General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
Queen Mary University London	BSc Oral Health

Outcome of Inspection	Recommended that the Bachelor of Science Oral Health programme 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 Annex 1

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 Dental Hygienist and a Dental Therapist.**
Learning Outcomes	**Preparing for Practice Dental Therapist and Dental Hygienist**
Programme inspection date	**Wednesday 22 & Thursday 23 June 2022**
Examination inspection date(s)	**Unseen Case Exams: Monday 20 June 2022 Subject Exam Board: Wednesday 22 June 2022**
Inspection team	**Katie Carter (Chair and non-registrant member) Erica Clough (DCP member) Pamela Ward (Dentist member) Marlene Ledgister (GDC Quality Assurance Officer)**

Executive Summary

The inspection of the BSc Oral Health programme ("the programme") offered by Queen Mary University of London (QMUL) (hereafter referred to as "the School") was conducted as a full new programme inspection.

The programme has recently had to deal with significant staff changes: one staff member left and one staff member is on long term sick leave. Further, several staff had taken on new roles shortly before the inspection. At the time of the inspection a new Quality Assurance Lead was in the process of being recruited.

The BSc programme is 75% integrated with the Bachelor of Dental Surgery (BDS) programme; students learn with year 2 BDS students from day one, with separate peer group teaching to maintain scope of practice. A 'shared care' model between BDS and BSc further supports the students' understanding of working in a team and of Scope of Practice. The programme also evidences strong and effective mechanisms for student feedback.

Clinical, academic and support staff work across BDS and BSc programmes sharing teaching, assessment, and administration, and demonstrate good cohesion and collaboration. Students were very satisfied with the integrated nature of the programme and were very positive about the level of support and feedback they receive. However, the panel felt that the jointly badged nature of much of the

paperwork not only created some confusion about the requirements for students from different courses, a concern echoed by the students, but also meant that the BSc programme does not have a distinct identity.

Requirements 2, 3, 4, 5, 6, 7, 8, 12, 14, 15 and 21 were judged to have been met. Requirements 1, 9,10, 11, 13, 16, 17, 18, 19 and 20 were partly met.

This inspection incorporated aspects of the GDC's targeted monitoring process which focuses on GDC Requirements 13 and 15. Additional data to assure that the graduating cohort would meet the level of 'safe beginner' was, therefore, requested and reviewed by the panel.

The GDC wishes to thank the staff, students, and external stakeholders involved with the Queen Mary University BSc Oral Health programme for their co-operation and assistance with the inspection.

Background and overview of qualification

Annual intake	16 students
Programme duration	3 years
Format of programme	Year 1: • Basic Clinical Sciences • Clinical Practice • PHEBD • PTSR Year 2: • Clinical Sciences • Clinical Practice • PHEBD • PTSR Year 3: • Clinical Practice – Child Oral Health • Clinical Practice – Restorative • PTSR
Number of providers delivering the programme	1 – Queen Mary University of London

Outcome of relevant Requirements[1]

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

Students sit Gateway assessments in all subjects, for which they are given two attempts that they must pass. The assessments are double marked, and students are offered a re-sit if they fail. The panel identified that the marking criteria were not consistent for each Gateway. In addition, the Gateways are defined by the School, in paperwork and quality assurance terms, as formative when in fact they are summative. This means that External Examiners do not have a role in overseeing them. The panel recommends that the School review and correct the assessment descriptions and marking criteria. The assessment handbooks do not contain a number of Learning Outcomes against a small number of Gateway assessments.

Good mechanisms are in place for students who fail Gateways, including extra sessions, and remedial training in clinical skills. Students who met with the panel were clear about the process and support available to them. A final decision is taken by the progression panel in the event of a student failing a second time.

Completion of compulsory training such as Basic Life Support and infection control are clearly logged and tracked and are revisited as students move from the simulated to the clinical environment.

The programme includes a 'patient-facing gateway' – a transitions course which takes place towards the end of year 1 to transfer skills from the lab to the patient/clinical environment.

