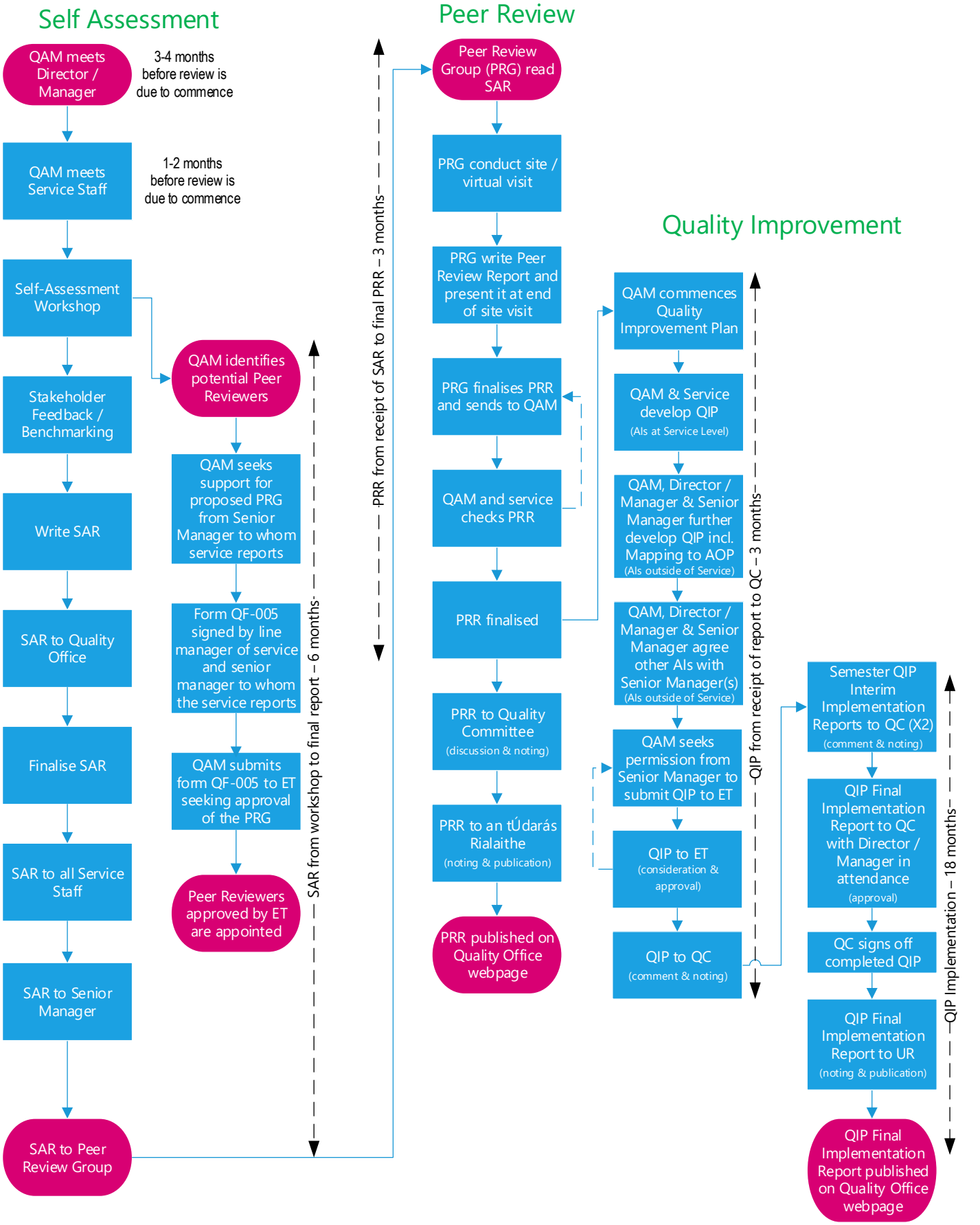
Professional Service Quality Review Process



Change History:
Revision Number: 1.4
Approved By: Quality Committee
Date: 13th **September 2022**

1. Purpose

1.1 Purpose of this document

The purpose of this document is to outline the quality review process for MIC Professional Services. This document describes in detail the process for the three phases of an internal quality review:

- Self-Assessment
- Peer Review
- Quality Improvement

1.2 Purpose of the Quality Review Process

The purpose of the quality review process is to:

- Provide a structured opportunity for the service to engage in periodic and strategic evidence-based self-reflection and assessment in the context of the quality of its activities and processes, and to identify opportunities for quality improvement;
- Provide a framework by which
    - External peers, in an evidence-based manner, can independently review, evaluate, report upon and suggest improvements to the quality of the service's activities and processes;
    - The service implements quality improvements in a verifiable manner;
- Provide MIC, its students, its prospective students and other stakeholders with independent evidence of the quality of the service's activities;
- Ensure that all MIC professional services are evaluated in a systematic and standardised manner in accordance with good international practice and in support of the objectives of the College's quality policy;
- Satisfy good international practice in the context of quality assurance in higher education and to meet statutory QA requirements as enshrined in national law;

1.3 Ethos

The ethos of the quality review process is that participants proactively engage in a mutually supportive and constructive spirit and that the process be undertaken in a transparent, inclusive, independent and evidence-based manner. The process provides scope for recognising achievement and good practice as well as identifying potential opportunities for quality enhancement. Above all, it needs to be constructive.

