General Dental Council

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regulating the dental team

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
King's College London	Bachelor of Dental Surgery	22 – 23 January 2019

Outcome of Inspection	Recommended that the BDS continues to be sufficient for the graduating cohort to register as dentists

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 GDC as a dentist. Risk based: focused on Requirements 2, 4, 6, 8, 9, 11, 12, 13, 15, 19 and 21**
Learning Outcomes:	**Preparing for Practice (Dentist)**
Programme inspection date(s):	**22 – 23 January 2019**
Inspection panel:	**Victoria Buller (Chair and Non-registrant Member) Andrew Buddle (Dentist Member) Khalid Mushtaq (Dentist Member) Shiv Pabary (Dentist Member)**
GDC Staff:	**Manjula Das (Head of Education Policy and Quality Assurance) Krutika Patel (Quality Assurance Officer)**

The inspection undertaken at King's College London (KCL) was risk-based, focusing on specific areas of their Bachelor of Dental Surgery (BDS) programme. The GDC quality assurance team and a panel of experienced education associates undertook an independent evaluation of information available to determine the content of each inspection. The information considered included annual monitoring returns, previous inspection reports (including progress against actions), responses to wider recommendations in the GDC Annual Review of Education, Fitness to Practise data and complaints received.

Following this assessment, it was decided that the inspection panel focus on Requirements 2, 4, 6, 8, 9, 11, 12, 13, 15, 19 and 21.

The BDS programme delivered by KCL is the largest in the UK, with approximately 150 students in each in of the five years. Given these high numbers, the panel was impressed with range of clinical experience that each student carried out. In addition, the clinical facilities and the nursing support available to all students in the dental hospital was considered to be excellent. The panel also noted the training and support that KCL made available to their staff, and the students spoken to provided positive feedback on the support they received from staff as they progressed through the programme.

The panel learnt that KCL will be introducing a new curriculum for the 2020 academic year. The education associates had concerns that there was a lack of planning concerning the transitional arrangements – that is how students studying under the old curriculum would be transitioned onto the new programme. Further information, including a risk register and action log was subsequently provided to the panel, and the panel is now assured that

sufficient processes are in place to manage this transition and the GDC will be monitoring these developments via its annual monitoring process.

Other areas that the education associates considered needed further development included the use of LIFTUPP to monitor students' clinical activity, which the panel considered had not been progressed since the last inspection in 2014. Again, in relation to clinical activity, there did not seem to be a regular audit of the data, which potentially could result in some students' exiting the programme without carrying out the necessary range of clinical experience.

Students were very positive about the experience they gained at their outreach placements. However, the panel was concerned that the experience received varied between the students. In response to these concerns, the panel was informed that an Outreach Lead had now been appointed, and one of their tasks would be to ensure that all students were receiving an equitable clinical experience when in their placements.

Background and overview of Qualification

Annual intake	The programme admits 128 students into Year 1, 20 graduate-entry students into Year 2 and 10 medically qualified students into Year 3.
Programme duration	194 weeks over 5 years
Format of programme	Year 1: scientific knowledge, clinic attendance, shadowing Years 2-4: direct patient treatment, clinic attendance, placements Year 5 direct patient treatment, clinic attendance, outreach, placements
Number of providers delivering the programme	King's College London Guy's & St Thomas' NHS Foundation Trust King's College Hospital NHS Foundation Trust University of Portsmouth

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

Outcome of relevant Requirements[1]

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

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

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

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

Requirement 2: Providers must have systems in place to inform patients that they may be treated by students and the possible implications of this. Patient agreement to treatment by a student must be obtained and recorded prior to treatment commencing. ***(Requirement Met)***

The School has processes in place to obtain appropriate, informed consent both in the Dental Hospital at the outreach sites at Denmark Hill, Portsmouth Dental Academy and West Norwood. The panel was presented with a selection of completed consent forms, which clearly stated that dental students would be carrying out treatment.

The Dental Hospital's Radiology Department has notices in the waiting room to advise patients that they will be treated by students, which was observed by the panel when on a tour of the clinical facilities.

