User Guide to the Annual Monitoring Report

Contents

What is an Annual Monitoring Review (AMR)?

The focus of this review is to quality assure a centre's management and administration to ensure they remain compliant with our approval criteria. No learners will be sampled as part of this review, as this will be covered as part of an external quality assurance or moderation review.

Centres will be allocated a Quality Reviewer (QR), who will conduct the AMR across all qualification groups. This means centre information around management and administration will only be reviewed once a year.

This User Guide to the Annual Monitoring Report will support centres when planning for reviews. The guide outlines the criteria that the QR will check as part of the AMR process, the evidence centres can provide to meet each criterion and how the centre risk status is calculated following the AMR.

The Annual Monitoring Report

The layout of the Annual Monitoring Report (AMR) is the same for all centres. Every centre (who has had active registrations within the past 2 years) will receive a minimum of one review per session which will cover all approved qualifications (regulated and unregulated).

Sections of the report

Section 1 - Centre details and our contact details
Section 2 - Previous action plan
Section 3 - Management systems and administration
Section 4 - Action plan for centre
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Centre grading

As a result of the AMR, centres will be awarded a risk status based on the evidence reviewed. This status will be displayed on the front of the annual monitoring report and will also show on all individual external quality assurance reports for the centre.

How is the risk status achieved?

Each criterion in section 3 of the AMR is profiled as being high/medium/low risk, as identified within this guidance document.

Each criterion can be marked as a 'yes' or 'no' within the report, if a 'no' is selected this will trigger the risk level applied to that question.

A 'no' would be applied when a centre is unable to satisfy the evidence requirements of an individual criterion. This guide outlines exactly what a QR will be looking for to satisfy each criterion, giving examples of evidence a centre could show to support discussions.

The overall centre risk status will be the highest individual criterion risk level that has been triggered in section 3 of the report.

For example, if ‘no’ is applied to both a medium and high rated criterion, the centre’s overall risk status would be high.

What is the impact of each risk status?

High risk – If a centre is rated as high risk an interim AMR would be arranged with the QR later in the session, to review what progress has been made with the actions set.

Medium and low risk – Any actions set for the centre would be reviewed at the next planned AMR, which would be in the following session.

The risk status of a centre may be used to inform an external quality assurance review and may be considered when an External Quality Assurer (EQA) selects the sample size they wish to review.

The risk status of a centre **will not** impact Direct Claim Status (DCS) of individual qualifications within a centre. DCS continues to be monitored via the external quality assurance process.

How long will a risk status last?

For centres who achieve either a medium or low risk status, this status will be applied for 12 months. It will be reviewed at the next AMR scheduled for the following session.

If a centre is given a high-risk status, an interim review will be arranged with the QR to check progress made towards actions set. The centre’s risk status could change during this review depending on evidence seen.

During the session if NCFE is made aware of any instances where a centre has not been compliant with our policies and procedures and an investigation takes place, the result of this investigation could impact and change a centre’s risk status. In such cases, the centre would be made aware through the investigation process. The Provider Assurance team would also inform the allocated QR alongside the sector-specific External Quality Assurer(s). The new risk status would remain until the next AMR takes place.

The report sections in detail

Over the following pages we'll look at each section of the report.

You'll find statements included in the report followed by an explanation. The explanations will detail what the QR is looking for and examples of evidence which could be presented to meet the criteria.

Please note that these explanations are not intended to be exhaustive. There is more than one way to a achieve a successful outcome for each criterion, if further clarification is required centres should speak to their QR about how to move forward.

Section 1 - Centre details and our contact details

Section 1 is the front sheet of the report and contains information on the centre, centre contacts, the review date and the centre risk status. There are only 3 fields in this section that will manually be completed by the QR, the review date, type (remote / visit), and duration.

Changes to centre contact details should be made as they occur and in advance of an AMR via our 'Change of centre contact details' form on the website, so that the correct details are available to plan the review. If any centre contact details need to be updated at the review, they will be captured in section 5 of the report under 'Actions for Head Office' and changes will be made following submission of the annual monitoring report.

