EQuIP
Enhancing Quality in Partnership
Healthcare Education
QA Framework Consultation

Skills for Health

better **skills**
better **jobs**
better **health**

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Foreword

I would like to thank you for taking the time to read this document and hope that you will respond to the questions asked within it. We have called the new quality assurance framework Enhancing Quality in Partnership (EQuIP). We hope that you will agree that that is what the framework does. Whilst the framework has been developed to support the National Standard Contract for non-medical professions' education published by the Department of Health in England in 2006, we believe that it could be used for all aspects of healthcare education.

EQuIP has been developed in consultation with many organisations and individuals who are named at the end of the document. I would like to thank them for the time they have invested in this work. Without their input we would not have reached this point.

By the end of December 2007 we plan to have consulted widely with all those who might use or be affected by EQuIP so, as well as responding yourself, please tell colleagues about the consultation. Throughout the consultation period there will be consultation workshops across the country which you can attend to gain more detail about the framework. You are welcome to come to any of these events.

John Rogers
Chief Executive
Skills for Health

Introduction

Everyone would agree that healthcare education matters. What healthcare professionals are learning, how they are learning and where it happens has the potential to have a major impact not only on the successful delivery of healthcare services, but also on the quality of care that patients and service users receive.

Strategic Health Authorities directly invest £650 - £700 million each year on healthcare learning programmes with about 75,000 people learning in healthcare settings. Given such large sums of public money involved, it's clear that we need robust measures in place to improve patient care and support efficiencies. It should come as no surprise to anyone that there are expectations of raised levels of service and improvements across government funded programmes.

At Skills for Health, we are delighted therefore to be working with our partners to develop supporting measures that will enhance the already high standards of healthcare education, and make our health services even better. We believe that a skilled, flexible and productive workforce for the whole health sector is vital in raising the quality of health and healthcare for the public, patients and service users.

Our work, to develop a better way of delivering Quality Assurance (QA) in healthcare education, has an important part to play in improving workforce skills. By helping employers have a say in influencing education and training supply, we are supporting them so they have the right people, with the right skills, to do the right jobs. The EQuIP Framework will have a major role to play in supporting healthcare learning programmes, so that they are of a higher quality to support a modern healthcare workforce for the 21st century.

Change for the better

A recent comprehensive review[1] shows that the quality of healthcare education is at a generally good or high level already. So how do we make sure this is maintained and further improved?

The recent Major Review of healthcare education assessed the quality of healthcare education at a given point in time. This snapshot picture provided a useful baseline but was not designed to support ongoing enhancement of quality.

Although lots of good work has been taking place in healthcare education, the numbers and complexities of learning programmes mean that there has to be a move towards simplification and standardisation. With 75 Higher Education Institutions (HEIs) and partner healthcare providers delivering 2,000 healthcare education programmes, it is possible that the quality of them could be affected by differing agendas. As well as some issues common to many other vocational areas of education and training, healthcare education has its own unique needs. It is

[1] Major Review of healthcare programmes 2003 – 2006 QA Agency. **http://www.qaa.ac.uk/health/majorreview/default.asp**

in everyone's interests that the quality and standards of healthcare education are safeguarded, with greater transparency and increasing use of external reference points[2].

Healthcare education is different

Anyone who is involved in healthcare education quickly appreciates that due to its complexities and specific features, it is different from other strands of learning:

- The stakes are higher in terms of the impact of unsafe practices on patients
- Environment and technology are changing rapidly
- A high proportion of learning experience happens in practice settings
- The contracting environment is unique – there is a commissioning and contracting process in which accountability has to feature

By education we mean both classroom and practice based learning. So the EQuIP framework applies to all learners because healthcare education could apply to people who are working for healthcare providers as well as those in full time study.

Skills for Health and its partners are building on the foundation of work carried out over a period of years. Now we have an opportunity to strengthen this solid partnership approach to healthcare education, involving both service users and learners to make the process as inclusive as possible.

In summary

For this guiding framework to be robust, meaningful and actionable, it had to be created through collaboration. We also need a partnership approach for it to succeed, so we invite you to be involved.

The more people that have their say in the consultation process, the more meaningful the QA framework will be. Partnership is at the heart of this work, and so, the more people that share, the more streamlined the QA process becomes. Work around streamlining processes and systems is already underway with organisations seeing the benefits and saving time and money.

We believe that the work can go much further. So please get involved, and send us your feedback.

To respond to this consultation go to our website **www.skillsforhealth.org.uk/EQUIPconsultation** If you have any difficulties doing this please contact the QA Team on 0207 716 7024 or email **helen.green@skillsforhealth.org.uk**

[2] ENQA Standards and Guidelines for QA in the European Higher Education Area.

Context

Why a QA framework for Healthcare Education is needed

The framework is a guiding set of principles and requirements for those involved in healthcare education. The intention is to drive improvements in quality of learning, harmonise standards, reduce the amount of paperwork to show compliance and reduce duplication of effort.

The QA framework aims to

- Improve the quality of healthcare education and ultimately improve patient care
- Help decision making for those commissioning and those who wish to participate in healthcare education and training
- Provide accountability for the major sums of public money involved (£650 - £700 million per year in direct costs alone)
- Streamline the system, which has a benefit to all

What are the benefits?

We believe the benefits are far reaching. QA is not simply about assurance. It's about enhancement, because we believe that we can always seek to improve quality standards. A QA framework that is built with consensus from a wide body of stakeholders will:

- Ensure safer, more effective practitioners and services
- Enhance patient and service user experience of healthcare
- Reduce QA burden on providers
- Lead to more responsive and increasingly competence based education programmes

Background

In 2001[3], when the National Audit Office looked at healthcare education in England, it was struck by the variability of costs and contractual arrangements, and so recommended a standardised approach. The Department of Health began negotiating with Higher Education to deliver a standard contract framework and several benchmark prices, underpinned by quality assurance principles. The intention was to move to a fuller national QA framework which would help commissioners by standardising the approach to the quality assurance of the education and training programmes they commissioned, and so improve standards. Skills for Health was asked to develop this framework, in conjunction with partners, by the Department of Health.

There were two strands to Skills for Health's QA work in these early stages. The first was the Major Review of around 90 universities and colleges providing healthcare education. The Department of Health and Skills for Health commissioned the Quality Assurance Agency to conduct the Major Reviews. These provided a consistent baseline of QA across healthcare education and a generally favourable conclusion on quality standards.

[3] National Audit Office March 2001 "Educating and Training the future health professional workforce for England". **www.nao.org.uk/publications/nao_reports/00-01/0001277.pdf**

In parallel to the review work, Skills for Health developed a process of ongoing quality monitoring (OQME) to support continuous improvement and facilitate initial approval of programmes. In 2006 we also developed a set of interim standards, which have since been further refined. Both OQME[4,5] and the Interim Standards were well received and are being increasingly used by commissioners and across HE Institutions, against the background of the recent streamlining of Strategic Health Authorities.

Since this time, we have been working with a wide range of stakeholders to move the QA process on to the next stage – a full QA Framework for healthcare education.

Who has been involved so far?

A number of stakeholders have helped to develop EQuIP proposals:

- Our advisory group Quality Assurance Stakeholders Development Group (QASDeG)
- The Strategic Health Authorities in England
- Higher Education Institutions
- NHS, Independent and Voluntary Sector healthcare providers
- Statutory Regulatory Bodies
- Professional Bodies
- Service Users and Carers
- Healthcare education learners
- Other quality assurance bodies such as the Quality Assurance Agency and Healthcare Commission

Other groups such as the National Workforce Commissioners Group and the QA Partners Forum have been kept fully informed of the work we have been doing. We have included a wider list of those who have attended working groups about the development of this consultation document in Appendix 1.

[4] QAA 2005 QAA Report on the evaluation of Prototypes for Ongoing Quality Monitoring Enhancement and Approval including evaluation of the standards template and evidence base.

[5] Homerton School of Health Studies 2005 Report of the Independent Evaluation of the Prototype Approval and Ongoing Monitoring and Enhancement Processes.

Broad range of scope across programmes

The QA Framework will be credible because it has been designed with broad areas of practice in mind. Whether programmes are for learners in nursing or the allied health professions, midwifery or support work, the idea is that the principles, steps and Requirements around those programmes will be equally meaningful and helpful for those who are responsible for its implementation.

The intention behind EQuIP is that whilst it is being developed at a national level, it will be locally owned and driven. It will be mandatory in respect of certain principles plus (but only where there is a need for comparability across providers) certain specific procedures and templates. Its scope is England only and it refers to non medical healthcare education and NHS funded healthcare education. It is being developed in line with international best practice, namely ENQA's guidelines and standards (European Association for QA in Higher Education)[6].

Since EQuIP covers NHS funded programmes, independent and voluntary parts of the healthcare sector will also be subject to this QA process if they accept NHS funded students.

How did we get to this point?

Earlier this year Skills for Health identified six working groups, named "cluster groups", which included several stakeholders who had helped to design the process. The six cluster groups were each tasked with different guidance. During a residential stakeholder event, representatives from the cluster groups plus some members of QASDeG and the Partners Forum reviewed the draft guidance for consistency and content to help shape the overall QA consultation document. Their comments have helped Skills for Health to produce this document to allow a wider audience, in particular those that might expect to use the framework, to comment on EQuIP, the proposed quality assurance framework for healthcare education.

The consultation process

The purpose of the QA consultation document is to propose different aspects of the framework and discuss what they mean. The Principles in the document are not for discussion as they have been agreed in consultation with stakeholders. They are mandatory to the framework.

After each of the next sections in the document you will find that we have asked some questions. What were previously known as 'interim standards' have been renamed as Requirements and Criteria but stakeholders have requested that few changes be made to them. We would like to know if you agree. The Key Steps show how these Principles will be put into practice when quality assuring healthcare education.

Consultation starts on 28th September 2007 and will finish on 31st December 2007. During this period, we will be holding regional workshops to help explain the QA framework. The consultation will also be part of the focus of our National Conference in November. We invite those who might use the framework, including healthcare practitioners, to come along and participate. We especially want to see those working on the frontline of healthcare so that they have the opportunity to make their voice heard. To have an influence you need to get involved.

[6] International Best practice in the Quality Assurance and Quality Enhancement of healthcare Education and Training" published by Skills for Health Oct 2005. **http://www.skillsforhealth.org.uk/page/quality-assurance**

The QA consultation document and response questionnaire are available online at **www.skillsforhealth.org.uk/EQUIPconsultation.** If you have any difficulty in accessing them, please contact the QA team at Skills for Health. It is important that you read the document fully before completing the response questionnaire.

What happens next?

Skills for Health will consider the responses and explore the issues raised in the feedback. A summary of the responses will be published and recommendations will be made to the Department of Health England in early 2008.

We will also produce support materials for use at a local level. Implementation planning will take place in the spring and summer of 2008. We anticipate that the framework will be introduced during the academic year of 2008/09.

The Principles on which EQuIP is based

The EQuIP model is based on eleven Principles. Seven of these can be found in Schedule 3 of the National Standard Contract framework for MPET funded non-medical education programmes. In addition to these, a further four Principles have been identified as being fundamental to healthcare education.

