

# Colin Wright Associates

## **Developing an evidence base for effective quality assurance of education and training**

### **Final Report**

**Presented to the  
General Medical Council**

**May 2012**

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## **Acknowledgements**

This research was commissioned by the General Medical Council (GMC) and conducted by three independent consultants; Colin Wright, Iain Armstrong and Sue Hunter.

We would particularly like to thank the many representatives of regulatory and other bodies who gave their time and expertise to participate in this research through various meetings, telephone discussions and responses to questionnaires.

The list of participant organisations is presented in Annex 3 of this report.

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## Executive Summary

The purpose of this report is to provide the General Medical Council (GMC) with a broad overview of the quality assurance (QA) of education in regulated professions to provide a contextual evidence base for its forthcoming comprehensive review of the quality assurance of medical education and training.

The scope of the research includes the current QA practice of UK regulators of education and training within and outside the health sector, and a sample of regulators from overseas and from other sectors. In total, individuals representing 43 organisations participated in the research. In-depth discussions were completed with 31 of these participants, and the remainder submitted detailed written responses using a topic guide or questionnaire.

In addition, an academic literature review was completed to identify evidence of good practice or innovation in QA and to provide another dimension to the research through the analysis of QA from the perspective of academic commentators.

The report begins with consideration of the current context for QA in the health sector, including the globalisation of medical education, the main international guidelines and standards already developed for QA in medical and non-medical education and training, and the CHRE approach to 'Right-touch regulation'.

Approaches to QA and regulation are then explored, supported where appropriate, by case studies describing approaches adopted by specific regulators. This includes:

- planning and targeting of QA
- standards or criteria use to form judgments
- self-assessment/evaluation
- visits to organisations
- composition of the QA team
- shared evidence
- reporting
- interest groups and provision of reports
- sanctions
- perceived added value provided by QA.

In conducting the research, a number of other trends and issues emerged which warranted further exploration including thematic QA, enhancement-led QA, systematic linking of QA to outcomes and the use of student/service-user surveys. Feedback was also obtained from a sample of Deaneries and Medical Schools.

The findings of the research suggest that there is an increasing emphasis on QA to support enhancement of provision. This is linked to recognition of the importance of rigorous internal QA processes, and a general (although not universal) recognition of the role of self-assessment (both through self-reporting for routine monitoring, and as a starting point for validation of provision during QA visits).

The cyclical model for re-approval of provision remains the most frequently reported approach to planning QA (e.g. a re-approval visit after a maximum of 5 years is most typical). However, there is also a shift towards more proportionate targeting of QA e.g. relying on a more risk-based, intelligence-led approach to monitoring provider performance. A small number of regulators have moved away from the cyclical approach to an entirely risk-based or open-ended model.

Standards or criteria used by regulators to judge performance take account of both process and outcomes, although in the standards that are more recently developed, there is clearly an increased emphasis on outcomes.

Narrative feedback is a key aspect of reporting for all regulators, with variation in the use and types of scoring or grading. A number of respondents expressed a preference for terms in scoring or grading which are, as far as possible, unambiguous e.g. standards are 'met' or 'met with areas for improvement', rather than 'satisfactory'.

The importance of transparency in QA was a common theme, and this is reflected in reporting, with outcomes of QA in the public domain and typically available from regulator's web sites. A wide range of different interest groups have an interest in QA outcomes including students, education providers, policy makers and the general public.

A number of further observations and challenges are identified for all health sector regulators of education and training:

- Use of thematic QA (as currently being piloted by the GMC) to recognise and share good practice and achieve greater consistency between providers.
- Inclusion of students on QA visits teams by other health sector regulators (as already established by the GMC).
- Effective training and support for all members of QA visit teams.
- Review of how self-assessments are validated with consideration for the use of additional data sets (e.g. collecting/collating data from key interest groups).
- Review of standards and QA processes to ensure they remain clear and respond to change.
- Co-ordination of joint inspections between regulators where practicable, to share evidence and minimise the assessment burden on providers.
- Clear definition of interest groups for QA and reporting formats which are tailored to intended target audiences.
- Continued sharing of good practice between health sector regulators.

Feedback from a number of regulators and Deaneries suggest that the GMC is considered to be at the forefront of excellence in regulatory practice, including practice in QA of education and training. It has been described as providing a "still, calm, centre" to medical education and medical regulators around the world look to the GMC for exemplars when refining their own systems. The sample of respondents from medical schools also observed the importance of the GMC as a regulator that drives enhancement and change.

Overall, the findings of this research suggest a broad QA landscape that shows a trend towards increasing alignment with principles such as those outlined in CHRE's "*Right touch regulation*" i.e. proportionate to risk, outcome focussed and enhancement-led.

# 1. Introduction

This report describes a project commissioned by the GMC to research the quality assurance (QA) of education and training. The scope of the research includes the current QA practice of UK regulators of education and training within and outside the health sector, and a sample of regulators from overseas and other sectors. The aim of the research is to provide the GMC with a contextual evidence base as a contribution to a comprehensive review of the QA of medical education and training.

The project commenced in mid-October 2011 and was completed at the end of February 2012.

## 2. Methodology

### 2.1 Awareness-raising

To raise awareness of the project, a 'Research Project Briefing' paper was developed to provide information to stakeholders and potential participants. This briefing provided a concise background to the project, the methodology, expected outcomes and timetable. It also provided contact details for anyone who required further information or wished to participate in the research.

The 'Research Project Briefing' paper was included as a flyer in the delegate pack at the GMC Education Conference on 1st November 2011. The conference was also attended by two of the research consultants in order to make contact with colleagues in the regulatory field and to hear prevailing views on regulation of medical education.

Text from the 'Research Project Briefing' paper was also used for a page about the project on the GMC website: <http://www.gmc-uk.org/education/10932.asp>

Links to this web page were subsequently used in email communications between the research consultants and contacts/participants. This proved invaluable in providing potential participants with a source of further information and in providing the research consultants with additional credibility (i.e. to establish a clear link between the research consultants and the GMC).

### 2.2 Development of the topic guide

Another early project activity was the development of a topic guide, to ensure that the research captured the required information and that research findings were recorded in a consistent format. Questions on the topic guide aimed to explore approaches to QA and identify examples of good or innovative practice (i.e. the ethos was one of sharing good practice, rather than attempting to uncover or highlight poor practice). A first draft of the topic guide was produced by the research consultants and this was then refined and further developed in consultation with the GMC project managers. A copy of the topic guide is attached as **Annex 1**.



## 2.3 Initial desk research

An initial internet and literature search was conducted to confirm organisations to target as potential participants for the research based on the following 'work packages'<sup>1</sup> i.e.

- WP4 UK regulators of education and training in the health sector and a sample of overseas regulators of medical education and training
- WP5 UK regulators of education and training outside the health sector and a sample of overseas regulators of non-health sector education and training
- WP6 A sample of UK organisations from other sectors, which may provide examples of good practice in quality assurance and regulation
- WP7 Medical schools, Deaneries and others providing background information on medical regulation

In addition, an academic literature review conducted during November 2011 provided further references to organisations for inclusion as participants in the research.

## 2.4 Academic literature review

The purpose of the academic literature review was to identify and review documents providing evidence of good practice and/or innovation in QA/regulation of health and non-health sector education in the UK and overseas. The literature review was also important in providing another dimension to the research through the analysis of QA from the perspective of academic commentators.

The search for relevant documents was primarily conducted using on-line academic search engines based on the topic 'Quality assurance of (medical) education'. A number of key words (and potential combinations) were selected as search terms, shown in the table below:

Activity	Combined with context
• <b>quality</b>	+ medical
• <b>quality assurance</b>	+ education
• <b>regulat*</b>	+ health
• <b>inspect*</b>	
• <b>assess*</b>	

The scope of searches was limited by the following inclusion criteria:

- English language material only
- Scholarly (peer reviewed)
- Publication date (since 2000)

Based on this strategy, searches for relevant articles were conducted through:

- EBSCOHost: Academic search complete
- Google Scholar
- Directory of Open Access Journals

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<sup>1</sup> Previous work packages (WP1, WP2 and WP3) covered the initial project planning, desk research and development of research documents.

In addition, detailed searches were carried out for relevant articles specifically from the following publications:

- Medical Education
- Higher Education
- The Quality Assurance Journal
- Quality Assurance in Education
- BMJ Quality and Safety

References to other relevant sources were also explored, for example, publications from the Research Directory at the University of Manchester.

From all these searches, appropriate documents were selected based on the relevance of their title and abstract. The bibliography from the literature review is presented in **Annex 2**.

## **2.5 Contacting UK organisations**

Key contacts from regulators of health and non-health sector education and training in the UK were sent an email from the GMC to introduce the project. The consultants followed this up with a second email attaching a copy of the topic guide – the consultants then also contacted the regulators by telephone. As anticipated, in some cases it required some perseverance to establish the most appropriate person to speak to within each organisation. However, once contact was established, arrangements were made for a mutually convenient time to conduct an in-depth discussion either through a face to face meeting, or by telephone. The topic guide was then used to provide a framework for the discussion and the consultant made notes to complete the topic guide.

There was also some flexibility in this approach – for example, where organisations were not regulators but have a more overarching role (e.g. CHRE and COPMeD), the topic guide provided a starting point leading to a broader discussion. A small sample of medical schools was also contacted and sent a slightly amended version of the topic guide to obtain their perspective on QA and regulation. In addition, discussions were conducted with other organisations (e.g. a number of Deaneries) which expressed an interest in the research.

For UK regulators from other sectors, contact details were not available through the GMC and therefore, the consultants established direct contact through email and telephone.

## **2.6 Contacting overseas organisations**

The approach to overseas regulators was slightly different from that for those in the UK. The sample of overseas regulators was sent an introductory email from the GMC and also a copy of the topic guide adapted for use as a questionnaire. The overseas regulators were asked to complete and return this questionnaire, with the option of a follow-up telephone discussion where required. The initial email to overseas regulators from the GMC was followed up with reminder emails both from the GMC and the consultants as required.

## 2.7 Summary of responses

A total of 43 organisations completed a response, either through a meeting with one of the consultants (x13), a telephone discussion (x18) or returning a self-completed topic guide/questionnaire (x12).

Respondents were advised that the name of their organisation would be acknowledged in the final report, but that the names of individual respondents would remain confidential. The full list of organisations providing a response is presented in **Annex 3**.

A summary of the types of organisations providing a response is shown in the table below:

Work packages	Location	Number of participant organisations
<b>WP4 Health sector regulators of education and training</b>	UK	7
	Overseas	3
<b>WP5 Non-health sector regulators of education &amp; training</b>	UK	10
	Overseas	6
<b>WP6 Other sectors providing QA and regulation</b>	UK	8
<b>WP7 Medical Schools, Deaneries and others providing background information on health sector regulation</b>	UK	9
<b>Total</b>		<b>43</b>

## 3. QA and regulation in context

### 3.1 International context

The literature review confirmed a diverse range of approaches to the QA of medical education (and education more widely) both between and within countries. In different countries, the evolution of medical education regulation and QA is at different stages and faces different challenges. Some commentators particularly note the difference between those countries where QA has a long tradition (e.g. UK and USA) and those countries where the practice of QA in education is relatively new.

### 3.2 Globalisation of medical education

The diversity in approaches taken to QA in different countries has become a more important issue in recent years due to the increased globalisation of medicine and medical education. In 2007, the World Federation for Medical Education (WFME) estimated there were more than 1,600 medical schools worldwide and described “the rapid increase in the number of new medical schools in the last decades, many established on unacceptable grounds (e.g. some private ‘for profit’ schools)”<sup>2</sup> By 2011 there were 2,218 recognised medical schools in 177 countries or territories listed in the International Medical Education Directory (IMED)<sup>3</sup>. The international migration of doctors is an established phenomenon with nearly all countries in Europe reporting increased in-flows of medical professionals<sup>4</sup>.

### 3.3 International QA guidelines and standards

One of the implications of globalisation has been the need to define global standards for medical (and non-medical) education. There are now numerous QA standards, associations and networks for education and training. This includes a number of international bodies with associated QA guidelines and standards. Although some of these guidelines and standards are primarily focused on those countries aiming to develop their QA practices, they nonetheless, provide a useful benchmark of good practice based on widespread consultation and research e.g.

- WHO/WFME Guidelines for Accreditation of Basic Medical Education (2005)
- WFME (World Federation for Medical Education), Global Standards for Quality Improvement in Medical Education, European Specifications (2007)
- INQAAHE (International Network for Quality Assurance Agencies in Higher Education), Guidelines of Good Practice (2006)

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<sup>2</sup> WFME (2007) [World Federation for Medical Education], WFME Global Standards for Quality Improvement in Medical Education; European Specifications

<sup>3</sup> Foundation for the Advancement of International Medical Education and Research (FAIMER) 2011, International Medical Education Directory, Available at: [www.faimer.org/resources/mapping.html](http://www.faimer.org/resources/mapping.html)

<sup>4</sup> RAND (2009), International Comparison of Ten Medical Regulatory Systems; Egypt, Germany, Greece, India, Italy, Nigeria, Pakistan, Poland, South Africa and Spain

- ENQA (European Association for Quality Assurance in Higher Education), Standards and Guidelines for Quality Assurance in the European Higher Education Area (2009).

An important driver of QA standards and guidelines in Europe is the Bologna Declaration (1999) whereby European Ministers of Education committed themselves to establish the European Higher Education Area by 2010. The Bologna Declaration encourages, among other things, European co-operation in quality assurance of higher education with a view to developing comparable criteria and methodologies. Other important goals agreed in Bologna are easily comparable degrees based on a three-cycle structure (Bachelor/Master /Doctorate), a common European system of credits and mobility of students and teachers.

As part of the Bologna Process, ENQA was given the remit to promote European co-operation in the field of QA. In 2005, the "Standards and Guidelines for Quality Assurance in the European Higher Education Area" drafted by ENQA were adopted by the European Ministers:

*'The standards and guidelines are designed to be applicable to all higher education institutions and quality assurance agencies in Europe, irrespective of their structure, function and size, and the national system in which they are located'* (ENQA 2009)

In the UK, the Quality Assurance Agency for Higher Education (QAA) has developed its Framework for HE qualifications to be compatible with the Bologna Declaration, and the development of QAA Scotland's Enhancement-led Institutional Review (ELIR) has been informed by the ENQA and INQAAHE guidelines.<sup>5</sup> Both the ENQA standards and guidelines and the WFME Guidelines are also referenced by the CHRE in identifying characteristics of good practice in QA of undergraduate education<sup>6</sup>. A summary of the ENQA standards and guidelines is presented in **Annex 4**.

