# User Guide to the Annual Monitoring Review Report

External Quality Assurance team

**Version 1.8 -** July / 2026

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# 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 criteria and how the centre risk status is calculated following the AMR.

# The annual monitoring report

The layout of the report 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).

Following an initial AMR in which a risk status will be awarded, AMRs will follow a risk-based assurance model. This approach allows us to focus on support where it's most needed, while reducing the burden on centres with a strong track record of compliance.

**Low-risk centres**
Will receive a **desk-based review every other year**, with a full* AMR taking place in the alternate year.

**Medium and high-risk** centres**
Will continue to receive a **full AMR every year**, delivered via Microsoft Teams.

**A full AMR includes the completion of a self-assessment form and the uploading of evidence for any criteria that has experienced a change or update. The External Quality Assurer (EQA) will hold a Teams meeting with the centre to discuss all criteria.*
***High-risk centres include all centres delivering **V Cert, T Level** (due to qualifications incorporating moderation)**, and Dental qualifications** (due to regulatory requirements).*

## Desk-based AMR

A desk-based review is completed remotely and does not require a Microsoft Teams meeting. Centres will be asked to complete a self-assessment and declaration form by a specific deadline. The QR will review the information provided and determine whether any further action is required.

A desktop review may revert to the standard AMR process where a centre reports significant changes to its management and administration arrangements. Significant changes could include multiple amendments (more than two) to previously agreed processes, or the complete redesign of an existing process.

Where such changes are identified, the QR will arrange a Teams meeting with the centre to discuss the impact of the changes and any associated requirements. The QR will contact the centre by email to agree a mutually convenient date and time for the meeting.
This will be recorded as 'remote' in Quality zone.

## Centre-facing AMR

Centres identified as medium or high-risk, as well as those delivering V Cert, T Level, or dental qualifications, will take part in an AMR via Microsoft Teams.
The QR will:

- arrange a meeting date and time with you
- review submitted evidence
- discuss key criteria during the meeting.

Centres will also be asked to complete a self-assessment and declaration form before the review takes place. This will be recorded as a 'visit' in Quality zone.

# 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 criteria in section three of the AMR is profiled as being high/medium/low-risk, as identified within this guidance document.

Each criteria 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 criteria. This guide outlines exactly what a QR will be looking for to satisfy each criteria, giving examples of evidence a centre could show to support discussions.

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

For example, if 'no' is applied to both a medium and high rated criteria, 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 within 6 months, 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 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 EQA. 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 criteria, if further clarification is required centres should speak to their QR about how to move forward.

# 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
Section 5 – Action for QR or head office
Section 6 – Additional information sheet
Appendix A

## 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 three fields in this section that will manually be completed by the QR, the review date, type (remote/visit)*, and duration.

*Remote/visit - a desk-based review will be labelled as a remote review and a centre-facing review will be labelled as a visit conducted via Microsoft Teams.

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 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 criteria.

*You do not need to provide every item on the suggested evidence list – only the documents 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.

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| **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 criteria 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
- Recognition of prior learning (RPL)
- Transfer of credits and recordings of exemptions and withdrawal of learner or qualifications 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 criteria must 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** |
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*Please note: this criteria 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 qualifications. They will also ensure policies and procedures are in place to ensure the work placement environment is suitable and safe.

**Evidence to meet this criteria 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 qualifications** |
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**Explanation**

This criteria is confirming that the centre is continuing to recruit sufficiently competent, suitable, and knowledgeable assessors and Internal Quality Assurers (IQAs) 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.

**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 criteria 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)

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| **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 continuing professional development (CPD)** |

**Explanation**

This criteria 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 criteria 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

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| **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 qualifications** |

**Explanation**

This criteria 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 (AC) 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 criteria 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 – for example all user emails, staff virtual learning environment (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 qualifications** |
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**Explanation**

This criteria 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 AC 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 qualifications 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 criteria could include:**

- Confirmation that staff are familiar with the AC 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 Development Plans (PDPs).

| 3.7 | **Marketing and advertising of all qualifications is clear, accurate, not misleading and complies with our guidelines** |
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**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 criteria.

**Evidence to meet this criteria 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** |
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**Explanation**

This criteria 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 criteria 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 criteria could include:**

- Learner recruitment schedule for example open events, interviews, parent evening taster sessions
- Course prospectus
- Learner registration process/policy

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| **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 criteria could include:**

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

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| **3.10** | **Processes are in place for the transfer of credits, the recording of exemptions and RPL as required** |

**Explanation**

This criteria is to ensure processes are in place to support the accumulation and transfer of credits, the recording of exemptions and RPL (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 criteria 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 criteria 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 criteria could include:**

- Use of initial assessments
- Individual learning plans/individual assessment plans
- System used to track learner progress for example tutorial or VLE system

| 3.12 | **A planned programme of delivery is in place for all active qualifications** |
|---|---|

**Explanation**

The delivery and assessment of every course must be in line with the requirements of the Qualification Specification. This criteria 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 criteria could include:**

- Planned programme of delivery for example 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** |
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**Explanation**

This criteria 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 criteria 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 |
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**Explanation**

If the centre is delivering qualifications that involve external assessment and/or controlled assessments or non-examined assessment (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. Centres delivering online only still need to maintain secure storage facilities, for example in the event a learner may require a paper-based examination as a reasonable adjustment.