Students who met with the panel were positive about the integrated nature of the programme, commenting that working with the BDS students gave them a good understanding of their role and scope of practice. Year 3 students commented that there were good transitions from clinics, and they had seen a good range of patients. They were clear about the process regarding failing gateway assessments.

The integration of the BSc and BDS programmes incorporates shared assessment, teaching, paperwork, and staff between the two programmes. The School confirmed that the programme is designed to allow bespoke timetabling for students to receive support and to catch up on missed sessions.

There was evidence of good support mechanisms in place for struggling students, who were clear about the process regarding Gateway assessments.

The panel considered the Requirement to be partly 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.

Staff and students were clear about the processes for informing patients they would be treated by a student and for obtaining consent. Students wear different coloured tops to identify them as students and the status of outreach as training environments is made clear. Students told the panel that they always introduce themselves to patients.

Students wear NHS badges, QMUL badges and CRS badges, which all show the students' status, and students and patients sign a 'consent to treatment by a student' form which is scanned into records. The School explained that there are also information leaflets explaining student treatment.

Consent is taught across all three years of the programme through the Professional, Teamwork and Social Responsibility (PTSR) module and is captured on Liftupp. The module is revisited in years 2 and 3 in the treatment planning context. Seminar sessions are delivered introducing the consent topics, with the inclusion of a virtual reality video whereby the student can join the tutor virtually and go through the patient checklist – history, examination, and transition programme.

The panel was satisfied that the Requirement is met.

Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care, including equality and diversity, wherever treatment takes place. Requirement Met.

The School submitted a full range of policies and procedures relevant to maintaining safe environments for students.

The panel had noted the Trust's latest Care Quality Commission Report had recorded a 'good' rating, which the School confirmed covered all three clinical learning environments. The School described the clear contracts in place for the maintenance and repair of equipment, and systems had been put in place and maintained in relation to Covid-19. Evidence viewed by the panel demonstrated that all staff complete mandatory equality and diversity training.

The School has a robust process for managing and escalating safety incidents on clinics using the DATIX system which also checks on student welfare. All DATIX incidents are reported at monthly governance meetings, and specific training has been introduced to minimise the risk, of for example, bur injuries. Students who met with the panel had a good understanding of the process. The panel was satisfied that the Requirement was 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.

Evidence presented to the panel described the Staff Student Ratios (SSR) in clinic as 1:5 or 6 with 10 chairs, and 17 students working in pairs with a minimum of 2 clinical staff. The School explained that the SSR was increased to 1:3 for paediatric treatment clinics. Whilst working in pairs, one student works as an assistant. The panel were told that to maintain the SSR the School were likely to reduce a clinic rather than cancel patients, for example cancelling check-up patients over treatment patients. Supervision is planned in weekly supervision rotas.

Students who met with the panel said they felt safe and supported by both BSc and BDS staff and receive particularly good supervision when new procedures are being introduced. The panel were also told that patients would be cancelled if there were insufficient staff to maintain safe SSRs.

The clinical timetable is centrally managed, although the on-call rota had lapsed during Covid-19, but this is all now being managed adequately. The panel were told that timetabling clearly indicates the roles of assistant and clinician in relation to students working in pairs, with allocations made based on scope of practice. In addition, the evidence demonstrated excellent teamwork between the students. The panel was satisfied that the Requirement was met.

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

The School presented a range of documentation detailing staff qualifications, training and development including equality and diversity. Staff training days include pedagogical aspects, and all staff have at least the year one CILT. New staff are fully supported and mentored by a senior tutor, with induction and training into the clinical environment and shadowing on gradings and communications with students, particularly for paediatric clinics. New staff are also paired with existing experienced staff with informal observation arrangements in place, and programme scheduling has been designed to get a better mix of staff working together to enable support.

Staff can complete statutory mandatory training and check their own records online. A delegated member of support staff maintains and updates all staff training records, contacting staff who have not completed the necessary training. The Equality Diversity and Inclusion training is hosted on the QM+ the School's virtual learning site and is always included in staff training days.

