RE-INSPECTION REPORT

Education Provider / Awarding Body:	**The University of Manchester**
Programme / Award / Qualification:	**Bachelor in Dental Surgery (BDS)**
Outcome of 2012/13 report:	**Recommended that the Manchester University BDS programme remains sufficient for registration. A re-inspection in the 2013/14 academic year is required to consider the newer elements of the programme.**
Remit and Purpose:	**Full re-inspection referencing the *Standards for Education* to determine continuing sufficiency of the award for the purpose of registration with the GDC as a dentist.**
Learning Outcomes:	***The First Five Years (Dentist)***
Programme Inspection Dates:	**7 April 2014 (Student sign-up meeting)** **29-30 April 2014**
Examination Inspection Dates:	**5-6 June 2014**
Inspection Panel:	**Susan Morison (Lay member and Chair)** **Kim Piper (Dentist)** **Shazad Malik (Dentist)** **James Newton (Dentist)**
GDC Staff:	**Luke Melia (Lead)** **Laura Harrison**
Outcome of 2013/14 re-inspection report:	**Recommended that the Manchester University BDS programme remains sufficient for registration as a dentist with the GDC.**

Re-inspection summary

The GDC inspected the BDS programme at the University of Manchester during the 2012/13 academic year. The inspection panel recommended that the qualification was sufficient for holders to apply for registration as a dentist with the GDC, but also recommended that a full re-inspection was to be undertaken in 2013/14. The decision was made on the basis that further evaluation was required of some of the newer aspects of delivery. The inspectors also wished to have the opportunity to assess the School's progress in addressing the actions contained in the 2012/13 report.

The inspectors' recommendation for a re-inspection was accepted by the GDC Registrar and completed in April 2014, with the inspection panel returning to the final examinations in June. The inspectors were impressed with the manner in which the School had responded to the 2012/13 GDC inspection report. The senior management had not only acknowledged the areas that were highlighted for improvement, but started an ambitious and well-targeted action plan. The reaction of staff at all levels was one of insight and innovation and should be commended.

A total of 13 Requirements have been revised from either Not Met or Partly Met to now being considered Met or Partly Met with clear plans for future compliance. One Requirement (21) was revised from a Met to a Partly Met. The School had made a significant change in no longer using external examiners to assess students. Instead, teams of internal examiners were utilised and external examiners took on the role of overall quality assurance. The inspectors felt that although this was a positive step forward, further training and experience was necessary for the internal teams to ensure a standardized approach. In addition, the inspectors considered that the School needed to ensure examiner pairs were allocated to examine in areas of dentistry most appropriate to their background and expertise.

The inspection panel was very encouraged to find the whole philosophy to the quality assurance of outreach placements had changed over the last 12 months. It was evident that outreach staff were more confident in their relationship with the School, with communication massively improved. An Outreach Lead had been appointed and started to work with the Clinical Directors from the four Trusts where the Outreach Placements were situated. This had fed into meetings of an Outreach Teachers Group, which had developed a formal policy that will include an agenda for annual visitations and calibration of grading. Outreach staff had also been included in School training away days.

The inspectors were pleased to see that the School had a made a positive start to the review of its assessment strategy. There was evidence that the School was reflecting on what might be the best range of assessments to suit the overall competency based structure of the programme. A lead in Assessment/Examinations had been appointed and an Assessment/Examinations Group was created to take on the overall responsibility for the area. With input from Year Leads and other senior staff, the group have been considering grading schemes, combination of grades and student achievement of their clinical competencies.

As a priority, the inspection panel felt that Assessment/Examinations Group needed to ensure that a clear progression pathway for students achieving their core clinical competencies was developed. It was necessary for the inspectors to request paper records to cross reference the data held in the CEDAR and LIFTUPP systems, which did not always accurately reflect the full attainment of a student's clinical activity. More comprehensive assessment blueprinting was also required and should be undertaken in conjunction with the programme being mapped to the learning outcomes published in *Preparing for Practice*.

The inspectors were aware that a number of the new initiatives being implemented by the School will need time to become fully embedded in the programme. In some areas,

particularly in relation to the assessment structure, the inspection panel felt unable to fully revise their original Requirement decisions from a Partly Met because a lot of the work remained in progress. The inspectors were optimistic that, were they to review the work completed by the School committees after a full year in operation, sufficient data would be seen to indicate the Requirements were being Met or significantly closer to becoming Met. These areas will be considered through the GDC annual monitoring process.

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

Inspection process and purpose of Inspection

1. As part of its duty to protect patients and promote high standards within the professions it regulates, the General Dental Council (GDC) quality assures the education and training of student dentists and dental care professionals (DCPs) at institutions whose qualifications enable the holder to apply for registration with the GDC and new qualifications where it is intended that the qualification will lead to registration.

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

3. The inspection focuses on four Standards, with a total of 29 underlying Requirements. These are contained in the document *Standards for Education*.

4. The purpose of this inspection was to make a recommendation to the Council of the GDC regarding the 'sufficiency' of the programme for registration as a dentist in the UK. The GDC's powers are derived under Part II, Section 9 of the Dentists Act 1984 (as amended) to determine sufficiency of the programme.

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

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

The Inspection

7. This report sets out the findings of a re-inspection of the Bachelor of Dental Surgery (BDS) awarded by Manchester University. The GDC publication *Standards for Education* (version 1.0 November 2012) was used as a framework for the inspection. This re-inspection forms part of a series of BDS inspections being undertaken by the GDC in 2012-2014.

8. The re-inspection was comprised of two visits. The first, referred to as the programme inspection, was carried out on 29 and 30 April 2014. This involved a series of meetings with programme staff involved in the management, delivery and assessment of the programme and a selection of BDS students. The second visit took place between 5 and 6 June 2014 and is referred to as the student sign-off inspection and was undertaken at the final examinations. In addition, one inspector and the lead QA Officer attended the student sign-up meeting for final examinations on 7 April 2014.

9. The report contains the findings of the inspection panel across the two visits together with consideration of supporting documentation prepared by the School to evidence how the individual Requirements under the *Standards for Education* have been met. The main focus of the re-inspection was in regards to Requirements that were deemed Partly Met or Not met, in the 2012/13 inspection report (published on the GDC website). However, the inspectors were also permitted to revise their consideration of any of the 29 Requirements under the *Standards for Education*.

Overview of Qualification

10. The BDS programme sits within the Faculty of Medical and Human Sciences within the University of Manchester. The programme has an annual intake of around 80 students. The duration of the programme is 188 weeks over five years of study and training. The programme is designed to deliver the learning outcomes contained in the GDC document *The First Five Years (3rd edition, 2008)*.

11. The BDS programme delivery has been designed around the three key principles of enquiry-based learning (EBL), integration of learning and team working. Students attain compulsory core components with clinical elements delivered in a variety of primary and secondary care settings including Manchester Dental Hospital and eleven Outreach Centres across Greater Manchester.

12. For the 2012/13 academic year, the School implemented the Longitudinal Integrative Foundation Training Undergraduate Postgraduate Pathway (LIFTUPP) system throughout the programme. LIFTUPP is a newly developed central recording IT programme that has established workplace-based assessment strategies which run on iPads with data captured and stored on a centrally held database. The aim for the system, once fully operational, is to continuously and longitudinally monitor learner development with easily accessible academic and clinical performance data for both students and tutors. LIFTUPP is designed to map learning outcomes to assessment and delivery, in addition to providing a means by which to centrally record and calibrate the assessment of students' longitudinal clinical activity. LIFTUPP thus supports the delivery of the BDS programme as a central mapping, monitoring and recording system. It is anticipated that LIFTUPP will also provide students with a portfolio of clinical activity that they can take forward into foundation training.

Evaluation of Qualification against the *Standards for Education*

13. The provider was requested to update their self-evaluation of the programme against the individual Requirements under the *Standards for Education*. This involved stating whether each Requirement is met, partly met or not met and to provide evidence in support of their evaluation. The inspection panel examined this evidence, requested further documentary evidence and gathered further evidence from discussions with staff and students.

14. The inspection panel once again used the following descriptors to reach a decision on the extent to which the BDS of Manchester University meets each the Requirements:

A Requirement is **met** if:

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

A Requirement is **partly met** if:

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

A Requirement is **not met** if:

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

Standard 1 – Protecting patients **Providers must be aware of their duty to protect the public. Providers must ensure that patient safety is paramount and care of patients is of an appropriate standard. Any risk to the safety of patients and their care by students must be minimised**			
Requirements	**Met**	**Partly met**	**Not met**
1. Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients *	✓		
2. Patients must be made aware that they are being treated by students and give consent *	✓		
3. Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care *	✓		
4. When providing patient care and services, students are to be supervised appropriately according to the activity and the student's stage of development	✓		
5. Supervisors must be appropriately qualified and trained. Clinical supervisors must have appropriate general or specialist registration with a regulatory body	✓		
6. Students and those involved in the delivery of education and training must be encouraged to raise concerns if they identify any risks to patient safety *	✓		
7. Should a patient safety issue arise, appropriate action must be taken by the provider *	✓		
8. Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC student fitness to practise guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance	✓		
* = Requirement has been revised from the 2012/13 report			

GDC Comments

Requirement 1: Students will provide patient care only when they have demonstrated adequate knowledge and skills. For clinical procedures, the student should be assessed as competent in the relevant skills at the levels required in the pre-clinical environments prior to treating patients *(Requirement remains Met)*

The inspection panel was satisfied that the good practices outlined in their 2012/13 inspection report were continuing. The School operates a highly detailed and well planned framework for ensuring students have been assessed as competent in the relevant skills before being allowed to treat patients. Students are aware that they have a professional responsibility not to perform any clinical work on a patient until they have passed the relevant clinical skills assessment.

The inspectors felt that senior tutors were suitably mindful that there could be a significant period between a student learning skills in a pre-clinical environment and their first opportunity to practise the procedure on a patient in clinic. As a further safeguard, the inspectors thought that skills tests could be given a formal expiry date. This would allow tutors to monitor a time period after which students will require a refresher programmes to ensure they have maintained an appropriate level of competency to be permitted to treat patients.

Requirement 2: Patients must be made aware that they are being treated by students and give consent *(Requirement revised from Partly Met to Met)*

In the 2012/13 inspection report, the School explained that students were identified on clinics by their blue tunics (a different colour to other staff members), and also wore badges which provided their name and indicated that they are part of 'The School of Dentistry'. The inspection panel felt that it was not entirely clear how patients were made aware of the significance of the colour of the tunic that their practitioner was wearing, either in the hospital or in outreach. No posters were seen that explained the different coloured uniforms and the School accepted that notices in outreach were not consistently displayed.

Two actions were recorded in regards to this requirement in the 2012/13 inspection report.

i. The School must highlight the significance of the blue tunics that students wear in the clinical environment so patients can clearly distinguish them from other members of the dental team. Staff seniority in relation to each colour of uniform should be clearly advertised.

ii. A patient information document to the same standard as the NHS Foundation Trust form entitled "Information for Patients Accepted for Restorative Treatment from Undergraduate Student Dentists" must be extended to all clinical facilities where students work.

