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Internal Quality Review

Guidelines for Professional Support Units

Document Control Sheet

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1 PREPARATION FOR SELF-ASSESSMENT FOR PROFESSIONAL SUPPORT UNITS

1.1 Introduction

RCSI has always been acutely aware of the need to assure and improve the quality of its products. It has a well-developed culture of self-reflection and critical evaluation of the programmes delivered by its component schools. Under our Independent Degree Awarding Status, quality processes in RCSI operate within national legislative and regulatory contexts (particularly the Universities Act 1997 and the Qualifications and Quality Assurance (Education and Training) Act 2012) that respect institutional autonomy and allow 'quality improvement' to be a fundamental principal governing all the associated procedures and practices. The procedures also incorporate the QQI Core Statutory Quality Assurance (QA) Guidelines April 2016 (Appendix 1) and the ESG Standards and Guidelines for Quality Assurance in the European Higher Education Area 2015 (Appendix 2).

Quality Assurance / Quality Improvement (QA/QI) procedures can be broken down into routine, rolling and 'on-demand'. Rolling reviews will take place for all academic and non-academic (support) units. The timetable for these reviews will be agreed between the Quality Enhancement Office (QEO) and the individual Units. Administrative/Service Units will go through such a process every six years. The procedure for these rolling reviews will include an initial self-assessment report (SAR) followed by a 2 or 3-day inspection [depending on the size of the Unit] by a team comprised of peer and external reviewers commissioned by the Quality Committee and supported by the QEO. Based on the SAR and the visit the team will produce a report and a series of recommendations which, in consultation with the Unit being reviewed, will form the basis for a Quality Improvement Plan (QIP). The QIP will consist of agreed timelines and will be monitored and supported by the Quality Committee and the Quality Enhancement Office.

The overall aim of the internal review process is on-going improvement. In order to obtain maximum benefit from the process, RCSI is keen to ensure that the approach to self-assessment and review should be simple, flexible and easy to implement. The internal review process is facilitated by the Quality Enhancement Office with the aim of making the process as simple and understandable as possible. The Director of Quality Enhancement or Quality Reviews Manager will be appointed as the Review Lead for each review.

1.2 Purpose of the Review

The self- assessment exercise is a process by which a Unit reflects on its mission and objectives, and analyses critically the activities it engages in to achieve these objectives. It provides for an evaluation of the Unit's performance of its functions, its services and its administration. In line with the RCSI strategic plan 'Transforming Health Care Education Research and Service 2018 - 2022' it provides assurance to the University of the quality of the units' operations and facilitates a developmental process to effect improvement. The fundamental objectives of the review process are:

- To monitor the quality of the student experience.
- To identify, encourage and disseminate good practice, and to identify challenges and how to address these.
- To provide an opportunity for units to test the effectiveness of their systems and procedures for monitoring and enhancing quality and standards.
- To encourage the development and enhancement of these systems, in the context of current and emerging provision.
- To inform the University's strategic planning process.
- The process provides an external benchmark on practice.
- To provide public information on the University's capacity to assure the quality and standards of its awards. The University's implementation of its quality procedures also enables it to demonstrate how it discharges its responsibilities for assuring the quality and standards of its awards, as

required by the Universities Act 1997 and the Qualifications and Quality Assurance (Education and Training) Act 2012.

1.3 Stages of the Internal Review Process

The key stages in the internal review process are:

1. Establishment of a Self-assessment Committee
2. Preparation of a Self-assessment Report (SAR) and supporting documentation
3. Site visit by a peer review group that includes external experts both national and international
4. Preparation of a peer review group report that is made public
5. Development of a Quality Improvement Plan (QIP) for implementation of the review report's recommendations.
6. Follow-up to appraise progress against the QIP.

1.4 Self-assessment Rationale

Self-assessment is the critical first step that a Unit takes in preparing for a quality review. The European University Association suggests that four basic questions are asked and addressed as part of this process, namely:

- What are you trying to do?
- How are you trying to do it?
- How do you know it works and what evidence can you provide?
- How do you change in order to improve?

Self-assessment is the process by which a Unit reflects on its objectives and analyses critically the activities it engages in to achieve these objectives. It provides an evaluation of the Unit's performance, of its functions, its services, and its support activities. The Unit records these evaluations in a Self-assessment Report (SAR).

The Self-assessment Report:

- presents detailed information about the Unit, its mission, functions and activities
- presents a succinct but comprehensive statement of the Unit's strategic aims and objectives and discusses how these are aligned with those of the University
- describes the quality systems and processes that are already in place along with sample outcomes
- provides a comprehensive self-critical analysis of the activities of the Unit, which may include a formal benchmarking exercise
- describes the collective perception of staff and students of their role not only in the University, but where appropriate, in the international community and in the social, cultural and economic development of Ireland
- provides evidence of the views of external stakeholders
- helps the Unit to identify and analyse its strengths, weaknesses, opportunities and challenges, and allows it to suggest appropriate remedies where necessary
- identifies weaknesses in procedural, organisational or other matters that are under the control of the Unit, and which can be remedied internally
- identifies shortfalls in resources and provides an externally validated case for increased resource allocation
- provides a framework within which the Unit can continue to work in the future towards quality improvement

Regular, formal self-assessment is the core component of the RCSI quality framework, where the emphasis is placed on the immediate value to the Unit of this analytical and self-critical process. The preparation of the SAR acts as a stimulus and provides opportunities for reflection and consultation, enabling Units to plan and manage strategically and to align their development plans with those of the organisation. The main emphasis in all of the self-assessment processes is on both quantitative and qualitative analysis, with a view to continuous improvement.

