General Dental Council

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regulating the dental team

Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award	Inspection Dates
University of Aberdeen	Bachelor of Dental Surgery (BDS)	22 & 23 January 2019 (Programme inspection) 24 April 2019 (Progression Committee) 17 May 2019 (Exam Board)

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

Inspection summary

Remit and purpose of inspection:	Inspection referencing the *Standards for Education* to determine approval of the award for the purpose of registration with the GDC as a dentist Risk based: Focused on Requirements 4, 5, 9, 11, 12, 13, 14, 15, 17, 18 and 19
Learning Outcomes:	Preparing for Practice (Dentist)
Programme inspection dates:	22 & 23 January 2019
Examination inspection dates:	17 May 2019 (Exam Board)
Inspection panel:	Amanda Wells (Chair and Non-registrant Member) James Ashworth-Holland (Dentist Member) Janine Brooks (Dentist Member) Angela Magee (Dentist Member)
GDC Staff:	James Marshall (Quality Assurance Manager) Marlene Ledgister (Education and Quality Assurance Officer) Exam Board only)

The inspection undertaken at the University of Aberdeen Institute of Dentistry was risk-based, focusing on specific areas of their Bachelor of Dental Surgery (BDS) programme. The GDC's Education and Quality Assurance team (EQA) and a panel of experienced education associates (hereafter referred to as "the panel", "the team" or "associates") undertook an independent evaluation of information available to determine the content of each inspection. The information considered included annual monitoring returns, previous inspection reports (including progress against actions), responses to wider recommendations in the GDC Annual Review of Education, Fitness to Practise data and any complaints received.

Following this assessment, it was decided that the inspection panel focus on Requirements 4, 5, 9, 11, 12, 13, 14, 15, 17, 18 and 19.

The BDS programme delivered at the University of Aberdeen Institute of Dentistry (hereafter referred to as "the Institute") is a graduate entry system and based on a spiral integration, with students commencing their studies in the second year, BDS2. The panel noted a high level of student motivation and enthusiasm for which the Institute should be commended for.

Recent developments within the provision of dental education at the Institute have included a change of programme leadership and establishment of Institute status. In addition, the Institute has become less isolated and more integrated into the wider local dental

community. This was aided by the hosting of an open evening for local practitioners, giving information about developments at the Institute.

The panel were pleased to note that as an Institute within the University, the programme team were able to draw on additional support from the School of Medicine, Medical Sciences and Nutrition and wider University. The panel was also pleased to note that staffing levels have stabilised since the last inspection, which has had a positive impact on the student experience.

The panel agreed the pre-inspection documentation was comprehensive and additional information requested during the inspection process was readily available.

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

Background and overview of qualification

Annual intake	20 students per academic year
Programme duration	41 weeks over 11 months/years
Format of programme	**Year** **1:** Graduate entry course, no year 1 **2:** Applied Medical Sciences (AMS), Oral Biology and Human Diseases teaching provided including key science knowledge & anatomy. Dental Public Health teaching begins. 'Soft skills' teaching in communication, professionalism and ethics begins. Simulated clinical teaching begins during first semester and continues throughout the year, with direct patient treatment (restorative sessions) beginning in Semester 2. **3:** Ongoing teaching in AMS builds upon Year 2. Research skills introduced to students. Simulated clinical teaching builds upon Year 2, introducing more complex restorative treatment areas. Treatment areas of Applied Dental Materials, Oral Surgery, Oral Medicine, Special Care and Paediatrics introduced. Direct patient treatment continues, with increased levels of patient clinic access. **4:** Much of the clinical teaching in Oral Medicine, Oral Surgery, Special Care and Paediatrics moves from didactic to the clinical areas. Direct patient treatment continues, with increased levels of patient clinic access, including access specialist clinical attachments (included Consultant Restorative, OMFS, Anaesthesia and Sedation). **5:** Much of didactic and simulate clinical teaching continues to build on previous knowledge. Introduction of Outreach for the full year. Clinical patient treatment becomes more complex. Increases attendance on specialist clinics.
Number of providers delivering the programme	One – University of Aberdeen

Outcome of relevant Requirements[1]

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

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

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

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

During previous GDC inspections, staffing has been an area of concern for the panel. However, we were pleased to note that since the last GDC visit, there have been a number of positive changes within the Institute. These include the appointment of a new Director of Dentistry, the appointment of a Senior Clinical Lecturer in Oral Surgery and the recruitment of a number of sessional Clinical Lecturers with a GDP background, who provide support and supervision on clinic.

