council for
healthcare
regulatory
excellence

Quality assurance of undergraduate education by the healthcare professional regulators
Unique ID: 16/2008
June 2009

1. Executive summary

1.1 We were asked by the Secretary of State for Health to provide advice on the approaches to quality assurance of undergraduate health programmes taken by the healthcare professional regulators.

1.2 Quality assurance of undergraduate education is not targeted at individual students aspiring to become healthcare professionals, but focused on education programmes and education providers. Successful completion of approved programmes by individuals, together with registration requirements allows individuals to apply to join a profession. Preserving the integrity of the register, and the fundamental role this plays in ensuring that regulators fulfil their duty to protect the public lies at the heart of quality assurance activities.

1.3 There are both similarities and differences in regulators' approaches. The broad structure is the same, following a pattern of programme approval, monitoring and reapproval, but differences become clear both in the methods and frequency regulators adopt in employing these aspects of quality assurance. The rationale for different approaches in part can be explained by the different role played by undergraduate education in meeting pre-registration requirements, but also reflects differences between the professions and the regulators themselves.

1.4 Regulators have demonstrated methods and approaches to manage the impact of changes in practice on education and their quality assurance processes, through planned reviews of standards, strategic reviews of approaches to education and focusing on high-level outcomes and criteria that allow education providers to keep curricula current. Furthermore, if practice is changing, quality assurance by the regulators is a means by which we can be confident that educational programmes ensure that new professionals are fit to practise.

1.5 Patient safety and public protection are at the heart of healthcare professional regulation and consequently underlie all work in quality assurance. The weakest student who passes a programme has to be fit to enter the register and fit to practise. The regulators work through a range of practical steps including methods and approaches in education programmes, involving patients and the public in quality assurance processes, integrating the principles of patient-centred care in the standards underpinning quality assurance, and through strong links to other areas of regulatory activity, including standards, registration and fitness to practise.

1.6 Relationships between regulators and professional bodies in this area depend greatly on the nature of the individual profession. For some they are the only profession-focused organisation involved in quality assurance. The HPC work with the greatest number of professional bodies and told us they work to ensure that they coordinate quality assurance activities wherever possible.

1.7 The regulators' activities should be considered in the context of other QA exercises that education providers are engaged with. At institutional level in England, Wales and Northern Ireland, the Quality Assurance Agency (QAA) carry out six-yearly institutional audits, focusing on the ability of the higher education institution to manage the quality of its educational provision. In Scotland a similar function, enhancement-led institutional reviews, are carried out on a four-yearly cycle. These external quality assurance activities are in addition to higher education institutions' own internal quality assurance processes.

1.8 For certain health programmes, other bodies take an active interest. In England strategic health authorities as the commissioners of nursing, midwifery and allied health education monitor value for money of the contracts they award to education providers. Lord Darzi's 2008 report, *A High Quality Workforce*,[1] placed further emphasis on this and work is ongoing to deliver an 'education commissioning for quality' programme through SHAs. We understand that similar processes are in preparation in Wales, where the National Leadership and Innovation Agency for Healthcare (NLIAH) are responsible for annual contract reviews with education providers. In Scotland, NHS Education for Scotland has recently taken on the role of contract monitoring on behalf of the Scottish Government Health Directorates.

1.9 Some professional bodies also have interests in the quality of undergraduate education, adopting similar approval and monitoring approaches in their rolling accreditation of programmes.

1.10 Views from higher education suggest to us that the legitimacy of the regulators' involvement in quality assurance is not questioned and indeed it is valued for the confidence and subject-specific insight that it can provide. But there is concern about the total impact and possible overlap of different quality assurance type processes on higher education, and that healthcare professional regulators are part of that impact.

1.11 This is a constantly changing field with many legitimate players who nevertheless cumulatively have disproportionate impact. We believe it would be impractical to try and seek a definitive solution. Instead it may be more productive to focus on establishing ways to live with change and manage tensions, and in that spirit we make the following observations and recommendations:

- Different approaches are inevitable given the current legislative framework for healthcare professional regulation.
- As programmes are subject to scrutiny by the different agencies, including the NHS, greater clarity and understanding is needed about their respective roles, including regulatory bodies.

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[1] Department of Health, 2008. *A high quality workforce: NHS Next Stage Review*. London: DH. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840 [Accessed 20 May 2009]

- All regulators must be willing and able to demonstrate how their processes link proportionately to patient safety and public protection, maintaining the focus on the issue of being fit to join the register, or making further progress towards this point, is essential. Demonstrating the contribution of quality assurance to the main duty to protect the public would be valuable, both in improving education and in assuring the public of the competency of newly qualified healthcare professionals.
- Finally, CHRE will work with the regulators and other stakeholders to review our standard of good regulation around quality assurance of education for the 2009/2010 performance review, taking into account current perspectives on good practice. Given the regulators' willingness to review and refine their approaches in the light of developments in practice, feedback and evaluation, there is potential to make changes that demonstrate good practice, proportionality and transparency in quality assurance.

2. Introduction

2.1 In October 2008 CHRE were commissioned by the Secretary of State for Health to provide advice on the process for quality assurance of undergraduate health programmes by the nine healthcare professional regulators:

The Secretary of State requests advice about the quality assurance regimes applied by the health professions regulatory bodies on Higher Education Institutions. The Secretary of State wishes to ascertain:

(i) the similarities and differences in approach that are taken by different bodies in the quality assurance of undergraduate healthcare programmes across the UK;

(ii) how the health professions regulators keep pace with changes in professional practice that may influence the structure or content of professional education;

(iii) whether the approaches of health professions regulatory bodies ensure they meet their statutory duties to ensure that future healthcare professionals are trained to sufficient competence to ensure high levels of patient safety in their everyday practice (taking account of the relative risk to patient safety of different areas of healthcare professionals' practice);

(iv) how the health professions regulators manage their relationships with the professional bodies; and

(v) whether there is potentially scope (should it be desirable to do so) to alter processes without adversely affecting public protection.

It would also be helpful if the Council could identify examples of good practice in the approach to quality assurance.

Public protection and patient safety must be the guiding principles throughout this analysis.

2.2 In February 2009 we provided an interim report on our work. This is reproduced in Annex 1, with slight revisions.

2.3 Our interim report discussed the current approaches taken by the regulatory bodies[2] we oversee, under powers given to us in the NHS Reform and Health Care Professions Act 2002. We identified the broad similarities and differences, discussed the means by which these regulators keep pace with changes in practice, how quality assurance contributes to patient safety and public protection, and the way they work with other organisations in this field. In brief we found that:

- There are similarities and differences in the approaches taken by the regulatory bodies to quality assuring undergraduate education. The broad structure of the approaches is the same, following a pattern of programme approval, monitoring and reapproval, but differences become clear both in the methods and frequency regulators adopt in employing these aspects of

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[2] General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, Health Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, Royal Pharmaceutical Society of Great Britain

quality assurance. The rationale for different approaches in part can be explained by the different role played by undergraduate education in meeting pre-registration requirements, but also reflects differences between the professions and the regulators themselves.

- Regulators have demonstrated methods and approaches to manage the impact of changes in practice on education and their quality assurance processes, through planned reviews of standards, strategic reviews of approaches to education and focusing on high-level outcomes and criteria that allow education providers to keep curricula current. Furthermore, if practice is changing, quality assurance by the regulators is a means by which we can be confident that educational programmes ensure that new professionals are fit to practise.

- Patient safety and public protection are at the heart of healthcare professional regulation and consequently underlie all work in quality assurance. The weakest student who passes a programme has to be fit to enter the register and fit to practise. The regulators work through a range of practical steps including methods and approaches in education programmes, involving patients and the public in quality assurance processes, integrating the principles of patient-centred care in the standards underpinning quality assurance, and through strong links to other areas of regulatory activity, including standards, registration and fitness to practise.