### 3.4 Guidelines and standards in other sectors

The literature review also identified examples of guidelines and standards from other sectors including public services<sup>7</sup>, local authorities<sup>8</sup> and social care<sup>9</sup>. In particular, there is a remarkable degree of convergence regarding the principles of inspection with emphasis on:

- focus on improvement/enhancement of provision
- focus on outcomes (e.g. focus on delivery of services rather than internal management arrangements)
- assessment that is proportionate to risk
- use of self-assessment

<sup>5</sup> QAA Scotland (2008), Enhancement-led Institutional Review Handbook (2<sup>nd</sup> Edition) p7-8

<sup>6</sup> CHRE (2009), Quality assurance of undergraduate education by the healthcare professional regulators p10

<sup>7</sup> Office of Public Services Reform (2003), The Government's Policy on Inspection of Public Services

<sup>8</sup> Hampton P (2005), Reducing administrative burdens: effective inspection and enforcement Philip Hampton, HM Treasury

<sup>9</sup> Healthcare Commission England (2005), Reducing the burden: Concordat between bodies inspecting, regulating and auditing healthcare

- transparency (e.g. in criteria used for judgements and reporting outcomes)
- use of shared evidence where practicable, to reduce the burden of QA assessment.

This is reflected in the ten principles of inspection published by the Office of Public Services Reform (2003) presented in **Annex 5**.

### 3.5 The multi-stage process of QA

The review of QA guidelines, standards and the wider academic literature provides a clear endorsement of the multi-stage process of:

- setting standards/criteria
- self-assessment
- external assessment/validation
- report and decision.

Bornmann L. Mittag S. & Daniel H. (2006) note that a number of studies have been conducted by researchers on quality assurance in higher education since the mid-1990s in Europe and beyond:

*‘The experiences collected by the studies show unanimously that in all the countries, multi-stage evaluation procedures as the main quality assurance instrument for evaluation of teaching and learning in HEIs have proved reliable and have gained acceptance. In the multi-stage procedure, academic review begins with internal self-assessment, whereby an academic programme or institute conducts its own analysis of strengths and weaknesses for a self-evaluation report. The next step is external evaluation. Here peer reviewers conduct a site visit of the programmes or units under evaluation and prepare an external evaluation report. The follow-up stage entails implementation of the reviewers’ recommendations.’<sup>10</sup>*

Although this multi-stage process provides an almost universal framework for the QA process, there are clearly differences in how this overall framework is applied. These differences are explored further in Section 4: Approaches to QA and Regulation.

### 3.6 Accountability or enhancement?

One of the main issues to emerge from the academic literature review was the contrast between the highly prescribed approach of ‘audit-based quality assurance’ and the lighter touch quality systems allowing for greater autonomy and innovation in the provision of learning.

The dual purpose of QA – both to provide accountability and to enable enhancement – has been described by many commentators. In this regard, the findings of the academic literature suggest a change in emphasis from QA providing ‘accountability’ towards QA as enabling ‘enhancement’.

This is explored further in Section 5.2: Enhancement-led QA.

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<sup>10</sup> Bornmann L. Mittag S. & Daniel H. (2006), Quality assurance in higher education – meta-evaluation of multi-stage evaluation procedures in Germany, Higher Education 52: p687-709

### **3.7 Right-touch regulation**

The approach to regulation described by CHRE as ‘right-touch regulation’<sup>11</sup> is also an important factor in the consideration of QA i.e. ensuring regulatory intervention that is proportionate to the intended result. CHRE identifies eight elements to help focus regulators on right-touch regulation in practice:

- identify the problem before the solution
- quantify the risks
- get as close to the problem as possible
- focus on the outcome
- use regulation only when necessary
- keep it simple
- check for unintended consequences
- review and respond to change.

### **3.8 Changes to health and social care regulation**

The Health and Social Care bill, currently being considered by Parliament, also has potential implications for Health and Social Care regulators, due to changes in delivery arrangements and to the supporting infrastructure that may come into being in the future. However this project was tasked with identifying regulators’ current practice. Therefore regulators’ potential responses to changes in Health and Social Care landscape were not actively sought.

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<sup>11</sup> CHRE (2010), Right-touch regulation

# 4. Approaches to QA and Regulation

## 4.1 Planning and targeting of QA

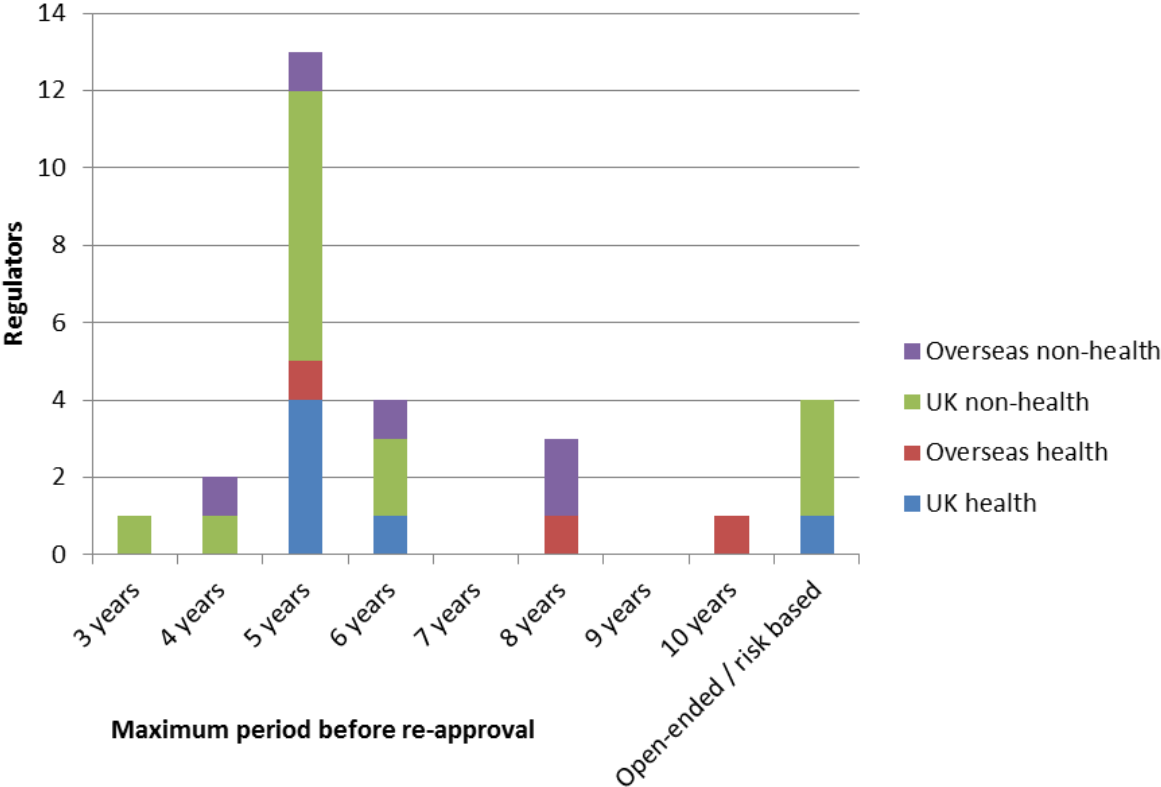
The planning of QA for undergraduate programmes is typically based on initial programme approval/accreditation followed by a cycle of re-approvals. While there are some exceptions, the period of time before re-approval most frequently reported by respondents is five years (See figure 1).

Monitoring between full re-approvals is typically annual and self-reported.

The format for full approval and re-approval tends to be submission of self-assessment, followed by a team visit to verify and gather soft data, followed by a decision on approval or re-approval (and any recommendations for further actions where required).

Regulators will also make triggered visits in response to risk, concerns or significant curriculum change and, where they are lightening their touch, are working to improve means to identify occasions where such visits are necessary.

**Figure 1:** Maximum period prior to re-approval reported by UK & overseas respondents





## **Health sector regulators of education and training**

Health sector regulators were generally found to adopt the cyclical model of approval and re-approvals. In most cases the frequency of assessment is adjusted according to risk assessment. For example, the General Optical Council cycle is based on a minimum of one year and maximum of five years, while the General Osteopathic Council approval is for three or five years depending on risk-based monitoring of performance. The General Pharmaceutical Council programme accreditation cycle is based on six years, but with an interim 'three year practice visit'.

One exception to the cyclical approach was provided by the Health Professions Council which normally approves programmes on an open-ended basis i.e. there is not a cyclical or periodic schedule of approval visits. Continued approval depends on annual monitoring and the 'major change process' which considers significant changes to a programme and the effect of these in relation to the required standards.

## **Non-health sector regulators of education and training**

In non-health sector education, the majority of UK regulators also adopted the cyclical approvals and annual monitoring approach. Again, the approvals cycle would be adjusted according to risk assessments.

The main exception to the cyclical approvals process was found in the regulation of schools where both Ofsted and Education Scotland are moving away from cyclical inspections, with an increased emphasis on inspections based on the assessment of risk. There is some evidence that other non-medical regulators are also moving in this direction. This approach is described in more detail in Case Study 1.

There were also examples of a 'lighter touch' for providers that perform well. For example, the Education and Training Inspectorate for Northern Ireland (ETINI) has a range of models of inspection including Short Inspection for organisations which demonstrate consistently good levels of performance over a period of time (See Case Study 2). Also, the Quality Assurance Agency for Higher Education (QAA) which currently conducts institutional reviews of Higher Education Institutions (HEIs) approximately every six years is looking at moving towards a more risk-based approach whereby HEIs that consistently perform well may be reviewed less frequently, or possibly with the same frequency but with a 'lighter touch'.

## **Thematic QA**

It was notable that in addition to cyclical approvals, the majority of non-health regulators also adopted thematic reviews/inspections. The thematic approach to QA is described in Section 5.1.

## **Case Study 1: Schools inspection proportionate to risk**

### **Ofsted**

Ofsted is the Office for Standards in Education, Children's Services and Skills. It inspects and regulates services which care for children and young people, and those providing education and skills for learners of all ages.

*The schools White Paper proposes that Ofsted will adopt a highly proportionate approach to inspection. Subject to the successful passage of the Education Bill, the routine inspection of providers previously judged to be outstanding will stop and inspection will only occur if there is evidence of significant decline in performance. Providers that were judged to be good at their previous inspection will continue to be inspected at approximately six-year intervals, unless we have concerns about their performance.*

*We currently assess the performance and other risk factors of all providers on an annual basis, regardless of their last inspection judgement, in order to make informed decisions about when a particular provider should be inspected. We propose to establish a secure web-based system for gathering the views of learners, employers and parents/carers between inspections and will ensure that these views are taken into consideration as part of risk assessment [See Section 5.4: Trainee/student surveys]. We intend to devote a higher proportion of our resources to poorly performing provision. The White Paper asks Ofsted to differentiate within the broad 'satisfactory' category, between schools that are improving and have good capacity to improve further, and those that are 'stuck'. We intend to adopt the same approach for further education and skills providers .*

(Ofsted 2011, Common Inspection Framework 2012: Consultation document p13-14)

### **Education Scotland**

Education Scotland is the body responsible for the inspection of education institutions and supporting quality and improvement in learning and teaching from early years to adult and community learning in Scotland.

Since 2010 Education Scotland has moved from a generational cycle of inspection (where a school is inspected every six to seven years) to a sampling model where around 240 inspections will take place each year across all sectors. The intention is to reduce the burden of inspections highlighted in the McCrone Report, which found that schools and Local Authorities (LAs) were spending a disproportionate amount of time on preparing for inspections. The aim is to be more proportionate, through adopting a risk-based, intelligence-led approach.

Hence the new model is based on inspection of a representative sample of schools every year, taking account of any areas of concern (or conversely, strong practice). The selection of the sample is based on statistical analysis, supported by information sharing and negotiation between Education Scotland and LAs.

## **Case Study 2: Models of inspection (ETINI)**

The Education and Training Inspectorate for Northern Ireland (ETINI) inspects further education colleges (up to and including provision at level 3), work-based learning suppliers and adult employment programme lead contractors in Northern Ireland. In addition, the ETINI evaluates the quality of these organisations' annual self-evaluation and quality improvement planning processes.

The range of models to externally inspect organisations, and the broad criteria used to determine which model is used in various circumstances, are described by the ETINI as follows:

### **Short Inspection**

*Organisations who demonstrate consistently good levels of performance over time based on an analysis of the outcomes of previous inspections, evaluations, information from District Inspectors (DIs), scrutiny inspections and their performance data may receive an inspection undertaken over a shorter period of time with a smaller team of inspectors.*

### **Focused Inspection**

*This is the most common inspection type and concentrates on a representative sample of the organisation's provision. The particular aspects being inspected are, whenever possible, set within the broader context of the organisation as a whole. This will normally occur over one inspection week, but may last longer in the small number of larger and geographically dispersed organisations.*

### **Longitudinal Inspection**

*A longitudinal inspection will take place over a period of time, usually a maximum of six months between the first inspection visit and the second and final visit. The purpose of this type of inspection is to ensure that sufficient evidence is analysed and evaluated by the Inspectorate to make reliable judgements regarding the quality of provision of an organisation. Longitudinal inspections are employed, for example, when organisations have just started to provide a range of education and training programmes for and on behalf of the Department, or where the provision is new to a number of organisations.*

### **Follow-Up Inspection, Including Interim Follow-Up Inspection Visits**

*The purpose of the Follow-up Inspection process is to evaluate the progress made by an organisation in addressing the areas for improvement identified in the original inspection report... The entire Follow-up Inspection process will be completed within 18 months of the formal report back of the original inspection.*

### **Scrutiny Inspection**

*The purpose of the scrutiny inspection process is to evaluate the quality of the annual self-evaluation report and quality improvement plan produced by an organisation...*

(ETINI, Models of Inspection)

## 4.2 Standards or criteria used to form judgments

Much of the academic literature described the QA 'dual mandate' of accountability and enhancement and this is often reflected in the standards or criteria which are used as the basis for decision making. A number of commentators note that the tendency for a shift towards QA for enhancement means standards or criteria must allow for greater autonomy and innovation within organisations i.e. standards or criteria that are less prescriptive and more concerned with broader categories and achievement of desired outcomes.

Commentators also noted the importance of transparency in QA and the standards or criteria used e.g.

*'The standards or criteria must be predetermined, agreed upon and made public...'*  
(WFME 2005<sup>12</sup>)

### Health sector regulators of education and training

All the respondents described their standards as taking account of both process and outcomes. However, overall there does appear to be a shift towards increased use of standards which are more outcomes focussed.