The panel interviewed students as part of the inspection process, who commented on the positive impact these staff changes have had. The students reported that levels of supervision have significantly improved. Students reported that if they had not undertaken a particular clinical procedure for a while, there was now provision to enable them to return to the clinical skills laboratory to practise and rebuild confidence levels.

The team was informed that the student to staff ratio for clinical activity within the Institute was 1:5. We considered that this was a sufficient level to ensure an adequate level of supervision. In addition to this, the panel noted a good level of dental nurse support, with a 1:2 ratio within the Institute clinic and 1:1 at the outreach settings.

The panel noted that when students commence the programme, they receive a comprehensive induction. This includes:
- an introduction to patient clinics and the level of supervision they can expect;
- guidance on support and welfare facilities;
- health and safety training;
- an overview of the Liftupp clinical experience recording system.

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

The panel was pleased to note that following the previous GDC inspection, the Institute developed a log to monitor the training needs of all clinical teaching staff. The team agreed that the Institute should continue to utilise and update this tool to ensure all members of staff remain appropriately trained to carry out their roles.

As noted in Requirement 4, the Institute reported that recent appointments have been made to the staff team, which the panel agreed have strengthened the programme leadership and have had a positive impact on the teaching and clinical experience of the BDS students.

The panel were informed that all University teaching staff must hold a teaching qualification. The panel saw evidence that the majority of Clinical Lecturers involved with the programme hold a postgraduate qualification in dentistry. The Institute stated that this could be more of a challenge for part-time staff, and there were some who had not yet achieved such a qualification. It is a mandatory requirement of the Institute that all new members of staff attend a two-day teaching and learning course.

The team was pleased to note that staff feedback is used to inform training and development needs. Staff comments and suggestions feed into the content of the annual education day, which is attended by all staff members, including outreach colleagues. In addition to this, there is an annual CPD day for outreach staff to ensure consistency of teaching and assessment across all sites. However, the panel noted the use of part-time members of staff can pose a challenge for ensuring everyone receives appropriate training. The Institute should explore further opportunities to deliver training for these staff members.

The panel was provided with evidence of staff members completing the mandatory equality and diversity training. This training, which includes how equality and diversity relates to educational practice and employment law, must be refreshed every three years. Equality and diversity case studies are utilised to ensure the training is relevant for Institute staff.

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

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

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

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

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

Overall management of the Institute sits with the Institute Executive Committee, which is chaired by the Director of Dentistry. The Director reports directly to the Head of the School of Medicine, Medical Sciences and Nutrition.

Following a review of the quality assurance mechanisms within the Institute, the Curriculum Management Committee (CMC) was introduced. The CMC reports to the Institute Executive Committee and is chaired by an Associate Director of the Institute. The CMC is responsible for the development, management and implementation of the BDS curriculum and to ensure mapping to all GDC Learning Outcomes. The panel was informed that the CMC provides the Institute with the ability to agree changes and development of the programme in a timely and efficient manner and to be responsive to recommendations from the External Examiners (EE). The CMC receives feedback from a variety of committees, including the Assessment Sub-committee, Academic Staff Committee, Clinical Progress Committee and Examination Boards.

The panel was provided with evidence of the processes and structures in place to manage the quality framework and ensure the curriculum maps to the GDC learning outcomes. The Institute is subject to a five yearly external review and the last internal teaching review took place two years ago. In addition to this, an annual review of the learning outcomes takes place, which feeds into programme development.

The Institute reported that the structures in place enable the programme to be reactive to changes and ensure the education delivered is appropriate and contemporaneous. The Institute provided evidence of new guidelines regarding the treatment of periodontal disease, which was discussed at both the Curriculum Management and Executive Committee and implemented.

The panel was provided with evidence of the University and Institute risk registers, which are reviewed during every monthly Senior Management Team meeting. We saw evidence of changes that were implemented following a needle stick audit and trend analysis carried out in 2018, which had been flagged on the risk register.

The BDS programme is also subject to oversight from the School Teaching and Learning Committee. Items considered and discussed at the Teaching and Learning Committee include annual programme reviews, EE reports and any major changes to the governance structure. This committee also includes members from postgraduate programmes and the Vocational Training scheme.