Section 2: Previous action plan

This section of the report will show any previous actions. The QR will confirm if they have been addressed and indicate any actions outstanding.

If the AMR is the first review since a centre's approval review, the QR will review any actions from the approval report.

Section 3: Management systems and administration

This section of the report is in relation to the centre's management systems and administration. The QR will discuss the criteria in this section with the Head of Centre or nominated person at the centre.

During the centres first AMR, evidence will be required to support discussions with the centre for each of the criteria in this section. Examples of evidence you may provide are detailed against each criterion.

You do not need to provide every item on the suggested evidence list – only the document(s) applicable to your centre.

In subsequent years, although all criteria will be discussed at your review, centres will only be required to submit evidence that has changed or been updated since your previous AMR. This will include evidence of any new processes or procedures.

3.1	**Aims, policies and procedures are in place that are supported by senior management and understood by the delivery and assessment teams**

Explanation

This criterion is to demonstrate and confirm that the centre has the required policies and procedures in place, that they are supported by senior management, are understood by delivery and assessment teams and that they are shared with learners.

The documented policies that will need reviewing are:

- Appeals
- Provider Contingency and Adverse Effects (to include withdrawal of provider approval status and protection of the learners' interest in the case of such a withdrawal)
- Complaints
- Conflicts of Interest (COI) – if NCFE has been notified of a COI the QR will also request evidence to confirm internal processes have been followed, as per the centre policy
- Equality, Diversity, and Inclusion (EDI)
- Data Protection including GDPR
- Risk Assessment and Health and Safety (including Public Liability)
- Learner Recruitment, Registration, and Certification
- Learner support/protocol
- Malpractice and Plagiarism
- Safeguarding
- Special Considerations and Reasonable Adjustments
    - Form VQ/IA will be reviewed for any reasonable adjustments made for internal assessments
- RPL
- Transfer of credits and recordings of exemptions and withdrawal of learner or qualification(s) from NCFE admissions and/or enrolment
- Controlled Assessment
- Assessment and Internal Quality Assurance (to include the use of an internal quality assurance strategy)

Evidence to meet this criterion <u>must</u> include:

- Copies of policies and procedures including who is responsible for updating them and when
- Details of how and when these are provided to learners
- Confirmation of support from senior managers to run the product

3.2	**Sufficient work placements are available to learners and supporting policies and procedures are in place**

Please note: This criterion is only applicable when running qualifications with a mandatory work placement.

Explanation

The centre will need to demonstrate that they have sufficient and suitable work placement opportunities available for all learners to be able to achieve the work placement requirement of the qualification(s). They will also ensure policies and procedures are in place to ensure the work placement environment is suitable and safe.

Evidence to meet this criterion could include:

- Copies of relevant policies and procedures
- Risk assessment documentation
- Copies of formal agreements between the learner, provider, and industry placement
- Process for recording the placement hours to show the number of hours is in line with the required hours outlined within the qualification specification
- Communication channels between employers/work placements.

3.3	**Recruitment and induction processes are in place for all staff involved in the qualification(s)**

Explanation

This criterion is confirming that the centre is continuing to recruit sufficiently competent, suitable, and knowledgeable Assessors and Internal Quality Assurers (IQA) who are able to meet the demand of qualifications being delivered. Where applicable the QR will also need to confirm that staff are registered with regulators in accordance with Qualification Specifications.

The induction processes for Assessors and IQAs will be reviewed to ensure an appropriate induction is in place for their role and that they are provided with appropriate information, training and support they need to deliver, assess and internally quality assure NCFE qualifications in line with NCFE requirements.

For T Level Providers only: If a provider wishes to allow a third party (for example training provider or satellite centre) to deliver any part of the T Level qualification, including its assessments, the approved provider must seek written agreement from NCFE before the third party is approved.

