General Dental Council

# Education Quality Assurance Inspection Report

| Education Provider/Awarding Body | Programme/Award |
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| University of Manchester | Bachelor of Dental Surgery (BDS) |

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| Outcome of Inspection | Recommended that the programme is only sufficient for the 2024/25 graduating cohort to register as dentists |

*Full details of the inspection process can be found in Annex 1*

## Inspection summary

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| **Remit and purpose of inspection:** | **Inspection referencing the *Standards for Education* to determine sufficiency of the award for the purpose of registration with the GDC as a Dentist.** |
| **Learning Outcomes:** | **Preparing for Practice (Dentist)** |
| **Programme inspection date(s):** | **11-13 February 2025** |
| **Examination inspection date:** | **2-4 April 2025** |
| **Other meeting dates:** | **Meeting with provider 18 March 2025<br>Student Progression Committee 19-20 March 2025 (observed)<br>Second sign-up 26 March 2025 (observed)<br>Year 5 viva exam board 11 April 2025 (observed)<br>Meeting with provider 4 June 2025<br>Meeting with provider 10 June 2025<br>First sign-off meeting 17 June 2025 (observed in-person)<br>Second sign-off meeting 24 June 2025 (observed)** |
| **Inspection team:** | **Michael Rivelin (Chair and non-registrant member)<br>Clare Mcilwaine (DCP member)<br>Kathryn Fox (Dentist member)<br>Gill Jones (Dentist member; BDS final exams onwards)<br>James Pennington (Education Quality Assurance Officer GDC)<br>Kathryn Counsell-Hubbard (Quality Assurance Manager GDC)** |
| **Report Produced by:** | **Kathryn Counsell-Hubbard and James Pennington** |

The inspection of the Bachelor of Dental Surgery (BDS) (hereafter referred to as "the programme") is awarded and delivered by the University of Manchester (hereafter referred to as "the provider" or "the Division").

The programme was subject to an urgent inspection in 2022/23 following risks identified during the regular monitoring exercise. A subsequent risk-based inspection was conducted in 2023/24 where concerns remained primarily surrounding student clinical experience,

supervision ratios, and the use of student data in progression meetings. The graduating cohort was found to have met the level of the safe beginner, and the programme retained sufficiency for those students, but future cohorts were contingent on an inspection of all 21 requirements listed within the Standards for Education.

Upon concluding the first part of the 2024/25 inspection, the GDC were not assured that sufficient action had been taken to address concerns raised in 2022/23 and 2023/24. Further to this, the panel were concerned that patient harm could occur. The most significant concerns are summarised immediately below.

First, that the progression decisions for students in their final year were found not to be based on full and accurate data.

Second, that there were students who reported that they do not feel competent, supported and, at times, safe in the clinical environment.

Third, although the panel observed that the programme is run by dedicated staff, that responsible members of the programme team often work in isolation with little succession planning should an individual be unexpectedly absent.

Fourth, there was found to be limited oversight of the programme by the University and relevant clinical partners, culminating in areas of chronic underinvestment for resources to support the programme team and students, such as in the clinical area. This has culminated in a programme that is operated without the requisite funding and support to ensure that:

A) Students receive safe and appropriate levels of clinical instruction and experience
B) The programme team is monitored and supported to make decisions using formal guidance and utilising all available student experience data
C) The programme is staffed to an appropriate level both in terms of time contracted to the programme and level of experience.

The risks identified with the BDS programme are severe and required immediate action by the University of Manchester. This was indicated at the end of the in-person inspection on 13 February 2025 and communicated formally to the provider on 12 March 2025.

Following the University confirming receipt of the formal communication on 12 March the GDC have met with the provider on numerous occasions and the inspection has been concluded, comprising attending the final BDS examinations, the final BSc examinations and subsequent meeting with the programme team on 4 June 2025, as well as attending all sign-up and sign-off meetings.

The meeting on 4 June highlighted some inconsistencies in the use of clinical grades which led to further concerns that non-competent students could progress through the programme. The GDC formalised their concerns in communication from the CEO and Registrar, and the provider undertook not to sign-off any student without the explicit agreement of the GDC.

Through a concerted effort on behalf of the Division and wider Faculty, the GDC were assured as to the progression decisions proposed for the students that the provider was content to graduate. While this has been an exceptional turnaround on the part of the provider, the GDC are assured that the graduating cohort are of safe beginner level. However, the GDC remains concerned that without the inspection intervention and subsequent actions students would have been graduated without the correct levels of experience to meet the level of a safe beginner or without the necessary evidence being in place to support such a decision.

There is extensive work required from the provider to assure the GDC that ongoing sufficiency should be granted for graduates of the BDS programme. The GDC aims to work closely with the provider to ensure necessary and appropriate changes are made, continue to be adhered to, and that comprehensive, evidence-based decisions are made.

The GDC appreciates the anxieties and impact an inspection and outcome like this can have on staff and student well-being, and we have tried to be supportive to colleagues by ensuring good communications and transparency. The GDC wishes to thank the staff, students, and external stakeholders involved with the BDS for their co-operation and assistance with the inspection. The GDC has liaised with other bodies during the inspection including the Office for Students, COPDEND and the Department for Education, to whom we would also like to give our thanks.

## Background and overview of qualification

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| **Annual intake** | 68 students |
| **Programme duration** | 202 weeks over 5 years |
| **Format of programme** | **Year 1:** Basic sciences, EBL, Weekly symposia, small group teaching, simulated clinical experience, clinical experience towards the end of the academic year<br><br>**Year 2:** Basic sciences, EBL, Weekly symposia, small group teaching, learning on dental public health, simulated clinical experience, direct patient contact<br><br>**Year 3:** Basic sciences, EBL, Weekly symposia, small group teaching, Teaching on law, ethics, and professionalism, simulated clinical experience, direct patient contact<br><br>**Year 4:** EBL, Weekly symposia, small group teaching, Teaching on critical appraisal and research methods, direct patient contact, outreach programme, medicine and surgery programme<br><br>**Year 5:** EBL, Weekly symposia, small group teaching, Teaching on clinical governance, direct patient contact, sedation training |
| **Number of providers delivering the programme** | (1) Manchester University Foundation Trust (MFT)<br>(2) Bupa Dental Care (BDC)<br>(3) Morris Dental Care<br>(4) Myriad Aesthetics Ltd |

## Outcome of relevant Requirements[1]

| Standard One | |
|---|---|
| 1 | Partly Met |
| 2 | Met |
| 3 | Met |
| 4 | Partly Met |
| 5 | Partly Met |
| 6 | Met |
| 7 | Met |
| 8 | Met |
| **Standard Two** | |
| 9 | Partly Met |
| 10 | Partly Met |
| 11 | Partly Met |
| 12 | Partly Met |
| **Standard Three** | |
| 13 | Partly Met |
| 14 | Partly Met |
| 15 | Partly Met |
| 16 | Partly Met |
| 17 | Partly Met |
| 18 | Partly Met |
| 19 | Partly Met |
| 20 | Met |
| 21 | Partly 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 Partly Met)***

Before treating patients, students must pass the clinical gateways which comprise assessments of skills already acquired by the students. These gateways are conducted under examination conditions and the following grades are available:

H = Harm – Adverse outcome or there is potential to harm
U = Unsatisfactory – Unsatisfactory, poor performance
Sp = Satisfactory outcome but the tutor had to physically intervene
Sv = Satisfactory outcome but after tutor's verbal intervention
I = At the day-1 dentist level
I+ = Done above what is expected of a day-1 dentist

The gateway includes different components which are graded separately and then the lowest grade awarded becomes the overall grade for the assessment. It was identified that students were able to pass with an Sv or an Sp but that the level of intervention allowable during the assessment was not defined or monitored. Despite citing examination conditions, the programme team were unable to assure the panel that examiners do not give assistance to the students during the gateway.

