

# General Dental Council

## Education Quality Assurance Inspection Report

Education Provider/Awarding Body	Programme/Award
University of Dundee	Bachelor of Dental Surgery

Outcome of Inspection	Recommended that the Bachelor of Dental Surgery continues to be sufficient for the graduating cohort to register as a Dentist.
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**\*Full details of the inspection process can be found in Annex 1\***

## Inspection summary

<b>Remit and purpose of inspection:</b>	Inspection referencing the <i>Standards for Education</i> to determine sufficiency of the award for the purpose of registration with the GDC as a Dentist.
<b>Learning Outcomes:</b>	Preparing for Practice Dentist.
<b>Programme inspection date:</b>	9 March 2023
<b>Examination inspection date</b>	Not applicable, to be concluded in 2024
<b>Inspection team:</b>	Jenny McKibben -Chair and non-registrant member Aradhana Tugnait - Dentist member Erica Clough - DCP member Angela Watkins - GDC Quality Assurance Manager
<b>Report Produced by:</b>	Angela Watkins - GDC Quality Assurance Manager

The inspection of the Bachelor of Dental Surgery (“BDS”) programme (“the programme”) offered by University of Dundee (hereafter referred to as “the Provider”) was conducted as a result of the 2019 Inspection where the new “4D” assessment method was identified. Due to the change in the curriculum the inspection was a full inspection covering all 21 requirements.

The inspection was conducted on site at the Dundee Dental Hospital and Research School. The inspection panel was comprised of GDC education associates (‘the panel’, ‘the associates’, ‘we’). The panel received a set of documents in advance of the inspection and a further set of documents on site during the inspection.

During the pandemic, the provider deferred students for one year, which meant that current Year Four students had completed five years on the programme. These students reflected that they appreciate now, that they would not have been ready to graduate and so feel that this was the right decision. However, it was clear that there were some processes still impacted by the pandemic and some processes were just starting to be restored (including patient feedback).

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

Overall, the panel had no major concerns about the BDS programme at this point in the programme (Year Four). A risk-based inspection of the Year Five graduating cohort must be conducted in 2024 before a decision on full sufficiency of the programme is considered.

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

## Background and overview of qualification

Annual intake	66 students 2022-23; 57 students for 2023-24.
Programme duration	<p>Year 1 (number of weeks) - 28</p> <p>Year 2 (number of weeks) – 33.5</p> <p>Year 3 (number of weeks) – 42.5</p> <p>Year 4 (number of weeks) – 44.5 including 5 weeks elective over the summer between 4<sup>th</sup> and 5<sup>th</sup> year and 3 weeks Outreach.</p> <p>Year 5 (number of weeks) – 35.5</p>
Format of programme	<p>Year 1 (modules 1 &amp; 2): Foundation knowledge and skills underpinning clinical care; Early exposure to the clinical environment. Clinical skills training in periodontal instrumentation and operative skills.</p> <p>Year 2 (modules 3 &amp; 4): Continued knowledge and skills development underpinning clinical care, including cariology, medical sciences, occlusion, pain management, pharmacology, behavioural sciences, developing dentition and craniofacial development. Clinical skills training in operative caries management and paediatric dentistry. Continued exposure to basic patient care (periodontology and operative dentistry).</p> <p>Year 3 (modules 5 &amp; 6): Further knowledge and skills development across clinical disciplines, including fixed &amp; removable prosthodontics, endodontics, paediatric dentistry and oral surgery. Continued knowledge development in subject areas including medical sciences, pain, communication and evidence-based dentistry.</p> <p>Year 4 (modules 7 &amp; 8): Knowledge and skills development underpinning the management of anxious patients, special care dentistry, healthcare law &amp; ethics, surgical dentistry and oral pathology. The management of more complex interdisciplinary cases in restorative dentistry. Management of simple cases in paediatric dentistry and orthodontics. Management of patients in outreach clinics.</p> <p>Year 5 (module 9): Consolidation, integration and enhancement of knowledge and skills across all disciplines</p>

	with increased exposure to more complex cases within the School, including consultant clinics, and in outreach. Additional knowledge and skills training to enable transition to independent practise and lifelong learning.
Number of providers delivering the programme	1

## Outcome of relevant Requirements<sup>1</sup>

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

### Standard 1 – Protecting patients

<sup>1</sup> 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.

**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)**

All clinical work is recorded on the “Liftupp” system and uses developmental indicators (DI) to monitor progress. The system is used to allocate students to patients on clinic. A “clinical alert” is raised on Liftupp if safety concerns are raised, and when appropriate, Liftupp can then be used to restrict a student’s patient care. If it is identified that a student is not permitted to progress to patient care they would be removed from the Liftupp system which stops them being allocated patients.

