General Dental Council

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
King's College London	Dental Therapy & Hygiene BSc

Outcome of Inspection	Recommended that the Dental Therapy & Hygiene BSc is approved for the graduating cohort to register as a dental therapist and a dental hygienist.

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 therapist and a dental hygienist.**
Learning Outcomes:	**Preparing for Practice (dental therapist; dental hygienist)**
Programme inspection dates:	**Day One: 18 January 2023 (on-site)** **16 February (remote meeting with students)** **Day Two: 30 March 2023 (remote meeting)**
Examination inspection dates:	**16 May (DTH3 Progress Committee: First Sign-up meeting)** **27 June (DTH3 Sub Board sign-off meeting)**
Inspection team:	**Helen Poole: Chair and non-registrant member** **Jo-Anne Taylor: Dentist member** **Linda Gunn: DCP member** **Kathryn Counsell-Hubbard: Quality Assurance Manager (16 May 2023 only)** **Martin McElvanna: GDC Education Quality Assurance Officer (except (16 May 2023)**
Report produced by:	**Martin McElvanna**

This was the first GDC programme inspection of the Dental Therapy & Hygiene BSc programme ('the BSc' or 'the programme') delivered and awarded by the King's College London ('King's' or 'the College'). Provisional approval of the programme had been granted in October 2020.

The programme inspection was conducted on site at King's on 18 January 2023. On all other subsequent dates detailed above, the inspection took place remotely.

The inspection panel was comprised of GDC education associates ('the panel', 'we'). The panel were grateful for a comprehensive and well-indexed set of documents received in advance of the inspection and a further set of documents on site during the inspection. Documents were also made available ahead of the examination board observations. The panel had further questions post-exam board and were grateful for the prompt response.

Of the 21 Requirements being considered, 14 were considered to be 'Met'. The remaining seven Requirements were considered to be 'Partly Met' with six actions being identified for the College to address by the end of quarter 1 of 2024.

Overall, the panel had no major concerns about the BSc programme and agree that it should be ‘approved’ for graduates to register with the GDC as a dental therapist and a dental hygienist (DTH).

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

Background and overview of qualification

Annual intake	• Y1: 29 students • Y2: 27students • Y3: 29 students
Programme duration	110 weeks over 3 years
Format of programme	e.g.: Year 1: basic knowledge, clinic attendance, shadowing 2: knowledge and simulated clinical experience 3: direct patient treatment, clinic attendance, outreach, placements
Number of providers delivering the programme	One

Outcome of relevant Requirements[1]

Standard One	
1	Met
2	Met
3	Met
4	Met
5	Partly Met
6	Met
7	Met
8	Met
Standard Two	
9	Met
10	Met
11	Partly Met
12	Met
Standard Three	
13	Partly Met
14	Partly Met
15	Partly Met
16	Partly 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 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)

In year 1, students attend the Introduction to Clinical Skills module. This is where they begin simulated clinical practice skills which includes the preparation and maintenance of a safe clinical environment as well as the management of medical emergencies.

In year 2, as a follow on from the Introduction to Clinical Skills in year 1, students attend the Simulated Clinical Practice module 1. This module covers a variety of simulation methods, using a staged and spiralling approach. It also includes the development of clinical practice skills in periodontal hand instrumentation and restorative dentistry.

Additionally in year 2, students attend the Restoration & Maintenance of Child & Vulnerable Adult Oral Health module in which students are prepared to manage the oral health of children and vulnerable adults.

Before students carry out any particular clinical treatments on a patient, they must pass the relevant number of summative skills tests (Clinical Activity with Feedback [CAFs]) within the simulated environment. Each CAF has clear agreed criteria that a student must meet to progress. Students may progress through the CAFs at different times and are provided with feedback, further practice and second attempts as necessary. Supervising staff are aware of any restrictions on students' practice until such time that all CAFs have been passed.

Additionally, students take part in an induction at the Denmark Hill centre before attending clinic. The induction has four parts covering administration, medical emergencies, introduction to equipment and cross infection control.

The panel had sight of the Introduction to Clinical Skills, Simulated Clinical Practice and Clinical Skills for Practice module handbooks, the CAFs, marking schemes and the Assessment Strategy.

We considered that this Requirement was 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 panel had sight of various documents indicating treatment provision by students such as leaflets, letters, signage, name badge and a consent to treatment form.

Students provide care at King's Denmark Hill clinic as well as several King's College Hospital Trust outreach / community clinics.

There are several points at which patients are made aware that they will be treated by a student.