The Principles themselves are not part of the consultation process but should be clearly seen within the EQuIP model. The eleven principles are:

1) Minimisation of burden on practice placement and education providers, consistent with ensuring quality

   There is no doubt that the use of supporting information technology will provide the greatest reduction of burden from the EQuIP process. However, the burden should be further reduced when other QA processes are used within or replaced by EQuIP. As with all new systems there will be some additional work required in the first year but the experience of previous prototypes suggests this reduces dramatically after that.

2) Emphasis on quality enhancement as much as quality assurance

   Instead of simply ensuring that threshold standards are met it is important that healthcare education is improved when the EQuIP model is used. One of the key steps which will be discussed later is the monitoring of outputs from the QA framework and as part of this we intend to evaluate whether use of the model has brought about enhancement. It is envisaged that enhancement will result from action planning and identification and dissemination of good practice.

3) Parity of practice-based with academic education

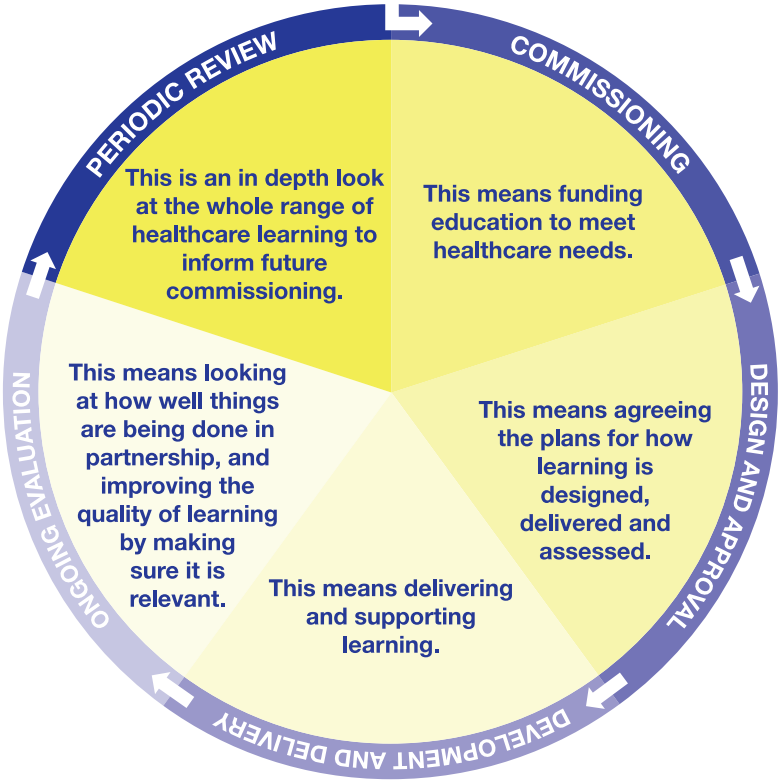
   In courses leading to registration for healthcare professionals up to 50% of learning takes place in the work place. Other education and training programmes, such as those leading to national vocational qualifications, are predominantly based in the practice setting. With this in mind it is important that the quality assurance framework focuses both on learning in practice as well as learning in the classroom setting.

4) Learner and Service User Involvement

   Learners, as those who are the recipients of healthcare education, and service users, whose healthcare is provided by the learners both during and after their programmes of learning, must be involved in all stages of the QA process. This includes past, current and potential users of health services. Skills for Health has worked together with staff, learners and members of the public to develop ‘the circle of influence’ to show how learners and service users can be involved in the process.

The Circle of Influence

You can get involved at any point to help achieve excellence



5) Interprofessional learning

This is defined as when two or more professions learn with, from and about each other to improve collaboration and the quality of care.[7] Healthcare professionals work together with patients and so it is important that they are fully aware not only of each others' roles but also have the knowledge and skills to work effectively as part of an interprofessional team. EQuIP is an interprofessional process and the interprofessional nature of healthcare is represented in all of its parts.

6) Risk based approach to quality

The QA framework is based on the principle of avoiding intervention except where there is a risk to learners' education or to the quality of healthcare provided to service users. The evaluation of risk is part of the self-evaluation process at organisational and contract level and the risk is managed by a variety of means. Where risk is seen to be less, a lighter touch will be applied.

[7]As defined by CAIPE: Centre for the Advancement of Interprofessional Education 2002.
http://www.caipe.org.uk/index.php?&page=mission&nav=1

7) Self evaluation by education and practice placement providers as the starting point

Practice placement providers and learning programme providers are aware of the environments they are working in. Evidence[8,9] suggests that when asked to self-evaluate against standards they tend to be very critical of themselves and carry out the process with rigour. Of course, both internal and external independent verification processes are needed to confirm this rigour but the self-evaluation process is seen to be the most appropriate starting point, and this approach is aligned with other QA frameworks within health and education settings.

8) Use of existing evidence sources and QA processes wherever possible

Part of the process of reducing burden is to avoid re-inventing the wheel. Where reports have been compiled for other purposes and/or organisations these should be used to provide the evidence that EQuIP standards have been met. In the same way it is expected that reports resulting from the EQuIP process will be accepted by other organisations. It should be considered poor practice to write reports or other documents with the sole purpose of showing that the EQuIP Criteria have been met.

9) Exception Reporting

Criteria that are met will not require any additional reporting although the location of the evidence for a met standard will need to be identified. Exception reporting means only reporting against those Criteria which are not met or where good practice is found that should be made more widely known.

10) Clear action plans for remedying shortcomings where they are identified

Where Criteria are not met, action plans should be created to manage risk bringing about improvement for learners and potentially the quality of care received by service users. Where action plans are developed, those using them need to be clear about what their responsibilities are, the deadlines for achieving actions and how often the action plan should be reviewed.

11) Publication of the findings of QA processes

The public and potential learners have a right to know about the quality of provision from healthcare and education providers. It is a requirement that the outcomes of the QA process are published both at local and national level, as appropriate, to help inform public choices.

[8] QAA 2005 QAA Report on the evaluation of Prototypes for Ongoing Quality Monitoring Enhancement and Approval including evaluation of the standards template and evidence base.

[9] Homerton School of Health Studies 2005 Report of the Independent Evaluation of the Prototype Approval and Ongoing Monitoring and Enhancement Processes.

Requirements and Criteria

The Requirements and Criteria for EQuIP have been modified, in consultation with stakeholders, from the document that became known as the Interim Standards[10]. That document had seven Requirements, each of which had several Criteria. These remain, although the wording of them may have been amended slightly. The Criteria are shown underneath each Requirement. As before, these are split into those which practice placement and practice provider organisations should self-evaluate against, those which academic programmes and academic programme provider organisations should self-evaluate against and those that should be evaluated together by practice and programme provider.

The main differences to the Requirements document from the previous Interim Standards document are:

1) The addition of shading to some of the boxes in which Criteria are detailed.

   The shaded boxes identify Criteria which only have to be self-evaluated at organisation level. Learning programme leaders and those responsible for self-evaluation at practice placement level do not have to self-evaluate against these Criteria, as it is likely that the outcome and evidence would be the same for each area within an organisation. Therefore, to reduce burden at learning programme and practice placement level, it has been proposed that these Criteria should only be completed at organisation level.

2) The identification of risk categories against each Criterion.

   These risk categories will be used at organisation level to determine the risk to the organisation when a Criterion is not met. See the section on risk assessment where this will be described in more detail.

3) The templates have been separated from the Requirements and Criteria.

   Because of the addition of more columns and the requirement for a different exception report template at learning programme and practice placement level from that at organisational level, the templates have been identified separately.

   In order to answer the consultation questions that are relevant to the Requirements and Criteria, as written below, you need to read them thoroughly. The Requirements and Criteria can be found in Appendix 2.

Consultation Questions

Are the Requirements and Criteria comprehensive?

Is the language of the Requirements and Criteria appropriate?

Do you agree that the Criteria can be applied to all learners within a learning environment?

Would it be helpful for EQuIP to include suggestions about types of evidence that might be used to meet requirements and Criteria?

[10] Skills for Health 2006 Assuring and Enhancing the Quality of Healthcare Education: Interim Standards

Key Steps

Over the next few pages are the key steps which make up the EQuIP model. These are:

- Self-evaluation
- Action Planning
- Dissemination of Good Practice
- Risk Management
- Independent External Verification and Scrutiny
- Outputs

Key Step Self-Evaluation

1. A self-evaluation against the Requirements and Criteria of EQuIP should take place at the level of the learner experience, i.e. practice placement and classroom level, and at the organisation level.
2. The self-evaluation process against the Requirements and Criteria should be ongoing and be updated continuously. However, a report of the self-evaluation should be made annually within the time frame determined by the commissioner and their partners.
3. The judgement as to whether a Criterion has been met, or not, must be based on evidence. It is recommended that a maximum of two pieces of evidence should be identified and wherever possible the evidence should already exist. New evidence to support the Criteria should rarely be needed.
4. Evidence from learners must be included in the self-evaluation and where appropriate evidence from service users should be used.
5. When undertaking a self-evaluation against the Criteria, the learning of all learners in the environment should be taken into account. Where Criteria are not met or good practice occurs for a specific group of learners, rather than all of them, the students affected should clearly be identified.
6. Reporting should be by exception, i.e. a report should only be made if a Criterion is not met or good practice has been identified.

7. If a group of learners are not mentioned within the exception report then it should be considered that the Requirements and Criteria have been met for those learners.

8. Reporting should be done on a standard exception report template (See section on templates).

9. At organisation level and above, the traffic light system identified in the section on risk later in the document must be used.

10. Each self-evaluation which generates an exception report should also lead to the development of an action plan.

11. At the learner level, all the Criteria except those in the shaded boxes should be used in the self evaluation. At the organisation level, all Criteria should be used.

12. Learner level exception reports and action plans should be sent to a named person at organisational level who will use them as the basis for the organisation's exception report.

13. The organisation must verify the claims and supporting evidence cited in its exception report in line with their usual governance procedures (i.e. the way this is done will be determined by the organisation, but should meet accepted arrangements for corporate governance).

14. Organisational level exception reports along with the action plan should be agreed and signed off at Board level prior to being incorporated by the contract holder into the final exception report to support the learning which has been commissioned.

15. Where the learning in an organisation supports more than one commissioned contract, the same exception report should be sent to each contract holder. However, where there are exceptions which relate to only one of the contract holders this should be clearly stated.

16. The exception report should form the basis of the contract monitoring between the commissioner and the holder of the contract.

Consultation Questions

Do you agree that Criteria can be met or not met with no intermediate category?

Do you agree that all Criteria should be used in all self-evaluations each year?