Liftupp calibration takes place mainly at staff training days attended by the whole School with additional separate training for the paediatric team. Attendance is not mandatory but is recorded and updated centrally via QM+. The School confirmed that training needs are identified in the usual way, through appraisal and continuous dialogue.

The School explained that training for technical practices was also delivered for radiography in response to a change in the system. The panel was satisfied that the Requirement was 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 panel reviewed a range of policies and documentation relating to raising and addressing safety and risk concerns on the programme. Raising concerns is taught throughout the three years of the programme as part of the Professionalism, Teamwork and Social Responsibility modules, and is covered in student handbooks. Students can raise concerns through Staff Student Liaison Committee (SSLC) meetings via their student representatives and are also encouraged to approach staff members.

Students who met with the panel were able to clearly articulate the mechanisms available for raising concerns. Clinical alerts are also reported on Liftupp. The panel was told that concerns raised in the clinical environment are channelled through the Programme Lead & for the Outreach Clinics through either the Clinical Lead for Outreach and or the Programme Lead.

The panel was satisfied that the Requirement was met.

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

There is a process in place for recording clinical alerts on Liftupp and for following up. Clinical incidents are also discussed at meetings of the Clinical Governance Committee. Clinical Governance Committee meeting minutes clearly showed that incidents are recorded and followed up.

The panel were satisfied that the Requirement is 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 School provided evidence of and explained a clear and robust Fitness to Practise (FtP) policy and process. The panel was given an overview of the tiered reporting and investigation structure in place to respond to incidents and issues, as defined in its Professional Capability and Fitness to Practise regulations. Options available are laid out regarding referral, recommendations, and sharing of information. An FtP Committee is in place with powers to recommend de-registration and inform the relevant regulatory bodies.

Fitness to Practise is taught as part of the PTSR module and the panel viewed evidence of good recording of issues in Liftupp free text entries.

The panel was satisfied that the Requirement was met.

Standard 2 – Quality evaluation and review of the programme
The provider must have in place effective policy and procedures for the monitoring and review of the programme.

Requirement 9: The provider must have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function. Requirement Partly Met.

The School has a range of quality assurance policies and procedures including a module evaluation process and two key committees – the Dental Quality Assurance Committee (DQAC) and Dental Education Committee (DEC) on both of which the Hygiene Therapy programme is represented. The panel were told that amendments to the programme have included the introduction of specialist teaching, with lectures recorded and shared with students.

The School has effective mechanisms for seeking students' views. There is a Staff Student Liaison Committee (SSLC). Students were positive about the role of the SSLC in supporting changes. The panel were told that amendments to the programme have included the introduction of specialist teaching, with lectures recorded and shared with students. SSLC meetings are formally minuted and the minutes are shared on QMPlus. There are also focus groups where student requests for enhancements to the programme are discussed. These

focus groups are set up as and when, instigated by either staff or students. Individual student concerns are fed into SSLC via student representatives or via the module lead. There is a student representative for each year cohort, and student support officers are also involved in DQAC meetings. The panel noted some areas of weakness in the quality assurance processes – weekly staff meetings, which had taken place in the past, no longer take place and only a small portion of students have been participating in the process of module review.

The panel also recommends that paperwork should be reviewed to afford the BSc programme its own identity, although the School assured the panel that the programme documentation on the QM+ virtual learning environment does show the identity of the programme.

The panel considered the Requirement to be partly met.

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. Partly Met.

The panel viewed a range of regular structured meeting minutes evidencing effective use of the quality management structures to identify and respond to arising issues. Minutes from the DQAC, DEC and SSLC showed a range of issues raised and addressed.

Evidence demonstrated effective use of the quality management structure. Actions had been taken to amend final assessment regulations for year 3 students to take into account a decrease in student opportunities to gain experience in longitudinal patient care as a result of Covid-19. This was brought to the DQAC for discussion and approval as a temporary measure. The School had also amended the unseen case examinations method in response to the pandemic. The School should, however, ensure that assessments which were amended to accommodate Covid-19 conditions are reinstated to pre-Covid conditions for future cohorts.

The panel considered the Requirement to be partly 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 Partly Met.