When treating patients, all students wear coloured name badges denoting their student status and introduce themselves at the beginning of each patient contact. The agreement to treatment is also recorded in the patient notes, again at each stage of the patient's treatment. All patients are also handed leaflets regarding consent and treatment upon arrival.

A review of the consent process was recently carried out by the Associate Dean for Undergraduate Clinical Education. The panel was informed there were no outcomes following this exercise, as the current processes were deemed to be fit for purpose.

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)***

The inspection panel was tasked with looking specifically at staffing levels and whether this has any impact on how this Requirement is met.

The School informed the panel that students carrying out any clinical activity are always supervised by GDC registered staff. Senior and experienced staff are allocated to supervising students in the latter years of the programme, who would be carrying out complex patient treatments. New staff shadow senior colleagues until they are experienced enough to supervise students independently.

In the Dental Hospital, the care planning consultant for each session is available and on call for all floors to ensure all patients have access to specialist advice where appropriate.

Registered dental nurses are also present to support students and will raise concerns if they consider the student to be practising unsafely.

As a contingency, scheduled clinics have allocated to them a 'floating' staff member who would step in if supervision fell below the necessary levels required to ensure patient safety.

In outreach, ratios are typically 1:5 or 1:6, which students stated was sufficient and meant they did not have to wait very long to have procedures signed off.

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)***

The topic of raising concerns is delivered to students during the first week of the programme. The subject of raising concerns is embedded within the curriculum and covered and assessed at various times during the five years of study.

The panel was informed that the raising concerns policy for the Dental School was reviewed following discussion at the Dental Education Committee in October 2018. The panel was given a copy of this revised policy during the programme inspection and considered it to be comprehensive and providing good examples of what constitutes a concern, and the processes in place in order to raise concerns and protect patients at all times.

As well as this formalised pathway, students are able to raise concerns anonymously online via their online student portal. Students also talked about the support and guidance available from the Director of Student Welfare, who they would approach should they wish to seek advice on any issues relating to patient safety. Students can train as peer supporters for the younger years, and this is yet another avenue for support, if assistance is needed on whether or not a situation or behaviour of a peer of member of staff is cause for concern.

Staff are provided with all the relevant policies when joining the School, with any significant changes being communicated by email, and training sessions being organised if required. In addition, the Dental Faculty organise drop in sessions, which allow clinical teachers to raise any concerns with they may have with the Executive Dean and the Associate Dean for Undergraduate Education.

Requirement 7: Systems must be in place to identify and record issues that may affect patient safety. Should a patient safety issue arise, appropriate action must be taken by the provider and where necessary the relevant regulatory body should be notified. ***(Requirement Met)***

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the

GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standard for the Dental Team are embedded within student training. *(Requirement Met)*

The inspection panel was tasked with looking specifically at the application of fitness to practise processes.

The School has a 'Student Fitness to Practise: Bachelor of Dental Surgery Faculty Policy and Procedures' which sets out:

- How will a fitness to practise issue be raised;
- What will happen when an issue is raised;
- What support can students' access while an allegation is investigated;
- Outcome of the panel; and
- Notification of Outcome.

Following the programme inspection, the School provided further documentation explaining when a concern becomes a student fitness to practise issue, and their plans in taking this guidance forward. The panel was therefore assured that the policy was sufficient.

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 Partly Met)*

The panel was tasked with looking specifically at staffing levels and whether this has any impact on how this Requirement is met.

Detailed information setting out the quality assurance framework was provided to the panel in advance of the inspection. The responsibility of ensuring the curriculum remains fit for purpose lies with the Quality Assurance and Quality Enhancement Committee (QAQE) which receives information from various Curriculum and Assessment Committees (CAC). The CACs meet once a term to review the curriculum and feedback from the Staff Student Liaison Committees (SSLC). The QAQE Committee would also consider changes to the course. A selection of minutes from these committees was provided to the panel, along with action plans and deadlines from implementation. Examples of recent changes included amendments to lectures in light of the changes to the infection control protocols and the inclusion of lectures on professionalism. The panel was assured that should urgent changes need to be actioned in the programme, staff are able to complete an online Course Change Request which would go to the Dental Education Committee (DEC), who would discuss the request or delegate to the relevant staff member/Committee as soon as possible.