Evidence to meet this criterion could include:

- Example job descriptions
- Recruitment and interview process/policy
- Induction manual, schedule or checklist indicating policies and procedures shared with staff
- Staff induction handbook
- Mentoring process
- Written confirmation from NCFE if using a third-party supplier (where applicable)

3.4	**Processes are in place to ensure all staff are provided with accurate advice and support to enable them to identify and meet their training and development needs, via ongoing continuous professional development (CPD)**

Explanation

This criterion is to ensure the centre is continuing to provide all staff access to training and support, to enable them to maintain and update their skills as required in the qualification specification. We don't specify the amount of time to be spent on staff development, but any updates affecting the qualifications being delivered should be accommodated as they take place.

Attendance at administration and standardisation training will be reviewed in this section for centres delivering Technical Qualifications and V Certs.

Evidence to meet this criterion could include:

- Confirmation of support available to ensure the reliable delivery, assessment, and internal quality assurance of NCFE qualifications
- Copies of staff development programmes and department development plans
- Records of training undertaken, such as CPD records
- CPD policy

3.5	**Procedures are in place to ensure effective communication and appropriate allocation of time for team meetings and standardisation activities between all staff involved in the qualification(s)**

Explanation

This criterion is to confirm that effective communication methods and channels are in place and are allocated appropriate time throughout the session. The QR will consider if adequate time is provided for communication to take place for all staff involved in the teaching, assessment and internal quality assurance of qualifications.

The main aim of team meetings alongside identifying any concerns, is to promote good practice within a team and to ensure there is a standardised approach to assessment and internal quality assurance of learners' evidence, which is consistent with the assessment criteria set for each qualification.

The QR will be looking for evidence that demonstrates that as minimum, standardisation activities are taking place and relevant information is being shared with all staff involved with the qualification in this forum.

Evidence to meet this criterion could include:

- Centre guidance on team meetings and standardisation activities – this could include a set template for each
- Copies of meeting agendas/minutes – team and cross centre (if applicable)
- Briefings and/or updates – e.g. – all user emails, staff VLE
- Schedule of activity for staff involved

3.6	**Responsibilities, authorities, and accountabilities are clearly defined, allocated and understood by all staff involved in the qualification(s)**

Explanation

This criterion confirms that all staff understand their role, what they are responsible for and who they are accountable for and to. The QR will ensure that staff involved in assessment and internal quality assurance are familiar with the assessment criteria stated in the Qualification Specification.

Management has the responsibility to make sure that appropriate time and resource (staffing and physical) are allocated, to support the qualification(s) delivery and review. It is expected that systems will be in place to monitor and evaluate the effectiveness of all delivery and assessment staff, and that changes would be made when required.

Evidence to meet this criterion could include:

- Confirmation that staff are familiar with the assessment criteria and have full access to the required resources, stated within the Qualification Specification, for the products they are responsible for
- Explanation to determine how products are adequately staffed by Assessors/IQAs who are sufficiently competent
- Organisational charts, explaining the various departmental roles
- Staff management processes, including the use of Performance Improvement Plans (PIPs) or developments plans (PDPs).

3.7	**Marketing and advertising of all qualification(s) is clear, accurate, not misleading and complies with our guidelines**

Explanation

The advertising, marketing, and promotion of all NCFE qualifications must adhere to NCFE's brand guidelines. The correct advertising must be implemented through all websites and other materials. Any marketing or advertising materials used to promote qualifications, including pages on your website, must accurately reflect the details of the qualification being offered.

When advertising Customised Qualifications the guide to advertising Customised Qualifications must be adhered to. The QR will review various advertising materials used by the centre to satisfy this criterion.

Evidence to meet this criterion could include:

- Copies of relevant promotional materials such as course prospectuses
- Webpages used to advertise qualifications
- Course handbooks

3.8	**Appropriate recruitment and registration processes are in place for learners**

Explanation

This criterion is to ensure the centre has appropriate recruitment and registration processes in place for each qualification being delivered. The QR will need to confirm that the centre is aware of and are implementing appropriate entry requirements onto qualifications, ensuring only appropriate learners are recruited and registered with NCFE.

The timeliness of registrations and the process of registration will be reviewed to confirm it is appropriate.