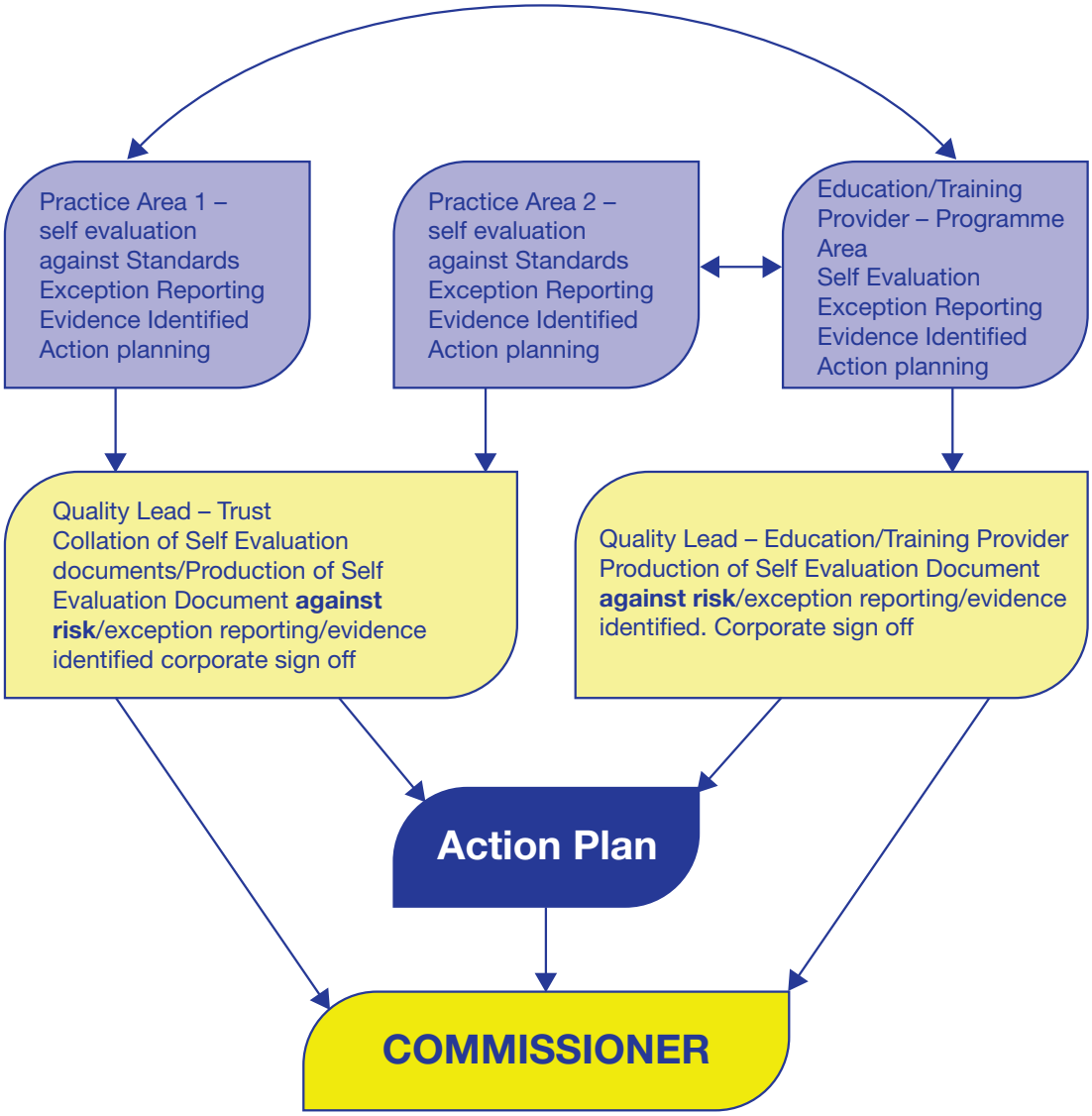
Do you agree that two is the ideal number of pieces of evidence to support meeting a Criterion in a self-evaluation?

In what circumstances might just one, or more than two, pieces of evidence be appropriate?

Do you agree that internal verification should be carried out at organisation level in line with local governance arrangements?

Do you agree that internal verification should be carried out before the exception report and action plan are signed off at Board level?

Flow chart showing Self Evaluation & Action Planning process



Key Step

Action Planning

1. Wherever possible action plans should be planned in partnership within teams and include learners and service users.
2. All exception reports at all levels must generate an action plan to ensure enhancement of learning takes place.
3. Action plans should contain actions around the dissemination of good practice as well as improvement actions where criteria have not been met.
4. Action plans must identify who is responsible for an action, the date an action is to be achieved, the information as to how everyone will know the action has been achieved and, in organisation action plans and above, the information as to whether any identified risk has been managed.
5. The standard action planning template should be used (See section on templates).
6. As with the exception report, action plans should be agreed and signed off by the Board at organisation level.

Key Step

Dissemination of Good Practice

1. How good practice is going to be disseminated must be identified in action plans.
2. Dissemination of good practice must occur at organisational, regional and national levels to bring about enhancement.
3. Dissemination of good practice must be part of each contract monitoring process.

We define good practice as follows:

- Good practice is practice that makes a difference in enhancing healthcare learning, and subsequently, education, student achievement and practice.
- Good practice is time limited: what is good practice now will become routine practice in time.
- Recognition of good practice is subjective: it is what one believes it to be, based on the available evidence.
- Good practice is practice recognised to be above minimum national standards where these exist.
- Normally good practice has the potential to cross professional, occupational, or organisational boundaries.
- Learners should normally endorse good practice.

Consultation Question

Do you agree that the consideration of good practice should be a part of every contract review meeting?

Key Step

Risk Management

1. Consideration of risk takes place within all components of the quality assurance framework.
2. The organisation sign off /adoption of the exception report and related action plans must include a formal risk assessment. Risk assessment is triggered by a Criterion being unmet.
3. The assessment of risk is determined using a 'traffic light' approach developed and modified specifically for the quality assurance framework (see Appendix 3). At any given time, the system will be at green, amber or red.
4. In the event of a Criterion not being met at organisational level, the traffic light position is derived from asking THREE questions:

   i. What sorts of risks are potentially generated by the Criterion not being met?

      To help in determining the type of risks that might occur, each Criterion has been indicatively mapped against its potential risks (see section on Requirements and Criteria). The need to use judgments in determining which risks are relevant is recognised.

   ii. What is the likelihood of the risk occurring?

      A score is attributed to the degree of likelihood ranging from one, when it is unlikely, to five, when it is certain to occur.

   iii. How severe or detrimental would this effect be?

      This relates to the breadth or level of impact, e.g. number of people affected, local/national, etc.

   Questions II and III lead to a calculated score matched to the relevant colour on the traffic light.

5. In the event of a red light or several amber lights being generated, there is a shared responsibility to agree and put in place risk management controls which will:

   a) identify an appropriate form of action

   b) determine who will undertake it and by when

   c) determine what the reduction in risk will be if the plan is successful and

   d) identify appropriate review process and dates and undertake a re-assessment of risk at this point

   Consideration must be given to external independent verification and scrutiny (see key step on external independent verification).

6. Duplication should be minimised. Where risks are identified and actioned in other processes, for example, in professional or regulatory body reviews, this should not be repeated.

Consultation Questions

Do you agree that Criteria should be mapped against the potential risk that might occur if they were unmet?

Are the risk categories identified appropriate?

Do you agree that a traffic light approach to the assessment of risk should be adopted by all in order to be able to make comparisons?

Do you agree that the traffic light risk assessment process should only start at organisation level?

Do you believe that the calculation of risk offers an appropriate balance of risk between ensuring public confidence whilst avoiding undue burden?

Key Step

External Independent Verification and Scrutiny

1. External independent verification and scrutiny must take place at least once every five years. **Normally** this is in the form of a desk based activity **only** but other approaches may be appropriate depending on the degree of risk. The timing of this is determined by the education commissioner in discussion with education partners.

2. A decision to invoke the process of external independent verification at additional times is the responsibility of education commissioners. It is determined by the identification of risk, e.g. in the event of risk assessment being judged as severe, indicated by a red traffic light or a number of amber lights **or** if there is doubt about the rigour of self evaluation (see risk assessment).

3. Additionally, where appropriate, verification on a small sample basis may also check the robustness of evidence linked to standards identified as being met.

4. Verifiers must have a recorded rationale for the sample selected based on the principle that evidence must:

    - Be kept to a minimum and linked to key issues arising from self-evaluation against standards according to perceived risk
    - Include the learner perspective, e.g. evaluation questionnaires, minutes of staff/learner liaison committees, etc.
    - Include priorities identified both by local partners and in the light of national policy concerns
    - Explore the ways in which service user perspectives have influenced learning and teaching
    - Give equal attention to learning in practice and academic settings
    - Explore both good practice and potential shortcomings
    - Be currently and readily available, preferably in electronic format
    - Normally, be from a minimum of two sources
    - Avoid unnecessary repetition and duplication of governance and quality assurance processes by using common/shared evidence sources wherever possible, e.g. evidence for Postgraduate Medical Education and Training Board standards or the Healthcare Commission regulated Standards For Better Health.

5. If the desk based activity indicates inadequate evidence/action plans or self evaluation against standards, thereby generating unreported and additional risks, verifiers may agree with education commissioners to undertake further enquiry. This must be proportional to the risk and in keeping with the principle of minimising of burden.

6. There are a number of graduated ways in which further enquiry may take place (see flowchart diagram). A decision to initiate an external visit is only taken in the event of immediate and severe risk or when all other approaches have been used and have failed to resolve the initial concern.

7. All external independent verification and scrutiny is published in a report which follows an agreed structure, following the timescale shown in the table below.

Process of external independent verification and scrutiny begins	Determined locally in accordance with other planned QA processes
Initial verification (desk based exercise) completed	Within 8 weeks of completion of self evaluation
No further enquiry agreed – final report published	Within a further 8 weeks
Further enquiry agreed and completed	As above (may be extended in exceptional circumstances)
Further enquiry report published	Within a further 8 weeks

8. Where there is a risk to the public and/or breach of legal or regulatory requirements, the verifiers must notify the education commissioner who has a responsibility to inform all relevant bodies so that appropriate action can be taken.