The General Pharmaceutical Council, which has made the most significant movement in this respect (see case study 12), reported that such a move is not without its challenges. Evaluating provision firmly on the basis of the outcomes may be seen as encroachment by the regulator into the area of curriculum design. Some providers seemed to believe that the regulator was simply paying lip-service to the concept of assessing the integration of educational outcomes into curricula and may have been surprised to find that this was not the case. Other providers though, have genuinely embraced the new standards and processes and reportedly find it rewarding and has facilitated positive development in their curriculum design.

A number of respondents made the distinction between standards that describe good practice in education, and standards that focus on the requirements for professional practice. For example, the General Osteopathic Council describes two key reference points for review of osteopathic courses and providers:

- Osteopathic Practice Standards and,
- UK Quality Code for Higher Education (published by the QAA).

The CHRE believe that, ideally, education standards should be linked to standards of practice and informed by providers, practitioners, users and the student perspective and that health regulators have worked hard to do this. Those regulators that described the development of professional/practice standards indicate that the development of their standards includes consultation with stakeholders. The range of stakeholder groups involved varied between regulators and included clinicians, students, professional bodies, educational institutions and the public.

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<sup>12</sup> WHO & WFME (2005), Guidelines for Accreditation of Basic Medical Education p5

## Non-health sector regulators of education and training

Again, the respondents (UK and overseas) described their standards as taking account of both process and outcomes, with a tendency for a shift towards standards which are more outcome focussed.

Typically, standards are structured in a 'Quality Framework' which includes descriptors of required standards, together with guidance or illustrations of the types of evidence which may demonstrate achievement of the standards. Although there is increased emphasis on outcomes, it was notable that many of the 'quality frameworks' were based on a number of similar domains i.e.

- leadership and management
- delivery of learning and teaching
- achievements/outcomes for learners.

A number of respondents commented on the importance of the standards for leadership and management i.e. the quality of an organisation's leadership and management was often an early indicator of the quality of its overall provision:

*"Poor leadership and management are at the core of most problems with providers"*  
(Education and training regulator)

*"There is a strong correlation between leadership and quality"* (Care sector regulator)

It was also noted that the quality frameworks frequently served the dual purpose of providing a standard, and acting as a source of guidance. For example, Education Scotland described how their quality frameworks are developed and revised in full consultation with the profession (including schools and Local Authorities), with the intention that the quality framework is 'owned' by the profession and entirely transparent i.e.

*"The same quality frameworks provide the indicators for schools' self-evaluation and for the external inspections. In effect, the quality frameworks provide a toolkit for robust self-evaluation and development."* (Education Scotland)

Similarly, the UK Quality Code for Higher Education (QAA) aims both to set and maintain academic standards and to enhance academic quality as described below in Case Study 3.

## Other sectors

Respondents from other sectors again described standards based on both process and outcomes. It was notable that in common with the QAA, HM Inspectorate of Prisons also conducts inspection against published criteria known as 'expectations'.

*'Expectations' describe the standards of treatment and conditions we expect an establishment to achieve. Expectations are outcome focussed and each is underpinned by a set of indicators. Indicators suggest evidence that may indicate whether the expectations have been achieved.* (HM Inspectorate of Prisons)

### **Case Study 3: The QAA UK Quality Code for Higher Education**

*The UK Quality Code for Higher Education (Quality Code) sets out the Expectations that all UK higher education providers are required to meet. It is the nationally-agreed, definitive point of reference for all those involved in delivering higher education programmes which lead to an award from a UK higher education awarding body. All higher education providers must sign up and adhere to the Quality Code.*

*The Quality Code covers all four nations of the UK and all UK higher education providers operating overseas. It applies to providers with the power to award their own degrees and to those who deliver higher education on behalf of another higher education awarding body. The Quality Code protects the interests of all students, regardless of where they are studying or whether they are full-time or part-time, undergraduate or postgraduate students.*

*The Quality Code gives individual higher education providers, who are independent and self-governing, a shared starting point for setting, describing and maintaining the academic standards of their higher education programmes and awards and for assuring the quality of the learning opportunities they provide for students. This makes it possible to ensure that higher education provision and outcomes are comparable and consistent at a threshold level across the UK...*

#### **What are Expectations?**

*Expectations express key matters of principle that the higher education community has identified as important for the assurance of academic standards and quality. They make clear what UK higher education providers are required to do, what they expect of themselves and each other, and what the general public can therefore expect of all of them. Individual providers should be able to demonstrate they are meeting the Expectations effectively, through their own management and organisational processes, taking account of institutional needs, traditions, culture and decision-making.*

#### **What are Indicators?**

*Each Chapter of the Quality Code comprises a series of Indicators which higher education providers have agreed reflect sound practice, and through which higher education providers can demonstrate that they are meeting the relevant Expectations. Each Indicator is accompanied by explanatory text which shows why it is important and suggests possible ways in which it might be addressed and demonstrated...*

*The Quality Code also forms the basis for the reviews of higher education providers that are carried out by the QAA. It provides a benchmark against which providers can be compared and QAA's reviews judge whether higher education providers are meeting the Expectations which the Quality Code sets out.*

(QAA 2011, UK Quality Code for Higher Education: General Introduction)

### 4.3 Self-assessment/evaluation

The academic literature highlights a correlation between an increasing emphasis on quality enhancement and the importance of effective internal QA processes. A number of commentators observe that self-assessment/evaluation is at the heart of the enhancement approach to QA, noting that self-assessment is key to embedding quality in the internal processes of the organisation.

*'Self-assessment is both the starting point for better quality and, through continuous application, one of the most effective methodological tools for improvement. This is confirmed by the examples from practice'* (CEDFOP 2009<sup>13</sup>)

This use of self-assessment, when aligned with the external QA of organisations, also has potential for a mutually advantageous process i.e. external QA is able to use existing evidence generated by internal QA processes and the external QA provides leverage to enhance and develop the organisations' internal processes. For example Singh observes that it is possible 'to connect external and internal evaluation processes in ways that add real value to the latter.' (Singh 2010<sup>14</sup>)

#### Health sector regulators of education and training

The majority of health sector regulators (UK and overseas) rely on self-assessment for the annual monitoring of education providers. The self-assessment would typically be verified through the periodic re-approval visit or earlier if there were grounds for concern. The General Optical Council also intends to use reports from external examiners and the QAA as validation of self-assessments in the near future.

However, there was no clear consensus on the value of self-assessment. Two of the health sector regulators suggested that self-assessment could not be relied upon, one commenting that *"providers are unlikely to be completely forthright about their weaknesses"*. In contrast, another UK health sector regulator described self-evaluation as *"a crucial element of quality assurance and good management"*. Similarly, one of the overseas medical regulators observed that *"self-assessments are a fundamental element of the regulatory system"*.

#### Non-health sector regulators of education and training

In contrast, self-assessment appears to be well established as a central component of QA for nearly all of the non-health sector education regulators (UK and overseas). Again, self-assessment would typically be verified through periodic visits including direct observation of teaching and learning, scrutiny of learners work, interviews with staff etc. In addition, other sources of validation described by some respondents were the views of students and staff (e.g. obtained by questionnaires or on-line surveys), reports from external examiners, and information from other regulators.

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<sup>13</sup> CEDEFOP (2009) [European Centre for the Development of Vocational Training], Accreditation and quality assurance in vocational education and training: Selected European approaches, Office of the European Union p27

<sup>14</sup> Singh M. (2010), Quality Assurance in Higher Education: Which Past to Build on, What Futures to Contemplate? *Quality in Higher Education*, Vol 16, No 2, July 2010 p191

Some comments on self-assessment/evaluation from respondents are as follows:

*Self-evaluation is “absolutely key” to the inspection process. In each of the past four 6 yearly inspection cycles, the emphasis on self-evaluation has increased. Self-evaluation is now the starting point for the inspection team. Every provider should regularly update their self-evaluation report – this is not just for the 6 yearly inspection, but should form part of internal QA processes every year. As inspectors “we are, in a sense, validating their self-evaluation” (Estyn)*

*‘Our approaches to inspection and review have increasingly focused on the ability of an establishment or service to evaluate itself (which is referred to as ‘self-evaluation’). We use its findings to take forward its plan to improve’ (Education Scotland 2011, Principles of Inspection and Review p5)*

*‘Increasingly, there is the realisation that if improvement in a school’s provision is to be initiated and sustained effectively, then it is crucial that the culture of self-evaluation is promoted and that the process of self-evaluation is embedded within a school’s way of working.’ (ETINI 2010, Together Towards Improvement p3)*

*‘Institutions have undertaken to design and implement their own Institutional Quality Assurance Process (IQAP) that is consistent not just with their own mission statements and their university Degree Level Expectations, but also with the protocols of the Framework. The IQAPs are at the core of the quality assurance process.’ (Ontario Universities Council on Quality Assurance 2010, Quality Assurance Framework p2)*

## **Other sectors**

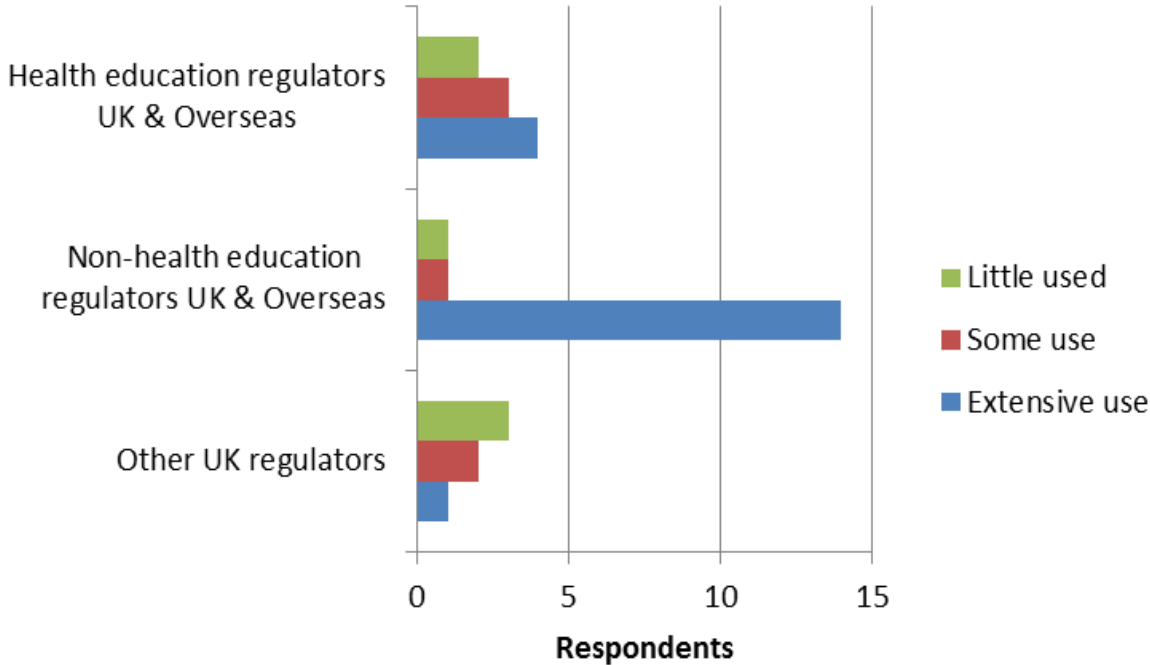
Healthcare Wales describe self-assessment as a key tool in changing the culture of organisations in relation to quality assurance. The aim is for Boards to understand that they are responsible for quality assurance and that the inspections are for validation. They are encouraged to use the self-assessment tools to carry out their own quality assurance but do not expect self–assessment to replace their visits.

In contrast, the use of self-assessment was less established among respondents from other UK regulators. For example, the HM Inspectorates of Prisons, Constabulary and Probation all made only limited use of self-assessment. In these cases, self-assessment was described as a useful ‘diagnostic’, but regarded as potentially unreliable and not widely used.

It would appear that the extent to which self-assessment is used varies significantly between organisations and occupational sectors. This is illustrated below in Figure 2.



**Figure 2:** Use of self-assessment in QA/regulation



## 4.4 Visits to organisations

### Health sector regulators of education and training

Respondents described the purpose of visits variously as to verify the provider's self-assessment, validate monitoring submissions, and/or to verify claims of practice made during the earlier approval process. Visits are also made for a new approval and in response to major changes or risk-based monitoring. Where visits take place in response to concerns there may be a changing dynamic between the regulator and the provider; these were described by one respondent as 'directed visits' which are less collaborative than standard approval visits.

Typically, visits will include speaking with relevant people (e.g. staff, students and service users), reviewing any additional documentation and triangulating evidence. For example, one regulator described visits as:

*“About collection of soft as well as hard evidence, evidence interrogation and testing, meeting students and practice placement educators, testing out and triangulating claims”*

Providers are given an average of one year's notice of a routine re-approval visit (ranging between 6 and 18 months depending on the regulator). Shorter notice would be given for a visit to investigate risk.

Some respondents describe focussing on specific aspects of provision during visits. For example, the General Pharmaceutical Council uses visits to explore the resourcing, staffing and management of whole programmes, but will sample a selection (around 15%) of outcomes to explore in depth with providers. The General Osteopathic Council observes a sample of clinical and non-clinical teaching during visits.

### Non-health sector regulators of education and training

Respondents typically described the purpose of visits as to verify the provider's self-assessment, speaking with relevant people, reviewing any additional documentation and triangulating evidence. In most cases, visits were carried out as part of a cyclical re-approval process, or in response to concerns (e.g. concerns arising from annual monitoring, previous inspections or reports from students).

Some respondents also referred to visits as part of maintaining on-going constructive 'dialogue' between the regulator and the provider. Some also described focusing on specific aspects of the provider's self-assessment during a visit. For example, the Education and Training Inspectorate for Northern Ireland describes its most common inspection type as 'Focussed Inspection' that concentrates on a representative sample of the provider's provision. Similarly, Education Scotland does not purport to cover all aspects of a schools provision, but in line with the principles of proportionality and responsiveness, prioritises inspection activities on 'areas of focussed attention'.

A noticeable difference from the health sector regulators was found in the shorter notice given for visits, tending to be in the region of two to three months. Indeed, Ofsted provides most schools with only one and two days' notice of an inspection and in some cases conducts unannounced visits.

## 4.5 Composition of the QA team

### Health sector regulators of education and training

The size and composition of the visit team would generally vary according to the size and scope of the provision being assessed. All respondents from health sector regulators (UK and overseas) described visit teams comprising professionals/peers. Typically visit teams are led or co-ordinated by a representative of the regulatory body although in the case of the Health Professions Council there is no lead visitor (the visit team is 'a panel').

