Internal Quality Review

PRG Guidelines for Professional Support Units

DOCUMENT CONTROL SHEET

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1 INTRODUCTION

This document is designed to support members of the Peer Review Group (PRG) in conducting the internal review of administrative / service units at RCSI. General information is provided to assist review groups in carrying out their assessment of the quality of the activities of the Unit under review and making recommendations for improvements, whilst taking into consideration the Self-Assessment Report SAR supporting documentation and the outcome of the site visit.

When reviewing the SAR and supporting documentation, the review group members are asked to familiarise themselves with the document entitled 'Internal Review Guidelines for Professional Support Units'.

The SAR and supporting documentation are provided by Royal College of Surgeons in Ireland (RCSI) to the PRG in confidence and must not be disclosed to anyone outside the PRG without written consent of the RCSI Quality Enhancement Office (QEO).

1.1 Background and Context

Ireland is a member of the European Higher Education Area (EHEA), a group of 48 countries which has adopted a common approach to higher education and professional training that has been developed through the Bologna Process[1]. The Bologna Process aims to ensure comparability, mutual recognition and mobility of qualifications across the EHEA through a common approach to higher education, the European Credit Transfer & Accumulation System (ECTS), qualifications frameworks and quality assurance of higher education. The Quality Assurance (QA) processes mandated by Bologna are set out in the European Standards & Guidelines (ESG) for Quality Assurance in the European Higher Education Area 2015 (Appendix 1). In addition, the regulatory body, Quality & Qualifications Ireland (QQI) developed Core Statutory Quality Assurance (QA) Guidelines (Appendix 2) for providers of higher education in Ireland. In contrast to the compliance-focused approaches to QA commonly encountered in healthcare and in industry, the unique features of these higher education QA processes are [a] the degree to which self-assessment drives the review process and [b] the overall focus on quality enhancement.

[1] https://www.eua.eu/issues/10:bologna-process.html

As a 'Designated Awarding Body' under the terms of the Qualifications and Quality Assurance (Education and Training) Act 2012[2], RCSI is required to review the effectiveness of its internal quality assurance policies and procedures through cyclical review of schools, faculties and administrative offices, including international programmes and branch campuses. Following the establishment of the Quality Enhancement Office (QEO) in late 2010, the first Internal Quality Assurance Reviews took place during 2011 and the process continues, following a calendar of 'rolling' reviews approved by the RCSI Quality Committee in the context of its operational and strategic plans.

1.2 Process

The Internal Quality Assurance Review process involves three distinct phases encompassing a six month time period.

Phase I – Self-assessment

The unit under review undertakes a period of self-assessment focusing on four key questions:

- What do we do?
- How do we do it?
- How do we know it works?
- How might we do it better?

Typically a unit will take 2-3 months to complete its self-assessment, the main output of which is a 'Self-Assessment Report (SAR)'. SAR documents are usually brief (40 pages max.) and accompanied by supporting documents as required. The SAR is a confidential document seen only by the unit which produces it, the QEO & Quality Committee and the Peer Review Group involved in Phase II of the review (see below). The confidentiality of the SAR in this type of review is a guarantor of a 'safe space' in which the unit under review can engage openly with the process.

Phase II – External Validation

In parallel with developing the SAR, the unit works with the QEO to appoint a 'Peer Review Group (PRG)' who will act as 'critical friends' to the Unit, carrying out a site-visit (of 2.5-3.0 days duration) and meeting with the unit's stakeholders. The PRG consists usually of four members [1 x QA specialist (Chair); 1 x internal RCSI nominee; 2 x external experts] but may be larger depending on the needs of

[2] http://www.irishstatutebook.ie/eli/2012/act/28/enacted/en/html

the unit under review. The primary role of the PRG is to validate the content of the SAR and to make recommendations for the future trajectory of the unit. The PRG will deliver an exit presentation at the end of the site-visit and then, some six weeks later, will issue a Peer Review Group Report detailing their findings, commendations and recommendations.

Phase III – Quality Improvement Planning

On receipt of the Peer Review Group Report, the unit develops a 'Quality Improvement Plan (QIP)' in response to the PRG recommendations. This takes a simple tabular format with assignment of responsibility, time-lines & budgetary implications. The final QIP, together with the Peer Review Group Report, is then presented for approval to the relevant governance body within RCSI [e.g. in the case of an administrative / service unit, this will be the Medicine & Health Sciences Board].