The panel were advised that achieving an Sp or Sv grade was not a bar to passing the gateway but may indicate that some additional work needs to be completed by the student in that area. The protocol for determining when additional work was required, what that work was and how it was subsequently graded was not defined, and it is the decision of individual clinical tutors as to what remediation or additional experience is required. Equally, there was no mechanism for longitudinal assessment so that the provider could view a student's progression or regression throughout a period of the programme. Audits are completed on 20% of the student assessment results. The findings of the audits are used to inform calibration, although how the results of these audits are fed back into the assessments themselves was not clear.

On discussion with both staff and students, there was a lack of clarity about grades, how they are used, and what variation is possible between examiners.

During the programme inspection, the panel found that there was a high possibility that students could pass a gateway assessment without having a baseline level of competence; a student who achieves an Sp grade has necessarily required physical intervention in order for the procedure to be deemed satisfactory (but has passed the gateway nonetheless). Following the inspection and further correspondence from the GDC's Chief Executive and Registrar, the provider changed the grade required to pass at a baseline to Sv, as well as undertaking other actions at key decision points (outlined later in this report) which have given the panel more assurance that consideration of student ability is reviewed holistically.

The changes recently made by the provider have elevated their achievement of this requirement to partly met. The provider must review their grading system and complete benchmarking to determine how much verbal or practical assistance is allowable before a student is deemed to be unsatisfactory. It is also vital that any changes to the grades or their

application is fully communicated, that all student handbooks are updated, and that all staff are calibrated to ensure that grades are being awarded consistently across all parts of the programme.

**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 mechanisms for patient consent are clear. The provider advertises for patients clearly stating that treatment will be performed by students. The provider has its own consent form which explains that treatment will be carried out by a student, and what level the student is at (i.e. what year they are). There are consultation clinics at the dental hospital and patients are informed at that stage that their treatment will be carried out by a student. Patients go to a specific student treatment reception and students wear specific badges and uniforms that enable patients to easily identify who is a student and who is not. The clinics also contain notices which inform patients of this. The Trust audits the consent forms and patients are always given a copy.

When patients are triaged, they are informed that all work will be checked by a registrant. They are also given advice on when they cannot expect an appointment (outside of term time) and signposted for emergency dental treatment.

On outreach at BUPA, BUPA uses its own consent forms, of which one is for consent to treatment, and a separate one for consent to be treated by a student.

**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 programme utilises the on-site Manchester Dental Hospital for the core training of students. The ground floor clinic is the patient facility which is run by the relevant NHS Trust. Outreach placements are provided by the private dental firm BUPA and subject to their own governance measures. All sites are subject to inspection by the Care Quality Commission. The provider works with the relevant Trust who are involved in meetings discussing clinical incidents.

The panel observed that the ground floor clinic is a very large space which can hold numerous students at one time. Students reported that issues with equipment can sometimes require them to use a bay placed far away from other students in their group which can make supervision difficult. The clinic also suffers from not having portable phantom heads or other equipment for the students to use should their patients cancel or fail to attend an appointment. This means that students can be left without any constructive activity during a clinical session, which then impacts on the ongoing development of their clinical skills.

The requirement is found to be met but the GDC strongly advises that the provider considers what can be introduced to support supervision and make use of clinical time when patients do not attend.

**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 Partly Met)***

The policy is that supervision levels, in the main ground floor clinic, per bay fall between 1:6 and 1:8. As students work in pairs, a supervisor should have up to 16 students to monitor. When questioned, students and staff advised that supervision ratios were frequently worse than the prescribed limits (1:10 was cited as common, i.e. 20 students). Moreover, on occasion, due to the size of the clinic, supervisors can be overseeing students that are situated some distance apart which can cause students some anxiety about whether they are being sufficiently supported.

The panel also heard evidence of deviation from the prescribed supervision protocol. It was reported by students that Graduate Teaching Assistants (who are in theory supernumerary) are frequently relied upon by BDS students as supervisors. Programme staff gave differing accounts of actual supervision ratios and also reported clinic cancellations are very rare despite students advising that these were still ongoing. The panel did note that timetables have been expanded to include a 'back-up' member of staff to attend the ground floor clinic in the event of supervisor absence.

It was reported to the panel that, although staff absence is recorded, supervisors, particularly NHS staff, can and do book annual leave without regard for staffing levels in the ground floor clinic. This means that supervision ratios decline further. The system used to request and/or report leave/absence does not integrate with the Division's systems for compiling timetables. This can sometimes lead to short notice changes or cancellations.

The panel observed that the ground floor clinic is a very large, busy space that is not conducive to easily supervising students. It is noted that a new facility has been built in one of the University's buildings and could offer up to 16 chairs from September 2025. Given the size of the current BDS cohort, it is unclear at this stage how much the new facility will address the issues currently identified. Moreover, it is not clear that adequate numbers of new staff will be recruited to properly utilise the new clinic, without impacting on supervision in the ground floor clinic. When asked about this, the response was that staff may be pulled from the ground floor clinic to cover.

For the reasons given above, the requirement is found to be partly met.

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

The Division uses a process of shadowing and mentoring for new supervisors. Shadowing is used for 4-5 weeks before a supervisor is allocated their own group of students, and the supervisor will be mentored after this time. Two staff training days also take place each year and cover calibration. The programme team also outlined that all staff must complete mandatory training on topics such as equality and diversity although there is no central recording system to check compliance. The programme relies on the professional integrity of staff that they have completed all their mandatory training.

Graduate Teaching Assistants (GTA)'s are present on student clinics. While the Division advised that they are not used as supervisors, students reported that they will approach a GTA for assistance and to sign-off their patient interaction on the central recording system CAFS. It is unclear as to whether these GTAs have received the appropriate level of training to supervise students. Students reported that some GTAs are unsure about what their scope of responsibility is on clinic when it comes to supervising students.

During a meeting with the programme leads, it was identified that the use of the Sv grade was not uniformly understood or applied as members of staff gave differing accounts of when an

Sv grade would be appropriate. As mentioned under requirement 1, the panel were concerned about the lack of benchmarking and how use of this grade is used in practice.

The requirement is partly met due to the Division being unable to demonstrate the ability to track compliance with mandatory training and the confusion over the purpose and use of GTAs and Sv grade. The provider will need to provide assurance that GTAs are not supervising students without the requisite training and GDC registration to do so. The provider will also need to calibrate all staff as to the use of all clinical grades to ensure consistency.

**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)***

Students are introduced to raising concerns in their induction onto the programme. The subject is then explicitly taught in Year 3 alongside GDC standards. The subject is taught within small groups though a problem-based learning exercise and is then assessed summatively. The University have student support groups in place and a 'no retaliation' policy which protects individuals if they have to raise a concern.

When questioned, students were confident on how they would raise a concern. Staff and student handbooks include relevant policies, such as the Escalation of Concerns process, which details what will happen and when.

**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)***

The Undergraduate Programme Committee (UPC) discusses patient safety issues and is attended by a representative of the NHS Trust. A digital reporting portal is used to record patient safety issues which are then reviewed and triaged using a traffic light system. Significant incidents are reviewed by the Director of Undergraduate Education at the UPC.

A programme-level risk register has been in use for a year and all programme staff have access to flag risks. These are reviewed at each UPC meeting. A clear escalation policy was provided.

It must be noted that the provider has been responsive to the concerns raised by the GDC throughout this inspection. Concerns have been escalated within the School for Medical Sciences and changes have been made to the programme within a short time frame.

**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)***

Students are made aware of the fitness to practise policy during their induction onto the programme, and the policy is available online and in handbooks. This is supported by a suspension policy which includes a clear process map to guide staff. Student fitness to practise

is also covered in Year 3 alongside raising concerns. This is underpinned by case-based learning to contextualise the guidance. When questioned, students were aware of the policy and felt comfortable with raising concerns about their or a colleague's fitness to practise with staff.