50% of respondents from the health sector regulators described the use of lay members although there appears to be a lack of clear definition regarding what constitutes a 'lay member'. For example, some lay members are service users, but often with a related area of expertise (e.g. in education or health). In one case (General Chiropractic Council) a lay member acts as the chair of the visiting panel.

It was notable that none of the respondents from UK health sector regulators referred to students as members of the visit team. In contrast, the GMC has included students as members of visit teams for many years and was described by CHRE as having led the way on greater patient and public involvement. Students were also described as part of the visit team for two of the overseas medical regulators (LCME and MCNZ).

### Non-health sector regulators of education and training

Non-health sector regulators also described visit teams comprising professionals/peers, typically led or co-ordinated by a representative of the regulatory body.

Again, approximately 50% of respondents from the UK described the inclusion of lay members (trained for their role) as part of the visit team. In particular, the General Social Care Council (GSCC) emphasised the important contribution provided by lay members. This is described below in Case Study 4.

Students are well established as full members of visit teams with a number of non-health sector regulators. In the case of overseas respondents, over 60% described the use of students as part of the QA visit team and indeed the ENQA guidelines suggest that external review panels should include a student member.<sup>15</sup>

In the UK, students are full members of visit teams with QAA and QAA Scotland. Education Scotland has also recently introduced students as members of inspection teams and reports that this has been very successful and "well received by college principals and staff". The involvement of student reviewers with QAA Scotland is described below in Case Study 5.

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<sup>15</sup> ENQA (2009), Standards and Guidelines for Quality Assurance in the European Higher Education Area p8

#### **Case Study 4: Visitors / lay reviewers (GSCC)**

The General Social Care Council (GSCC) is the regulator of the social work profession and social work education in England. The Care Standards Act 2000 grants GSCC powers to make rules under which social work training courses are approved and to produce lists of approved courses. The Act proposed that lay people should have a role in inspecting social work degree courses and referred to these people as “visitors”. The GSCC brought visitors into the regulation of social work degree courses in 2007, following a well-received pilot approach at two HEIs.

In 2011 GSCC produced a report on the contribution of visitors to the inspection process to consider what impact visitors make on social work education inspection processes. Conclusions from this report indicate that GSCC inspectors have a ‘strong level of support for bringing visitors into the inspection processes in order to support and emphasise the duty for HEIs to include service users and carers in the social work degree... There is overall agreement that visitors do not impact upon the outcomes of inspections; their impact centres on the process.’

The report also describes the perspectives of the higher education teaching staff including the following key messages:

- *HEIs appreciated the relevant and specific knowledge which derives from the visitors’ experience of using social work services.*
- *HEIs identified some scope for greater clarity of the role and breadth of scope of the visitors.*
- *The presence of the visitors stimulated reflection by HEIs about the roles of people with experience of using social work services in the delivery of the curriculum.*
- *Overall there was a positive view of the impact made by the visitors.*

Recommendations included that the GSCC:

- *acknowledge and value the important contribution people with experience of social work services have brought to the organisation in raising awareness of diverse needs and perspectives;*
- *work with other regulators to develop standards for involvement that take account of responsibilities to encourage and facilitate participation by a diverse range of people. The standards should be co-produced with people with experience of social work services and informed by an equality impact assessment (Equality Act 2010). The standards are likely to be of value and interest to our successor, the HPC;*
- *promote consistency amongst visitors and inspectors in its current work, by working together to produce a handbook which details expectations and clarifies boundaries in the regulation of social work education.*

(GSCC 2011, Inspecting social work degree courses)

Discussion with the GSCC confirmed that the introduction of ‘visitors’ initially met with some resistance from providers, but are now generally regarded as greatly enhancing QA.

### **Case Study 5: Student engagement with quality (QAA Scotland)**

QAA Scotland has developed an enhancement-led approach to quality in the Scottish higher education sector. One element of this approach is ‘a greater voice for student representatives in institutional quality systems’.

In particular, student representation is supported by a national development service; [sparqs](#) (student participation in quality Scotland). Hosted by NUS Scotland, ‘sparqs’ assists and supports students, students’ associations and institutions to improve the effectiveness of student engagement in quality processes and provides advice to the SFC and institutions on good practice in student engagement.

*Every Enhancement-led institutional review (ELIR) team includes a full student member and students are represented on all our working groups and committees... The student reviewer brings a learner perspective to the review. Their responsibilities will focus on lines of enquiry relating to the institution's management of the student learning experience and the effectiveness of the institution's approach to engaging students.*

(QAA Scotland, 2008, Enhancement-led Institutional review handbook: Scotland, 2<sup>nd</sup> Edition)

## International reviewers

The use of international reviewers is recommended by ENQA<sup>16</sup> and INQAAHE<sup>17</sup> guidelines. In this research, only three respondents described the use of international reviewers: QAA Scotland, Education and Training Inspectorate for Northern Ireland (ETINI) and New Zealand Universities Academic Audit Unit.

It is significant that all these countries have a relatively small population. In this context, an international perspective is perhaps valued to share good practice with a wider range of professionals and to demonstrate that their delivery and regulation of education and training is not insular.

*By adding an international reviewer to all Enhancement-led Institutional Review (ELIR) teams, the range of experience and expertise is extended, and both institutions and the ELIR process will benefit from this wider global perspective. The international reviewer will bring international perspectives on quality assurance and enhancement and will generally be in a position to draw the enhancement and assurance discussions in ELIR on a wider canvas. In addition to the direct benefits, international reviewers will facilitate dissemination abroad of Scottish higher education quality and standards... To get maximum benefit, it is important that international reviewers are trained, and drawn from institutions, organisations and countries appropriate to the diverse higher education institutions in Scotland. (QAA Scotland, 2008, Enhancement-led Institutional review handbook: Scotland, 2nd Edition)*

## Support and preparation of reviewers

Respondents typically described the provision of training and support for members of visit QA teams. For example, the Nursing & Midwifery Council commented that assessment and monitoring teams “have a detailed handbook outlining duties and processes and they are further supported by annual learning events and a buddy system whereby experienced reviewers buddy the less experienced.” The General Pharmaceutical Council also described development of a new handbook and rigorous training for accreditation team members around the introduction of new standards and new visit structures (see Case Study 12).

Education Scotland described the innovative use of a behavioural framework (the ‘PRAISE framework’) to support inspectors in carrying out inspections in a constructive and positive manner. The framework is based on feedback gathered from establishments and services that have been inspected and from post-inspection questionnaires.

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<sup>16</sup> ENQA (2009), [European Association for Quality Assurance in Higher Education], Standards and Guidelines for Quality Assurance in the European Higher Education Area p21

<sup>17</sup> INQAAHE (2007) [International Network for Quality Assurance Agencies in Higher Education], Guidelines of Good Practice in Quality Assurance p10

## 4.6 Shared evidence

The use of shared evidence appears to be problematic for the majority of regulators. Typically, respondents described difficulties in using shared evidence due to concerns regarding lack of currency, and the difficulties of utilising evidence produced for other purposes. However, most regulators do also recognise the benefits of minimising the assessment burden on providers and hence the desirability of using shared evidence if practicable.

### Alignment with Quality Assurance Agency for Higher Education (QAA)

The most frequently reported use of shared evidence referred to the potential use of evidence produced by and for the QAA. Examples of respondents include:

*“The General Pharmaceutical Council proposed new methodology will complement and not duplicate the Quality Assurance Agency’s new quality check on higher education... Universities have their own well established quality assurance processes and our data set will draw on the outputs of those processes. Our new education & training standards make it clear that we will draw on existing university documentation as a large part of our evidence base.”* (General Pharmaceutical Council)

*“Universities offering Social Work degrees also have to meet the requirements of the QAA (e.g. regular subject health reviews). In the past, re-approval of social work degrees by SSSC has been ‘dovetailed’ with QAA subject approval to reduce the assessment burden on providers.”* (Scottish Social Services Council)

### Partnership work with other regulators

A number of respondents also described partnership work with other inspectorates and regulators, in particular the co-ordination of joint inspections where practicable e.g.

*“We work closely with the Care Inspectorate – evidence and intelligence is shared and on occasions joint inspections are conducted i.e. there is close liaison where there is overlap or integration in roles.”* (Education Scotland)

*“In a number of sectors, we work with other regulators and inspectorates to inspect provision. We work in partnership with Ofsted to inspect the work-based learning provision which operates both in Wales and England. We also inspect five independent special colleges in Wales, working in partnership with Ofsted when there are 10 or more students from England. Our inspectors liaise with CSSIW to inspect residential schools and a local authority secure children’s home. We also take part in inspections, led by HMI Probation, of youth offending teams (YOTs) in Wales and we join HMI Prisons and Ofsted to inspect institutions for young offenders in England that have significant numbers of young people from Wales. In addition, we include inspectors from the Wales Audit Office when we inspect local authority education services.”* (Estyn 2010)

*“We undertake joint inspections with various bodies”* (Healthcare Improvement Scotland)

*“We do not use shared evidence at the moment but are developing a model for IVF services and will be working with the Royal College of Psychiatrists on a model of shared evidence.”* (Healthcare Wales)

Ofsted uses success rate data collected for schools and colleges by 'The Data Service' (<http://www.thedataservice.org.uk/>) and information is shared between inspections within Ofsted (particularly where providers sub-contract provision). There are also many examples of Ofsted conducting joint inspections with other inspectorates (e.g. with the HM Inspectorate of Prisons). Indeed, joint inspections are frequently used in the Justice sector as described below in Case Study 6.

### **Evidence from other sources as monitoring / risk assessment**

Evidence from external sources is also used to support monitoring and risk assessment by some regulatory bodies. For example:

*A QAA verdict of limited or no confidence in systems would, and has triggered a visit (Health Professions Council)*

*We routinely gather and analyse information relevant to social work education that provides the foundation for risk analysis and risk management of social work education. Intelligence gained informs the risk assessment of social work education provision... In addition to information provided by universities, other institution specific information is drawn from a range of sources including for example, other regulators' reports, stakeholder feedback, External Examiner feedback and audits specifically relating to complaints (GSCC 2011, Risk management and regulation of social work education – Revised March 2011)*

*QAA looks at Professional, Statutory and Regulatory Body (PSRB) reports and reports from other regulators. QAA also reviews outcomes of the National Student Survey (conducted since 2008/09), which every student in their final year is asked to complete. Outcomes of this satisfaction survey are scored by institution and subject area (including medical schools) and are useful to compare with other equivalent universities and departments. The NSS is commissioned by Higher Education Funding Council (HEFCE) and available from <http://unistats.direct.gov.uk/>. This can provide an initial 'trend analysis' to indicate potential areas to explore further and as part of the evidence base. (QAA)*



### **Case Study 6: Joint inspection activity in other sectors**

Joint inspections activity across the Justice sector is commonplace: HM Inspectorate of Constabularies, HM Crown Prosecution Service Inspectorate, HM Inspectorate of Court Administration (now abolished), HM Inspectorate of Probation and HM Inspectorate of Prison frequently conduct joint inspections. The Police and Justice Act of 2006 established a statutory responsibility on each of the five (now four) inspectorates to:

- co-operate with each other and other named inspectorates
- draw up a joint inspection programme and associated framework
- consult their Secretary of State, other inspectorates and named stakeholders in the formulation of the plan
- act as gatekeeper for all inspection of specified organisations, and
- delegate authority to inspect such organisations to each other, or other public authorities, as appropriate.

Joint Inspection business plans are developed – the current one being the **Joint Inspection Business Plan 2011-13** with the aim of “effective targeting of joint activity to ensure an equitable balance of administrative impact and service benefit for those agencies and partnerships subject of scrutiny”. A new plan is due to be published early in the 2012-13 business year.

Organisations such as Ofsted, Estyn, CQC and Healthcare Wales may also be involved in joint inspections and teams will be made up of people from each inspectorate involved with one Inspectorate taking the lead.

*“Our test of Purposeful Activity is inspected jointly with Ofsted and our Expectations in this area reflect HMIP’s inspection criteria and Ofsted’s Common Inspection Framework”* (HM Prisons).

Evidence is shared both ways between HMI Prisons and CQC and the Independent Monitoring Boards (IMB). They also use evidence provided by the Prisons and Probation Ombudsman in relation to complaints and deaths in custody.

**The Financial Services Authority** shares information with external bodies on individuals through use of the Shared Intelligence Service (SIS). SIS contains references to data held by its 19 participant members, who range from government departments to Designated Public Bodies and Regulated Investment Exchanges.

**Healthcare Wales** make use of shared information which informs their approach to a subject/review. They;

- work closely with the Welsh Audit Office
- share information with the CQC
- hold annual Health Summits including all key partner organisations
- work with the other four Nations Healthcare Regulators
- work with the Healthcare Professionals Crossing Borders (HPCB).

## 4.7 Reporting

### Health sector regulators of education and training

A range of reporting methods was described by respondents. Typically, the method of grading/scoring was similar although the terminology used varied between regulators e.g.

- standards are met / partially met / not met
- approval without conditions / with conditions / approval denied
- outstanding / good / satisfactory / unsatisfactory.

The grading/scoring is based on the required standards or criteria (See Section 4.2). For undergraduate courses grading/scoring is usually applied at programme level i.e. they refer to the course rather than the institution as a whole.

CHRE has received feedback that regulators should be mindful of terms like 'satisfactory', the impact of which is loaded. Terms that simply communicate that the standards were met or that the standards were met with areas for improvement are perhaps clearer and less prone to misinterpretation. This approach is consistent with the recent developments in judgment descriptors used by Ofsted and QAA, described below in Case Study 7.

Reports always include a narrative, for example including comments on strengths and areas for improvement.

It is often a requirement of the regulatory acts and statutory instruments that empower regulators that reports are in the public domain. Reporting is therefore made public by all health sector regulators (e.g. on web sites) and generally not anonymised, although one regulator commented that reports on non-approval are anonymised and another observed that reports in the public domain identify the provider but not individuals.

### Non-health sector regulators of education and training

Again, a range of reporting methods was described by respondents, most frequently with the use of a grading/scoring system with variations in the terminology used e.g.

- confident / partially confident / not confident
- outstanding / good / satisfactory / inadequate
- outstanding / very good / good / satisfactory / inadequate / unsatisfactory
- good with outstanding features / good features and no important shortcomings / good features outweigh shortcomings / some good features but shortcomings in important areas / many important shortcomings.

In some cases, the grading/scoring applies at programme level, although the regulators of schools and Higher Education Institutions provide judgments on institutions as a whole (See Case Study 7).

There were a few exceptions to the use of grading/scoring. For example, the Scottish Social Services Council commented that they do not use scores of any kind – their reports are narrative with recommendations for enhancements.