On completion of the review process, the Peer Review Group Report and QIP are published on the RCSI web-site as required by the legislation. However, due to its confidential nature, the SAR is never made public.

The overall timeline for the review process therefore is:

Phase I – Self-assessment: 2-3 months

Phase II – External Validation: 4-6 weeks approx.

Phase III – QIP Development: 4-6 weeks approx.

1.3 QIP implementation and continuity in the review process

Ordinarily the parallel review cycles run by the QEO operate on a 6-7year cycle, though some units which do not fall within the scope of these cycles may be subject to review on a one-off basis at the behest of RCSI Senior Management. As a means to ensure some continuity between reviews, implementation of the QIP arising from the previous review will be assessed mid-Cycle (i.e. after approx. 3-4 years) by the relevant governance body.

2 PEER REVIEW GROUP (PRG)

A key element to the internal review process is the PRG. It is generally comprised of four members, three independent external experts and one internal senior staff representative. It is recommended that the external experts include national and international representatives with relevant expertise, capable of making national and international comparisons in respect of the activities of the unit. 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 representative should be a senior academic and a senior non-academic staff member not associated closely with the unit.

2.1 Selection and contact with the 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 in agreement between the QEO and the unit. 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 and will bring PRG member nominations to the RCSI Quality Committee for formal approval. All contact with the PRG, including planning for the site visit, will be conducted through the QEO.

2.2 Functions of the Peer Review Group

In broad terms the functions of the Peer Review Group are to:

- Study the SAR prepared by the unit and any other supporting documentation
- Conduct a two and half-day site visit, meeting with staff, students, representatives from all categories of users of the services of the unit, and external stakeholders as appropriate
- Clarify and verify 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 the Draft Report and present the main findings in an exit presentation to the staff of the unit
- Write the PRG Final Report

2.3 Role of the chair of the Peer Review Group

The Chair of the PRG will be selected in advance from among the external members of the panel. The QEO will make a recommendation as to who should Chair the group and contact the members to seek agreement.

The key functions of the Chair of the PRG are:

- to study the SAR prepared by the unit and any other supporting documentation
- to confirm the site visit schedule in consultation with the QEO in advance of the visit. The PRG may request changes to the schedule before or during the site-visit
- allocate aspects of the review to each PRG member, in consultation with the QEO
- ensure preparation of initial discussion points on the SAR and supporting documentation for circulation to PRG members prior to the site visit
- chair meetings of the PRG and ensure that the review process is carried out in a spirit of co-operation and constructive dialogue; and insofar as it is possible, to keep all meetings on schedule
- participate in a review visit to the unit, contribute to and comment on the judgements being made by the reviewers.
- liaise with the QEO on any relevant matters raised by the PRG during the site-visit
- under no circumstances should any PRG member communicate any aspect of the PRG discussions and/or PRG Report content to anyone (other than the RCSI Quality Enhancement Office staff or the CEO or Dean of the Faculty of Medicine and Health Sciences)
- oversee the preparation of the Draft Report and present summary findings in an exit presentation to unit staff at the end of the site visit (commendations and recommendations)
- ensure that the PRG members complete the first draft of their section(s) of the report (including key points for commendation and recommendations for improvement) prior to completion of the site visit (note: recommendations should have a reference point in the report narrative)
- agree timelines for receipt of each reviewers draft section of the report
- take responsibility for the co-ordination and initial editing of the Draft Report, liaising with members of the PRG
- to send Draft Report to the QEO and the unit for consideration and review for factual accuracy
- to liaise with the QEO and correct any factual errors and sign-off on the Final Report

2.4 Role of the Peer Review Group members

The responsibilities of the Peer Review Group members include:

- reading and analysing the Self-assessment Report prepared by the unit and any other documentation sent in advance of a review (it should be noted that the Self-assessment Report is confidential to the Peer Review Group)
- preparing initial points on the advance documentation for circulation to Peer Review Group members prior to the review site visit
- identifying and communicating to the RCSI Quality Enhancement Office any additional requests for information/documentation
- participating in a review visit to RCSI in order to gather, share, test and verify evidence
- drawing conclusions, making recommendations and judgements on the service quality and standards achieved
- preparation and completion of the allocated draft sections of the Peer Review Group Report and commenting on the overall draft of the Peer Review Group Report, as agreed with the Chair
- under no circumstances should any Peer Review Group member communicate any aspect of the Review Group discussions and/or Review Group Report content to anyone (other than the RCSI Quality Enhancement Office staff, the CEO or Dean of Faculty of Medicine and Health Sciences) prior to the final report being circulated to the unit by the RCSI Quality Enhancement Office
- being available for the whole period of the review site visit and committing to complete all processes of the review once they have embarked on it

Reviewers will evaluate the Self-assessment Report provided by the Unit, for example, by:

- assessing the coherency of the unit's strategy for the future
- identifying factors which inhibit/enable the delivery of the service(s)
- assessing the performance of the unit against its own planning objectives
- could the organisation of the unit be improved?
- are resources and facilities adequate/optimal?
- is there a process of continuous improvement in service delivery? Is it effective?
- what is the user perspective on service provision?
- how does the unit develop and involve its staff in achieving improvements in service provision?

Review skills required include the ability to:

- conduct meetings and interviews with staff, students and external stakeholders
- write succinctly and coherently
- meet tight timescales and deadlines
- work effectively as a member of a team
- work courteously and professionally
- maintain confidentiality
- communicate electronically, including emails, attachments and word processed documents and files

2.5 Technical Writer / Rapporteur

When possible, the QEO will engage a Technical Writer / Rapporteur for each review, to assist the PRG during the site-visit and in formatting and finalising the PRG Report. The Technical Writer / Rapporteur will support the PRG as follows:

- Attend all meetings during the site visit, including the planning meeting on the evening before day one of the site-visit.
- Assist the PRG in planning for meetings with stakeholders.
- Take comprehensive notes (mainly in bullet point format) during all meetings including planning meetings and meetings with stakeholders.
- Provide notes to the PRG members at the end of each day.
- Liaise with the QEO on behalf of the PRG during the site-visit when required.
- Assist in drafting the exit presentation on the final day of the site-visit.
- Format the final draft PRG Report to ensure consistency in ‘house-style’ report generation.

3 THE SITE VISIT

As part of the internal review process the PRG will carry out a two and a half-day site visit to the unit under review. The QEO will contact the members of the PRG to confirm dates for the site visit. The PRG are required to convene a meeting on the evening before day one of the site visit. This meeting will take place in the University or the hotel where the PRG members are staying. The review group will then meet with the RCSI Director of Quality for dinner at the hotel or a nearby location.

3.1 Travel and Accommodation arrangements

All flight arrangements and hotel accommodations are booked through RCSI Travel. The QEO will liaise with PRG members to arrange travel and accommodation where necessary. Hotel accommodation including meals taken at the hotel, are charged by the hotel directly to the QEO. For additional expenses incurred during the course of the site visit, such as taxi or train fares, external PRG members are required to fill out an expense claim form (available from the QEO) and to submit it along with receipts to the QEO for processing of payment. Mileage will be paid at the rate of €0.40 per kilometre or the equivalent cost of public transport, e.g. train fare, whichever being the lowest amount. Prepaid parking tickets are available for the RCSI car park. Please advise the QEO in advance if you require parking at RCSI. RCSI internal PRG members should contact the QEO to make arrangements for payment of expenses.

3.2 Documentation

The QEO will forward the review documentation to the PRG approximately four weeks before the site visit. The documentation will include the Self-assessment Report, appendices, draft schedule, Internal Review Guidelines for Administrative / Service Units and a template for completion of the Peer Review Group Report. Depending on the size and nature of the activities of the unit under review, additional supporting documentation may be made available to the PRG on a dedicated page on the RCSI virtual learning environment, Moodle. The PRG will be given access to the Moodle site by the QEO.

The Review Group are requested to consider and analyse the self-assessment report, and to identify any requests for additional information. The draft timetable (see Appendix 3), organised by the Quality Enhancement Office in consultation with the Chair of the Peer Review Group and the Chair of the unit's review co-ordinating committee, should be considered in the light of the self-assessment report, and any additional categories of staff and/or students identified to meet with the Peer Review Group. Any requests from the Peer Review Group should be communicated through the Quality Enhancement Office.