The SAR provides the Review Group with essential information to prepare both for the review visit and the review group report. The preparation of the SAR follows essentially the same process for all Units within RCSI. However, the content of reports may vary with the nature of the Unit's activities.

The major pitfall encountered by Units in writing the SAR is to be overly descriptive and not sufficiently self-reflective and/or analytical. The SAR should be at least 40% analytical in its emphasis and content.

1.5 Initial consultation with Head of Unit

Approximately 10 months before the review the Director of Quality Enhancement will meet with the head of the Unit. The purpose of this meeting will be to discuss the review process and agree a timeline for the review. The timeline for review process is outlined in Appendix 3. The QEO will provide further briefing(s) to the Unit staff and co-ordinating committee in consultation with the Unit.

1.6 Establishment of the Self-assessment Committee

At the outset of the process the Unit appoints a co-ordinating committee that is responsible for preparing the self-assessment report. The committee should be representative of all staff in the Unit, and should include members from all categories of staff and perhaps also a user representative. Units are required to ensure that students are involved systematically in all appropriate aspects and stages of the self-assessment phase. Schools should include at least one undergraduate student and where a school offers taught postgraduate programmes, at least one postgraduate student. The committee will appoint a Chair (not necessarily the Head of the Unit). The committee should be operational and meet frequently, usually every month at the start of the process but more frequently as the report is being finalised.

Members of the Co-ordinating Committee should be assigned, where appropriate, responsibility for various sections for the SAR [with the exception of the student representative(s) who are not expected to devote a large amount of time to the process]. All staff members of the Unit should be kept informed fully about the self-assessment process and given opportunities to contribute their views.

Example of a Co-ordinating Committee for an Administrative/Service Unit

- Head of Unit
- Representative of staff at each grade
- Unit secretary / administrator

The above is a guideline only and should be adapted to suit a particular Unit's needs. Subgroups may be formed with additional members from outside the core committee with specific responsibility for the preparation of aspects of the self-assessment report. All members participate in the drafting of the self-assessment report prior to its consideration by all members of the Unit.

Following consultation with the Unit, the Quality Enhancement Office may provide a further briefing to the Co-ordinating Committee. Before making a detailed plan for the self-assessment, the Co-ordinating Committee should read the Guidelines carefully, discuss these with their colleagues, and

importantly consult with the Director of Quality Enhancement or the Quality Reviews Manager. The Head of Unit and/or Chair of the Co-ordinating Committee and Director of Quality Enhancement/Review Lead should then agree provisional dates of formal meetings. The Director of Quality/Quality Reviews Manager should be invited to the first meeting of the Co-ordinating Committee, and thereafter to appropriate meetings, to provide advice and guidance, to monitor progress and to review the final draft of the SAR. Regular communication between the Quality Enhancement Office and the Co-ordinating Committee is encouraged. The best results for reviewed Units have occurred most often when this contact has been maintained.

1.7 The Self-assessment Report for an Administrative/Service Unit

Nature and Length of SAR

It is expected that the SAR will be evaluative and reflective in nature as well as being critical and concise. A typical SAR consists of approximately 40 pages, excluding appendices.

References to Supporting Documentation

Where the Unit wishes to refer to specific supporting documentation it can do so by including appendices in the SAR, by referring to area secure area on Moodle where all such documentation is gathered or by making it available to the PRG during the site-visit. The secure Moodle page will be set up by the QEO. Detailed information available in another existing document should not be reproduced in the SAR, rather it should be included as an appendix or referred to and made available on the Moodle page. Supporting documentation will be to some extent dependent on the Unit under review but would typically include: an organisation chart, staff profiles, Unit plans, Unit profile comprising staff and student statistical information, any previous internal or external review reports, Professional and Statutory Body accreditation reports. See Appendix 4 for further information.

Gathering Views to Inform the SAR

As self-assessment reports are evaluative and reflective in nature, they commonly require contributions from a range of parties internal and external to the Unit. The Unit is encouraged to consider how it might establish these views and ensure that they are represented in its SAR. Common mechanisms for doing so include:

- An internal SWOT analysis;
- Surveys
- Reports of focus groups or semi-structured interviews in support of the self-assessment

The QEO can assist in gathering views of other stakeholders and any requirements for stakeholder surveys should be discussed at an early stage with the Review Lead. Units should note that best practice dictates that any surveys to be undertaken in the course of preparing the SAR should be run by the QEO on behalf of the Unit, rather than by the Unit itself.

Writing the Self-Assessment Report

The SAR is the main vehicle through which the Unit conveys information about itself. Equally, and perhaps more importantly, it is the starting point for critical reflection by the Unit about the way it is managed and handles quality with regard to its particular activities. It is an evidence-based reflection of what the Unit believes to be working well in the Unit and what it believes to be working less well. It should be full and frank, not attempting to hide problems, but not to overlook its strengths; and it should be developmental, offering thoughts on how to improve provision within the Unit. When writing the SAR

the Unit should bear in mind what changes/improvements they would like to make as an outcome of this process.