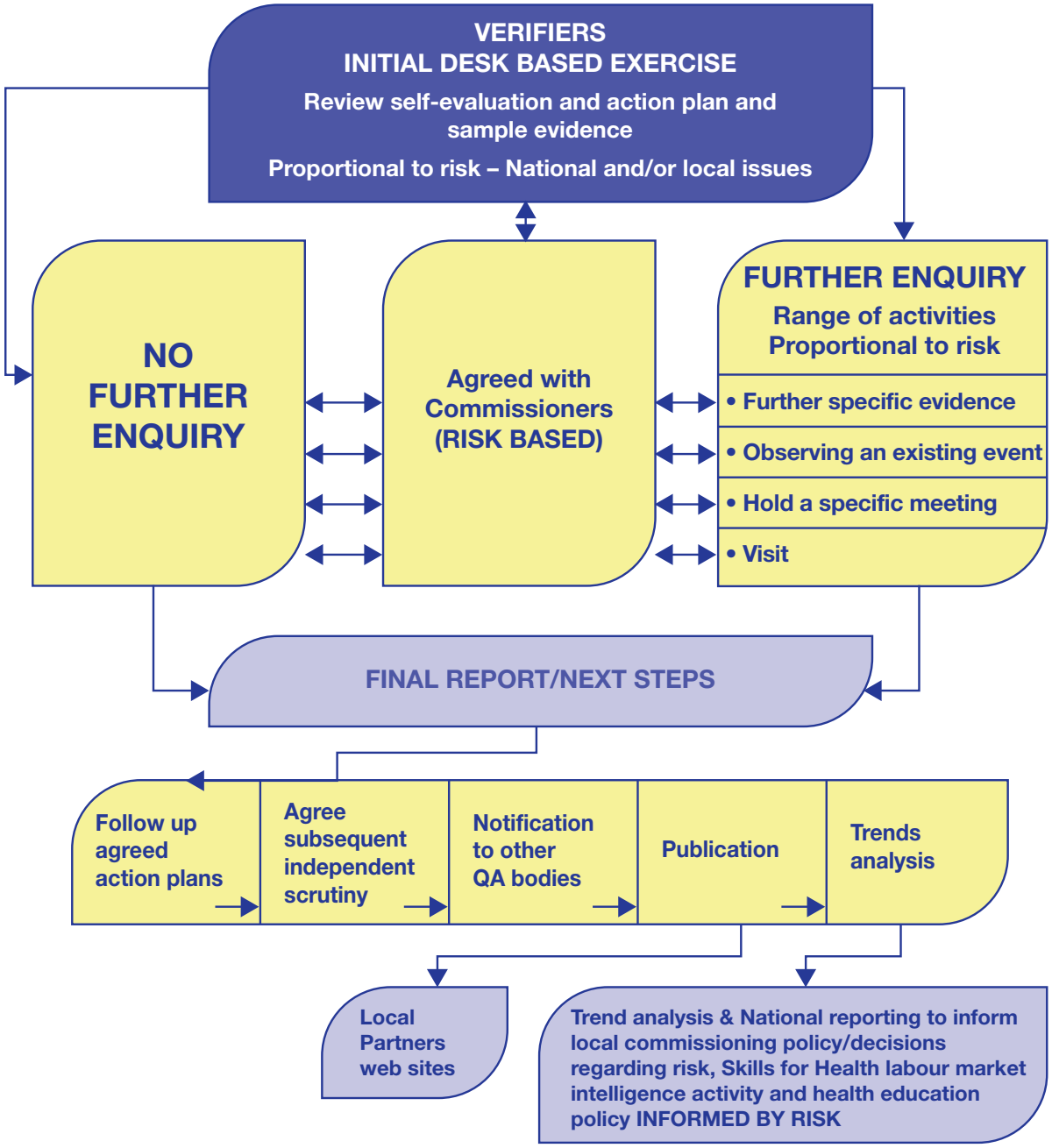
9. The external independent verification and scrutiny process must involve at least two verifiers (one of whom must be a lay verifier).

10. In the event of further enquiry, especially where a profession/discipline specific issue arises, it may be appropriate to involve an additional verifier with the relevant profession/discipline specific expertise.

11. All verifiers must demonstrate competence against Skills for Justice National Occupational standards IPS 1.3, IPS 2.2 and IPS 2.2 and have completed induction training in the specific process in order to confirm they are appropriately trained (these can be accessed at www.ukstandards.org.uk).

12. Commissioners are responsible for ensuring that a record of decision making, the steps taken and outcomes achieved is maintained and held for ten years to inform any subsequent audit activity.

Flow chart showing External Verification process



Consultation Questions

Do you agree that the proposals for independent external verification and scrutiny are sufficient to provide public reassurance that self evaluation is operating effectively?

Do you agree that lay verifiers should be used in external independent verification and scrutiny?

Do you agree that learners should be able to be independent verifiers?

Key Step

Outputs

1. Outputs will be both quantitative (numerical and statistical) and qualitative (descriptive and analytical statements) and must be 'owned' by all contributors.

2. Outputs must be written in plain English, easy to read, as concise as possible and be accessible to a wide audience. To achieve this, outputs should be presented in different ways/modes, e.g. written and audio.

3. Learning providers (academic and practice) must complete a self evaluation against criteria (see template) for each area/unit. These self evaluations will be collated and a single risk based exception report completed for each institution, signed off at Board level.

4. Learning providers in agreement with education commissioners must complete a final action plan (see template).

5. Verifiers, in agreement with education commissioners, must produce a final report written in an agreed format. The verifiers' final report must:

    - Be published locally on education commissioners' and education providers' web sites.
    - Inform decisions about risk and future verification activities.
    - Inform decisions about contract continuity.
    - Be made available to the identified agency to facilitate analysis and publication of national trends.

6. To inform commissioning, including the dissemination of good practice, capacity will need to be determined to identify trends, building on models such as the well-received QAA Major Review summary overviews. Areas of focus will include:

    - The extent to which there has been implementation of agreed policies.
    - Identification of those elements of the quality assurance process that work successfully as well as those that require further refinement.
    - Analysis and commentary upon standards paying equal attention to standards within practice learning environments.
    - The extent and nature of innovation and change.
    - A comparison of the quality of education offered by more than one education provider
    - The extent and nature of innovation and change.
    - A comparison of the quality of education offered by more than one education provider over time.
    - The quality and effectiveness of education provision across the whole sector at any time.
    - The quality and effectiveness of education provision across the whole sector over time.

Consultation Questions

Do you agree that there is a need for the analysis of outcomes and trends to support future policy development and programme commissioning?

Do you agree that outcomes of the self-evaluation and action planning should be published on the websites of local learning providers and programme commissioners?

Templates

Below are the templates to be used with the EQuIP framework. The action plan template is common to everyone who carries out a self-evaluation. However, because of the need to carry out a risk assessment at organisation and contract level, this template is different to the one used at practice placement and learning programme level.

Consultation Question

Do you agree that the templates are:

a) usable?

b) appropriate?

Learner Level Exception Report

Requirement/Criteria	Outcome	Evidence (max 2 pieces per standard) N.B. attach electronically if possible	Issue/need identified where standard not met
	Met ☐ Not Met ☐		
	Met ☐ Not Met ☐		
	Met ☐ Not Met ☐		
	Met ☐ Not Met ☐		
	Met ☐ Not Met ☐		

Risk Based Exception Report

Requirement/ Criteria No.	Issues/need/ good practice	Examples of evidence used to meet Requirements	Date Reviewed: Person Reviewing:	Number of Exception reports viewed	Outcome	Type of Risk identified
			Date:..... Person:.....	Met ☐ Not Met ☐	Red ☐ Amber ☐ Green ☐	....

Skills for Health

Action Plan

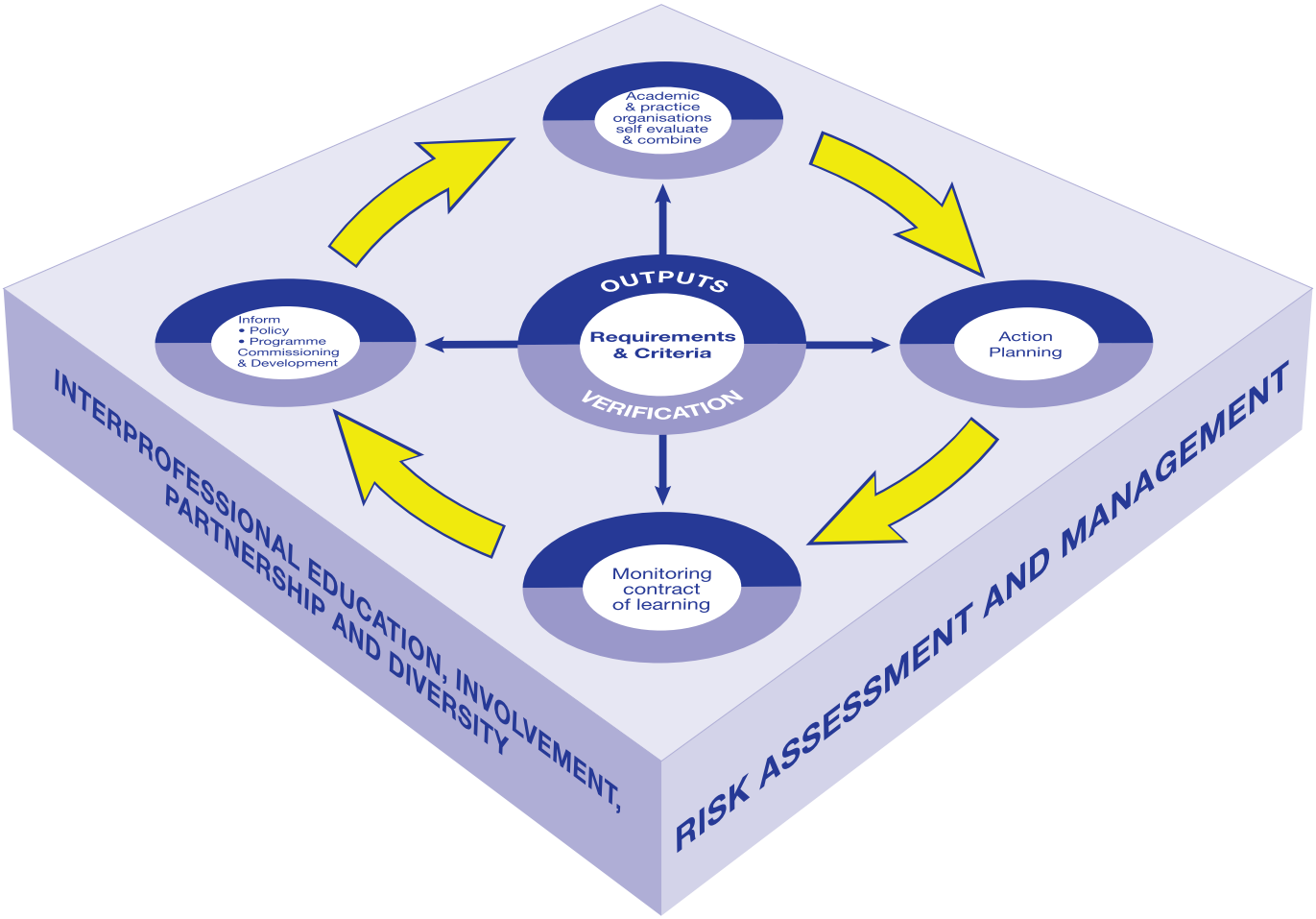
Criteria No.	Issue/Need/ Good Practice	Action	Review date	By whom (Title, not Name)

	Evidence that action has been achieved	Evidence that action has been achieved	Confirmation that action has eradicated risk	Signature of person confirming actions have been met	Date confirmed

An overview of the EQuIP framework

This section of the document is intended to provide a summary of how the EQuIP framework should be used. More detail about the stages of the framework is given within the key steps section of the document. The diagram below represents the framework:

Enhancing Quality in Partnership (EQuIP)



Summary of what the EQuIP process involves

The table below does not contain any new information but attempts to summarise the information discussed in more detail in each of the key steps. See also flowcharts on pages 15 and 22 for illustration of how EQuIP works.