The Chair of the Peer Review Group will provisionally allocate aspects of the review to each Review Group member (for example, planning, organisation and management of resources). Normally the external review members will cover the following aspects:

- Planning, Organisation and Management
- Functions, Activities and Processes
- Management of Resources

As part of the preparation phase, Peer Review Group members should prepare initial points on the advance documentation, and on those aspects assigned to them (see Appendices 4 and 5). The initial points will be circulated to Group members, approximately one-two weeks prior to the review. These summaries have proved to be very useful in stimulating initial discussions at the pre-visit briefing meeting (see Appendix 4).

3.3 Structure of the Site Visit

3.3.1 Aim of the Site Visit

The aim of the site visit is to clarify and verify details in the self-assessment report, and for staff, students and other stakeholders to meet with the Peer Review Group. The Peer Review Group have a collective responsibility to gather, verify and test judgements evidenced in the self-assessment report and the site visit meetings. It is a function of the Chair's role to ensure that this objective is achieved. An overview should be provided of the present status of the unit, with a comment on each core aspect of the unit's activities, and how well the aims and objectives of the unit are fulfilled, having regard to available resources. The Peer Review Group should also check the suitability of the working environment, as well as identifying examples of good practice, outlining critical resource limitations, commenting on the unit's plans for improvement, and making recommendations for improvement. The report will also include the extent to which the unit is aligned with the University's strategic objectives and structures. The Review Group report will reflect the collective conclusions of the group.

3.3.2 Preliminary Meeting

The site visit takes place over the course of two and a half days. The PRG will convene a preliminary meeting on the evening before day one of the visit to discuss the SAR, the structure of the site visit, to review feedback summaries of each reviewer, as previously circulated, and to confirm the agenda for

review meetings. While each reviewer will have responsibility for specific aspects of the review, each member may contribute to these aspects and will have an opportunity to comment on preliminary drafts of the Review Group Report. The final draft will reflect, insofar as it is possible, the collective views of the group. Working meals, including those in the hotel, should, for example, be used for an exchange of general views on the findings up to that point, issues still to be clarified, and further information to be reviewed.

3.3.3 Site Visit Meetings

During the course of the visit the review group usually:

- Meets with the unit co-ordinating committee, head of the unit, members of staff not on the coordinating committee, students and graduates, users of the unit and external stakeholders (as appropriate)
- Meets with the Chief Executive Officer of RCSI, the Dean of the Faculty of Medicine and Health Sciences and/or members of the University's Senior Management Team.
- Visits the facilities that support the activities of the unit, including as appropriate, lecture rooms, laboratories, offices, library and other relevant services (as appropriate)
- Completes the first iteration of the Draft Report and presents its principal findings and recommendations in an exit presentation to all available staff of the unit, prior to departure

The PRG can request to meet with members of the unit individually if appropriate. Staff from the unit under review, may be anxious about the review exercise, and efforts should be made to ensure that (within reason) they are made to feel as comfortable as possible when meeting with the Peer Review Group. A confrontational approach should be avoided.

Meetings with students are confidential and no members of the unit should be present during the meetings.

Site visit meetings are used to evaluate the evidence gathered; to form preliminary judgements; to identify aspects of provision that are considered commendable and to identify areas for improvement. The working dinners will also provide opportunity for the Peer Review Group to discuss, review and confirm findings.

3.4 Exit Presentation

At the end of day four of the site visit, the PRG will first meet with the QEO to outline their key findings and recommendations (for example, bullet point headings on points of commendation and improvement), which they will then present in an exit presentation to the staff of the unit. A template for the PowerPoint presentation will be provided by the QEO or Technical Writer. At this meeting the PRG will not engage in discussion with the staff of the unit; however it should be made clear to staff that the PRG may modify their findings in light of any factual error identified in the Draft Report after it is sent to the QEO and the unit for consideration.

4 THE PEER REVIEW GROUP REPORT

In keeping with the formative nature of the process, review groups should express their recommendations in a positive manner that encourages quality enhancement. 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.

