General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Date(s)
Queens University, Belfast	Bachelor of Dental Surgery (BDS)	5-6 March 2019 24 October 2019 (re-inspection)

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

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: focussed on Requirement 4, 9, 11, 12, 13, 14, 15 and 19**
Learning Outcomes:	***Preparing for Practice (Dentist)***
Programme inspection date(s):	**5-6 March 2019** **24 October 2019 (re-inspection)**
Inspection team:	**Catherine Boyd (Chair and Non-registrant Member – March 2019 only)** **Victoria Buller (Chair and Non-registrant Member – October 2019 only)** **Shiv Pabary (Dentist Member)** **David Young (Dentist Member)** **Barry Quinn (Dentist Member – March 2019 only)** **Rachael Mendel (GDC Quality Assurance Officer – March 2019 only)** **Manjula Das (GDC Head of Education Quality Assurance – March 2019 only)** **James Marshall (GDC Quality Assurance Manager – October 2019 only)**

Executive Summary

The BDS inspection undertaken at the Queen's University Belfast was a risk-based inspection looking at specific areas of focus identified by the GDC's Education & Quality Assurance team in 2018. The inspection team returned in October 2019 to review how the Student Intervention Plans were being implemented and to gain further assurance that student progression was being adequately monitored.

Information considered when identifying potential or actual risks included annual monitoring returns, previous inspection reports (and progress against any actions) and responses to wider recommendations in the GDC Annual Review of Education.

The inspection focused on Requirements 4, 9, 11, 12, 13, 14, 15 and 19 and specific areas within those Requirements which are detailed below.

The education associates comprising the inspection panel were grateful that the documentation received in advance of the inspection was comprehensive and the evidence demonstrating the Requirements being considered was easy to find. Requests for additional information during the inspection were provided quickly.

The panel was impressed by the positive student feedback with regard to the programme in terms of support, supervision and action within the school following review feedback from student representatives.

The education associates had no major concerns with the programme and agreed the progression of students as they moved through the programme was clearly evidenced and the panel was satisfied that upon graduation the students were fit to practise as safe beginners.

Background and overview of qualification

Annual intake	60 students
Programme duration	180 weeks over 5 years
Format of programme	**Year 1 and 2** Students are attached to dental clinics for observation and also undertake modules where they learn about the foundations of clinical practice including the biomedical and behavioural sciences as well as the principles of dental patient management, dental health promotion and core clinical dental skills. **Year 3** Students are attached to the full range of dental clinics and undertake personal treatment sessions, while continuing to develop clinical skills. Students also learn about the impact of systemic disease in dentistry. **Year 4 and 5** Emphasis is on teaching advanced dental clinical skills within the range of clinical specialties in dentistry. Students carry out the full range of dental treatment for their own adult and child patients

The GDC wishes to thank the staff, students, and external stakeholders involved with the BDS 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	Met
10	Met
11	Met
12	Met
Standard Three	
13	~~Part Met~~ *Met following re-inspection*
14	~~Part Met~~ *Met following re-inspection*
15	Met
16	Met
17	Met
18	Met
19	Met
20	Met
21	Met

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

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

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

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

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

Requirement 4: When providing patient care and services, providers must ensure that students are supervised appropriately according to the activity and the student's stage of development. *(Requirement Met)*

The panel was tasked with looking specifically at whether staffing levels has had any impact on this requirement.

The panel saw evidence that the staffing levels had been improved since the last inspection. The programme has 18 clinical academic consultant staff, two more than they considered optimal for the number of students. The students reported that they were being supervised appropriately on clinic and that there was always sufficient numbers of staff available. The panel also saw evidence of succession planning, to ensure that staff are being recruited and trained to fill gaps when staff members retire.

The programme should continue to keep the GDC informed about changes in staffing levels, to ensure that appropriate staff levels continue to be maintained.

Update following re-inspection visit:

During the re-inspection visit, the programme team confirmed that recruitment to some clinical academic posts had been a challenge in the past. However, the panel was pleased to note that improvements had been made with recruitment following funding support from government.