Any concerns regarding the experience or ability of individual students are brought to the attention of the relevant Year Leads and then discussed at the providers Progress Committee. The Progress Committee meets six times per year to monitor student progress, considering academic and clinical performance, attendance, and professionalism.

Students must pass gateway examinations to progress to patient care and were happy that once they had passed there was no delay on being given access to patients which helped maintain confidence.

Following the pandemic, students noted that they had practical sessions back in the opt-tech and with phantom heads to re-familiarise themselves and to gain confidence before working with patients.

The panel agreed that this requirement is met and are assured that the systems in place to monitor students ensured students do not access patients until they have the relevant skills at the appropriate level.

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

The panel reviewed the patient pack which contained a letter to new patients explaining the use of students in clinic and a consent form for them to complete. The pack contains a link to the providers website page that explains the use of students on clinic [Get treatment from Dundee Dental Hospital | University of Dundee](#).

Students are taught to obtain valid consent and check patients’ understanding of treatments, and options, through multiple methods including clinical assessment and reflection. Consent is incorporated into a range of modules that the students must complete.

The panel are satisfied that the provider had a robust process in place to make patients aware of students treating patients and that students understood the importance of consent. Therefore, the panel agreed that this requirement is met.

**Requirement 3: Students must only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and**

**requirements regarding patient care, including equality and diversity, wherever treatment takes place. (Requirement Met)**

The panel saw evidence that there are structural policies and a robust risk assessment in place. The panel reviewed a list of staff, qualifications and training completed, including compulsory training in Equality, Diversity & Inclusion. Students complete the NHS LearnPro training on these areas.

During, and in response to COVID the Dental Hospital has upgraded clinical environments, involving the complete refit of some floors and the installation of enclosed PODs to enable the safe provision of aerosol generating procedures (AGPs).

All students must have Occupational Health clearance before attending clinics. Annual skin health surveillance checks are undertaken for all students, with Occupational Health follow up where problems are detected.

The responsibility for managing health and safety in the clinical environment lies with NHS Tayside. This is overseen by the Hospital Safety, Clinical Governance and Risk Committee. Quality and service improvement workstreams throughout the Dental Hospital. Students are invited to the bi-monthly Clinical Effectiveness and Governance sessions run within the Dental Hospital.

The panel are assured with the process within the Dental School and Hospital and satisfied that this is underpinned by the overall University and NHS policies. Therefore, the panel are satisfied that this requirement is met.

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

The panel reviewed a full staffing list and supervisor CVs. The panel was assured that all supervising staff are registered with the GDC and have had appropriate training prior to undertaking supervisory duties with students.

Staff to student ratio for clinical supervision at the Dental Hospital is never less than 1:5. If the student is performing surgery, then this is 1:1.

Outreach staffing confirmed that ratios within outreach are no more than 1:5. It was noted that in line with Local Health Board rules, clinics would be reduced or cancelled, unless there are other staff that could cover.

It was noted on the risk register that there had been some staffing shortages and workload pressures. Although it was felt that this is an industry wide problem, the provider is proactively trying to work innovatively across the clinical network to source and share subject experts in areas such as radiology and other bespoke subjects.

Early Clinical Experience handbooks provide clear guidance to staff regarding the experience and expectations of the students. Student treatment of patients is closely supervised and a permission to treat form is signed once it has been established that the student understands the task assigned and this is checked at each stage of the procedure.

The panel are assured that there was good supervision in place and therefore, this requirement is met.

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

The panel saw CVs for all supervisors and a full list of staff mandatory training, including annual equality and diversity. The staff list also included details of GDC registration. The staff complete mandatory training through the NHS LearnPro system which is monitored.

It was noted by the provider that they were having difficulties recruiting some roles, there is particularly a shortage of dentists. Therefore, the provider is responding by using a Teaching fellowship programme to develop “home grown” talent pool and succession planning. Staff also have access to two-year internal mentorship and mentorships from outside the Dental School.

The panel are assured that supervisors are appropriately qualified and trained and as a result this requirement is met.

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

The panel are assured by The Raising Concerns Policy, that the provider has clear policies and procedures in place for staff and students to raise any patient safety concerns. Students are taught about Raising Concerns in all modules and in particular Module 7, through coursework and assessments.

All staff, including outreach supervisors, are trained on Liftupp alerts and the notification of lapse of professionalism (NLP) process. Liftupp alerts can be used by staff if there is a patient safety concern. Points are given to NLP incidents and depending on the severity of the incidents these will be added into the Datix system.