This criterion will also confirm that appropriate information, advice, and guidance is provided to potential learners prior to enrolment, so they can make an informed decision to determine if the qualification is suitable for them.

Evidence to meet this criterion could include:

- Learner recruitment schedule e.g., open events, interviews, parent evening taster sessions
- Course prospectus
- Learner registration process/policy

3.9	**An enrolment and induction process which provides sufficient information, advice and guidance is in place for all learners**

Explanation

The QR will review the centres enrolment and induction process for learners to ensure it is robust and that it provides learners with sufficient information, advice, and guidance about the qualification(s) they have chosen to study. This should include advising learners of any technical needs required for the qualification they have chosen to study and also what support will be available to them.

Evidence to meet this criterion could include:

- Enrolment process/schedule/forms
- Information on any initial assessments carried out e.g., English and maths
- Induction schedule/timetable
- Course handbook
- Learner agreements/contracts
- Open events
- Exit interviews for early leavers

3.10	**Processes are in place for the transfer of credits, the recording of exemptions and recognition of prior learning as required**

Explanation

This criterion is to ensure processes are in place to support the accumulation and transfer of credits, the recording of exemptions and recognition of prior learning (if applicable). This will include the QR checking there are appropriate staff, resources and tracking systems in place.

Detail of how the transfer of credits, the recording of exemptions and recognition of RPL is verified and recorded, to ensure it is valid and current will be discussed and documented in the report.

Evidence to meet this criterion could include:

- Policy/process to validate claims for exemptions and RPL
- Records of learner exemptions
- Records of learner credit transfers
- Records of RPL claims

3.11	**Learners' development needs are matched against the requirements of the qualification, and are regularly reviewed in agreed individual assessment plans**

Explanation

This criterion will explore how learner development needs established during enrolment, are matched against the requirements of the qualification learners are registered to. The QR will review the centres processes and systems used to record, review, and monitor progress.

Evidence to meet this criterion could include:

- Use of initial assessments
- Individual learning plans/individual assessment plans
- System used to track learner progress e.g., tutorial or VLE system

3.12	**A planned programme of delivery is in place for all active qualification(s)**

Explanation

The delivery and assessment of every course must be in line with the requirements of the qualification specification. This criterion will be satisfied by a review of how well the delivery and assessment of qualifications are being conducted within the centre, including what assessment methods/facilities and resources are being used.

Evidence to meet this criterion could include:

- Planned programme of delivery e.g., schemes of work or lesson plans
- Assessment plans
- IQA sampling plans
- Verbal overview of centre facilities including resources required for the qualification as detailed in the qualification specification

3.13	**Learner records and details of achievements are accurate, kept up to date and securely stored**

Explanation

This criterion confirms that learner records of achievement are accurate and kept up to date, procedures are in place to retain records of learner achievement and that these records are stored securely for a minimum of 3 years.

There should be evidence that learner personal data is collected and held in accordance with data protection legislation.

Evidence to meet this criterion could include:

- Learner registration details
- Assessment/IQA records
- Portfolio evidence
- Security and access arrangements
- Data Protection policy – how this is applied.

3.14	**Adequate procedures exist to ensure secure and safe storage of live and completed learner assessment records and examination materials**

Explanation

If the centre is delivering qualifications that involve external assessment and/or controlled assessments or NEA, the centre must ensure:

- They are maintaining the security of live assessments, including where they are stored. There is a designated person who manages the process and has access to the material, the distribution and security of the material.
- There are processes in place for the secure storage of passwords, live assessments, and recorded assessments.
- Any learner assessment records/materials complete as part of a synoptic project are stored and administration in line with NCFE guidelines.

For Functional Skills and Essential Digital Skills Qualifications (EDSQ) – the QR will comment on the secure storage of assessment materials and whether this is in line with the relevant Regulations for the Conduct of Controlled Assessments.