**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 Partly Met)***

The programme is part of the Division of Dentistry which sits within the School of Medical Sciences. In the main, two groups undertake quality management for the programme: the UPC and the Dental Leadership Team (DLT). The UPC is a programme level group that includes student representation, while the DLT involves colleagues from across the School. An Assessment and Examination Group (AEG) is also utilised to oversee assessments and is also a programme level committee.

Transition to the GDC's Safe Practitioner Framework (SPF) is being undertaken by the Curriculum Lead who had provided the GDC with a completed Transition Action Plan. This triggered the provider to submit a Programme Modification as it was taken as an opportunity to revise the curriculum. The transition is overseen by both the UPC and DLT. However, the Curriculum Lead appears to be the only member of staff with responsibility for the transition which the panel felt was a risk considering the change to SPF is a significant one. While DLT provides some oversight from above the programme level, the support from that group (and any above DLT) was not evident, meaning that the programme is attempting to implement a major curriculum change without adequate levels of support from the University.

While the individual components are evident the panel were not assured that the overall quality framework is effective in tracking changes to the programme and utilising and responding to feedback. During inspection meetings, one staff member stated that they could make minor assessment changes without having to go through an agreed process which required auditable forms to be completed or formal approval. The panel were concerned as this indicated that multiple changes could be made without the proper approval and subsequent evaluation in place. The use of any form of feedback from receipt to consideration, implementation and response was not in evidence.

The requirement is partly met because the framework in place is not cohesive. Decisions can be made in isolation of individual members of staff and the panel could not identify how issues or changes were taken through the entire quality management process from identification to resolution.

**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 Partly Met)***

Students use 'Rate my tutor' to provide feedback about staff. Student representatives on AEG provide a summary of how students have found the assessments. There is also a student focus group at the end of the year as well as Staff Student Liaison Committee.

Peer feedback for programme staff is given and received informally during away days. The panel saw no evidence that this is used for staff development.

In response to the GDC's 2023/24 report, the provider has now developed a risk register. This is reviewed at every UPC and is accessible to all members of the committee. However, the register is being used to a limited degree as several risks, both notified by staff and identified by the panel, were not present on the register. The review of recorded risks does not appear to be governed by any guidance or policy, and it was unclear how any risks are fed upwards to a School or University-level register.

The provider advised that they make plans to address each item on the register, but this does not appear to be recorded in a way that is easy to monitor, inhibiting checks on progress. There is also no clear end point for each risk where it can be removed from the risk register because mitigation has been completed. The provider stated that 70-80% of the risks on the register have been addressed but the panel did not see evidence of this.

The provider advised that they would escalate necessary risks to the School of Medical Sciences. However, the procedure for this could not be described and no examples were given.

The panel recognises the provider's efforts to introduce the register, but the requirement is partly met for the reasons given above.

**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)***

Following the 2023/24 inspection, the provider implemented an action plan to address the issues identified at that inspection. Results from the National Student Survey (NSS) have subsequently been published and the GDC-specific action plan has been superseded by the University's NSS action plan.

External Examiners (EEs) are being used to review assessments, oversee final clinical assessments and attend sign-up meetings. EEs provide reports each year on their findings although the provider's written responses to any suggestions made is not centrally recorded. The programme's progress against any of the EE's suggestions for change is also not centrally recorded. The EE handbook it is not clear on how feedback will be used.

The panel reviewed some of the responses to EE reports where the provider advised that they would endeavour to make the changes suggested. Upon questioning, the provider advised that they will often write responses of that kind without intending to act upon the suggestion made. This caused great concern and highlighted the lack of external oversight of the programme by the School and University as the programme leads do not appear to be held accountable for what is included in their written responses to EEs.

The University previously utilised a periodic review process which meant that every programme was reviewed on a five yearly cycle. This process was "paused" in 2017 and the next is scheduled for October 2025. This means that the programme has not been rigorously reviewed by the University for nearly 8 years. Such lack of oversight means that the programme team has operated without scrutiny and also without the University being fully aware of the resources the school requires to operate the programme safely

Following the programme part of this inspection (February 2025), the requirement was found to be not met. This was based on external quality assurance being conducted by the EEs but the provider's response and use of their feedback is limited and without oversight. The School and University have neglected to provide oversight and support which has promoted poor practice within the quality management of the programme.

Since the formal notification of concerns from the Registrar the GDC have seen increased and improved input from the School of Medical Sciences. This has included attendance and participation in progression meetings and ongoing communication with the GDC to discuss and resolve concerns. The GDC has been made aware that longer-term plans for change are in process. This increased interaction and oversight of the programme has mitigated the concerns identified and demonstrated that the University can and is willing to provide increased oversight to this programme. The requirement is now therefore found to be 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 Partly Met)***

A member of staff at BUPA meets with the programme lead every other week to discuss student progress and any issues arising. These are then discussed at UPC meetings. This should allow for capturing of all concerns so that they can be addressed. Staff at outreach do not receive a handbook or any guidance on how they should raise issues with the provider.

There is a plan in place to use the CAFs system to collect and record student and patient feedback, but this was not in place at the time of the inspection.

The provider endeavours to accommodate students on outreach to ensure they attend a practice that is easily commutable for them. Students are able to discuss swapping locations with another student if possible. Reasonable adjustments are taken into account, and the University offers bursaries to help fund students travel to and from outreach placements.

The provider employs an outreach lead on a 0.1 full-time equivalent basis, which includes communication with and inspection of the outreach sites. The panel were concerned that, as highlighted in the 2023/24 report, this was insufficient time to ensure effective quality assurance of outreach. Indeed, the Outreach Lead confirmed that her work cannot be completed in the time allocated.

The provider does not have a process in place to compare the assessment grades awarded to students on the ground floor clinic with those given in outreach. This means that it is not possible for areas requiring calibration of supervisors to be identified. Staff at outreach are invited to away days with internal staff for calibration training, but not all outreach staff are able to attend. There is also training available over Zoom but it was not clear whether this was mandatory nor what the uptake was. Staff identified that questions asked by the inspection panel around calibration of outreach staff were difficult to answer and that the process is not formal.

The requirement is partly met. Patient feedback would be a useful tool, especially in light of the concerns raised under Standard One concerning the ground floor clinic. The outreach programme requires sufficient resources to adequately inspect and quality assure the placements, particularly as the number of placements has increased. The mechanism for training outreach supervisors also requires formalisation.

**Standard 3– Student assessment**
**Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task.**

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

The programme utilises a range of assessments, clinical targets and formative 1-2-1 progression meetings with students to inform the programme team as to student attainment. However, significant concerns with how progression decisions are being made were identified at the programme inspection and were fed back to the provider via a formal letter from the Registrar.

At the programme inspection, the panel attended a sign-up meeting within which data was presented in an anonymised format and included the numbers of procedures completed clinically. The GDC had directed an action point following the 2023/24 inspection for the data to include information such as the complexity of procedure and the level to which it had been completed, as the panel at that inspection were concerned that students could progress through the programme completing simple procedures to a minimally competent standard. The depth of the data discussed at the sign-up meeting did not demonstrate that the programme team could be assured that students had completed procedures to the complexity and competency required to be a safe beginner.

Similarly, there was no process to review the longitudinal assessment of clinical competence and professionalism over time, because the data did not allow for such an assessment to be made. Competence against other non-technical skills, such as communication, professionalism, and management and leadership was not considered, and students were therefore held back or allowed to proceed to their final summative assessment without their total abilities as dental professionals being discussed. The panel noted the card system in place, but did not find that it adequately addressed our concerns about assessing professionalism as it did not allow for ongoing, lower levels of unprofessional behaviour to be identified or discussed.

