General Dental Council | protecting patients, regulating the dental team

INSPECTION REPORT

Education Provider / Awarding Body:	**University of Dundee**
Programme / Award / Qualification:	**Bachelor in Dental Surgery (BDS)**
Remit and Purpose:	**Re-inspection referencing the *Standards for Education* to determine the continuing sufficiency of the award for the purpose of registration with the GDC as a dentist**
Learning Outcomes:	***The First Five Years (Dentist)***
Programme Inspection Dates:	**24-25 March 2015**
Examination Inspection Dates:	**17 April 2015** **26-29 May 2015**
Inspection Panel:	**Kim Tolley (Chair and Lay Member)** **Barbara Chadwick (Dentist Member)** **Peter Heasman (Dentist Member)** **Khalid Mushtaq (Dentist Member)**
GDC Staff:	**Laura Harrison (Lead)** **Ross Scales**
Outcome:	**Recommended that the Dundee BDS Programme remains sufficient for registration as a dentist**

Re-inspection summary

The School is to be commended for the positive manner in which it has engaged with the need to develop the BDS programme and its quality management framework. The inspectors were impressed by the attitude and dedication shown by the team, which has resulted in the majority of the issues highlighted as requiring action in last year's report, being satisfactorily addressed. To implement such a wide range of improvements across the space of one academic year, alongside the normal delivery of programmes is a substantial achievement and one which has required an enormous amount of work, careful management and strong leadership.

As noted last year, there was evidence of an open and friendly culture within the Dental School and students reported they felt comfortable approaching staff to discuss issues or concerns. The School and staff are to be commended for their ability to maintain strong relations with students during what has likely been a difficult period.

Key improvements evidenced in this inspection were the much improved standardisation of assessment and feedback across all clinical settings and the robust processes for determining progression to the final examination. The full and accurate recording of student clinical activity on the Liquid Office database underpinned the processes for monitoring student progress and helpfully allowed students to self-monitor. Setting targets reduced the likelihood of inadequate exposure to procedures and patients. The final examination assessments showed greater validity and reliability and the simplification of the grading scheme allowed for a clear and appropriate aggregation of marks to reach a total.

The inspectors felt that the new Committee structure and remits were a significant improvement on the old format and they were confident that they would facilitate good quality evaluation and management of the programme.

The training of supervisors and examiners and the guidance provided to them was much improved and induction processes are now clearly documented.

Credit must also be given for the careful piloting and initial implementation of LIFTUPP, which has taken place alongside the programme of improvements.

This report highlights a few actions which the School is asked to consider and which will be reviewed during the 2016 Annual Monitoring exercise.

Re-inspection process and purpose of re-inspection

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 and new qualifications where it is intended that the qualification will lead to registration.

2. The aim of this quality assurance activity is to ensure that these institutions produce a new registrant who has demonstrated, on graduation, that he or she has met the outcomes required for registration with the GDC. This is to ensure that students who obtain a qualification leading to registration are fit to practise at the level of a safe beginner.

3. The initial inspection, which took place in 2014, focused on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education.*

4. The purpose of this re-inspection was to assess the progress made by the School against the required and advisory actions listed in the 2014 inspection report. It is also to make a recommendation to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist in the UK. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended) to determine sufficiency of the programme.

5. Inspection reports may 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 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, the report and observations would be presented to the Council of the GDC for consideration.

The Re-inspection

7. The inspection comprised two visits and a videoconference. The first visit, referred to as the programme inspection, was carried out on 24 and 25 March 2015. This involved a series of meetings with programme staff involved in the management, delivery and assessment of the programme and a selection of BDS students. The second part of the inspection took place on 17 April and involved an observation (via video-conference) of the Final Progress Committee meeting during which student sign-up decisions were made by the School. The third visit took part on 26- 29 May when the panel of inspectors reviewed documentation and observed the final examination and examination board meeting.

8. The report contains the findings of the inspection panel across the two visits and with consideration to supporting documentation prepared by the School to evidence how they have addressed the actions from the 2014 inspection report. It reflects the findings of the panel in respect of the Requirements associated with each of these actions. **The Requirements which were reconsidered during this inspection are highlighted in bold in the summary tables at the front of each section.** The inspection panel used the following descriptors to reach a decision on the extent to which the University of Dundee BDS degree programme currently meets each Requirement :

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.