Evidence to meet this criterion could include:

- Discussions with the examinations department
- Relevant centre policies
- Evidence to show JCQ compliance – e.g., annual inspection report/outcome

3.15	**Adequate and compliant processes are in place for external and controlled assessment(s) which meet NCFE and JCQ requirements**

Explanation

If the centre is delivering qualifications that involve external assessment and/or controlled assessments, the QR will outline how these are being implemented to comply with NCFE 'Regulations for the Conduct of External Assessment' and 'Regulations for the Conduct of Controlled Assessment', as well as complying with JCQ requirements.

For Functional Skills and EDSQ – the QR will comment on the booking and distribution of assessment materials and whether this is in line with the relevant Regulations for the Conduct of Controlled Assessments. The arrangements for the delivery of the controlled and external assessments, including invigilation will be commented on in line with the Regulations for the Conduct of Controlled Assessments – EDSQ.

Evidence to meet this criterion could include:

- Discussions with the examinations department
- Relevant centre policies
- Evidence to show JCQ compliance – e.g., annual inspection report/outcome.

3.16	**Processes are in place for withdrawing qualification(s) and learner(s)**

Explanation

This criterion is to confirm that the centre has a robust process in place for the withdrawal of qualifications and learners both internally within the centre and also with NCFE via the Portal.

Evidence to meet this criterion must include:

- Withdrawal process

3.17	**Appropriate certification processes are in place for learners**

Explanation

This criterion will review the centres process for claiming and issuing learner certificates. The centre will need to evidence how the process works, which departments/individuals are involved, and how policies and systems are used to ensure the process is robust.

Evidence to meet this criterion could include:

- Certification claiming process/exams policy
- Assessment/IQA records
- Exams officer records

3.18	**Feedback is used to evaluate the quality and effectiveness of qualification(s) which leads to continuous improvement**

Explanation

To meet this criterion the QR will explore how the centre gathers feedback from both learners and staff on the quality and effectiveness of qualifications being delivered and how this leads to continuous improvement.

Evidence to meet this criterion could include:

- Evaluation forms/surveys
- Centres Self-Assessment Report (SAR)
- Quality Improvement Plan (QIP) or equivalent

3.19	**Processes are in place to notify us of any changes that would affect the ability to maintain delivery or assessment of qualification(s)**

Explanation

This criterion is to ensure that centres have a process in place to inform NCFE of any changes that would affect the centre's ability to maintain the delivery and assessment of qualification. The QR will need to confirm that designated personnel are in place and know who and how to contact NCFE.

Centres must complete the 'Change of centre contact details' form via the website on the external quality assurance page to notify us of any change in Head of Centre, Programme Contact, Finance Contact and Exams Officer. The QR will need to confirm that designated personnel are in place and know how to contact NCFE.

Evidence to meet this criterion could include:

- Policy/process
- Roles and responsibilities of staff

3.20	**A robust process in place to ensure that content is fit for purpose where Customised Qualifications are developed**

Explanation

This criterion is to ensure that where customised qualifications have been developed by the centre there is a robust process in place to ensure the content is fit for purpose. The QR will require confirmation and evidence that assignment briefs meet the qualification specification and delivery is in line with the approval application.

Evidence to meet this criterion could include:

- Evaluation forms/surveys
- Product review process
- Meeting minutes
- Development plans
- Occupationally competent staff/person to carry out the qualification review

Section 4: Action plan for centre

The QR will use the following prompts to determine if a 'yes' or 'no' should be applied for each criterion. If the QR selects 'No' an action will be added to the action plan in section 4 of the report.

Each criterion has a level of risk applied to it which is indicted below by colour:

Red: High Risk
Amber: Medium Risk
Green: Low Risk

When 'No' is selected against a criterion i.e. the criterion was not achieved, the applicable risk status will be applied, the overall centre risk status will be the highest risk score applied.

When all criteria are awarded a 'yes' the centre overall risk status will be 'low risk'.

Example 1

Centre scores 'no' for
3.1 Red
3.3 Amber
3.5 Green

The overall centre risk status will be high as they've scored 'no' for a red criterion.