2. Scope

2.1 Scope of this document

This procedure applies to the MIC Quality Office as facilitator of the quality review process and the MIC Professional Services which engage with the quality review process as scheduled in the MIC Professional Service Quality Review Schedule, which is published on the MIC Quality Office Reviews webpage: https://www.mic.ul.ie/about-mic/college-services/quality-office?index=3.

2.2 Scope of the Professional Service Quality Review Process

In addition to addressing the general purpose of MIC's quality review activity, the terms of reference of the review include the following:

1. To consider and advise on the appropriateness, effectiveness and efficiency of the mission, strategy and principal activities undertaken by the service and how these support MIC's strategic direction and operations.
2. To consider and advise on all aspects of the appropriateness and effectiveness of the structure, infrastructure, governance, management (including budgetary) and operation of the service.
3. To consider and advise on the appropriateness and effectiveness of linkages, relationships and interactions between the service and its key stakeholders.

3. Definitions and Background

3.1 What do we mean by 'quality', 'quality assurance' and 'quality improvement'?

The quality of an activity or process is a measure of its 'fitness for purpose'. 'Quality assurance' (QA) refers to actions taken to monitor, evaluate and report upon the fitness for purpose of a particular activity in an evidence-based manner, while 'quality improvement' (QI) (sometimes referred to as 'quality enhancement') refers to initiatives taken to improve the fitness for purpose of the target activity/process. QA and QI are intrinsically linked, and often the term QA is taken to incorporate QI activity. QA/QI activities are applied at institutional, department, service and individual (personal) level. Continual improvement is achieved by applying QA/QI on an ongoing basis.

The periodic quality review of functional areas (academic and professional service) within the College represents a cornerstone institutional QA/QI mechanism. This document provides details on the quality review process for Professional Services.

3.2 Acronyms

DoQ	Director of Quality
ET	Executive Team
MISU	Mary I Students Union
PR	Peer Review
PRR	Peer Review Report
PRG	Peer Review Group
PRV	Peer Review Visit
QIP	Quality Improvement Plan
QMS	Quality Management System
QAM	Quality Assurance Manager
SA	Self-Assessment
SAR	Self-Assessment Report
SCOT	Strengths, Challenges, Opportunities, Threats
VPAF	Vice President of Administration and Finance
VPGS	Vice President of Governance and Strategy

3.3 Background

MIC's quality review process, as applied to both academic departments and professional services, was developed and continues to evolve in order to satisfy college quality policy and meet legislative QA requirements. MIC complies with the Qualifications and Quality Assurance (Education and Training) Act 2012, which places a legal responsibility on the provider and linked provider to establish procedures in writing for quality assurance for the purposes of establishing, ascertaining, maintaining and improving the quality of education, training, research and related services. (Part 3, Section 28). These QA procedures must take due account of relevant quality guidelines issued by Quality and Qualifications Ireland (QQI) and/or predecessor organisations. QQI is the statutory body

responsible for reviewing and monitoring the effectiveness of QA procedures adopted and implemented by higher (and further) educational institutions within Ireland.

4. Related Procedures and Forms

QP-016	Professional Service Quality Review Process Flowchart
QT-004	Professional Service SAR Template
QT-005	Professional Service PRR Template
QT-006	Professional Service QIP Template
QT-007	Professional Service Peer Review Visit Schedule Template
QT-016	Peer Review Virtual Visit Schedule Template
QT-019	QIP Interim Progress Report
QT-020	QIP Final Progress Report
QF-002	Peer Review Honorarium Claim Form
QF-003	Peer Review Visit Preparation Checklist
QF-005	Peer Reviewer Nomination Form Professional Services Quality Review
	MIC Expenses Claim Form

5. Responsibilities

5.1 Quality Office

It is the responsibility of the Quality Office to facilitate the quality review process as outlined in section 6 of this document.

5.2 Professional Service

The key responsibilities of the professional service under review are to:

- Engage with the self-assessment process and write the self-assessment report;
- Meet with the Peer Review Group during their visit and provide additional information requested by the group;
- Develop a Quality Improvement Plan based on the Peer Review Report and implement the action items that are actionable at the level of the Professional Service;

5.3 The Professional Service's Obligations

The Quality Assurance Manager must satisfy themselves that the department has engaged fully, constructively and in accordance with the ethos of the quality review process over all of its stages. In particular, they must be satisfied that the department has genuinely made all reasonable efforts to pursue the quality improvement plan and provides a sufficiently compelling justification in cases where a recommendation has been rejected.