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

Requirements	Met	Partly met	Not met
1. Students will 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	✓		
2. Patients must be made aware that they are being treated by students and give consent	✓		
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care	✓		
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development.	✓		
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body	✓	✓	
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety	✓	✓	
7. Should a patient safety issue arise, appropriate action must be taken by the provider	✓	✓	
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.	✓		

2014 inspection determinations are shown by a grey tick '✓' where they differ from the 2015 findings

GDC comments

Requirement 5: **Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body *(Requirement Met - was Partly Met in 2014)***

2014 Actions:

i. The School must formalise its induction and training of dental School and outreach staff in their role as supervisors and maintain full records of attendance at the training

ii. The School should formalise its approach to peer review of supervision within the dental school

The School has created a full and informative induction pack for new members of staff which includes an induction process flowchart, information about the BDS programme, the Dental School and key policies. There is a defined and thorough process of induction into the role of supervisor which involves peer observation and review and this is clearly outlined to the new starter.

The School holds an annual training day for outreach supervisors and the training event held in November 2014 was opened up to staff from the conservation department of the Dental School and visiting dentists. This enabled a full discussion on the assessment of restorative treatments and the calibration of assessors based in the Dental School and in outreach placements. The School confirmed that standardisation of assessment would be a standing agenda item for future events, which demonstrates an ongoing commitment to refining marking practices. The School stated that there was about 70% attendance at the November 2014 training day and those who did not attend received the training material on a CD. Attendance at the annual training will be compulsory for outreach and conservative dentistry staff from next year and the School now keeps full records of attendance.

The School has created a formal peer supervision policy which was implemented in April 2015. It aims to encourage and support the improvement of teaching and staff development. This is achieved by the observation of teaching or supervision of a member of staff by another and the subsequent provision of feedback and discussion. A 'self-awareness event' is planned for all staff in Summer 2015 to further support staff self-development.

The School is making efforts to ensure individuals involved in the programme are kept fully informed of developments relating to the teaching and assessment of students. University members of staff have access to a VLE site where updates are posted. Clinical leads also disseminate information via emails to Dental School staff. Outreach supervisors and NHS staff based at the Dental School are, at present, unable to access University networks but they are kept informed via emails and through contact with the School. It was noted that there was co-operation between the University and NHS to facilitate the creation of a portal which is accessible to all in the near future. This is likely to generate a more inclusive mind-set and further support uniformity in approach across clinical settings.

Requirement 6: Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety *(Requirement Met - was Partly Met in 2014)*

Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider *(Requirement Met - was Partly Met in 2014)*

2014 Action:

i. The School must create and make available to staff based in the Dental Hospital and School and in the Outreach placements, and to students, a clearly documented policy and set of procedures, which details how patient safety concerns issues should be raised and dealt with. There should be transparency in the management of such concerns through to the point of resolution

The School produced an appropriate 'Raising Concerns' policy which was approved by the Dental School Board in April 2015. This policy incorporates the NHS Datix system and the whistle-blowing processes with the intention of ensuring parallel reporting to the NHS and

the Dental School. The School considered how students and staff could raise concerns in a systematic manner and created a specific email address for this purpose. Students who the panel spoke to said that at present they would speak to their year lead or adviser but it was recognised that for those students in Outreach, this may pose difficulties. The School continues to raise staff and student awareness of the policy and it is anticipated that students will use the designated email address to raise concerns in future.

The NHS Liaison Committee meets monthly and a standing item on the agenda is issues relating to patient safety. The Committee considers patient safety reports which are produced by the School after an investigation has taken place into a patient safety concern raised by a staff or student. The inspectors were informed that, in future, feedback reports would be shared with staff and students. These reports will detail concerns raised by students and/or staff and confirm how the issues have been resolved.

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 *(Requirement remains Met)*

2014 Action:

i. The School should ensure all members of staff involved in the delivery of the programme are familiar with the GDC Student to Fitness Practise guidance document

The School has circulated the document to staff in the Dental hospital and in the Outreach clinics and discussions with members of staff assured the inspectors that they were familiar with this document.