Guidelines and policy governing sign-up decisions were not in evidence. It was unclear why some students were not allowed to progress and why others were; there was no reference to any policy or procedure which outlined exactly the level of competence (as per their grading scale detailed under requirement 1) and the complexity of procedures a student should reach to progress or not.

The data used identified students by their student number only in the interests of fairness and to eliminate staff bias. However, on several occasions when reviewing the data, staff felt that they were able to identify students and therefore give some context or background as to why they might not have achieved as high numbers as other students. Decisions were made based on this context without any checks being made to ensure that the staff member was correct about the student they thought they had identified. It was identified on one occasion during the meeting that staff were incorrect about the identity of a student. This also means that different outcomes could be awarded to students with similar data without reference to any rules or guidance permitting the committee to do so. The panel found that this reduced the equity and robustness of the sign-up process as it would be possible for two identical students to be given different outcomes based on anecdotal evidence.

It was observed on a number of occasions, including the sign-up meeting and the Student Progression Committee (SPC) meetings, that the outcome a student obtained was influenced by the decisions for students immediately prior. For example, staff made comments about how many clinical skills a student had completed relative to other students in order to justify provisional sign-up. Equally, it was repeatedly observed that multiple members of the sign-up committee would not contribute to discussions, and the recommendations of those who did speak were rarely discussed or challenged.

Outside of sign-up, it was also found that OSCE assessments did not appear to be robust. Due to compensation between OSCE stations, the panel identified a risk in that a student could pass the assessment by achieving a very high score for a limited number of stations but a very low score in many of the others. An example was highlighted to the provider by the panel where a student had failed four out of six stations, with scores as low as 20%, but still passed the overall assessment. The panel noted that a stipulation for the forthcoming diet of examinations has been added to the 2024/25 Assessment Handbook that a minimum overall score of 50% with a pass at a minimum of half the stations.

The marking system and use of compensation indicated a high risk of students progressing through and graduating from the programme with poor skills in multiple areas as these can be masked by stronger skills in other areas.

The panel were concerned that decisions on appeal relating to student progression are decided solely by the Assessment Lead in the first instance without consultation with colleagues or formal committees. This process means that significant decisions are left to one individual to decide upon alone, which does not support the individual.

The panel went on to attend all the subsequent sign-up, SPC, final clinical viva assessment, exam board and sign-off meetings with a view to ensuring that all students were meeting the level of a safe beginner. The SPC meetings were observed online and the panel were concerned that three students were met with and spoken to without notes being taken of the meeting. It was also not clear what evidence was reviewed in preparation for the meeting to support the decisions being made nor whether a copy of the notes was shared with the student or any subsequent SPCs sign-up or sign-off committees.

The final clinical vivas were largely found to be well-run with an effective use of EEs, particularly when reviewing the recordings for the D and E fail grades. All the exams were run to time. The briefings ahead of the vivas were useful to observe although the provider may wish to consider running more rigorous calibration sessions further in advance of all the vivas. This was highlighted in one of the examinations by the need to return for a second briefing after the first candidate. Recalling examiners back to the briefing session could lead to difficulties in timekeeping and would not be needed if examiners were aware of the standard required in advance. This also means that students marked before examiners are recalled are marked differently to those following later. It was also noted that not all the examiners had arrived by the time the briefing began, which the provider should also consider addressing. The vivas exam board was found to be well-run and accurately conveyed the student results.

After the BSc Hygiene and Therapy final clinical vivas, the panel took the opportunity to meet with the provider to gain clarification on the documentary evidence kindly provided. During that meeting, it was identified that an understanding of the Sv grade was not uniform across all members of staff. While some staff stated that Sv would be given to students who simply required assurance of their completion of a procedure, others awarded the grade when a student had had to have verbal instruction to complete a procedure satisfactorily. This, combined with the lack of benchmarking discussed under requirement 1, caused concern, especially as the grade that is at the level of a day one dentist, a safe beginner, is actually stated in the handbooks as the I grade.

Feedback was given to the Registrar of the panel's concerns. Upon notification of the GDC's concerns from the Registrar, the provider agreed to postpone the first sign-off meeting and not to graduate any students without the GDC's explicit agreement. The inconsistencies in the use of the Sv grade, along with the sustained absence of progression against actions set down in the 2023/24 report, gave the GDC significant concerns that student data may not be used to a sufficient standard that progression decisions were evidence-based and to the correct standard.

Following communication of this and assurances as detailed above from the provider, a contingent of the panel attended the sign-off meeting and observed significant and effective changes to the sign-off process.

Sign-up and sign-off meetings observed in 2023/24 and in February 2025 showed a lack of consideration for the depth of student knowledge and experience, focussing on total numbers of different clinical procedures. Insufficient analysis of student data was observed at those meetings. At the meeting on 14 June 2025 (the first sign-off meeting of the academic year) the provider broke down the student experience so that all assembled could see achievement of clinical competencies and the grades achieved for each milestone assessment. The provider had also calculated a 'confidence' factor (known as the C Factor) for each student that was designed to give a snapshot as to the student's overall competence. This was calculated as being:

$$\frac{\text{number of Sv/I/I+ grades}}{\text{number of total grades}} = \text{C Factor \%}$$

Expected % are Median minus 1 x SD
This year is used as its own control

The provider had also calculated the percentage of grades in the Sv, I and I+ range for the different domains marked following a patient procedure, being quality of treatment, student knowledge and preparedness, professionalism, and communication. Benchmarks were provided for each domain (being the lowest percentage that the provider would ideally accept from a graduating student) and percentages were calculated for both the September to January period, before GDC feedback was received, and then for the entire year.

These additional calculations allowed for a depth of scrutiny to take place. The committee could see how students had progressed and gained additional assurance as to their overall competency from the C Factor, which played a significant role in the discussions.

The provider had also been proactive in making sure that students were contacted prior to sign-off where they had missing procedures or milestones to complete. Students were asked to explain how they would be able to make up the shortfall in time for the final sign-off meeting. Having this information readily available meant that the sign-off committee could see whether or not the student had the patients in place to address any gaps. The provider also took the step to create three lists of students at the first sign-off meeting, being those students who had met the criteria to be graduated, those who needed to complete further procedures or milestones and would therefore be discussed at the final sign-off meeting, and those students who would not be graduated.

The structure of the first sign-off meeting was mirrored at the second and final sign-off meeting. Additional mechanisms to support students in meeting the deadline were implemented such as

a shorter completion time for laboratory work, increased clinical sessions, and a request to all clinical supervisors to ensure written milestones were marked in a timely manner. All of these mechanisms meant that the students who had to be referred to the second sign-off meeting completed their outstanding work within six days, which enabled the provider to bring the second sign-off meeting forward.

The achievement of all but four students graduating the programme is one that has taken significant resources and required a heightened dedication of programme staff, particularly the Assessment Lead. While the provider was successful in assuring the GDC of their students' safe beginner standard, it must be noted that the activity needed to give that assurance is not sustainable in terms of staff or student wellbeing. Earlier intervention with students to ensure that they are meeting their clinical objectives is a crucial step in the Division achieving long-term sustainable success, and for decreasing the amount of GDC oversight required.

The provider has taken significant steps forward in addressing issues identified by the panel. However, the requirement is partly met on the basis that these changes may not have occurred without the significant amount of GDC oversight. Concerns still remain as to the proliferation of satisfactory clinical marks awarded, as opposed to I or I+ grades, even at an advanced stage of the programme. Ongoing monitoring of students also needs to be strengthened to ensure that the stress on staff and students in marking all the work, making additional clinics available to students, and in completing those procedures is not repeated, or at least lessened, for future cohorts.