The programme team confirmed that since the initial inspection, the School has appointed clinical academic posts for both paediatric dentistry and restorative dentistry.

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

Requirement 6: Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong. Providers should publish policies so that it is clear to all parties how concerns should be raised and how these concerns will be acted upon. Providers must support those who do raise concerns and provide assurance that staff and students will not be penalised for doing so. *(Requirement Met)*

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

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC Student Fitness to Practise Guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance. Providers must also ensure that the GDC's Standards for the Dental Team are embedded within student training. *(Requirement Met)*

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

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

The panel was tasked with looking specifically at whether staffing levels has had any impact on this requirement.

The school uses the Annual Programme Review process to manage the quality of the BDS programme. Each module within the programme is reviewed. Feedback on content, delivery and assessment, and recommendations for change are provided by teachers, students, external examiners and other relevant stakeholders. Each year the Module Co-ordinator and the relevant Associate Director complete a Module Review Proforma. External examiners' reports and feedback from students is also reviewed in this meeting. The module reviews then feed into The Annual Programme Review report, which is reviewed by the Head of the School of Medicine, Dentistry and Biomedical Science and the Faculty Dean for Education. The Programme Review Report is also considered by the University Education Committee who then provide the Dental School with a feedback Report.

The panel saw evidence of this framework and were satisfied with the quality framework functions and where responsibility for these functions lie. The panel concluded that the current staffing levels were adequate to ensure the appropriate management of quality framework.

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 panel was tasked with looking specifically at how student feedback was used to inform the development of the programme and how this impacted the requirement.

The programme uses a variety of methods to collect and use student feedback in programme development.

Individual student feedback questionnaires for each module. This feedback is utilised by the Module Co-ordinators and Associate Directors as part of the Annual Programme Review Report.

Staff Student Consultative Committee (SSCC) meets four times a year and is co-chaired by a Year 5 student. This committee enables students across the 5 years of the programme to bring issues to the attention of the SSCC including teaching, curriculum and assessment

issues. An action plan is then agreed by the staff and students on the SSCC. Following the SSCC meeting the Action Plan is circulated with a description of the action needed to be taken and the person(s) responsible for completion of the action. Actions are reviewed at subsequent meetings of the SSCC.

Student feedback is a central part of the Module Review process and is a specific agenda item on the Module Review meeting agenda. The Module Coordinator is required to provide a list of the key issues raised by students, by considering evidence from students through module evaluation questionnaires and issues raised at Staff Student Consultative Committee meetings as well as any other sources of student feedback. The Module Coordinator is also required to explain in the Module Review Proforma how they will address the issues raised by the students.

Module Co-ordinators complete the Module Review Proforma which is then shared with the relevant student year representatives so that the student representatives can include further comments from their year groups within the Module Review Proforma.

Proposed changes, in any module, must be approved by the Dental School's Staff Student Consultative Committee and the Dental Education Committee. Module Co-ordinators also ensure any changes to their module are included in the students' Module Study Guide.

The panel spoke to a number of students, who confirmed that they were able to feedback to the programme and gave examples of changes that had taken place to the programme as a result of their feedback.

The panel were satisfied that student feedback was being utilised in programme development.

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)*

The panel was tasked with looking specifically at how the quality assurance of placements and outreach takes place and how patient and student feedback is collected and utilised.

All placements are required to complete a health and safety checklist and follow the health and safety protocol. Module Co-ordinators carry out regular outreach placement visits when a placement checklist needs to be completed. A formal Service Level Agreement exists with all placement providers.

Outreach clinical supervisors are full members of the relevant Dental School teaching committees (Dental Education Committee, the Restorative Group, the Dental Specialities Group) or Dentists who report to the Senior Management Team.

The panel saw evidence of these completed checklists and service level agreements. However, there is no dedicated outreach lead and the management of the outreach placements is done by the specialty leads resulting in the management of the outreach centres being done on an ad-hoc basis. While this is currently working, and any issues are being picked up, due to the close relationships between the programme and outreach centres the programme should consider appointing a dedicated outreach lead in order to formalise and standardise the outreach process.