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

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

The panel was informed that at the time of the inspection there were three EEs involved with the BDS programme, with one further EE to be appointed. The panel agreed that the Institute should ensure there is sufficient EE support for the programme.

EEs are provided with a thorough induction which covers Institute policies and procedures, reporting requirements and expectations for the role. New EEs are also required to shadow a senior examiner and they are invited to attend the Institute's annual Education Day. However, the panel noted there was no formal ongoing training for EEs. The Institute should consider providing training opportunities for EEs on relevant topics.

As part of their role, EEs review all assessments to ensure they are appropriate and mapped to the learning outcomes. In addition to this, they carry out assessment observations and review marked scripts. The panel was pleased to note the EEs also meet with students to discuss the assessments. The EEs are provided with minutes from assessment standardisation meetings. The panel noted that feedback from the EEs was used to inform the recent assessment change within BDS5, from a case presentation to an unseen treatment planning exercise.

The panel was pleased to note that EE reports were published and made available for students to review. However, during the inspection we were concerned that there was limited evidence of the University formally responding to the reports. In future, the Institute must ensure that EE reports receive a formal response to ensure recommendations are recorded and addressed.

Feedback from students is received via the formal Student Course Evaluation Feedback (SCEF) surveys, which are completed once per semester. The SCEF surveys gather feedback and comments on teaching rather than assessments. Feedback from these surveys enable Year and Theme Leads to develop and improve the programme.

The SCEF surveys are reviewed at Staff Student Liaison Committee (SSLC) meetings where core staff from each year meet with student representatives. The SSLC discusses feedback received and to develop action plans. The SSLC reports into the Curriculum Management Committee.

The Institute currently collects patient feedback from the following sources:

- Face to face contact / discussion on clinics
- Recently introduced patient feedback card
- NHS feedback and complaints procedures
- Good news stories from the Institute's Social Media feeds

The panel was informed that the Institute does not currently use patient feedback to inform programme development unless this arises through the formal governance procedures. However, we noted that going forward, patient feedback that is collected will be discussed by staff and shared with students as required. The Institute must ensure the use of patient feedback to inform programme development continues to be reviewed.

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

The panel was informed that the Institute Outreach Lead makes regular visits to the outreach centres. The panel held meetings with members of staff from the outreach centres, who described a good level of communication with the Institute. The panel noted regular meetings took place between all parties involved in student placements, to ensure consistency is maintained. Students provided the panel with positive feedback on their experience in the outreach settings, noting the high level of support provided by both outreach and Institute staff members.

The Institute noted that with education delivered at arm's length in outreach centres, there is a risk that the student experience may differ from that delivered by the centre. To counter this, the Institute regularly reviews assessment data and delivers calibration to outreach staff. These training sessions are also recorded, so those who cannot attend are able to benefit from these learning opportunities.

The panel was pleased to note the systems in place for raising concerns in the outreach setting. Outreach staff are able to utilise the Liftupp system for reporting concerns with a student's performance. As noted above, the Institute has a dedicated Outreach Lead for supporting staff in the Stornoway and Elgin centres.

The team was pleased to note progress is being made to develop a mechanism for recording outreach patient feedback via a new iPad system. We were informed that this process is being rolled out during 2019-2020. The Institute must continue to develop its outreach patient feedback system and update the GDC in their 2020 monitoring return.

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 Met)*

In advance of the inspection, the panel was provided with the Institute's blueprinting document, which demonstrated that all GDC learning outcomes were being taught and assessed through the programme.

Student progression and sign-up for examinations is undertaken via the Clinical Progress Committee (CPC) which is a sub-committee of the Institute's Curriculum Management Committee. CPC meetings take place at regular intervals from year two onwards. The CPC is chaired by the Assessment Lead with a membership comprised of BDS Year Leads, Academic (Theme) Leads and the Director of Dentistry. Each student is discussed individually during these meetings and decisions regarding progress are made on the basis of the evidence presented by Year Leads. The panel observed a CPC meeting during the programme

inspection and was satisfied that student performance and progression was adequately monitored and recorded.