In addition, there is a Programme Enhancement Plan in place which is a live document which the School stated was developed with students, and in response to feedback received from students, staff and external examiners. The plan is reviewed throughout the year by the Dental Education Committee to ensure all noted issues are addressed.

The panel agreed that although clear lines of responsibility for change/amendment/monitoring of the curriculum was in place, there was a concern about the lack of planning that had taken place across the introduction of the new curriculum due to start in 2020. Subsequently an

action log and risk register were provided for the panel's review. The panel considered that timelines in place for implementation are ambitious and the School need to ensure there is sufficient time allocated to test ideas/concepts and consult with all relevant staff and the student body. The risk register did identify some key considerations, but again the education associates were of the view that this document needed to be reviewed to ensure that all risks were indeed captured and there was a cohesive action plan in place to address them.

The panel's other concern was the fact that not all of the learning outcomes had been mapped for the current programme and the School needed to ensure this had been completed prior to the new curriculum being introduced.

The panel concluded that currently staffing was sufficient to support the framework and that the current staff had the knowledge to understand when changes or decisions needed to be considered by certain committees and when. However, there was no evidence provided to demonstrate any succession planning had or was planned to take place and there was a significant risk that should a key staff member leave, information or actions would not be efficiently passed on to the remaining programme team.

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

Requirement 11: Programmes must be subject to rigorous internal and external quality assurance procedures. External quality assurance should include the use of external examiners, who should be familiar with the GDC learning outcomes and their context and QAA guidelines should be followed where applicable. Patient and/or customer feedback must be collected and used to inform programme development. ***(Requirement Met)***

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

The panel was provided with a range of evidence to demonstrate that the student voice of the KCL BDS programme is taken seriously and changes are implemented where possible. Evidence included a selection of minutes from the Progress Committee and SSLC, and BDS Student Evaluation forms. The panel was able to see that issues raised were either addressed or a clear explanation was provided as to why they were not possible. In relation to the development of the BDS programme, examples of changes that have been actioned include the teaching of certain topics and modules.

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)***

Students attend outreach in years 4 and 5 of the programme. There are two locations - West Norwood and Portsmouth Dental Academy. Both centres have passed a Care Quality Commission inspection and are all therefore deemed to be safe environments for patient treatment.

At a School level, there are leads for each of the outreach locations, who produce an annual report, including feedback from students which is then considered at the BDS Programme Committee. The panel met with outreach staff who stated that there were named people at the School that could be contacted should there be any difficulties. Each of the placements also has to comply with its respective Trust policies, thereby adding another layer of checking to make sure the placement remains fit for purpose.

Whilst the current outreach placements are beneficial in allowing students to treat a variety of patients, the School has recognised that the experience received, differs amongst the cohort and in a bid to have greater consistency have created a 'Chair in Primary Care including Outreach' post, which is due to be taken up in June 2019. Part of the role will involve the postholder '*providing clinical and academic leadership to all outreach centres ensuring quality assurance, standardisation of teaching, service delivery and compliance across all sites.'*

In terms of feedback, students are able to feedback via anonymous online questionnaires and formally through the SSLC. The panel noted that the placements have made changes to patient allocation systems where possible, to ensure students get as much clinical experience as they can.

The collection of patient feedback is less formalised, and although examples of feedback were provided to the education associates, the information collected was not meaningful enough to be effectively used to contribute to the development the programme.

Standard 3– Student assessment
Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.

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

The inspection panel was tasked with looking specifically at the process of sign-up for final examinations and access to a range and number of patients and whether this has any impact on how this Requirement is met.

To ensure that students are fit to practise at safe beginner level, they must sit and pass the summative assessment at the end of every year. Students are not able to compensate between clinical and academic assessments. Attendance, punctuality and communication skills are monitored in conjunction with assessment grades, to ensure students are maintaining the level of professionalism required to practise as a dentist.