Example 2

Centre scores 'no' for
3.3 Amber
3.5 Green

The overall centre risk status will be medium as they've scored 'no' for an amber criterion.

Example 3

Centre scores 'no' for
3.5 Green

The overall centre risk status will be low as they've scored 'no' for a green criterion.

Where ‘no’ has been selected for any of the criteria in section 3 or where a previous action (from an AMR, EQA review or approval report) has not been fully actioned in section 2, this will generate an action within the action plan section of the report.

The QR will set clear actions based on the criteria that was not achieved. Our aim is for the centre to read any actions and understand exactly what they need to do before the next review. Most reviews will take place annually, however, if there is a need for actions to be checked prior to the next annual review (high risk status) an interim review will be required.

All actions will be attributed to a specific owner and be given a reasonable and clear timescale for completion.

Recommendations will not be included in this section of the report. Any recommendations will be included in the body of the report. The QR will review these recommendations during the next review, however, as they are recommendations, they will not be set as mandated actions.

The QR will discuss the set action plan with the centre prior to submitting the report, allowing opportunity to ask any questions linked to the given actions. They will indicate in this section that the action plan has been discussed and who with. If it has not been discussed detail will be added to section 6 of the report to confirm actions have not been discussed with the centre prior to submission of the report.

Section 5: Action for Quality Reviewer or head office

This section of the report is used to enter any action that NCFE may need to take following the AMR. For example, a centre may inform the QR that particular qualification contact details are incorrect or advise that further information regarding some of our qualifications is required. The QR will complete this section and any actions entered for head office will be passed to the relevant department.

Section 6: Additional information sheet

This section is used to provide any information that does not fit into the other narrative sections of the report. Where there are no further comments to make, this will be marked as NA.

Appendix A: Approved products with active registrations

The appendix section of the report will detail all approved qualifications for the centre that have had active learner registrations within the last 2 years. Information will be presented by qualification group and will show the qualification name/number, the number of registrations, the number of certificates claimed, the last date of learner registration and the last date of learner certification.

This will provide an audit trail of which qualifications were deemed live at the time of the AMR taking place.

Appendix B: Registered profession qualifications

- NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing (Integrated Apprenticeship) 610/1340/7
- NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing QN: 601/2251/1

All information here must be provided ***in addition*** to the information in the previous sections.

General Dental Council Standards for Education

The Standards for Education are the requirements that underpin dental qualifications, and these apply to all UK programmes leading to registration with the General Dental Council (GDC). They cover programmes in dentistry, dental hygiene, dental nursing, dental technology, dental therapy, clinical dental technology and orthodontic therapy.

The Standards cover three areas the GDC expects centres to meet in order for training programmes to be accepted for registration. These areas are:

- Patient protection
- Quality evaluation and review
- Learner assessment

The qualification is approved by the GDC, and the Standards for Education have been mapped across the approval, Annual Monitoring Review (AMR) and external quality assurance process. Centres must evidence at each review that they continue to meet these standards.

Centres should be familiar with the standards and must ensure that they are using and adhering to the mandatory documents outlined in the qualification specification and associated qualification appendices, which are available on the NCFE website.

3.1	**Aims, policies and procedures are in place that are supported by senior management and understood by the delivery and assessment teams**

Explanation

This criterion is to demonstrate and confirm that the provider has the required policies and procedures in place, that they are supported by senior management, are understood by delivery and assessment teams and that they are shared with Learners.

The documented policies that will be reviewed are:

- Complaints/Appeals **(GDC 1.3, 1.6, 1.8).**
- Malpractice and Plagiarism **(GDC 1.3).**
- Fitness to Practise **(GDC 1.8).**
- Patient Safety Procedure Confirmation the centre has policies and procedures in place regarding the raising of concerns that are clearly communicated to all staff, learners, and patients and any concerns raised by learners or staff regarding risks to patient safety including any instances that are reportable to a regulatory organisation. Confirmation the provider has policies and procedures in place regarding the raising of concerns that are clearly communicated to all staff, Learners, and patients **(GDC 1.2).**