- Relationships between regulators and professional bodies in this area depend greatly on the nature of the individual profession. For some they are the only profession-focused organisation involved in quality assurance. The HPC work with the greatest number of professional bodies and told us they work to ensure that they coordinate quality assurance activities wherever possible.

2.4 This final report complements the interim report. Here we briefly describe the wider context of quality assurance of undergraduate education, before considering whether there is scope to change current approaches by regulators and identifying good practice.

2.5 We would like to acknowledge the help, advice and time given by colleagues across a range of organisations in completing this work. We have benefitted tremendously from the useful and wide-ranging discussions.

3. The regulators' role

3.1 Quality assurance of *pre-registration* education by healthcare professional regulators is driven by a need to ensure the fitness of new entrants to practice the profession, confirming that they may join the register. An absence of quality assurance of programmes at this point before registration, without the use of alternative means of assurance, would pose a serious challenge to the integrity of registers.

3.2 This commission is focused on undergraduate education. Completing undergraduate education does not mean the same thing or have the same value for all healthcare professions. For some, the next step is registration. For others, graduation enables progress to another period of pre-registration training or study, before eventually joining the register. This variation may help explain some of the differences in the approaches currently taken by the healthcare professional regulators.

3.3 Quality assurance of undergraduate education is not targeted at individual students aspiring to become healthcare professionals, but focused on education programmes and education providers. Successful completion of approved programmes by individuals, together with registration requirements allows individuals to apply to join a profession. Preserving the integrity of the register, and the fundamental role this plays in ensuring that regulators fulfil their duty to protect the public lies at the heart of quality assurance activities.

4. The wider context of quality assurance

4.1 The regulators' activities should be considered in the context of other QA exercises that education providers are engaged with.[3] At institutional level in England, Wales and Northern Ireland, the Quality Assurance Agency (QAA) carry out six-yearly institutional audits, focusing on the ability of the higher education institution to manage the quality of its educational provision. In Scotland a similar function, enhancement-led institutional reviews, are carried out on a four-yearly cycle.

4.2 These external quality assurance activities are in addition to higher education institutions' own internal quality assurance processes, including external examiners, described by QAA as 'the keystone of supporting academic quality in the UK'.

4.3 For certain health programmes, other bodies take an active interest. For example, in England strategic health authorities as the commissioners of nursing, midwifery and some allied health education monitor value for money of the contracts they award to education providers.

4.4 Lord Darzi's 2008 report, *A High Quality Workforce*[4], placed further emphasis on this and work is ongoing to deliver an 'education commissioning for quality' programme through SHAs. We understand that similar processes are in preparation in Wales, where the National Leadership and Innovation Agency for Healthcare (NLIAH) are responsible for annual contract reviews with education providers. In Scotland, NHS Education for Scotland has recently taken on the role of contract monitoring on behalf of the Scottish Government Health Directorates.

4.5 Alongside the funders (commissioners) of education programmes, some professional bodies also have interests in the quality of undergraduate education, adopting similar approval and monitoring approaches in their rolling accreditation of programmes.[5]

4.6 The tension is sometimes described as the need for successful students on these programmes to achieve three qualitatively different outcomes at the same time. They are fit to practise in the eyes of their regulator, fit for purpose in the eyes of the employer/commissioner, and fit for award of a degree in the eyes of the education provider.

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[3] Universities UK. *Quality and standards in UK universities: a guide to how the system works.* London: Universities UK. Available at www.universitiesuk.ac.uk/Publications/Pages/Quality-and-standards-in-UK-universities-A-guide-to-how-the-system-works.aspx [Accessed 20 May 2009]
[4] Department of Health, 2008. *A high quality workforce: NHS Next Stage Review*. London: DH. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840 [Accessed 20 May 2009]
[5] Elsewhere professional and statutory regulatory bodies are often grouped as one sector – PSRBs – but for the purposes of our work here, it is important that a distinction is retained.

4.7　These overlapping but fundamentally distinct interests in the quality of education are not peculiar to health. Statutory regulators of other professions are active in quality assurance relevant programmes, in broadly similar ways to those adopted by the regulators we oversee, with expected similarities and differences reflecting of the nature of the programme, the nature of the profession, and the route to registration.

4.8　For example, the General Social Care Council's oversight of institutions providing social work training in England is a two stage process. The institution is approved every five years in a joint event alongside internal quality assurance, followed by paper-based annual monitoring exercises. Reapproval of a course can be based on a site visit if risk suggests this is appropriate, alternatively this may be solely paper-based. The Architects Registration Board does not carry out approval visits except in exceptional circumstances, relying on a paper-based approval of a programme following the submission of evidence by the education provider. Recognition of the course in this case last for up to four years and the annual monitoring process within this includes checks on any conditions that may have been imposed when the course was approved. The Royal College of Veterinary Surgeons requires a site visit every ten years, assuming approval is unconditional and paper reviews carried out after five years do not suggest any major concerns are need for a new visit.

5.　Views on quality assurance of health programmes

5.1　A study of international best practice by Skills for Health in 2005 found that the UK is seen as a front runner in the quality assurance of healthcare education, and commented that this area had become more complicated since devolution. Reflecting on the question of similarities and differences, this review also concluded that a single model or 'one size fits all' is not appropriate.[6]

5.2　A quality assurance review of all NHS funded healthcare education in England, 'Major Review', carried out in 2003-2006, drew together regulators, professional bodies, workforce planners and education providers in a coordinated effort. There were 90 reviews across 15 healthcare disciplines. Reviewers had confidence in the academic and practitioner standards across all 90 reviews and the project concluded that 'healthcare programmes ensured that students who successfully completed their programmes were fit for practice, purpose and award.'[7] However, subsequent reviews of quality assurance have questioned the proportionality of Major Review.[8]

5.3　Institutions themselves have, over time, expressed views about the approach and collective impact of quality assurance. Universities UK has described PSRB

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[6] Skills for Health, 2005. *QA international best practice report. Executive summary*. Available at www.skillsforhealth.org.uk/js/uploaded/Quality%20Assurance/QA%20International%20Best%20Practice%20Report%20Summary%20-%20Dec%202005.doc [Accessed 20 May 2009]
[7] Quality Assurance Agency, 2007. *Major review of NHS-funded healthcare programmes in England. Final review trends report 2003-06*. Gloucester: QAA. Available at www.qaa.ac.uk/health/majorreview/reviewTrends0306/ReviewTrends0307.pdf [Accessed 20 May 2009]
[8] Quality Assurance Framework Review Group, 2008. *Review of the Quality Assurance Framework.Phase three outcomes: Assessment of the impacts of reviews of collaborative provision*. HEFCE: 2008. Available at: www.hefce.ac.uk/pubs/hefce/2008/08_21/ [Accessed 20 May 2009]

oversight as helping to provide independence, objectivity and additional confidence that standards and quality of the degree are appropriate.[9]

5.4 However, concerns have also been raised. The final report of the Higher Education Regulation Review Group (HERRG) in July 2008 commented on the 'large number of bodies' involved in the regulation of healthcare programmes and they expressed concern that in their view they sensed a 'lack of commitment to better regulation'.[10]

5.5 Through the course of this project we have received feedback and views from some working in higher education about the impact of regulators' quality assurance:

- *We have struggled on occasions to match the narrative with the grade provided*
- *It is proportionate, targeted and transparent*
- *We have been made to validate the same course three times in one year. No problems were ever discovered.*
- *The reporting was helpful to the quality enhancement of an emerging source and institution as well as providing assurance of the quality of provision*
- *Overall the QA is targeted and transparent however aspects of the process do not seem proportionate*
- *What upsets people the most is when they cannot identify where you have 'gone wrong'*
- *I think current arrangements have been very effective*
- *Harmonisation of the regulatory and professional bodies would be welcomed by Higher Educational Institutions*
- *It was mostly useful and positive*
- *Overall the process is a comprehensive and searching review (if slightly too protracted) which has a very high degree of legitimacy*

5.6 These comments should not be considered a representative view, but they help to provide a flavour of the some perspectives on regulators' quality assurance. Time constraints prevented us establishing a more comprehensive view of the higher education sector.