The following outline is a guide for Administrative / Service Units and may need some modification depending on the nature of the Unit. The Unit is not required to provide a detailed description of what it does, though some background information may be necessary to set the context, but the emphasis should instead be on the critical self-evaluation on how effective and successful it believes the various aspects of its provision to be. This exercise provides a useful opportunity to explain why the Unit is reassured that service provision is excellent and points to the evidence that supports this view; or where provision could be improved and provide recommendations for corrective action. This section should be no longer than three pages. A template for the SAR with a number of guiding prompts (not exhaustive) is available from the QEO or on the QEO web page www.rcsi.ie/quality. The template should be used to structure the SAR, however where necessary, the Unit may modify the structure to meet the needs of the Unit. This should be done in consultation with the Review Lead. Example outline for the Self-assessment Report

- Introduction and Context of the Unit
- Planning, Organisation and Management
- Functions, Activities and Processes
- Management of Resources – Staff (including Staff Development), Facilities, Budget and Financial Issues
- Service Users and Feedback
- Ongoing Quality Enhancement
- Analysis of Strengths, Weaknesses, Opportunities and Challenges – Overall analysis and Recommendations for Improvement
- Appendices

1.8 Benchmarking

Benchmarking is an internal organisational process which aims to improve the organisation's performance by learning about possible improvements of its primary and/or support processes by looking at these processes in other or better-performing organisations.

'Benchmarking involves, a self-evaluation including systematic collection of data and information with a view to making relevant comparisons of strengths and weaknesses of aspects of performance, usually with others in the sector. Benchmarking identifies gaps in performance, seeks new approaches for improvements, monitors progress, reviews benefits and assures adoption of good practices'[1]

Where feasible the Unit is required to carry out a benchmarking process as part of the preparation and information gathering process for the SAR.

1.8.1 Who to benchmark against?

The Unit identifies two suitable institutions to benchmark against. This is done on a collaborative basis between the institutions.

[1] European Centre for Strategic Management of Universities. 2008. A Practical Guide Benchmarking in European Higher Education. ESMU

1.8.2 Identification of criteria to benchmark

The Unit will be required to categorise its core areas of activity and as an outcome of that process identify comparable information for each core area. However, it is expected that it may not be possible to carry out a full benchmarking exercise for all the activities of the Unit rather it may choose to focus on selected key areas.

1.8.3 Collecting data

The Unit carries out desk-based research and a visit the institution if appropriate(s)

1.8.4 Funding

The QEO will provide an allowance of up to €500.00 to the Unit towards the costs of conducting a site-visit to the collaborating institution, for the purpose of data gathering.

1.9 Submitting the Self-assessment Report and supporting documentation

The Quality Reviews Manager is available to support the Unit during the process of drafting the SAR. The Unit is required to submit a draft copy of the SAR 8 - 10 weeks prior to the site-visit. The draft SAR will be reviewed by the Quality Reviews Manager and where appropriate, submitted to the Chair of the Review Group. Constructive feedback on the SAR from the Quality Committee and the Chair of the Review Group will be submitted to the Unit by the QEO. The Unit is encouraged to review the feedback and edit that SAR if appropriate. The final SAR and appendices must be submitted to the QEO in electronic format as a Word file not later than five weeks before the site visit. The QEO will convert the document into a PDF file and email it to the Review Group and also send hard copies of the documents by post. The supporting documentation must be available on the Moodle page not later than four weeks before the site visit.

1.10 The confidential nature of the SAR

Self-reflection by the Unit under review is critical to the success of the RCSI Internal QA/QI Review process. In order to facilitate open and frank self-reflection, and in accordance with current best practice in the University sector, the SAR is treated as a confidential document and will be made available only to those involved directly in the review process, the Unit under review, the PRG members, the QEO and the RCSI Quality Committee. The SAR is not published or otherwise circulated.

2 PEER REVIEW GROUP

2.1 Peer Review Group Composition and Selection

A key element of the internal review process is the Peer Review Group (PRG). Typically it is comprised of four members, three independent external experts and one internal senior staff representative. It is recommended that the external experts include national/international representatives with relevant expertise, capable of making national and international comparisons in respect of the activities of the Unit; and a national/international expert in the field of QA/QI in higher education. The QA/QI expert panel member will also take the role of Chairperson of the Review. However, the number and composition of the PRG members may vary, as appropriate, to reflect the size and diversity of the Unit under review. **The external panel members should not have had any formal connections with the Unit during the last five years, e.g. acted as external examiner or a partner on a research project etc. The internal representatives may be as senior academic or a senior non-academic staff member not associated closely with the Unit.**

2.1.1 Selection of Peer Review Group

The selection of the PRG members is made in consultation between the QEO and the Unit under review. The Unit will have the opportunity to nominate external and internal representatives. The QEO will also put forward nominations and the PRG members will be selected by agreement between the QEO and the Unit. Nomination forms are set out in Appendix 3 and are available electronically from the QEO. Once the members have been selected, the QEO will contact the panel members to confirm their participation in the review process. Once full membership of the group is confirmed, the QEO will inform the Unit accordingly. The final selection of the Review Group will be reported to the Quality Committee. **All contact with the PRG, including planning for the site visit, will be conducted through the QEO.**

Note:

1. All genders (wherever possible) should be represented on the nomination lists.

2. The Unit must declare any relationship it might have with a proposed external reviewer. This must be done during the initial consultation period and outlined on the external nomination form (Appendix 3).