Patients can self-refer for dental care through the King's website which clearly states that treatment will be carried out by students who are supervised by qualified clinicians.

First appointments with patients are confirmed via an appointment letter which includes a patient information leaflet advising that dental care will be carried out by a student.

In addition, in patient waiting areas clinics at outreach / community placements, there is clear signage that students will be carrying out dental care.

All students wear name badges clearly stating 'student'. Staff wear different coloured uniforms to easily identify who is qualified and who is in training. There is also a distinction between BSc and BDS students.

Students must gain patient consent for any treatment that will be provided. All patients must complete a consent to treatment form which is checked and signed off by a qualified member of staff.

We considered that this Requirement was 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)

BSc students provide patient care at clinics supported by King's NHS placement provider, King's College Hospital NHS Foundation Trust ("the Trust"). The clinics are based at Denmark Hill and across several outreach / community clinics.

The panel noted that the Care Quality Commission (CQC) report had identified some staffing shortages at King's College Hospital in its report. For example, 11% of nursing staff vacancies. The College explained that it was offering support and that the vacancies had been advertised. In any event, if there were shortages affecting patient safety, clinics would be cancelled.

In terms of the shortage of available tutors for clinical sessions, as raised by students in the Staff Student Liaison Committee meeting (SSLC) UG 1 & 2 2021-22 Minutes & Attendance, the College explained that adverts had been posted for the vacancies. In the absence of adequate cover, the number of students had been reduced.

The College confirmed that an adult and child safeguarding lead had been appointed. For the assessment and senior assessment officer roles, there had been temporary cover and interviews were ongoing.

We had sight of the Local Safety Standards for Invasive Procedures (LocSSIP) policy which is used for all invasive procedures in all clinics to ensure patient safety. This also includes reference to morning 'huddles' which should be attended by all clinical staff (nurses and clinicians) due to work that morning. Key information for the day and any issues identified can thus be addressed in advance of the clinics commencing.

Daily checks are carried out each morning by the lead nurse to ensure all equipment including the emergency drugs kit and oxygen are in working order. Additionally, the 'crash trolley' is checked daily.

The Roadmap to Inclusion 2022-2024 outlines the Trust's equality, diversity and inclusion (EDI) strategy. This includes reference to Targeted Interventions which are invoked to address inequalities in access, experience and outcomes across the Trust's sites and services.

We noted the fire safety risk that was raised by CQC in their report and the Trust's subsequent efforts to try to address this particular concern.

We considered that this 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)

The panel learnt that the staff to student ratio varies depending on the patients being treated. For paediatric patients, the ratio is 1:3 and for adult patients it's 1:6.

Students attend outreach / community clinics in groups containing 1 pair of students, one of which is the clinician and the other a student who acts in a chairside support role. A registered dental nurse supports the day-to-day running of the clinics.

These ratios are monitored regularly. Should the ratios get close to being breached, due to staff sickness for example, patient bookings are reviewed. This may result in the cancellation of clinics to ensure that patient safety is not impacted and that the maximum ratios are maintained.

Prior to the inspection, the panel had sight of staff timetable rotas highlighting the ratios for adult and paediatric patients as well as student timetables for outreach / community clinics.

At the inspection students indicated that they felt well supported. They had clear objectives, action plans and activity goals set every three months and had as a minimum, termly meetings with their personal tutors who would review progress. Students can approach their Personal Tutor (PT) at any time and they see staff on each day they attend clinics. Students indicated their supervisors are courteous and supportive and students informed the panel that they would have no problem raising any issues of concern with or about supervising staff.

Students have a variety of resources available for academic and clinical support, as well as for personal wellbeing and mental health support. These include a self-help portal, peer support, counselling at College level and access to the student library service which includes essay writing and study skills.

Students noted that the use of clinical simulation was helpful to maintain skills.

The panel considered that this 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 Partly Met)

King's explained that all new staff members have a mandatory induction upon joining the team. This includes a period of shadowing an experienced clinical teacher and they are also offered the opportunity to participate in a 'work buddy' scheme.

Ahead of the inspection, the panel had sight of an induction checklist and records of staff mandatory training, qualifications, annual appraisal and GDC registration.

All staff are required to complete mandatory training on the Trust's Learning Education Appraisals Platform (LEAP) platform. This forms part of their annual appraisal. Training covers EDI and management of medical emergencies, amongst others. All staff are expected to undertake equality, diversity and inclusion (EDI) training every year.

King's confirmed clinical supervising staff are qualified dental professionals and are registered with the GDC.

Community leads are invited to Teacher Education Days and in-service training days (INSET) presentations to keep up to date on the delivery of education and supervision.