Two External Examiners (EEs) are assigned to the BSc programme. EE reports were available to the panel and demonstrated a responsive approach to issues raised. The panel met with one EE who explained his role in the process for ensuring fairness, reliability, and validity of assessment.

The EE confirmed that he worked collaboratively with the School, which is responsive to feedback regarding suggested amendments to the programme assessment process. However, he had not been formally inducted into the role. In addition, the panel were told that there had been no regular opportunities for the EEs to collaborate.

The EEs were present at the unseen case examinations observed by the panel, including the pre-examination calibration meeting. However, the panel had concerns that the meeting was too short to enable adequate calibration. EEs were clear of their external role and purpose with regards to external presence in the examination process.

The panel saw evidence of systems in place for collecting basic patient feedback at clinic, but there was no clear demonstration that this was being used to inform programme development. The School confirmed that it is in the process of developing a new process for collecting and using patient feedback.

The panel considered the Requirement to be partly met.

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

Outreach clinics are part of QMUL, and staff also work at the QMUL's Dental Institute, thus supporting to ensure the effective, informal sharing of information. Consistency across locations is assured as outreach tutors are also hub tutors. There is a clinical lead at each outreach location. The School explained that the Trust, the Dean, and undergraduate leads meet to discuss challenging issues, maximise communication and ensure the best processes for students. Students are also included in the start of the day 'huddle' and stated that they are encouraged to get involved and supported to contribute.

The School has a designated head of outreach who works closely with the Trust. Regular meetings take place with both the Trust and QMUL staff, and there are weekly coordinated meetings with all outreach leads. The outreach lead also attends the monthly DQAC meetings.

The panel were told that patient satisfaction feedback is collected electronically monthly and scores uploaded to Liftupp. The School explained that the Trust also recently introduced a QR code system which patients can use to give feedback and are working to get this fed back to students. The School confirmed that feedback forms have not been collected from students since the Covid-19 pandemic, but this will be reinstated once clinics are back to full function.

Issues relating to outreach can be raised by students via SSLC. The School presented evidence of the end of module surveys which included feedback on outreach. Students were positive about the mechanisms and opportunities to feedback.

In depth student feedback is collected via module evaluation. However, there is no separate formal process for evaluating outreach. Students who met with the panel said they were able to comment about outreach at SSLC and that their views are taken seriously. From the evidence given, the panel concluded that there is a robust process for feedback, but opportunities for students to give feedback on outreach could be strengthened.

The panel were satisfied that the Requirement is met.

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

Requirement 13: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, and that they are fit to practise at the level of a safe beginner. Evidence must be provided that

demonstrates this assurance, which should be supported by a coherent approach to the principles of assessment referred to in these standards. Requirement Partly Met.

A wide range of assessment types are used on the programme. Assessments are blueprinted across all years. The panel noted that there a lot of assessments in year one but were told that that the assessment burden had been reduced, with health and human science being removed from year 1, due to overlapping with assignments. In addition, summative assessments covering caries and periodontics have also been removed. This is being kept under review to ensure that students are clear of expectations. Students are expected to engage with all assessments and pass at a high standard.

The School has a designated assessment lead, and the assessment strategy is discussed by the DQAC. The panel were told that the School is considering reconstituting an assessment panel/board to oversee all examinations. No timescale was given for implementation.

The panel identified that the Gateway assessments are incorrectly defined in programme literature as formative when, as they must be passed for the students to progress, they are, in fact summative. Because of the error in classification the EEs do not have oversight.
The Panel noted the absence of LOs against a small number of assessments.

Remediation plans are put in place for students who require support to pass Gateway assessments.

The panel were concerned that the Continuing Care case has been removed from the final assessment. In relation to patient management and assessment the panel felt that an opportunity was lost regarding history taking, diagnosis and treatment management.

The panel observed several sessions of Unseen Case Examinations to assure adherence to University regulations and good assessment practice. Improved pre-test calibration involving all assessors and the EEs would help to ensure a consistent approach to the questioning of students.