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

The provider is now using a system called CAFs which has been seen to be effective in other schools. Evidence presented at the inspection indicated that the system is not being used to its full capability as the data being recorded does not allow for proper analysis. The panel felt that the provider may benefit from partnering with another dental education provider to see how the system can be used to best effect. At present the implementation of CAFs is ongoing and the school is working closely with the developer to produce their bespoke product.

During a progression point, such as a sign-up meeting, students can be referred to a Student Progression Committee (SPC) where their attainment is considered in greater detail. Referral to SPC appeared to be very subjective as the panel was not presented with any clear policy or thresholds about when referral was necessary.

The panel were informed that struggling students may be identified in a one-to-one meeting between students and the Year Lead which are held once or twice per year. However, upon questioning students it was identified that these meetings are often very short (of around 15 minutes) and do not cover the depth of student attainment required to identify longitudinal issues.

Downloads from CAFS were provided to the panel following the final clinical viva assessments and reviewed. These revealed that multiple entries were incomplete and did not include supervisor feedback or student reflection.

The requirement is partly met because, while a central recording system is in place, and this can be reviewed by the programme team at any time, the data collected and the subsequent review of that data is not robust. The panel were not assured that a struggling student would be identified. It is understood from the provider that discussions are taking place with the CAFS software developers to ensure they are better able to capture the data required which will be a

positive step forward. The provider must also ensure that entries onto the system are complete.

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

Students treat a range of patients at the Manchester Dental Hospital and while at the outreach BUPA placements. Students also have the opportunity to observe specialist clinics. Occasionally the provider advertises for patients and take-up for this is very good. Some challenges remain in terms of patient flow, as there is a delay between patients being referred to the student clinic and such patients being triaged and suitable candidates being added to student treatment lists. Lower year students found it difficult to get the patients they required to complete their milestones.

Milestones are written or observed practical components. These are in addition to gateway assessments and clinical targets, and are defined in the student handbook. Some students with whom the panel met felt that there were not enough milestones to allow their clinical competence to be fully assessed. Students must inform their supervisor that they wish to complete an observed milestone ahead of completing the treatment, and supervisors are required to review the student's CAFS record to see how the student has performed in that particular procedure previously. When questioned, staff and students said that this did not happen in every case, thereby meaning that students may be regressing from a previously high level of competency to an Sp or Sv without such a regression being identified and duly flagged.

Patients requiring multiple treatments can have their care shared, meaning that multiple students can practise different procedures on one patient. However, the arrangement for this is informal as students are required to work as a team and decide when to share patient care. The shared care arrangement is subsequently noted in the patient's notes. Similarly, the provider currently does not have a patient coordinator to ensure that students get the experience they need. The provider advised that an individual was in post for a short amount of time but they have not been replaced. The panel considered this to be a significant concern as the lack of a coordinator could lead to difficulty in students in getting the experience they need. A patient coordinator could also help to formalise shared care arrangements.

Students also reported issues with having the correct instruments available when patients do attend.

The panel noted that the clinical experience students gained treating paediatric patients was low in comparison to other schools. Some students had only just completed their paediatric rotation which meant that they were acquiring the experience required to graduate from the programme very close to the graduation date. Similarly, some students had only just completed their radiography rotation which caused a rush to complete milestones.

The requirement is partly met due to the inconsistent review of student experience and the lack of patient coordination ensuring an adequate and appropriate flow of patients and formalisation of shared care.

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

Assessments are governed by University processes and the programme's own Handbook for Assessments 2024/25. The weighting for each summative assessment is clearly defined, as are the targets for the longitudinal clinical assessments. The provider informed the panel that psychometric reports are compiled but no other data analysis reports have been seen. All statistical analysis is completed by the programme lead without support or collaboration from the wider University structure.

Assessments are reviewed by the AEG and minutes from that group were provided. These demonstrated discussion on the assessments as whole, such as timings and markers, but did not include any form of systematic review of individual assessment methods and whether these are still being tested appropriately. Limited use of psychometrics in determining poor performing questions was seen. The panel were concerned by the compensation (discussed under requirement 13) utilised and found that, due to the limited involvement of the School of Medical Sciences and wider University until the point that GDC concerns were notified, the programme team had little support or resources to ensure that assessments are robustly reviewed and updated. Assessments appeared to be reviewed by the Assessment Lead and Director of Undergraduate Education only with no evidence of a committee to support these individuals.

The requirement is partly met due to the limited formal review evidenced.

**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)***

Manchester Dental Hospital will obtain patient feedback at random intervals and will share any that relates to students.

As described earlier in this report, the quality management of the programme requires improvement. This extends to the use of feedback as there is no policy or procedure for the consistent collection, recording, review and actioning of any feedback received.

Students advised the panel that they receive feedback (via the I/Sp/Sv grading system) on every patient interaction but that this can be received days or even weeks after the treatment has taken place. Students also informed us that it was rare to receive any free-text written feedback. Consequently, the usefulness of such feedback was variable. Feedback from students via the NSS was negative.

To meet the requirement the provider must ensure formal collection of feedback from all sources. This feedback must be logged centrally and demonstrably used when considering student assessment.

**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 Partly Met)***

Feedback to students can be completed on CAFS at the end of each clinical interaction. The system is available online and across all clinical areas. Despite this availability, students reported that feedback is not always completed on the system and is often provided verbally. The level of feedback given was also inconsistent, being dependent on the supervisor's availability. This was evident in the sample of CAFS provided to the panel, and staff advised that feedback was only mandatory if a student received a U or H grade.

The support provided by tutors and supervisors was generally felt to be good by the students. The feedback given on clinic can be effective, and one group of students described the staff as

"amazing", but this does not appear to be consistent across all student groups. Some students in Year 4 felt that preference was given to the final year cohort which impacted on the amount of support they received.

Student reflection is included on CAFS and must be completed; however, it was noted in the sample of CAFS provided to the panel that reflections were not always completed by students. Not completing the required reflection can have an adverse effect on a student's professionalism score. The students who met with the panel were aware of the need to reflect and the mechanisms for this.

To meet the requirement the provider must ensure that feedback is consistently given, and feedback consistently completed, on CAFS.

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

The panel heard that induction onto the programme for new members of staff involves shadowing and mentoring. Examiners are calibrated twice a year and briefings given ahead of final clinical examinations.

While formal clinical supervisors are appropriately registered, the panel were concerned that students reported being supervised by Graduate Teaching Assistants, particularly as these individuals are not included within calibration exercises. It was also not clear whether such assistants have been inducted and trained to supervise and potentially assess students appropriately.

Mandatory training is required by the University but it is not possible for the programme team to check compliance with this, so the panel could not be assured that all assessors had completed this.

Limited evidence was provided in respect of assessor calibration, and the briefings observed ahead of the final clinical exams did not give adequate time for the examiners to be clear on what the safe beginner level looked like. Calibration events also do not appear to be mandatory, and it was not clear whether such events included supervisors at the outreach placements.

The requirement is partly met. The provider must ensure that calibration for examinations is completed ahead of the exams to ensure that ample opportunity is allowed for the standard required to be understood. Calibration should, as far as possible, be mandatory and should include outreach supervisors. The provider must also ensure that if Graduate Teaching Assistants are supervising students then they are appropriately trained and included in calibration events.

**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)***

A number of EEs are in place to oversee different assessment elements of the programme. These examiners were present for the final assessments that dealt with their particular specialism and were able to observe all the examiner pairs from within the Division. The EEs also attended the pre-assessment briefing and, more crucially, had specific responsibility for reviewing the recordings of those students who had been awarded one of the fail grades (D or

E). Different elements of each viva were marked and if any such element were only of a D or E standard then that grade would be applied to the entire viva. As this could determine the pass or failure of the entire final clinical assessment, comprising three separate vivas, the EEs were called on to listen to the recordings and determine whether they upheld the internal examiners' decision or felt that this required revision. The panel felt that using the EEs in this way and recording the exams constituted good practice.