The structure of the Review Group Report should broadly reflect that of the unit's self-assessment report (see Appendix 8). Comment (in short paragraphs) should be analytical rather than descriptive and refer to either source documentation or direct observations.

As part of the Report the PRG is asked to:

- confirm and comment on the details of the SAR
- provide an overview of the present state of the unit under review
- comment briefly on each aspect of the unit's activities
- acknowledge achievements and quality where they exist
- point out unambiguously any deficiencies or inadequacies in management and operations that might be eliminated or restructured
- identify critical resource limitations (if any) that bar the way to successful improvement
- comment on all plans for improvement that the unit has made in the SAR
- emphasise the recommendations for improvement that the PRG consider appropriate

The Draft Report is written as an independent document. In the report summary any deficiencies identified should be categorised as follows:

- strategic, i.e. involving RCSI policies, regulations or practices, or dependent on the university/faculty or other schools/units, where appropriate
- due to limited resources
- caused by poor management, policies or operations within the department, and rectifiable with current resources

Recommendations

- In the Report the PRG are required to give commendations and make constructive recommendations for improvement where appropriate.
- When making recommendations the PRG should take into consideration strategic, resource and operational implications.
- No comments or recommendations should be attributed to individuals.
- Recommendations should have a reference point in the Report narrative.

A template for completing the report will be provided 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.

The Peer Review Group Report is an independent document prepared by the Peer Review Group 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 Peer Review Group 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 RCSI Quality Enhancement Office 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 draft Unit responses to 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).

4.1 Report Completion

At the end of the site visit, the Peer Review Group Chair should ensure that the Peer Review Group has prepared a reasonable first draft. An agreed timeline for finalising the report and sign-off by the Peer Review Group should be set and communicated to the Quality Enhancement Office (see Appendix 9 for outline of completion timeline). The Draft Report is sent to the Quality Reviews

Manager approximately four weeks after the site visit. It will be forwarded to the unit's co-ordinating committee for review of factual accuracy. Factual errors (if any) are corrected and the Final Report is requested. The Final Report is signed off by the Chair of the PRG and sent to the Quality Reviews Manager within eight weeks of the site visit. The Final Report is considered by the Director of Quality Enhancement, the Quality Reviews Manager and the Quality Committee (QC). The Director of Quality enhancement will disseminate the report to the President, CEO, Dean of Faculty of Medicine and Health Sciences, Medical and Health Sciences Board (MHSB), Head of the Unit and to all staff members of the unit. The unit is required to respond initially to the report and indicate how it intends to implement the recommendations of the report.

5 QUALITY IMPROVEMENT PLAN (QIP)

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.

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

5.1 Approval of the QIP

The Head of the Unit, on receipt of the Peer Review Group 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.

5.2 Progress Report

Implementation of the plan is monitored by means of subsequent reports. A follow-up exercise may be conducted within 24 - 36 months of the QIP been approved, where the Head of the 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, Medicine & Health Sciences Board and (if appropriate) members of the Senior Management Team.

6 PUBLICATION OF THE PRG REPORT

The Universities Act 1997 provides for publication 'in such form or manner as a governing authority thinks fit' of findings arising out of the application of quality assurance procedures, and the governing authority is required to implement the findings having regard to the resources available, unless it would be unreasonable to do so.

Following approval by the governing authority, the Final Report and Quality Improvement Plan are published on the RCSI website. However, the SAR is confidential and therefore not published or made widely available.

APPENDIX 1: STANDARDS AND GUIDELINES FOR QUALITY ASSURANCE IN THE EUROPEAN HIGHER EDUCATION AREA 2015 (ESG)

Part 1: Standards for internal quality assurance (summary)

Full Publication 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 2: QQI CORE STATUTORY QUALITY ASSURANCE GUIDELINES 2016

Full Publication 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

9 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 3: SAMPLE SITE VISIT SCHEDULE

Review Defined meetings: Units are required to specify up to 10 Review defined meetings. Examples of review defined meetings may include:

- Meeting with Unit staff.
- Meeting with Academic Staff
- Meeting with Clinical Staff
- Meeting with 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 professional 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. For example, the theme/focus of the meeting might be 'Representatives from Academic Staff with a focus on Teaching and Learning, Curriculum Development'; Representatives Quality Assurance and Quality Improvement; Meeting with members of SMT re RCSI Strategy and plans for the future. 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 –	50 mins	8	**Time allocated for meeting unit staff**	