The scoring ratings for the Unseen Case Examination weightings could be improved by for the inclusion of an 'safe/unsafe'/'red flag' criterion which would result in an automatic failure notwithstanding the rest of the students' mark for this assessment. The panel did, however, observe appropriate conferring and discussion between two external examiners regarding scoring leading to summative judgements that ensured only those who were safe beginner level were passed.

As part of the GDC targeted monitoring activity the panel reviewed and were satisfied with evidence that the assessment, remediation and Sign Off process gave assurance that only students who were safe beginners would pass. The School also explained that simulation forms part of clinical experience data, but it is not considered as an exit point and not included in the Sign Off process. Evidence viewed showed clear delineation between the recording of clinical experience and simulation is made on Liftupp.

The panel considered the Requirement to be partly met.

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

The panel was given a demonstration of the Liftupp system, used to record clinical data and track student progress. The system is used to record soft skills and various clinical parameters

when on clinic with staff, such as case presentations, time management and the students' interaction with patients. Students access the information and use it to identify strengths and weaknesses and areas for discussion.

Liftupp data is reviewed and feeds into formal review periods to check students' progress, with outcome scores of between 1-6. Scores between 3 and 4 gives rise to concern about progression. Academic leads use RAG rated scores generated to inform student progress discussions in the form of termly review meetings.

There was a clear demarcation of the simulated and patient clinical experience. Staff and students were very clear about the process for inputting records on to Liftupp. Checks are made to identify students in need of particular clinical, procedures, and detect where students may be falling behind so that measures can be put in place to ensure achievement. There are indicative targets in the Liftupp protocol, and these are used to track students and ensure patient availability.

The panel observed evidence of the alerts triggered by Liftupp with regards to struggling students, via development indicators. There was a clear reporting structure in place to respond to alerts.

Staff were clear about the training they must undertake to effectively utilise Liftupp, which is included in staff development days. The panel were told that new clinical advisers are given training on grading and descriptors. The Panel were given access to staff training resource which is readily available via QM+. The panel was satisfied that the Requirement is 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.

It was clear that the programme team is working hard to ensure that students have exposure to an appropriate number of procedures. Good efforts are made to manage patient flow and attract patients from a variety of sources, with additional funding made available to staff clinics.

There was evidence of communication to students outlining their progression and any procedures that needed to be achieved. There are indicative clinical targets in the Liftupp protocol, and these are used to track students and ensure patient allocation.

The panel were told that year 3 BSc students were given priority over year 4 BDS for access to restorative care treatments, and outreach clinics run at Stratford side by side to ensure adequate allocation of patients to students. There was communication between the main clinic and the outreach centres to manage patient allocation. The School added that they are keen to introduce continuing care (whole patient care model). The impact of the pandemic led the School to focus on managing to make sure students had access to the range of procedures. In addition, the capacity of the floor clinic was increased.

Patient flow is actively managed to give students the best chance of getting experience in the necessary competences.

Students are proactive in identifying and alerting staff to their clinical needs. Steps are being taken to move to electronic management of the centralised patient records system, giving access from any site.

The panel met with the School administrator who allocates patients to both BSc and BDS students at the Dental Institute. Students commented that they approach the administrator to

secure allocation of patients for treatments they need to achieve, and that this works well. It was noted that where the shared care model is used, the supporting students' activities are recorded as 'assisted' on Liftupp.

To support the GDC targeted monitoring activity, the School was asked to submit the latest clinical data for panel scrutiny. From the clinical data submitted, it was identified that some students had low clinical activity in paediatric direct restorations and extractions. However, given the challenges posed by the pandemic over the last two years, the panel were content with what the students had achieved, although direct restorations were limited. The panel recommends that this treatment should be increased for future cohorts. The panel were also told that face to face lectures were suspended during the pandemic to accommodate students to get more clinical experience, but this has now been reverted.

The School explained that both before and during the pandemic students identified as having low clinical numbers were supported with extra clinical sessions up to a cut-off date of the date of graduation until they were ready to be signed off. In addition, the panel was told about steps taken to address a lack of chair space and nursing support. Priority was given to senior year students with evening and Saturday clinics set up, and the working day extended to maximise opportunities to increase clinical experience. Strong teamwork, additional funding and ongoing risk assessment has supported this.