In response to action i. the School has produced posters, which show students and staff in their different coloured tunics together with a clear indication for what the specific colours mean. The posters are displayed in all areas where students see patients.

In response to action ii. the Dental Hospital form entitled "Information For Patients Accepted for Restorative Treatment from Undergraduate Students Dentists" has been modified. A separate one to cover children treated by students has been produced. These have been circulated through all clinical areas in the Trust. A "New Patient Information" leaflet has also been designed. It is sent out by the Trust with a patient's first appointment. The posters and information for patients were presented and approved by a new Outreach Teachers' Group in advance of their roll out.

Students in all years showed an excellent understanding of the importance of consent and the importance of clear communication with patients. Formal guidance is published and included in their inductions at the beginning of each year. The year three, four, and five students displayed a more progressive appreciation of the principles of informed consent having spent time working on clinics.

Requirement 3: Students will only provide patient care in an environment which is safe and appropriate. The provider must comply with relevant legislation and requirements regarding patient care *(Requirement revised from Partly Met to Met)*

The inspection panel was satisfied that the clinical environment was safe, and relevant legislation was met throughout the Dental Hospital, School and within outreach placements. The School has improved the communication with the Dental hospital and are implementing an excellent plan for the quality assurance of outreach placements (detailed in full at Requirement 10). The plan will include a regular round of visits to all placements, the findings of which will be compiled into an Outreach Placement Report for consideration at the Undergraduate Programme Committee (UPC). The inspectors' understanding was that reports by such bodies as the Care Quality Commission (CQC) and other formal monitoring of the safety and propriety of the clinical environments will be managed through this reporting mechanism.

The inspection panel was encouraged to hear staff from the School and Hospital talk about the shared responsibilities for maintaining a safe environment. It was a theme repeated in several areas of discussion over the course of the inspection. Individuals were eager to explain measures such as a Clinical Effectiveness Committee with University representation and clinical dash boards that offer easy access to a wealth of NHS data that is being captured locally.

The School also highlighted that Health Education England North West continually updates the Learning and Development Agreement, which includes ensuring all clinical work is undertaken in a safe of environment. Any impact on the provision of dentistry is jointly considered by the University of Manchester, University of Liverpool and University of Central Lancashire.

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

The inspection panel remain satisfied that the supervision levels within the programme are appropriate. The ratio of staff to students continues to be one staff member to eight clinically active students. The students confirmed that they were content with the level of supervision and staff showed an understanding of the importance of appropriately matching supervision to a student's stage in development.

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

The inspection panel once again considered the qualifications and registration of the staff members to be appropriate for working in the capacity as supervisors on the programme.

In the 2012/13 report, the School acknowledged that there needed to be further recruitment in some areas, particular within senior restorative roles. The School provided an update on their recruitment plans, which were very positive. Positions that have been signed-off at either an advertising or shortlisting stage include a Researcher in Basic Science, Senior Lecturer and Consultant in Restorative Dentistry with a special interest in Periodontology, a Clinical Academic in Paediatrics, a Health Service Researcher (Biostatistics and Methodology), and a

Consultant in Special Care Dentistry.

The inspection panel felt the appointments will strength the programme and provide further depth to the clinical and teaching teams.

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

In the 2012/13 inspection report, the inspection panel were advised of several reporting mechanism for patient safety incidents. However, it was difficult for the inspectors to see how the School actively encouraged staff and students to make use of the system.

One action was recorded in regards to this requirement in the 2012/13 inspection report:

The School must introduce a clear policy for how students and those involved in the delivery of education and training can formally raise concerns relating to patient safety. The document should show the pathway for dealing with such issues and indicate at what stage University protocols are to be engaged.

The inspection panel was shown a new policy in regards to raising concerns within the School. The document has formally set down the appropriate pathways to follow once a concern is raised. There are clear mechanisms and points of contact for the students to bring any issues of concern to the School's attention and an indication for when School and University protocols are to be engaged. The guidance has been developed with input from all relevant parties (School, NHS, and outreach) and shows a strong insight into the need for a culture of candour following the publication of the Francis Report in 2013.

The inspection panel was encouraged by the attitude of the staff and students when the importance of raising concerns was discussed. There was a sound awareness of the professional obligation to raise concerns with the students sharing the ethos and being considered a member of a professional team with the same responsibilities as senior staff members.

The School has recently introduced a 'Dental School Charter' which was developed in conjunction with the Faculty and the NHS Trust in 2012. The agreement has been updated to cite the key themes of the newer GDC publication *Standards for the Dental Team*. Students are expected to sign and return a slip that confirms they have read and understood the charter's content. It is annually renewed at the beginning of each year of study.

Requirement 7: Should a patient safety issue arise, appropriate action must be taken by the provider *(Requirement revised from Partly Met to Met)*

It was noted in the 2012/13 inspection report that the inspection panel was confident that patient safety issues would be escalated and appropriately handled. Their judgement was based on the professionalism displayed by staff and senior management and their appreciation of the vital importance of all patient safety issues being correctly dealt with as a matter of priority. However, the inspectors were concerned that the management systems the School were operating could not be relied on to identify the full range of potential risks to patient safety.

On re-inspection, the inspectors were pleased to see that the management system in the School of Dentistry has been revisited. A review has been undertaken of the remit, membership and roles of the committees and the reporting lines have been made more efficient with defined responsibilities spread amongst the various groups. The role of the Director of Undergraduate

Education has been revised so other team members are included in the dissemination of information (these changes are detailed in full at Requirement 9).

The inspection panel are now satisfied that the School is operating a management structure that will identify the full range of potential risks to patient safety. The improved reporting lines will help ensure appropriate actions are taken should a patient issue arise. The revised committee framework will also allow for a clear audit of process and decision points.

Requirement 8: Providers must have a student fitness to practise policy and apply as required. The content and significance of the student fitness to practise procedures must be conveyed to students and aligned to GDC student fitness to practise guidance. Staff involved in the delivery of the programme should be familiar with the GDC Student Fitness to Practise Guidance *(Requirement remains Met)*

The inspection saw evidence that the School has a student fitness to practise policy that is aligned to GDC guidance and staff were familiar with the guidance.

As of the 2012/13 academic year, a professional traffic light system has been used by the School for staff to report incidents relating to student professionalism. The cards (red, amber and green) can be issued by any member of hospital staff and are also active within outreach. A guidance poster was published to act as an *aide memoire* for the application of the system. The poster was placed in all clinical areas and distributed to placements.

It was noted in the 2012/13 inspection report that students felt there were some inconsistencies with how staff had been applying the criteria for issuing professionalism cards.

One action was recorded in regards to this requirement in the 2012/13 inspection report:

The School should ensure that the issuing of professional traffic light cards are reviewed regularly to ensure consistency of approach when staff are awarding the cards. Calibration should be included within formal staff training events.

The inspection panel was encouraged to find that further training and calibration material has been produced in regards to how staff should apply the criteria for the Professionalism Traffic Light System. An online training package has been produced and is now available following a pilot period. The training includes cases which can be used a calibration tool for when the issuing of a professionalism card is appropriate.

The Dental Hospital held an Annual Clinical Effectiveness (ACE) day in January 2014. The online training for the professionalism cards was presented at the day and staff had the opportunity to go through the cases and discuss them live. Attendees included Hospital and University staff, dentists, nurses, reception and records staff. Outreach teaching staff have also been given access to the online training with the chance to go through the cases and discuss them live at a half day away day organised by the Dental School in April 2014.

The inspection panel appreciate that some decisions will never be popular with students and remain mindful that the system is still a fairly new initiative. They echo their opinion from the last inspection report that the system is an excellent addition to the programme and offers a framework for professionalism to be monitored in all clinical environments. The inspectors were encouraged to note that staff fully understood how important it was that the system is operated consistently. As discussed, this was a topic covered at a staff away day and a Year Lead is reviewing students' views as part of their PhD study. The inspectors want to see the School's commitment to training and calibration continue, as this will be the only way to ensure the cards remain a fair and reliable tool.

Actions		
Req. Number	**Actions for the provider**	**Due Date (if applicable)**
1	All tutors must be mindful of the periods of time between a student learning skills in a pre-clinical environment, and the first opportunity for them to practise the procedure on a patient in clinic. The School should introduce formal expiry dates to the achievement of skills tests by students. There should be a clear policy on revocation and reinstatement following any further assessment.	GDC Annual Monitoring 2015
8	The School should continue its commitment to staff training and calibration for the issuing of professionalism cards to ensure the system remains fair and reliable.	GDC Annual Monitoring 2015

Standard 2 – Quality evaluation and review of the programme **The provider must have in place effective policy and procedures for the monitoring and review of the programme**			
Requirements	**Met**	**Partly met**	**Not met**
9. The provider will have a framework in place that details how it manages the quality of the programme which includes making appropriate changes to ensure the curriculum continues to map across to the latest GDC outcomes and adapts to changing legislation and external guidance. There must be a clear statement about where responsibility lies for this function		✓	
10. The provider will have systems in place to quality assure placements *	✓		
11. Any problems identified through the operation of the quality management framework must be addressed as soon as possible		✓	
12. Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity *	✓		
13. Programmes must be subject to rigorous internal and external quality assurance procedures *	✓		
14. External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow QAA guidelines on external examining where applicable *	✓		
15. Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *	✓		
* = Requirement has been revised from the 2012/13 report			

GDC comments

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

The pre-inspection documentation states that the Undergraduate Programme Committee (UPC) continues to be the framework that the School uses to manage programme and curriculum changes.

In the 2012/13 inspection report, the inspection panel was unable to see how curriculum changes were proposed, considered and ultimately authorised through the UPC. Review for

new initiatives appeared informal with the recorded discussion centring on more day to day logistics of the School's operations rather than a strategic quality assurance of the programme. It was acknowledged by the senior staff at the time that the UPC minutes had not been clear enough in representing and monitoring curriculum changes and more needed to be done to reflect where decisions had been made.

A committee organogram was considered during the 2012 programme inspection that showed the Undergraduate Programme Committee (UPC) had a number of subcommittees operating beneath it. There included a Dental Progress Committee, a Staff/Student Liaison Committee, an Outreach Liaison Committee and a Vocational Training Liaison Committee.

The inspection panel noted that organogram structure appeared a sound framework for the School management. However, the inspectors could not find sufficient evidence of the discussions from each of the various committees being fed into the UPC. The material reviewed suggested that the UPC actually had management of the remits defined in some of the names of the sub-committees, with the sub-structure operating in a somewhat isolated and limited capacity.