Step	Activity	Lead/who actions
One	Education commissioners and education partners agree the timing of the annual quality assurance review of healthcare education.	Education commissioners in collaboration with education partners
Two	a. On an ongoing basis, learning and practice providers complete self evaluation against the EQuIP criteria that apply to them. These are in the unshaded boxes. The self evaluation is undertaken wherever the learning takes place. b. To fit in with the annual discussion of quality and contract monitoring, mentioned above, an exception report is developed from the self evaluation against criteria. The following is identified and exceptionally recorded: • Those EQuIP criteria which have not been met • Good practice for dissemination • The location of key evidence to support the self evaluation c. Action plans must be developed to identify how good practice will be identified and to address unmet standards.	Practice/placement staff Academic programme staff Practice education leads Academic education lead
Three	a. For the self evaluation at organisational level, two things need to happen: • A self evaluation is undertaken against the criteria in the shaded boxes • A self evaluation is undertaken against the rest of the criteria based on the exception reports and action plans received from within the organisation (as in step two above). b. The organisation undertakes an internal verification of the evidence provided from step two in line with its normal governance activities. c. The collated report is agreed and signed off at Board/Corporate level. The report must include an assessment, using an agreed traffic light approach (see Appendix 3) of the risks that might occur where criteria are unmet and identify how these will be managed within the action plans.	Nominated organisation education lead Nominated organisation education lead/governance lead Chief Executive/ NHS Trust Board/Board of Governors/University senate

Step	Activity	Lead/who actions
Four	a. The contracted education provider produces a final exception report based on the relevant organisational reports, arising from step three. An action plan for the whole education contract is also developed. The final report is required to contain identification of potential risk against the agreed "traffic light" system. b. The final report is submitted to the education commissioner. c. If a significant risk is identified, the commissioner will consider whether or not to initiate external independent scrutiny in a form which is proportional to the identified risks. d. A quality assurance/contract monitoring meeting is held which must also include consideration of good practice. e. The report and action plans are published on local education partner and commissioner websites.	Nominated academic education lead in collaboration with practice education leads Higher education corporate body or nominated chief officer/Vice Chancellor Education commissioner Education commissioner Education commissioner/ practice education lead/ academic education lead
Five	a. External independent scrutiny is required at least once every five years. Normally this scrutiny will be in the form of a desk based review. Scrutiny must consider unmet criteria but may also test met criteria on a sample basis. b. As an outcome of the desk based review, there may be a need for further scrutiny activities depending on the degree of risk identified. c. Education commissioners are ultimately responsible for determining in proportion to risk: • when external independent scrutiny should take place • the number of criteria to be examined • education programmes to be involved and • the learning environments to be included d. Normally the details of the above will be negotiated with education providers. These choices should be informed by any relevant national trends/issues and quality issues arising from other relevant quality processes.	Education commissioner Agency tasked with coordinating verification Education commissioner
Six	The external independent scrutiny report will normally be published within eight weeks.	Education commissioners supported by verifiers
Seven	In the event of a risk to the public, learner and /or a breach of legal or regulatory requirements, the commissioners must notify the appropriate organisation/s responsible for investigating such concerns so they can act on that information.	Education commissioners
Eight	All published reports are analysed to determine national trends and issues. This information is used to provide labour market intelligence and inform both local and national healthcare and education policy.	To be determined by stakeholders

Overview Framework Questions

Having read the whole document there are a few questions we would like to ask you about the EQuIP framework:

- Does the proposed approach support education delivered through partnership?
- Does the proposed approach help to avoid undue duplication of QA processes?
- Do you agree that the proposed approach supports quality enhancement as well as quality assurance?
- Do you agree that the proposed approach has a logical order to it?
- Does the proposed approach reflect the eleven principles outlined on page?
- What type of support materials will be needed for EQuIP to be put into use?
- Do you agree that few changes are made to the requirements?
- Did you attend one of Skills for Health EQuIP consultation events?
- If so, did you find that the event helped your understanding of the framework?

As this work is being carried out on behalf of the Department of Health (DH) in England, the consultation process follows Department for Enterprise and Regulatory Reform guidelines which include a requirement for a Regulatory Impact Assessment of the QA framework on those organisations that might be affected by it. You will find the Partial Regulatory Impact Assessment, which is a requirement at this stage, in Appendix 4. A full Regulatory Impact Assessment will be included with the recommendations sent to DH after the consultation is complete.

Thank you for reading this document. To respond to all the consultation questions please go to **www.skillsforhealth.org.uk/EQUIPconsultation** and click on the consultation response button. If for any reason you have difficulty doing this please contact the QA Team on 0207 716 7024.

If you would like to attend a consultation workshop please email **qaconferencebookings@skillsforhealth.org.uk** stating which venue you wish to attend and whether you would like a morning or afternoon session. The workshops are being held at:

23 October	Liverpool	Foresight Centre
7 November	Bristol	Holland House Hotel
8 November	Birmingham	Aston Business School
15 November	Peterborough	Holiday Inn
28 November	London	Westminster Central Halls
13 December	Newcastle	Newcastle United Football Club

Thank you for your participation.

Consultation Questions

Requirements and Criteria (Page 12)

Are the Requirements and Criteria comprehensive?

Is the language of the Requirements and Criteria appropriate?

Do you agree that the Criteria can be applied to all learners within a learning environment?

Would it be helpful for EQuIP to include suggestions about types of evidence that might be used to meet Requirements and Criteria?

Self-Evaluation (Page 13)

Do you agree that Criteria can be met or not met with no intermediate category?

Do you agree that all Criteria should be used in self-evaluation by all areas each year?

Do you agree that two is the ideal number of pieces of evidence to support meeting a Criterion in a self-evaluation?

In what circumstances might just one, or more than two, pieces of evidence be appropriate?

Do you agree that internal verification should be carried out at organisation level in line with local governance arrangements?

Do you agree that internal verification should be carried out before the exception report and action plan are signed off at Board level?

Dissemination of Good Practice (Page 17)

Do you agree that the consideration of good practice should be a part of every contract review meeting?

Risk Management (Page 18)

Do you agree that Criteria should be mapped against the potential risk that might occur if they were unmet?

Are the risk categories identified appropriate?

Do you agree that a traffic light approach to the assessment of risk should be adopted by all in order to be able to make comparisons?

Do you agree that the traffic light risk assessment process should only start at organisation level?

Do you believe that the calculation of risk offers an appropriate balance between ensuring public confidence whilst avoiding undue burden?

Independent External Verification and Scrutiny (Page 20)

Do you agree that the proposals for independent external verification and scrutiny are sufficient to provide public reassurance that self evaluation is operating effectively?

Do you agree that lay verifiers should be used in external independent verification and scrutiny?

Do you agree that learners should be able to be independent verifiers?

Outputs (Page 24)

Do you agree that there is a need for the analysis of outcomes and trends to support future policy development and programme commissioning?

Do you agree that outcomes of the self-evaluation and action planning should be published on the websites of local learning providers and programme commissioners?

Templates (Page 25)

Do you agree that the templates are:

a) usable

b) appropriate

Overview Framework Questions (Page 33)

Does the proposed approach support education delivered through partnership?

Does the proposed approach help to avoid undue duplication of QA processes?

Do you agree that the proposed approach supports quality enhancement as well as quality assurance?

Do you agree that the proposed approach has a logical order to it?

Does the proposed approach reflect the eleven principles outlined on pages 9-11

What type of support materials will be needed for EQuIP to be put into use?

Do you agree that few changes are made to the Requirements?

Did you attend one of Skills for Health EQuIP consultation events?

If so, did you find that the event helped your understanding of the framework?

Glossary

Academic Education Provider
The university or college contractually responsible for delivering healthcare programmes and, where appropriate, meeting Regulatory Body requirements

CNST
The NHS Litigation Authority's Clinical Negligence Scheme for trusts. CNST handles all clinical negligence claims against member NHS bodies. Cost of membership to each organisation is influenced by attainment of CNST Risk Management Standards.

Commissioner
The organisation responsible for deciding what learning is needed and then purchasing the appropriate education. For the standard contract framework, this relates to pre and post registration for most Allied Health professionals, Nurses, Midwives and Health Visitors.

Criteria
Criteria are ways of demonstrating compliance with, and performance relevant to, the requirement. Criteria establish specific, objective expectations drawing on suggested evidence and/or locally agreed evidence.

Evidence
Information in a variety of formats which demonstrates the academic and practice education providers' attainment of the Criteria. Evidence should be agreed locally between the commissioner and academic and practice education providers. Both partners should agree shared evidence. Evidence should where possible draw on that which is collected/generated to meet other quality assurance and/or inspection processes. Evidence does not need to be provided at the point of self evaluation.

Exception
Academic or practice education that does not meet or exceeds the criteria. Exceptions may occur at any time, not just at the point of self-evaluation. Exceptions can also include significant changes in provision such as reorganisation of departments or services. Exceptions may be highlighted through other QA processes e.g. Healthcare Commission reviews.

External Independent Scrutiny
The process requested by a commissioner to ensure that self evaluation has been undertaken rigorously and has used appropriate sources of evidence. This process involves the use of verifiers who have no connection with the healthcare learning that is being scrutinised.

FHEQ
The framework for higher education qualifications, in this context the framework refers to that developed by the QAA for England, Wales and Northern Ireland.

Internal Verification
The process undertaken within an organisation to confirm that self evaluation processes have been carried out rigorously and are based on appropriate sources of evidence. The way this is done is left to the organisation, but should be in line with other verification processes.

Learner Level
This refers to the level in the organisation that the student is working and learning. In an academic organisation this is likely to be the classroom. In a practice organization this is likely to be the practice placement

MPET
Multi-professional education and training levy. The funding stream allocated from the Department of Health to commissioners to purchase education and training for allied health professionals, nurses, midwives and doctors.

NMET
The Non Medical Education and Training part of the MPET levy.

OQME
Ongoing Quality Monitoring & Enhancement. This is the unconfirmed element of the PQAF which introduced the concepts of self evaluation and enhancement.

PQAF
Partnership Quality Assurance Framework which is the QA framework published in 2004 by Skills for Health of which Major Review was a significant part.

Practice Education Provider
The organisation that is responsible for supporting the attainment of the programme outcomes through the provision of practice learning experiences. Practice education providers may be organisations within the NHS or in the independent, voluntary, social care and education sectors.

Practice Learning Environment
The practice learning environment is the geographical location in which active supervised learning takes place. The learning is usually clinical in nature and should be managed and supervised by either a specialist within the subject area and/or a registered healthcare professional. The practice learning environment provides placements for student learning, often to more than one 'type' of student. The Practice Learning Environment is not confined to 'traditional' healthcare settings.

Practice Supervisor/mentor
The named, suitably experienced and qualified clinician allocated responsibility for supporting and managing the student/learner in the practice setting environment in line with the student/learner and programme outcomes. The accountable clinician responsible for assessing the practice performance of a student/learner.

Professional Bodies
Professional bodies are actively involved in the quality assurance of professional specific education and learning. Examples of these include

- College of Radiographers
- Chartered Society of Physiotherapists
- British Psychological Society

QAA
The Quality Assurance Agency for Higher Education

Requirement
A broad statement describing the total outputs achieved by meeting the specified Criteria, for the purpose of the quality assurance process. For practice education providers, Requirements are related to core standards within Standards for Better Health.

Shared
Criteria support attainment of the overarching Requirements and require all partners to contribute. Commissioners should name a lead partner for coordinating the actions required to meet the Criteria. This should not imply that the academic education provider is by default the named lead.