2.2 Terms of Reference of the Peer Review Group

The terms of reference of the PRG are to:

- Evaluate critically the SAR and the supporting documentation
- Verify how well the aims and objectives of the Unit are being fulfilled, having regard to the available resources, and comment on the appropriateness of the Unit's mission, objectives and strategic plan
- Comment on how well the Unit fits with the strategic plans for the University as a whole
- Comment on how well the Units' provision is cognisant of the ESG Standards and Guidelines 2015, QQI Core Statutory QA Guidelines 2016 and/or equivalent local policy
- Evaluate the Unit's strengths, weaknesses, opportunities and challenges as outlined in the SAR
- Discuss any perceived strengths and weaknesses not identified in the SAR
- Assess the suitability of the working environment(s)
- Comment on any recommendations proposed by the Unit in its SAR
- Make appropriate recommendations for improvement, with due consideration of resource implications

2.3 Functions of the Peer Review Group

In broad terms the functions of the PRG are to:

- Review and analyse the SAR prepared by the Unit and any other supporting documentation
- Conduct a two and a half-day site visit, meet with staff, students, representatives from all categories of users of the services of the Unit, and external stakeholders as appropriate
- Critically evaluate details in the self-assessment report and consider other relevant documentation
- Review the activities of the Unit in light of the self-assessment report
- Prepare brief summary feedback and present the key findings in an exit presentation to the staff of the Unit
- Complete the first draft of the report prior to departure
- Write the PRG Final Report

Further information on the role and function of the PRG is contained in the document 'PRG Guidelines for the Review of Administrative/Service Unit' which is available on the QEO web page www.rcsi.ie/quality.

2.4 Site Visit

2.4.1 Planning

As part of the internal review process the PRG will carry out a two and a half day site visit. This site visit is central to the process and must be planned carefully. Close liaison is required between the Unit's co-ordinating committee and the QEO. The QEO will engage the Chair of the Peer Review Group at appropriate times.

The dates for the site visit are arranged by the QEO in consultation with the Unit. This has important implications for the timing of all other activities. In particular, in order to give everyone involved the opportunity to clear their diaries, the membership of the PRG is arranged as early as possible and the dates for the site visit are fixed. All members of the Unit are expected to be available for the duration of the site visit. Prior to and following the site visit, all contact with the Review Group will be conducted through the QEO.

Two rooms will be booked by the QEO for the site visit. One room will be the base-room for the PRG and meetings with stakeholders will also take place here. Documents such as management reports, and any other relevant material should be made available to the Review Group in the base-room. The second room will be a waiting/briefing room for stakeholders. Catering, AV requirements, room layout etc. for the PRG will be co-ordinated by the QEO through Conference and Events.

2.4.2 Timetable for the Peer Review Group meetings

The site visit will take place over 2.5 days, though this may vary depending on the size of the Unit. A draft site-visit schedule is available in Appendix 6. Guidance on drafting the site visit schedule will be provided by the QEO. The schedule for the site visit meetings is initially organised by the Head of Unit and/or Chair of the Unit's Co-ordinating Committee, in consultation with the QEO and the Chair of the Review Group. Individuals and groups who will meet with the PRG are selected by the Co-ordinating Committee and confirmed following consultation with the QEO and the Chair of the PRG. The Unit is required to provide details of the individuals/groups in an excel template which is available from the QEO. The QEO will invite individuals/groups to the meetings and advise the Chair of the Co-ordinating Committee of availability of invitees. The schedule and list of stakeholders should be finalised no later than one week prior to the visit. The schedule is then made available to all relevant staff and students by the QEO.

The Unit is responsible for proposing categories of staff/students and other stakeholders for between six and nine review defined meetings. However, following receipt of the SAR, the PRG may request additional scheduled meetings.

As a guide, during the site visit the PRG should typically:

- meet with the CEO and the Dean of the Faculty of Medicine & Health Sciences and/or members of the RCSI Senior Management Team; the Head of the Unit; the Co-ordinating Committee; a representative group of the staff not on the Co-ordinating Committee; representative groups of staff (academic, technical, administrative); representatives from support Units (IT, Library, SARA, Finance, Admissions, HR etc.); employers and other appropriate stakeholders.
- visit Unit facilities; offices and other facilities that contribute to the activities of the Unit.
- complete the first draft of their report and present the provisional key findings and recommendations to a brief exit meeting of the Unit.

The PRG can request to meet with members of the Unit individually if appropriate. When the site visit is over, no member of the Unit should be in contact with the PRG on matters relating to the Self-assessment Report, the site visit or the PRG Report. If contact has to be made it should be through the QEO.

2.4.3 Exit Presentation

At the end of the site visit the one of the external PRG members or the Chair will make the exit presentation to the Unit. This will simply be a presentation of preliminary findings (for example, bullet point headlines on points of commendation and recommendation) of the PRG and will not involve discussion with Unit, as these initial findings may be modified in the light of subsequent reflection and discussion by the PRG.

2.5 The Peer Review Group Report

In keeping with the formative nature of the process, PRGs should express their recommendations in a positive manner that encourages quality improvement. Such an approach is in keeping with the spirit of an exercise in which an ethos of partnership and trust ensures that real enhancement can result.

A template for completing the report will be provided to the PRG by the QEO. The structure of the Draft / Final Report reflects the structure of the SAR. The report may include any other issues that the PRG deem appropriate. The PRG generally will identify the strengths and weaknesses of the Unit, point to examples of good practice to be disseminated throughout RCSI, and make constructive recommendations on matters that require improvement. Comment by the PRG should primarily be analytical rather than descriptive and refer to source documentation, oral evidence and/or direct observations. Recommendations should have a reference point in the Report narrative.

2.5.1 Report Completion

By the end of the site visit, the Review Chair should ensure that the PRG has prepared a reasonably advanced first draft. An agreed timeline for finalisation of the report and sign-off by the PRG should be set and communicated to the QEO. Typically, a draft final report should be made available no later than 4 weeks after the site visit, and should be sent to the QEO, with emails from all PRG members, confirming that this is the agreed report.