Again, there is a commitment from non-health regulators for reports to be in the public domain and are typically made available on the regulator’s web site.

### **Overseas regulators of education and training**

One point of interest regarding respondents from overseas regulators was the emphasis given to the narrative in reports. In particular, 66% of respondents from overseas regulators rely solely on descriptive or narrative reports with no scores or grading used at all e.g.

*“No scores are generated but schools are provided an extensive narrative report”* (Liaison Committee on Medical Education - USA)

*“Descriptive and qualitative information [is used] to report on the outcomes of evaluation and accreditation. There is no rating system of provider through performance in the evaluation.”* (Health Professions Council of South Africa)

*“Reports are descriptive – there are no scores used”* (Ontario Universities Council on Quality Assurance)

*“The judgement is solely done in text form”* (ACQUIN - Germany)

One of the overseas regulators that do use scores also commented:

*“There is always an extensive accompanying narrative - in fact the narrative is more important than the scores.”* (Quality Assurance Netherlands Universities)

## Case Study 7: Recent developments in judgment descriptors in Ofsted and QAA

### Ofsted

Every week, Ofsted carries out hundreds of inspections and regulatory visits throughout England, and publishes the results on its website. Currently all school inspections (and those for adult education and skills) carried out by Ofsted use the same grading scale:

grade 1: outstanding

grade 2: good

grade 3: satisfactory

grade 4: inadequate.

In January 2012, Ofsted's Chief Inspector confirmed his intention to scrap the 'satisfactory' judgment for school inspections. The move is designed to tackle the number of coasting schools that have remained stubbornly 'satisfactory' over a number of inspections, as highlighted in Ofsted's Annual Reports over recent years. The proposals, which will be subject to consultation, would mean that any school that does not provide a good standard of education will be given a new 'requires improvement' grade. This proposal is congruent with moves to focus more inspection activity on those providers who are not yet 'good'.

(Ofsted press release, 25 January 2012)

### Quality Assurance Agency for Higher Education (QAA)

In September 2011 QAA launched a new process for reviewing academic quality and standards in higher education institutions in England and Northern Ireland. The process, called Institutional review, replaces the previous method, Institutional audit. The new process is characterised by an intention to place current and prospective students' interests at its heart, with a commitment to clear communication with the general public.

As part of this development, QAA will be replacing its previous judgment based on a confidence score (confidence / limited confidence / no confidence) with new judgments in three areas:

*Institutions will receive one of two judgments on **standards**. Academic standards will either 'meet UK expectations for threshold standards' or 'not meet UK expectations for threshold standards'.*

***Quality and enhancement** will be graded against four possible judgments: 'is commended', 'meets UK expectations', 'requires improvement to meet UK expectations', and 'does not meet UK expectations'.*

*Formal judgments on the quality of **public information** will begin in 2012-13.*

*The changes to the judgments and the way they are reported emphasise the need for clear information about quality and standards at institutions to be accessible to a wide public audience.*

(QAA 2011, Summary of Institutional Review in England and Northern Ireland)

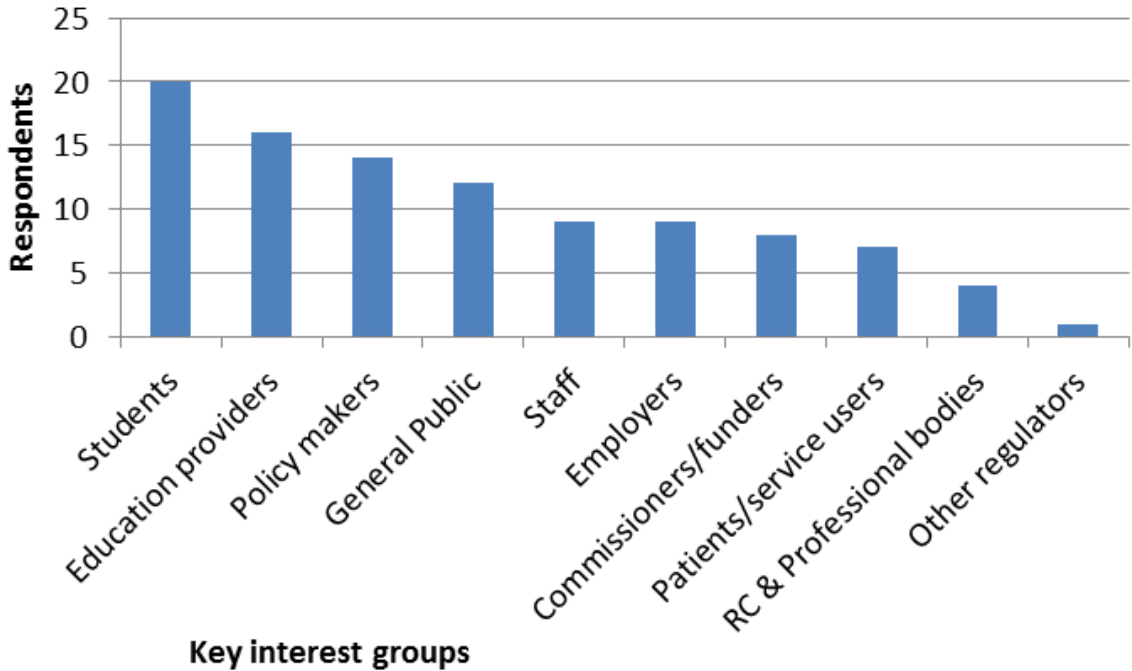
# 4.8 Interest groups and provision of reports

## Regulators (health sector and others) of education and training

Regulators of health and non-health sector education and training (UK and overseas) were asked who they regarded as the key interest groups for QA and regulation outcomes. A few responses were “everyone with an interest”, although most respondents described a range of specific stakeholders. It may be of interest that many regulators appeared to provide an ad-hoc list in response to this question, rather than a formal, stated list of stakeholders and would often add to the list as they considered the question and its implications. The most frequent responses were:

Students (current and/or prospective)	20 (77%)
Education providers	16 (62%)
Policy makers	14 (54%)
General public	12 (46%)

**Figure 3:** Key interest groups reported by UK and overseas regulators of education and training



## Tailoring of reports on regulation outcomes

Despite the wide range of interest groups, most regulators published their reports in one format, although generally with a commitment to achieving, as far as possible, an accessible and jargon-free format.

QAA and Education Scotland were two notable examples of regulators which tailored their reports to several interest groups – this is described below in Case Study 8.

### Case Study 8: Reports tailored to different interest groups

#### Quality Assurance Agency for Higher Education (QAA)

QAA reports of quality audits are designed to be useful to several audiences, making a clear distinction between that part of the reporting process aimed at an external audience and that aimed at the institution. For 2010/11 there were three elements to the reporting:

- the **summary** of the findings of the report, including the judgements, is intended for the wider public, especially potential students
- the **report** is an overview of the findings of the audit for both lay and external professional audiences
- a separate **annex** provides the detail and explanations behind the findings of the audit and is intended to be of practical use to the institution.

For 2011/12 the high level findings and profile for each institution (including background statistics, judgement, recommendations and feature of good practice) are on the QAA web site. These new reports are intended to be more concise and accessible to the public. The annex has been replaced with an evidence base, providing a detailed citation of the evidence for the team findings. This evidence base is not published but shared with the institution.

#### Education Scotland

In the past, one detailed report was produced on inspection findings. However, in response to feedback that this was too long/technical for most parents, HM Inspectors now produce the following::

1. A “letter-style” report to parents/guardians summarising and highlighting key outcomes.
2. Evaluations against the Quality Indicators and questionnaire feedback from parents, staff and pupils are available on the web site for those who wish to see it. In secondary schools attainment data is also included.
3. A full Record of Inspection Findings is sent to the head teacher, Local Authority and the chair of the school's Parent Council.

‘We aim to provide the school with a draft copy of the report in letter format for parents within two weeks... The letter will normally be published on our website within eight working weeks after the end of the inspection. It will include a link to other evidence from the inspection such as pre-questionnaire findings, attainment information and Education Scotland’s evaluations of the five quality indicators’ (Education Scotland 2011).

## 4.9 Sanctions

### Health sector regulators of education and training

All respondents (UK and overseas) reported that they could withdraw approval from providers as an ultimate sanction if required standards were not being met. However, they also commonly described a range of measures which would be taken prior to this ever happening e.g.

- reduce the approval period
- restrict approval (e.g. impose conditions)
- require a corrective action plan to be addressed.

For new programme providers, one regulator also described a provision for providers to withdraw from a programme rather than not be approved in order avoid the final (public) non-approval.

Two of the overseas regulators (LCME and MCNZ) also made reference to shortening the term of accreditation as a possible sanction, applied alongside requirements for improvement.

### Non-health sector regulators of education and training

Sanctions available to non-health sector regulators of education and training were various, depending on the regulator's remit, size and scope of the regulated population and powers of the regulator. Some regulators do have the power to withdraw approval from providers as an ultimate sanction. However, in many cases regulators could only make recommendations for sanctions to the appropriate funding bodies. In practice, the withdrawal of approval is rare, with some regulators having never arrived at this point and regulators relying on measures to prevent this occurrence e.g.

- instigation of a process of investigation or inspection, which would normally lead to a set of recommendations for improvement
- requirement for implementation of an improvement plan/action plan
- more frequent and in-depth inspections.

For some regulators, an 'inspection' was itself regarded as a sanction (i.e. this would be beyond the cyclical review, and take the form of an 'investigation').

A number of regulators also commented on the impact of poor performance with regard to loss of reputation among peers. This was particularly relevant in smaller countries where institutions would often be aware of each other's audits and the recommendations made.

## 4.10 Perceived added value provided by QA

Regulators from the health and non-health sectors were asked for their views on what added value external QA, as undertaken by the regulator provides. The most frequent responses described the following factors:

- **Provides public accountability**

*“Provides confidence among the public”*

*“Aims to give the public confidence in the profession and provide students with transparency of the education system”*

*“Safeguard for the public – providing some externality”*

- **Supports internal QA**

*“Independent assessment requires providers themselves to think about their own QA and performance against standards”*

*“Supports development of robust quality management in institutions and development of provider practice”*

*“Stimulates self-reflection through the self-assessment phase of the evaluation process”*

- **Supports development/improvement**

*“It provides independent objective interface oriented towards the identification of areas for improvement.”*

*“Teachers and managers of degree programmes report to us that an external view and discussion with peer experts is very valuable to them and helps them improve their quality.”*

*“QA, based on internal evaluation and improvement leads to better learning and teaching provision”*

*“There is a huge improvement agenda”*

*“Drives improvement”*

- **Supports sharing of good practice**

*“It opens up new views on study programmes or Quality Assurance systems and gives the opportunity to discuss quality enhancement together with parties involved and external people.”*

- **Maintains consistency**

*“It provides... a standardised and independent process which mitigates the risk of bias and conflicts of interest and which is therefore robust.”*

*“Re-approval and monitoring ensures provision is at a high standard”*

Some respondents also commented that the expectations of external QA are helpful for programme leaders in provider organisations to compete for resources, observing that “professional courses are notoriously resource hungry”.



Respondents from the medical schools particularly emphasised the importance of external QA as a driver for change:

*“QA drives change and improvement within the medical school. The standards set out by the GMC require us to continually enhance our programme.”*

*“The external regulator adds a nationally recognised perspective, has the overview of many institutions and thereby adds gravitas to the feedback... It is an important agent for change.”*

*“The GMC’s review is used as a very strong argument for change (and action) for the medical school. The recommendations often support things the medical school want to change and give the University the push that is needed.”*

## 4.11 Significant factors for delivery of effective QA

Respondents were asked for their views on what key factor or factors were most significant for delivery of effective QA. A summary of responses is as follows:

- *Independence - transparent and fair framework/standards.*
- *Independent judgement and triangulation of data.*
- *Partnership with providers is invaluable – feedback bears this out.*
- *Integration between visiting and documentary evidence and reducing the burden of required information leads to better depth of quality information.*
- *To achieve a balance between the advisory role and the regulatory role.*
- *Transparency and crystal clear standards are the basis of a strong QA system.*
- *The focus must always be on outcomes for learners, not on the QA process itself.*
- *Clear inspection frameworks.*
- *Much depends on how robustly providers conduct self-assessment.*
- *Independent scrutiny coupled with self-assessment and self-reflection.*
- *Partnership working and dialogue is key – the QA process is then owned by the sector.*
- *Students must be at the heart of the system – their opinions can be respected and listened to.*
- *The role of regulator is characterised by relationship building and being enhancement-led.*
- *Less focus and quality assurance, but more on quality enhancement.*
- *Effective quality assurance needs to encourage the internalisation of quality and support the sustenance of a quality-aware culture in the institutions concerned.*
- *Well-trained and knowledgeable peer reviewers.*
- *Processes which are evidence based, robust and which are perceived to be implemented fairly.*
- *Ensuring that it is risk based and proportionate.*

## 5. Further trends and issues

### 5.1 Thematic QA

Thematic QA was **not** described by any of the health sector regulators of education and training (UK or overseas) participating in the research.

In contrast, the GMC is already piloting thematic QA focussing on assessment. Thematic inspections/reviews were also described as an important aspect of QA for the majority of respondents from UK non-health sector regulators, for example:

*Thematic reviews take place to look at particular aspects of social work education. These may be decided upon to address issues of concern, or of topical interest. (Care Council for Wales)*

*This year, curriculum and thematic inspections have been introduced as a new initiative – looking at 3-18 curriculum areas and educational themes across sectors. The first is due to be completed by summer 2013. (Education Scotland)*

*There is an extensive programme of thematic inspections. Each year, around 15 thematic reports are published which look at specific areas of education and training and set out recommendations. (Estyn)*

*Themed inspections have been “invaluable” – often unearthing much that would not have been apparent from the annual monitoring reports, providing a more rigorous and focussed assessment. Themed inspections have been well received by the Universities (perhaps as it does not feel like singling out particular HEIs, but is a more helpful and constructive process of looking at practices across the board and recognising good practice as well as identifying any areas of concern). Themed inspections fit well with the need to ensure consistency across all provision especially where there is a public protection role. (General Social Care Council)*

*The NISCC will undertake Thematic Reviews that will apply across all provision. These Thematic Reviews may be dictated by, for example, issues raised by employers or issues that have been identified through RQIA inspections and by other relevant inspection bodies. (Northern Ireland Social Care Council)*

*Thematic inspections and surveys are conducted primarily to identify and share good practice. Therefore, the inspectors mainly go to providers which have been judged outstanding to glean good practice. (Ofsted)*

### **Case Study 9: Thematic elements of QAA reviews**

Since September 2011, QAA reviews have two components: a core section leading to judgments, and a thematic element which will not lead to a judgment. The thematic element will allow reviewers to explore an institution's engagement with a particular quality assurance topic.