The College indicated that all staff attend twice yearly INSET days which covers team and programme updates as well as focussed training on areas of assessment, digital technology, student support and EDI. Additionally, there are annual Teacher Education Days with various workshops covering aspects of the curricula and education and general updates.

King's explained that all staff are supported to develop their educational training. Any staff who do not have a teaching qualification are encouraged to complete King's Learning and Teaching Programme and apply for the nationally recognised Fellowship of the Higher Education Academy (FHEA).

The panel noted that some staff hadn't completed mandatory training, and in particular, some EDI training was out of date, with some dating back to 2016. King's explained that this has been flagged and that the staff concerned must complete the mandatory training by the July 2023 appraisal.

Given that some staff hadn't completed mandatory training, including EDI, King's should provide confirmation that the staff concerned have completed the mandatory training by the July 2023 appraisal.

King's should maintain more detailed records of the teaching qualifications and HEA status of the academic and clinical staff.

The panel considered that this Requirement was Partly 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)

King's explained that coverage of raising concerns is embedded in the BSc curriculum and students are introduced to this obligation right from the first week of the programme. This is continued in the Professionalism, Ethics, Management & Leadership (PEML) and Dentistry in Society modules through each year of the programme.

Staff are also made aware of the raising concerns process, including pathways for appropriate escalation, from their induction and as a continuing responsibility.

The Trust's Raising Concerns Policy allows both staff and students the 'freedom to speak up' if they identify any issues that impact on patient safety.

Staff and students can complete an online form on King's College E-learning And Teaching System (KEATS) should a concern need to be raised.

There are reminders about the obligation to raise concerns in newsletters and in signage throughout teaching and outreach areas and on the online portals.

All new Trust staff have induction training in which understanding and managing the Raising Concerns process is an element which requires formal sign-off.

The panel saw an example of a Raising Concerns matter concerning professionalism of a student.

The Trust has a commitment to be open with its patients. If a patient complaint regarding their treatment is reported, the Trust aims to investigate and respond honestly and openly and explain any actions they are taking as a result.

The panel had sight of both King's and the Trust's Raising Concerns policies and associated forms as well as Professionalism Policies.

The panel considered that this 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)

Prior to the inspection, the panel had sight of NHS documents relating to the recording of patient safety incidents. This included the Protocol for NHS Trust Datix reporting, NHS Trust Flow-chart and NHS Incident Reporting Log and Actions as well as committee minutes for the Dental Care Group, Risk & Governance and DTH Clinical Governance Committee.

Clinical placements utilise the NHS Trust online incident reporting system, DATIX, to record clinical incidents affecting patient care and action any follow-up issues. All incidents are logged, including those that are 'low level'. There have not been any "near misses".

Incidents are presented at both departmental clinical governance meetings and the wider Trust governance meetings.

Should an incident arise, this is followed up by enquiry based learning, with a focus on treatment and discussion about the incident.

Serious issues of patient safety are reported at the senior level of the Trust. Any follow-up action is determined by senior management within the Trust and within the King's College Dental Institute.

We considered that this Requirement was 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)

We had access to KCL's Fitness to Practise Policy and Student Fitness to Practise Policy, as well as examples of CAFs and Student & Teacher Observation of Clinical Activity with Feedback (STOCAF) domains.

In year 1, students receive lectures entitled Introduction to the GDC and Fitness to Practise.

Professionalism is a core component of the three Dentistry in Society modules which students undertake in each year of the programme.

Students attend professionalism lectures, tutorials and seminars which include digital professionalism, appropriate use of social media, ethics and consent across the three Dentistry in Society modules.

If any concerns are raised regarding the behaviour of students, the Faculty Professionalism Chair has a number of options available to manage this. The Chair may stipulate remediation requirements, refer to Occupational Health, recommend the issues be managed by King's Support for Study procedure or refer a student to a Fitness to Practise Committee. If a student is referred to remediation and fails the requirements stipulated, they are automatically referred to a Fitness to Practise Committee Hearing.

At the inspection, we learnt that no Fitness to Practise cases have been reported so far.

Staff also receive training on the reporting pathways and processes for managing Fitness to Practice matters which align with the GDC's Student Fitness to Practise Guidance.

We considered that this 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 Met)

In advance of the inspection, the panel had access to a range of detailed documents from the Faculty Of Dentistry, Oral & Cranial Sciences (FoDOCS). These included the Governance and Quality Assurance Structure, Clinical Governance Committee, minutes of the Quality Assurance and Quality Enhancement Committee (QAQE), documents relating to the Undergraduate Programmes Committee, Dental Committee and Undergraduate Assessment Committee. We also noted the contents of King's Quality Assurance Handbook 2022-23 which was a very comprehensive document.