It is also important that the PRG should not contact the Unit with regard to any matter relating to the review. Any request should be made through the QEO.

The QEO will circulate the draft report to the Co-ordinating Committee for correction of factual error. In addition the Unit may also submit a brief response (no more than two pages, if appropriate) relating to the Report. Please note that this is not an opportunity to open up further dialogue.

The Peer Review Group Report is an independent document prepared by the PRG members. Rarely is there any requirement to undertake any editing other than, for example, reformatting or correction of factual errors. These minor edits are undertaken in consultation with the PRG Chair. In exceptional circumstances, however, there may be a need for more considered reflection regarding a phrase or a small section of the Peer Review Group Report, in order to ensure, for example, the judicious use of language and/or appropriate alignment with presentational and drafting guidelines. In these exceptional instances, the QEO will, in consultation with the Peer Review Group Chair, discuss alternative presentation/phrasing options. As appropriate, a similar consultation process involving the relevant Head of Unit will also apply to the draft Unit responses to the Peer Review Group Reports. In the event that agreement cannot be reached on alternative presentation/phrasing, the issue(s) will be referred to the external panel members of the RCSI Quality Committee who will make a final determination on the issue(s). In the event that a unit does not agree with the content and/or recommendations in the report, the appropriate right to reply should be addressed in the Quality Improvement Plan (QIP).

The Director of Quality Enhancement or the Quality Reviews Manager finalises the Review Group Report by correcting any factual errors and appending and Unit response(s) as an annexe to the Report. No other amendments are made by the Quality Enhancement Office. The Report is now final.

The Director of Quality Enhancement or the Quality Reviews Manager will disseminate the report to the President, CEO, Dean, Medicine and Health Sciences Board (MHSB) and the Peer Review Group members. The Director of Quality Enhancement or the Review Lead also sends the report to the head of Unit for circulation to members of the Unit.

2.5.2 Publication of the Report

The Peer Review Group Report will be considered by the Quality Committee. The Peer Review Group Report will be published on the RCSI Quality Enhancement web page (www.rcsi.ie/quality) together with the QIP (see below) at the end of the review process, in accordance with the Universities Act 1997 / Qualifications and Quality Assurance (Education and Training) Act 2012. The final Quality Improvement Plan will also be published alongside the Review Group Report (see Section 3). However, as stated above, the Self-assessment Report is considered to be confidential and may be commercially sensitive in nature and therefore is not published or made widely available.

3 FOLLOW-UP TO QUALITY REVIEW

Follow-up is an integral part of the review process. The decisions on improvement, which are made in the follow-up to self-assessment and review, provides a framework within which each Unit can continue to work toward the goal of developing and fostering a quality culture in RCSI. With the support of the Senior Management Team, each Unit is also required, under the Universities Act (1997)/Qualifications and Quality Assurance (Education and Training) Act 2012, to implement each of the recommendations of the Report, unless it would be unreasonable or impractical to do so.

3.1 The Quality Improvement Plan (QIP)

Following the Review the Unit is required to develop a Quality Improvement Plan (QIP). The purpose of the QIP is to be a strategic operating tool that will help the Unit to manage the Unit and work towards its successful improvement and development. The QIP can:

- act like a road map for improvement and development
- assist with management control
- help brief all concerned
- help secure financial resources

The Head of the Unit, on receipt of the PRG Report and following a meeting with the RCSI Quality Enhancement Office, will establish a Quality Improvement Committee. The membership of the Quality Improvement committee should be made up of the same members of the Co-ordinating Committee where possible. The Quality Improvement Committee will draft a Quality Improvement Plan (QIP within twelve weeks, based on the PRG Report findings. Guidelines and templates for the completion of Quality Improvement Plans are available from the Quality Enhancement Office and/or at www.rcsi.ie/quality.

3.1.1 Structure of the QIP

The QIP should usually take the form of short summaries of the action taken/planned, or if actions are not being taken, an explanation provided. The recommendations, with the associated actions taken or planned, may be structured as follows:

(i) Teaching and learning, research, organisational, administrative and other matters which are completely under the control of the Unit
(ii) Shortcomings in services, facilities or procedures which are outside the control of the Unit
(iii) Inadequate staff levels, facilities and other resources which require capital or recurrent funding. Realistic estimates of the capital and recurrent costs to implement recommendations/ planned action should be included.

It is the Unit's responsibility to compile a full response. This means that it must obtain responses to those recommendations relating to other areas of RCSI, to which actions arising from the report were addressed. For instance, if the Report recommended that office space needs to be increased, it is the Unit's responsibility to find out from the Senior Management Team and/or Head Estate and Support Services what action has, or will/will not be taken, in response to this recommendation. A realistic assessment of available resources (both at Unit and institutional level) should be borne in mind when formulating plans.

It is important that all recommendations in the PRG Report be addressed. Some recommendations for improvement may appear in the text of the PRG Report narrative. Please ensure these are included for consideration. Some recommendations may not be explicitly stated but are implied as consequences of a concern and these too, should be included in the Quality Improvement Plan.

The Quality Improvement Plan should address all recommendations (and/or other suggestions) in the PRG Report and should include:

(a) recommendations implemented already
(b) a list of goals which can be achieved realistically in the following year
(c) a list of longer term goals to be achieved, for example, over five years
(d) recommendations which the Unit and/or Senior Management Team consider to be unreasonable or impractical: in such instances, the Committee should give reasons for such a conclusion, and should, if possible, suggest alternative strategies for quality improvement.