	12.20			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 –	60 mins	27	**PRG Review of afternoon's meetings; draft**	

	18.00			**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**	

APPENDIX 4: PEER REVIEW GROUP TEMPLATE FOR PRELIMINARY COMMENTS

Peer Review Group Template for Preliminary Comments

Internal Quality Review of [Insert Name of Unit]

Reviewer	
Review Aspect	

1	Positive/Good Aspects	
2	Apparent weaknesses and /or areas of concern	
3	General Observations	
4	Issues which need exploration during discussion	
5	Additional data required	
6	Opportunities/recommendations which the unit has identified for future work	

APPENDIX 5: PEER REVIEW GROUP PRELIMINARY COMMENTS ON THE SELF-ASSESSMENT REPORT

Peer Review Group Preliminary Comments on the Self-assessment Report

Reviewers are asked to identify comments, queries and concerns arising from their first impressions of the Self-assessment Report (SAR) and begin the process of individually and then collectively identifying general themes, issues and areas for further investigation or clarification. This process should result in a shared list of issues that will form the basis of discussions at the initial planning meeting of the Peer Review Group.

The range of questions asked by reviewers when reading the SAR for the first time might include:

- who was on the co-ordinating committee?
- were a range of staff, students and stakeholders consulted?
- what timeline was it prepared on?
- is it overly descriptive?
- does it provide a degree of genuine self criticism and self reflection?
- does it provide evidence of any shortcomings or issues of concern in relation to the area under review?
- does it provide evidence of any shortcomings or issues of concern in the University's management of quality assurance and enhancement?
- does it provide evidence on how it benchmarks itself against national and international reference points?
- does it provide evidence of a commitment to quality assurance and to ongoing quality enhancement?
- does it explicitly identify any issues that the University would welcome the Review Group exploring?
- Are there examples of good practice?

APPENDIX 6: INTERNAL QUALITY REVIEW: REVIEWER CODE OF CONDUCT

Internal Quality Review: Reviewer Code of Conduct[3]

Reviewers are asked throughout their engagement with the review process to observe the following code of conduct:

Personal Conduct throughout the RCSI Review Process

- be open, honest and transparent throughout the process, operating with impartiality and integrity
- be tolerant, courteous and constructive
- work co-operatively with your fellow reviewers under the direction of the Chair
- do not disclose any personal, confidential or commercially sensitive information regarding RCSI or the unit under review, outside the context of the Review process
- keep clear and accurate notes throughout the review process to ensure the report findings are based on gathered, accountable evidence
- identify and declare any conflicts of interest that might arise at any point of the review process to the Chair or the RCSI Quality Enhancement Office
- avoid anything that could be construed as impropriety or a form of bribery
- keep all electronic and hard copy documents and information secure and confidential. Shred, delete or return any unwanted documents at the end of the process to the RCSI Quality Enhancement Office for safe disposal

Professional Conduct within Review Visit Meetings

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[3] Based on the following references

(i) IUQB Institutional Review Guidelines

(ii) IHEQN Principles of Good Practice in Quality Assurance/Enhancement

(iii) Standards and Guidelines for Quality Assurance in the European Higher Education Area

- be well prepared in advance for all meetings
- remain punctual throughout the process as the programme of meetings is demanding
- ensure all electronic devices are turned off during all meetings within the University
- follow the direction of the Chair in all meetings
- do not debate with or challenge other reviewers during meetings with the University
- ask clear, direct questions in a friendly, constructive manner
- ensure diversity in responses by encouraging open exchanges of opinions amongst all participants
- actively engage in and take notes from all meetings attended throughout the visit, discuss the findings and ensure the evidence you have collected contributes to the final review reports

Continuity of Conduct – Post Review

- contribute to the production of the final report in a timely and constructive manner to ensure delivery of the report by the Chair to the RCSI Quality Enhancement Office within 8 weeks of the Main Review Visit
- avoid disclosing any unpublished information regarding the University or the review process in public, orally or in writing, without the written permission of RCSI
- the review reports are written jointly by the Peer Review Group but the intellectual property rights are retained by RCSI. Only the RCSI CEO or other designated staff members or Chair are authorised to make any public comment or statement on the outcomes of the process, if requested. Any approach from the press should be directed to RCSI

Any serious breach of conduct may lead to an immediate cessation of a reviewer's involvement in the review process.