Three actions were recorded in regards to this requirement in the 2012/13 inspection report:

i. The School must provide a clear statement about where the function of strategic quality assurance of the programme lies within the management framework. Decision making within this area must be clearly audited and demonstrate what topics were covered at which committee and how new initiatives received authorisation to be implemented. Interactions between the School, the University Faculty and the Hospital should be evident within the process.

ii. The School must improve the clarity of its recording of discussions within the management structure and its various committees. Each committee must have a distinct remit with a schedule for frequency of meetings and appropriate underpinning policy or regulations. How information is fed into a central administrative framework and disseminated to staff and students must be clearly defined.

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

In response to the actions, the School has revisited their management system and committee structure. A review has been undertaken of the remit, membership and roles of the committees and the reporting lines have been made more efficient with defined responsibilities spread amongst the various groups.

The UPC meets monthly during the academic year and retains responsibility for the curricula, teaching and assessment of undergraduate students. The senior management team explained that some of the other committees have been renamed and some new ones created though the model remains similar to the Organogram considered in 2012.

A Health and Conduct committee has replaced the Progress Committee which has taken on the role of monitoring student progress as directed by the provision of the University's Academic Regulations. The group assesses students referred to it from the sign-up to final examinations, who may require remedial action plans or have mitigating circumstances to be considered.

The Staff/Student Undergraduate Liaison Committee has been reconstituted. Previously, there

was student representation on the UPC. The Staff/Student Liaison Committee now meets monthly on its own accord to consider matters of undergraduate education including delivery of curriculum and student experience. The minutes are then considered at the following UPC meeting.

The Outreach Liaison Committee has now become the Outreach Teachers' Group. It is chaired by an Outreach Lead, which is a newly created role for the oversight of outreach placements, and meets once a semester. The forum will consider the delivery of teaching, learning and assessment outside of the Dental School and Hospital. Health and safety, training of Outreach Teachers and monitoring of student's clinical activity is also included in the terms of reference.

The Vocational Training Liaison Committee has been renamed the Foundation Training Liaison Committee. It is chaired by the Regional Programme Director of Dental Foundation Training North West Deanery and meets on a biannual basis.

An Assessment/Examination Group has been created and started to meet in December 2013. The forum has been set up to consider the appropriateness and structure of assessments, plan for their execution and review and quality assure their suitability. It has also taken on responsibility for the consideration and responses to External Examiner reports. The group is scheduled to meet on a monthly basis.

A Clinical Development Review Panel has been created and will meet each semester. The group is chaired by the Director of Undergraduate Education and considers clinical development of undergraduate students using LIFTUPP. It will review Professionalism traffic light cards, student absences, and the attainment of clinical competencies.

The inspectors were pleased to note evidence that the UPC is now considering the findings of the subcommittees working beneath it rather than attempting to manage the vast majority of the undergraduate programme in a single forum. There was an acceptance amongst the staff that the UPC had become weighed down by its previous functions, and the ability to focus on specific elements of the course in smaller, dedicated groups has proven hugely beneficial. The UPC has been freed up to become more strategic in its discussions and decisions.

As part of the process of review, the School has looked at its minutes of meetings. The inspectors were told that there has been a concerted effort to ensure that actions and decisions are followed through and suitably audited. Evidence was seen that improvements have been made in this area with discussions recorded in the most appropriate committee and then fed into the UPC for ultimate consideration.

In the 2012/13 inspection report, the inspectors highlighted the wide ranging scope within the role of the Director of Undergraduate Education. This role has been revised with other members of the team taking on some of the responsibilities for the position. This has helped with the dissemination of information throughout the School as more people are involved and empowered with decision making. There was also evidence of a management team operating together at a senior level, which mitigates the risk of one key person becoming unavailable without suitable cover.

The inspection panel were able to identify more formal interaction between the Dental School and the Dental Hospital, but the relationship with University Faculty remained somewhat unclear. As outlined in the 2012/13 inspection report, the School has a significant degree of autonomy for making changes to course design without having to interact with the wider University. There was also limited evidence for when or how overarching quality assurance reviews of the School were undertaken by the University and how the system was aligned with School processes and fed into the current management. (This area will be considered in more detail at Requirement 13).

The inspectors were disappointed to note that the School has not yet mapped their curriculum against the latest GDC learning outcomes published in *Preparing for Practice* in September 2011. With some recent changes in senior management, there was a degree of uncertainty for when the transfer from the old learning outcomes detailed in *The First Five Years* will take place. There appeared to have been some work completed on the project, but worked on in isolation, outside of the relevant committees.

With the mapping unchanged, there remained some difficulty for the inspection panel to understand exactly how the mapping of the learning outcomes always worked in practice. The School are urged to start their mapping to *Preparing for Practice* immediately and ensure there is a coherent transition plan in place. The inspectors are encouraged by the work being done by the Assessment/Examination Group and would expect the School to utilise this forum when completing the new mapping. The inspectors look forward to reviewing this piece of work through the GDC annual monitoring exercise.

The inspection panel felt that the function of the revised committee structure was showing promising signs and, in time, will provide a robust structure to manage the programme and curriculum. However, the inspectors agreed that they were unable to fully revise their original decision that the requirement is partly met because the committee structure has not been in place long enough for a complete review of its running. Not enough evidence was available during the inspection period but it is thought that there will be within the next academic year. The inspectors are therefore optimistic that were they to review committee minutes after a full year in operation, sufficient data would be seen to warrant the requirement being deemed met. This is something that will be reviewed through the GDC annual monitoring process.

Requirement 10: The provider will have systems in place to quality assure placements *(Requirement revised from Partly Met to Met)*

It was detailed in the 2012/13 inspection report that the range of outreach placements operated by the School was commendable but the inspection panel was disappointed that there was no formal, centralised system of quality assurance. The evidence indicated a passive approach to interacting with outreach and coordinating placements, which required significant improvement. The School acknowledged at the time that the monitoring of placements should be more pro-active and further development was needed in this area.

Four actions were recorded in regards to the requirement in the 2012/13 inspection report:

i. The School must indicate how it proposes to quality assure the delivery of education for students in outreach placements. This should include a defined policy and formal links to ensure a safe environment at each location with regular opportunities for information to be shared with the School. A designated coordinator for outreach placements is highly recommended.

ii. The School must devise formal inductions for outreach placements that are standard procedure at the beginning of a student's time at each location. This must offer the outreach staff an opportunity to gauge clinical skill levels and review the competencies that the student has met and those still to be attained. Such information must be readily accessible at the outreach site.

iii. The School must provide a clear policy on the use of clinical activity data gained from outreach placements. If the policy states that these data may influence decisions regarding a student's competency to sit a final examination, the quality assurance of the assessment of students must be sufficiently robust and a relevant policy relating to the quality assurance of assessment in outreach placements must be produced.

iv. The School must provide training for all clinical staff within outreach in the School's assessment practices. It must ensure that there are regular opportunities for calibration of the awarding of grades between other outreach sites and the School itself.

In response to the actions, a former Head of School has taken on the role of Outreach Lead, tasked with co-ordinating and quality assuring outreach placements. The School currently has eleven outreach placements operating over four NHS Trusts: Manchester Community Dental Service, Salford Community Dental Service, Pennine Care NHS Foundation Trust, and Bridgewater Community Health Care NHS Trust.

A first meeting was held with the four Clinical Directors of Outreach Placements in December 2013. A meeting was also convened with the outreach teachers separately. Though the meetings were initially informal, notes were taken and available for consideration by the inspectors. More formal evidence of the School's progression was subsequently seen in the workings of the Outreach Teachers Group, where formal minutes are kept and presented to the UPC.

The minutes of the Outreach Teachers Group show that the Outreach Lead has been working closely with all relevant staff to produce a workable quality assurance framework that will be effective across the various sites and NHS Trusts. A formal policy has been set down in draft. This includes an agenda for annual visitations, the first round of which was completed between March and May 2014. The results of the visits will form the basis of an Outreach Placement Report to be annually submitted to the UPC. Other criteria for the inclusion in the report will be Facilities, Infection Control, Health and Safety, Medical Emergencies and Patient and Student Experience.

There had been some concern during the 2012/13 inspection that students were not given formal inductions when they arrived at new placements. The evidence suggested that procedures varied from site to site and outreach staff had taken it upon themselves to make initial reviews of a student logbook to establish the clinical level the student could operate at.

The inspectors were encouraged to find that LIFTUPP data is now supported with a Centralised Electronic Dental Academic Record (CEDAR). LIFTTUP provides details of clinical skill levels from clinics at the Hospital and other outreach sites, while CEDAR records student achievement of competencies. Outreach teachers have full access to both systems, which feeds into a centralised monitoring system. All supervisors are able to see students' progression and are aware of everyone's input into the database. They can review records of tutor meetings that are written into the system, which will highlight any clinical skill weaknesses, or emerging patterns of behaviour for School intervention. The aim is for a formal induction to be introduced at the start of each outreach placements, which will include dialogue between student, Year Lead and outreach teachers. In addition, formal feedback mechanisms for staff students and patients are being piloted.

Outreach staff attended the training day in April 2014 and will be invited to future training events. This will ensure that everyone will know how to access relevant information and are updated on a regular basis.

The grading of students will be a frequently reviewed and calibrated though the Outreach Teachers Group and staff training sessions. The inspectors were satisfied that this area has improved with the LIFTUPP grading scale more embedded in the programme. However, further work is required to provide a clear approach to the use of clinical activity data gained from outreach placements in relation to progression. There should be clear evidence of the clinical activity undertaken by a student prior to the 'sign-off' of a competency. This aspect of the student attainment will be further discussed at Requirements 16 and 19.

The inspectors were very encouraged to find the whole philosophy to the quality assurance of outreach placements has changed over the last 12 months. Outreach staff were more confident in their relationship with the School, with communication massively improved in what is now a three way process between the School, the Trust, and the staff working in the clinical sites. This regular communication provides an excellent basis for the quality assurance of clinical placements. Its collaboration has already been seen in the development of raising concerns policy.

Requirement 11: Any problems identified through the operation of the quality management framework must be addressed as soon as possible *(Requirement remains Partly Met)*

The inspection panel remain satisfied that problems identified through the quality management framework would be addressed. Senior management and staff have consistently showed a sound understanding of the importance of identifying risk and acting accordingly to prevent issues from escalating.

As outlined in Requirement 9, the quality management framework has improved with the UPC now working more strategically, considering the findings of the subcommittees working beneath it (as depicted in the organogram in the School of Dentistry Management document).

As with Requirement 9, the inspection panel felt unable to fully revise their original decision that the requirement is partly met because the committee structure has not been in place long enough for a complete review of its running. Not enough evidence was available during the inspection period but it is thought that there soon will be. The inspectors are therefore optimistic that were they to review committee minutes after a full year in operation, sufficient data would be seen to warrant the requirement being deemed met. This is something that will be reviewed through the GDC annual monitoring process.

Requirement 12: Should quality evaluation of the programme identify any serious threats to the students achieving learning outcomes through the programme, the GDC must be notified at the earliest possible opportunity *(Requirement revised from Partly Met to Met)*

The inspection panel remain confident that should any serious threats to the students achieving learning outcomes be identified, the GDC would be notified at the earliest opportunity. The School have adopted a more team minded approach in their management structure with all senior figures displaying a strong awareness that serious threats to any aspect of the programme would require contact with the regulator.