Datix reporting is completed after any clinical safety events are identified and is monitored through Local Adverse Event Reviews (LAER).

LAER's take place to enable learning from adverse events raised through the Datix system. Learning from such events is shared to maximise patient safety.

The panel were shown an example of a student raising a concern about another student. The concern was triangulated through staff interviews, committee minutes and documented evidence of the concern, outcomes and lessons learned. Therefore, the panel are satisfied with the process in place and that this requirement is 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. (Partly Met)**



The panel was informed that students must attend NHS Occupational Health before commencing practical skills on clinics.

The panel are assured that a good system is in place to identify and record issues. The Notification of Lapse of Professionalism (NLP) is an in-house tool which informs students and staff of student's performance. These NLP are discussed through various committees, including, when a lapse of professionalism has deemed to have taken place, the Progress Committee. The panel reviewed the NLP tariff which demonstrates what "points" should be issued. If a student receives more than 6 "points" the case is automatically sent to the Professionalism and Capability (P&C) committee for assessment. If a major issue is identified, then the P&C committee will be convened, as soon as practicable, and this committee will give notification to the student of the level of investigation. The student may be removed from LiftUpp until P&C have agreed an outcome. NLP feed in to the Datix system and the LAER process, where appropriate.

The Datix system is used by the NHS to record clinical safety issues. The NHS Clinical Directors are members of the School Executive Group, which facilitates ready communication of any issues. There is also University representation on the NHS Safety, Clinical Governance and Risk Committee.

The panel followed the journey of one BDS student who had received a "clinical alert". The panel noted that there was not a clear trail of evidence held in one place, which meant it was not possible to see a full oversight of the issue. The panel agreed that there was not enough context or information contained within LiftUpp to allow clinicians to make a real time decision on clinical restriction which may have been imposed. The provider's own guidance states that LiftUpp is the process for "Restricting or Removing Student Access", therefore, this is the area which should hold all the required information. The use of other means of communication (emails and telephone) is an additional contingency and therefore should not be the source of detail.

The panel are assured that there are systems in place to record issues, however, the LiftUpp system had gaps of information which are held elsewhere. Going forward the provider should create an overarching system to integrate and make trackable in one place all the various means of monitoring and managing patient safety issues, including LiftUpp, Progress Committee minutes, email alerts etc. The panel also recommend that more contextual information is added onto LiftUpp to enable clinicians to make real time decisions on students providing clinical treatment. This would also provide clearer direction to students. Therefore, this requirement is partly met.

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

The panel reviewed the Fitness to Practice Policy and the Programme Handbook and was assured that all expectations are clear.

It was noted by the panel that the current Fitness to Practice Policy was due for review in October 2019, it was not clear in the document if this had been completed. The panel noted that in line with the described internal quality assurance, that this should be clearer and documents reviewed more frequently.

The panel reviewed the Management of Student Concern flowchart which clearly demonstrated how Failed to Practice cases are discussed and disseminated.

The Student Fitness to Practice in the Programme Handbook was reviewed, which included a link to the GDC Student Fitness to Practice document. The link is also included on the students virtual learning environment (MyDundee). Failed to Practice processes are introduced to students during their first semester and subsequently re-visited throughout the curriculum.

Any Failed to Practice cases are considered by the Professionalism and Capability Committee. Students are taught about Failed to Practice in the first week of their first year and this is then reiterated throughout core modules and clinical cases. Professionalism and FtP processes are available on MyDundee. Ethics is an integral part of the students assessed work in the final year and brings together all these elements.

The panel are assured that the policies and process in place made it clear for staff and students to apply. Therefore, this requirement is met.

## **Standard 2 – Quality evaluation and review of the programme**

**The provider must have in place effective policy and procedures for the monitoring and review of the programme.**

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

The panel are satisfied that there is an open and robust framework in place to make change and there is now, a clear understanding that the GDC should be notified of any changes to curriculum. The provider has dedicated pages on their website demonstrating transparency [Policy and guidance on the annual review of taught provision | University of Dundee](#). Therefore, this requirement is met.

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

The panel was fully assured that the quality of the programme was underpinned by the overall University Quality Assurance Framework process.

The programme is monitored and reviewed by 8 External Examiners and the panel was assured that the External Examiners were involved with the setup of the programme.

The provider demonstrated a robust structure to collect feedback from across all stakeholders including students who noted that they felt the school listened to their feedback.

The students explained that they can feedback to any of the team, or they can speak to their year representative who will discuss at the committee meetings. The students told the panel that they notice that change is made in response to their feedback and added that if the provider can't implement change, the feedback is acknowledged, and a reason given.