As they enter the latter years of the programme, students are informed what clinical activity must be completed (to a passing standard), in order for them to be eligible to sit their final examinations. Students are able to keep a track of their progress on-line, as well as through meetings with their personal tutors. Student progress data is discussed at the Progress Committee, and students identified as being in difficulty, are contacted and offered the necessary support or remediation.

The panel was provided with a list of this criteria and was satisfied it was robust enough to ensure students entered for finals, would have the requisite knowledge and skill in order to sit these examinations.

The panel was also provided with progression data for the current final year cohort and was impressed that given the high numbers of students, the pass rate was very high, and students who had to re-take certain components always passed on their second attempt.

The panel do have concerns regarding the use of LIFTUPP in monitoring student progression. The School acknowledge the software is not being used to its full capability but as of yet have no agreed timeframes for the implementation of an enhanced version.

Blueprinting was another area of concern, in that not all the learning outcomes have been formally blueprinted. The education associates reviewed the current course and assessments against the learning outcomes and were assured that students in the current cohort will not exit the programme without covering them all, but recommend the School review its blueprint so all learning outcomes are formally delivered.

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)*

The inspection panel was tasked with looking specifically at access to a range and number of patients and whether this has any impact of how this Requirement is met.

As mentioned under Requirement 13, students must complete a number of specific clinical procedures in order to be eligible to sit finals. The numbers or quotas are defined when students enter their third year, and the School state that quotas will be reviewed in light of patient availability across the programme.

The School explained that patient numbers are monitored by the leads in each of the subject areas for each of the years. The panel was informed that the volume of patients has never been an issue, its recruiting patients that require specific treatments that is sometimes a difficulty. To ensure students are meetings their quotas, Student Liaison Officers will triage patients requiring specific treatments to the more senior students so that they meet their sign-up criteria. Both students and staff informed the panel that system is working quite well and none of the final year students are struggling to meet the requirements.

The panel was provided with a breakdown of the types of clinical activity the students were carrying out and was satisfied the necessary range and number of patients were being treated. The panel also noted the emphasis the School puts on team working and heard the students' feedback on how valuable they found working with other members of the dental team as its further developed their knowledge of when to refer and how dental care professionals can support dentists in practise.

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 Partly Met)*

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

For all new staff there is a formalised induction process which they must participate in. New examiners shadow experienced ones, until they feel confident to examine independently. Those involved in marking written assessments are recruited according to their discipline. All written assessments are double marked to ensure consistency of grading. Criteria for both written and practical assessments is detailed and it is clear to the examiner what students are being tested on and how marks should be allocated.

Those staff who are examining, are provided with assessment information in advance of the exams. A briefing takes place on the day of the assessment along with a calibration exercise. Examples of examiner briefings were provided to the panel which included information such as exam objectives, what topics were going to be covered and information on the actual process for example, the timings.

The panel concluded that staffing levels were sufficient and had no negative impact on the assessment process. However, this Requirement is part met due to the lack of monitoring of staff training, especially training related to equality and diversity. The School acknowledge this is an area they struggle with due to the different employment contracts the programme staff work under. All KCL staff must complete training on unconscious bias and equality and diversity and a spreadsheet setting out which staff had completed this was presented to the panel but was dated 2013. Trust employees must also complete training in equality and diversity, but this is logged with their respective workplaces. The panel was of the view, that the School should ensure that staff training is logged centrally, to ensure all staff have current knowledge on the topic of equality and diversity.

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)*

Standard setting is carried out for all summative assessments, using either the Ebel or Angoff method. The panel was provided with clear evidence that standard setting was being employed across all summative assessments and the criteria for this activity was clear and understood by

the staff involved. So that standard setting remains fit for purpose, the School carry out a review at the end of the programme to ensure that attainments are comparable in terms of age, gender and ethnicity.

The panel was able to view Course Handbooks for students and noted that they contained information on the assessments related to particular modules and what criteria was expected to be met, in order to achieve a pass mark.