Statutory Regulatory Bodies
In the context of these standards, these are the organisations with a statutory responsibility for safeguarding the public through regulation of either services, organisation or specific groups delivering healthcare in a range of settings and are primarily but not exclusively the:

HCC – Healthcare Commission
HPC – Health Professions Council
NMC – Nursing and Midwifery Council
GMC – General Medical Council

Appendix 1

Organisations and individuals involved in consultation events:

QASDeG Members	
Sarah Bazin	Heart of England NHS Foundation Trust
Helen Evered	University of Portsmouth
Janet Hargreaves	University of Huddersfield
Frances Harkins	Department of Health
Elaine Harries Jenkins	Quality Assurance Agency
Sue Harris	NHS West Midlands
Val Health	University of Plymouth
Sue Hooton	5 Boroughs Partnership NHS Trust
Lucy Horder	The British Psychological Society
Dorothy Kennerley	University Campus, Suffolk
Victoria MacMillan	Central Manchester & Manchester Children's University Hospitals NHS Trust
Joe McArdle	NHS North West
Penny McCracken	Foundation Degree Forward
Ian McGonagal	Centre for Clinical Excellence and Innovation
Audrey Paterson	The Society of Radiographers
Anne Peat	University of Sheffield
Neil Prime	Healthcare Commission
Rob Smith	NHS London
Gail Thomas	University of Brighton
Roger Thompson	Nursing and Midwifery Council
Alan Weale	University of Wolverhampton

Partners Forum Members	
Helen Bowles	GuildHE
Peter Butler	The General Dental Council
Tony Butterworth	NHS Employers
Kathy George	The Nursing and Midwifery Council
Frances Harkins	Department of Health
Elaine Harries Jenkins	Quality Assurance Agency
Kathy Hinchliff	National Commissioners Group
Lucy Horder	British Psychological Society
Graham Ixer	General Social Care Council
Eve Jagusiewicz	Universities UK
Patricia LeRolland	Postgraduate Medical Education and Training Board

Partners Forum Members - continued	
John McLaughlin	Department of Innovation, Universities and Science
Chris Middleton	Independent Healthcare Forum
Georgie Pomfrey	Department of Innovation, Universities and Science
Elisa Pruvost	Council for Regulatory Excellence
Deborah Ribchester	Association of Colleges
Mark Rogers	Healthcare Commission
Julia Tabraham	The Carers Federation Ltd
Rachel Tripp	The Health Professions Council
Paul Turner	Council of Deans of Health
Kirsty White	The General Medical Council

Programme Commissioning and Development Group Members	
Sarah Bazin	QASDeG & Heart of England NHS Foundation Trust
Paul Blakeman	Skills for Health
Clare Chivers	NHS South West
Rob Cox	Learner (Matthew Boulton College of Further and Higher Education)
Wayne Drakes	Service User (University of Central England) Public and Learner Advisory Group
Stephanie Fade	NHS London
Johanna Finn	Service User
Kath Hinchcliff	NHS Yorkshire and Humberside
Dorothy Kennerley	QASDeG and University Campus Suffolk
Bryony Lamb	Centre for the Advancement of Interprofessional Education
Roger Minett	Matthew Boulton College of Further and Higher Education
Pauline Pearsall	Medacs Nursing
Betty Perry	Learner (University of Central England)
Maggie Stiles	Oxford City PCT
Roger Thomson	Nursing and Midwifery Council
Angelo Varetto	Skills for Health
Donna Wareham	University of Central England & Public and Learner Advisory Group

Self-evaluation, Action Planning & Dissemination of Good Practice	
Helen Bulpitt	Higher Education Academy
Ian Clarke	NHS East Midlands
Karen Couldridge	Learner (University of York) Public and Learner Advisory Group

Self-evaluation, Action Planning & Dissemination of Good Practice - continued	
Tess Green	Skills for Health
Janet Hargreaves	QASDeG & University of Huddersfield
Barrie Holt	Service User (University of Huddersfield)
Janet Kruger	Learner (University of Huddersfield)
Sonya Murray	Worcestershire Acute Hospitals NHS Trust
Sally Taber	Independent Healthcare Forum
Shelagh Titchener	Canterbury Christ Church University
Alan Weale	QASDeG & Wolverhampton University
Judi Wren	NHS East of England

Engagement & Diversity Group Members	
Jill Brunt	Widening Participation Strategy Group
Jim Connolly	NHS East Midlands
Karen Couldridge	Learner (University of York) Public and Learner Advisory Group
Wayne Drakes	Service User (University of Central England) Public and Learner Advisory Group
Chris Essen	University of Leeds & Public and Learner Advisory Group
Helen Evered	QASDeG & University of Portsmouth
Audrey Harmer	Skills for Care
Chris Joseph	NHS East Midlands & Public and Learner Advisory Group
John Lahiff	Coventry University
Shun Marawli	Learner (Coventry University)
Graham Maton	Service user (Coventry University)
Giles Matsell	Nottingham Primary Care Trust
Ian McGonagol	QASDeG & Centre for Clinical & Academic Workforce Innovation
Alan Meadows	Service User & Public & Learner Advisory Group
Mervyn Morris	Service User Organisation CHANGE
Helen Pearson	Learner (Southampton University)
Betty Perry	Learner (University of Central England)
Bob Sang	London South Bank University
Donna Wareham	University of Central England & Public and Learner Advisory Group
Alexina Weston	Essex Rivers NHS Trust

Outputs Group Members	
Heather Burkinshaw	Leeds PCT
Helen Evered	QASDeG & University of Portsmouth

Outputs Group Members - continued	
Johanna Finn	Service User
Tony Griffin	Further Education
Jenny Harvey	Learner
Val Heath	University of Plymouth
Kerry Hemsworth	NHS North West
Sue Hooton	QASDeG & 5 Boroughs Partnership NHS Trust
Mary Lovegrove	London South Bank University
Chris Middleton	Independent Healthcare Forum
Elisa Pruvost	Council for Regulatory Excellence

Independent External Verification Group Members	
Elaine Harries Jenkins	QASDeG & Quality Assurance Agency
Kerry Hemsworth	NHS North West
Janine Ling	NHS Education South Central
Victoria MacMillan	NHS North West
Ian McGonagal	QASDeG & Centre for Clinical & Academic Workforce Innovation
Susan O'Halloran	Association of Colleges
Anne Peat	QASDeG & University of Sheffield
Peter Purkiss	Service User
Jonathan Spackman	Learner

Retreat Participants	
Mirren Baglin	National Practice Learning Partnership
Heather Burkinshaw	Leeds PCT
Karen Couldridge	Learner (University of York) & Public & Learner Advisory Group
Johann Finn	Service User
Kate Gregory	General Medical Council
Nikki Hale	Royal College of Nursing/Skills for Health
Elaine Harries Jenkins	QASDeG & Quality Assurance Agency
Jenny Harvey	Learner
Val Heath	University of Plymouth
Marion Helme	Higher Education Academy
Kerry Hemsworth	NHS North West
Chris Holroyd	NHS Yorkshire & Humberside
Lucy Horder	QASDeG & British Psychological Society
Dorothy Kennerley	QASDeG & University Campus Suffolk
Bryony Lamb	The Centre for the Advancement of Interprofessional Education

Retreat Participants - continued	
Janine Ling	NHS Education South Central
Victoria MacMillan	NHS North West
Ian McGonagal	QASDeG & Centre for Clinical & Academic Innovation
John McLaughlin	Department of Innovation, Universities & Science
Alan Meadows	Service User & Public and Learner Advisory Group
Chris Middleton	Independent Healthcare Forum
Roger Minett	Matthew Boulton College of Further and Higher Education
Mervyn Morris	Service User Organisation CHANGE
Unnati Negi	General Dental Council
Helen Pearson	Learner (University of Southampton)
Maggie Stiles	Oxford City PCT
Chris Taylor	Higher Education Funding Council for England
Paul Turner	Council of Deans of Health
Donna Wareham	University of Central England & Public & Learner Advisory Group
Alan Weale	QASDeG & University of Wolverhampton
Alexina Weston	QASDeG & Essex Rivers NHS Trust
David Williams	Royal Pharmaceutical Society of Great Britain
Judi Wren	NHS East of England
Glenise Yellott	National Practice Learning Partnership

Appendix 2

Requirement 1

Values

Partners can demonstrate a commitment to the safety of patients, service users, carers, staff and students and a commitment to promoting diversity, inclusion and equality of opportunity for all.

Shared

Criteria	Strategies are implemented & regularly evaluated for:	Indicative Areas of Risk
S1	Equal Opportunities, supporting diversity & inclusion	Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation
S2	Patient/service user consent in learning (includes being cared for by a student, contributing to formal teaching etc)	Learner not meeting learning outcomes/competences Poor quality service user experience Litigation

S3	Patient/service user involvement in education & service provision	Learner not meeting learning outcomes/competences Poor quality service user experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
S4	Preventing harassment/oppressive behaviour	Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Organisational underperformance or performance decline Litigation
S5	Confidentiality of patient and individual information	Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Litigation
S6	Confidential concerns/whistle blowing	Poor quality service user outcomes Litigation

Academic Education Providers

A	Academic Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
A1	Ensuring that learning resources and programme design meet the diverse learning needs of actual and potential learners	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Unduly high level of attrition Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A2	Ensuring that students/learners are adequately and safely prepared for academic and practice based learning	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation Poor value for money Commissioners being unable to meet workforce needs or targets

A3	Managing risk to students/learners on campus and supporting risk assessment and management approaches in the practice learning environment	Unduly high level of attrition Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Organisational underperformance or performance decline Litigation Commissioners being unable to meet workforce needs or targets

Practice Education Providers

P	Practice Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
P1	Maintaining patient/service user safety at all times	Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Failure to deliver agreed service Litigation
P2	Maintaining staff and student/learner safety at all times. (Includes mandatory training.)	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Inappropriate workforce - not fit for purpose Litigation

P3	Supporting practice and academic staff to work in partnership at all times	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
P4	Managing risk to/of students/learners in the practice learning environment	Learner not meeting learning outcomes/competences Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Organisational underperformance or performance decline Litigation

Requirement 2

Evaluating, Maintaining & Improving Quality

Partners can demonstrate a commitment to the safety of patients, service users, carers, staff and students and a commitment to promoting diversity, inclusion and equality of opportunity for all.

Shared

Criteria	Partners' strategies for QA ensure that:	Indicative Areas of Risk
S7	QA processes are developed and implemented by partners at local and organisational level	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
S8	QA processes and outcomes are shared with all institutions accessing practice learning environments (e.g. placement audit)	Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

S9	Action plans are implemented, monitored and evaluated at local (programme/unit) level and organisational level	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Poor value for money Commissioners being unable to meet workforce needs or targets
S10	The views of students/learners are actively included in QA processes	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Academic Education Providers

A	Academic Education Providers' strategies for QA of programmes ensures that:	Indicative Areas of Risk
A4	Processes are implemented to meet institutional, QAA and Regulator requirements. (Should include processes for managing students' complaints.)	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A5	The views and evaluations of students/learners, employers and commissioners are actively included in QA processes	Learner not meeting learning outcomes/competences Poor quality service user experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

A6	Academic education providers are working towards the active involvement of service users and carers in QA processes	Learner not engaged/responding positively to the learning experience Poor quality service user experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Poor value for money Commissioners being unable to meet workforce needs or targets
A7	Subject and programme annual reports are available to commissioners and partners	Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A8	Commissioners and Regulators are informed of exceptions identified by institutional processes QA processes at subject and programme level	Learner not meeting learning outcomes/competences Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

A9	The outcomes of QA processes are demonstrated by the development of programmes to meet stakeholders' needs	Learner not meeting learning outcomes/competences Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Practice Education Providers

P	Practice Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
P5	Ensuring QA processes are in place in practice and are shared with all academic education providers	Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
P6	Enabling senior practice staff to contribute to QA processes, e.g. placement audit, action planning and evaluation	Learner not meeting learning outcomes/competences Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

P7	Ensuring that student/learner evaluations are used to improve practice and learning at local and organisational level	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Requirement 3

Resources, Management & Governance

Partners can demonstrate that programmes are effectively planned and managed with adequate resources, so that learning is maximised, governance arrangements are transparent and the integrity of learning and resources is established and maintained.