The Risk Management policy was found to be robust, and it was clear that the risk register was identifying risks.

The panel are assured that there is a good quality management framework in place, therefore, this requirement is 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 are assured that there is a robust quality assurance framework in place and that the BDS programme had to comply with the overall University Quality Framework. Quality and Academic Standards are responsible for the Quality Framework.

The provider must return to the pre-Covid patient feedback mechanism. The panel felt that the provider could be more innovative in obtaining feedback from patients, including making use of patient input to help inform programme and curriculum design and ensuring diversity and equality is considered.

The panel agreed that further work was required to obtain patient feedback, this will help to inform programme development. As a result, the panel agreed that this requirement is partly met.

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

Direct clinical experience is carried out within the Dental Hospital and then out in Outreach centres.

Quality assurance of outreach is shared between the University of Dundee and NHS National Education for Scotland (NES) through a local service level agreement. The panel reviewed Outreach reports up until 2019-20, however, these are no longer required from NES. It was noted by internal and outreach staff that these reports were useful to create and evaluate the effectiveness of outreach. The panel noted that it would be good practice for the provider to revive the reports and use as part of the evaluation process.

Students noted that they enjoyed Outreach and felt that the transition from the hospital is smooth, with a clear induction and that they felt clinically prepared.

The panel agreed that there are good systems in place to quality assure placements and received good feedback from the outreach staff about the access and support from the Outreach Leads. As a result, the panel agreed that this requirement was met.

### Standard 3– Student assessment

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

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

The panel saw evidence of how the programme learning outcomes are aligned to GDC Learning Outcomes. These are also aligned to the University standard criteria to ensure that students are assessed as safe beginners.

The BDS 4D Assessment Plan is assessed by a mixture of knowledge papers, clinical assessments, coursework and a reflective (Portfolio) piece of work.

The panel reviewed minutes of the Progress Committee, which meets six times a year to monitor. The minutes covered individual student progress, academic and clinical performance, attendance and events that lead to Notification of Lapse of Professionalism (NLP).

The panel were assured that good systems were in place to capture progress and that the Progress Committee is where information is reviewed to reach decisions on individual student progress, and where appropriate, identify and implement student supportive measures. Therefore, the panel agreed that this requirement is met.

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

The panel was given a demonstration of the Liftupp system which the provider uses as its central record for monitoring student achievement. Student reflection is not stored in LiftUpp; it is held in the students' individual logbooks. The provider uses Development Indicators (DI) to assess student progress.

Outreach staff have full access to Liftupp and told the panel that they attend an annual tutors training day which includes calibration exercises. The outreach staff are given an opportunity to shadow experienced outreach supervisors to gain experience in the Liftupp grading system.

The panel are assured that there are systems in place to plan and monitor student clinical experience, therefore, this requirement is met.

**Requirement 15: Students must have exposure to an appropriate breadth of patients/procedures and should undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes. (Requirement Met)**

The panel was given access to the Liftupp system and shown how clinical assessment data is collected for each patient contact and entered on the Liftupp system. This information provides reports on the number of procedures completed. This report summarises the breadth of procedures undertaken and their quality.

The panel are assured that students get good access to a breadth of patients and procedures and that there is a good cohesive relationship across the provider and outreach to enable skills to be developed.

The provider and students are involved in a number of local and national initiatives to try to engage with hard-to-reach patients, such as Ukrainian families, via food bank projects, those who are experiencing homelessness and substance use.

The panel were informed of the wealth of resources and initiatives available to ensure that students get access to a breadth of patients and procedures and therefore, this requirement is met.

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

Standard setting is used for all summative examinations within the programme. The provider uses the Rubric method for ensuring staff and students understood the expectations of the marking criteria of each assessment.

The staff confirmed that they carried out “dummy runs” for calibration of examiners and to test exam questions. Exam questions are sent out to all appropriate staff to comment before all questions were finalised, using a written comment template. The panel reviewed examples of exam papers and post exam analysis and found these to be satisfactory.

The panel are assured that all staff have been trained on standard setting at team away days and that there was a standard setting panel that reviewed these. Therefore, the panel agreed that this requirement was 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. (Partly Met)**

The students told the panel that each year group has a student representative who collates feedback as a group and attends committees. Students strongly feel that their views are valued and if there is anything that cannot be changed, that the provider gives clear reasoning.

The provider must return to the pre-Covid patient feedback mechanism and panel felt that the provider could be more innovative in obtaining feedback as detailed above. As a result, the panel agreed this requirement was partly met.