Patient feedback is collected for patients treated in outreach clinics in the same way as for clinics in the Dental School. Patient feedback is considered and monitored by the Module Co-ordinators, Associate Directors, Senior Management Team and the Clinical Progress and Monitoring Committee.

Student feedback is collected for Outreach attachments at the end of the relevant module. It is monitored by the Module Co-ordinators and Associate Directors as part of the annual module review process. Student feedback is also monitored by the Director as part of the Annual Programme Review process.

The panel saw evidence of outreach centres being quality assured and the use of student and patient feedback being used in the processes.

Update following re-inspection:

The panel was pleased to note that following feedback during the initial inspection visit, the School has instigated a new Outreach Co-ordination Committee. This committee is comprised of representation from a range of dental disciplines with a rotating chair from among staff members. The committee uses student and patient feedback to inform its decisions. The panel was informed that one of the main aims of this new committee is to share good practice between individual outreach centres.

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

The 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.

The programme assesses clinical skills from year 1, but subject-specific modules in the clinical disciplines begin in Year 3 and are assessed at the end of the academic year in each module. The modular system means that there is no 'sign-up' to Finals but students must pass all parts of Finals in order to proceed to graduation.

The programme has three parts to Finals, where subject-specific knowledge and skills and generic knowledge and skills are assessed. Compulsory elements include clinical competency assessments, indicative clinical attainment requirements or targets and clinical progression data (monitored through LIFTUPP, a software package which triangulates assessment data) in each specific discipline/module. There is no compensation between the different disciplines or between assessment components so that students must pass all summative assessments and complete the compulsory elements for each module. Satisfactory progress and completion of clinical attainments is reviewed and confirmed at the Clinical Progression Monitoring Committee meetings during 4th and 5th year.

Clinical experience is monitored on an on-going basis by the Module Co-ordinator and more formally each semester for years 3-5 students by the Clinical Progress Monitoring Committee (CPMC). At these meetings progress of each individual student is assessed in terms of; attendance, development indicator scores recorded on LIFTUPP, competency assessments and clinical attainment/targets.

Students with clinical attainments meet with the Module Co-ordinator and additional clinical opportunities are organised for those students as required. Where more significant concerns exist regarding clinical development and progression, the student is asked to meet with the Dental Student Progression Committee, where all aspects of clinical development and progression are reviewed and appropriate action taken.

Prior to the Board of Examiners meetings for each component part of the Finals examination, clinical attainments are reviewed by the Compulsory Elements Committee (CEC), to ensure each student has reached the required quality and quantity of clinical procedures (attainments).

If a student has not satisfactorily completed any compulsory element, including clinical procedure attainments, their results will be withheld until this has been completed and they will not be allowed to progress through the course or to graduate until this has been achieved.
In 1st and 2nd year, students are monitored via a Monitoring and Concerns Committee.

The GDC had concerns that the programme did not have the appropriate measures in place to identify in a timely way struggling students or those with ongoing clinical performance issues.

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In response, the programme introduced intervention plans as an additional way of monitoring student progression. If any concerns are raised about the student, they are recorded and monitored, with regular follow up meetings scheduled. The student is monitored and provided with additional support where necessary until there is no longer any concerns and the intervention plan is closed. The panel felt that the introduction of the intervention plans was a positive addition to the current monitoring systems. However, as they have only recently been introduced, the programme must continue to provide quarterly updates on the implementation of the intervention plans.

Update following re-inspection visit:

During the re-inspection visit, the panel was given a full update on the implementation of the new Intervention Plans and the impact they now have on the monitoring of student progression. The panel was informed that since the introduction of the plans, the Senior Management Team have reviewed the effectiveness of the system and confirmed they will remain a permanent feature of student monitoring systems at the School.

The panel was informed that an Intervention Plan can be initiated for a student to address a number of issues. These include concerns about performance in assessments or competency tests, progress towards clinical targets, attendance, clinical "Alerts", LIFTUPP developmental indicator scores, or professionalism.