Actions

Req. Number	**Actions for the provider**	**Due date (if applicable)**
5	The School should provide an update on the shared access to key documents for all members of staff	Annual Monitoring 2016
7	The School should provide an update on the development of patient safety reports and how they are shared with students and staff.	Annual Monitoring 2016

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**			
Requirements	**Met**	**Partly met**	**Not met**
9. **The provider will 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**	✓		✓
10. **The provider will have systems in place to quality assure placements**	✓	✓	
11. **Any problems identified through the operation of the quality management framework must be addressed as soon as possible**	✓		✓
12. **Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity**	✓		✓
13. **Programmes must be subject to rigorous internal and external quality assurance procedures**	✓		✓
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow QAA guidelines on external examining where applicable	✓		
15. **Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment**	✓		✓
2014 inspection determinations are shown by a grey tick '✓' where they differ from the 2015 findings			

GDC comments

Requirement 9: The provider will 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 - was Not Met in 2014*)

Requirement 11: Any problems identified through the operation of the quality management framework must be addressed as soon as possible (*Requirement Met - was Not Met in 2014*)

Requirement 13: Programmes must be subject to rigorous internal and external quality assurance procedures (*Requirement Met - was Not Met in 2014*)

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *(Requirement Met - was Not Met in 2014*)

2014 Actions:

i. *The School must provide evidence of clear, effective and efficient reporting mechanisms both within the School structure and with the wider University. There needs to be greater clarity and transparency in respect of the management of internal and external quality assurance. This must include clear records of discussion, the creation of clear and deliverable action plans, regular monitoring against set deadlines until the point of resolution and the evaluation of changes implemented.*

ii. *The School must provide a clear statement about where the function of strategic and operational quality assurance of the programme lies within the management framework. Decision making within this area must be clearly audited and demonstrate what topics were covered at which committee. Interactions between the School, the University Faculty and the Hospital should be evident within the process. The School should consider streamlining the existing Committee structure to avoid inefficiencies within the quality assurance programme.*

iii. *The School must provide further management support to the Year 5 Lead and review the remit within the role. Consideration must be given to where delegation of responsibilities might be appropriate as well as contingency planning for circumstances where the Year 5 Lead may become unavailable.*

iv. *The School must clarify the staffing levels and staffing structure within the Dental School*

Following last year's inspection, the School has undertaken a thorough review of its Committee structure. The School advised that the aim of the review was to create effective and responsive Committees and a structure which enabled clear reporting lines and locations for decision making. The scope of the review was wide as it looked at the remits, constitutions of Committees and reporting lines within and outside of the Dental School. It was clear that the School has worked hard with the College and University QA leads to ensure that reporting lines in to both College and University QA Committees have been streamlined and clarified. The new Committee structure was approved by the Dental School Board in April 2015 and will be implemented in the 2015/2016 academic year.

Under the new Committee structure, the Learning and Teaching Committee meets more frequently, on a monthly basis, rather than bimonthly as previously. The duration of each meeting remains the same The Committee has a strategic focus and oversees the direction of the programmes within the School. It receives proposals and makes decisions on changes to assessment or Learning Outcome delivery and is also responsible for ensuring that internal and external reviews of programmes are monitored and acted upon. This Committee also considers resource issues, although decisions are ultimately taken by the Senior School Management Committee. It was noted that the School had appointed a new Associate Dean for Learning and Teaching who took up their post in June 2015. A new role, a deputy Associate Dean for Learning and Teaching will commence in September 2015.

Sitting beneath the Learning and Teaching Committee are the Years 1-4 Group Management Committees and the Year 5 and Outreach Management Committee, which have responsibility for operational issues. The enhanced involvement of Outreach within the Committee structure is a key feature of the new structure, as is the formalising of the NHS Liaison Committee.

A significant concern which arose during the 2014 inspection was the high level of responsibility carried by the Year 5 Lead and the panel was pleased to learn that the new Associate Dean would take over responsibility for overseeing the development of the new BDS curriculum. The Assessment and Curriculum Manager has also taken on the role of Deputy Year 5 Lead which is also helpful. The inspectors were impressed at how well the School had managed the staff changes since the last inspection and were satisfied that the staffing levels and structure were healthier than in 2014.

New templates for meeting minutes were created and implemented in February 2015. These have enabled much clearer recording of discussions, identification of actions arising, timescales for action to be taken and identification of the owner of the actions.

The School recognised that an interim management structure was required for the academic year 2014/2015 and as a result, a Year Leads Group was established as an effective forum for key individuals to meet on a weekly basis and the Outreach Management Group was re-instated.

The School is to be commended on its prompt and effective management of the restructuring of its quality and management framework.