5.7 Taken together these perspectives suggest to us that the legitimacy of the regulators' involvement in quality assurance is not questioned and indeed it is valued for the confidence and subject-specific insight that it can provide. But there is concern about the total impact and possible overlap of different quality assurance type processes on higher education, and healthcare professional regulators are part of that impact.

6. Is there scope for change?

6.1 We were impressed by regulators' plans for regular evaluation, feedback and review of their quality assurance processes. Several outlined their mechanisms for feedback and evaluation that are built into annual monitoring and approval

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[9] Universities UK. *Quality and standards in UK universities: a guide to how the system works.* London: Universities UK. Available at www.universitiesuk.ac.uk/Publications/Pages/Quality-and-standards-in-UK-universities-A-guide-to-how-the-system-works.aspx [Accessed 20 May 2009]
[10] Bundred, S, 2008. *The better regulation of higher education and the work of HERRG in 2007/08.* Available at: www.dfes.gov.uk/hegateway/uploads/HERRG%20Annual%20Report%20V5%20-%20FINAL.doc [Accessed 20 May 2009]

events. We are aware that some – the GDC, GMC, GOC and RPSGB – are currently in the midst of larger strategic reviews of education and alterations to quality assurance processes may well result from these activities. Other regulators have highlighted their desire for change, for example establishing complaints processes, increasing involvement by lay people and students, or having the power to approve their own programmes rather than the Privy Council, which does seem to suggest an unnecessary level of involvement.

6.2   The CHRE performance review standards offer an opportunity to identify where changes in individual approaches could be introduced. Our standards, against which the regulators' performance is reviewed on an annual basis, describe what the public should expect from regulators and identify some principles of good practice. For quality assurance of education we ask that:

'The regulator has a transparent and proportionate system of quality assurance for education and training providers.'

6.3   This standard covers the regulators' quality assurance activities across all education and training, not only those focused on undergraduate education, and as with all our standards we set out minimum requirements. They are not exhaustive, but they must be met in order to meet the standard. For quality assurance these are:

i.   The regulator assesses education and training providers, including arrangements for placements, at appropriate intervals which may vary between establishments proportionally to risk.
ii. Educational providers that meet the required standards are approved, and appropriate and targeted steps are taken where a provider falls short of the standards.
iii. Students' and patients' perspectives are taken into account as part of the evaluation.
iv. Information on the assessment process and final results of assessments are accessible to all stakeholders.

6.4   In terms of undergraduate education, while we can see that all regulators through their different ways are working to achieve these minimum requirements, it is evident from views expressed above that there are concerns about some current approaches. This highlights to us a constant need for regulators to be able to demonstrate the evidence that provides support for their style and approach. Where activities may be felt to be disproportionate, we would expect that regulators can demonstrate the need for such action in terms of the value to patient safety and public protection, or to make changes as necessary.

6.5   The importance of securing patients' perspectives is something that some regulators have indicated is a current challenge in certain programmes, so we are encouraged that the NMC are leading a project on behalf of other regulators that aims to deliver greater direct involvement of patients and the public in future quality assurance activities. We look forward to seeing how this initiative develops over time. It may also be possible for regulators to increase the involvement of the public and students as part of teams on approval visits, and we note that QAA are presently recruiting student members of institutional audit teams, echoing an aspect of the GMC's methodology.

6.6   The fourth minimum requirement focuses on the accessibility of information. This involves the publication of assessment reports, a requirement fulfilled by

some but not all regulators and we expect to see action in this area shortly by those who do not presently publish this information.

6.7 There are inherent tensions in any system of quality assurance that seeks to be proportionate and targeted. We believe there is scope to go beyond these current requirements, and a broader discussion about the characteristics of such a system of quality assurance would be valuable.

6.8 We asked the regulators what they considered to be good practice in quality assurance and their responses included the following:

- Clear focus on the aims and objectives
- Linking quality assurance work into the wider work of the regulator
- Encouraging education providers to work together
- Avoiding duplication
- Being robust without being burdensome
- Multiprofessional standards
- Balancing minimum burden against role in public protection
- Consistency, transparency, clear communications, evidence based, timeliness
- Following principles of good regulation – proportionality, transparency, accountability, consistency, targeted
- Identifying and sharing good practice in education
- Promoting equality and diversity
- Being transparent and publicly accountable
- Evaluation and reflection on the process
- Complementing other quality assurance processes
- Using experts and peers
- Seeing quality assurance as a developmental process offering opportunity for reflection and improvement

6.9 The question of good practice in quality assurance has been considered by other organisations. The European Association for Quality Assurance in Higher Education has published standards and guidelines for both external quality assurance and external quality assurance agencies (see Annex 2)[11] and the World Federation for Medical Education has published 'elements of proper accreditation', with the aim of supporting international mobility of medical students and professionals (see Annex 3).[12]

6.10 Taken together these have led us to identify the following characteristics of good practice in quality assurance of undergraduate education by the healthcare professional regulatory bodies:

- Builds on other quality assurance activities, including the processes adopted internally by the education provider and other external interests to minimise impact, and works to coordinate visits with other bodies with an interest wherever possible
- Actively involves and seeks perspectives of students, patients and other members of the public

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[11] European Association for Quality Assurance in Higher Education, 2009. *Standards and guidelines for quality assurance in the European higher education area*, 3rd edition. Available at: http://www.enqa.eu/files/ESG_3edition%20(2).pdf [Accessed 20 May 2009]

[12] Karle, H, 2008. *World Federation for Medical Education Policy on International Recognition of Medical Schools' Programme*. Ann Acad Med Sing 37:1041–1043

- Builds from duty to protect the public that underpins all regulatory activity and this objective drive the process
- All processes, criteria and procedures are predetermined and publicly available, and decision-making is based on criteria that are consistently applied
- All elements within quality assurance are fit for purpose and subject to review, including visitor/reviewer recruitment, training and appraisal
- Reports are publicly available and narratives clearly support decisions taken and subsequent actions
- Summary reports providing analysis of trends and general findings produced on periodic basis demonstrating the value of quality assurance and facilitating the sharing of good practice in education and training

6.11 We propose these for the basis for further discussion with the regulators, and other stakeholders, ahead of our performance review of regulators in 2009-2010. Once agreed, if it is not possible to account for activities as proportionate and transparent, seeking alterations to specific elements of individual regulators' approaches may be necessary. An approach may appear disproportionate, as some of the reports from higher education have indicated, but we would expect regulators to be able to point to evidence that supports their style and approach in terms of a proportionate response to their duties in protecting the public.

6.12 Going beyond this, as we have already described, undergraduate education is not a common point in pre-registration across all regulators. Across nine organisations and more than twenty five professions, working in a variety of contexts and routes to entry, each regulator is operating in a qualitatively different environments and similarities and differences are to be expected.

7. Conclusion

7.1 Patient safety and public protection drive the work of CHRE and the regulators we oversee and both are supported by quality assurance of undergraduate education. In our view quality assuring education programmes represents a proportionate approach to the task of maintaining the integrity of the register at this point in an individual's career. Equally it is reasonable to expect that quality assurance will be carried out in a proportionate and transparent manner. In theory too much or too little quality assurance, or poorly focussed quality assurance could all threaten fitness to practise. To maximise the benefit from the costs of this aspect of regulatory activity we need a balanced, proportionate approach, focused on fitness to join the register.

7.2 We can anticipate current and future policy developments around innovation and quality in healthcare, and the prospect of greater international mobility of healthcare students and the workforce. Throughout this the duty of regulators to protect the public should not be hampered.