Requirement 13: Programmes must be subject to rigorous internal and external quality assurance procedures *(Requirement remains Partly Met)*

The inspection panel reviewed evidence that showed a significant amount of improvement has been made with regards to internal and external quality assurance, but there are still some areas that require further improvement.

External examiners are now employed to review specific aspects of the School's examinations and sign-up process. Since the 2012/13 inspection report, there has been a change in the role of the external examiner. The external examiner no longer participates in the assessment of the student but instead functions as a quality assurance observer and reviews all aspects of the examinations. Details of the deployment of external examiners will follow in Requirements 14 with further aspects explored in Requirements 15 and 22.

The changes made to the School's internal management framework have been detailed in Requirements 9 and 11. As noted at Requirement 9, the inspection panel was able to identify more interaction between the Dental School and the Dental Hospital within the new committee structure, but the relationship between the School and University Faculty remained somewhat unclear.

Apart from the annual monitoring reports and quinquennial periodic reviews, there appeared limited evidence of the Schools formal interaction with University quality assurance mechanisms. The last periodic review undertaken by the Faculty of Medical and Human Sciences was in 2009. The School was due to have its next Faculty Periodic Review in April 2014, but this was cancelled to focus on addressing the actions in the 2012/13 GDC report. The Periodic Review will now be undertaken in the 2014/15 academic year.

The inspectors heard that within the University, there is a Faculty Committee and a Teaching Committee. The Year Five Lead currently chairs the latter. However, there were few details for the exact nature of the information provided to Faculty, or what information and decisions were then returned to the School. Further scrutiny of committee minutes suggested that the information being shared took the form of brief updates that were not recorded in any purposeful way.

It was also seen that under the previous programme management structure, a wide ranging annual monitoring report could be compiled within the School but only receive input from a very limited number of senior authors or author. The document did not seem to be shared within any of the committees operating at the time, with the accuracy of the review suffering from its creation in such isolation. Once submitted to the Faculty, the reports seemed to simply be logged for reference with the exact purpose of the exercise not defined with any clarity.

The inspectors reviewed some of the policies that are produced by the University Faculty but not adopted by the School. The School is afforded special dispensation due to the nature of the subject and its regulatory requirements. While it is appreciated that a BDS has certain inherent aspects that requires exemption from some of the rules that govern other subjects, a number of the policies appeared to offer an excellent foundation, which could be adopted by the School. For example, the University assessment framework appeared clear and well-structured and may be something for the Assessment/Examination Group to consider in future.

With the School's significant degree of independence, the inspectors felt they were unable to say the programme has been subject to what can be described as rigorous external quality assurance. The gap between the School and the University Faculty remains too wide. There are some benefits to a certain level of autonomy for the School to manage its own operations, particularly in regards to changes to the curriculum. However, without University Faculty overview, there is a lack of overall quality assurance, which would strengthen the programme and provide a valuable external perspective.

Requirement 14: External examiners must be utilised and must be familiar with the learning outcomes and their context. Providers should follow Quality Assurance Agency (QAA) guidelines on external examining where applicable *(Requirement revised from Partly Met to Met)*

The inspection panel was satisfied that those undertaking the external examiner role were appropriately qualified and familiar with the learning outcomes. External examiners are included in monitoring the progress routes through Year 1 to Year 4, and an external examiner scrutinised the student sign-up meeting for final examinations.

The School no longer uses external examiners in the undertaking of assessments, which has brought their practice more in line with the latest understanding of QAA guidance. External

examiners have been given a new remit for overall quality assurance with access to all aspects of the examinations. The inspectors were told by the External Examiners that all documentation was provided in advance and the School were happy to field all queries and take feedback.

Requirement 15: Providers must consider and, where appropriate, act upon concerns raised or formal reports on the quality of education and assessment *(Requirement revised from Not Met to a Met)*

In the 2012/13 inspection report, the inspection panel was not satisfied that formal reports were considered appropriately by the School. Evidence was reviewed that indicated a passive approach to external examiner reports. The UPC minutes provided showed very little discussion on external examiner reports. The panel were provided with 11 sets of UPC minutes, none of which indicated that external examiner reports were discussed in any detail and there was no evidence provided that they were considered elsewhere.

One action was recorded in regards to this requirement in the 2012/13 inspection report:

The School must improve its system of reviewing external examiner reports. There must be an identifiable forum that is responsible for interaction with the external examiners and consideration of their reports. A defined process is necessary for authorising amendments based on the advice, and rationale should be recorded for when guidance is not taken forward for changes.

The inspection panel was pleased to note that the new Assessment/Examination Group has taken on responsibility for the consideration and response of External Examiner reports. The Group is chaired by an Assessment/Examinations Lead who now manages assessment design, progression of students, standard setting, auditing, and quality assurance. Early indications are that Assessment/Examination Group is functioning well and has provided a suitable forum for the review of all external examiner feedback, whether submitted in a written report or provided in person during Examination Boards or other assessment meetings.

The inspectors would urge more attention to detail is paid to external examiner reports. One of the written papers for final examinations had been standard-set too high. The high pass threshold had been commented on by an external examiner prior to the examination but these comments were not acted upon by the School. In addition, an unseen clinical scenario had to be changed after the GDC inspection panel highlighted it had already been used in a written paper. Again, this oversight had already been reported to the School by an external examiner and was not followed up. These oversights will be considered in more detail at Requirements 22 and 23.

Actions

Req. Number	Actions for the provider	Due Date (if applicable)
9	(i) The School must continue to establish its revised management framework and provide relevant committee minutes in their response to the GDC annual monitoring exercise next year	GDC Annual Monitoring 2015
	(ii) The School must make the mapping of the programme to the learning outcomes in the GDC document *Preparing for Practice* a matter of priority.	GDC Annual Monitoring 2015

10	The School should include minutes from the Outreach Teachers Group and details of staff training sessions involving Outreach staff, in their response to the GDC annual monitoring exercise next year	GDC Annual Monitoring 2015
13	(i) The School must include details of the Periodic Review scheduled to be completed in the 2014/15 academic year in their response to the GDC annual monitoring exercise next year (ii) The School must provide evidence for where consideration has been made in having closer ties with the University Faculty. This should be included in the response to the GDC annual monitoring exercise next year	GDC Annual Monitoring 2015 GDC Annual Monitoring 2015
15	The School should include minutes from the Assessment/Examination Group in their response to the GDC annual monitoring exercise next year	GDC Annual Monitoring 2015

Standard 3– Student assessment **Assessment must be reliable and valid. The choice of assessment method must be appropriate to demonstrate achievement of the GDC learning outcomes. Assessors must be fit to perform the assessment task**			
Requirements	**Met**	**Partly met**	**Not met**
16. To award the qualification, providers must be assured that students have demonstrated attainment across the full range of learning outcomes, at a level sufficient to indicate they are safe to begin practice. This assurance should be underpinned by a coherent approach to aggregation and triangulation, as well as the principles of assessment referred to in these standards		✓	
17. The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes		✓	
18. Assessment must involve a range of methods appropriate to the learning outcomes and these should be in line with current practice and routinely monitored, quality assured and developed		✓	
19. Students will have exposure to an appropriate breadth of patients/procedures and will undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes		✓	
20. The provider should seek to improve student performance by encouraging reflection and by providing feedback[1]		✓	
21. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment, appropriate general or specialist registration with a regulatory body *		✓	
22. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted	✓		
23. Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments *		✓	
24. Where appropriate, patient/peer/customer feedback should contribute to the assessment process *		✓	

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

25. Where possible, multiple samples of performance must be taken to ensure the validity and reliability of the assessment conclusion		✓	
26. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard *		✓	

* = Requirement has been revised from the 2012/13 report

GDC comments

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

The inspection panel agreed that there had been some significant improvements in the School's assessment strategy. In the 2012/13 inspection report, it was noted that the inspectors required several aspects of the School's assessment strategy to be clarified and did not always receive satisfactory explanations to their further enquiries. Throughout the inspection process, there was insufficient evidence to enable the inspectors to fully determine how students' skill acquisition had been recorded and evaluated before the introduction of LIFTUPP. It was also not possible to adequately determine how various assessment components and grading criteria operated in making a final decision on a student's clinical ability.

Seven actions were recorded in regards to the requirement in the 2012/13 inspection report:

i. The School must review its assessment structure to ensure a clear progression pathway can be audited. There must be an overall strategy for how each component of the programme fits together to produce final assessment decisions, particularly on a student's clinical ability. Assessment decision points must be openly and robustly evidenced.

ii. The School must review the clinical competencies. Consideration must be given to the system's appropriateness as a hurdle to progression when competencies are currently being carried forward by students from Year 3 to Year 5.

iii. The School must improve the monitoring and recording of students achieving clinical competencies. There must be a clearly defined policy for when and how students are assessed in these skills, which must be developed with an accurate central management system to track student progress.

iv. The School must review the role of the Academic Advisor. Consideration must be given to whether the system has the appropriate robustness and policy to function as a tool for student monitoring and to influence progression decisions, including sign-up to final examinations. The use of non-dental School staff in this role must also be examined.

v. The School must clarify how continuous clinical performance contributes to overall student attainment across the programme and its consideration at student sign-up. A distinction must be evident between assessment of clinical performance and the achievement of clinical competencies with any interrelation between the two components clearly defined in School policy.

vi. The School must ensure that a clear audit of evidence is maintained throughout the process for student sign-up to final examinations. The evaluation of students that are signed up with conditions still to be met or are to be considered by a Dental Progress Committee should be precisely tracked through each subsequent stage of appraisal with a final decision point clearly evidenced. The system needs to be transparent and display exactly what evidence has been used to underpin decision making on student ability and attainment.

vii. The School must ensure that every component of student assessment is monitored and that the results are centrally recorded.

In response to the actions, the School has reviewed its assessment structure and introduced the Assessment/Exam Group that has been described in Requirements 9 and 15. There have been some encouraging developments in the clarity of the assessment strategy and progress pathways.

One member of the inspection panel and the lead Quality Assurance Officer from the GDC attended the student sign-up meeting on 7 April. The meeting was once again identified by the School to be where the aggregation of decision-making was performed with further triangulation to be conducted at the Examination Board.

The criteria for sign-up to final examinations for Year 5 candidates has been revised and was recorded as:

- Attendance
- Academic Advisor meeting
- SDR meetings
- Professionalism Cards
- Competences
- Clinical Performance
- Coursework
- Integrated Patient Care cases
- Trust Core E-learning

Attendance

Satisfactory student attendance was again recorded as missing fewer than 10 sessions or having mitigating circumstances accepted for a higher number of absences that was not deemed critical to a satisfactory level of achievement. Students with 10 or more absences were now considered at the newly established Health and Conduct Committee (previously the Progress Committee).