Theme topics will be confirmed on an annual basis by the Quality in Higher Education Group (QHEG) which includes representatives of HEFCE, NUS, QAA and heads of HEIs.

QAA will publish theme topics six months before the start of the academic year for any particular annual tranche of reviews. The theme for 2011-12 is the First Year Student Experience: [2011-12 theme: First Year Student Experience](#)

(See also QAA Scotland Case Study 11: Enhancement-led QA)

### **Case Study 10: Thematic QA in the Justice sector**

Her Majesty's Inspectorate of Constabularies (HMIC) has powers under the 1996 Police Act to inspect forces in England, Wales and Northern Ireland. They also inspect and regulate other major policing bodies including SOCA, PSNI and the British Transport police and inspect HMRC and the Police and Guarding agency.

Inspections are based on principles of efficiency and effectiveness on a comparative basis e.g. performance in relation to everyone else. Inspections are aimed at sharing best practice, learning and continuous improvement. HMIC consults on the programme each year with Government and the police forces.

Thematic inspections are a key element of their work plan. Thematic inspections examine a key issue across a representative number of forces, and comment solely on performance in relation to that issue. The benefits of this type of inspection are that it identifies deficiencies relevant to the Police Service as a whole and spreads good practice regarding a specific aspect of policing. Such inspections have proved important in identifying and exploring critical issues and sticking points and offering solutions for moving the Service forward in areas such as race and diversity, efficiency and value for money. Thematics may cover wide ranging topics e.g. ASBOs, Public order, safeguarding and may be recurring themes. Some thematics such as 'custody' are rolling programmes ongoing all the time. Race and Diversity are covered every two or three years. Other thematics are issue/risk based e.g. in 2012 they will be looking at undercover work.

HMI Prisons conducts thematic inspections both on their own and in conjunction with other criminal justice organisations covering areas such as mental health and race. Thematics make national recommendations for improvement.

## 5.2 Enhancement-led QA

The dual purpose of quality assurance – both to provide accountability and to enable enhancement – was described by many commentators in the literature review. In a history and critique of quality evaluation in the UK, Harvey argues that in the past

*‘...quality monitoring in the UK has been beset by overlapping and burdensome processes, competing notions of quality, a failure to engage learning and transformation, and a focus on accountability and compliance’ (Harvey 2005<sup>18</sup>)*

Much of the literature is concerned with a critique of the ‘accountability’ approach to QA in higher education and is concerned to transform external QA, ‘to refocus and re-orientate it to the actual improvement of teaching and learning’ (Singh 2010<sup>19</sup>)

For example, Houston (2010) argues for a shift towards achieving enhancement of education, rather than just ‘accountability’ interventions and notes that some quality agencies such as the Scottish QAA and the Australian Learning and Teaching Council seem to be shifting their focus from control and surveillance to the development of negotiated mechanisms for enhancement; ‘increasing attention is being paid to improvement of teaching and to engagement with academics around enhancement agendas’ (Houston 2010<sup>20</sup>)

Similarly, the Bologna process and related initiatives in Europe such as ENQA and the European Higher Education Area (EHEA) are promoting quality enhancement:

*‘...current approaches are reorienting focus from quality assurance towards contextual quality enhancement and that quality enhancement becomes the primary responsibility of universities and university stakeholders (students, academic and administrative staff).’ (Gvaramadze 2008<sup>21</sup>)*

The emphasis on quality enhancement was described by many respondents, although perhaps this was most explicit in the enhancement-led approach developed by QAA Scotland and described below in Case Study 11.

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<sup>18</sup> Harvey L. (2005), A history and critique of quality evaluation in the UK, *Quality Assurance in Education*, Vol. 13 No 4 p263-276

<sup>19</sup> Singh M. (2010), Quality Assurance in Higher Education: Which Pasts to Build on, What Futures to Contemplate? *Quality in Higher Education*, Vol 16, No 2, July 2010

<sup>20</sup> Houston D (2010), Achievements and Consequences of Two Decades of Quality Assurance in Higher Education: A Personal View from the Edge, *Quality in Higher Education* Vol. 16, No 2 p179

<sup>21</sup> Gvaramadze I. (2008), From Quality Assurance to Quality Enhancement in the European Higher Education Area, *European Journal of Education*, Vol 43, No 4 p443

### **Case Study 11: Enhancement-led QA (QAA Scotland)**

QAA Scotland worked closely with the Scottish Funding Council (SFC), Universities Scotland and NUS Scotland to develop an **enhancement-led** approach to quality in the Scottish higher education sector. The strategy adopted has five main elements:

- **a comprehensive programme of institution-led reviews**, carried out by higher education institutions with guidance from the SFC
- **Enhancement-led institutional review**: external reviews run by QAA Scotland that involve all Scottish higher education institutions over a four-year cycle
- **improved forms of public information about quality**, based on addressing the different needs of a range of stakeholders including students and employers
- **a greater voice for student representatives** in institutional quality systems, supported by a national development service. [sparqs](#) (student participation in quality Scotland)
- **a national programme of Enhancement Themes**, managed by QAA Scotland. The programme encourages academic staff, support staff and students to share current good practice and collectively generate ideas and models for innovation in learning and teaching.

The work of QAA Scotland feeds into all these elements. This collaborative approach to quality is unique in many respects: in its balance between quality assurance and enhancement; in the emphasis which it places on the student experience; in its focus on learning and not solely on teaching; and in the spirit of cooperation and partnership which has underpinned all these developments. (QAA Scotland<sup>22</sup>)

#### **Enhancement-led institutional review (ELIR)**

ELIR is conceived and designed to support institutions' self-evaluation and reflection. Central to the ELIR method, therefore, is the institution's Reflective Analysis (RA), which will highlight the main and the distinctive features of the institution's arrangements for enhancing the student learning experience and securing academic standards. Crucially, the RA will set out the institution's reflections on the effectiveness of its approach in those areas, citing the evidence on which these reflections are based.' (QAA Scotland 2008)

'Annual discussions facilitate the review process and provide an important opportunity for information sharing between QAA Scotland and the institution. These annual meetings will be held between a member of QAA Scotland staff and a small group from the institution, which is likely to comprise senior colleagues and a representative of the student body... a particular focus of the annual meetings will continue to be discussion of the institution's approach to institution-led quality reviews, and what the institution is learning from the outcomes of the reviews that have been held in the preceding year.' (QAA Scotland 2008)

This approach is also informed by international perspectives and contributions, including developments in the [Bologna Process](#) and the creation of the European Higher Education Area:

'In general, the Enhancement-led institutional review (ELIR) method has been revised in line with international good practice in the management of quality in higher education. The

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<sup>22</sup> QAA Scotland web site: <http://www.qaa.ac.uk/Scotland/AboutUs/Pages/Quality-enhancement-framework-in-Scotland.aspx>

'Standards and Guidelines for Quality Assurance in the European Higher Education Area', central to the Bologna process, have been fully embraced as have the International Network of Quality Assurance Agencies in Higher Education (INQAAHE) 'Guidelines of Good Practice' (QAA Scotland 2008)

### **Enhancement Themes**

A national programme of Enhancement Themes encourages academic staff, support staff and students to share current good practice and collectively generate ideas and models for innovation in learning and teaching. Previously completed themes include:

- Graduates for the 21<sup>st</sup> Century (2008-2011)
- Research-Teaching Linkages: Enhancing Graduate Attributes (2006-08)
- The First Year: Engagement and Empowerment (2005-08)
- Integrative Assessment (2005-06)
- Flexible Delivery (2004-06)
- Employability (2004-06)
- Responding to Student Needs (2003-04)
- Assessment (2003-04)

There was, and is, no expectation that the outcomes of the Enhancement Themes will lead to compliance with specific approaches. Rather, the outcomes now provide a rich repertoire of reference points for institutions and their students to draw on in developing their own policies and practice within the context of their own timeframes and priorities.' (QAA Scotland 2008)

Initially, topics for enhancement themes were selected by the Scottish Funding Council. However, in order to increase 'ownership' the Universities are now fully involved in managing the programme of enhancement themes. The Scottish Higher Education Enhancement Committee (SHEEC) agrees the themes and there are steering groups for individual themes chaired by academics with representation from every university. Universities are given some funding to participate in this process.

Initially, enhancement themes ran for one year, but it was found that a longer time period was required for the process of: Discovery – Sharing – Embedding. Enhancement themes now run for two to three years.

See: [www.enhancementthemes.ac.uk](http://www.enhancementthemes.ac.uk)

### 5.3 Systematic linking of QA to outcomes

A shift towards the use of standards focussed on outcomes has already been described elsewhere in this report. This change in emphasis towards QA focussed on outcomes was most explicit in the recent revision of the accreditation process and standards by the General Pharmaceutical Council, described below in Case Study 12.

#### **Case Study 12: Outcome-focussed standards and inspection**

Having recently completed a standards setting process, the General Pharmaceutical Council (GPhC) has the most recently developed education standards among the UK health sector regulators. "[Future pharmacists](#) Standards for the initial education and training of pharmacists" was published in May 2011 and represents the Council's intention to move from process to outcome focussed QA. That is to develop standards that strongly support the assessment and quality assurance of education against the required outcomes of the programme (described in Standard 10 of Future Pharmacists) rather than simply its content and management.

The education standards were drafted by a group of 10 academics and 10 pre-registration training leads, the latter providing input from the larger employers in the field. An initial consultation on the draft standards was held between October 2009 and January 2010, hosted by the Council for Healthcare Regulatory Excellence (CHRE) because the GPhC was not yet formally established.

The first consultation on the draft standards was very successful in generating a wide range of views and, following redrafting of four sets of standards a second formal consultation process was held, this time facilitated by the GPhC. The brief, to develop a more modern set of outcome-focussed standards, has been achieved successfully.

Developing standards however, has only been part of the move towards an outcome-focus. The approach has required a programme of change, which has been supported at various key points.

The accreditation process for pharmacy programmes was radically re-designed on a Miller's triangle model. As well as standard meetings about staffing, resources, etc, schools are required to demonstrate the pathway by which outcomes will be achieved. The visit core comprises several meetings where the above is explored. Visit teams will select around 15 (of around 100) outcomes per visit and the school will describe how the programme they have designed delivers those outcomes. So, rather than taking a general overview, the team undertakes selective in-depth verification of standards on a risk basis.

A practice visit, conducted 3 yearly, looks a work in both pharmacy practice and laboratory settings. It focuses on required outcomes and is used to verify the provider's claim of practice to outcomes made during the earlier accreditation process.

The Council worked with providers to develop [New guidance](#) to support them in working with the new framework. Accreditation teams also needed to be supported in conducting accreditation visits in a new and quite different way. A new handbook was produced for accreditation teams and there was particularly rigorous training for accreditation team members around the introduction of the new standards, covering new visit structures and topics such as, "what you will no longer be doing" and "how to ask questions" e.g. open questions, not out of interest, not leading.



The GPhC believes that this approach provides significantly better evidence, rather than the "impressionistic" views previously gained from set-piece meetings about teaching, learning, assessment, curriculum and resources. Schools have to describe in detail: (1) how an outcome is introduced, (2) how it is developed year on year, (3) how the curriculum is integrated, horizontally and vertically and (4) how it is assessed at each level and how the assessment is progressive.

Feedback from the accreditors about this approach indicates that they feel much more confident in their decision making as a result of it. Also, schools have accepted negative decisions more readily, because evidence can be fed-back to them in a more structured and detailed way.

Because the process is new to providers, there have been occasions, where they have not fully grasped the concept and teams have had to return to support the provider in understanding what is required.

The regulator anticipated a greater reaction to the changes from providers than was actually initially the case. However it has since become apparent that some providers may not have expected the rigor with which the new standards would be applied and have been surprised when challenged on the degree of integration of outcomes into curricula. This has led to a higher than usual number of deferred accreditation decisions or decisions to accredit for a limited period of time (to enable a proper curriculum redesign to take place).

Providers reportedly find the process draining but rewarding. They accept that the clear evidence-based approach is appropriate

The GPhC believes that this new framework is helping education providers to develop courses that are genuinely outcome-focussed.

## 5.4 Trainee/student surveys

The GMC national surveys of trainee doctors and trainers were widely applauded by other health sector regulators, CHRE and members of the postgraduate medical education community. It is regarded as innovative and highly valuable in establishing a picture both of headline themes and potentially more granular local data, thus offering data to improve strategic and programme level responses by the regulator.

*“Deaneries find the survey invaluable for triangulating their evidence from visits and placement questionnaires”*

*“The Trainee Survey is a fundamental and accepted aspect of the national QA system now”*

*“The Trainee survey is brilliant – gives frontline experience that no other regulator can provide”*

No comparable data system appears to exist among other health sector education and training regulators. However, it may be of interest that the General Pharmaceutical Council is currently running a pilot project to obtain feedback from students via twitter and Facebook.

In other sectors, some examples were found of student and service user surveys:

- Ofsted currently has an on line questionnaire for parents to provide feedback about their children’s school: <http://parentview.ofsted.gov.uk/> Ofsted hopes to develop similar on line questionnaires in the future for use by students and employees.
- Education Scotland encourages parents, teaching staff and pupils to submit questionnaires to obtain their views on standards in their school as part of inspections. The questionnaires can be submitted on line or as hard copies.
- QAA reviews the outcomes of the National Student Survey (conducted since 2008/09), which every undergraduate student in their final year is asked to complete. Outcomes of this satisfaction survey are scored by institution and subject area (including medical schools). This can provide an initial ‘trend analysis’ to indicate potential areas to explore further and as part of the evidence base. The NSS is commissioned by HEFCE and available from <http://unistats.direct.gov.uk/> .
- HM Inspectorate of Prisons collects information from many sources, including people who work in an establishment and the people who are imprisoned or detained there. If an inspection is announced, one month prior to the inspection researchers will visit the establishment to obtain preliminary information. They will conduct a confidential and anonymous survey of a representative proportion of the prisoner or detainee population in order to obtain prisoners' and detainees' views. Full unannounced inspections and unannounced full follow-up inspections also include a survey.

## 5.5 Meetings with Postgraduate Deaneries

During the research for this project, the team met with a number of colleagues from Postgraduate Deaneries. While the remit of the research was to explore the practice of other regulators, rather than that of the GMC, Deanery colleagues were keen to discuss their relationships with the GMC in relation to QA of Postgraduate Medical Education. The GMC will no doubt be aware of much of this, but it would seem remiss not to acknowledge the key points that arose consistently in these meetings.