7.3 During our work a wider question was raised about the readiness of new entrants to professions to practise. One indirect assessment of the effectiveness of quality assurance of undergraduate education is the performance of newly registered professionals in practice. A recent GMC-commissioned study on the preparedness of medical graduates identified that undergraduate placements should have greater consistency and structure, that medical students should have a role in teams, and there should be more prescriptive guidelines on shadowing F1 roles. This research is feeding into the current review of

Tomorrow's Doctors.[13] In contrast, recent work commissioned by the Scottish Government has found that new entrants to nursing in Scotland were fit to practice and cautioned that lack of confidence at the start of a career should not be confused with a lack of competency.[14] The respective roles and responsibilities of regulators and employers in ensuring safe practice at this point in a registrant's career may be worth further examination, taking into account the variety of routes to registration. Analysis of such data may also help in targeting future quality assurance and in informing strategic reviews of regulators' approach to education.

7.4   We are aware from work predating this project that the issue of quality assurance of health programmes in higher education is one that appears difficult to resolve. Many different agencies and organisations can take an interest in undergraduate health programmes, and it is apparent that tensions arise. The anecdotal feedback we have received shows some feel that more could be done to demonstrate the proportionality and transparency of current approaches.

7.5   However, in as fluid a field, it would be impractical to try and seek a definitive solution. Instead it may be more productive to focus on establishing ways to live with change and manage tensions. In that spirit we make the following observations and recommendations:

- Different approaches are inevitable given the current legislative framework for healthcare professional regulation.
- As programmes are subject to scrutiny by the different agencies, including the NHS, greater clarity and understanding is needed about their respective roles, including regulatory bodies.
- All regulators must be willing and able to demonstrate how their processes link proportionately to patient safety and public protection, maintaining the focus on the issue of being fit to join the register. Demonstrating the contribution of quality assurance to the main duty to protect the public would be valuable, both in continuing improvements in education and in assuring the public of the competency of newly qualified healthcare professionals.
- Finally, CHRE will work with the regulators and other stakeholders to review our standard of good regulation around quality assurance of education for the 2009/2010 performance review, taking into account current perspectives on good practice. Given the regulators' willingness to review and refine their approaches in the light of developments in practice, feedback and evaluation, there is potential to make changes that demonstrate good practice, proportionality and transparency in quality assurance.

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[13] Illing, J, et al, 2008. *How prepared are medical graduates to begin practice? A comparison of three diverse UK medical schools*. London: GMC. Available at: www.gmc-uk.org/about/research/REPORT%20-preparedness%20of%20medical%20grads.pdf [Accessed 20 May 2009]
[14] Lauder, W, et al, 2008. *Nursing and midwifery in Scotland: being fit for practice*. Available at: www.nes.scot.nhs.uk/practice_education/work/evaluation/ [Accessed 20 May 2009]

Annex 1 Interim report

The quality assurance regimes applied by the health professions regulatory bodies on higher education institutions
Unique ID: 16/2008
Interim report, February 2009[1]

INTRODUCTION
The Council for Healthcare Regulatory Excellence is an independent body accountable to Parliament. Our primary purpose is to promote the health, safety and well-being of patients and other members of the public. We scrutinise and oversee the health professions regulators[2], work with them to identify and promote good practice in regulation, carry out research, develop policy and give advice.

The request for advice
On 24 October 2008, in accordance with section 26(7) of the NHS Reform and Health Care Professions Act 2002, the Secretary of State for Health asked CHRE for advice on the matter of the quality assurance regimes applied by the health professions regulatory bodies on higher education institutions.

In particular, the Secretary of State wished to ascertain:
(i)   the similarities and differences in approach that are taken by different bodies in the quality assurance of undergraduate healthcare programmes across the UK;
(ii)   how the health professions regulators keep pace with changes in professional practice that may influence the structure or content of professional education;
(iii)   whether the approaches of health professions regulatory bodies ensure they meet their statutory duties to ensure that future healthcare professionals are trained to sufficient competence to ensure high levels of patient safety in their everyday practice (taking account of the relative risk to patient safety of different areas of healthcare professionals' practice);
(iv)   how the health professions regulators manage their relationships with the professional bodies; and
(v)   whether there is potentially scope (should it be desirable to do so) to alter processes without adversely affecting public protection.
Taking public protection and patient safety as guiding principles in the analysis, CHRE was also asked to identify examples of good practice in this area.

This report provides an interim update on early findings. The final report will be submitted by end of March 2009.

Scope of the study
Ahead of a discussion of our early findings, it is worth describing the scope of our work. We have taken a broad definition of 'healthcare' and below consider the approaches by all health professions regulators overseen by CHRE.

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[1] Revised May 2009
[2] General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, Health Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, Royal Pharmaceutical Society of Great Britain

We were asked to focus on undergraduate programmes. Not all healthcare professionals join the register following a period of prescribed undergraduate study – some do more, some do less. While for some regulators and some professions undergraduate education corresponds exactly to pre-registration requirements, it should not be assumed to be the case for all. We have not considered regulators' approaches to quality assurance of other education and training, for example, post-registration training, continuing professional development and return to practise courses.

Acknowledgements
We wish to formally acknowledge the considerable help, support and cooperation in the nine health professions regulators in this project so far. Annex A summarises the QA approaches taken by the nine regulators.

QUALITY ASSURANCE OF UNDERGRADUATE EDUCATION BY REGULATORY BODIES

An essential element of the legislation establishing health professions regulators is their role in quality assuring education of aspiring professionals. As guardians of the register and through their duty to protect the public, it is essential that regulators are able to judge whether a healthcare student is fit to join the register once they have completed their pre-registration education and training.

However, the challenge for regulators in delivering against this duty is by no means uniform. While GMC, GCC, PSNI, and GOsC all regulate a single profession, GDC regulates the dental team, GOC regulates both optometrists and dispensing opticians, NMC regulates nurses and midwives, and HPC regulates a total of 13 allied healthcare professions in areas as otherwise unrelated as radiography and art therapy. There are advanced plans to regulate pharmacy technicians alongside pharmacists in the RPSGB.[3]

As well as the differences between the ranges of professions administered by each regulator, the complexity of each profession's educational demands also varies greatly, from five years of undergraduate study for dentists or doctors to mostly on the job training for dental nurses. The risks associated with poor performance vary greatly between the professions too.

Considerable variation exists in the nature of courses, numbers of programmes and institutions requiring approval, before considering the relative risk of the different professions and the rate at which professional practice evolves. The workloads associated with QA processes for undergraduate education can vary too; while there are currently three institutions offering chiropractic qualifications, there are 84 institutions offering over 1100 nursing and midwifery programmes.

So while primary legislation governing regulators may appear broadly identical in many cases, the interpretation of this statutory duty may look and feel quite different in practice.

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[3] The register of Pharmacy Technicians opens on 1 July 2009.

Alongside this inherent variation, this is also a dynamic area of regulatory practice. We asked regulators how their quality assurance processes have changed over recent years, and received a wide range of responses highlighting:

- periodic reviews of standards
- introduction of lay visitors and student visitors
- open recruitment, appraisal and training for visitors
- visit evaluations
- greater involvement of patients and the public
- wholesale strategic review of education
- online case management systems
- outsourcing supply of QA
- increased transparency
- increased emphasis on patient protection
- focus on outcomes of education
- shorter reports
- streamlined visits
- greater engagement with stakeholders.

Given the plans regulators have for future revisions in QA approaches, this report should be seen as a snapshot in time.

1. Similarities and differences in the approach to quality assurance
In broad terms regulators quality assure education against outcomes and processes. Learning outcomes are usually high level principles describing the level and breadth of knowledge, skill and practical experience an aspiring health professional must have at the point they join the register. These outcomes are explicitly linked to the standards of proficiency and codes of conduct that regulators expect of their registrants.