3.1.2 Approval of the QIP

Upon completion of the draft QIP a meeting is scheduled between the QEO and the Unit, to review the draft QIP where the responses/actions planned are considered. Following this, the QEO will schedule a meeting between the CEO, Dean, members of SMT (as appropriate), the Director of Quality Enhancement/Quality Reviews Manager, Head of Unit and where appropriate, the Quality Improvement Committee. The purpose of this meeting is to agree objectives, to ensure that they are aligned with the RCSI Strategic Plan and to identify and approve additional resources where necessary. It is important to note that occasionally not all recommendations will be approved and/or may be deferred due to ongoing or planned changes in the University environment. Significant additional resource requirements may need further negotiation and approval by the RCSI Finance Committee. Once all parties are satisfied that each recommendation is being addressed appropriately, and that there is sufficient detail in the response, the final QIP is sent to the Quality Enhancement Office.

The final QIP is submitted to the Quality Committee for approval and upon approval, the QIP will be published on the RCSI website (www.rcsi.ie/quality) alongside the relevant Review Group Report.

Throughout the process the QEO monitors the development, completion and approval of the QIP by the Unit, Senior Management Team and the Quality Committee.

3.2 Progress Report

Implementation of the plan is monitored by means of subsequent reports. After three years the Head of Unit submits a progress report on actions taken with (if necessary) the reasons why agreed actions have not been completed. The progress report will be considered by the Quality Enhancement Office, the Quality Committee, with a formal presentation to Medicine & Health Sciences Board or Surgical and Postgraduate Faculties Board as appropriate and (if required) to members of the Senior Management Team.

APPENDIX 1: QQI CORE STATUTORY QUALITY ASSURANCE GUIDELINES 2016

Full Report QQI Core Statutory QA Guidelines 2016

Summary of main areas to be addressed in provider quality assurance procedure are as follows:

1 Governance and management of quality

1.1. Governance: The quality assurance systems include procedures that ensure (as fit for context and purpose)

a) A system of governance where objectives are aligned with mission and strategy
b) The quality assurance system is owned by the provider
c) A system of governance that protects the integrity of academic processes and standards
d) A system of governance that considers risk.
e) A system of governance that considers the results of internal and external evaluation

1.2 Management of quality assurance

1.3 Embedding a quality culture

2 Documented approach to Quality Assurance

2.1 Documented policies and procedures

2.2 A comprehensive system

3 Programmes of Education and Training

3.1 Programme development and approval

3.2 Learner admission, progression and recognition

3.3 Programme monitoring and review

4 Staff Recruitment, Management and Development

4.1 Staff recruitment

4.2 Staff communication

4.3 Staff development

5 Teaching and Learning

5.1 Teaching and learning

5.2 A provider ethos that promotes learning

5.3 National and international effective practice

5.4 Learning environments

6 Assessment of Learners

6.1 Assessment of learning achievement

7 Supports for Learners

7.1 Supports for learners

8 Information and Data Management

8.1 Information systems

8.2 Learner information systems

8.3 Management information system

8.4 Information for further planning

8.5 Completion rates

8.6 Records maintenance and retention

8.7 Data protection and freedom of information

Public Information and Communication

9.1 Public information

9.2 Learner information

9.3 Publication of quality assurance evaluation reports

10 Other Parties Involved in Education and Training

10.1 Peer relationships with the broader education and training community

10.2 External partnerships and second providers

10.3 Expert panellists, examiners and authenticators

11 Self-Evaluation, Monitoring and Review

11.1 Provider-owned internal review, self-evaluation, monitoring

11.2 Internal self-monitoring

11.3 Self-evaluation, improvement and enhancement

11.4 Provider-owned quality assurance engages with external Quality Assurance

APPENDIX 2: STANDARDS AND GUIDELINES FOR QUALITY ASSURANCE IN THE EUROPEAN HIGHER EDUCATION AREA 2015 (ESG)

Part 1: Standards for internal quality assurance

Full Report ESG 2015

1.1 Policy for quality assurance

Institutions should have a policy for quality assurance that is made public and forms part of their strategic management. Internal stakeholders should develop and implement this policy through appropriate structures and processes, while involving external stakeholders.

1.2 Design and approval of programmes

Institutions should have processes for the design and approval of their programmes. The programmes should be designed so that they meet the objectives set for them, including the intended learning outcomes. The qualification resulting from a programme should be clearly specified and communicated, and refer to the correct level of the national qualifications framework for higher education and, consequently, to the Framework for Qualifications of the European Higher Education Area.

1.3 Student-centred learning, teaching and assessment

Institutions should ensure that the programmes are delivered in a way that encourages students to take an active role in creating the learning process, and that the assessment of students reflects this approach.

1.4 Student admission, progression, recognition and certification

Institutions should consistently apply pre-defined and published regulations covering all phases of the student "life cycle", e.g. student admission, progression, recognition and certification.

1.5 Teaching staff

Institutions should assure themselves of the competence of their teachers. They should apply fair and transparent processes for the recruitment and development of the staff.

1.6 Learning resources and student support

Institutions should have appropriate funding for learning and teaching activities and ensure that adequate and readily accessible learning resources and student support are provided.

1.7 Information management

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

1.8 Public information

Institutions should publish information about their activities, including programmes, which is clear, accurate, objective, up-to date and readily accessible.