The panel were told that simulated activity is used to enable students to meet the Learning Outcome due to the ongoing issue with low pulpotomy patients. The panel were told that there will be a move back to students providing ongoing care for patients.

Treatment planning workshops set up under the shared care concept ensured consistency in treatment planning and supported calibration of cross-site tutors. This will continue for future cohorts.

The panel was satisfied that the Requirement is met.

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

Internal question writing workshops take place to ensure all assessments are blueprinted and mapped to the GDC Learning Outcomes. The School has an Assessment Lead who covers both the BSc and BDS programmes and is also the lead for all taught undergraduate and postgraduate programmes.

Assessments are reviewed externally before being formatted ready for use. A post assessment review is carried out, and the outcome presented to the DQAC. The panel were told that an Examination Review Board is being considered for the coming 2022-23 academic year.

The School explained a clear process for developing, approving, and implementing changes to assessment methodologies. Where areas for improvement are identified, proposals for change are made via the module amendment form and representation made to DQAC. The process includes consultation and student input.

The School Examinations Officer is a psychometrician and analyses Assessment outcomes. The School provided evidence demonstrating that Examiner training is very robust and thorough. However, as highlighted in Requirement 1 the School paperwork incorrectly describes some assessments as being formative when they are summative. Because of this, it was identified that these assessments are not being subject to routine review by the EEs.

The panel considered the Requirement to be partly 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 Partly Met.

The School presented some evidence that feedback is collected and used to inform assessment. The outcomes of summative assessments are fed back to all students, giving an awareness of performance in comparison, and an awareness of what they need to do to improve. There is a focus on working in pairs using peer feedback to inform assessment. The School is concerned that such a system compromise working relationships between students. Within the reflective practice element of the programme, students will comment on good practice and areas for improvement for each other and reflect on this, and this will be evaluated over the three years.

The panel was told that patient feedback is collected and uploaded to the central records system. Some examples of feedback were presented but there was no clear demonstration of how it is used to inform assessment.

The panel considered the Requirement to be partly 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 Partly Met.

The School told the panel that students are encouraged to reflect throughout the programme. A lecture on reflection is delivered in year one, and students complete reflective assignments. Students who met with the panel reported that they found this structured and helpful. year 3 students said that their reflection had become much more natural, positive, and developed through the programme. The School is developing a theme of reflective practice through the three years of the programme. Students will be asked to complete reflective logs and draw out key points for discussion with tutors, with a ‘social responsibility requirement to reflect on how their experience will shape them as a dental professional. Generic classroom-based feedback is also in place.

The panel were told that individual feedback on summative assessments would, ideally, be provided to students within 2-3 weeks of submission, but that the pandemic and changes to course delivery had led to delays. Students confirmed that feedback was not always given in a timely way. The School is reviewing the process for providing feedback.

The panel considered the Requirement to be partly 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.

The panel were given access to documentary evidence regarding staff qualifications and training. The School presented a range of assessment training materials and guidance for staff.

Guidance for External Examiners was clearly linked to QAA criteria. A staff training matrix is maintained. As reported earlier the panel learnt that there had been no structured EE

induction, and a lack of facilitated collaboration between the EEs. This also included a lack of adequate involvement in pre-examination calibration.

The panel considered the Requirement to be partly 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 Partly Met.

The programme is supported by two External Examiners. The School's External Examinations policy and EE reports were made available to panel. The panel were told that all assessments are reviewed and brought to the DQAC. However, the EE is not required to undertake annual training for their role, as there is no annual training in programme in place for EEs.

The EEs observed the unseen case examinations. A pre-examination calibration took place, however the panel noted that there had not been sufficient time to for the assessment team to discuss a consistent approach. EEs were clear of their external role and purpose with regards to external presence in the examination process.

Observation of the Unseen Case Examinations satisfied the panel that the process was generally robust.

The panel considered the Requirement to be partly 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.