To guide the achievement of these outcomes regulators provide guidance on the processes to be undertaken by institutions. This may include what is expected to be included in the curriculum of a course of study for the given profession. The degree of specificity for this varies between regulators, but none are so prescriptive as to remove course curricula decisions from the institution. Other areas covered by standards include admissions, assessment, recruitment, student health and welfare and staffing.

One example of the distinction between outcomes and processes can be found in the approach of HPC in their Standards of Proficiency (SOPs) for graduates in each profession it regulates and generic Standards of Education and Training (SETs) that institutions must meet in order to ensure they can deliver suitably proficient graduates.

GDC, meanwhile, makes a point of emphasising an outcomes focus and a desire to leave institutions relatively free to develop their programmes as they wish, so long as they result in dental and dental-health graduates of an acceptable standard for registration.

The GMC's standards for undergraduate medicine, which provide the framework for quality assurance, are published in the document *Tomorrow's Doctors* (currently under review). This sets high level outcomes and principles so that medical schools are able to devise and quality manage evolving curricula that are responsive to emerging practice and changing healthcare environments.

The NMC takes a different approach. Alongside their standards for pre-registration education, their QA approach focuses on risks to be controlled in the delivery of programmes, including:
- resource inadequacy
- inadequate safeguards for monitoring student conduct
- inadequate governance of practice learning
- failure to provide learning opportunities of a suitable quality
- unreliable conformation of achievement
- failure to incorporate essential skill clusters or address required learning outcomes
- failure of internal QA systems to provides assurance against NMC standards.

The approach to quality assurance
There are four main areas of QA activity:
- New programme approval
- Ongoing monitoring of approved programmes
- Approving major changes to programmes
- Programme re-approval

a. New programme approval
All the regulators have specific processes for the initial approval of professional courses offered in their field of healthcare. The GMC, GOC and RPSGB take a cohort approach to the approval of new courses, visiting each year to assess the development and delivery of the course. The GDC adopt the same approach with new BDS (dentistry) programmes.

Other regulators approve the course on a single visit. For the HPC, this programme approval is open-ended, with any subsequent visit prompted only by major change or a concern raised during in annual monitoring processes. The GDC visit dental care professional training programmes towards the end of the first cohort. For GCC initial approval is usually offered for five years, as does the NMC, who approve new programmes jointly with education providers and their placement provider partners. For new osteopathic courses, it is unlikely that they will be granted a 5 year RQ as the GOsC will want to visit shortly after to ensure that the establishment of the course has gone to plan. This would usually be in the space of 1-2 years.

b. Ongoing monitoring of approved programmes
Once approved, a programme is subject to ongoing monitoring and re-approval (where carried out). Monitoring is usually undertaken at yearly intervals when programme re-approval is not scheduled. The majority of regulators adopt a purely paper-based approach to ongoing monitoring. In doing so, they allow institutions to provide material already compiled and supplied for other purposes, for example QAA monitoring or internal QA processes. The intention is to establish what progress has been made against particular conditions of approval, identify any significant changes in programmes, and to ensure that standards are being maintained. Should annual monitoring throw up significant concerns, regulators may opt to revisit.

Exceptions to this are the GOsC and the NMC. The GOsC also include site visits as part of their monitoring reviews. The NMC through their QA suppliers carry out annual monitoring visits to the majority of institutions as well as annual reporting. In 2008-2009, around a third of providers have 'earned autonomy' status from the NMC exempting

them from a visit, and allowing additional visits to be carried out at those institutions who, based on monitoring reports, have been judged to have 'weak control of risk'.

c. Approval of major changes to programmes
Changes made to programmes can vary in their impact on outcomes. Generally, regulators' requirements are broad and flexible enough that education providers are free to make necessary changes to their curriculum and administration processes with minimal involvement from their respective regulators beyond annual monitoring, providing there is no impact on learning outcomes. However, there are situations in which major changes to programmes may demand more intensive scrutiny, including a visit.

d. Programme re-approval
As described above, HPC's 'open-ended' approval is the notable exception to the formal re-approval process. The other regulators re-approve programmes approximately every 5 years. There can be some flexibility in this timescale if conditions are placed on programme approval. Institutional visits form the foundation of programme re-approval by regulators. Alongside re-approval visits, the NMC and the GOsC also use visits in the ongoing annual monitoring of approved programmes (see above).

For the majority, this is a process carried out and managed in-house drawing on the expertise of external visitors (reviewers). Two regulators contract out the visit process to external suppliers: GOsC use QAA and NMC use HLSP in England, Northern Ireland and Scotland and HIW in Wales.

In the broadest terms, the visit process for each regulator can be broken down into three basic phases:
- pre-visit planning and information gathering
- the visit itself (one to three days)
- report preparation (including providing/receiving feedback from the education provider).

However, the execution of each of these phases differs from regulator to regulator, as does the time-frame for the process from start to finish. The GMC visit and reporting process takes 18 months from initial notification of a visit through to final endorsement of the visiting team's report, whereas the NMC process sees annual monitoring visits completed within 10-11 weeks of process initiation.

The number and range of visitors varies between regulators from two (HPC) up to ten (GMC). In part this arises from the different types of visitor engaged. Across the regulators, visitors are drawn from:
- the regulator (staff and/or council)
- lay people (patients and the public)
- educationalists
- members of the profession
- students
- QA consultants.

No regulator uses all these groups.

While on the visit, feedback is sought from a range of sources: university administrators, academic and clinical staff, and students. Beyond this, some regulators seek input from prospective employers, NHS and patients.

While the terminology may vary, in each case regulator's visit processes result in one several possible judgments on an institution/course:

- Approved
- Approved with conditions
- Approved with conditions and recommendations
- Approved with recommendations
- Not approved.

The result of a conditional approval is generally the provision of assurances and evidence (action plans) by the institution that any issues identified will be addressed. Providers may not be required to meet recommendations but they are likely to be considered subsequently.

Finally, while for the most part regulators are assessing similar things with broadly similar processes, the level of detail provided in their final accreditation reports varies between them and not all approval reports are available online.

2. Keeping pace with change

Innovation and evolution of professional practice provides considerable benefits for patient care. This is sustained, in part, through changes in structure and content of education. We asked the regulators how they ensured flexibility and agility in their QA processes to 'keep pace with changes in practice'.

In their work to manage the impact of change in practices on their approach to QA, the regulators highlighted number of strategies:

- Periodic review of standards – for example the GMC are currently reviewing *Tomorrow's Doctors*. Also GCC, GOC, GOsC, HPC, NMC, RPSGB
- Indicative standards – broadly describing the outcome needed rather than prescriptively identifying the inputs required (GDC,GMC, HPC, NMC, RPSGB)
- Focus on high level outcomes and principles to allow education providers to devise curricula in variety of ways and phrasing criteria to demand that programmes remain current (GMC, NMC, RPSGB)
- Specific criteria to ensure syllabus remains up to date and responds to evolving legislation (RPSGB)
- Swift decisions on programme changes where appropriate (HPC, RPSGB)
- Peer reviewers introduce contemporary practice perspective, from across employment sectors (GMC, NMC, PSNI, RPSGB)
- Targeted visits to ensure areas of greatest interest are focused on (NMC)
- Risk-based approach to monitoring helps to target on areas of greatest impact on patients and the public (NMC)
- Issuing supplementary guidance as necessary, for example around student fitness to practise, disability and health (GDC, GMC, GOC, HPC, NMC, RPSGB)
- Devising urgent revisions to standards if circumstances demand (GOsC, HPC)
- Annual monitoring tailored to institutions, focused on conditions specific to each provider, encouraging continuous development and corrective action (GDC, GMC, GOC, NMC)
- Asking for feedback from education providers and visitors to highlight areas for improvement (GMC, GOC, HPC, RPSGB).