The panel also reviewed the external examiner reports and found these to be appropriate. EEs were present at the sign-off meetings and had the opportunity to contribute to the discussions.

**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 Partly Met)***

Angoff is used for standard setting assessments and marks are normalised to work within the University-set pass mark of 50%. Marking matrices were in use for the final clinical vivas and EEs are able to review written papers.

The assessment handbook was reviewed and found to be well written. A separate handbook is used to inform students about gateway and milestone assessments. This includes the marking sheets supervisors will use so the students are well informed as to how they will be assessed.

The grading criteria used did not appear to be fully understood by the students, and it was not clear if higher grades were expected as students progressed or based on the complexity of the procedure. Similarly, from discussions with staff it appeared that an understanding as to the use of the 'satisfactory' grades was inconsistent. The panel felt that this could be addressed with more robust calibration, and for this reason the requirement is found to be partly met.

## Summary of Action

| Requirement number | Action | Observations & response from Provider | Due date |
|---|---|---|---|
| 1 | 1. The provider **must** ensure that gateway assessments are conducted according to internal criteria that mitigates against variation between examiners. | We have established an enhanced programme of staff development workshops as part of our new PRiDE (Professionals in Dental Education) programme, the first of which was delivered the week commencing 22nd September 2025. The programme has been aligned with PRiME (Professionals in Medical Education) which has been well received by the General Medical Council (GMC) in our medical programme.<br><br>As part of PRiDE, all tutors will be trained on the newly defined grade descriptors to ensure consistency and the protocol for gateway assessments along with clinical activity and milestone assessments. This is part of an annual mandatory programme of staff development rather than a one-off activity and has been well received by attendees. To enable us to evaluate and measure effectiveness, we are embedding an audit process so that we can verify the consistency of application of clinical grades.<br><br>According to the new grade criteria, the pass mark for gateway assessments is S (Satisfactory) – see observation and response to action number 2. This has been communicated to students and is contained within our student facing materials on our new learning environment Canvas, and within the programme handbook. The quality assurance of gateway assessments is embedded in the role description of the Clinical Skills Lead, who is responsible for coordinating | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | calibration events, overseeing audit sampling of gateway results and reporting outcomes to the Assessment and Examination Group (AEG) for review. | |
| 1 | 2. The provider **must** review the grading scale to ensure that only students who are competent pass the gateway assessments. | In response to GDC feedback, the programme has undertaken a comprehensive review and revision of the clinical grading system. The revised scale was approved by the Assessment and Examinations Group (AEG) in August 2025 following consultation with Faculty Quality colleagues, External Examiners, and student representatives.<br><br>The grading system was implemented from September 2025 and forms part of the PRiDE (Professionals in Dental Education) staff training framework including outreach colleagues.<br><br>The new grade scale has been communicated to students by the Assessment Lead in their year group inductions, and to staff in mandatory PRiDE staff training sessions. According to the new grade criteria, the pass mark for gateway assessments is S (Satisfactory). The grade descriptors are also explained in the programme handbook and in CAFS (Complete Assessment Feedback System) where gateway assessments are recorded. | |
| 1 | 3. The provider **must** formalise the mechanism for requiring additional work by a student on a specific area of clinical practice following a gateway to ensure that this is a | Student progression through clinical gateways will be monitored at formative clinical activity review meetings (which have a defined terms of reference and will meet twice per semester to review student clinical practice including milestones, gateways and general clinical | |

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| | transparent process adhered to by all staff. | procedures and observation) and at progression exam boards. Where a student is found to require additional support from multiple failed gateways, or for other reasons such as reduced attendance, a support plan will be determined by the clinical activity review committee which will feed into a student development review meeting for the Year Lead to take forward with the student in question.<br><br>A protocol has been developed to ensure that all staff understand their role in this process, and part of this identifies the need for standardised responses for additional support. The pass mark for gateway assessments if S (Satisfactory) which has been covered in the PRiDE staff development workshops mentioned in the response to action 1. | |
| 3 | 4. The provider should consider how the clinical environment can be made more conducive to the supervision of students. | The majority of undergraduate clinical teaching takes place within facilities operated by our placement provider, Manchester University NHS Foundation Trust (MFT). The programme continues to work closely with MFT to ensure that the environment remains safe and conducive to effective clinical supervision and patient care.<br><br>The main restorative clinic (Ground Floor Clinic) operates as an open-plan environment with a defined staff-to-student ratio compliant with Dental Schools Council guidance. Improvements which have been implemented for this academic year include a zonal supervision model, whereby tutors are allocated to specific areas of the | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | clinic to enhance visibility and support for students under their supervision. The presence of senior clinical staff has also been increased at key teaching times to support less experienced supervisors and ensure immediate escalation where needed.<br><br>Senior colleagues from the School of Medical Sciences (SMS) and Division of Dentistry attend the twice monthly Trust liaison meetings and we will continue to work in partnership to consider what further enhancements might be made for this action point. | |
| 3, 15 | 5. The provider should introduce activities to the clinical environment for students to complete if patients do not attend, such as portable phantom heads. | We have worked with our main clinical provider, MFT, to consider how to provide additional activities for our students in the event that patients do not attend. Staff and students have access to the MFT Hive system, which shows a complete list of the daily clinics running on any session. If a patient fails to attend a scheduled appointment, students are expected to stay in clinic and can practice suitable procedures on each other. They also have the opportunity to attend and observe consultant restorative clinics.<br><br>In addition, the option to enhance this arrangement is under review in order to ensure that all students have easy access to other activities in the Manchester Dental Hospital (the Dental Hospital) which are timetabled on a daily basis. | |
| 4 | 6. The provider **must** create a mechanism whereby the timetabling | Timetabling of clinical sessions follows defined processes led by the Faculty Scheduling Team. The | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | of clinical supervisors is robust and based on known availability. | annual leave of all clinical supervisors is recorded on the MFT managed system to which the Faculty Scheduling Team have access. However, timetabling occurs prior to the start of the semester which is longer than the 6-week notification timeline required for a clinician to request leave and cancel a clinic. This can mean that timetabling is accurate at the time of production but in-semester changes lead to a poor student experience and confusion in the timetable.<br><br>We are currently working with the MFT to identify whether we can change the process and timetable students to a clinic rather than an individual clinician. A further potential change that we are considering, is for MFT to be responsible for the timetabling of specialist clinics rather than the University. Discussions are currently taking place between the School Head of Teaching, Learning and Student Experience, Faculty scheduling colleagues, the programme year leads and representatives from MFT. This is a key priority for all concerned. | |
| 4 | 7. The provider **must** provide a statement to explain how the new dental facility will impact on undergraduate dental students. | The new Advanced Dental Education Centre (ADEC) has been established as an additional clinical teaching facility to expand, rather than redistribute, existing undergraduate clinical capacity. The main Restorative Ground-Floor Clinic at the Dental Hospital remains the primary base for undergraduate teaching and continues to operate at full capacity with its existing supervisory team. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | A Clinical Lead for ADEC commenced in role in April 2025 and additional clinical staff (including tutors) have been recruited to run the facility adhering to the same staff:student ratio policy used in the Ground Floor Restorative Clinic.<br><br>The facility underwent a positive CQC inspection at the end of September 2025 and will be operational imminently. | |
| 4 | 8. The provider **must** review the ground floor clinic and implement any changes necessary to ensure the consistent supervision of students and the safety of patients. | The staff:student ratio policy has been reviewed by the programme in conjunction with the Dental Hospital to ensure it is fit for both patient and student safety. We are working closely with the Dental Hospital to ensure that senior clinical cover is provided during all clinic sessions. Our staff:student ratio complies with Dental Schools Council guidance.<br><br>Over the Summer we have also carried out a recruitment drive for new tutors to significantly bolster cover within the Ground Floor Clinic cover which brings us to a full complement of staff. We are confident that this will address staff:student ratio concerns with the role description stating that they will be expected to take annual leave out of term time.<br><br>All new tutors are being inducted and calibrated through the PRiDE (Professionals in Dental Education) staff-development framework (see response to action 1) and will receive ongoing mentoring from senior colleagues. | |