Shared

S	Strategies are implemented & regularly evaluated for:	Indicative Areas of Risk
S11	Ensuring that partners communicate with each other and to commissioners changes to strategic and operational plans that may affect the provision of academic or practice education	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
S12	Demonstrating that programmes are planned, commissioned and developed in line with local and national workforce requirements, and are responsive to local and national health and social care policy	Learner not meeting learning outcomes/competences Poor quality service user experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

S13	The development of practice learning placements so that quality and volume requirements of commissioned programmes are met, in line with Regulatory Body standards	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
S14	Recording and maintaining current and approved practice learning placements, practice supervisors and/or mentors in line with Regulatory Body requirements	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

Academic Education Providers

A	Academic Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
A10	Ensuring that the faculty and/or commissioned programmes have a key position in the Institution's strategic vision and business plan and that this is made available to commissioners and partners	Poor quality service user experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A11	Ensuring that commissioned programmes have robust and secure governance arrangements	Failure to deliver agreed service Organisational underperformance or performance decline Litigation Poor value for money Commissioners being unable to meet workforce needs or targets
A12	Ensuring that each programme has appropriate and effective administrative, management and teaching resource	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Organisational underperformance or performance decline Poor value for money Commissioners being unable to meet workforce needs or targets

A13	Ensuring that there is adequate and accessible provision of physical resources to support students/learners and meet programme outcomes	Learner not meeting learning outcomes/competence Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Organisational underperformance or performance decline Poor value for money Commissioners being unable to meet workforce needs or targets
A14	Identifying and approving appropriate practice learning placements that meet the needs of • students/learners • programme outcomes • Regulatory Body requirements	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

A15	Meeting commissioners' requirements with regards to the National Minimum Data Set of the National Standard Contract Framework, including data on progression and attrition	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Practice Education Providers

P	Practice Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
P8	Ensuring that the corporate management and governance of practice based education is formalised within organisational structures	Learner not meeting learning outcomes/competences Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

P9	Indemnifying, as employees, whilst in the practice learning environment: • students/learners • teachers/lecturers of partner academic education providers	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Litigation
P10	Providing adequate physical resources to support students/learners including access to IT facilities	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Organisational underperformance or performance decline Poor value for money Commissioners being unable to meet workforce needs or targets
P11	Providing appropriate supervision of student/learners in line with Regulatory Body requirements	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Litigation Inappropriate workforce - not fit for purpose

Requirement 4

Teaching & Learning

Partners can demonstrate that curricula, supporting processes and learning, assessment and teaching methods.

- are patient/service user focused
- embed the approaches of interprofessional learning appropriately
- meet the needs of students/learners, regulatory bodies, academic organisations, employers and commissioners.

Shared

S	Partners can demonstrate that:	Indicative Areas of Risk
S15	They work with commissioners to implement clear structures that enable all partners to contribute effectively to the development and delivery of programmes	Learner not meeting learning outcomes/competences Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
S16	There are shared strategies for the implementation of interprofessional learning in both academic and practice education environments	Learner not meeting learning outcomes/competences Poor quality service user outcomes Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

S17	All academic and practice education staff involved in delivering a programme understand the curriculum and learning outcomes and are updated effectively	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Academic Education Providers

A	Academic Education Providers implement & regularly evaluate strategies:	Indicative Areas of Risk
A16	To ensure that curricula, including learning outcomes, are developed in partnership with: • Employers • Practice Education Providers • Current & past students/learners • Service users	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Poor quality service user experience Poor quality service user outcomes Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

A17	To demonstrate that curricula meet the requirements of: • Regulatory bodies • Profession specific regulatory bodies • Framework for higher education qualifications (FHEQ) • Subject benchmarks • QAA Code of Practice • National Occupational Standards • National Workforce Competences • Locally agreed requirements • Collaborative health and social care practice	Learner not meeting learning outcomes/competences Poor quality service user experience Poor quality service user outcomes Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A18	To demonstrate that the programme curriculum ensures fitness for practice, purpose and award	Learner not meeting learning outcomes/competences Poor quality service user experience Poor quality service user outcomes Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
A19	To ensure that curricula reflect the interprofessional nature of health and social care	Learner not meeting learning outcomes/competences Poor quality service user experience Poor quality service user outcomes Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

Practice Education Provider

P	Practice Education Providers implement & regularly evaluate strategies for:	Indicative Areas of Risk
P12	Enabling appropriate practice staff to work with academic education providers to develop relevant curricula and learning outcomes	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Poor quality service user experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
P13	Developing practice learning opportunities that are appropriate to the student/learner's level and programme learning outcomes	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
P14	Sharing interprofessional learning opportunities in practice learning environments with learners from all academic education partners	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Poor quality service user experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

Requirement 5

Student/Learner Selection, Progression & Achievement

Partners can demonstrate that students are selected appropriately and the programme of learning supports student selection, progression and achievement to meet the needs of commissioners, employers and individual funders and that outputs demonstrate fitness for purpose, practice and award.

Shared

S	Partners put in place and regularly evaluate strategies and procedures to ensure:	Indicative Areas of Risk
S18	Recruitment and selection to programmes are fair and equitable and meet HR best practice	Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation Poor value for money Commissioners being unable to meet workforce needs or targets
S19	Subject specific academic and practice staff select students/learners	Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

S20	Student/learners receive induction to: • The programme • The academic education provider • The practice education provider(s)	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff)
S21	There are agreed approaches to supporting students/learners to obtain employment on completion of programmes that lead to registration	Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
S22	Programme recruitment, progression, achievement and attrition are managed through shared action plans that address academic and practice education related attrition	Learner not meeting learning outcomes/competence Learner not engaged/responding positively to the learning experience Unduly high level of attrition Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Academic Education Provider

A	Academic Education Providers implement and evaluate strategies to ensure:	Indicative Areas of Risk
A20	Programmes have a clear information and marketing plan to maximise appropriate recruitment	Unduly high level of attrition Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money
A21	Selection criteria meet Regulatory Body requirements, address widening participation requirements and meet statutory healthcare employment requirements. (To be specified by the commissioner in line with current policy and legislation.)	Unduly high level of attrition Learner not engaged/responding positively to the learning experience Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation Poor value for money Commissioners being unable to meet workforce needs or targets
A22	Clear processes are in place to manage student/learner performance and progression and that these are actively shared with practice education providers	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

Practice Education Provider

P	Practice Education Providers put in place strategies to:	Indicative Areas of Risk
P15	Support practice supervisors/mentors manage the student/learner's performance and progression whilst in the practice learning environment (cross-reference A24). This includes poor performance and non-attainment of competence.	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Poor quality service user experience Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets
P16	Ensure that sufficient, appropriately trained and experienced practice supervisors/mentors are available to support the management of student/learner performance and achievement of professional and interprofessional learning	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Poor quality service user outcomes Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

Requirement 6

Student/Learner Support

Partners can demonstrate that support provided meets the needs of the student/learner in all settings and that the student's safety is maintained at all times

Shared

S	Partners develop and implement strategies to:	Indicative Areas of Risk
S23	Ensure that appropriate student/learner information is shared to provide a safe and effective learning experience at all times. (Details to be agreed by the commissioner but could include information on performance or specific learning needs, etc.)	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation Poor value for money Commissioners being unable to meet workforce needs or targets

Academic Education Provider

A	The Academic Education Provider has processes in place to:	Indicative Areas of Risk
A23	Enable students/learners to have access to the facilities and resources available to the wider student/learner body	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Poor value for money
A24	Implement appropriate arrangements to prepare and update practice supervisors/mentors	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
A25	Provide agreed academic education support in the practice learning environment	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Poor value for money

A26	Ensure that students/learners manage their own learning experience through effective academic support and have attained appropriate skills prior to their practice learning experience	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Poor quality service user experience Inappropriate workforce - not fit for purpose

Practice Education Provider

P	Practice Education Providers put in place strategies to provide:	Indicative Areas of Risk
P17	Students/learners with a named practice supervisor/mentor who meets Regulatory Body requirements	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Failure to deliver agreed service
P18	Students/learners with supervision and assessment in line with best practice to include: • Agreement of a learning contract • Agreed timely schedule of appointments to review progress and achievement • Written constructive feedback	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Poor quality service user outcomes Poor value for money

Requirement 7

Assessment

Partners can demonstrate that academic and practice assessment procedures are transparent, equitable and reliable so that successful completion of a programme ensures fitness for

- purpose in line with national workforce competence
- practice in line with regulatory bodies
- award in line with requirements of awarding bodies.

Shared

S	Partners implement strategies to demonstrate that:	Indicative Areas of Risk
S24	Assessment processes are developed in partnership and shared with all organisations	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
S25	Assessment strategies ensure that academic and practice learning are relevant to meeting the programme outcomes and promote student/learner progression and achievement	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose Poor value for money Commissioners being unable to meet workforce needs or targets

S26	Students are actively involved in self and peer assessment in both academic and practice settings	Learner not meeting learning outcomes/competences Unduly high level of attrition Learner not engaged/responding positively to the learning experience Inappropriate workforce - not fit for purpose

Academic Education Providers

A	The Academic Education Provider has processes in place to:	Indicative Areas of Risk
A27	Ensure that assessment approaches and schedules address the requirements of: • Regulatory Bodies • QAA • FHEQ • Institutional regulations	Learner not meeting learning outcomes/competences Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Litigation Commissioners being unable to meet workforce needs or targets
A28	Show that assessment processes follow logical progression to support the achievement of competence	Learner not meeting learning outcomes/competences Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets

Practice Education Providers

P	Practice Education Providers ensure that approaches to assessment are:	Indicative Areas of Risk
P19	Consistent and equitable for all students/learners	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Failure to deliver agreed service Litigation Commissioners being unable to meet workforce needs or targets
P20	Regularly monitored and evaluated	Learner not meeting learning outcomes/competences Failure to deliver agreed service Organisational underperformance or performance decline Inappropriate workforce - not fit for purpose Commissioners being unable to meet workforce needs or targets
P21	Integrated within the delivery of services in the practice learning environment	Learner not meeting learning outcomes/competences Learner not engaged/responding positively to the learning experience Physical or mental harm to individuals (service users, learners, staff) Poor quality service user experience Failure to deliver agreed service Organisational underperformance or performance decline Commissioners being unable to meet workforce needs or targets