Requirement 10: The provider will have systems in place to quality assure placements (*Requirement Met - was Partly Met in 2014*)

2014 Actions:

i. *The School must clarify how the rotations in outreach placements are co-ordinated and overseen by the School.*

ii. *The School must explain how it intends to address the issue of perceived generous marking by outreach supervisors.*

iii. *The School must provide improved and regular training and guidance to all outreach supervisors on assessment and supervision.*

iv. *The School must formalise its contact with outreach supervisors and record all discussions. The School should consider holding meetings on a regular basis with outreach supervisors.*

The School has worked hard to understand and remedy issues relating to the management, teaching and assessment in outreach.

A number of actions have been taken since the previous inspection to ensure standardisation of assessment in Outreach. It was noted that during the academic year 2014/2015, the Year 5 Lead visited each of the Outreach centres in order to assess and support the standardisation of marking by Outreach supervisors. The School also planned a series of assessment focused events for Outreach supervisors, the first of which was incorporated into the training day held in November 2014. It was clear from the students who the inspectors met with that they were content with assessment in Outreach and this represents a marked improvement on the student feedback obtained last year.

There is now a considerable level of staff exchange between the Dental School and Outreach placements – this encompasses Outreach supervisors working in the Dental School and Dental School staff attending Outreach centres. The inspectors were also impressed that

Outreach supervisors took part in the SCR (Structured Clinical Reasoning) and CP (Case Presentation) elements of the final examinations and that the School aims to extend its use of Outreach supervisors in School examinations for the next diet.

Contact with the outreach centres has been formalised through the re-establishment of the Outreach Management Group meetings. Under the new Committee structure this group will be combined with the Year 5 Management Group.

The School explained the process by which it manages the allocation of students to placements in Outreach and the inspectors were confident that students and staff were informed of any changes to the allocation in a timely manner.

Requirement 12: Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity (*Requirement Met - was Not Met in 2014*)

2014 Actions:

i. *The School must develop a robust mechanism for identifying threats to students not achieving the Learning Outcomes through rigorous quality evaluation. It is essential that the GDC is notified promptly if this risk is actual or potential*

The inspectors felt that the improved Committee structure gave broad assurances that rigorous quality evaluation of the programme would take place. More specifically, the School has expanded the annual module and programme monitoring forms to include a section which requires information on any potential risks to the continued delivery of the module or programme and how any such threats would be addressed. These reports will be reviewed by the Management Groups and the Learning and Teaching Committee.

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**			
Requirements	**Met**	**Partly met**	**Not met**
16. **To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards.**	✓		
17. **The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes**		✓	
18. **Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed**	✓		
19. **Students will have exposure to an appropriate breadth of patients/procedures and will 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**	✓		
20. **The provider should seek to improve student performance by encouraging reflection and by providing feedback**[1].	✓		
21. **Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body**	✓		
22. 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	✓		
23. **Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments**	✓		
24. **Where appropriate, patient/peer/customer feedback should contribute to the assessment process**		✓	

[1] Reflective practice should not be part of the assessment process in a way that risks effective student use

25. **Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion**	✓	✓	
26. **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**	✓	✓	

2014 inspection determinations are shown by a grey tick '✓' where they differ from the 2015 findings

GDC comments

Requirement 16: To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards *(Requirement Met - was Partly Met in 2014)*

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes *(Requirement Partly Met - was Not Met in 2014)*

Requirement 18: Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed *(Requirement Met - was Partly Met in 2014)*

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will 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 - was Not Met in 2014)*

Requirement 25: Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion *(Requirement Met - was Partly Met in 2014)*

2014 Actions:

i. *The School must complete the mapping of the Learning Outcomes within Preparing for Practice to the new curriculum*

ii. *The School must complete the blue-printing of assessments*

iii. *The School must create a reliable centralised recording system which facilitates the monitoring and analysis of individual student's clinical activity and progress against learning outcomes. Database generated reports must be sufficiently detailed and they must enable a clear overview of students' breadth, depth and quality of clinical activity. The School should consider revising the log-books so they capture this information*

iv. *The School must decide on clinical targets and convey this information to students.*

v. *The School must strengthen its process for making progression decisions to the final examinations. The involvement of external examiners in this process should be given consideration. The School must be accurate in its assessment of students who are considered too 'low' in clinical procedures.*

vi. *The School must clarify how it triangulates students' performance.*

vii. *The School must streamline the aggregation of marks and develop an assessment framework that is less complicated.*

viii. *The School must use different examination papers for re-sit examinations.*

ix. *The School must provide information about the implementation plan for LIFTUPP and how it will facilitate the recording and monitoring of student clinical activity*

x. *The School must clarify the process of patient allocation in hospital clinics and outreach placements and how students with a shortfall in patient treatment experience are managed*

xi. *The School must provide greater information to outreach supervisors about students' level of clinical experience*