3. Ensuring patient safety and public protection

We asked regulators how they thought their quality assurance processes contributed to patient safety and public protection. The role of QA and approval of education programmes means that successful students will obtain the skills and competencies needed to join the register. This was described by the GOC: 'Patient safety and public protection are at the heart of the GOC's quality assurance role. When setting the standard required by developing and reviewing the core competencies and the requirements for approving optics training programmes, the GOC has to assure itself that even the weakest student who passes the programme meets the standard required to ensure that they are fit to practise.'

Broadly, there are three main approaches to ensuring patient safety and public protection:

a. Practical steps
   • Ensuring student fitness to practise processes are in place
   • Strong internal quality assurance processes and robust assessment systems to ensure that students meet learning outcomes
   • Explicit emphasis on patient safety and public protection in the course
   • Supplementary guidance, for example on student fitness to practise, where needed
   • Encouraging the sharing of good practice in education between providers
   • Patient and public involvement in education, through visitor teams, provision of feedback, involvement in design and delivery of education.

b. Principles of patient-centred care
   • Learning outcomes are derived from standards of practice
   • Principles of good health and good character are emphasised in courses and at admissions
   • Emphasising the patient – in standards and in education programmes derived from them.
   • Focusing on outcomes rather than inputs.

c. Integration of quality assurance with other regulatory activity
   • Within the regulatory body, through strong links with standards, fitness to practise, and registration.
   • With other regulators – for example, GMC and NMC have memoranda of understanding with the Healthcare Commission to enable them to share information when education has wider implications for patient safety.

4. Managing relationships with other organisations
We asked the regulatory bodies whether other bodies in their sector were involved in QA and if they were, how, when and where the regulators worked with them.

This prompted a mixed response. For some regulators, they are the only profession-specific organisation with a formal role in quality assurance. However, this does not preclude good working relationships with professional bodies, for example around regular reviews of standards of proficiency and codes of practice.

The widest experience, unsurprising given their breadth of register, came from the HPC. Many professional bodies are involved, but there is no consistency to the extent and level of involvement. Some develop detailed curriculum guidance (referred to in 4.2 of

HPC's standards of education and training). Some have their own accreditation processes, such as the Chartered Society of Physiotherapy. In these situations, the HPC told us they would aim to run visits alongside other bodies if that was what the education provider wanted. However, all decision-making remained independent.

The GMC reported a close informal working relationship with the QAA. In their current review of *Tomorrow's Doctors* the GMC have undertaken standards mapping exercises and are proposing that QAA standards be referred to where they are relevant and sufficient rather than creating medicine-specific standards. The Postgraduate Medical Education and Training Board is due to be merged with the GMC in 2010, placing responsibility for all medical education in the GMC.

Beyond the professional bodies, there are other organisations with an interest in QA that regulators work with – QAA, Skills for Health, Ofsted, QCA, SQA. Regulators also told us of close working relationships with representatives of higher education and deans of schools. For example, the RPSGB referred to the value of a single forum in which they can speak to all heads of pharmacy in the Council of University Heads of Pharmacy.

5. Summary and next steps
Our work so far has revealed some of the similarities and differences in approaches taken by regulatory bodies to quality assuring undergraduate (pre-registration) education, outlined how patient safety and public protection are ensured in education, the flexibility in current approaches and the nature of relationships with some other bodies in the sector.

A key question is whether the nature of these similarities and differences is a cause for concern, and for whom, and what the impact (direct or indirect) may be on patient safety and public protection. The assurance of clinical practice placements, and relationships between employer and education providers on this issue is worthy of further investigation. We intend to gather views from across the sector, and beyond, and from this we will seek to identify areas of good practice and whether there is scope for alteration in current approaches.

Annex A – brief overview of regulators' quality assurance processes

General Chiropractic Council
The GCC publish *Criteria for Recognition of Degrees in Chiropractic*, focusing on programme outcomes. These outcomes are linked directly to the GCC standards for the ethical, competent and safe practice of chiropractors and must be met for a degree programme to gain approval. Currently three institutions provide chiropractic degree programmes in the UK. Between them they generate around 270 graduates per year.

GCC operates a recognition system whereby every five years the course offered will be 're-recognised' under the same process as initial recognition. Following submission of business plans and other documentation to the Education Committee, and the Committee is satisfied about the financial position for delivering the degree programme, full recognition process begins.

At least two months after the submission of the document a visit will take place involving a panel of 5-6 visitors, chaired by a lay member of the Council, and including two chiropractic members, one or two educationalist members and a QA consultant. During this time, a detailed analysis of the documentation will have been undertaken and considered by the Education Committee, so that it can identify any particular areas of concern to be pursued by the visiting panel. A report and recommendations are sent to the Education Committee normally within six weeks.

The Committee considers the report and invites the Institution to comment before final recommendations are made by the Education Committee to the General Council. From here, the GCC then seeks the approval of the Privy Council. It can take some months for the Privy Council to respond, so to avoid undue delay the GCC asks the Privy Council Office to agree that the Institution can advertise the qualification as being 'subject to the approval of the Privy Council' (much as some degrees are advertised as 'subject to validation').

Recognition, with or without conditions, is always given for a specified period of time so Institutions will need to build this into their ongoing planning and development. Conditions will identify whether additional visits are required during the period of recognition. All institutions are required to submit an Annual Report to the GCC's Education Committee.

General Dental Council
In the UK there are 16 university dental schools, 19 institutions (mostly universities) producing about 200 dental hygienists and dental therapists per year; 11 institutions producing about 150 dental technicians per year; seven institutions producing 20-30 orthodontic therapists per year; and two institutions training clinical dental technicians in small numbers.

The GDC are midway through implementing the findings of an extensive strategic review of their work in education. As a consequence, QA processes are being radically revised to focus on learning outcomes (i.e. what a new graduate is competent and safe to do) and away from prescriptive guidance on what should be contained in a training programme (inputs). Thorough review of all curriculum guidance and QA processes is ongoing, complemented by new student fitness to practise guidance.

Previously, each dental school was visited in every six years, in the same two year period, based on the standards document *The first five years*. Traditionally very thorough, the last round of visits took place in 2003-2005. For new schools, visits happened annually to follow the progress of the first cohort.

For those providing education for dental care professionals, a more flexible approach to QA has been adopted over the last two years with a smaller panel of visitors, appropriate to the course, looking at thresholds and sufficiency.

Paper-based annual monitoring has been introduced for all dental education providers. While the strategic review is being fully implemented, annual monitoring will stay in place for 2009, and the new process will be introduced in October 2010.

General Medical Council
There are 29 universities offering undergraduate medical degrees in the UK.

The GMC's standards for undergraduate medicine, which provide the framework for quality assurance, are published in the document *Tomorrow's Doctors* (currently under review). The GMC's role is to define the outcomes graduates are expected to reach and sets standards for the delivery of the programme. These outcomes and principles are set at a high level so that medical schools are able to devise and quality manage evolving curricula that are responsive to emerging practice and changing healthcare environments. *Tomorrow's Doctors* is a flexible framework that allows the provision of supplementary guidance in response to needs identified through quality assurance processes or other stakeholder engagement.

The GMC's quality assurance programme is known as QABME (Quality Assurance of Basic Medical Education). QABME has two key elements: an annual return provided by all medical schools and a visit process that is adapted for new medical schools and medical schools undergoing significant change.

The annual returns process facilitates monitoring of corrective action, innovation and other changes without the constraint of a bureaucratic approvals process. It encourages continuous development of curricula while allowing the GMC to keep abreast of development and target further investigation and quality assurance activities where there are concerns.

The GMC will visit each medical school at least twice within every 10 years. Visits are undertaken on behalf of the GMC by a team of approximately 8-10 medical and educational professionals, medical students and lay members. The visiting teams are assigned to a school and are responsible for all stages of the visit process for their school. Visitors undergo mandatory annual training.