In advance of each CPC meeting, Year Leads prepare reports for each student after analysing Liftupp clinical performance data, academic results, professionalism and fitness to practise. In the final year, this task is undertaken by the Clinical Mentors, who are responsible for two students each. Mentors meet students regularly each semester in order to review performance and progression.

The panel was informed that if a student has not demonstrated adequate performance to be considered for progression, the Year Lead is required to meet with the student and a remedial plan is established. In circumstances where the CPC has serious concerns regarding a student, the University's Student Monitoring Process may be implemented, which is a formal process that places a student at risk of being unable to complete the work required of them. We saw evidence of a student not being permitted to progress during a CPC and an appropriate action plan being implemented.

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

The panel was informed that the Institute has several management systems in place to plan, monitor and record the assessment of students, including clinical experience. These include the Liftupp system, which records experience across several settings where students carry out clinical activity, and the Student Clinical Skills Passport, which documents a student's competency in specific clinical skills areas.

The team was informed that Liftupp was initially introduced within the student clinics at the start of the 2016/17 academic year. Liftupp was subsequently rolled out to clinical skills teaching at the start of the 2018/19 academic year. The panel agreed that the link from the clinical skills laboratory to the teaching clinics allows the Institute to use a continuous recording and feedback system from the start of the course, through to completion and into vocational training placements. Throughout the Liftupp process, students register each procedure carried out for patients, which includes clinical data and complementary skills such as communication, professionalism, management and leadership. Liftupp enables a supervising tutor to record both the type of treatment undertaken and the complexity.

At the beginning of the programme, students receive training on how to use Liftupp and are advised to regularly review feedback that has been submitted and reflect on their performance. Year Leads review the clinical data on a monthly basis. A formal review of all student performance data takes place during the CPC, as detailed in Requirement 13. If a clinical alert is raised on Liftupp an email alert is produced which enabled the programme team to develop an action plan for remediation via the Student Clinical Skills Passport process.

As noted above, the Student Clinical Skills Passport records student competency in specific clinical skills areas. The passports are a paper document that is stamped and signed within the clinical environment. The passport can be withdrawn if a student is awarded a Developmental Indicator of 1 in a clinical domain on Liftupp or an alert has been recorded during a clinical session. If the passport is withdrawn, the student will be given feedback and a remediation plan implemented. The student must then demonstrate satisfactory completion of any remediation prior to their passport being reinstated. The panel agreed that the passport is an innovative method for developing a student's performance, however they were concerned that it is a paper document that is not centralised or electronically recorded. The panel agreed that

the Institute should consider further development of the passport, including the viability of transferring it from a paper based to electronic system.

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)*

The panel were informed that the Institute has a number of routes for patients to access treatment carried out by the students. These include self-referral, referral from the secondary care restorative dentistry service, via the oral surgery Managed Clinical Network (MCN) and via local GDPs for dental extractions.

All patients are screened by a member of staff or a final year student under supervision to determine if they are suitable. If the patient is accepted, they are allocated to the most appropriate student group, depending on the level of development and progression through the programme. The administrative management of patients requiring treatment by BDS students is the responsibility of the Dental Coordinator Team Leader (DCTL) who liaises with the Year Leads regarding the needs of the students. Reference is made to student Liftupp data to identify students who require patients needing particular types of treatment.

The panel noted that there is a supply issue for paediatric patients requiring pulpotomies and preformed crowns. If a student struggles to gain this experience to meet their targets, they are permitted to demonstrate competency within a simulated environment. Going forward, the Institute must review the availability of paediatric patients to ensure students are gaining exposure to these treatment types.

The Institute utilises a range of outreach settings in order to support students gaining a broad range of clinical experience. The panel noted the positive impact these placements had on the clinical development of the students and received complementary feedback on their use from both staff and students. During the Exam Board inspection, the panel was informed that the Institute is reviewing how students will undertake their outreach placements. Previously students would attend outreach for two-week periods in Years Four and Five. Going forward, students will spend a prolonged period within the outreach setting in Year Five which will enable students to treat patients holistically. The panel was supportive of this development within the programme.

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

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

The panel was informed that currently there is limited opportunity for feedback from patients to be used effectively within the assessment process. However, this is an area of development that is currently being investigated by the programme team.