Appendix 3

Carrying out a risk assessment - step by step illustration

Step	Action
One	Identification of an unmet Criterion
Two	Consider the type of risk (risks) that can arise from the Criterion being unmet. Refer to the indicative mapping of Criteria to the types of risk within the quality assurance documentation
Three	For each of the risks identified from step two consider: A. What is the likelihood of occurrence? Attribute a score to the likelihood with 1 being rare to 5 being certain to occur B If it occurred, how severe would the impact of this be? Attribute a score to the severity of impact with 1 being judged as a minor impact and 5 being unacceptable
Four	To obtain a total risk score for each risk considered in step three, multiply the score awarded for the likelihood of occurrence (Three A) by the score for the severity (Three B)
Five	Match the total risk score obtained (for each identified risk) to the colour indicator chart (healthcare education quality assurance traffic light approach) Hence a total risk score of between: 1-8 generates a low risk or Green traffic light 9-16 generates a medium risk or an Amber traffic light 17-25 generates a high risk or a Red traffic light
Six	To determine or assess the overall risk review the pattern of traffic lights generated across all of the identified unmet Criteria and the risks associated with these. What is the balance between Green, Amber and Red traffic light signals generated across all of the standards?
Seven	The traffic light signals and associated risk scores generated are recorded and used to inform; action planning, nature of independent, frequency and timing of quality assurance activity, independent scrutiny/verification
Eight	The traffic light signals (rather than associated scores) feature within published reports

Healthcare education quality assurance traffic light approach

Totally Unacceptable = 5	5	10	15	20	25
Major = 4	4	8	12	16	20
Serious = 3	3	6	9	12	15
Moderate = 2	2	4	6	8	10
Minor = 1	1	2	3	4	5
Impact/Severity	Rare = 1	Unlikely = 2	Moderate = 3	Likely = 4	Certain = 5
	Likelihood				

(Modified from **Australian** Standard Risk Management AS/NZS 4360: 1999)

Risk Rating Score	Traffic Light Level	Action Level
1-8	Low Risk	Accept Risk. To be managed by local management.
9-16	Medium Risk	Management action required to reduce risk level to low risk level.
17-25	High Risk	Significant Risk. Board Level Action/Awareness required

(Modified from **Australian** Standard Risk Management AS/NZS 4360: 1999)

Appendix 4

Quality Assurance Framework for Healthcare Education in England

Partial Regulatory Impact Assessment

This partial regulatory impact is produced in line with Cabinet Office guidelines. A Final Impact Assessment will be published once the consultation outcome has been reported.

Issue and policy background

What is the issue under consideration? Why is intervention necessary?

1. In 2001, the National Audit Office (NAO) recommended that the Department of Health (DH) and education commissioners needed to work with the regulatory bodies, the Quality Assurance Agency (QAA) and other stakeholders to implement new integrated arrangements for the quality assurance of NHS funded health professional education.[11] DH subsequently contracted Skills for Health to work with partners and stakeholders to develop these quality assurance arrangements on its behalf.

2. Subsequently, the Cabinet Office agenda on Better Regulation has reinforced the need to develop more integrated quality arrangements as translated through the concordats of the Higher Education Regulation Review Group (HERRG) and the Healthcare Commission.

3. This draft quality assurance framework also fulfils the commitment by DH, Strategic Health Authorities (SHAs) and Universities UK to develop new quality assurance arrangements as part of the standard agreement between academic institutions and SHA commissioners of non-medical education and training (NMET).

4. The national standard NMET agreement, published in March 2006 includes a commitment that the quality assurance framework developed by Skills for Health and its partners will form part of the national standard contract framework for non-medical education. The national standard NMET agreement defines quality assurance as:

"The processes of ensuring that learning programmes are developed and approved in such a way as to meet the standard required by the NHS and its partners, and are delivered effectively in accordance with those standards."

What are the policy objectives and the intended effects?

5. To minimise the burden of quality assurance on commissioners, practice placement and education providers, consistent with ensuring and enhancing the quality of healthcare education.

[11] National Audit Office March 2001 "Educating and Training the future health professional workforce for England". **www.nao.org.uk/publications/nao_reports/00-01/0001277.pdf**

This framework is concerned with enhancing the quality of non-medical education and training both in practice and academic settings.

6. Options

What policy options have been considered?

Option 1: no intervention beyond current Quality Assurance Agency (QAA) benchmark statements, institutional audit and professional regulatory standards.

Option 1 advantages	Disadvantages
• Familiarity • No change from status quo would meet with approval from some stakeholders	• NAO requirements for an integrated framework not addressed, i.e. duplication of requirements and different monitoring cycles • Requirements of the standard contract agreement not addressed • Limited direct engagement with practice

Option 2 Revise and reapply QAA Major Review. QAA conducted a full round of Major Review 2003 – 2006 to provide a comprehensive quality baseline of all non-medical healthcare education. QAA published the Final Major Review Trends Report in 200712.

Option 2 advantages	Disadvantages
• Commissioners' and providers' familiarity with process	• Consistent feedback from partners and stakeholders indicates that Major Review (MR) was highly successful as a baseline exercise but it is too resource intensive to be an ongoing process • Five yearly cycle of MR limits its ability to focus on continuous quality enhancement • Considerable updating required, e.g. to reflect new statutory duties of healthcare providers to engage service users • MR evaluation found ambiguity in role of SHAs • Commissioners would still require additional processes for annual contract review • Future rounds of MR Review are not in QAA business plan

[12] www.qaa.ac.uk/health/majorreview/reviewTrends0306/ReviewFactSheet2007.pdf

Option 3: Ongoing Quality Monitoring & Enhancement (OQME) part of the prototype Partnership Quality Assurance Framework (PQAF) tested in several sites in 2004-05 and rigorously evaluated both internally and externally.

Option 3 advantages	Disadvantages
• Widespread use of Ongoing Quality Monitoring and Enhancement (OQME) element especially in prototype sites • OQME was found to enhance partnership working between academics and practice educators evidenced through internal and external evaluation • Based on principles of self evaluation and action planning • Good practice identified and disseminated	• Feedback from prototype evaluations indicates considerable room for improvement, e.g. need to review and modify OQME standards and greater clarity required on the use of evidence for self evaluation • Prototype evaluations consistently commented on the perceived burden of the processes being prototyped • Not overtly risk based

Option 4: Preferred option
Enhancing Quality in Partnership (EQuIP): an integrated multi professional framework comprising:

- Quality Standards
- Shared principles
- Mandatory key steps
- Common templates for self evaluation, risk assessment and action planning.

Option 4 advantages	Disadvantages
• Result of extensive and diverse stakeholder input including learners' views and service user/carer input • Retains positive elements of previous OQME prototypes, e.g. partnership, equality of practice education and the focus on enhancement, whilst simplifying the processes • Enshrines principle of utilising evidence from existing quality standards and processes both for academic and practice elements • Builds on Skills for Health (SfH) 'Interim Standards' • Reduction in burden after Year 1 • Meets requirements of NAO Report, HERRG principles and NMET contract • When available, IT will considerably reduce burden • IT will inform trend analysis • IT supported trend analysis will inform policy and future commissioning plans	• Feedback from prototype evaluations indicates considerable room for improvement, e.g. need to review and modify OQME standards and greater clarity required on the use of evidence for self evaluation • Prototype evaluations consistently commented on the perceived burden of the processes being prototyped • Not overtly risk based

7. High level implementation and delivery plans for each option

Option 1 – do nothing

- Would require re-negotiation of national NMET contract framework for non-medical education

Option 2 – revise and reapply Major Review

- Would require DH/SfH negotiation for new Major Review contract utilising Quality Assurance Agency (QAA) Major Review methodology
- Would need to reverse stakeholder expectations that this won't happen
- Would require major modifications and updating to incorporate revised stakeholder expectations including lay involvement

Option 3 – Ongoing Quality Monitoring and Enhancement (OQME)

- Would require extensive re- development of original PQAF to ensure issues identified through evaluations were addressed
- Would need to develop a risk based element and incorporate approach to lay involvement

Option 4 – Enhancing Quality in Partnership (EQuIP) framework

- Publish SfH Quality handbook as a training and development resource for use with commissioners, academic and practice education providers. This is already under development with extensive stakeholder input
- SfH to facilitate/co-ordinate training during Spring/Summer 2008
- Commence roll out of new system to start during academic year 2008/09
- Liaison with Council of Deans, SHAs, National Workforce Commissioners Group, National Practice Facilitators network and other stakeholders to agree details of roll out plan
- Agree an approach with SHAs to generating trends data

8. Who would be affected?

	Affected groups	Disproportionately affected	Costs	Benefits	Key Risks	Potential Unintended consequences
Option 1 [Do nothing]	All stakeholders	DH, SHAs, UUK would need to re-negotiate contract framework	• Duplication of effort for higher education faculties contracting with multiple SHAs[13]	Familiarity may aid implementation	• Not fulfilling NAO requirements • Variable publication of findings • Parity between higher education and practice varies between regulators	• Sustainability of contracted provision under threat due to uncertainty over national contract • Lose commitment of partners and stakeholders
Option 2 [Revise & Reapply Major Review]	DH, UUK, SHAs, QAA, Practice learning sites	SHAs, QAA, academic and practice education providers	Costs would fall into three categories: • Contract for delivery using QAA methodology • Project costs for updating • SHA costs for additional quality monitoring as part of NMET contract Framework	Familiarity may aid implementation	• Failure to reduce burden of activity • Not compliant with all key principles/ concordat agreements and current policy, e.g. service user engagement	Lose commitment of partners and stakeholders
Option 3 [OQME]	SfH, commissioners, Higher Education and practice learning providers	Commissioners, Higher Education and practice education providers	Additional costs for updating and incorporating prototype evaluation findings	• Would partially meet principles in NMET contract • Familiarity may aid implementation	• Failure to reduce burden of activity • Not compliant with all key principles, e.g. not a risk based approach	Lose commitment of partners and stakeholders

[13] HEFCE 2005 "The costs and benefits of external review of quality assurance in higher education"
www.hefce.ac.uk/pubs/RDreports/2005/rd17_05

Option 4 EQuIP	SfH, SHAs, Higher Education and practice education providers	SHAs, Higher Education and practice education providers	• Resource concentrated in year 1 • Release of staff for training and preparation	• Completes non-medical education contract framework for NMET • Reduces burden of QA after Year 1 • Utilises shared evidence gathered for other purposes • Likely to become cost neutral in longer term as it replaces other internal QA and audit processes • Good fit with draft European quality guidelines for vocational education and training	• "Gold plating", i.e. reluctance of stakeholders to apply exception reporting principle • Assumes education and training element of licensing arrangements for new healthcare service providers	None foreseen

9. Small Firms Impact Test

Engagement with representatives of small businesses, (nursing home sector and independent hospitals) at partnership forum meetings and residential events has identified a minor impact for some small firms providing practice learning environments. In most cases, the preferred option would be *instead* of, *not additional* to existing partnership processes with higher education.

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Skills for Business is an employer-led network consisting of 25 Sector Skills Councils and the Sector Skills Development Agency. Through labour market intelligence, the identification of skills needs at all levels and its influence on the UK's education and learning infrastructure, the network aims to increase productivity in business and public services.