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

Students confirmed that supervisors give feedback on clinic after each treatment, this is discussed and collectively they agree their development indicator mark on Liftupp. Students are then required to write their reflection into their student logs and this then culminates in an enhanced student reflective assessment.

The panel are assured by the clear understanding of reflective practices and as a result the requirement is met.

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

Staff confirmed that all new staff including internal examiners, shadow experienced examiners before they begin to examine independently.

Examiner briefings are held prior to objective structured clinical examination (OSCE), objective structured practical examination (OSPE) or integrated structured clinical examination (ISCE) examinations. Ahead of any practical examinations dummy runs are undertaken to calibrate the examiners.

The panel are assured that this requirement is met.

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

All External Examiners have access to the External Examiner Portal. The portal allows access to all necessary resources appropriate to the role, including all previous external examiner reports and MyDundee VLE.

The panel reviewed a range of external examiner reports and are assured that allocation of modules is appropriate. The provider confirmed that they respond to any comments made by external examiners within six weeks. These responses are then reviewed by the University of Dundee Director of Quality and Academic Standards. The panel are assured that this is a robust system.

Whilst reviewing external examiners report the panel identified that external examiners had been involved in the examination of candidates. To avoid conflicts of interest and to maintain objectivity, this must stop immediately.

The panel are assured that the External Examiner Induction and the use of the External Examining of Taught Programmes Policy and Code of Practice was good. Therefore, the panel agreed that the requirement is 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)**

Examination regulations are published to students at the beginning of each academic year. These describe eligibility criteria, the structure of the examination and arrangements for resits.

Marking of examinations is anonymous wherever possible. All examination mark sheets are anonymised until the results have been confirmed at the Examination Board meeting. The staff noted that wherever possible anonymised double marking is employed, the panel agreed that this was a good practice.

All papers are moderated in accordance with the University of Dundee assessment policy.

The panel are assured by the examples of disability adjustments that had been made.

The panel agreed that standards are clear and there is an appropriate standard setting process in place. Therefore, this requirement is met.

## Summary of Action

Requirement number	Action	Observations & response from Provider	Due date
9	1. The next cyclical review will take place in 2025, the provider must inform the GDC of changes to programme using the GDC Programme Modification process.	The School acknowledges the updated process for reporting programme modifications to the GDC and will comply with this.	Immediate.
11 & 17	2. The provider must return, as a minimum, to pre-Covid patient feedback collection.	The programme will return to pre-Covid patient feedback in academic year 2023-24. Feedback from other members of the dental team will be sourced throughout the curriculum. The School is working in conjunction with the local NHS to develop Patient and Public Involvement (PPI) groups, which will include patient input into curriculum development/enhancement.	
20	3. External Examiners must not be involved in the examination of candidate.	This requirement was actioned with immediate effect.	Immediate.
7 & 14	4. The provider should make better use of the LiftUpp system by capturing and unifying all sources of information on students' progress especially relating to limits on practice and context to be available in one central place.	<p>The School has met with staff from LiftUpp to explore whether LiftUpp would be able to act as a central resource for all sources of student progress information. Presently, LiftUpp software is unable to do this.</p> <p>The School will develop a central resource where all information regarding student progress can be accessed by staff. Furthermore, more detailed information regarding restrictions to individual student clinical practice will be added to the current "alert" information displayed on LiftUpp (e.g. clearly stating any procedures not to be carried out). All students will be expected to work within the restrictions imposed by the School and their professional obligation to communicate this to supervising staff.</p>	



8	5. The Fitness to Practice Policy should be reviewed regularly and in line with university internal quality assurance schedule.	The School has discussed the Fitness to Practice Policy with the University and have confirmed that the document posted to the panel is still current, although a review will take place shortly.	
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### Observations from the provider on content of report

The School is satisfied with the content of the report and the summary of action. We have outlined some minor suggested changes to the report using Track Changes. The School would like to thank the panel for the enhancement-led approach to the inspection of the BDS 4D curriculum.

### Recommendations to the GDC

<b>Education associates' recommendation</b>	The Bachelor of Dentist Surgery continues to be sufficient for holders to apply for registration as a Dentist with the General Dental Council.
<b>Date of reinspection</b>	Risk-based Inspection in 2024 to review elements of standard three, current action points and to carry out inspection of examinations and assessment board for the first graduating cohort of the BDS 4D curriculum.

# Annex 1

## Inspection purpose and process

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

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

3. The GDC document 'Standards for Education' 2nd edition<sup>1</sup> is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

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

A Requirement is met if:

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

A Requirement is partly met if:

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

A Requirement is not met if:

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

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

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

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