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| 5 | 9. The provider **must** create a process for checking that staff have completed mandatory training. | All University members of staff who work in the Dental Hospital have an honorary contract with the NHS Trust. All University members of staff are required to complete a programme of essential training which is recorded and stored by the University's central People Directorate. We recognise that there are additional elements of training which are required of clinical colleagues which are hosted and recorded on the MFT system.<br><br>Our Operations Team within the Division of Dentistry are putting in place a new records management system (working with MFT and the University's People Directorate) so that mandatory training records from both the University and MFT can be kept at Divisional level, which will give us greater visibility of this area. As part of this we will also be including elements of our new staff development programme PRiDE which relate to the new grade criteria.<br><br>We are currently working with MFT to explore the inclusion of a clause in honorary contracts that specifically addresses mandatory training requirements | |
| 5, 19 | 10. The provider **must** provide a statement about the use of GTAs, what their role and purpose is in the clinical area, and whether they are supervising students. | The Graduate Training Assistants (GTAs) role and purpose is to provide additional support for students in clinical areas. However, all work completed by our students will be signed off by GDC registered individuals.<br><br>We have revised the role description of GTAs to ensure additional sections related to clinical supervision | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | establish scope of practice. GTAs are no longer able to access the record of student activity on CAFS and all student activity requires sign off by a GDC registered member of clinical staff. | |
| 9 | 11. The provider **must** ensure that the quality management framework is fully evidenced and that a defined change management process is in place to prevent changes being made to the programme in isolation. | All curriculum and assessment changes have now been through the University's regulatory and approval process by way of programme amendment. The changes have been approved by the Faculty and recorded at School level by the Curriculum and Programmes team.<br><br>As such, the new and better-defined governance structure for Undergraduate Dentistry was implemented from the start of this academic year and this provides a clear reporting route to the School of Medical Sciences Teaching, Learning and Student Experience Executive (School TLSE Exec). This will prevent any changes to the programmes being made in isolation. | |
| 10 | 12. The provider **must** implement a mechanism for the formal consideration of items on the risk register and note when risks have been addressed with how this has been accomplished. | Since the inspection we have considered this feedback and made significant improvements to the detail which is captured within the Programme(s) risk register.<br><br>From the start of this academic year, the risk register will be considered at each monthly meeting of the Undergraduate Programme Committee and reported to the School TLSE Exec to ensure that the School is aware of risks to programme delivery. This will feed up to the Faculty TLSE Exec and Leadership on a quarterly basis. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| 11 | 13. The provider **must** implement a formal mechanism for the recording and consideration of feedback from external examiners. | All External Examiner reports are received by the University's Division of Student and Academic Services within the Directorate for the Student Experience where they are processed and disseminated to the relevant Programme Director and School Assessment and Progression Team.<br><br>BDS and BSc Programme External Examiner feedback falls within the remit of the Assessment and Examinations Group and the action log/recommendations are considered at their monthly meetings. In addition, each External Examiner is provided with an examiner pack which contains an overall 'you said' 'we are working on' and 'we plan' summary. The action log/feedback from External Examiners is further considered by the Undergraduate Programme Committee to ensure progress.<br><br>We are finalising a more defined protocol which will see this being reported up through the programme(s) to the School TLSE Exec to ensure we document a transparent process for actioning the feedback. | |
| 11 | 14. The provider **must** ensure that written responses to external examiner feedback truly reflects how the feedback will be used for programme management. | Currently we are finalising a more robust system to address External Examiner comments ensuring they are embedded in action plans that are tracked at both programme and school level (see response to action 13). | |
| 11 | 15. The provider **must** be subject to regular review by the School of Medical Sciences and the University | As stated in the response to action 11, the governance structure of the programme(s) has been revised and strengthened since the inspection with the programme(s) | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | of Manchester to ensure adherence to best practice and to identify support needs. | reporting directly to the School of Medical Sciences TLSE Exec. This is to ensure correct quality assurance processes are followed in accordance with University regulations.<br><br>The School TLSE Exec reports directly to the decision-making body of the School, the School Executive Team, and also to the Faculty TLSE Executive, again ensuring operational support and investment, along with education quality oversight. Furthermore, The Vice-Dean for TLSE and the Faculty Head of TLSE are amongst the membership of the Faculty Executive which is the key governing and decision-making body for the Faculty. The Faculty Exec holds monthly strategic meetings and weekly operational meetings to oversee key priorities and this group reports to the University's Teaching and Learning Strategy Group where appropriate.<br><br>The Programme was subject to a University level periodic review on 22nd October 2025 as part of the oversight of the programmes. In addition, we are also currently in the process of a UNIAC audit which has been commissioned by the Faculty. UNIAC are independent internal audit and risk management consultants dedicated to support UK universities and higher education institutions | |
| 12 | 16. The provider **must** gather patient feedback and use this to quality assure the clinical environments. | Patient feedback is gathered routinely in clinical environments and any concerns regarding patients treated by students is reported to the programme. We are working with MFT and outreach partners to identify | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | whether we can enhance the amount of feedback obtained from patients treated specifically by our undergraduate students.<br><br>We are also in discussion with CAFS about the inclusion of patient feedback within the system. | |
| 12 | 17. The provider **must** implement a substantial outreach lead post to ensure appropriate quality assurance. | We recognise that our Outreach Lead is stretched in her role, and we are currently working to identify ways to embed and support the role more substantially.<br><br>We are looking at additional support via the clinical delivery model we use elsewhere in the Faculty with Professional Services support working alongside the Outreach Lead. This will ensure that the Outreach Lead has a support network to enable robust quality assurance of our providers. | |
| 12 | 18. The provider **must** implement a formal mechanism to train outreach supervisors. | Colleagues at our outreach providers have already attended our new mandatory PRIDE induction sessions (see response to action 1) in September 2025.<br><br>In addition, we are in the process of establishing a page on our virtual learning environment (Canvas), which will contain all information relating to staff development opportunities and will include information such as details of face-to-face workshops; an e-learning module on how to mark all assessments and milestones as well as written exams, OSCEs and VIVAs; information on annual away days and a compendium of learning resources. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| 13 | 19. The provider **must** use full and complete data when making progression decisions. | We established a different method of considering student clinical activity data at our sign-up meeting on 26th March 2025 and further developed the data presentation for the exam board on 14th June 2025.<br><br>We intend to continue to consider data in this detail at all clinical activity review meetings and exam boards and have been establishing systems to ensure we are able to consider the data in this way. Recognising the comments in the report that our methods were not sustainable, we have worked with data analyst colleagues within the School and trained our Professional Services staff to ensure we will be able to maintain this level of detail. We also continue to work with the developers at CAFS to ensure we are using the system as effectively as possible. | |
| 13 | 20. The provider **must** implement guidelines for the handling of anonymised data and introduction of any mitigating circumstances during progression meetings. | The University regulations require all progression exam boards to be carried out anonymously and we have further tightened up our processes and reminded colleagues of the requirement. Going forward, all exam boards will be chaired by the School's Director of Education (or deputy) to ensure University regulations are adhered to.<br><br>Sign-up meetings are recognised as exam boards with terms of reference that align with the University's formal Guidance on Examination Boards. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| 13 | 21. The provider **must** review their current use of compensation in clinical summative assessments to ensure that such assessments do not allow nominally competent students to progress. | Each student must pass at least 50% of the stations.<br><br>In order to successfully pass a station, students must achieve a pass mark of 50% or above. This is clearly communicated to students via the student handbook. | |
| 14 | 22. The provider **must** ensure that an appropriate amount of detail for each patient procedure is collected so that reviews of student experience are based on robust sets of data. | The need for an appropriate amount of detail for each patient procedure recorded in CAFS is covered within our PRiDE staff development programme (see response to action 1).<br><br>Going forward compliance with regards to the quality of the detail recorded in CAFS for each student against a clinical procedure will be monitored by the Assessment Lead or deputy to ensure that there is robust and defendable information/data for decisions on progression. | |
| 14 | 23. The provider **must** continue to work with the developer to ensure that their use of CAFS is as effective as possible. | Our Assessment and CAFS Leads have been working with the developer throughout 2025 and have ensured that the system is now updated with the new grading criteria and also includes the complexity rating for procedures.<br><br>We recognise that the assessment schedule of our programme limits the way we can present data on CAFS. We will continue to consider how we can use the system with effective student assessment as a longer-term goal. The School Head of Teaching, Learning and Student Experience is also working closely with CAFS to identify how other institutions are successfully using the system for both assessment and feedback, and other | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | elements of the programme such as attendance monitoring.<br><br>We intend to continue to develop this partnership. | |
| 14 | 24. The provider **must** implement a stringent review policy so that student data is checked in enough depth on enough occasions to identify struggling students. | As stated in the response to action 3, student progression through clinical gateways will be monitored at regular formative clinical activity review meetings and at progression exam boards.<br><br>Where a student is found to require additional support from multiple failed gateways or for other reasons such as reduced attendance, a support plan will be determined by the clinical activity review committee which will feed into a student development review meeting for the Year Lead to take forward with the student in question. | |
| 14 | 25. The provider **must** ensure that policies regarding progression meetings are stringent and understood by all members of staff to ensure that consistent decisions are made. | The regular clinical activity review meetings and progression exam boards have established terms of reference that have been shared with the committee members.<br><br>A policy has been developed alongside these to ensure that consistent decisions are made. | |
| 15 | 26. The provider **must** ensure that processes are adhered to when students ask to complete an observed milestone. | This requirement overlaps with actions 1 and 2, appreciating these are focussed on gateways rather than milestones. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | As mentioned previously in the response to actions 1, 2 and 3, all tutors have completed mandatory training (as part of PRiDE) focussing on clinical grading and the process of assessing milestones and gateways in September 2025. | |
| 15 | 27. The provider **must** formalise the shared care arrangements for patients to ensure that this is appropriate and within the principles of good patient care. | We are working with our main placement provider, MFT, to recruit a Patient Coordinator in order to identify shared care requirements and ensure a process is established and completed.<br><br>We aim to have this person in place by January/February 2026. | |
| 15 | 28. The provider **must** provide support for students to access patients required to meet clinical targets. | Our main placement provider, MFT, has triaged a large cohort of patients over the Summer and has developed a volunteer patient register to ensure the availability of more patients suitable for undergraduate education in restorative dentistry and oral surgery. The volunteer patient register is accessed as a sign-up system on the Dental Hospital website and is proving to be very successful.<br><br>In addition, we also work with a number of outreach providers to provide alternative clinical experiences for students, | |
| 16 | 29. The provider **must** formally review assessments on a regular basis and document the changes made as result of such reviews. | As part of the newly defined governance structure (as described in action 11 and action 15), the Assessment and Examination Group sub-committee has assessment design and emendation as part of its terms of reference. | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | This sub-committee is scheduled to meet monthly and review of assessments will be considered at the November, December, January, February and April meetings. | |
| 17 | 30. The provider **must** collect feedback from different sources and use this within student assessment. | The main source of feedback for the assessment of students is via CAFS. The requirement for detailed and quality feedback has been covered in the staff development sessions (PRiDE), the first of which was delivered in September 2025. Accompanying guides and video tutorials have also been developed and will be accessible to all staff on our virtual learning environment Canvas. The overall progress of a student will reflect on academic achievements, patient and tutor feedback, and milestone and gateway assessments.<br><br>We are also strengthening the message to our students that they should not leave clinical sessions without a debrief with their tutors. | |
| 18 | 31. The provider **must** ensure that feedback is given in a consistent and timely manner. | See response to action 30 above.<br><br>Colleagues are aware that the feedback in CAFS is required to be submitted and signed off within 24 hours of treatment. The Assessment Lead and (or) Deputy Assessment Lead will be monitoring this and will address any lapses in protocol with the tutor(s) in question.<br><br>In the case of poor practice, this will be escalated to the relevant line manager and the Head of the Division of | |