1.9 On-going monitoring and periodic review of programmes

Institutions should monitor and periodically review their programmes to ensure that they achieve the objectives set for them and respond to the needs of students and society.

These reviews should lead to continuous improvement of the programme. Any action planned or taken as a result should be communicated to all those concerned.

1.10 Cyclical external quality assurance

Institutions should undergo external quality assurance in line with the ESG on a cyclical basis.

APPENDIX 3: INTERNAL REVIEW INDICATIVE TIMELINE

STAGE 1	SELF ASSESSMENT	RESPONSIBILITY
- 10 months	The Director for Quality Enhancement or Quality Reviews Manager initiates the formal process of the quality review. An initial meeting will be set up with the Head of the unit to discuss the process and agree provisional dates.	Quality Enhancement Office (QEO)
- 10 to 9 months	Unit selects Self-assessment Co-ordinating Committee in accordance with the guidelines set out in the Internal Quality Review Guidelines for Administrative /Service Units.	Head of Unit
- 9 to 8 months	The Quality Committee (QC) considers nominees for the peer review group (PRG) and appoints group. The QEO conducts all liaison with reviewers.	Quality Committee/ QEO
- 8 to 3 months	Unit prepares self-assessment report (SAR), including collection of data, surveys, self-critical analysis etc.	Head of Unit / Co-ordinating Committee
- 3 months	Draft SAR and supporting documentation is sent to the QEO for review prior to the planning meeting. Room bookings, AV equipment and logistical requirements are made with the Communications Dept.	Head of Unit / QEO
- 6 weeks	Planning meeting held to consider SAR, supporting documentation and schedule for site visit. Stakeholders should be contacted at this point and invited to participate in the review process.	Head of Unit / QEO
- 1 month	SAR and supporting documentation is sent to PRG. Additional documentation is uploaded to Moodle page.	QEO
STAGE 2	PEER REVIEW AND SITE VISIT	RESPONSIBILITY
Site visit dates	Site visit take place over three days.	Head of Unit / QEO
STAGE 3	IMPLEMENTATION AND FOLLOW-UP	RESPONSIBILITY
+ 4 weeks	Draft peer review group report is received by QEO and sent to the unit. The report is considered and reviewed for factual accuracy.	QEO / Head of Unit
+ 6 weeks	The QEO is advised of any factual errors. QEO inform reviewers of factual errors (if any). Final report is requested.	QEO
+ 8 weeks	Copies of the final report will be distributed to the President, CEO, Dean and Head of Unit.	QEO
+ 3 to 4 months	The unit prepares a quality improvement plan (QIP) using SMART actions (specific, measurable, achievable, realistic and timed).	QEO / QC / Head of unit.
+ 4 months	The units QIP is sent to the QEO and a meeting is scheduled with the Head of Unit, CEO, Dean and Director of Quality Enhancement or Quality Reviews Manager to agree the QIP.	Head of unit
+ 6 months	The QEO the PRG Report and the QIP for consideration by the QC. The peer review group report and QIP are published on the QEO website.	QEO
+ 12 to 18 months	Progress meeting between the unit and the QEO to review progress on the units' QIP. QEO present progress report to the QC.	Head of unit / QEO
+24 to 36 months	Head of Unit presents follow-up report to MHSB or SPFB as appropriate. QEO present follow-up report on the implementation of the QIP to the QC.	QEO

APPENDIX 4: ADDITIONAL SAR RELATED INFORMATION

Where the Unit wishes to refer to specific supporting documentation it can do so be including appendices in the SAR or be referring to a secure area on Moodle where all such documentation is gathered or by making it available to the PRG during the site-visit.

(i) Surveys

Copies or samples of questionnaires circulated to students and staff, user groups, unit staff, as appropriate, and the analysis of results of such surveys conducted, should be included with the Report, or alternatively, these may be made available to the Review Group for consultation during the visit.

(ii) Appendices to the SAR. These may include:

- Unit Plan
- Staff Handbook
- Where appropriate, Annual Review/Monitoring Action Plans plus a record of the outcomes of the actions taken for the previous five years
- Diagram showing the Unit's committee structure
- Statistical data
- Any previous review reports

Sources of Information

Documentary evidence that may be useful to you in writing a SAR would include:

(Please remember that the panel can request copies of particular documents that have been referred to in the text of the SAR).

- Statistics relating to service provision
- Reports of previous internal reviews
- Annual review/monitoring reports
- Organisational structure
- Sample committee minutes
- Budgets
- Space allocation
- RCSI Strategic Plan
- RCSI Teaching and Learning/Research Strategy
- Documents relating to procedures and quality

Please remember that the Review Group can request copies of particular documents that have been referred to in the text of the SAR. Also note that prior to, or during the site visit, the Review Group may request additional information, from the Unit, such as management reports, financial or statistical information.

Units should note that best practice dictates that any surveys to be undertaken in the course of preparing the SAR should be run by the QEO on behalf of the Unit, rather than by the Unit itself.

APPENDIX 5: PRG NOMINATION FORMS

Nomination of External Reviewer for an Academic or Administrative/Service Unit

Name of Unit to be reviewed	
Details of Proposed External Reviewer: **Title, Name:**	
Position:	
Address:	
Email:	
Telephone:	
Brief details of Relevant Professional Experience: *You may attach supporting documentation relevant to this nomination (e.g. professional profile; research profile)*	

I confirm that the information given above is correct and that the nominee has had no formal contacts with unit over the last 5 years, to the best of my knowledge.