Protocol for Meetings

Each meeting will normally be opened and closed by the Chair (or acting Chair for that session). Peer Review Group members must operate in accordance with this Code of Conduct. At the start of each meeting the Chair should typically provide a brief introduction and outline the nature of the review process to set the macro level context for the discussion. The Chair should then confirm that in order to triangulate information throughout the Site Visit, the Peer Review Group may ask questions and opinions on a wide range of topics that might be outside of the topic set for the specific session but falls within the scope of the overall review. This might seem odd to the participants if they are being asked about matters that appear to be outside of their particular areas of responsibility, or the scope of the scheduled session, but the Chair should reassure them at the start of each meeting that the topics for discussion will include a degree of flexibility, where considered necessary by the Peer Review Group.

The Chair should also confirm that he/she reserves the right to move the discussion on if time is short or if sufficient (or insufficient) information and evidence has been gained on a particular topic area. Furthermore, if conflicting opinions or experiences emerge within a meeting and there is insufficient time to cross reference, or to explore the matter further – it will either be addressed or tested in subsequent meetings or the review report will confirm inconsistencies and outline the reasons for inconsistencies as evidenced by Peer Review Group.

Questioning Style

Creating an atmosphere of genuine dialogue during the visit is essential and reviewers should act as critical friends or informed observers rather than inspectors. To this end, questioning and discussions within meetings must be fair, courteous and constructive but also inquisitive, focusing on the collation and testing of evidence. Reviewers must ensure by the end of each meeting they have obtained new information or gathered sufficient evidence to contribute to the findings, commendations and recommendations that will be presented in the review report.

Evidence-gathering must be thorough, monitored and documented. Try to ensure that all participants in meetings have an opportunity to speak and that meetings are not dominated by a few individuals. Where appropriate, reviewers should use open ended questions and then test issues further, probing a variety of participant views and experiences based on the answers to the original questions. The Chair should seek to confirm that impressions obtained are accurate and representative of the majority of participants before moving on. It is important that reviewers, particularly the Chair, are sensitive to the needs of the enquiry and allow colleagues to pursue necessary lines of questioning, particularly if the issue under discussion is likely to be featured in the final report.

Ideally, the profile of questions to be presented at each meeting should be agreed in advance of the meeting, with the Chair having a checklist of what questions will be covered and by whom. This will ensure that the key requirements and evidence from each session is gathered systematically, accountable and monitored. The Chair should ensure that grandstanding by fellow reviewers or participants is prohibited.

Furthermore, reviewers are advised against:

- asking multiple part questions
- using wordy preambles to questions
- influencing or steering answers
- getting into a debate with fellow reviewers or participants
- providing lengthy anecdotes or speeches
- detailing best practice from their own or other institutions
- presenting personal views, suggestions, advice or expressing criticisms

APPENDIX 7: PROCEDURE TO ADDRESS ISSUES OF CONCERN THAT MAY ARISE AT PEER REVIEW GROUP SITE VISITS

Procedure to address issues of concern that may arise at Peer Review Group Site Visits

Good practice suggests that an appropriate mechanism be in place to ensure that any issues of concern that may arise for a Peer Review Group member, during the conduct of the business of the Group, can be addressed.

A problem will always be best resolved by, and with those, closest to the problem. In this context the following steps apply:

1. A Peer Review Group member with a concern relating to the operation of the Group should in the first instance speak with the chairperson of the Group explaining the matter of concern and seeking a resolution, where that is practicable.

2. Should an appropriate resolution not result from this communication, or if the concern relates to the role of the chairperson, the RG member should then raise the matter with the relevant member of the RCSI Quality Enhancement Office staff, or if unavailable, the Director of Quality Enhancement.

3. The RCSI CEO and the Director of Quality Enhancement shall have the final adjudicating role should resolution not be obtained at earlier stages.