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
9	The School must provide an update on its implementation of the new curriculum in 2020. This must include an updated risk register and action log setting out timeframes.	KCL is currently planning and developing a new BDS curriculum for implementation in 2020-21. A steering group and working groups are meeting regularly. The initial project plan, with action log, and risk register has been shared with the GDC and an update will be provided in the Annual Report.	Annual Monitoring 2020
9, 13	The School must provide evidence demonstrating the current BDS programme has been mapped to all the learning outcomes set out in Preparing for Practise.	KCL provided the mapping document learning outcomes and preparing for practice in advance of the GDC visit	Annual Monitoring 2020
9	The School must provide evidence of succession planning.	Succession planning is undertaken by the Faculty within the wider KCL environ and business planning. The Faculty actively engages with the NIHR ACF and ACL process to ensure recruitment and succession at a junior level together with recruitment at a more senior level. In the last academic year, the Faculty has made Professor/HCC appointments in oral pathology, periodontology and restorative dentistry additional to the existing staff base.	Annual Monitoring 2020
12	The School should continue developing a process to collect patient feedback that could be meaningfully used to contribute to the development of the programme.	KCL is examining the most efficient and effective way of collecting patient feedback that also provides individual feedback to the student. The NHS trust collects patient feedback but this is anonymised and not tied to the student which is utilised to inform programme development. Patient representation is actively sought on the curriculum steering group for BDS 2020	Annual Monitoring 2020
12	The School must provide timescales to explain when the enhanced LIFTUPP software will be implemented.	Following the GDC visit, we have instigated an ongoing review of the use of LiftUpp to inform our decision on whether to proceed with the planned upgrade or move to an alternative system. The CAFS (Clinical Assessment and Feedback System) software is being	Annual Monitoring 2020

		considered following a demonstration to the faculty and business planning and procurement guidance is currently ongoing. An update on the software used to record clinical and reflective practice will be provided in the Annual Report.	
19	The School should look at ways in which it can centrally record details of all programme staff training, including equality and diversity.	Equality and diversity training for staff is currently carried out across KCL, the NHS Trust and HEE. KCL is reviewing how this record of training could be recorded within the faculty. In addition, the faculty is launching in Jan 2020 a process of developmental peer observation informed by current good practice and supported by the Kings Academy. This process will be collated by the Faculty quality assurance manager so that any Quality improvement outcomes can be supported and delivered	Annual Monitoring 2020

Observations from the provider on content of report

We were pleased to note that KCL met all the requirements for the Protecting Patients standard with adequate patient consent processes, a safe & appropriate clinical environment and support from appropriately qualified and trained supervisors. We have revised our Raising Concerns and Professionalism (Health & Conduct) policies to ensure that there are efficient mechanisms in place for raising concerns and managing student health and conduct.

Continuing the development and implementation of the new BDS curriculum is a priority, whilst ensuring that the students on the old curriculum are fully supported. Positive changes for the new curriculum are already being implemented within the old curriculum, such as a move from fixed number quotas of clinical experience towards a more bespoke system, based on the individual student's learning needs and reflective practice. The learning outcomes of the current curriculum are already fully blueprinted and these will be mapped across. We are working to a project plan to ensure the timeline is adhered to, and hold regular meetings across all years of the programme to enable all stakeholders to be consulted and updated on the changes.

Concerns over the use of LiftUpp have been noted and KCL is aware that it is not being fully utilised across all areas of the BDS programme. KCL is currently investigating moving to a different software provider, CAFS. Once this has been confirmed, timeframes for trialling and implementing this, ensuring a successful transition from LiftUpp to the new system, will be agreed. This will include communication with, and training of, students and staff. It is hoped that either an upgraded version of LiftUpp or the new system will allow us to formalise patient feedback for each student, which can then also be used in the quality assurance of the BDS.

The governance of the BDS programme has been reviewed and revised to best support the new and outgoing cohorts, to provide effective leadership for each year of the programme as well as across the whole programme.

Recommendations to the GDC

Education associates' recommendation	Qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council
Date of 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.