This pre-inspection material was most informative and at the inspection, King's gave us a helpful background and overview of the current quality assurance framework.

We learnt that, following a review in 2018, a new QAQE Committee was created. The QAQE is responsible for the monitoring and review of academic standards across the Faculty's programmes and ensures that they adapt to any changing College regulations, external

legislation and GDC learning outcomes. The QAQE also formally scrutinises any proposed changes to the curriculum and assessments.

The Governance and Quality Assurance Structure illustrates the interconnection between various committees, panels and boards that regulate how the BSc programme is monitored and reviewed.

The Clinical Governance Committee convenes around three times per year to oversee various elements of the BSc programme, such as audits, risk management, staff development, patient and public involvement, amongst others.

The panel considered that this Requirement was 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. (Requirement Met)

The College explained that any serious threats to the programme would be identified through the Committees and the Governance Team. The Dean of Education would notify the GDC of these.

At an external level, we had sight of external examiner (EE) reports and it was apparent that EE feedback was being addressed. For example in one module, feedback on the size of assessments had been considered and amendments made. We noted that EE feedback feeds back into action plans. There is further discussion on the role of EEs at Requirement 20.

Regarding the systems in place that King's has to quality assure placements, please see Requirement 12.

The panel considered that this Requirement was 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)

The College explained that the BSc programme is reviewed annually by the College Education Committee. A report is written entitled the Programme Enhancement Plan (PEP) which contains an improvement plan for the programme for the next 12 months. This report is developed with student, staff and EE feedback. The College indicated that the PEP has been replaced by the Continuous Enhancement & Review of Programmes (CERP) report from the 2022/2023 academic year. This is still relatively new to the Faculty and acts as a live and dynamic document.

Regarding the input of EEs, the Faculty appoints three EEs who provide impartial and expert advice on academic and assessment standards for each year of the programme. EEs are provided with the Programme Handbook and Programme Specification and assessment calendar.

Each EE is sent all of the summative assessment information for the year to which they are appointed. These are sent prior to the exam date, inviting feedback. Following completion of

assessments, the EE receives a selection of marked assessments to review for continued scrutiny of the assessment process.

Patient feedback on the care provided by students, staff and the service provider is regularly obtained. The department has a nominated feedback lead who collates the feedback and reports it to the Clinical Governance Committee as a standing item on the Committee agenda.

At the inspection we learnt that the way patient feedback is collected is being developed so that it can be more useful for informing programme development. The College should provide an update to the GDC on how it is strengthening the patient feedback process to meaningfully inform programme development.

The panel learnt how student feedback was being considered. Two student representatives are nominated for each year and are invited to attend and provide feedback from their cohort at curriculum committee meetings. Students can also provide feedback through their clinical teachers and PTs.

At the end of each module, student feedback is gathered and evaluated which informs the development of teaching and assessment in the module.

Students and their student representatives also attend the Staff Liaison Committee (SLCC) and we saw the agenda and minutes of these.

At the inspection, students gave examples of feedback which had been actioned by the College, such as changes to examination timetables.

The panel considered that this Requirement was Partly Met, subject to developments with the collection and use of patient feedback.

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)

Before the inspection, the panel had sight of the Outreach/Community Site visitation Audit Form and Clinical Governance Committee minutes. We noted that the Outreach/Community Lead is a member of this Committee.

The College explained that all new outreach / community placements have an initial site audit, then ongoing yearly audits. The panel noted that visits to placements had increased to every six months.

The Department audit lead oversees department audits and reports back to staff during the clinical governance meetings as a standing agenda point. This ensures that clinical practice is continuously monitored and any areas for improvement are identified and acted upon.

Clinical governance of the Department and Outreach sits under the Clinical Governance Committee to ensure there is a robust clinical governance framework in place for managing clinical systems and processes.

The outreach sites are also subject to external quality assurance by the CQC and we noted that the CQC inspected King's College Hospital Dental Care in 2022.

The panel noted a comment regarding clinical governance of clinical activity at Denmark Hill in some QAQE minutes. The issue was that there was no College representative on the panel. Governance arrangements between Outreach and the College were subsequently improved by the use of outreach proformas, revision of terms and clearer lines of communication.

The panel was satisfied that there is a robust process in place for the quality assurance of clinical / outreach placements where treatment is delivered.

There is discussion regarding patient and student feedback at Requirement 11 above.