A Curriculum Design Group features in the new Committee structure and whilst the membership of this group had not been finalised at the time of the inspection, the School informed the panel that it would be chaired by the Associate Dean for Learning and Teaching (ADLT). The creation of the new BDS curriculum and the mapping of the programme to the Learning Outcomes in *Preparing for Practice* will be the responsibility of the ADLT and the School anticipated that this exercise should be completed by the end of 2015. It is hoped that the new curriculum will be implemented at the beginning of the 2016/2017 academic year, although it is acknowledged that it may take an extra academic year to ensure complete blue-printing of assessments to the *Preparing for Practice* Learning Outcomes. The Deputy ADLT and Year Leads will work with the ADLT on the assessment blue-printing and they aim to develop a comprehensive and referenced question bank as part of this process. Requirement 17 was found to be partly met due to the fact that whilst planned for, the full blue-printing of assessments is yet to be achieved.

It was clear that the School had gone to significant lengths to ensure the Liquid Office database contains full and accurate electronic data on student clinical activity. The School employed a specialist data entry team to ensure that information from every clinical contact form for each student was entered on to the database. This was an immense exercise as marks from thousands of assessment forms had to be transferred. Students reported that there is now only a 2 -3 week delay between submission of a mark sheet and the data being entered on to Liquid Office.

The database has been developed since last year so that it can reflect the quantity, quality and breadth of activity across a cohort. Liquid Office categorises clinical activity under specific areas. The inspectors assured themselves that the data on the database was accurate by sampling a small number of student log books and cross-checking the data contained on the paper forms in the log books with the database.

The School identified minimum required totals for core procedures, which the inspectors considered to be at an appropriate level. These totals were clearly stated on Liquid Office. The students the inspectors spoke to were all aware of these requirements and stated that they

were happy that they could check on Liquid Office where they were in terms of experience against the year average. If they are below their requirements, this is flagged in red. The School stressed that their focus was to ensure continuity of patient care, wherever possible, which would necessarily lead to a variation in the treatment numbers across a cohort. There was a documented process for ensuring students are able to gain sufficient exposure to the range of treatments across the various clinics and placements they attend.

Students the inspectors spoke with were happy that they could self-monitor their progress by accessing Liquid Office and they are encouraged to assume responsibility for identifying the need for and arranging extra clinical sessions as appropriate. Students also discuss their progress on a weekly basis with their tutors, again with reference to the Liquid Office data.

The School undertook a trend analysis of patient numbers over the past three years based on data in annual ACT reports. A new system of recording patient numbers and student activity at the point of booking patients on to clinics will be fed through into the newly formalised NHS Liaison Committee and this represents another level of checks in respect of student exposure to patient and treatment types.

Refinements made to the Liquid Office database have enabled the School to generate student clinical activity reports. The reports for the 5th BDS students were reviewed by the School Progress Committee, which meets in November, February and April. The clear format of the reports enabled quick and easy identification of any areas students needed to concentrate on. In November 2014, the School gave the 5th BDS students guidelines on where they should be in terms of their clinical targets which helped them to keep on track. This information was relayed to students in advance of the April Progress meeting where sign up to finals is considered. The reports are also made available on a monthly basis to Outreach tutors, who in addition, are able to access the Liquid Office database. This was seen as a key development in the process as it is in Outreach that students are often able to make up on any treatment shortfalls they may have.

The School has started to introduce a new piece of software called LIFTUPP, which will supersede Liquid Office. The primary purposes of transitioning to LIFTUPP is to have a system which will record and monitor students' clinical progress in a variety of ways, monitor their progress against Learning Outcomes and in addition, enable close analysis of clinical assessment grades. There is also the facility for feedback to be recorded.

LIFTUPP requires the use of iPads to record information relating to clinical activity. The system appears to have been carefully introduced and piloted with 3rd year students across all disciplines with paper forms also being used, as a back-up during the pilot. Following staff training, discussions and regular information updates, the School 'went live' with LIFTUPP as the sole method of capturing data for the 3rd year students from March 2015 and this will extend across all disciplines and year groups as the 3rd year group progresses. The School has begun a scoping project for the use of LIFTUPP in Outreach and does not foresee insurmountable issues arising. This new initiative has been met with a positive response from both staff and students.

