitoring at the time of the inspection as we were waiting for the drive. Work has been undertaken since the implementation of the shared drive to update all records and keep them updated. Named module leads have the responsibility to keep the modules up to date. Student monitoring is collected once a month an inputted by admin staff and overseen and reviewed by the Acting Deputy Director.	Monitoring 2020

			The options of a secure online platform for this information is not one the Trust is able to provide.	
8	The provider should review the senior leadership support available and consider seeking administrative and IT support from the wider Trust so that the senior team can be relieved of administrative tasks.	10, 14	See earlier comments about the implementation and use of the shared drive. At the time of the GDC inspection Kings College Hospital were in discussion with Kings College London regarding the way forward with fulfilling the senior management roles. Therefore, it was reasonable to say that there were no known plans to fill the Director of Programme vacancy. However, since the inspection, the job description, banding and structure accountability within the organisation has been agreed between KCH and KCL. The role in of Programme Director for both programmes is currently being advertised. Evidence of the job description and the flowchart of accountability can be submitted as required.	Monitoring 2020
9	The Risk Register should be more comprehensive and include timeframes and roles and responsibilities. This should include a contingency plan to counter unexpected staff absence and to define this in writing.	10	The risk register that was submitted as evidence was completed when there were uncertainties within the department due to the departure of senior management and the lack of clarification about the structure within BSc programme. None of the existing staff were instrumental in completing this. With greater clarification from KCL about the senior management structure, this risk register is to be reviewed.	Monitoring 2020
10	The provider must develop a policy regarding the use of patient and student feedback to ensure it is formally considered and used to develop the programme.	11, 12	We would like to ask for clarification and further detail on the scope required for this policy, given that as the programme is due to end in June 2021 there is limited opportunity for developing it.	Monitoring 2020

11	The provider should consider reviewing questions on patient feedback forms so that such feedback can meaningfully help to inform developments to the programme.	11, 12	The department is due to review the patient feedback forms at the staff plenary scheduled for 23rd April 2020. See earlier comments about developing the Diploma programme.	Monitoring 2020
12	The provider must improve and formalise the use of external examiners. The process for collection, use and response to feedback should be clearer.	11	All the remaining exams for the programme (due to end in June 2021) are under the control the RCS. RCS appoint the external examiners and define the format of feedback that they give. KCH therefore has no control over the process of collection, and so we understand that our response to this action would be limited to the aspects of use and response to the feedback.	Monitoring 2020
13	The provider should introduce quality assurance measures for all outreach placements with clear reporting and audit trails on any actions being taken.	12	Outreach placements are quality assured on an annual basis and evidence of this was provided. To date there was only one minor action necessary and this is in the process of being followed up.	Monitoring 2020
14	The provider must improve the system of checking and validating student data. A process must be implemented to mitigate against errors with the inputting of data and ensure that this data is reliable.	14	See earlier comments about the implementation of a shared drive in January 2020. Data on student numbers is inputted by admin staff and is spot checked by the Acting Deputy Director against the student log books. Data on academic progression is inputted by staff responsible for the module or exam. Data on student attendance and lateness is inputted by the member of staff responsible for collating that information.	Monitoring 2020
15	The provider must formally document the method by which assessments and examinations are standard set. The provider should consider the use of external examiners.	21	The report made comment about use of a statistician apparently in the context of use of the Angoff method. We use this method for standard setting for all summative examinations. The statistical content is the calculation of an average, but the method fully defines this calculation, and so we are unsure what the intent for a statistician is in this action. Please could this be elaborated on.	Monitoring 2020

			See earlier comments about use of RCS as external examiners for final exams. An external examiner is used for the end of year 1 exam and the most recent report was submitted as additional evidence. This exam will not run again due to the programme ending in June 2021.	
16	The provider must formally document the assessment processes used to ensure fairness of assessments so there is a clear audit trail and for the leads' own reference. This should include details on student appeals and mitigating circumstances. This will ensure transparency should a student dispute the accuracy or fairness of their marks. The provider should also consider having a separate Exam Board meeting to finalise results.	21	The clinical grading criteria that was reviewed and submitted as evidence is not used for exam assessment, as suggested in the report. This criteria is used as a guideline on the clinic every time a student carries out a clinical task. It explains what level of clinical competence is expected of a student at each stage of the course. The process of submitting mitigating circumstances and raising concerns is clearly laid out in the student handbook. The particular incident referred to in the report was dealt with in an appropriate manner.	Monitoring 2020
17	The provider should consider consulting a statistician for standard setting of the OSCE and other summative examinations.	21	The report made comment about use of a statistician apparently in the context of use of the Angoff method. We use this method for standard setting for all summative examinations. The statistical content is the calculation of an average, but the method fully defines this calculation, and so we are unsure what the intent for a statistician is in this action. Please could this be elaborated on.	Monitoring 2020

Observations from Provider on content of report

The panel advised that they wished to meet outreach leads, and the report suggests a negative tone where it comments that the panel only had opportunity to meet with one. The panel gave just 9 weeks' notice confirming the inspection dates. As NHS policy requires that clinicians need a ***minimum*** of 8 weeks' notice to cancel clinics, we feel that this demonstrates that the panel did not have an adequate understanding of the role and relationship of the Provider within the NHS, and that the responsibility for the unavailability of additional outreach leads rests with the panel.

Although the panel did give notice that they wished to meet outreach leads, they gave no notice that they wished to meet certain senior hospital staff, and the report has a similarly negative tone in commenting about these people not being available. This included staff with clinical duties, who would be subject to the NHS 8 week notice period, which we feel further underlines the potential lack of understanding of the Panel in their ability to properly assess the operation of the Provider being within the NHS.

We are unclear about the meaning or intent of some of the action points and have asked for clarification to ensure that we understand correctly how to address the actions.

It is appreciated that the report acknowledges a number of circumstantial difficulties that the Provider was facing at the time of the inspection, notably the very recent retirement of both the programme director and the resignation of the Deputy Director. None of the current staff had been involved with the annual GDC monitoring form submitted in March 2019 that instigated this inspection. Neither were any of the current staff able to be involved in the 1st round of evidence submitted to the GDC. The lead host to the inspection was a member of staff who had been temporarily deputised as Deputy Director only a short while earlier, and the team lacked experience with inspections. Given these circumstances, the notice given was insufficient time for the team to adequately prepare for the inspection in the circumstances.

Recommendations to the GDC

Education associates' recommendation	The qualification continues to be approved for holders to apply for registration as a dental hygienist and a dental therapist with the General Dental Council
Date of next regular monitoring exercise	2020

Annex 1

Inspection purpose and process

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC. It also quality assures new qualifications where it is intended that the qualification will lead to registration. The aim of this quality assurance activity is to ensure that institutions produce a new registrant who has demonstrated, on graduation, that they have met the learning outcomes required for registration with the GDC. This ensures that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).

3. The GDC document 'Standards for Education' 2nd Edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards for Education. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is met if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the inspectors with broad confidence that the provider demonstrates the Requirement. Information gathered through meetings with staff and students is supportive of documentary evidence and the evidence is robust, consistent and not contradictory. There may be minor deficiencies in the evidence supplied but these are likely to be inconsequential."

A Requirement is partly met if:

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

A Requirement is not met if:

"The provider cannot provide evidence to demonstrate a Requirement or the evidence provided is not convincing. The information gathered at the inspection through meetings with staff and

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

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

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

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