The team noted that the Institute has started the process of developing a patient feedback form, both paper-based and electronically, in order to gather this information. This process has begun. The rollout of these feedback mechanisms will take place during 2019-2020 and this will include the outreach centres. In addition to patient feedback informing the assessment process, the Institute is developing ways in which effective 360-degree feedback from other

members of the dental team can inform student development. The panel supports the development of these areas of work and will continue to review it via the GDC's annual monitoring process.

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)*

The panel noted that students receive training on reflective practice in years BDS2 and BDS3. The panel were also provided with evidence of teaching sessions where students are required to reflect on ethical and professional issues.

The use of the Liftupp system gives students the opportunity to reflect on their performance, however the panel saw limited evidence of this taking place. We acknowledged that a significant amount of feedback and reflection will be verbal, however we also agreed that the Institute should consider ways in which reflection can be recorded to enable longitudinal development.

During meetings with students, the panel noted positive feedback from all year groups regarding the approachability of staff. The students commented that the Institute had developed a positive and constructive environment which enabled students to feel empowered to seek out feedback from the teaching staff.

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

During the inspection, the panel was provided with a staff list which detailed names, academic posts, clinical status and professional qualifications. The team noted a range of assessor training opportunities were provided for staff members, however we agreed that further support and training could be made available for part-time members of staff. Going forward, the Institute should consider various methods to ensure all staff members, both full and part-time, are given appropriate training in order to undertake assessment exercises within the programme.

The panel noted with interest the Yammer group that has been set up to review and calibrate assessments during the programme. We agreed this was a positive step forward in ensuring there is a consistent and collegiate approach within the Institute in order to develop and calibrate assessments. The GDC will review the ongoing assessment calibration undertaken by the Yammer group during the next monitoring exercise.

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

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

Summary of Action

Req. number	Action	Observations & response from Provider	Due date
5	The Institute should explore further opportunities to deliver training for these staff members.	The Institute will continue to ensure that all staff complete the appropriate Equality and Diversity training, taking into account additional responsibilities they may have (for example, lecturer, recruiter). The Institute recognises the need to ensure that all staff receive key training where required and the difficulty faced by part-time members of staff to attend training scheduled for specific dates. Training which is deemed key for staff will be provided on multiple occasions to allow part-time staff the opportunity to attend sessions. Our full CPD and Education days will continue to be arranged with appropriate notice to provide all staff the opportunity to rearrange responsibilities to attend. With respect to part-time members of staff we will continue to be as flexible as possible with respect to the switching of work sessions to allow attendance. Audio recordings of our short CPD & mandatory training sessions will continue, with these distributed to relevant staff as required. These recordings provide the opportunity for all staff, but particularly part-time staff, to follow CPD & mandatory training sessions at a time convenient to them. Work has commenced to enhance these recordings to include an assessment component, which evidences completion and understanding. We continue to utilise our recently updated Assessment Central software which delivers and marks OSCE/ISCE examinations. This software includes a mandatory	All Annual Monitoring 2020/21

		training package for examiners to work through prior to assessment diets. The successful completion of this training is recorded within Assessment Central and allows staff members to examine our students. The software sends automated e-mails to staff members when the training is due for renewal.	
11	The Institute should ensure there is sufficient EE support for the programme.	A new Deputy Lead for Assessment role will be introduced to allow further development and training work to be undertaken by the Assessment team. This will include additional support for our EEs. The anticipated start date January 2020.	January 2020
		EEs will continue to receive an invitation to our all staff Education Day (scheduled August 2020) where staff discuss updates and innovative improvements planned for our curriculum / assessment.	All Monitoring 2020/21
		We continue to review our Institute EE induction pack. All EEs receive this information pack when joining our programme.	
		In addition, we will introduce annual EE update information to ensure all examiners are up to date with any material changes to the curriculum or assessment. This will be located on the Assessment Central system.	
		We are continuing our internal process where all new EEs are paired with an experienced EE for the first full academic year of their term for support and knowledge exchange.	
11	The Institute should consider providing training opportunities for EEs on relevant topics.	EEs will continue to receive an invitation to our all staff Education Day (scheduled August 2020) where staff	All Monitoring 2020/21