A student with 5-9 absences received a warning letter outlining the consequences should they reach 10 or more. A student with less than 5 absences is deemed to have fulfilled this requirement for sign-up.

The inspection panel felt this was an appropriate standard and procedure. Student attendance appeared to be logged in the CEDAR and LIFTUPP systems with a central review overseen by an Administration Manager.

Academic Advisor meeting

In the 2012/13 inspection report, the inspection panel was not satisfied with the adequacy of the Academic Advisor system and are pleased to see it underwent an immediate review.

Academic Advisors have now become a purely pastoral function and no longer play any part in the monitoring of student progress. They do not review or consider clinical logbooks, or assist students in obtaining treatments that they may be requiring for competencies. This has removed the risk of a student being advantaged by having an advisor within the Dental School over a student who has a non-dental member of staff fulfilling the role.

There is an Academic Advisor Meeting Proforma in CEDAR for meetings to be recorded. Academic Advisor meetings are noted at the sign-up meeting for information purposes only. Should it be found that a meeting has not occurred, a letter will be generated to remind a student to arrange one, however this is no longer critical for sign-up.

SDR meetings

The School have introduced Student Development Review meetings, which are recorded on CEDAR. They are conducted by the Year Lead as a running check on student progression throughout the year. Academic Advisors were previously responsible for this appraisal and the inspection panel are pleased to see the Year Leads have taken over. A Year Lead is a far more appropriate person to fulfil the role.

The inspectors appreciate that the SDR meetings are a new initiative and hope that the School can see the potential for further development. Currently, there is no formal policy stating how many SDR meetings are required with the number of meetings recorded for information only at the sign-up meeting.

Professionalism Cards

Professionalism cards were considered at the sign-up meeting in 2013 though not formally cited within the sign-up criteria. In the 2014 meeting, professionalism cards have been recorded as a requirement for sign-up. Students who have received Red Cards are discussed with the potential for referral to the Health and Conduct Committee for more serious issues or multiple offensives.

Competences

The inspection panel found that the student achievement of core clinical competences was far more in line with its stated function as a hurdle for yearly progression. However, there remained a lack of clarity within the overall system and its central recording.

The School explained that competences are now recorded in the CEDAR system, which is monitored by the Year Leads in SDR meetings, and the Undergraduate Administration office. The underlined data for all student clinical activity is held in LIFTUPP and forms the base for continuous assessment.

At the sign-up meeting in April 2014, there was evidence to show that the competencies were now largely being attained within the relevant year. The small number of students who were carrying over outstanding procedures to another year, had clear deadlines for when non-completion would be a matter for escalation and/or a failure of a hurdle to progression. For sign-up to final examinations, Year 5 students had to have achieved a satisfactory performance in all of the core clinical competences, including Year 3 and 4 competencies.

The inspection panel felt that the School still needed to do more to show the progression pathway of students achieving the core clinical competencies. It was necessary for the inspectors to request paper records to cross reference the data held in the CEDAR and LIFTUPP systems, which did not always accurately reflect the full attainment of a student's

clinical activity. Students that had been signed-off as having achieved their competencies, did not have the corresponding evidence against their clinical performance recorded in LIFTUPP. After scrutiny of the paper records, the inspectors were satisfied that any gaps found in student attainment were subsequently down to some of the students' clinical work not being recorded in the databases.

Core clinical competencies will be considered further at Requirement 19.

Clinical Performance

Student clinical performance was monitored in LIFTUPP, a system now in its second year in operation. The system flagged students as either green (developing at expected level), amber (development needed in areas specified), or red (requiring the student to see Year Lead). For sign-up to final examinations, Year 5 students must have achieved satisfactory overall performance with any candidate highlighted in red within the system, discussed at the meeting on 7 April.

The inspectors were able to see how LIFTUPP is developing and were impressed with the amount of information that is recorded in the database. The specific details of the treatments being performed by a student are excellent. For example, the exact tooth and quadrant being worked on can be seen along with the materials used for any procedure.

It was indicated in the 2012/13 GDC inspection report that there needed to be more of a distinction between assessment of clinical performance and the achievement of clinical competencies with any formal interrelation between the two components clearly defined in School policy. This has not been developed yet and the interrelationship between the two remains unclear. The School needs to formalise this area to show the clear accumulation of a student's clinical skills.

Student clinical performance will be considered further at Requirement 19.

Coursework

Students complete a clinical audit in Year 5 and a number of case scenarios. The progression is monitored by a coursework tutor and was considered a workable approach.

Integrated Patient Care cases

The Integrated Patient Care cases for case presentations in the final examinations were once again well monitored. Any aspect of treatment that was still to be done in time for the examinations in June had been planned and appointments scheduled with patients.

Trust Core E-learning

A new element of sign-up for final examination is the Trust Core E-learning modules. These are split into four categories:

- Annual Corporate Mandatory Training modules
- CORE Clinical Mandatory Training modules
- Stand Alone Training modules for Dental Hospital.
- Ad-hoc Stand Alone Clinical Mandatory Training modules

Final examinations

As they did at the 2013 inspection, the inspection panel tracked the students identified with caveats to their sign-up for final examinations. They reviewed the minutes from the Health and Conduct Committee and considered evidence of student attainment. The minutes and paperwork demonstrated that the Health and Conduct Committee had reviewed each of the students highlighted with deficiencies and considered suitable evidence for their progression decisions.

The inspectors went on to scrutinise student clinical activity. The inspection panel accepts that the CEDAR and LIFTUPP systems will grow to provide detailed monitoring of student clinical activity. As outlined under Competences and Clinical Performance, there currently remains a lack of detail in the evidence that is used to underpin the assessment of student clinical ability. Without a formal policy for the achievement of core clinical competencies or a full record for the continuous assessment that has led up to achievement of a competency, the true amount of a student's clinical exposure and the evidence of their skill are not entirely evident. The GDC does not set a minimum target of numbers for clinical procedures, and appreciates that raw numbers are not necessarily an indication of competence. However, without accurate recording of the level achieved for each item of dentistry that a student has performed, the inspectors had some difficulties in seeing how clinical tutors can get a full picture of student skills.

The inspection panel was mindful that the degree award is a competency based programme and the students have completed their clinical training in advance of the final examinations. Without satisfactory achievement of the core clinical competencies, a student will not be signed up to take part in presentation and unseen cases. The inspectors accept that this is a common structure for final year dental students to complete their course of study, but felt the School might seek to introduce some aspect of practical clinical dentistry to finals.

The current model for the final assessments is mainly a test of a student's knowledge rather than their practical skills. The unseen cases were focused on patient management and the presentation case was an overall review of some work completed by students. The technical skills were not assessed at the point of delivery. The Assessment/Examination Group are encouraged to consider how the School's framework might be developed to bring in a clinical aspect to the final examinations.

Ultimately, the inspection panel was assured that the students had reached the level of being fit to practise as a safe beginner and should be permitted to join the GDC register. There was a better base of evidence for the School to show their rationale for assessment decisions, though further clarity in this area is still needed.

The inspectors will review the progress in this area through the GDC annual monitoring exercise.

Requirement 17: The provider will have in place management systems to plan, monitor and record the assessment of students throughout the programme against each of the learning outcomes *(Requirement remains Partly Met)*

The inspection panel was informed that the School remains confident in its overall programme structure but, in light of the 2012/13 GDC inspection report, acknowledged the crucial need to adopt better management systems for the recording of student assessment.

The learning outcomes remain developed in five themes that run vertically through the programme. The themes are:

- Human Health and Disease
- The Mouth in Health and Disease
- Clinical Competence and Patient management
- Teamwork, ICT, Reflective Practice and Communication
- Scientific Understanding and Thought

The School described the development of the five themes as providing vertical integration. The framework has been designed to ensure continuous progression through the five years with the student gaining knowledge, skills and attitudes that build on those gained in previous years.

The inspection panel still had some reservations about the difficulty in identifying where specific topics were formally taught. The EBL framework, by its nature, is one that lacks formal structure and the School needs to be mindful that there should always be an audit of evidence for each student's attainment across the learning outcomes.

There were signs that the revised management system will, in time, enable the School to appropriately track the practical progression of all of the students through each theme, particularly in relation to clinical achievements. As they received more and more information, the CEDAR and LIFTUPP systems will build a strong base of knowledge of student achievement for the various committees to be able to make well evidenced progression decisions. The inspectors felt that more comprehensive assessment blueprinting would add significant robustness to applying this data to the achievement of learning outcomes.

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

In the 2012/13 GDC inspection report, the inspection panel noted that the School had demonstrated a range of assessment methods within their mapping of the learning outcomes. The inspection panel was satisfied that there was an assessment strategy that discriminated against weak and strong students although the structure for how each component fitted together was unclear, and some aspects could not be described as current practice.

Two actions were recorded in regards to the requirement in the 2012/13 inspection report:

i. The School must review its delivery of OSCEs and consider whether they could be structured to be more focused on clinical skills testing.

ii. The School must improve the monitoring of assessments and their appropriateness. There must be a clear strategy for assessment reviews, with a designated forum that has responsibility for overall quality assurance of assessment design and implementation.

In response to the actions, the School has set up the Assessment/Examination Group, which has already been detailed in Requirements 9 and 15. The group has taken on the responsibility for the monitoring of assessments and their appropriateness and has made a strong start.

There was evidence that the Assessment/Examination Group have reviewed the content of the OSCE stations for this year's exam diet and made some modifications to make them more clinically oriented. An online training package has been designed for all examiners to ensure calibration. LIFTUPP has been used to manage a bank of Single Best Answer (SBA) questions with several new questions set for use across each year of the programme. The questions have been peer reviewed and standard set.

The inspection panel was confident that the Assessment/Examination Group will improve the range of assessment methods and promote the use of best practice in the area. Once again, the inspectors felt unable to fully revise their original decision that the requirement is partly met because a lot of the work remains in progress. The inspectors are optimistic that were they to review the work completed by the committee after a full year in operation, sufficient data would be seen to warrant the requirement being deemed met. This is something that will be reviewed through the GDC annual monitoring process.

Requirement 19: Students will have exposure to an appropriate breadth of patients/procedures and will undertake each activity relating to patient care on sufficient occasions to enable them to develop the skills and the level of competency to achieve the relevant GDC learning outcomes *(Requirement remains Partly Met)*

The inspection panel considered the clinical competencies that students are expected to achieve year on year in some depth.

There are 10 competencies for achievement in Year 2, 50 in Year 3, 24 in Year 4, and 3 in Year 5. The range of skills that the students must obtain showed an appropriate depth and range. However it remained difficult to audit how and when student competences were achieved, and the exact detail of the breadth of patients and procedures being undertaken. In addition, it continued to be unclear what capacity the student had been operating in on clinics; whether the candidate had been observing, providing treatment under supervision, or practising independently.