The panel noted that the process for determining progression had been strengthened. There was evidence of reliable recordings of assessment grades which were relied upon at the Progress Committee meetings. Although there was a slight mismatch between the categorisation of clinical activity in the Liquid Office database and the data reviewed by the Progress Committee, the inspectors were confident that the data considered by the Committee were accurate. The inspectors observed the April Progress Committee for the 5th year students and they were pleased to note that an external examiner was in attendance and had reviewed the data before the meeting. The Committee used clear criteria to establish whether students could progress to finals and where any shortfalls in clinical experience were identified, clear

actions were agreed. The inspectors were provided with a guidance note detailing the process used by the School to triangulate student performance across a range of assessment points.

A revised logbook had been created to supplement the central recording of data. The log book assessments have been significantly strengthened and they now involve a dual review of the quantity and quality of clinical activity plus students' reflection on their practice. Students are required to reflect on each episode of treatment. The inspectors were pleased that the grade awarded to the log book reviews had changed to a percentage from the previous 1-8 scale. This enabled a far easier aggregation of marks at the point of progression.

Different Structured Clinical Reasoning scenarios were used in the class examinations during the final year to those used in the re-sits and the School confirmed that the students' performance in this component was reflected in the percentage carried forward from continuous assessment.

Based on feedback from the external examiners and the GDC, the School altered the manner in which the results from various components of the final examination were aggregated to reach a final outcome. Whilst retaining the knowledge and clinical division and also the pre-sign up / finals weighting, the School opted to use a numerical scale in the Structured Clinical Reasoning and Case Presentation elements, with each element contributing a set proportion in percentages to the overall total. This made for a far more straightforward, transparent and streamlined approach to aggregating marks and strengthened the appropriateness of the overall total. The School reduced the amount of compensation allowed across elements and they also introduced a veto fail in the final examinations if a student achieved $\leq$90% of the standard-set pass mark. Compensation was possible between 90 and 99.5% of the standard-set pass mark in only one element of the clinical part of the exam (SCR1, SCR2 or CP). The inspectors considered this new approach to be fair and proportionate.

Requirement 20: The provider should seek to improve student performance by encouraging reflection and by providing feedback *(Requirement remains Met)*

2014 Action:

i. The School should ensure consistent feedback is provided to students on clinic

Feedback from the students the inspectors spoke with suggested that there was a greater consistency in the feedback received on clinic and that there has been an increased effort in giving feedback in Outreach. Students welcomed the fact they could always discuss the feedback and grading and if they so wish, contest it. The open and relaxed culture in the School fosters constructive discussions between staff and students.

Requirement 21: Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body *(Requirement Met - was Partly Met in 2014)*

Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments *(Requirement Met - was Partly Met in 2014)*

2014 Actions:

i. The training of assessors/ examiners in assessment must be strengthened. They must be provided with guidance so that they are clear on marking systems, the way

in which an examination should be conducted and the amount and type of prompting allowed

ii. *The School must improve assessor calibration with the aim of minimising inter examiner variation.*

iii. *The School must provide evidence of a formal moderation process and demonstrate use of it by the external examiners*

iv. *The School should use a matriculation number in every assessment*

v. *The School must use clear grade descriptors in every assessment*

vi. *The School must review and streamline the grading schemes to give a consistent approach.*

vii. *The School must develop clear and robust processes for the conversion and combination of grades to ensure clarity in reaching the final mark in the Case Presentation assessment.*

viii. *The School must review its approach to standard setting in the SCR and CP assessments*

Students who the inspectors spoke with considered that their continual assessment was now marked more consistently across clinics and placements. This was likely due to the training and guidance documents produced, in addition to the use of the same marking criteria and assessment form across clinical settings. The School is to be commended on the degree of improvement made here.

In addition to the staff training day held in November 2014 and the additional training events planned, as described under Requirement 5, it was apparent that the School had made considerable effort to enhance their instructions to examiners for the final examinations. Clear and thorough documents for external and internal examiners were produced which outlined how the various components of the final examination (and fifth year assessments as a whole) should be marked. There was also guidance on the extent to which examiners were allowed to prompt students in the Structure Clinical Reasoning Examination (SCR) and how to factor prompting in to their marking. The inspectors felt that the revised structure of the SCR and the well organised calibration of examiners beforehand were helpful and resulted in greater consistency across examining pairs than had been observed during the previous inspection. The inspectors also noted a standardised approach to the CP examination. Pairs of examiners were consistent in respect of questions asked, marks awarded and the process followed to reach an agreed mark.