		discuss updates and innovative improvements planned for our curriculum and assessment. We continue to review our Institute EE induction pack. All EEs receive this information pack when joining our programme. Online training documents and programme information will be uploaded onto our Assessment Central system. EEs are able to access updated and new information from this central point. Continuation of our internal process where all new EEs are paired with a more senior external for the first full academic year of their term for support and knowledge exchange.	
11	The Institute must ensure that EE reports receive a formal response to ensure recommendations are recorded and addressed.	We continue to follow the University approved process for EE reports, responding in a timely manner and ensuring these are circulated to the required University Committees in line with the process timeline. The Institute Assessment Lead has the responsibility to ensure a formal response is sent to all EEs. Any responses from University Committees will be the responsibility of the Assessment Lead to address, alongside the Assessment Sub-Committee. Our Assessment Lead will attend the scheduled annual feedback session with University Quality Assurance Committee members and to respond to recommendations made at this forum. The Institute will ensure full engagement with the Quality Assurance SharePoint process, whereby all	All Monitoring 2020/21

		Quality Assurance documents are recorded on this central repository to be reviewed and responded to by central teams and committees as required.	
11	The Institute must ensure the use of patient feedback to inform programme development continues to be reviewed.	A full review of our patient feedback form is underway, led by two senior clinical staff members. Updated feedback forms will standardise the feedback received from our internal Institute clinics as well as our Outreach facilities. Evaluation of these new forms and the data recorded will be undertaken to ensure they are fit for purpose. Development has begun on the electronic versions (IPad) of our new patient feedback forms to enable patients to complete them at the end of clinical sessions. A new standing agenda item will be included on our Curriculum Management and Executive Committees to receive and review all feedback provided, identifying and responding to trends and issues and how these might inform curriculum development. The Institute will continue to actively engage with the local community to promote its work (via such events as Doors Open Day). These events provide valuable opportunities to gather feedback from members of the public on the Institute, and dentistry more generally, to help develop and respond to suit the best needs of the population. The Institute will consider patient representation on development and short life working groups, in particular where these groups discuss the development and	Monitoring 2020/21

		improvement of the curriculum and/or our student clinics.	
12	The Institute must ensure the use of patient feedback to inform programme development continues to be reviewed.	Response to action in Section 11.	
14	The Institute should consider further development of the clinical skills passport, including the viability of transferring it from a paper based to electronic system.	Development of an electronic clinical skills passport is underway. The passport will be fully implemented at the beginning of the Academic Year 2020/2021. Using the real time data we have from the LiftUpp system enables the Institute to highlight any student who has not maintained 'currency' in a particular skill and allows review of the Clinical Passport data in real time on our clinics. The system highlights students who may need to undertake additional training to maintain clinical 'currency' thus providing a valuable opportunity to provide additional relevant teaching whilst also maximising patient safety and enhancing the experience of both staff and students. The passport is one section within a new electronic Clinical Toolbox App current in development and planned for initial release in December 2020. The Toolbox App also provides real time information to supervisors on Multiple Step Procedures. The standard Liftupp interface does not easily provide information to supervisors regarding the steps previously assessed for Multiple Step Procedures. The Toolbox App provides supervisors with the opportunity to review the treatment steps already assessed for a particular patient and procedure as well as an opportunity to review a	Monitoring 2020/21

		students' overall clinical experience in that particular type of procedure. The Toolbox App also contains sections which provide our clinical supervisors information and guidance to assist in the calibration of Qualitative Grading and Difficulty Grading. The Qualitative Grading section provides an easily accessible review of the LiftUpp qualitative statements against which a student's independence and quality of work are to be compared. Use of this information will be key when working to mitigate any bias generated by the assignment of a numerical label. The Difficulty Grading section provides a reference for grading of complexity and difficulty of specific treatments. Full staff training will be provided on each of the Toolbox sections.	
15	The Institute must review the availability of paediatric patients to ensure students are gaining exposure to a variety of treatment modalities.	We continue to engage with a range of partners and stakeholders to increase the availability of finding suitable paediatric patients. A proposal for an improved patient pathway is to be presented to the local Public Dental Service leads and General Practice Representatives for discussion. This proposed pathway would allow paediatric patients to remain registered with their GDP whilst being treated by dental students for a course of treatment. Proposals for a working partnership with local primary and secondary schools, throughout Aberdeen City Council, will be developed. The working partnership would highlight the services that we provide for	Monitoring 2020/21