APPENDIX 8: INDICATIVE STRUCTURE OF THE PEER REVIEW GROUP REPORT

Indicative Structure of the Peer Review Group Report

A template for completing the Peer Review Group Report is available from the RCSI Quality Enhancement Office. Typically the Peer Review Group Report should broadly discuss the following:

- **Context for the Review**
    - Membership of the Peer Review Group
    - Terms of reference
        - The Peer Review Group is required to form an opinion on the 'health' of the unit under review, based primarily on the unit's self-assessment report and site visit meetings. This should be achieved through discussion of the quality of the educational process, its research activity, the needs of students, society and relevant employers.
        - To make suggestions on quality enhancement
    - A brief outline of the review method. This should include a comment on the Unit's Self-assessment Report. Is the report sufficiently critical and analytical? Are the aims clearly articulated and operationalised? Does the Self-assessment Report convey a clear picture of the unit and its activities?
- Introduction/overview of the unit
- In addition to briefly outlining an overview of the unit the PRG should make reference to benchmarking process conducted as part of the self-assessment process. **Planning, Organisation and Management**

The Peer Review Group may consider:

- How does the unit organise its activities? Are these structures effective?
- Are the goals and aims clearly articulated in the unit's strategic plan with agreed implementation goals?

- Is the current committee structure satisfactory? Are all staff adequately involved in the formal decision-making process?
- Are current budgetary systems robust and reflect current good practice?
- Are there effective communication structures in place between staff in the unit and between service users?

- **Functions, Activities and Processes**

The Peer Review Group may consider:

- Are the facilities and services appropriate and sufficient to fulfil the service Unit's objectives?
- Is there a comprehensive system for ensuring that user requirements are taken into account?
- Is there a process of continuous improvement based on identifying opportunities and needs through the analysis of operation and user data, and of external benchmarks?
- Does the Unit have a system to ensure that all activities operate and are controlled, to the prescribed standards or requirements?

- **Management of Resources**

The Peer Review Group may consider:

- Does your Unit have an approach that ensures that the allocation and use of its financial resources reflects and supports its mission statement and its quality aims and values?
- Are the staff plans directly derived from the needs of the strategic plans and goals?
- Does your Unit have a process for regular staff development reviews and which includes training and career development needs?

- **Service Users and Feedback**

The Peer Review Group may consider:

- Are there well-defined standards and service levels addressing key user requirements, and does your Unit routinely measure and know its performance in meeting these standards?
- Are the user satisfaction results (i.e. the actual perceptions of the user) regularly measured and known for both product and service attributes?

- How well does the Unit communicate with its users?

- What arrangements exist for promoting the Unit's facilities and services? Are these arrangements effective?

- **Ongoing Quality Enhancement**

The Peer Review Group may consider:

- How does the unit review and seek to enhance its activities?

- What evidence is there to indicate the unit has responded to feedback/reflection?

- Does the unit have an effective evaluation system?

- **The Peer Review Group should comment on the unit's overall consideration of the QQI Core Statutory Quality Assurance Guidelines April 2016 (Appendix 2) and the ESG Standards and Guidelines for Quality Assurance in the European Higher Education Area 2015 (Appendix 1).**

- **The Peer Review Group should comment on the unit's overall analysis and recommendations for improvement**

- **Summary of the Review Group Conclusions**

- **Review Group points for Commendation and Recommendations for Improvement**

APPENDIX 9: TYPICAL OUTLINE TIMELINE FOR COMPLETION OF THE PRG REPORT

Typical Outline Timeline for Completion of the PRG Report

1	Day 4 of site visit	Review Site Visit concludes and date is set for the initial draft sections
2	+ 1 week	Draft Report sections returned to Review Chair to compile and undertake initial edit (cc RCSI Quality Enhancement Office).
3	+ 2 weeks	Next version of the Report is circulated to the Peer Review Group members (cc RCSI Quality Enhancement Office). This step is repeated if necessary.
4	+ 4 weeks	When Peer Review Group Members are prepared to 'sign off' on the Report, it is forwarded, via the Chair, to the RCSI Quality Enhancement Office. The RCSI Quality Enhancement Office will ask the unit under review to correct factual errors.
5	+ 8 weeks	Upon receipt of unit feedback, the RCSI Quality Enhancement Office will correct factual errors. If no outstanding issues remain, an updated Report is sent to the Chair for final sign off and copies sent to the Peer Review Group members. The Report is then final.