Among those Deaneries and those with expertise in the work of the Deaneries that took part in the research, the view that the QA relationship was markedly improved since GMC took over the role was fairly widely expressed. This was variously described in terms such as:

*“There is high esteem for the GMC.”*

There is clearly recognition of areas where the GMC lead the way in regulating education, such as patient and public involvement or the involvement of students in accreditation teams. There is also appreciation for the strategic role that the GMC play in working to integrate the Royal Colleges and the Medical Schools Council and providing a central focus for the UK health regulators.

*“National systems are better, making more explicit and transparent what was tacit.”*

Improvements since the merger with PMETB were noted.

*“GMC has resources that were not previously available – this is 100% valuable.”*

More specifically, the benefits of these increased resources were described as:

- Significant improvements to the Trainee Survey - the extra resources that GMC have put in (for instance in taking over the hosting of the survey from a third party and are now developing it in-house) have already improved the Survey's reliability and will result in a much more flexible and powerful tool.
- Response to Concerns process - the GMC is recruiting a standing team of clinicians to undertake emergency visits to health providers and is also taking part in deanery visits by invitation where there are significant concerns. The process has been considerably beefed up and is now much clearer.

The cultural shift is seen as developmental, supportive and positive, neatly encapsulated by describing a move from a 'bad cop' role to a 'good cop' role.

Another theme to emerge strongly was that of perceived inconsistency in the QA by the GMC across Deaneries. While all Postgraduate Medical Education is Quality Assured against the same standards there was a clear feeling that deaneries are Quality Assured differently, with different levels of data required and varying interpretations of requirements. Overall there was a call for QA of Deaneries to be more homogenous and for central direction of Deanery Quality Management to improve consistency and to clarify the GMC's overview of Postgraduate Medical Education.

It is unclear from this study, whether these perceived inconsistencies are genuinely a weakness in the QA system, or proportionate risk-based QA by the GMC.

Deanery colleagues were forthcoming with suggestions for data that the GMC might usefully examine in order to gain a clearer overview of the quality of Postgraduate Medical Education. The most often-mentioned concerned data about trainees including the Annual Review of Competence Progression (ARCP) Review being piloted by COPMeD, which would make anonymous information on trainees' progression commonly available to the GMC, Deaneries and Royal Colleges using the GMC registration number as the Unique Reference Number (URN). There is also a very strong belief in the value of trainee 'end of placement' questionnaires, the use of which, it is suggested, would provide the regulator with a more granular picture of the quality of Postgraduate Education.

## 5.6 Feedback from Medical schools

The remit of this research was to focus on the QA practice of regulators within and outside the health sector. In addition, to provide another perspective on QA practice, responses were also obtained from three University medical schools. Clearly this is too small a sample to infer any firm conclusions but their comments do highlight some important considerations for QA practice:

- Some use of shared evidence was reported, but the view was that it could be used more. It was recognised that GMC is looking at evidence sharing with other bodies (e.g. Higher Education Statistics Agency) and this was very much welcomed to 'reduce the burden of data provision on the medical school'.
- One respondent noted that the university's internal QA process might also produce information that could be used by the GMC:

*"Within our own University we have Periodic Subject Reviews (PSR). These are every 5 or 6 years with annual reporting dependent upon the outcomes of the most recent PSR. There is a self-evaluation report submitted ahead of the two-day panel visit. The panel is led by a Vice Principal and has an external subject expert. There is a wide range of domains covering teaching and assessment, resources and accommodation, staff development, policies and processes, student experience and so forth. The comprehensiveness of this process and the follow-up and ongoing scrutiny could very well feed into the GMC's requirement for information."*

In contrast, another respondent observed that:

*"it's quite difficult to use internal reviews to inform external QA in any meaningful way: the format and frequency of such reviews will differ substantially between institutions and the GMC would have to rely on an expectation of equal rigour applied to these processes at different universities"*.

- The move towards a more risk-based approach was welcomed, noting that QA should be proportionate to an institution's record for delivering quality.
- Self-assessment is recognised as a key component of QA. One respondent described self-assessment as 'the main method of regulating' and another described self-assessment as 'an opportunity to highlight areas of good practice as well as areas of concern'.
- Visits were recognised as an important part of QA, although one respondent commented that visits only give a snapshot of activity and regulators must continue to use a range of metrics (self-assessment, student evaluation surveys or committees, external examiner reports, information gathered at visits, etc.) to triangulate data. It was noted that visits are taken 'incredibly seriously' and take a lot of staff time.
- Views were expressed that external regulation adds a nationally recognised perspective. GMC has the overview of many institutions which thereby adds gravitas to the feedback. Its views also add weight to any improvement required by the School and is therefore 'an important agent for change'. Respondents commented that the School 'uses outcomes from QA reviews as one mechanism to drive enhancement' that 'the standards set out by the GMC require us to continually enhance our programme' and the GMC's review 'is used as a very strong argument for change (and action) for the medical school.'

## 6. Conclusions

While there are exceptions, the findings of this research suggest a number of general themes and trends in current approaches to QA. These are summarised as follows:

1. QA can provide both accountability and support for enhancement. The academic literature and respondents from regulators suggest a trend for reduced emphasis on QA for accountability and greater emphasis on QA to support enhancement of provision.
2. The emphasis on enhancement is closely aligned to QA being embedded within organisations rather than based on an external 'audit'. This enhancement-based approach is most effective when organisations develop robust internal QA processes. It is then possible for external QA and internal QA to be mutually reinforcing e.g. review of internal QA is the starting point for external validation, and external validation drives further development of internal QA processes.
3. The enhancement-based approach also relates to the role of self-assessment. A number of commentators from the academic literature observe that self-assessment/evaluation is at the heart of the enhancement approach to QA and observed the importance of effective internal QA processes. There was however, some variation in the perceived value of self-assessment between different health sector regulators.
4. The majority of regulators continue to adopt the cyclical model of approval and re-approval of providers, with re-approvals most typically required after a maximum of five years. However, this situation does seem to be changing, with some regulators adopting an approach to QA which is more proportionate or risk-based. There does generally appear to be a desire to focus QA on those areas of provision which are a cause for concern, or require further development. This is partly for a more effective use of the regulator's resources and also to reduce the assessment burden on providers that are performing well. This more 'proportionate' QA requires a risk-based, intelligence-led approach to monitoring of provider performance (usually required annually) in order to target QA appropriately.
5. Respondents in all sectors describe their standards as taking account of both process and outcomes although there appears to be a trend for increased use of standards which are outcomes focussed. This should allow for greater innovation and autonomy by providers and is therefore consistent with the shift towards QA to enable enhancement. It is also clear that standards or 'quality frameworks' frequently have a dual purpose of providing a required standard and acting as a source of guidance for further development or enhancement of provision.
6. Use of shared evidence was generally regarded as problematic due to issues of currency of evidence and utilising evidence produced for other purposes. There were however, some exceptions whereby regulators shared data and/or conducted joint inspections.
7. Across the regulator sample, there was a consistent commitment to transparency in their reporting and all reports were in the public domain (usually available from the regulators web site). All regulators include a narrative in their reports and many stress the importance of the qualitative narrative. Indeed respondents from some regulators outside the health sector (particularly the overseas regulators) use only a narrative without any grading/scoring. Respondents from the UK health sector do all use grading or scoring

although of various types. A number of respondents expressed concerns about the use of terms such as “satisfactory” in grading/scoring, suggesting it is perhaps clearer and less prone to misinterpretation to communicate that the standards are ‘met’ or that the standards are ‘met with areas for improvement’.

8. It was observed that a regulator’s approach to QA is often dependent upon the size and diversity of the regulated profession/s. For example, regulators with a remit for relatively few providers (e.g. in smaller countries or sectors) describe maintaining a close relationship and ongoing ‘dialogue’ with providers, which would be more difficult to achieve for the larger regulators. In such circumstances, the importance of boundaries was also recognised in order to achieve an appropriate balance between providing guidance and providing regulation.
9. The GMC is clearly regarded by UK and overseas healthcare regulators as at the forefront of excellence in regulatory practice, including practice in QA of education and training. It has been described as providing a “still, calm, centre” in medical education and medical regulators around the world look to the GMC for exemplars when refining their own systems.
10. Overall, there is evidence of a trend towards QA which is proportionate to risk, outcome focussed and enabling enhancement. This is entirely consistent with the CHRE definition of Right-touch regulation:

*“Right touch regulation is based on a proper evaluation of risk, is proportionate and outcome focussed; it creates a framework in which professionalism can flourish and organisations can be excellent.”<sup>23</sup>*

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<sup>23</sup> CHRE (2010), Right-touch regulation

## 7. Further observations and challenges for the regulators

The following observations and challenges are applicable to health sector regulators of education and training; some refer to actions that are already being taken forward by the GMC and others.

1. Thematic QA was not used by respondents from the health regulators, despite already being piloted by the GMC and commonplace among the non-health regulators. Thematic QA could play an important role in recognising and sharing good practice, and in achieving consistency of standards between providers. This may be particularly significant in positively engaging with providers that are performing well, especially in a 'proportionate' QA environment where more resources are focussed on those providers which perform less well.
2. Students are well established as full members of QA visit teams with the GMC, a number of non-health UK regulators and in the overseas health sector. Further use could be made of students as members of QA visit teams with other UK health sector regulators. Respondents using students on visit teams report that this has been well received by providers and that the students generally make a valuable contribution to the QA process.
3. All members of QA visit teams require sufficient training and support to ensure they are clear about their role and the purpose of every aspect of the visit (see Section 4.5 'Support and preparation of reviewers'). For example, there appeared to be some variation in the degree to which discussions during visits are structured, ranging from the informal to the highly structured. The preparation of all members of the visit team is important to maintain consistency in their judgements and their credibility with providers.
4. Regulators should review how self-assessments are validated and consider how these can be further corroborated through the use of additional data sets (which might involve collecting/collating evidence for key interest groups e.g. students, members of the public etc).
5. It is important that standards and QA processes are regularly reviewed and up-dated, in particular to ensure that standards are clear and QA processes transparent for those being regulated. This is consistent with the CHRE right touch elements to 'keep it simple' and 'review and respond to change'.
6. Use of shared evidence is problematic but from the perspective of providers, has the potential to reduce the burden of assessment. Where possible, opportunities should be explored for the use of already existing evidence and co-ordination of joint inspection with other regulators. For example, there may be scope for greater partnership working between GMC and QAA where University medical schools are subject to QAA reviews and GMC approval. There may also be scope for increased sharing of information between regulators and other bodies.
7. There appears to be a wide range of interest groups and stakeholders for QA and regulation outcomes (the most frequently mentioned being students, education providers, policy makers and the general public). However, most regulators publish their reports in a single format. The target audiences for regulation outcomes should be clearly defined (i.e. explicitly stated) and the reporting formats tailored to be accessible to the intended



target audiences as illustrated by Ofsted and QAA (See Case Study 7). This is again consistent with the element of the CHRE right touch approach to 'keep it simple' i.e. to help patients and the public understand the QA system.

8. The use of outcome-based approaches to QA is increasing (e.g. the General Pharmaceutical Council's recent revision of standards and inspection processes described in Case Study 12). A focus on the outcome is one of the elements of the CHRE right touch approach; however there are various outcome-based approaches used by different regulators. This demonstrates the importance of continued sharing of good practice and learning from new initiatives between regulators.
9. The GMC trainee survey was found to be highly regarded by other health sector regulators and should continue to be developed and enhanced.
10. Finally, there appear to be a number of areas where Deaneries seem keen to work with the GMC to improve QA in Postgraduate Education, further exploration of which are beyond the scope and capacity of this research. The GMC may wish to explore these further in the forthcoming review of QA of Medical Education.

# Annex 1: Topic guide

## Introduction

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. One of the ways it does this is by setting standards for undergraduate and postgraduate medical education and training and by checking that those standards are being met.

The GMC's *Education Strategy 2011-2013* commits to a comprehensive review of how the quality of medical education is assured. The review will run throughout 2012. To help inform the work of the review, the GMC has commissioned research into how medical education (and education more widely) is quality assured by other bodies.

**The research will be undertaken by Colin Wright Associates, on behalf of the GMC.**

## Research to support the review

The research will combine a literature review and a series of in-depth discussions with organisations that have a role in quality assuring the provision of education and training in a number of sectors.

## Topic guide for the in-depth discussions

The in-depth discussions will be based on 14 questions, presented on the following pages. The questions are intended to guide our discussions - not all questions may be relevant in all cases.

You may wish to reflect on these questions prior to a discussion with one of our researchers.

If you wish to respond in writing, please return this document to us with your responses.

## Research outcomes

A final report based on the research will aim to analyse, and comment upon the wide spectrum of approaches to quality assurance within a regulatory context. In so doing, the report will additionally highlight instances of good practice where appropriate.

In the report, whilst we will refer to those organisations that have contributed to the research, the names of individual respondents will remain confidential.

## Research timetable

The research will run from November 2011 to the end of February 2012.