The panel considered that this Requirement was 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)

King's provided the panel with various documents ahead of the inspection, including the Assessment Strategy, Assessment mapping documents, Module handbooks, Progress Agenda and Minutes, Student Progress Reports and the Sign-Up Committee agenda.

The Assessment Strategy explains the BSc programme's approach to assessment which is based on a competence framework. The focus is on clinical assessment based on holistic clinical practice with a person-centred approach to patient care, resulting in safe beginners.

The College explained that all modules must be passed before students can progress to the following year and student progress is monitored through the programme. There is more detail on this in Requirement 14.

Attainment across all of the GDC's learning outcomes is demonstrated via a range of assessments across the programme. Please refer to Requirement 16 for further commentary on this.

The panel also had the opportunity to observe both the Sign-up DTH3 Progress Committee and DTH3 Sub Board sign-off meeting.

The sign-up panel reviews student progress to ensure students have met the full range of learning outcomes across the programme and have gained sufficient progress to be signed up to sit final examinations.

The panel received assurances that students are undertaking clinical procedures at a competent level, however, we considered that some of the evidence provided to the panel lacked sufficient detail to support this assurance. Although the panel had sight of summary data at both the sign-up and sign-off meetings, we considered that the granularity of detail being considered at these meetings was less than would be expected. More detailed evidence of reporting and monitoring attainment across the full range of learning outcomes is required, particularly in the lead up to the summary data at the sign-up and sign-off meetings.

We considered that decision-making could be more transparent to demonstrate the maintenance of skill and experience (currency of competency) throughout the programme.

An example of this is the statistics regarding “not met” in the clinical practice statistics. The panel considered that more detail was needed regarding the specific clinical competencies they refer to. The College explained how the “not mets” are being reviewed, managed and remediated which provided assurance to the panel. We felt it would have been useful to have this information earlier in the inspection process. However, it wasn’t entirely clear how the “not mets” were being analysed or addressed in the student action plans we saw.

The panel considered that this Requirement was 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 Partly Met)

The panel had sight of the Progress Meeting Agenda and minutes for years 1, 2 and 3, as well as sign-up documents.

At the inspection, the College gave us a demonstration of the systems in place to monitor and record student progression. King’s e-portfolios are used to record Reflective Practice Reviews, where formative continuous assessment on personal development, reflection, self-management and professionalism is logged. The e-portfolios also contain student guidance including videos, student assessments, assessment criteria and various policies. All clinical supervisors have access to them. It was unclear how frequently student e-portfolios are viewed by the clinical supervisors.

The panel were given a demonstration on the use of CAF forms. This is one of the main tools that the Faculty uses to monitor student progress in the clinical environment. Students must successfully complete all clinical CAFs in order to progress to sit final examinations.

We also saw examples of STOCAF forms. Students are also required to complete and submit self-reflection for every clinical session attended as well as in all domains. There is a section (Form B) for staff to review student progress and breadth of clinical experience. All of the dental team are involved in the completion of STOCAFs as students are assessed by dentists, dental therapists, dental hygienists and dental nurses.

In addition, students are required to complete STOCAFs for simulated practical skills sessions.

We had an introduction to KEATS, which is a bespoke virtual learning environment (VLE) exclusive to King’s College. All staff can access this VLE, as well as all outreach / community staff who have access via their King’s College email account given as part of their teaching role. Online staff training on STOCAFs and CAFs is undertaken on KEATS. Concerns can also be raised here. Various policies are also available on KEATS, such as the Fitness to Practise policy, Raising Concerns and CAF Domains and Assessment Guidance.

King’s explained that student progress is monitored throughout each year. In addition there are termly progress meetings where student progression is reviewed and any concerns with a student are followed up with the personal tutor and progress chair.

In Year 3, each termly Progress Meeting results in an individual student progress report. This takes into consideration academic, clinical, professional and engagement data. If areas are identified for further development, action points are formulated. Students are provided with

their personalised progress report each term and they can approach their PT to help with any actions.

The sign-up committee panel endorses student recommendations and an outcome letter is sent to the student, informing them of the recommendation and if there are any stipulations that need to be met before the final cut-off date. We considered that the data presented at the sign-up meeting was limited to an overview rather than a detailed report to demonstrate that each of the learning outcomes were being closely monitored.

Although the panel took general assurance that students were being monitored throughout the programme, it had some questions regarding how some of the learning outcomes were being recorded. For example, data which illustrates the range of appropriate materials being used by students. Although we received an assurance that students are exposed to a range of materials, we didn't see clear evidence of a student's individual experience of using each type of material.