| Requirement number | Action | Observations & response from Provider | Due date |
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| | | Dentistry where appropriate. The Clinical Delivery Committee holds responsibility for ensuring CAFS is completed in a timely manner. | |
| 19 | 32. The provider **must** ensure that if GTAs hold supervising responsibility then they are included within all staff training and calibration events. | See the response to action 10 detailing GTA roles and responsibilities.<br><br>All GTAs who are involved in teaching will not be the primary supervisor. All clinical work will be signed off by a tutor who is GDC registered. | |
| 19 | 33. The provider **must** ensure that calibration of supervisors, assessors and examiners ensures that the standards required of students are fully understood. | We are addressing this with the comprehensive staff development programme (PRiDE) which was rolled out in September 2025 and will become an annual programme.<br><br>In addition, the Assessment Lead has established a report within CAFS to enable us to review how clinical grades are applied across different tutors. This will highlight any tutors who may potentially be scoring out of line with grade descriptors. | |
| 19 | 34. The provider **must** make calibration events mandatory (as far as is possible) and include outreach placement supervisors. | This overlaps with action 18.<br><br>As set out in the response to action 18, we have invited our outreach providers to staff development sessions (PRiDE) which are mandatory to attend and will be an annual requirement. | |
| 21 | 35. The provider **must** ensure that assessment criteria is fully | As referenced in the response to actions 1, 2, 3,18, 22, 26 and 33 we have introduced the PRiDE Staff Development | |

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| | understood by staff and students and applied consistently. | programme where all tutors have been trained on the newly defined grade descriptors to ensure consistency of assessment. The Programme has strengthened both understanding and consistent application of assessment criteria through a combination of staff calibration, transparent documentation, and systematic monitoring. All assessment criteria are published in the Programme Handbook, providing staff and students with clear grading descriptors, marking criteria, and detailed descriptions of the standard-setting methods used for each summative examination. Regular calibration sessions are held for staff to reinforce consistent interpretation of clinical grades.<br><br>With regards to students, the assessment criteria have been explained to them by the Assessment Lead in their year group inductions. Students are further supported through student facing materials on our virtual learning environment Canvas which includes marking rubrics and formative feedback sessions illustrating performance expectations across levels of complexity. Clinical assessments are recorded contemporaneously within the CAFS System, providing an auditable record of grading and feedback. CAFS data and samples of feedback are reviewed through the Clinical Activity Review and Assessment Sub-Committees and the Undergraduate Programmes Committee to ensure consistency across assessors and cohorts. | |

## Observations from the provider on content of report

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| We are grateful to the inspection panel for their robustness and candour throughout this inspection period and we are keen to demonstrate the progress made towards these actions at the next inspection in March 2026. |

## Recommendations to the GDC

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| **Education associates' recommendation** | The BDS is sufficient for holders graduating in 2025 to apply for registration as a dentist with the General Dental Council. Ongoing sufficiency will be decided upon at the next inspection. |
| **Date of reinspection** | March 2026 |

# Annex 1

**Inspection purpose and process**

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

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

3. The GDC document 'Standards for Education' 2nd edition1 is the framework used to evaluate qualifications. There are 21 Requirements in three distinct Standards, against which each qualification is assessed.

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

A Requirement is met if:

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

A Requirement is partly met if:

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

A Requirement is not met if:

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

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

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

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