- Self-Assessment Report - The QR will check evidence of how equality and diversity data is being used in course design and must also check how equality and diversity is embedded in course delivery e.g.: Self-Assessment Review (SAR) data.
- Supervision of Learners procedure **(GDC 1.4).**
- Patient Safety Procedure **(GDC 1.3, 1.7).**
- Whistleblowing procedure for reporting incidents **(GDC 1.6).**
- Procedure for checking and retaining copies of Learner vaccination records.
- Learner Recruitment/admissions procedure **(GDC1.1, 1.3),** Registration, and Certification.
- Learner support/protocol.

Evidence to meet this criterion could include:

- Copies of policies and procedures including who is responsible for updating them and when.
- Details of how and when these are provided to Learners.
- Confirmation of support from senior managers to run the product.

3.21	**A Fitness to Practise Policy and Procedure is in place**

Explanation

This criterion is to ensure that providers delivering registered professional qualifications have a fitness to practise policy in place. We require providers to demonstrate how they are ensuring Learners are fit to practice when they enter the qualification and how they deal with any fitness to practise issues among Learners or trainees throughout the delivery of the programme.

Fitness to practise covers three areas: clinical/technical practice, professional conduct and health. Some examples of fitness to practise concerns include bullying, drug or alcohol use, dishonesty or misuse of social media. (You can find further information on the GDC's website and in their document 'Learner Professionalism and Fitness to Practise').

Evidence to meet this criterion would include:

- Fitness to Practise Policy and Procedure. It must be applicable to both staff and Learners, written with reference to the relevant regulator, which includes how you'll ensure Learners are fit to practise and how you'll deal with any fitness to practise issues at the point of selection **(GDC 1.1, 1.6, 1.8).**
- The centre's Professional Misconduct Panel membership in place and a General Dental Council registrant, not involved with the delivery/assessment/internal quality assurance (therefore independent) of the Learner's qualification on the panel **(GDC 1.8).**
- Appeal policy **(GDC 1.3, 1.6, 1.8).**
- Procedure for checking and retaining copies of Learner vaccination records.
- Admissions/enrolment procedure **(GDC 1.1, 1.3).**
- Equal opportunities and diversity policy and procedure.
- Learner support policy/protocol.

3.22	**There is a work-based supervising registrant in place for each Learner**

Explanation

This criterion is to ensure that evidence is in place and must show that professional registration of work-based supervisors is checked before the qualification starts and that ongoing checks for any changes are in place.

Any General Dental Council (GDC) registrant involved in the supervision, teaching and assessing of a Learner's work must be named. Providers must complete a supervising registrant list for each Learner. Providers will be expected to update this list annually to ensure registration has been maintained.

A declaration confirming that the named workplace mentor/supervisor has read policies and procedures listed and provided copies for the Learner (where appropriate) and their practice manager to read, and also that the content was discussed and clarified with the Learner and their manager.

Evidence to meet this criterion could include:

- Statement as to how this is to be completed **(GDC 1.4)**
- Guidance on the role of the supervising professional registrant and evidence of how this person has been supported with training **(GDC 1.4, 1.5)**
- Evidence that the supervisor/mentor has a current DBS certificate
- Annual updating of these records
- Work-based supervising registrant (workplace mentor or supervisor) documented for each Learner/workplace
- Policies and procedure for supervision of learners/supervisor induction/training/qualifications **(GDC1.5)**

3.23	**There is a work-based placement procedure in place, which includes a formal agreement between the learner, centre and employer/workplace**

Explanation

This criterion is in place to ensure that learners sign and comply with a learner contract. This contract details the expected behaviours that learners must comply with in line with NCFE and GDC requirements.

Employers/workplaces/placements must ensure that learners have been formally inducted into the workplace. Topics must be covered to evidence that the learner is fully prepared to work safely and ethically in the dental practice.

Centres must gather evidence that demonstrates that the clinical environment/workplace is safe and appropriate. Through the workplace Assessor, they must request evidence from the employer.