Regarding student competence in pain management, the panel were advised that students routinely give local anaesthesia when providing restorative or periodontal treatment, and as such there appears to be an assumption that competency is maintained. However, the recording and monitoring of local anaesthesia throughout the programme was not evidenced. It was therefore unclear how the college ensures this skill is maintained throughout the programme.

Regarding the management of periodontal therapy by students, it was not clear if students had completed complex as well as simple periodontal therapy procedures.

We also considered that the maintenance of competency in radiographic practice was also not apparent in the evidence that was presented to the panel.

The panel consider that the College should more explicitly record and monitor clinical experience against each of the learning outcomes and throughout the programme.

The panel considered that this Requirement was Partly 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 Partly Met)

Students begin patient care in term 2 of the second year of the programme and start to carry out preventative care, adult periodontal and restorative care. In term 3 of Year 2, students begin treating paediatric patients.

In Year 3 of the programme, students attend an outreach /community clinic treating adult and paediatric patients, as well as attending the Denmark Hill clinic.

The panel had sight of the Year 3 Progress Academic and Clinical Data Report and Student Progress Reports.

Following every clinical session, students and staff must complete a STOCAF. This is where they submit formative self-reflection along with feedback from their clinical supervisor. This provides an opportunity for students and their supervisors to discuss their clinical progress.

The panel noted the catchment area for patients was large, with a broad demographic and good access to a variety of patients including paediatric patients and patients with special care needs. We noted that there had been an issue with access to paediatric patients but that this had been addressed.

Although the statistics were acceptable regarding the breadth of patients and procedures, we noted that the range of experience across the cohort at sign-up was variable. The College should consider how to regulate this divergence in student patient experience.

As with Requirements 13 and 14, we considered that the full complexity and type of clinical experience was not clearly presented in the evidence we saw.

The panel considered that this Requirement was Partly 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)

As explained above, the College's Assessment Strategy outlines the programme's approach to assessment and is based on a competence framework.

We noted documents regarding the Assessment Working Group, including terms of reference, agenda, minutes and paperwork. The College explained it is a small and focused group led by the Associate Dean for Assessment. It meets on a weekly basis to quality assure that assessments are consistent with the Faculty Assessment Strategy. It helps to create assessment support resources for Faculty staff and to develop staff understanding of best practice in assessment.

The panel also noted the function of the Undergraduate Assessment Committee. It meets termly to manage and develop assessments in line with the College academic regulations and Faculty assessment strategy. It helps develop staff understanding of assessment best practice and has a membership which allows for wide circulation of assessment guidance and support resources. The Assessment Committee serves as a forum for discussion of assessment goals and examines statistical analyses of assessment results in relation to their validity, reliability and inclusivity.

The panel considered that the grade criteria was clear. When we met students, they knew what standard is expected of them.

The College has recognised that they do have a significant number of assessments using multiple choice questions (MCQ). The College acknowledged this, and that development of MCQ is required, for example expanding the bank of questions. External examiner feedback also noted this. The panel wish to have an update on this in due course.

The panel considered that this Requirement was 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 Met)

The panel noted the CAF feedback table 21-22, patient feedback forms and peer review slides.

We learnt that at the end of each module, student feedback is collected and evaluated. This helps to inform the development of the assessment process.

The College explained that peer assessment feedback model has been introduced throughout the BSc programme. The model is formative and uses peer, self and teacher graded formative assessment, adopting clear marking criteria which is shared with students. As part of the termly Reflective Practice reviews, students reflect on their performance and submit written comments.

Given that a variety of dental team members are involved in the completion of STOCAFs, students are typically assessed by dentists, dental therapists, dental hygienists and dental nurses.

Patient feedback is obtained via a QR code that is given to them at the end of each clinical session. This enables IT-literate patients to complete a Patient Feedback Questionnaire which is reviewed by staff and shared with the student. As per Requirement 11, the College is reviewing ways in which the collection of patient feedback could be expanded and developed.

The panel considered that this Requirement was 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)

We noted that the Assessment Strategy mentions that student feedback must be given continuously across the programme, across all four domains and both at formative and summative level.

Each STOCAF has a Form B section to record reflection on activities and an area for teacher or nurse feedback. STOCAFs therefore provide continuous formative feedback and reflective opportunities on the four main domains also.

Students indicated that reflection is highly encouraged and expected. They have discussions with their PTs and receive regular feedback from supervisors. Students also indicated that they are introduced to the expectations of self-awareness and reflection from the very earliest modules in the BSc programme.