In the event that a student is given an Intervention Plan, they may be required to complete additional teaching sessions in the Clinical Techniques Laboratory, which is open to students requiring additional support each week, or other targeted clinical and non-clinical teaching, support and assessment.

The panel was pleased to note that staff members are provided with additional training in the use of the plans and support systems are in place for students.

The panel agreed that following the additional evidence provided during the re-inspection, Requirement 13 should move from Partly Met to Met.

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

The panel was tasked with looking specifically at how the implementation of LIFTUPP is being used to monitor clinical experience and whether this has any impact on how this Requirement is met.

After the previous inspection, the programme implemented LIFTUPP to replace the paper-based system they were using to monitor clinical progress. The use of LIFTUPP data in Years 3 to 5 is fully integrated into the Clinical Progress Monitoring Committee (CPMC).

The panel saw evidence of the implementation of LIFTUPP and it being used to monitor student progress. However, a paper-based system was also still being used in some cases. The panel saw evidence of the modular leads picking up issues regularly, but this was done on an ad hoc basis on a modular level rather than on a whole programme level. While there is a system in place to record the students clinical work, it was not evidenced that the school was monitoring this data effectively. The programme should aim to formalise the monitoring

process, to ensure that each student is monitored on a systematic programme level, rather than in isolation of each module.

Update following re-inspection visit:

During the re-inspection visit the School confirmed that there are no longer any paper-based recording systems in use. The School informed the panel that at the time of the initial inspection some paper-based recording was being used because of legacy systems and to ensure the new LIFTUPP system was working properly. Following a review of LIFTUPP performance, the School was satisfied it was working appropriately and now all student performance data is recorded electronically.

The panel agreed that following the additional evidence provided during the re-inspection, Requirement 14 should move from Partly Met to 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 panel was tasked with looking specifically at access to a range and number of patients and whether this has any impact on how this Requirement is met.

The Dental School has clearly defined the number of clinical procedures each student must achieve before completing a module and progressing to the next stage of the course. Clinical attainment is recorded through LIFTUPP and monitored through CPMC. The school and the students both felt like they were achieving a wide range and breadth of experience.

During the inspection, the panel saw evidence of the clinical attainments for all students. While some students were short on some treatments, specifically, endodontic treatments, these shortfalls had been picked up and were being monitored by the programme through the intervention plans.

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

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

Requirement 18: The provider must support students to improve their performance by providing regular feedback and by encouraging students to reflect on their practice. *(Requirement Met)*

Requirement 19: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, including appropriate general or specialist registration with a UK regulatory body. Examiners/ assessors should have received training in equality and diversity relevant for their role. *(Requirement Met)*

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

The panel saw evidence of how the new members of staff had been inducted into their roles of examiners and assessors through training, shadowing more experienced staff members and how the school makes use of calibration, to ensure that assessment is being carried out appropriately.

The programme has also recently implemented standardisation training for all staff, to ensure that all tutors are marking at the same level. The panel heard positive feedback about this training.

The inspection panel concluded that staffing levels were appropriate and there were effective systems in place to monitor the training of new and existing staff, examiners and supervisors.

Requirement 20: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented. *(Requirement Met)*

Requirement 21: Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments. *(Requirement Met)*

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
4	The programme should continue to keep the GDC informed about changes in staffing levels, to ensure that appropriate staff levels continue to be maintained.	The Centre for Dentistry will continue to ensure staffing levels are maintained and to keep the GDC informed about any changes to staffing through the annual monitoring process.	Annual Monitoring

Observations from the provider on content of report

We would like to thank the GDC Inspection team for their approach during the inspection and the very helpful and positive Report. The University places a high value on the expert external advice it receives from the General Dental Council and will continue to support the Centre for Dentistry in enhancing the educational experience of our dental students.

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 reinspection / next regular monitoring exercise	2021

Annex 1

Inspection purpose and process

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

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).
3. The GDC document 'Standards for Education' 2nd edition 1 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.