As outlined in Requirement 16, competences are recorded in the CEDAR system, which is monitored by the Year Leads in SDR meetings, and the Undergraduate Administration office. It remained that students have two attempts to pass a competency with a third attempt possibly granted if mitigating circumstances are accepted by the Health and Conduct Committee. Competencies can be achieved in outreach, and the understanding once again gathered by the inspectors was that students opted to have a competency assessed when they felt ready.

The inspection panel reiterate that they are satisfied with the outlined framework for the achievement of competencies, but continue to be concerned by a lack of clarity and formality for the actual assessment used for the achievement of the core targets. There was no guidance on how many times a student has to complete a procedure before they can indicate they feel ready to be tested, or whether a first attempt may be the one and only time the procedure is performed if deemed satisfactory. There also remained no detail for how the actual tests are standardised each time, or how calibration between assessors was managed, particularly in outreach.

It was seen that LIFTUPP records each stage of a clinical treatment, which is then counted under a relevant title. The inspection panel could appreciate the benefits of counting the individual stages of a treatment, particularly in regards to identifying transferable skills, but it was felt that an overall record of completed work was also required. This would avoid any possibility of the numbers being misleading, as initially, it was thought that students had a high number of restorations and/or extractions to their name, though when the data was fully explored, it was found that a number of stages of the same treatment had been recorded separately, rather than a large number of completed restorations and/or extractions.

The inspectors wished to point out that stages of treatment should not necessarily span the achievement of skills in separate areas of clinical work. For example, under Minor Oral Surgery (MOS), a distinction should be made between a student doing an extraction and performing a item of MOS. It would not be appropriate for the same treatment to be counted twice to fulfil criteria in both areas of skill.

The inspectors were able to see a much fuller picture of the details that are produced by the CEDAR and LIFTUPP systems. There is evidence to show that tutors and students are able to see clinical attainment and feedback, which can allow teaching to be tailored to an individual's needs and weaknesses. Staff and students commented that the buy-in to LIFTUPP is time consuming but manageable and the benefits have been considerable. The inspectors appreciate that the recording systems are still fairly new and the databases need time to build. Having had to request paper records to verify the findings in the systems, the inspectors urge the School to ensure that the accuracy of the data being inputted into CEDAR and LIFTUPP is closely monitored and reviewed. Accuracy of data will be paramount for supporting the progression pathway of students achieving core clinical competencies.

The inspection panel was informed that part of the Assessment/Examination Group remit will be to look at competencies and review what exactly core skills are. The School acknowledged that there were a large amount of competencies for achievement in Year 3 and there could be a more even spread across the years. The inspectors were strongly of the opinion that a more equal distribution of competencies between the years would be beneficial and reduce the potential for some being carried over from year to year.

The inspectors once again felt that the relationship between the monitoring and achievement of clinical performance and the monitoring and achievement of clinical competencies should be more defined. The interrelation between the two components should be developed into a real strength with LIFTUPP showing the progression of a student as they build their skills into the achievement of the competencies, which can then be noted in more of an overview on CEDAR.

Requirement 20: The provider should seek to improve student performance by encouraging reflection and by providing feedback[2] *(Requirement remains Partly Met)*

The 2012/13 GDC inspection report highlighted that Academic Advisors had been employed as the main reviewer of student portfolios. There was a "Summary of Progress" sheet used for meetings, which recorded a rudimentary level of reflection and feedback. The inspectors noted that student reflective practices appeared narrowly focused with the examples reviewed suggesting a limited engagement in the practice, with small details recorded rather than any serious reflections on clinical practice noted.

Two actions were recorded in regards to the requirement in the 2012/13 inspection report:

i. The School must continue to develop the engagement of students with reflection. There should be more clarity about how self-reflection is evaluated and used to influence assessment and/or progression decisions.

ii. LIFTUPP offers the potential for feedback to be well targeted and extensive. The School should continue to explore maximising this element of the system.

As detailed in Requirement 16, Academic Advisors have now become a purely pastoral function and no longer play any part in the monitoring of student progress. The School have introduced Student Development Review meetings, which are recorded on CEDAR and include elements of reflection and feedback recorded in the database.

The School informed the inspectors that they are currently reviewing all aspects of student reflection. A member of staff has been given a lead role and will consider the best strategies for encouraging student reflection. The inspectors' understanding is that CEDAR and LIFTUPP

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

will play a key role in promoting reflection and providing targeted feedback.

It was demonstrated how LIFTUPP can summarise a student's performance and provides immediate feedback. The database can also display a feedback summary. Students once again were of the opinion that LIFTUPP had improved the quality of feedback with more tutor interaction, a view echoed in the inspectors' discussions with clinical teaching staff.

The inspection panel look forward to considering further updates on the findings of the staff member's review, along with any subsequent new initiatives, via the GDC annual monitoring process.

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

As noted in Requirement 14, the School no longer uses external examiners in the undertaking of assessments. Internal examiner pairings were used for the first time during final examinations this year.

One action had been recorded in regards to the requirement in the 2012/13 inspection report:

The School must provide a more comprehensive examiner briefing at the final examinations. There must be a consistent approach adopted by all assessors to ensure examinations are conducted fairly. Independent marking must be undertaken before discussion is entered into among examining teams. Leading questions should not be permitted at any stage of the clinical examinations. There should be no changes made to the examination methodology once the first candidate has been assessed.

The School submitted details of the internal examiners, and all held the appropriate registration with the GDC. A comprehensive examiner briefing was provided in advance of the final examinations with clear guidelines and advice. Consistent examination conditions were maintained throughout the case presentations and unseen cases, managed by a dedicated team of dental nurses.

The inspectors did find evidence to suggest that some examiner pairing may not have been the most appropriate with regards to experience and training in the specific areas of dentistry being assessed. There were also examples of examiners not following the guidance from the examiner briefing, with leading questions or prompts seen on a number of occasions. It was thought that the practice might have occurred less had there been marking descriptors for presentation cases, which would help standardise the questions being asked. However, it was also seen in the unseen cases that there was an inconsistent approach between the examiner pairs in relation to using the radiographs and including questions around what was seen on the x-rays. Standardisation of examiner practice is something that should be developed through the Assessment/Examination Group.

The inspection panel appreciated that the change from using external examiners for examining, to utilising a team wholly comprised of internal staff, is a significant one. The inspectors were optimistic that as the internal team build their experience, errors will reduce and the best combinations of people will become more apparent. This needs to be supported with a regular and comprehensive training schedule linked to staff development plans.

Requirement 22: Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted *(Requirement revised from a Partly Met to a Met)*

The Inspection panel was very encouraged by the School's revision of its remit for external examiners.

Two actions had been recorded in regards to the requirement in the 2012/13 inspection report:

i. The School must employ external examiners to provide an overview of the complete examination process. In accordance with QAA guidance, external examiners should not directly participate in assessing students and should be given the freedom to review wider aspects of the assessments.

ii. Written papers should be reviewed by more than one external examiner.

As reported at Requirement 14, external examiners have been given a new remit for overall quality assurance with access to all aspects of the examinations. They did not actively participate in the assessing of students anymore.

Written papers were reviewed by more than one external examiner with time built into the schedule to review the assessment of coursework. This would have been particularly beneficial as it was found one of the written papers had been standard-set too high. However, the School did not act on the feedback (detailed at Requirements 15 and 23).

External examiners are included in monitoring the progress routes through Year 1 to Year 4, and an external examiner scrutinised the student sign-up meeting for final examinations. The inspectors were once again informed by the external examiners that they felt the standard of the presentation cases seen at the School was equivalent and comparable to other institutions. Students had prepared well with appropriate cases for assessment.

Requirement 23: Assessment must be fair and undertaken against clear criteria. Standard setting must be employed for summative assessments *(Requirement revised from Not Met to Partly Met)*

The inspection panel indicated in the 2012/13 report that they could not determine to their satisfaction, the rigour and defensibility of the assessment criteria outlined in the School documentation and within their findings on the inspection.

Three actions were recorded in regards to the requirement in the 2012/13 inspection report:

i. The various assessment grading schemes and current style of intention marking must be re-evaluated. There must be a clear model for how each area of student attainment is combined into an overall grade which is underpinned with clear grade descriptors. The criteria for progression must be understood by staff and students.

ii. Standard setting for summative assessments must be more explicit and clearly defined.

iii. The discussion during ratification of final grades at the examination board must be more rigorous and open. Consideration should be given to the complexity of converting marks and whether some students are disadvantaged by the rubric used to finalise grades.

The inspection panel was pleased to see that the School has a made a positive start to the

review of its assessment strategy. As outlined in earlier Requirements, the Assessment/Examinations Group has taken on overall responsibility for the area. With input from Year Leads and other senior staff, the group will be considering the grading scheme, combination of grades and the application of intention marking in the A-E scale used outside of LIFTUPP. It is appreciated that this will take some time to review, as the School reflects on the best range of assessments to suit the overall competency based structure of the programme.

Standard setting for summative assessments was more explicit and defined. There was a process for reviewing the Multiple-Choice Questions (MCQ) question bank within LIFTUPP. A Theme Lead will be tasked to review subject specific questions and be able to change or reject any which are judged not appropriate. Once agreed, the questions are standard-set using the Angoff system. Short Answer Question papers (SAQ) are also standard-set using Angoff, though this is undertaken outside of LIFTUPP.

This year, all written papers were submitted to the external examiners in advance. Further input was subsequently required during the year five final examination diet where the external examiners were asked to provide an independent review of the standard set pass mark. The inspection panel accepted this was an appropriate action.

The inspectors noted that an external examiner had commented on the initial pass mark for the written paper. The matter was not investigated by the School and might have been rectified in advance of the final examinations had it been. In addition, an unseen clinical scenario had to be changed as it had already been used in a written paper. Again, this oversight had already been reported to the School by an external examiner and was not followed up. It was also agreed that a more comprehensive blueprinting exercise should have been undertaken when planning the assessments, which would have identified the same question overlapping two components of the examinations.

Summative Objective Structured Clinical Examinations (OSCES) are run through years 2 to 4. These are standard set once again using the Angoff method with a new observer sheet to only allow for marks as dictated by the relevant station. Data is checked with a regression analysis. The Assessment/Examinations Group are currently considering the potential benefits of changing the grading to a global scoring system.

The inspection panel felt that the descriptors used for the Unseen cases could be clearer. There was an A-E grade scale but also a criteria given for Honours, Distinction and Passes as well, which might have confused the awarding of grades on occasions. As mentioned in Requirement 21, there were no marking descriptors for presentation cases, which is something that should be developed to help standardise the questions being asked by the examiner teams.

The inspection panel once again observed the collation of intention marking into a final overall grade at the examination board. The guide for determining overall marks combined the three components of the final examination – unseen case scenario, presentation cases, and a combined mark for the MCQ and SAP written papers – into a final grade. The marking scheme for each element was A-E with the School rubric translating the marks into an overall A, B, C for a pass and D or E for a fail.