The School has revised their marking scheme for the SCR and CP examinations so that the marks are now awarded as a percentage. There was a clear division of marks between the two CPs presented by the students and the calculation of the overall mark for the CP element of the finale examination was straightforward. The inspectors considered that the grading scheme for the SCR was slightly generous and that the examination did not discriminate well between weak, average and strong candidates. The removal from the marking scheme of the global mark in place of a clear points mark scheme gave the inspectors confidence that each SCR question was appropriately standard set using the modified Angoff method. The grading criteria for the CP were clearly articulated and sufficiently detailed to ensure a fair and consistent approach to assessing students.

The School indicated that a flow chart would be prepared for the final examination, which would outline the process by which external examiners should moderate the examination results. This document was not available at the time of the inspection however the inspectors did see evidence of appropriate moderation by the external examiners.

Students were identifiable by matriculation number only in respect of the written paper scripts. Both name and number were referred to in the SCR and CP examinations, which the inspectors considered appropriate.

Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process *(Requirement remains Partly Met)*

2014 Actions:

i. The School must consider how to incorporate patient feedback into student assessment

ii. The School should consider how to gain feedback from other dental professionals

The School indicated that they have commenced a pilot survey of student performance from dental nurse, dental technicians and patients during their sessions in the Integrated Oral Clinic. They will use the data obtained to inform future use of feedback questionnaires. It is intended that feedback gathered will be used to assess students formatively, but there were no clear timeframes in place for when and how this would be incorporated. Requirement 24 was found to be partially met due to the fact that although there are plans to incorporate patient feedback into assessment this has not been commenced yet.

Requirement 26: 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 *(Requirement Met - was Partly Met in 2014)*

2014 Actions:

i. The School should enhance the student handbook so that it provides information on assessments and grading systems

ii. The School must create clear guidance for assessors/ examiners

The School has developed the student handbook so that it now contains full and clear information on the assessments and approach to marking. As already mentioned, the examiner guidance document is thorough and clear.

Actions

Req. Number	**Actions for the provider**	**Due date (if applicable)**
16	i. The School should provide an update on the development and likely implementation date of the new curriculum mapped to the Learning Outcomes in Preparing for Practice	**Annual Monitoring 2016**

	ii. The School should provide an update on the blue-printing of assessments and the creation of the question bank	
23	i.The School should consider altering the allocation of marks within the SCR so that it discriminates more effectively. ii.The School should provide evidence of a formal moderation process	**Annual Monitoring 2016**
24	The School should develop plans to incorporate patient feedback into student assessment	**Annual Monitoring 2016**

Standard 4 – Equality and diversity
The provider must comply with equal opportunities and discrimination legislation and practice. They must also advocate this practice to students

Requirements	**Met**	**Partly met**	**Not met**
27. Providers must adhere to current legislation and best practice guidance relating to equality and diversity	✓	✓	
28. Staff will receive training on equality and diversity, development and appraisal mechanisms will include this	✓	✓	
29. Providers will convey to students the importance of compliance with equality and diversity law and principles of the four UK nations both during training and after they begin practice	✓		

2014 inspection determinations are shown by a grey tick '✓' where they differ from the 2015 findings

GDC comments

Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity *(Requirement Met - was Partly Met in 2014)*

2014 Action:

i. The University must update its Equality and Diversity policy in respect of the Dental School

The School provided a policy which referred to current Equality and Diversity legislation.