If a student fails the summative CAF, written report, poster, SAQ or integrated exam, they are offered one to one feedback from the assessor before the resit attempt.

The panel considered that this Requirement was 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 College confirmed that staff involved in assessment are registered with the GDC and although not detailed in all staff training records (see Requirement 5), the panel were advised that staff have relevant experience and training in dental education.

The Assessment Working Group and Undergraduate Assessment Committee play important roles in developing resources and training so that Faculty staff have the understanding and experience necessary to undertake their roles as assessors and to ensure delivery of best practice in assessment.

For CAFs, examiners receive assessment information ahead of the exam and on the day of the assessment they have briefings. There is also a calibration exercise at the start and end of the assessment and examiner discussion.

Faculty staff receive assessment training at INSET, KEATs, online videos, Teacher Education Days and Study Days.

The panel noted that some staff training records were out of date. This included training in EDI. We understand this is to be updated by the July 2023 appraisals.

As with Requirement 5, the College should update the GDC with confirmation that the staff concerned have completed the mandatory training by the July 2023 appraisal.

The panel considered that this Requirement was 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 Met)

Prior to the inspection, we had access to various documents relating to the role of the External Examiner (EE).

The College confirm that they have input from three EEs. The panel had the opportunity to meet one of the EEs online at Day One of the inspection, who explained their role to us, gave good feedback on their involvement in the pre- and post-assessment process and who noted the need for improvements regarding the question bank.

EEs broadly provide impartial and expert advice on academic and assessment standards for each year of the programme.

Prior to all the date of summative assessments, each EE is sent information for scrutiny and their feedback.

After the assessments have been completed, the EE receives a selection of marked assessments. Any EE comments that require a response from the Faculty are recorded and addressed in the EE report.

The College keeps a log and action points are developed from EE feedback, which is gathered at the various points as indicated above, and EEs are invited to give feedback on the assessment process at the Sub-board meeting and Award-board meeting. The Undergraduate Programme Committee is also responsible for monitoring EE reports.

The panel considered that this Requirement was 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)

Prior to the inspection, the panel reviewed the Mark Scheme 2022-23 for all three years of the BSc. These included details of all the assessments in the year and outlines how each is marked.

We also saw CAF Domains and Assessment Guidance and Assessment Working Group exam review examples.

We also noted the Assessment Presentations to students at the beginning of each years 1, 2 and 3, explaining the assessment modes and contribution of each to the overall final grade.

The Assessment Strategy outlines the standard setting methods used and the marking of assessment carried out for each assessment.

Calibration of CAFs is carried out 30 minutes prior to the start of the assessment and the module lead facilitates discussion on each of the CAF domains.

Calibration of the marking of written assessment is required by the faculty of examiners. The first and second markers grade a set of the same scripts and meet to discuss the marks given.

The panel considered that this Requirement was Met.

Summary of Action

Require-ment number	Action required by end of Q1 of 2024	Observations & response from King's College London
5, 19	1) The College should provide confirmation that the staff concerned have completed the mandatory training that was due by the July 2023 appraisal. 2) King's should provide more detailed records of the teaching qualifications and HEA status of the academic and clinical staff	1 - A recent change to Kings College Hospital (KCH) mandatory training frequency has meant all staff need to update mandatory requirements as part of their appraisal process. This was carried out prior to July and records are attached (1.1 Leap rag report) The department accepts that the Hospital Leap training differs from the GDC recommended training for registrants. We have designed a Staff Registration and Training Record (2.1) which will include mandatory CPD requirements, Registration and indemnity. This will be self-completed and monitored by our administration assistant at regular intervals and outdated items will be flagged. We are adding the monitoring of the Staff Registration and Training record (2.1) as a standing agenda point at our local (DTH) Risk & Governance (R&G) meetings. (1.2 DTH R G Agenda Dec 23) 2 - The Staff Registration and Training record also includes teaching qualifications and HEA status and whether the HEA pathway has been identified for new members identified staff's appraisals. (2.1 Staff Registration and Training Records)
11	3) The College should provide an update on strengthening the patient feedback process to meaningfully inform programme development.	Outpatients are all typically very supportive of their students and provide positive feedback about their oral health care. All patients are encouraged to feedback. This is analysed by our feedback lead and feedback which requires attention is raised with the appropriate channel. Recent Feedback on Equipment issues were raised as an In Phase incident (local reporting system). This incident is then flagged with estates to manage and action, and the progress of the