The process for combining the three components within the A to E grading scheme remains confusing. The inspectors are still not satisfied with the clarity of the amalgamation and strongly believe the use of the rubric to convert the marks is not modern best practice in assessment methodology. It was concluded that for all the depth of work being undertaken to improve the standard setting of the examinations, the benefits of the statistical calibration is somewhat lost within the second, less coherent round of translation and possible compensation. In addition, at the high end of the scale, poor grades were hidden by the

compensation process and students could end up with potentially 'commendation' or 'honours' which were not appropriate. The inspectors wish to see the practice reviewed by the Assessment/Examinations Group at the earliest opportunity.

Ultimately, the inspection panel was reassured by the work being done by the Assessment/Examinations Group. It has evidenced a commitment to improving the overall clarity of the School's assessment strategy with a better focus on how to ensure assessments are valid and reliable. Further developments are still needed, particularly in regards to the overall combination of grades, the clarity of grade descriptors, examination blueprinting, and attention to detail when considering feedback from external examiners.

The inspectors will review the progress in this area through the GDC annual monitoring exercise.

Requirement 24: Where appropriate, patient/peer/customer feedback should contribute to the assessment process *(Requirement revised from Not Met to Partly Met)*

In 2012, the School indicated there was a broad range of reporting mechanisms cited as potential paths to receive feedback from patients. However, the inspectors found no evidence for the information being centrally managed and contributing to the assessment process.

One action was recorded in regards to the requirement in the 2012/13 inspection report:

The School must continue to develop its policy on patient feedback and explore how it might contribute to assessments.

The inspectors saw evidence that the School has started to review how patient feedback might contribute to the assessment process. The inspectors were told that the School has looked at the Trust based patient feedback activity and systems used within Outreach clinics, but these tended to be related to service provision and patient experience rather than student performance.

It was seen that LIFTUPP has a section for patient feedback and feedback from Dental Nurses, which could also be a valuable source of information. How best to incorporate these facilities are currently being discussed at staff training days.

The inspection panel was mindful that this is an area that several Schools are still developing, and Manchester is now working towards fulfilling the Requirement. It was thought that senior staff should continue to evaluate where patient feedback can contribute to the assessment process and start considering the matter within the appropriate committees.

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

The inspection panel saw evidence that the School are beginning to adopt an assessment strategy which brings together various components to produce robust, triangulated final decisions. Multiple samples of student performance had been taken and the inspectors were eventually satisfied of the reliability of the assessment conclusions.

Once again, further assurance of student attainment in their competencies was required by the inspection panel. This was due to LIFTUPP data not always tallying with what was found on CEDAR. Paper records were reviewed and the inspectors were satisfied that there had been

suitable coverage of assessment.

As detailed in earlier Requirements, the Assessment/Examinations Group are reviewing several aspects of the assessment structure. It was also evident that the CEDAR and LIFTUPP systems have started to become more embedded in the programme. The inspectors felt that the School has an opportunity to build on these positive developments.

To take advantage of the progression data that will now be available, a round of assessment blueprinting would be highly beneficial and could be incorporated with the mapping to the learning outcomes in Preparing for Practice. This would provide ready access to multiple samples of performance to support overall assessment decisions. The inspectors also agreed that the accuracy of the performance data providing the assessment samples needs to be more robustly checked. CEDAR and LIFTUPP are separate systems with no function for the databases to cross-reference the recordings in one system with the other. The School must ensure there are protocols in place that samples the accuracy and reliability of the information being used.

Requirement 26: The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard *(Requirement revised from Not Met to Partly Met)*

In the 2012/13 GDC report, the inspection panel had not been assured that students understood the assessment strategy and were unable to identify what the School considered a minimum level of student clinical experience.

At the re-inspection, the inspectors felt that the student groups were more confident in their knowledge of what would be expected of them. They were pleased to find that a Student's Guide to Assessment had been published this year. The document has been created by Assessment/Examinations Lead and provides an excellent reference for students to see how they will be assessed over the whole five years of the programme. It includes details of examination formats, when they occur, and whether they are formative or summative.

As outlined in earlier Requirements, there remains a number of areas within the assessment strategy that still requirement improvement but the inspectors were impressed with the amount of hard work that has already been done. Staff appeared to have more confidence in how the programme was operating on a strategic level under the new management framework. There was evidence of a better distribution of expertise amongst the committees, which has fed into the work being done by the Assessment/Examinations Group. The inspectors are confident the assessment strategy will be improved and strengthened with a comprehensive schedule of review and quality assurance.

Actions

Req. Number	**Actions for the provider**	**Due Date (if applicable)**
16/25	(i) The School must develop the SDR meetings and consider a formal policy on the number of meetings required per year and whether their recording would be an appropriate requirement for sign-up rather than something for noting	GDC Annual Monitoring 2015

	(ii)	The School must continue to review its assessment structure to ensure a clear progression pathway can be audited. There must be an overall strategy for how each component of the programme fits together to produce final assessment decisions, particularly on a student's clinical ability. Assessment decision points must be openly and robustly evidenced.	GDC Annual Monitoring 2015
	(iii)	The School must continue to improve the monitoring and recording of students achieving clinical competencies. There must be a clearly defined policy for when and how students are assessed in these skills, which must be developed with an accurate central management system to track student progress.	GDC Annual Monitoring 2015
	(iv)	The School must complete a comprehensive blueprinting of their assessment strategic to illustrate the achievement of learning outcomes within the programme.	GDC Annual Monitoring 2015
	(v)	The School should consider whether it might be appropriate to introduce some aspect of practical clinical dentistry to the final examinations.	GDC Annual Monitoring 2015
19	(i)	The School must continue to review student achievement of clinical competencies. The review must include:	
		(a) The development of a formal policy for the achievement of clinical competencies that outlines where and how the tests are undertaken, what the assessment are standard set against, and how assessment calibration is maintained across the School and Outreach sites.	GDC Annual Monitoring 2015
		(b) Clear guidance on how many times a student has to complete a procedure before they can indicate they feel ready to be tested.	GDC Annual Monitoring 2015
		(c) Between CEDAR and LIFTUPP, there must be full and accurate record of a student's clinical exposure and a clear indication for how the continuous clinical assessment has led up to achievement of competencies.	GDC Annual Monitoring 2015
		(d) The School must consider the distribution of competencies between the years. Consideration must be made of the benefits of a more even spread of competencies between the years of the programme.	GDC Annual Monitoring 2015

20	(i) The School must continue to develop the engagement of students with reflection. There should be more clarity about how self-reflection is evaluated and used to influence assessment and/or progression decisions. (ii) CEDAR and LIFTUPP offer the potential for feedback to be well targeted and extensive. The School should continue to explore maximising these elements of the systems.	GDC Annual Monitoring 2015 GDC Annual Monitoring 2015
21	(i) The School must ensure that examiners have the most appropriate experience and background for the areas of dentistry they are assessing. (ii) The School must develop its training for examiners and ensure that a consistent approach is adapted by each team of assessors. Particular attention must be paid to the use of radiographs during the examinations.	GDC Annual Monitoring 2015 GDC Annual Monitoring 2015
23	(i) The School must develop marking descriptors for presentation cases. (ii) Further consideration must be given to the complexity of converting marks at the examination board meeting, and whether some students are disadvantaged by the rubric used to finalise grades.	GDC Annual Monitoring 2015 GDC Annual Monitoring 2015
24	The School must continue to develop its policy on patient feedback and explore how it might contribute to assessments.	GDC Annual Monitoring 2015
25	The School must develop protocols for the regular sampling of the accuracy and reliability of the information being held on the CEDAR and LIFTUPP systems.	GDC Annual Monitoring 2015

Standard 4 – Equality and diversity **The provider must comply with equal opportunities and discrimination legislation and practice. They must also advocate this practice to students**			
Requirements	**Met**	**Partly met**	**Not met**
27. Providers must adhere to current legislation and best practice guidance relating to equality and diversity	✓		
28. Staff will receive training on equality and diversity, development and appraisal mechanisms will include this *	✓		
29. Providers will convey to students the importance of compliance with equality and diversity law and principles of the four UK Nations both during training and after they begin practice *	✓		

* = Requirement has been revised from the 2012/13 report

GDC comments

Requirement 27: Providers must adhere to current legislation and best practice guidance relating to equality and diversity *(Requirement remains Met)*

The University equality and diversity policy was once again noted. The document sets out a commitment to promoting equality of opportunity and embracing diversity. There was policy coverage for disability, respect and dignity, and a student complaints procedure was noted. No incidents concerning an equality and/or diversity issue, either with staff or students, had been recorded.

Staff and students showed a good awareness of equality and diversity issues and their responsibility to uphold current best practice in the area. Standard NHS polices were in operation within the dental hospital and at outreach placements, which is now monitored by the Outreach Teachers Group.

Requirement 28: Staff will receive training on equality and diversity, development and appraisal mechanisms will include this *(Requirement revised from Partly Met to Met)*

The 2012/13 inspection report noted that staff received Equality and Diversity training from a range of sources but a record of the respect awards was not held centrally by the School. Plans were being put in place to introduce such a system and link it up with staff annual appraisals.

One action was recorded in regards to the requirement in the 2012/13 inspection report:

The School must continue to develop its plans to incorporate a review of equality and diversity training in staff appraisals.

The inspection panel was informed that all staff are expected to complete appropriate Equality and Diversity training. The UPC has agreed that annual staff appraisals will include a check on relevant E&D training. This will form part of staff PDR and recorded on a central database. Anyone who has student contact will have annual the online training including part-time staff, NHS consultants, and outreach.

E&D training is also included in an assurance with the School's annual learning and teaching contract with the four NHS Trusts that operate the outreach placements.

Requirement 29: Providers will convey to students the importance of compliance with equality and diversity law and principles of the four UK Nations both during training and after they begin practice *(Requirement revised from Partly Met to Met)*

In the 2012/13 inspection report, the inspection panel was directed to one intended learning outcome for this area. It was formatively assessed in on-going staff assessment through each year of the programme. There was also a suggestion that summative assessment may occur during OSCE examinations. The inspectors were unsure why the School only indicated that a summative assessment may occur and felt it was entirely appropriate for such an area to always have some form of summative assessment.

One action was recorded in regards to the requirement in the 2012/13 inspection report:

The School must consider whether the taught component for equality and diversity should be expanded. Summative assessment in this area should become standard within the programme.

The School indicated that all undergraduate students are expected to complete an online E-learning package entitled "Quality, Diversity and Human Rights." This is the same NHS package that is completed by all the Consultants in the Dental Hospital as part of their Corporate Mandatory.

Completion of all E-learning packages has become a requirement for sign-up to year on year progression and final examinations. The School also has various EBL sessions that contribute to formative assessment in this area. The inspectors felt this showed good progress though further development would still be beneficial. There was some concern that a student might be able to perform poorly in the formative assessments yet still progress as the e-learning examination appears to have some element of rote learning.

Staff and students once again showed a good awareness of equality and diversity and their responsibility to comply with the relevant laws. Students appreciated there would be differences in legislation from country to country within the UK.