Requirement 28: Staff will receive training on equality and diversity, development and appraisal mechanisms will include this *(Requirement Met - was Partly Met in 2014)*

2014 Action:

i. The School must maintain full training records on the provision of Equality and Diversity training to all members of staff (including honorary and NHS)

The School experienced difficulty in obtaining Trust information relating to the training of individuals but the inspectors were provided with a full record of this information. There is a clear commitment within the School to ensuring students understand and embrace Equality and Diversity principles and it is expected that the School will routinely monitor the uptake of training by staff

Summary of Actions

Req.	Actions for the provider	Observations Response from the Provider	Due date (if applicable)
5	The School should provide an update on the shared access to key documents for all members of staff	*All documents relating to 'raising concerns', 'fitness to practise' and the Induction pack for new staff including all probationary material are available on the virtual learning environment and is to be the focus of a 'launch' to all staff in the Autumn Semester 2015.*	Annual Monitoring 2016
7	The School should provide an update on the development of patient safety reports and how they are shared with students and staff	*The School is working closely with NHS managers in NHS Tayside and partner Boards (where outreach placements are held) to collate these and provide summaries for staff and students. These summaries, when available, will be discussed at: Year Management Groups; the Learning and Teaching/ Quality and Academic Standards Committee (to respond to any learning needs); SSLC and School Board to ensure wide dissemination.*	Annual Monitoring 2016
16	i.The School should provide an update on the development and likely implementation date of the new curriculum mapped to the Learning Outcomes in Preparing for Practice ii.The School should provide an update on the blue printing of assessments and the creation of the question bank	*Gap analysis of existing curriculum, against PfP learning outcomes and curriculum review is now under the direction of the ADLT. It is expected that a new curriculum will be implemented in 2017/8 academic year. However implementation of some aspects (such as those identified by the Gap analysis) will be done before that.*	Annual Monitoring 2016

		In parallel with the curriculum planning there will be an Assessment review. The question bank will not be formed until exam formats and question types to be used are defined.	
23	i.The School should consider altering the allocation of marks within the SCR so that it discriminates between students. ii.The School should provide evidence of a formal moderation process	*The School is looking at this issue to determine the most beneficial way in which the allocation of marks within the SCR could be used better to discriminate between students.* *The professional exams always have an external examiner present and they are explicitly asked to moderate both the academic and practical/clinical components of the exams. All exam boards' agendas also include an item for the external examiners to comment on the moderation process and whether marks were modified by this process.* *As part of assessment review, and the school's implementation of the new University Assessment Policy formalised moderation guidelines will be developed. We will produce a flow diagram describing the process before the next diet of degree exams.*	Annual Monitoring 2016
24	The School should develop plans to incorporate patient feedback into student assessment	*We are looking carefully at this issue. We are working with the NHS to see if the process of patient feedback can be incorporated into the student assessment scheme. There are a number of issues we are considering including how best to collect this data in both the Dental Hospital*	Annual Monitoring 2016

		and School and outreach placements and also whether this feedback should be formative or summative	

Observations from the provider on content of report

The School would like to thank the GDC Inspection Team for their report on the Re-inspection of the BDS Programme at Dundee, and for the positive tone in which it was written. We were very pleased that the work undertaken by staff following the disappointing 2014 programme inspection report has been recognised. In response to this report, the collation of student clinical activity has been significantly improved and governance processes have been simplified resulting in communication between committees within and outwith the school up to University level being improved and the latter (as it turns out) much shorter.

Over the course of the 2015 summer, the University has undergone a major restructuring exercise which resulted in the removal of the four Colleges. Dentistry was one of three schools in the College of Medicine, Dentistry and Nursing and its committees traditionally reported into College level committees (such as College Learning and Teaching Committee). As of 1st August 2015 Dentistry is now recognised as one of nine Schools in the University and as such our internal arrangements for managing all activity have changed. The core senior management team for the school now consists of the Dean and four Associate Deans (AD) – (Learning and Teaching (L&T), Quality and Academic Standards (QAS), Research (R) and Internationalisation (I)) and the School Manager. The post-holder for L&T remains unchanged and the 'Deputy Associate Dean for L&T mentioned in the report above has now been appointed to the AD QAS post. In practice this will mean that all Learning & Teaching and QA and academic standards issues in the BDS curriculum are now led by two Associate Deans and minutes from the School's L&T and QA committees are sent directly to the University level committees where the School is represented by the ADs.

As part of the restructuring the School Secretary has moved to be School Manager for medicine and The Dental School Curriculum and Assessment Manager has been appointed to be School Manager for Dentistry but retains a significant interest in and responsibility for the educational process' relating to the BDS programme.

Commensurate with the new academic structure the School Manager is reorganising the administrative support for the school so that it is closely aligned with the Associate Deans' portfolios. The intention being to strengthen the support across the school and have a positive impact on the BDS programme.

Dundee, October 2015

Recommendations to the GDC

The inspectors recommend that this qualification is sufficient for holders to apply for registration as a dentist with the General Dental Council.