The main stages of the visit process are:
1. Collecting information (June to December)
2. Confirming information (January to July)
3. Integrating information and making judgements (June to August)

These time frames may vary slightly to respond to individual school timetables. The visit process for an established school is generally 18 months from notification of selection to the GMC's endorsement of the visiting team's report.

The visit process may vary for established schools proposing major changes to curriculum, facilities or supervisory structures. For example, if changes are limited to one or two years of the school's curriculum the visit process may be completed in the standard 18 month timeframe. Alternatively, if extensive changes are planned across the curriculum the visit process may be repeated over a number of years as the changes are rolled out. Similarly, the visit process will vary for established medical schools wishing to change their degree awarding arrangements.

Four new medical schools have been established in recent years. The process for monitoring the progress of these schools involves the same systematic three-stage process applied to established schools. However, quality assurance activities are carried out for each year for the duration of the first medical student intake's degree course, assessing the development and delivery. This process results in annual reports that enable the Education Committee to gauge the progress of each school and compare progress across schools.

Final reports provide summary of key findings including any requirements, identification of areas for quality enhancement and identification of areas of innovation and good practise. The main body of the report then provides a detailed analysis of curricular outcomes, curricular content, student performance and competence and student health and conduct. Reports also include a response by the medical school.

Through the Annual Return process every year, each medical school must provide a return to the GMC that:
• Identifies significant changes to curricula, assessments or staffing.
• Highlights risks or issues of concern, proposed solutions and corrective actions taken.
• Identifies examples of innovation and good practice.
• Responds to issues of interest and debate in medical education, including promoting equality and valuing diversity.
• Identifies progress on any requirements or recommendations arising from the QABME visit process.

If there is need to investigate an issue, for example the introduction of a new curriculum or significant changes to the curriculum or facilities, the school may be requested to submit detailed information for analysis or may be selected for the QABME visit process.

General Optical Council
GOC approves eight training institutions to provide optometry degree programmes and five institutions to provide ophthalmic dispensing training programmes in the UK. GOC requirements for both optometry and dispensing optician courses address course construction, teaching learning and assessment, student progression and achievement, staffing and resources and facilities.

In 2008, the GOC concluded that the curriculum for UK undergraduate training in optometry should be redefined as competency statements to be:
• compatible with the GOC's strategy of a competency based registration process;
• to allow for easier comparison with European curricula; and
• to be compatible with the principles of the Bologna Agreement.

The GOC operates a visit process to quality assure optics training in the UK. Currently, visits are annual for the first cohort of students taking the course, and every three to five years thereafter. Each Visitor Panel consists of six members, supported by a GOC Officer, who are on site for no more than three days. The GOC maintains a list of 18 fully trained Visitors, made up of dispensing opticians, optometrists, ophthalmologists and educationalists. Panel members undergo comprehensive training throughout their tenure, including annual refresher sessions, self assessments and appraisals.

A letter to be sent to existing providers one year before the process is due to commence, and with negotiation to determine the broad time frame for the visit. The visiting process for optometry courses takes approximately 30 weeks from the initial letter from GOC to the education provider through to the final report (week 26) and the provision of an action plan by the education provider (week 30)

In 2008 the GOC also undertook a review of the QA visit process to ensure that the process remained fit for purpose and wherever possible the GOC was able to utilise existing quality assurance reports and processes to obtain the information it requires and to reduce the burden of the accreditation process on both the institutions and the regulator.

The outcome of the review was a decision to introduce an annual monitoring scheme, which would enable the GOC to gain data, monitor progress and be informed on any proposed changes to optics programmes on an annual basis.

The new process requires each institution to submit an annual monitoring form in which they must provide details of progress against the conditions and recommendations of the previous visit, notification of any changes (or proposed changes) to the programme structure, content, assessment methods etc or to staffing and resourcing, student progression and achievement data and clinical records.

This will allow the quinquennial visits to be much more focused on the areas of risk, on clinical patient experience, supervision and areas identified for improvement or change. The length of visits themselves will be reduced from four to two days. The annual monitoring forms for the years proceeding a visit will be used as pre-visit information for the panel, together with additional feedback collected from employers, supervisors and patients via questionnaires which will be send to these groups in advance of a visit and the responses will be collated into a meaningful report to assist the Panel.

This new scheme is being piloted in February 2009 with full roll out to all Optometry programmes planned for Autumn 2009. Roll out will then be extended to dispensing programmes in early 2010 following full panel visits to all dispensing courses in 2009.

General Osteopathic Council
The GOsC accredits ten providers of osteopathy courses to ensure they meet the minimum standards required to produce osteopaths who are safe and competent to practise. The standards that must underpin osteopathy courses are:
- Standard of Proficiency –the standards of osteopathic practice expected of registrants and the level to be attained by a graduating osteopath.
- Code of Practice – requirements in relation to conduct and ethics to be observed by osteopaths and the level expected of graduating osteopaths.

- Osteopathy Benchmark Statement – an educational benchmark developed and published in conjunction with the QAA, outlining the expected standards of delivery of education.

If a course meets these standards, then it is awarded a 'Recognised Qualification' (RQ) which generally lasts for a period of between one and five years, although in practice new courses are approved for one to two years. The initial award of an RQ is based on a report of a team of specialist reviewers, who review the course documentation and visit the institution to gain any necessary evidence. The visit generally lasts three days and takes account of teaching (clinical and theory), as well as including interviews with staff, students and reviews of patient feedback where possible. This process is repeated at the point where an RQ is due to expire, in order to renew the accreditation.

The GOsC contracts with the QAA to undertake the review, the visit and production of an evaluative report. The QAA trains specialist reviewers, both lay and osteopaths, selects teams to conduct RQ reviews and produces reports which are considered by both the GOsC Education Committee and Council before a final recommendation on course accreditation is made to the Privy Council (which has final say on the approval of osteopathic courses).

The review team in recognition and renewal reviews will normally consist of a Review Coordinator, two specialist osteopath visitors and one lay visitor. In advance of the review, QAA will communicate to the GOsC the suggested composition of the review team. Providers to be reviewed will have the opportunity to comment on suggested review team composition. Responsibility for the appointment of visitors rests with the GOsC.

In addition to the RQ reviews conducted by the QAA, the GOsC also requires institutions offering osteopathic courses to submit an annual report to the Council, outlining any significant changes to the course provision, providing statistics on student and patient profiles and answering any specific areas of interest that the GOsC may have. The GOsC also include site visits as part of their monitoring reviews.

Health Professions Council
The HPC standards of proficiency (SOPs) are threshold standards for safe and effective practice that all registrants must meet. They include both generic elements, which all registrants must meet, and profession-specific elements. These standards play a central role in how to gain admission to and remain on the Register and thereby gain the right to use protected title(s).

HPC's Standards of Education and Training (SET) are the standards that an education programme must meet in order to be approved as an education provider for any of the 13 professions overseen by HPC. These generic standards ensure that anybody who completes an approved programme meets the standards of proficiency and is therefore eligible for admission to their profession's Register. The standards cover:
- the level of qualification for entry to the Register;
- programme admissions;
- programme management and resources;
- curriculum;
- practice placements; and
- assessment.

All courses will be visited as part of the initial approval process, but there is no structured visit schedule thereafter. Programmes are awarded 'open-ended approval' subject to satisfactory ongoing monitoring. Both annual monitoring and major change processes may trigger a new approval visit.

Visits are coordinated and managed by the HPC. The HPC visit panel is normally made up of one education executive and two visitors, at least one of whom is from the same part of the Register as the profession with which the programme is concerned.

Once approved, the HPC monitor programmes annually on a two year cycle. It involves two different processes of monitoring submissions – audit and declaration. Declaration forms are submitted to the Education & Training Committee for ratification. Audit forms are reviewed by an HPC visitor from the same part of the register, and preferably one involved in the initial approval visit. Following this, additional information may be requested.