There should be feedback mechanisms available to promote a two-way communication process that aims to improve the outcomes of the programme for all key stakeholders.

Centres must ensure that workplaces comply with the requirement that all trainee Dental Nurses should be easily identifiable from registered Dental Nurses in the work setting (eg by learners wearing name badges).

Patients must also be made aware if a trainee Dental Nurse is assisting in their treatment, the possible implications and give consent. Consent must also be recorded prior to treatment

commencing. If patients wish to decline, this will not affect their treatment they receive at the practice. Workplaces may wish to use this poster which informs patients of the above requirements.

Centres must ensure that they have a formal process in place to monitor and record patient safety incidents, and to communicate these with work placements/employers. Work placements/employers have a responsibility to report such incidents back to the centre. An incident reporting form that can be used by both the centre and the work placement/employer is provided to support this process.

Evidence to meet this criterion could include:

- Three-way agreement.
- Work-based placement procedure (including quality assurance/ health and safety of placements) and additional placement procedures **(GDC 2.12, 1.3)** (where applicable).
- Learner handbook.
- Risk assessments/evidence of review **(GDC 1.3).**
- Consideration of patient safety.
- Insurance - public liability, employer.
- Process in place to check the workplace/placement is registered with the appropriate regulators.
- Details of study, workplace-based assessments and support required for the learner in the workplace.
- Induction policy/procedure/ employer declaration of work-place induction.
- Employer declaration of workplace induction (Appendix B of Approval Guidance document). Signed copy for each learner required for subsequent EQA reviews.
- Contracts setting out specific roles and responsibilities that centres/employers must agree, sign and comply with throughout the course of the qualification (Appendix F and Appendix G).
- Process in place to check the workplace is registered with the Care Quality Commission (CQC) (England). Evidence of this being carried out will be required for subsequent EQA reviews.
- Initial safety check and monitoring of learners' workplace (Appendix C: Initial safety check and workplace monitoring). Completed checklist required for subsequent EQA review.
- Raising Concerns in the Workplace policy and procedure for the placement/employer
- Process in place to check the workplace is informing patients and gaining their consent regarding a trainee Dental Nurse being involved in their dental treatment **(GDC 1.2).**
- Process in place to check the workplace mentor/supervisor is keeping records of mentorship.
- Patient feedback surveys **(GDC 2.12, GDC 3.17).**

3.24	**Procedure for checking good character and good health including vaccinations (where required) are in place**

Explanation

This criterion is in place to ensure all GDC registrants are vaccinated, and centres must confirm that learners comply with this and keep the appropriate records. Checks must be made to ensure all staff and learners are of good character.

Evidence to meet this criterion could include:

- Procedure for checking and retaining copies of learner vaccination records **(GDC 1.4).**
- Centre organogram – setting out the staffing structure for the delivery of the qualification.
- Proof of General Dental Council (GDC) registration number for those listed in centre organogram.
- Current CVs, continuing professional development (CPD) records, copies of vocational qualification certificates, education/training qualifications.
- Details of current Disclosure and Barring Service (DBS) checks, job descriptions: i.e., department supervisor(s)/tutor(s)/assessor(s)/IQA(s).

It is important that all evidence is submitted alongside the evidence located in Pages 5-20, so that your Quality Reviewer can confirm that you are adhering to the GDC Standards of Education.

Version control:

Date approved	August 2023
Approved by	Kay Barrass QA Manager (EQA)
Review date	August 2024

Only approved versions of this document should be documented in the below table:

Version	Date	Revision author(s)	Summary of changes
V1	July 2022	Rachael Lacey	NA
V1.2	December 2022	Rachael Lacey	Reference to Form VQ/IA added to 3.1
V1.3	January 2023	Kay Barrass	Additional information added to strengthen existing requirements around resources
V1.4	May 2023	Kay Barrass	Additional roles added to 2.19 for change in provider contacts
V1.5	July 2023	Juliet Meeres Rachael Lacey	Rregistered Professions information now located in the Appendix B. AMR process updated page 6.