		children. This proposal will be presented to the Executive Committee during the first half of 2020. We continue to engage with our local GDP community, in the main via our Odonatological Society evenings. These evenings have been successful in attracting large numbers of local GDPs to the Institute to receive wide-ranging talks from our staff, whilst also discussing opportunities for improved patient pathways between the local community and our student clinics.	
17	The Institute must continue to develop how feedback and reflection can inform the assessment process.	As per Action 11, a full review of our patient feedback form is currently underway, led by two senior clinical staff. Updated forms will standardise the feedback received from our internal Institute clinics as well as our Outreach facilities. Development has begun on the electronic versions (iPad) of our new patient feedback forms to enable patients to complete them at the end of clinical sessions. Training will be provided to the dental nurse teams within our student clinics to ensure we capture meaningful feedback via the LiftUpp system. The Assessment Sub-Committee will implement a formative assessment of student feedback (including patients and the wider dental team).This review will include students in years 3 to 5 meeting with a clinical member of staff to discuss feedback received, with a learning action plan be developed for the student to act on.	Monitoring 2020/21

		Feedback from patients and the wider dental team will be discussed at our Clinical Progress Committee, which reviews all student progression.	
18	The Institute should consider ways in which reflection can be recorded to enable longitudinal development.	Students are required to submit reflective essays during each academic year related to their clinical experience. This is part of their reflective module. This is outwith any reflective account required should a clinical alert or remediation be required. The essays are marked and feedback provided to the students. All reflective essays will be reviewed by the module lead to consider whether these have implications for curriculum review and development and/ or patient safety. This overview will be reported to the Curriculum Management Committee on an annual basis. Feedback from clinicians on student reflection continues to be evidenced via LiftUpp. The Clinical Progress Committee will ensure student reflection is discussed during meetings. Work is underway to introduce a reflective logbook for early clinical skills (Years 2 and 3) which gathers feedback from clinicians and peers. Students will be required to reflect on the feedback provided to them and to then develop short plans on how they might improve their clinical performance.	Monitoring 2020/21
19	The Institute should consider various methods to ensure all staff members, both full and part-time, are given appropriate training in order to undertake assessing within the programme.	The Institute alongside with the School of Medicine, Medical Sciences and Nutrition (SMMSN) assessment team has developed a set of Standard Operating Procedures (SOPs) in relation to invigilation of examinations and marking of written papers. These	Monitoring 2020/21

| | | SOPs will be circulated to all members of staff in advance of any examination taking place and will be available on the staff induction website.

Further development of our Assessment Central system, which delivers and marks OSCE/ISCE examinations, includes a mandatory training package for examiners to work through prior to assessment diets. The successful completion of this training is recorded within Assessment Central and allows staff members to examine our students. The software sends automated e-mails to staff members when the training is due for renewal.

The Institute Assessment team will develop a series of podcasts on the topic of writing exam questions. These podcasts will be available to all staff members when required. We will continue to provide protected time within our timetables for staff to attend supportive exam questions writing sessions.

All academic members of staff are provided the opportunity to complete the PG Certificate in Higher Education in Healthcare Programmes. A full module of this programme is dedicated to assessments in Healthcare Programmes. This blended learning programme allows part-time staff the opportunity to complete the work at a suitable time. | |

Observations from the provider on content of report

Recommendations to the GDC

Education associates' recommendation	Qualification continues to be sufficient for holders to apply for registration as a dentist with the General Dental Council
Date of next regular monitoring exercise	Monitoring 2020

Annex 1

Inspection purpose and process

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

2. Inspections are a key element of the GDC's quality assurance activity. They enable a recommendation to be made to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist and 'approval' of the programme for registration as a dental care professional. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended).
3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

4. The education provider is requested to undertake a self-evaluation of the programme against the individual Requirements under the Standards for Education. This involves stating whether each Requirement is 'met', 'partly met' or 'not met' and to provide evidence in support of their evaluation. The inspection panel examines this evidence, may request further documentary evidence and gathers further evidence from discussions with staff and students. The panel will reach a decision on each Requirement, using the following descriptors:

A Requirement is met if:

"There is sufficient appropriate evidence derived from the inspection process. This evidence provides the panel 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' be used to describe the obligation on the provider to undertake this action. For these actions the panel 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' be used and for these actions there will be no due date stipulated. Providers will be asked to report on the progress in addressing the required actions through the annual monitoring process. Serious concerns about a lack of progress may result in further inspections or other quality assurance activity.

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

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