The annual monitoring process draws heavily on the education providers' existing documentation and is guided by previous QA activity. Each academic year, programmes that were approved by HPC in the prior academic year, or are currently going through the approval process, will not normally be subject to annual monitoring.

Once an assessment has been made, visitors can make the following recommendations:
- the programme continues to meet standards
- there is insufficient evidence to show how the programme continues to meet standards and a visit is required to gather evidence to show how the programme meets the SETs and SOPs and, if required, place conditions on ongoing approval
- additional information is required in order for the visitors to make their recommendation

The major change process considers significant changes to a programme and the impact of these changes in relation to standards. Any change that significantly alters how SETs and SOPs are met should be reported to the HPC who make a decision on the most appropriate course of action. HPC can decide to assess the impact of a change using the annual monitoring, major change or approval processes at this stage. If the major change process is used, education providers are asked to map the impact of the change against the SETs. This is assessed alongside previous reports by visitors and recommendations are sent to the Education and Training Committee.

Nursing and Midwifery Council
The NMC currently approve 84 programme providers across the UK. These offer over 1100 approved programmes covering pre-registration nursing and midwifery, return to practice for all three parts of the register and post registration qualifications, including specialist community public health nursing, teacher programmes and non-medical prescribing.

The NMC base their annual monitoring on a range of identified risks to quality education and requires all education providers to show they are accurately controlling those risks, which include:
- Resource inadequacy
- Inadequate safeguards for monitoring student conduct

- Inadequate governance of practice learning
- Failure to provide learning opportunities of a suitable quality
- Unreliable conformation of achievement
- Failure to incorporate essential skill clusters or address required learning outcomes
- Failure of internal QA systems to provides assurance against NMC standards

The NMC contract out their QA operations to two suppliers: HLSP in England, Scotland and Northern Ireland and Healthcare Inspectorate Wales (HIW).

Approval/re-approval events for programmes take place every five years; risk-based monitoring events for providers take place annually. Programme approval/re-approval is undertaken jointly between the NMC, an approved programme provider and other stakeholders, which will normally include the placement providers and commissioners of the programme, as well as students, users and carers. If a programme is approved subject to conditions, these must be completed before the programme is allowed to run. Any recommendations identified will form part of subsequent annual monitoring.

Annual monitoring is the process by which the NMC seeks assurance that approved programmes continue to be delivered in accordance with NMC standards, that key risks to public safeguarding are controlled. Underpinning this quality assurance event is the production of an annual report by programme providers. The annual monitoring event itself takes place over one to three days and from the information gathered the managing reviewer's hypotheses of risk is tested, a collective judgment is reached and a draft evidence based report on the programme(s) is developed. The NMC uses a Red Amber Green approach to reporting as an effective method of reporting outcomes and risk control. Feedback on the process is then provided to (and requested from) the education provider. A final report is then submitted to the NMC. Monitoring reports are concise (1-3 pages) and consist of a summary of key findings which addresses the extent to which key risks are controlled.

A provider is awarded one of the following grades:
- Outstanding: Exceptionally and consistently high performance with examples of effective practice which is innovative and worthy of dissemination and emulation by other programme providers.
- Good: The element/programme enables students to achieve stated learning outcomes without need for specific improvements.
- Satisfactory: The element/programme enables students to achieve stated learning outcomes but improvement is needed to overcome weaknesses.
- Unsatisfactory: Exceptionally low performance. The element / programme makes a less than adequate contribution to the achievement of stated learning outcomes. Significant and urgent improvement is required to become acceptable.

The overall outcomes of monitoring activity in 2007-08 resulted in providers being placed in one of the following categories for monitoring in 2008-09:

- Programme providers with well-developed risk control: these are asked to carry out a self-assessment for one year, using the same reporting format as the NMC's reviewers (31 providers)
- Programme providers with acceptable risk control: these are considered to be managing acceptably and are subject to a standard 2-day visit (33 providers)

- Programme providers with weaker levels of risk control; these will be subject to a 3-day visit. Visits to these institutions will be carried out early in the academic year to allow time for a re-visit if required (20 providers)

Under normal circumstances approved institutions can undertake improvement and enhancement of NMC approved programs through their own internal processes. NMC must be notified however, and all programme modifications and developments must be reported in the Annual Report. Where modifications introduce more significant changes to approved programs it may be necessary for NMC reviewers to participate in the programme provider's internal processes in order to provide assurance of continued compliance with the relevant NMC standards.

Pharmaceutical Society of Northern Ireland
The PSNI adopts the RPSGB system of quality assurance of undergraduate education in Northern Ireland. From September 2009 there will be two schools of pharmacy in Northern Ireland.

Having assessors with specific knowledge of Northern Ireland legislation (e.g. Medicines Act 1968, Pharmacy Northern Ireland Order 1976) and practice (e.g. emerging cross border service and regulation issues, Northern Ireland specific services such as the Minor Ailment Scheme etc) on the accreditation panels of Northern Ireland Pharmacy Schools enables changes in practice specific to devolved areas to be reflected in the quality assurance process.

Royal Pharmaceutical Society of Great Britain
There are 22 undergraduate schools of pharmacy in the United Kingdom.

The RPSGB accredits all UK MPharm degrees and successful completion of a course allows a pharmacy graduate to apply for preregistration training. The accreditation process is different for new and existing schools, although the underlying principles are the same: it is evidence based, involves peer review and is cyclical. New schools are required to submit a business plan and detailed syllabus in advance of students entering the course: the school is then visited in each of the first four years of delivery of the MPharm; only then is full accreditation given. Once a new school becomes an existing school it is reaccredited quinquennially. Accreditation can be suspended or withdrawn (by Council) if there are concerns about the standard of an MPharm.

Accreditation panels have a range of expert practitioners from the main pharmacy sectors, plus lay visitors whose remit is patient safety and public protection.

UK MPharm degrees are designed with reference to the Society's Indicative Syllabus, which has 51 items under the following broad headings:
- The Patient
- Medicines: drug action
- Medicines: the drug substance
- Medicines: the medicinal product
- Healthcare systems and the roles of professionals
- The Wider Context

As a framework around which MPharm degrees are designed, the RPSGB has defined 50 criteria, all of which need to be met by providers (except one, the use of inter-professional learning, which is recommended). The first five relate to EU requirements, the sixth to minimum entry standards for English Language and Mathematics (GCSE grades A-C or equivalent), seven-31 outline graduate outcomes (the nearest thing to competencies the Society uses) and the remainder, 32-50, deal mainly with the academic infrastructure supporting delivery.

A condition of accreditation is that annual reports on student progress and resources available for the course are submitted to the RPSGB. Furthermore, when course changes are substantial, the RPSGB should also be informed. Generally changes are dealt with by staff, if the proposed change is reasonable and it does not substantially affect accreditation and the institution is informed as soon as possible. If changes are so substantial that the MPharm alters drastically, a full accreditation event would have to be arranged. If there are concerns about the standard of an MPharm, accreditation can be suspended or withdrawn.

Annex 2

European standards for the external quality assurance of higher education[1]

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.

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

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[1] European Association for Quality Assurance in Higher Education, 2009. *Standards and guidelines for quality assurance in the European higher education area*, 3rd edition. Available at: http://www.enqa.eu/files/ESG_3edition%20(2).pdf [Accessed 20 May 2009]

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 3

World Health Organization / World Federation of Medical Education Guidelines for Accreditation define a number of essential elements[1]

- Authoritative mandate
- Independence from governments and providers
- Transparency
- Predefined general and specific criteria
- Use of external review
- Procedure using combination of self-evaluation and site visits
- Authoritative decision
- Publication of report and decision

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[1] Karle, H, 2008. *World Federation for Medical Education Policy on International Recognition of Medical Schools' Programme.* Ann Acad Med Sing 37:1041–1043