The School demonstrated a robust process for developing and reviewing assessments, ensuring validity and reliability. All assessments are reviewed and brought to the DQAC and follow university guidelines on double-marking. Assessments are sent to the programme EEs for review and feedback, and there is evidence that the school addresses EE comments. Module proposals are presented at the DQAC and then sent to the Quality Committee for changes.

The panel had access to standard setting evidence which demonstrated input from staff across the programme. The information presented showed that all assessments are reviewed by the EE and feedback is received.

The panel was satisfied that the Requirement was met.

Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
1/16	The School must review its Gateway assessments to ensure these are appropriately defined giving rise to the correct oversight process.	The Gateway assessments are currently being reviewed by the year leads responsible for these assessments. The assessment descriptions and marking criteria will be amended to meet this action.	April 2023
1	The School must review programme documentation to 're-badge' enabling a separate identity for the BSc programme	This will be implemented for future cohorts	January 2023
?	The School must review proposed quality assurance developments to ensure timescales for completion are set and monitored. (Assessment Board with overall strategic responsibility, weekly programme team 'huddle')	The Assessment Lead has set timescales for all assessments and regular meeting have been scheduled. Team Huddles have been replaced by regular individual meetings with The Programme Lead due to staff availability to attend huddles. Information is then disseminated to the required team members.	Completed
9	The School should consider how to improve student participation for future cohorts as this is a key aspect of the School's quality management of this course.	Regular meetings with the students will take place in addition to SSLC & DQAC, feedback from these meetings will be disseminated to the required team members.	January 2023
10	The School should ensure that assessments which were amended to accommodate COVID conditions are reinstated for future cohorts.	We can confidently say that we have started implementing the reinstatement of the assessments as they were before COVID, this was pushed forward at the assessment meetings regarding the current cohort.	December 2023
11	The School must improve the patient/public feedback process to ensure this feeds into programme development.	This is in the process of being developed as stated in the report and the school will implement this as a matter of urgency.	July 2023
12	The School should review approach/process for evaluation of outreach.	The Lead for Outreach has scheduled monthly meetings with staff members, where any issues raised by staff, students or patients can be discussed. The school will review its process for student feedback and evaluation of the outreach sites.	January 2023

13	The School should review Unseen Case Examination weightings to identify overriding criteria for 'safe/unsafe'/'red flag' reasons for failing.	The criteria is being reviewed and will be amended for the next diet of examinations to include safe/unsafe/red flag criteria.	July 2023
13	The School should review weightings for the significant Unseen Case Examination marking criteria.	This is being reviewed and will be amended for the next diet of assessments.	July 2023
13	The School should consider reviewing the assessments relating to Continuing Care and patient management and assessment.	This is being discussed with the assessment team to be reintroduced. The students have been allocated patients for continuing care, this will ensure that the history taking, treatment planning diagnosis and patient management outcome is met.	July 2023
15	The School should consider increasing direct paediatric restorations for future cohorts.	This will be reviewed and measures taken to ensure the students have sufficient access to paediatric patients to meet this action	April 2023
17	The School develop an approach to ensure the use of patient feedback to inform programme development.	This is in the process of being developed as stated in the report and the school will implement this as a matter of urgency.	July 2023
18	The School must ensure students receive timely feedback on assessments.	Staff workload is being reviewed and appropriate time will be set aside to ensure feedback is giving in a timely manner following assessments. This will be monitored by the Programme Lead/Deputy Programme Lead.	January 2023
19/20	The School should consider improved timeliness and context of pre-examination calibration.	The assessments processes are being reviewed and this will be addressed to allow for sufficient time following pre-examination calibration for the assessment team to adopt a consistent approach. The external examiners will be asked for their feedback in the development of this calibration method and this will be incorporated in the finalisation and roll out of the process.	July 2023

Observations from the provider on content of report

Recommendations to the GDC

Education associates' recommendation	The BSc Oral Hygiene programme continues to be approved for holders to apply for registration as a dental hygienists and a dental therapist General Dental Council.
Next regular monitoring exercise	Monitoring 2024

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

A Requirement is partly met if:

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

A Requirement is not met if:

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

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

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

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