Actions

Req. Number	Actions for the provider	Due Date (if applicable)
29	The School should continue to consider whether the taught component and summative assessment for equality and diversity should be further expanded.	GDC Annual Monitoring 2015

Summary of Actions

Req. Number	Action	Observations Response from Provider	Due date
1	All tutors must be mindful of the periods of time between a student learning skills in a pre-clinical environment, and the first opportunity for them to practise the procedure on a patient in clinic. The School should introduce formal expiry dates to the achievement of skills tests by students. There should be a clear policy on revocation and reinstatement following any further assessment.	Through the Assessment and Examinations Group (AEG) and Undergraduate Programme Committee (UPC), core skills will be identified. Competency exercises in each of these skills will be repeated annually. Failure to complete these will stop progression.	By academic year 2015-16.
8	The School should continue its commitment to staff training and calibration for the issuing of professionalism cards to ensure the system remains fair and reliable.	Staff will be requested to undertake the calibration exercises annually as part of their annual Performance and Development Review.	With immediate effect.
9	(i) The School must continue to establish its revised management framework and provide relevant committee minutes in their response to the GDC annual monitoring exercise next year (ii) The School must make the mapping of the programme to the learning outcomes in the GDC document *Preparing for Practice* a matter of priority	This continues and the appropriate documents will be provided. This work has already been carried out. The Inspectors were invited to see the mapping on a database, however, as far as I am aware they did not wish to. The mapping occurred during the last academic	Ongoing Completed

		year as described to the Inspectors and was available for them to see. All year leads were then asked to confirm that each part of the course conformed to Preparing for Practice. Because of the Intended Learning Outcomes that The Manchester Dental Programme has and how they mapped across to Preparing for Practice, we are content that our students are currently being produced against Preparing for Practice so that this will have been fully embedded by summer 2016.	
10	The School should include minutes from the Outreach Teachers Group and details of staff training sessions involving Outreach staff, in their response to the GDC annual monitoring exercise next year	This work is ongoing and will be reported on. BSc Outreach tutors are now also included in the Outreach Teachers Group.	Ongoing
13	(i) The School must include details of the Periodic Review scheduled to be completed in the 2014/15 academic year in their response to the GDC annual monitoring exercise next year (ii) The School must provide evidence for where consideration has been made in having closer ties with the University Faculty. This should be included in their response to the GDC annual monitoring exercise next year	The date has yet to be set by Faculty but will be done as soon as reasonably possible and will be reported on in the annual monitoring exercise. This has been considered by the Undergraduate Programme Committee and there is now a standing report from the School of Dentistry as part of Faculty Undergraduate Teaching and Learning Committee. The appropriate minutes will be provided in the annual monitoring exercise, however, it is worth noting that there is a move to devolve more responsibility for administrative and management processes to School level within	Ongoing Ongoing

		Faculty.	
15	The School should include minutes from the Assessment/Examination Group in their response to the GDC annual monitoring exercise next year	These will be included in the annual monitoring exercise next year.	Annual monitoring exercise, ongoing
16/25	(i) The School must develop the SDR meetings and consider a formal policy on the number of meetings required per year and whether their recording would be an appropriate requirement for sign-up rather than something for noting	The SDR meetings will take place for every student in each term under the chair of each Year Lead, they will be recorded and form part of the sign-up process.	Within the next 6 months.
	(ii) The School must continue to review its assessment structure to ensure a clear progression pathway can be audited. There must be an overall strategy for how each component of the programme fits together to produce final assessment decisions, particularly on a student's clinical ability. Assessment decision points must be openly and robustly evidenced.	This work is ongoing. There will be a summative assessment at the end of each relevant clinical skills course, double marked with referenced criteria. Students failing will be referred to the Health and Conduct Committee for an action plan.	By academic year 2015-16
	(iii) The School must continue to improve the monitoring and recording of students achieving clinical competencies. There must be a clearly defined policy for when and how students are assessed in these skills, which must be developed with an accurate central management system to track student progress.	See above, this will be recorded through the CEDAR system and use made of the Assessment Handbook written by the AEG.	By the end of the academic year

	(iv) The School must complete a comprehensive blueprinting of their assessment strategic to illustrate the achievement of learning outcomes within the programme.	This work is completed and relates to the mapping of the ILOs with PfP. It will be reported in the annual monitoring exercise. AEG will constantly review the mapping to ensure that ILOs are tested in a timely and valid manner.	Ongoing
	(v) The School should consider whether it might be appropriate to introduce some aspect of practical clinical dentistry to the final examinations.	The School has considered this in the past and will revisit the issue in collaboration with other Schools in the UK. At the moment we are content that our IPCs demonstrate appropriate clinical skills and that other assessments test other clinical areas satisfactorily. We question how meaningful an OSCE simulation exam is at the stage of Finals, particularly when the students are demonstrating a full range of skills in both the Integrated Presentation Cases and unseen examination. Indeed, the School has considered this at Assessment and Examination Group and Undergraduate Programme Committee level, and made the decision not to have an OSCE as part of Finals as it was felt that the allocated time per station in OSCE, does not allow many aspects of clinical dentistry to be assessed. The summative clinical skills test will NOT be observing “a filling” under the exam condition but we were planning to include one indirect restoration and one RCT in a single diet of the exam, which are too complex and too time-consuming to be assessed using OSCE. An OSCE will still remain as part of the yearly examinations throughout the rest of the course.	By academic year 2015-16

19	(i)	The School must continue to review student achievement of clinical competencies. The review must include:		
		(a) The development of a formal policy for the achievement of clinical competencies that outlines where and how the tests are undertaken, what the assessments are standard set against, and how assessment calibration is maintained across the School and Outreach sites.	AEG continues to monitor this activity and are considering formulating clearer descriptors for the assessments. The use of videos and away day sessions addresses the issue of examiner calibration. In addition to this, AEG is piloting the introduction of mini-cases and clinical portfolios that allows a more structured way of recording the core competences. This will be extended to all the BDS years upon a successful experience of the current pilot. It is likely that the skills would be marked using the 6-point scale and therefore the group will consider setting a mark as the minimum requirement for each skill tested. This will be subject to further discussion by the group when implementing the portfolio system in future	Ongoing
		(b) Clear guidance on how many times a student has to complete a procedure before they can indicate they feel ready to be tested.	This is and has always been intended to be; student led, under the advice of the relevant member of staff.	Ongoing
		(c) Between CEDAR and LIFTUPP, there must be full and accurate record of a student's clinical exposure and a clear indication for how the continuous clinical assessment has led up to achievement of competencies.	The AEG discussed this and felt that by implementing the suggested plans in 19 i.a), it will be a matter of demonstration of competency in all the skill sets to allow a student to progress; therefore the matter of "number of attempts" will no longer play a role.	Ongoing

	(d) The School must consider the distribution of competencies between the years. Consideration must be made of the benefits of a more even spread of competencies between the years of the programme.	Clinical exposure is recorded through LIFTUPP and competency acquisition through CEDAR. A large number of competencies are tested in Year 3 on a stand alone basis, the use of portfolio based assessment currently being piloted in Year 2, when appropriately evaluated will address these issues if deemed to have been successful. This work is currently part of a larger review being undertaken by the AEG.	By academic year 2015-16
20	(i) The School must continue to develop the engagement of students with reflection. There should be more clarity about how self-reflection is evaluated and used to influence assessment and/or progression decisions.	The area of reflection is currently under development, students will be required to complete 2 exercises prior to their SDR meetings, which will inform those meetings.	Ongoing, within the next 6 months
	(ii) CEDAR and LIFTUPP offer the potential for feedback to be well targeted and extensive. The School should continue to explore maximising these elements of the systems.	This work is ongoing, involving AEG and UPC.	Ongoing
21			
	(i) The School must ensure that examiners have the most appropriate experience and background for the areas of dentistry they are assessing.	This area has been reviewed and in future will involve more of our part time GDP staff.	By 2015 diet of Finals
	(ii) The School must develop its training for examiners and ensure that a consistent approach is adapted by each team of assessors. Particular attention must be paid to the use of	We continue to require examiners to complete our online and face to face training and calibration and the use of radiographs has been discussed at AEG.	By 2015 diet of Finals

	radiographs during the examinations.	The AEG will also use "common scenarios" for the calibration of Seen Case Scenario examiners.	
23	(i) The School must develop marking descriptors for presentation cases. (ii) Further consideration must be given to the complexity of converting marks at the examination board meeting, and whether some students are disadvantaged by the rubric used to finalise grades.	These descriptors have been developed and were used in 2014 following comments from internal and external examiners. We appreciate the complexity of the examination rubric, this has been removed and a simpler system will be used this summer.	By 2015 diet of Finals By 2015 diet of Finals
24	The School must continue to develop its policy on patient feedback and explore how it might contribute to assessments.	Patient feedback is being sought both in the Dental Hospital and Outreach and will form part of the student's portfolio for discussion at SDR meetings.	In place
25	The School must develop protocols for the regular sampling of the accuracy and reliability of the information being held on the CEDAR and LIFTUPP systems.	Data on LIFTUPP is generated by student, verified by tutor and acknowledged by the student. The QA is quite tight and there is no need to check the accuracy; however, to check the reliability, data has to be sampled by 1 or 2 senior members of staff to identify doves and hawks. This is currently being explored by AEG. Both systems are independent and record different things; CEDAR records the clinical competencies, red and yellow cards, absence, and meetings with Academic Advisors etc. LIFTUPP also records clinical alerts, which can on consideration become red or yellow cards;	By the end of the current academic year

		however, LIFTUPP's main role is the recording of clinical activity and progress through assessment of that activity. This data was reviewed as part of sign-up in May and because both systems are relatively recent in implementation, it was necessary to refer to previous paper based systems to capture all of a student's experience and progress. We anticipate that we will be fully electronic by summer 2016 so the need for both paper and electronic records will no longer exist.	
29	The School should continue to consider whether the taught component and summative assessment for equality and diversity should be further expanded.	This will be considered by UPC, however, the University and Faculty consider that our commitment to equality and diversity and our engagement with our E and D staff is very high. AEG will ensure that E&D will be part of the blueprint of the summative exams.	Ongoing

Observations from the provider on content of report

We thank the Inspection Panel for their time and their efforts during the inspection. We are delighted that they have deemed us as sufficient. We are glad that the Panel have clearly appreciated the efforts that The School has made over the past 18 months since the previous inspection, particularly in terms of our outreach delivery and assessment strategy and in terms of the number of Requirements that they now feel that we have met. In terms of those Requirements still Partly Met, I invite the Panel to consider our Action Plan, which addresses all of these issues.

With regards to Requirement 21 which has slipped to Partly Met, this has been addressed as a matter of priority by the Assessment and Examinations Group with the action as listed in our formal response.

Recommendations to the GDC

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

Instructions to the School

To compile an action plan for the implementation of all actions outlined in report and submit the document to the GDC within six weeks of receipt of the finalised report.