Signed: **(Head of Unit)**	
Date:	

Please submit completed nomination form and supporting documentation to: Anne Weadick, Quality Enhancement Office, RCSI, 123 St. Stephen's Green, Dublin 2. Email aweadick@rcsi.ie

Nomination of RCSI Reviewer for an Academic or Administrative/Service Unit

Name of Unit to be reviewed	
Details of Proposed External Reviewer: **Title, Name:**	
Position:	
Address:	
Email:	
Telephone:	
Brief details of Relevant Professional Experience: *You may attach supporting documentation relevant to this nomination (e.g. professional profile; research profile)*	

I confirm that the information given above is correct and that the nominee has had no formal contacts with unit over the last 5 years, to the best of my knowledge.

Signed: **(Head of Unit)**	
Date:	

Please submit completed nomination form and supporting documentation to: Anne Weadick, Quality Enhancement Office, RCSI, 123 St. Stephen's Green, Dublin 2. Email aweadick@rcsi.ie

APPENDIX 6: SAMPLE SITE VISIT SCHEDULE

The following schedule is a sample schedule only. Units may need to modify the schedule based on the specific nature and requirements of the Unit.

Review Defined meetings: Units are required to specify up to 8 Review Defined Meetings. Examples of review defined meetings may include:

- Meeting with Unit staff.
- Meeting with Academic Staff, Cycle Directors and/or Heads of Departments
- Meeting with members of RCSI SMT
- Meeting(s) with students: undergraduate; postgraduate; alumni
- Meeting with support units: SARA, Admissions, Finance, Conference & Events, Communications/Marketing, Alumni, IT, HR, Library, Estates
- Meeting with administrative support staff; technical staff
- Meeting with Research Staff; PIs; Post Docs; Institute of Research Staff
- Meeting with external stakeholders e.g. Accrediting Body, Employers, Academic Partnerships

Meeting theme/focus: When planning the Review Defined Meetings, Units should also consider the theme or focus of the meeting and in what capacity the stakeholders are being invited to the meeting. Think about each section in the SAR and who the panel needs to meet to investigate those sections further. The PRG need to meet the right people to answer their questions and validate what is in the SAR.

Date	Time	Dur. Mins	Mtg. No.	Mtg. Title	Venue
	16.00 – 16.30	30 mins	1	**Welcome and Introduction for PRG** Director of Quality & Quality Reviews Manager	
	16.30 – 18.45	135 mins	2	**Private Planning Meeting for PRG**	
	19.00 – 21.00	120 mins	3	Dinner PRG & QEO	
Date	Time	Dur. Mins	Mtg. No.	Mtg. Title	Venue
	08.45 – 09.10	25 mins	4	PRG: Review of preparatory work	
	09.15 – 10.05	50 mins	5	**Meeting with Head of Unit (optional: other members of senior staff nominated by the unit)** Meeting Theme: Relevant SAR Sections:	
	10.15 – 11.00	45 mins	6	**Meeting with SAR Coordinating Committee and/or time allocated for meeting unit staff** Meeting Theme: Relevant SAR Sections:	
	11.05 – 11.25	20 mins	7	Tea/coffee. Private meeting time for PRG	
	11.30 – 12.20	50 mins	8	**Time allocated for meeting unit staff** Meeting Theme: Relevant SAR Sections:	
	12.30 - 13.15	45 mins	9	**Tour of facilities**	
	13.15 – 13.55	40 mins	10	Lunch. Private meeting time for PRG	

	14.00 – 14.45	45 mins	11	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	14.55 – 15.40	45 mins	12	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	15.45 – 16.05	20 mins	13	Tea/coffee. Private meeting time for PRG	
	16.15 – 17.00	45 mins	14	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	17.00 – 18.00	60 mins	15	**PRG Review of afternoon's meetings; draft commendations & recommendations; planning for next day**	
Date	**Time**	**Dur. Mins**	**Mtg. No.**	**Mtg. Title**	**Venue**
	08.40 – 09.00	20 mins	16	PRG: Review of preparatory work	
	09.10 – 09.55	45 mins	17	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	10.05 – 10.50	45 mins	18	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	10.50 – 11.10	20 mins	19	Tea/coffee. Private meeting time for PRG	
	11.15 – 12.00	45 mins	20	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	12.10 – 12.55	45 mins	21	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	13.05 – 13.50	45 mins	22	Lunch. Private meeting time for PRG	
	14.00 – 14.45	45 mins	23	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	14.55 – 15.40	45 mins	24	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	15.45 – 16.05	20 mins	25	Tea/coffee. Private meeting time for PRG	
	16.15 – 16.55	45 mins	26	**Review defined meeting** Meeting Theme: Relevant SAR Sections:	
	17.00 – 18.00	60 mins	27	**PRG Review of afternoon's meetings; draft commendations & recommendations; planning for next day**	
Date	**Time**	**Dur. Mins**	**Mtg. No.**	**Mtg. Title**	**Venue**

	08.45 – 11.45	180 mins	28	**Private meeting time for PRG – discussion and finalisation of commendations and recommendations for all sections.**	
	10.30			Tea/coffee	
	11.45 – 12.15	30 mins	29	**Private meeting time with QEO**	
	12.20 – 12.35	15 mins	30	**Meeting with Head of unit & QEO**	
	12.40 – 13.00	20 mins	31	**Exit presentation to all unit staff**	
	13.00 – 13.45	45 mins	32	Lunch & private meeting time with QEO	
	14.00			**Review Ends**	