		investigation and resolution of the incident is reviewed at the Risk and Governance monthly meetings. (3.1 R G Minutes) The feedback received is shared and discussed at the DTH Clinical Governance Committee (under 'Patient Feedback and Public Involvement') and where relevant, will be used to inform development of the curriculum. (1.2 DTH R G Agenda Dec 23) Our long-term plan to elicit meaningful feedback from patients is to set up a patient forum and this is currently in the process of development with the Patient communication and liaison team at KCH. The proposals will then be referred for review at the FoDOCS' Quality Assurance & Quality Enhancement Committee and once approved will be implemented at the earliest available opportunity.
13-15	4) The College should ensure that more detailed evidence of reporting and monitoring across the learning outcomes is presented during future inspections and monitoring. Decision-making should be more transparent during the sign-up and sign-off board meetings to clearly demonstrate not only the acquisition of, but also the maintenance of students' skill, competence and experience throughout the programme.	In response to point 4 we are obtaining more detailed evidence of reporting and monitoring by increasing the amount of data analysed at Sign up and sign off board meetings. These will include the type of material, local anaesthetic and radiographs. (4.1 DTH3 Clinical Competence monitoring spreadsheet) Simple (one surface) and complex (more than one surface) is integrated as part of the STOCAF and CAF data part of the STOCAF data collection and monitoring. (4.2 Blank STOCAF) (4.3 CAF Domain and assessment guidance) Criteria that are not met are analysed through several processes depending on the type of clinical remediation required. Examples of these are • Chairside remediation • Personal tutor meetings • RPR Termly reviews • Meeting with Module Lead • Progress meetings

		Professionalism criteria that are 'Not Met' are flagged with the personal tutor for immediate follow up and reported at the termly progress meetings
15	5) The College should consider how to ensure that the range of clinical experience across the cohort is more equitable.	Competence Assessments with Feedback (CAFs) provide students with the minimum range of clinical experience to complete the required learning outcomes. We accept that each student's breadth of clinical experience will differ slightly, however, to ensure this is as equitable as possible, we have the following mechanisms in place: • Students are rotated to each clinic or outreach. • We have a dedicated team member who regularly monitors clinical activity and allocates suitable patients to meet the clinical experience required for each student. (4.1 DTH3 Clinical competence monitoring spreadsheet) • Year 3 termly progress meetings monitor student progress and as an outcome of these meetings each student has a personalised action plans (5.1 Student Progress Report)
16	6) The College should provide an update on the development of MCQ, for example, the expansion of bank questions.	The faculty continue to develop new contextualised items assessing both GDC 'Preparing for Practice' and FoDOCS local learning outcomes. The faculty aims to increase the question banks for each module by about 25% each year so that we have a bank that has at least three times as many items than are needed for each year. We have focused on human health and disease (HHD2) creating more than 140 new items for a 120-item paper. In BSc DTH1 modules, we are increasing the banks by approximately 40 new items, so that we meet targets of 20% new items in the papers. A few new items do not

		meet the redesign requirements and are rejected. Our focus for question writing will shift to pathology in HHD2 for this current year, with a target of at least 24 items. Question items are reviewed for relevance and difficulty to ensure we focus primarily on essential and important content and to ensure that they are contemporary. This means some bank items may be removed. Post-examination analyses are carried out to help identify any problematic items. These items are then reviewed by the DTH panel to ensure the answer keys are correct and to improve item quality. G (Generalisability) and D (Decision) Studies are carried out to obtain estimates of reliability and help improve assessment design. Variance components for items range from 20% to 25% of total variance indicating that items vary in difficulty. In contrast candidate variance components are small ranging between 3% and 5% of the total variance indicating that candidate ability is rather homogeneous. Some recent data from 2022 and 2023 are given below: • Estimates of reliability for all assessments are 0.8 or greater. • The estimates of reliability for DTH1 MCQ containing only 60 items was 0.7 in 2022. • The recommendation was to limit the number of easy items to 20% and to include a larger proportion of discriminating items of moderate difficulty. • In the 2023, the estimates for the 60-item paper increased to 0.8.

King’s College London observations on content of report

The faculty are pleased to note that the panel had no major concerns and that the programme is approved for graduates to register with the GDC. We would like to thank the panel for their visit to King’s College London, their time and valuable feedback which will help shape this new programme. **We would also like to thank both our colleagues at King’s College Hospital and at King’s College London and our students for their hard work and commitment to the success of the programme.**

Recommendations to the GDC

Education associates’ recommendation	The Dental Therapy & Hygiene BSc is approved for holders to apply for registration as a dental therapist and a dental hygienist with the General Dental Council.
Date of next regular monitoring exercise	Monitoring in the 2024/2025 academic year.

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.