## Further information

If you require any further information or clarification about this research, please contact

Colin Wright Associates at:

Email: [colin@colinwrightassociates.co.uk](mailto:colin@colinwrightassociates.co.uk)

Tel: 01227 477106

**Colin Wright Associates**

**General  
Medical  
Council**

Regulating doctors  
Ensuring good medical practice

<b>Organisation name:</b>	
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**Contact details:**

<b>Name:</b>	
<b>Job title:</b>	
<b>Telephone:</b>	
<b>Email:</b>	

1) **What is your organisation's role in quality assurance/regulation?** *For example:*

- a) *Briefly describe the scope of your organisation's responsibilities for QA/regulation*
- b) *Are there any principles, frameworks or powers which underpin those responsibilities?*

2) **How are QA assessments planned and targeted?** *For example:*

- a) *Are QA assessments routinely scheduled and/or triggered by other criteria, such as risk assessments or trainee concerns?*
- b) *What is the frequency of QA assessments?*
- c) *Can organisations performing / achieving at higher levels achieve greater regulatory autonomy or 'inspection holidays'?*

3) **What standards or criteria are used to form judgements for QA purposes?**

*For example:*

- a) *Do standards/criteria focus on outcomes, processes or both?*
- b) *How are standards/criteria determined?*
- c) *Are there specific standards for staff delivering education and training (e.g. accreditation or registration of trainers)*

4) **To what extent do regulators rely on self-assessment (as conducted by those organisations being Quality Assured)?** *For example:*

- a) *How are self-assessments validated (e.g. are there random as well as risk based inspections)?*
- b) *What other sources of evidence are used to validate self-assessment?*

5) **Where visits are undertaken, what is the purpose of these visits?** *For example: to validate self-assessment, collect additional data, respond to concerns etc.*

6) **How are visits scheduled and organised?** *For example:*

- a) *How frequently are visits made?*
- b) *How much notice are providers given of visits?*
- c) *What is the composition of visit teams (e.g. do they include an assessor/inspector, a peer reviewer, a lay member of the public)?*

7) **To what extent is 'shared evidence' used (e.g. evidence obtained through collaborative working with other organisations / third party findings)?** *For example,*

- a) *Can the use of shared evidence lead to 'exemptions' e.g. not requiring evidence in areas that have been assessed in other inspections?*
- b) *Are the standards used 'mapped' against other frameworks to indicate areas where shared evidence may be relevant?*
- c) *If shared evidence is not used, what are the reasons?*

8) **Are any other QA systems or processes used (i.e. not already described above)? If so, how?**

9) **How do regulators report on performance?** *For example:*

- a) *Are performance scores used, and if so, what type? E.g. are scores aggregate for the entirety of provision and/or for different elements; do they grade on a scale or binary only (e.g. met/not met)?*
- b) *Are performance scores solely quantitative, or is there an accompanying narrative?*
- c) *Are performance outcomes publicly reported?*
- d) *Are performance outcomes anonymised or not?*

10) **Who do you consider to be the key interest groups for QA/regulation outcomes?**

*For example, staff, service users, students, policy makers etc.*

- a) *Do you tailor information on QA/regulation outcomes for different interest groups?*

11) **In your opinion, what added value does the external QA, as undertaken by the regulator, provide?**

*For example, to what extent does QA contribute to improvement of providers/services?*

12) **What sanctions are available should providers fail to meet the acceptable level of quality?**

**13) In summary, what key factor or factors are found to be most significant for delivery of effective QA?**

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**14) Finally, are there any other comments?**

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**Additional notes for researchers**

**References (i.e. any documents reviewed to support the above findings)**

Author, document name, date

**Interview/s conducted**

<b>Interview date</b>	
<b>Name:</b>	
<b>Job title:</b>	

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## Annex 3: Participant organisations

### Health sector regulators of education and training (UK)

1. General Chiropractic Council (GCC), [www.gcc-uk.org](http://www.gcc-uk.org)
2. General Optical Council (GOC), [www.optical.org/](http://www.optical.org/)
3. General Osteopathic Council (GOsC), [www.osteopathy.org.uk/](http://www.osteopathy.org.uk/)
4. General Pharmaceutical Council (GPhC), [www.pharmacyregulation.org/](http://www.pharmacyregulation.org/)
5. Health Professions Council (HPC), [www.hpc-uk.org/](http://www.hpc-uk.org/)
6. Nursing and Midwifery Council (NMC), [www.nmc-uk.org/](http://www.nmc-uk.org/)
7. Pharmaceutical Society of Northern Ireland (PSNI), [www.psni.org.uk/](http://www.psni.org.uk/)

### Health sector regulators of education and training (overseas)

8. Health Professions Council of South Africa, [www.hpcsa.co.za/](http://www.hpcsa.co.za/)
9. Liaison Committee on Medical Education (USA), [www.lcme.org](http://www.lcme.org)
10. Medical Council of New Zealand (together with the Australian Medical Council), [www.mcnz.org.nz/](http://www.mcnz.org.nz/), [www.amc.org.au/](http://www.amc.org.au/)

### Non-health sector regulators of education and training (UK)

11. Care Council for Wales (CCW), [www.ccwales.org.uk](http://www.ccwales.org.uk)
12. Education and Training Inspectorate for Northern Ireland, [www.etini.gov.uk](http://www.etini.gov.uk)
13. Education Scotland, [www.educationscotland.gov.uk](http://www.educationscotland.gov.uk)
14. Estyn (Education and Training Inspectorate for Wales), [www.estyn.gov.uk](http://www.estyn.gov.uk)
15. General Social Care Council (GSCC), [www.gsccl.org.uk](http://www.gsccl.org.uk)
16. Northern Ireland Social Care Council (NISCC) [www.niscc.info](http://www.niscc.info)
17. Ofsted, [www.ofsted.gov.uk](http://www.ofsted.gov.uk)
18. Quality Assurance Agency for Higher Education (QAA), [www.qaa.ac.uk](http://www.qaa.ac.uk)
19. QAA Scotland, [www.qaa.ac.uk/Scotland](http://www.qaa.ac.uk/Scotland)
20. Scottish Social Services Council (SSSC), [www.sssc.uk.com](http://www.sssc.uk.com)

### **Non-health sector regulators of education and training (overseas)**

21. Canada - Ontario Universities Council on Quality Assurance, [www.cou.on.ca/quality.aspx](http://www.cou.on.ca/quality.aspx)
22. Germany - Accreditation Certification and Quality Assurance Institute (ACQUIN), [www.acquin.org/en/index.php](http://www.acquin.org/en/index.php)
23. Ireland - Higher Education and Training Awards Council, [www.hetac.ie](http://www.hetac.ie)
24. Netherlands - Quality Assurance Netherlands Universities (QANU), [www.ganu.nl/](http://www.ganu.nl/)
25. New Zealand Universities Academic Audit Unit, [www.nzuaau.ac.nz/](http://www.nzuaau.ac.nz/)
26. Sweden - The Swedish National Agency for Higher Education, [www.hsv.se/english/](http://www.hsv.se/english/)

### **Organisations from other UK sectors with a regulatory/QA function**

27. Bar Standards Board, [www.barstandardsboard.org.uk/](http://www.barstandardsboard.org.uk/)
28. Financial Services Authority, [www.fsa.gov.uk](http://www.fsa.gov.uk)
29. Healthcare Improvement Scotland, [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)
30. Healthcare Wales
31. HM Inspectorate of Constabulary, [www.hmic.gov.uk/](http://www.hmic.gov.uk/)
32. HM Inspectorate of Prisons, [www.justice.gov.uk/about/hmi-prisons/index.htm](http://www.justice.gov.uk/about/hmi-prisons/index.htm)
33. HM Inspectorate of Probation, [www.justice.gov.uk/about/hmi-probation/index.htm](http://www.justice.gov.uk/about/hmi-probation/index.htm)
34. Skills for Justice, [www.skillsforjustice.com](http://www.skillsforjustice.com)

### **Medical schools, Deaneries and others**

35. Conference of Postgraduate Medical Deans for the United Kingdom (COPMeD), [www.copmed.org.uk/](http://www.copmed.org.uk/)
36. Council for Healthcare Regulatory Excellence (CHRE), [www.chre.org.uk/](http://www.chre.org.uk/)
37. Imperial College School of Medicine, [www.imperial.ac.uk/medicine](http://www.imperial.ac.uk/medicine)
38. Keele Medical School, [www.keele.ac.uk/health/schoolofmedicine/](http://www.keele.ac.uk/health/schoolofmedicine/)
39. Kim Scrivener – Individual Expert Contributor – Former Head of Quality & Committee Services at London Deanery
40. South West Peninsula Deanery, [www.peninsuladeanery.nhs.uk/](http://www.peninsuladeanery.nhs.uk/)
41. University of Glasgow undergraduate medical school, [www.gla.ac.uk/schools/medicine/mus/](http://www.gla.ac.uk/schools/medicine/mus/)
42. Wessex Deanery, [www.wessexdeanery.nhs.uk](http://www.wessexdeanery.nhs.uk)
43. West Midlands Deanery, [www.westmidlandsdeanery.nhs.uk](http://www.westmidlandsdeanery.nhs.uk)

## **Annex 4: Standards and Guidelines for Quality Assurance in the European Higher Education Area<sup>24</sup>**

### **Summary list of European standards for quality assurance**

This summary list of European standards for quality assurance in higher education is drawn from Chapter 2 of the report and is placed here for ease of reference. It omits the accompanying guidelines. The standards are in three parts covering internal quality assurance of higher education institutions, external quality assurance of higher education, and quality assurance of external quality assurance agencies.

### **Part 1: European standards and guidelines for internal quality assurance within higher education institutions**

#### *1.1 Policy and procedures for quality assurance:*

Institutions should have a policy and associated procedures for the assurance of the quality and standards of their programmes and awards. They should also commit themselves explicitly to the development of a culture which recognises the importance of quality, and quality assurance, in their work. To achieve this, institutions should develop and implement a strategy for the continuous enhancement of quality. The strategy, policy and procedures should have a formal status and be publicly available. They should also include a role for students and other stakeholders.

#### *1.2 Approval, monitoring and periodic review of programmes and awards:*

Institutions should have formal mechanisms for the approval, periodic review and monitoring of their programmes and awards.

#### *1.3 Assessment of students:*

Students should be assessed using published criteria, regulations and procedures which are applied consistently.

#### *1.4 Quality assurance of teaching staff:*

Institutions should have ways of satisfying themselves that staff involved with the teaching of students are qualified and competent to do so. They should be available to those undertaking external reviews, and commented upon in reports.

#### *1.5 Learning resources and student support:*

Institutions should ensure that the resources available for the support of student learning are adequate and appropriate for each programme offered.

#### *1.6 Information systems:*

Institutions should ensure that they collect, analyse and use relevant information for the effective management of their programmes of study and other activities.

#### *1.7 Public information:*

Institutions should regularly publish up to date, impartial and objective information, both quantitative and qualitative, about the programmes and awards they are offering.

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<sup>24</sup> ENQA (2009), [European Association for Quality Assurance in Higher Education], Standards and Guidelines for Quality Assurance in the European Higher Education Area

## **Part 2: European standards for the external quality assurance of higher education**

### *2.1 Use of internal quality assurance procedures:*

External quality assurance procedures should take into account the effectiveness of the internal quality assurance processes described in Part 1 of the European Standards and Guidelines.

### *2.2 Development of external quality assurance processes:*

The aims and objectives of quality assurance processes should be determined before the processes themselves are developed, by all those responsible (including higher education institutions) and should be published with a description of the procedures to be used.

### *2.3 Criteria for decisions:*

Any formal decisions made as a result of an external quality assurance activity should be based on explicit published criteria that are applied consistently.

### *2.4 Processes fit for purpose:*

All external quality assurance processes should be designed specifically to ensure their fitness to achieve the aims and objectives set for them.

### *2.5 Reporting:*

Reports should be published and should be written in a style, which is clear and readily accessible to its intended readership. Any decisions, commendations or recommendations contained in reports should be easy for a reader to find.

### *2.6 Follow-up procedures:*

Quality assurance processes which contain recommendations for action or which require a subsequent action plan, should have a predetermined follow-up procedure which is implemented consistently.

### *2.7 Periodic reviews:*

External quality assurance of institutions and/or programmes should be undertaken on a cyclical basis. The length of the cycle and the review procedures to be used should be clearly defined and published in advance.

### *2.8 System-wide analyses:*

Quality assurance agencies should produce from time to time summary reports describing and analysing the general findings of their reviews, evaluations, assessments etc.

### **Part 3: European standards for external quality assurance agencies**

#### *3.1 Use of external quality assurance procedures for higher education:*

The external quality assurance of agencies should take into account the presence and effectiveness of the external quality assurance processes described in Part 2 of the European Standards and Guidelines.

#### *3.2 Official status:*

Agencies should be formally recognised by competent public authorities in the European Higher Education Area as agencies with responsibilities for external quality assurance and should have an established legal basis. They should comply with any requirements of the legislative jurisdictions within which they operate.

#### *3.3 Activities:*

Agencies should undertake external quality assurance activities (at institutional or programme level) on a regular basis.

#### *3.4 Resources:*

Agencies should have adequate and proportional resources, both human and financial, to enable them to organise and run their external quality assurance process(es) in an effective and efficient manner, with appropriate provision for the development of their processes and procedures.

#### *3.5 Mission statement:*

Agencies should have clear and explicit goals and objectives for their work, contained in a publicly available statement.

#### *3.6 Independence:*

Agencies should be independent to the extent both that they have autonomous responsibility for their operations and that the conclusions and recommendations made in their reports cannot be influenced by third parties such as higher education institutions, ministries or other stakeholders.

#### *3.7 External quality assurance criteria and processes used by the agencies:*

The processes, criteria and procedures used by agencies should be pre-defined and publicly available. These processes will normally be expected to include:

- a self-assessment or equivalent procedure by the subject of the quality assurance process;
- an external assessment by a group of experts, including, as appropriate, (a) student member(s), and site visits as decided by the agency;
- publication of a report, including any decisions, recommendations or other formal outcomes;
- a follow-up procedure to review actions taken by the subject of the quality assurance process in the light of any recommendations contained in the report.

#### *3.8 Accountability procedures:*

Agencies should have in place procedures for their own accountability.

## Annex 5: The Government's Policy on Inspection of Public Services

The Government's Policy on Inspection of Public Services (2003) provides ten principles of inspection:

1. 'The **purpose of improvement**. There should be an explicit concern on the part of inspectors to contribute to the improvement of the service being inspected. This should guide the focus, method, reporting and follow-up of inspection. In framing recommendations, an inspector should recognise good performance and address any failure appropriately. Inspection should aim to generate data and intelligence that enable departments more quickly to calibrate the progress of reform in their sectors and make appropriate adjustments.
2. A **focus on outcomes**, which means considering service delivery to the end users of the services rather than concentrating on internal management arrangements.
3. A **user perspective**. Inspection should be delivered with a clear focus on the experience of those for whom the service is provided, as well as on internal management arrangements. Inspection should encourage innovation and diversity and not be solely compliance-based.
4. **Proportionate to risk**. Over time, inspectors should modify the extent of future inspection according to the quality of performance by the service provider. For example, good performers should undergo less inspection, so that resources are concentrated on areas of greatest risk.
5. Inspectors should encourage rigorous **self-assessment** by managers. Inspectors should challenge the outcomes of managers' self-assessments, take them into account in the inspection process, and provide a comparative benchmark.
6. Inspectors should use **impartial evidence**. Evidence, whether quantitative or qualitative, should be validated and credible.
7. Inspectors should disclose the **criteria** they use to form judgments.
8. Inspectors should be **open** about their processes, willing to take any complaints seriously, and able to demonstrate a robust quality assurance process.
9. Inspectors should have regard to **value for money**, their own included:
  - Inspection looks to see that there are arrangements in place to deliver the service efficiently and effectively.
  - Inspection itself should be able to demonstrate it delivers benefits commensurate with its cost, including the cost to those inspected.
  - Inspectorates should ensure that they have the capacity to work together on cross-cutting issues, in the interests of greater cost effectiveness and reducing the burden on those inspected.
10. Inspectors should **continually learn** from experience, in order to become increasingly effective. This can be done by assessing their own impact on the service provider's ability to improve and by sharing best practice with other inspectors'.

(Office of Public Services Reform 2003, *The Government's Policy on Inspection of Public Services*)