**Evidence to meet this criteria could include:**

- Discussions with the examinations department
- Relevant centre policies
- Evidence to show Joint Council for Qualifications (JCQ) compliance – for example annual inspection report/outcome.

| 3.15 | Adequate and compliant processes are in place for external and controlled assessments which meet NCFE and JCQ requirements |
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**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 criteria could include:**

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

| 3.16 | **Processes are in place for withdrawing qualifications and learners** |
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**Explanation**

This criteria 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 criteria must include:**

- Withdrawal process

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

This criteria will review the centre's 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 criteria could include:**

- Certification claiming process/examinations policy
- Assessment/IQA records
- Examinations officer records

| 3.18 | **Feedback is used to evaluate the quality and effectiveness of qualifications which leads to continuous improvement** |
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**Explanation**

To meet this criteria 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 criteria 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 qualifications** |
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**Explanation**

This criteria 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 examinations officer. The QR will need to confirm that designated personnel are in place and know how to contact NCFE.

**Evidence to meet this criteria could include:**

- Policy/process
- Roles and responsibilities of staff

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

**Explanation**

This criteria 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 criteria 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 the centre

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

Each criteria 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 criteria as it 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 criteria.*

**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 criteria*.

**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 criteria.*

Where ‘no’ has been selected for any of the criteria in section three or where a previous action (from an AMR, EQA review or approval report) has not been fully actioned in section two, 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 (within a maximum of 6 months).

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 QR 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 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 N/A.

## 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 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 QN: 610/3114/8
- *NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing (Integrated Apprenticeship) QN: 603/6671/0
- *NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing (Integrated Apprenticeship) QN: 610/1340/7
- *NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing QN: 601/2251/1

* Withdrawn qualifications

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. These have been revised by the GDC and apply from 01 September 2025.

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

- Patient protection and safety
- Student development and support
- Quality assurance of programmes

The new GDC ‘Safe Practitioner Framework’ (which in September 2025 replaced the GDC ‘Preparing to Practice’ standards), has now been included in the latest dental qualification:

NCFE CACHE Level 3 Diploma in the Principles and Practice of Dental Nursing QN: 610/3114/8 which is approved by the GDC.

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 criteria 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 3.1, 5.1)
- Malpractice and Plagiarism (GDC 13.1, 13.2, 13.3)
- Fitness to Practise (GDC 5.4, 5.5, 6.1, 6.2)
- 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 5.1, 5.2, 5.3, 5.4, 5.5)
- 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 for example Self-Assessment Review (SAR) data
- Supervision of Learners procedure (GDC 4.1, 4.2, 4.3)
- Patient Safety Procedure (GDC 3.1, 3.3, 5.3)
- Whistleblowing procedure for reporting incidents (GDC 5.1, 5.2, 5.3, 5.4, 5.5)
- Procedure for checking and retaining copies of learner vaccination records
- Learner Recruitment/admissions procedure (GDC 1.2, 3.1) Registration, and Certification
- Learner support/protocol.

**Evidence to meet this criteria 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 criteria 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 criteria 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 2.1, 5.1, 5.2)
- 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 (GDC 4.2, 5.1, 5.5)
- Appeal policy (GDC 17.4)
- Procedure for checking and retaining copies of learner vaccination records
- Admissions/enrolment procedure (GDC 10.2, 12.2)
- Equal opportunities and diversity policy and procedure. (GDC 12.1, 12.2)
- Learner support policy/protocol. (GDC 9.3, 9.4).

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

**Explanation**

This criteria 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 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 criteria could include:**

- Statement as to how this is to be completed (GDC 4.1, 4.2, 4.3)
- Guidance on the role of the supervising professional registrant and evidence of how this person has been supported with training (GDC 4.3)
- Evidence that the supervisor/mentor has a current Disclosure and Barring Service (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 (GDC 4.2, 4.3, 15.2, 16.1).

| 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 criteria 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 (for example 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 the treatment they receive at the practice. Workplaces may wish to display a 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 criteria could include:**

- Three-way agreement
- Work-based placement procedure (including quality assurance/ health and safety of placements) and additional placement where applicable (GDC 2.1, 2.2, 2.3, 15.2)
- Learner handbook
- Risk assessments/evidence of review (GDC 3.1, 3.3)
- 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 workplace 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 2.1, 2.2)

- Process in place to check the workplace mentor/supervisor is keeping records of mentorship
- Patient feedback surveys (GDC 8.3).

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

This criteria 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 criteria could include:**

- Procedure for checking and retaining copies of learner vaccination records (GDC 6.2)
- Centre organogram – setting out the staffing structure for the delivery of the qualification
- Proof of GDC registration number for those listed in centre organogram
- Current CVs, CPD records, copies of vocational qualification certificates, education/training qualifications
- Details of current DBS checks, job descriptions such as supervisors/tutors/assessors/IQAs.

It is important that all evidence is submitted alongside the evidence located in pages 5-20**,** so that your QR can confirm that you are adhering to the GDC Standards for Education.

# Version control

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|---|---|
| **Date approved** | July 2026 |
| **Approved by** | Kay Barrass QA Manager (EQA) |
| **Review date** | July 2027 |

**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 | N/A |
| 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<br>Rachael Lacey | Registered Professions information now located in the Appendix B.<br>AMR process updated page 6 |
| v1.6 | September 2024 | Juliet Meeres | Updated registered professions section |
| v1.7 | September 2025 | Juliet Meeres/<br>Craig Coates | Updated registered professions section<br>Reviewed for 25/26 session |
| v1.8 | July 2026 | Rachael Lacey | Reviewed for 26/27 session |