Although not an anticipated occurrence, if the QAM forms an evidence-based opinion that the department fails to satisfy the above obligations, they must discuss this with the VPGS. In consultation with the VPGS and at their joint discretion, the following actions may be considered:

- A formal 'note of concern' is forwarded by the QAM to the director / manager of the service and copied to the member of senior management to whom the professional service reports.
- A formal 'note of concern' is forwarded by the QAM to the director / manager of the service and copied to the member of senior management to whom the professional service reports, and the head of department is invited to the next meeting of Quality Committee to discuss the concerns.
- Referral to Executive Team for appropriate action.

6. Procedure

6.1 Self-Assessment (SA)

Self-assessment is the first phase of the quality review process and takes approximately 6 months. It culminates in an analytical, evidence-based, Self-Assessment Report (SAR), which is written by the professional service using a template provided by the Quality Office, *QT-004 Professional Service SAR Template*. The SAR must be evidence-based and must include an appropriate balance of description and analysis (ideally 50/50). The SAR and its appendices are reviewed by the peer review group (PRG) in advance of the site / virtual visit and forms the basis of the PRG's assessment of the service's fitness for purpose.

The Self-Assessment Report remains confidential to the professional service, the member of senior management to whom the professional service reports, the peer reviewers and the Quality Office throughout the quality review process.

6.1.1 The Quality Assurance Manager (QAM) meets with the director /manager of the professional service 3-4 months before the quality review process is due to start. The purpose of this meeting includes:

- Overview of the quality review process
- Explore suitable dates for the events that occur during the quality review process.
- Explore a quality review timeline that takes the operational demands of the service into consideration.
- Explore a suitable date / time to meet with the service staff in advance of the commencement of quality review.

6.1.2 The QAM meets with the service staff to explain the quality review process and what their role will be in the process.

6.1.3 The Quality Office creates a Dropbox folder for the review that is accessible to the staff of the Quality Office and the staff of the service under review. This folder is used by the Quality Office to disseminate guidelines, templates and institutional information and data that are required for the SAR. The service staff use this folder to share files that are necessary for the SAR and its appendices.

6.1.4 The QAM and the director / manager of the professional service agree a date for a facilitated workshop that initiates the SAR process and is attended by the director / manager of the service and service staff.

6.1.5 The Quality Office arranges the workshop including facilitator, venue, catering etc.

6.1.6 The Quality Office informs the campus community of upcoming Quality Reviews via email at the beginning of each academic year. The email includes a link to previous peer review reports.

The QAM emails the member senior management to whom the professional service reports to inform them that the quality review has commenced.

6.1.7 The facilitated workshop typically covers:

- Mission and Strategy

- Aims and Objectives
- Stakeholders
- SCOT Analysis – Strengths, Challenges, Opportunities and Threats
- Delegation of SAR content and other tasks
- Discussion of the stakeholder feedback that is required and the appropriate feedback mechanisms – survey, focus group etc.
- Setting of SAR timeline including key targets and meetings
- Supports required

6.1.8 The QAM shares the workshop report via the Dropbox folder along with the list of key targets and meetings. The QAM meets with the service at least once per month during the SAR process and makes the necessary arrangements for these meetings.

6.1.9 The service staff begin to complete the SAR by inputting the relevant information in the SAR template and uploading supporting documentation to the Dropbox folder. They also incorporate information from the workshop report, particularly the SCOT analysis, is into the relevant sections of the SAR template.

6.1.10 The Quality Office liaises with the service to develop the required stakeholder feedback questions.

6.1.10.1 If the feedback mechanism is a survey, the Quality Office works with the department to develop the survey questions, drafts the survey in Qualtrics and sends a link to the draft survey to the relevant staff for review and feedback. Once the survey questions are agreed, the Quality Office administers the survey to the appropriate stakeholders, writes the survey report and shares it via the Dropbox folder.

6.1.10.2 If the feedback mechanism is a focus group or interview, the Quality Office works with the department to develop the focus groups / interview questions, drafts the list of questions and shares them with service staff via Dropbox for review and feedback. Once the questions are agreed, the Quality Office runs the focus groups, writes the report and shares it via the Dropbox folder. The Quality Office makes all the focus group arrangements including recruiting participants, engaging a facilitator, recording equipment, transcription, venue, catering etc.

6.1.11 After the Quality Office shares the stakeholder feedback report with the service the QAM meets with service staff to review the findings. The service then incorporates the findings into the relevant sections of the SAR and identifies Planned Improvements and Recommendations based on the findings.

6.1.12 Following this meeting the service staff finalise the draft SAR and its appendices and uploads them to the shared Dropbox folder. At this stage, all service staff are given time to review the draft SAR and its appendices for comment. To the extent that it is possible to do so, the opinions/conclusions expressed in the SAR should reflect the consensus views of the service as a whole.

6.1.13 The service provides the SAR and its appendices to the QAM one month before the SAR is due to be sent to the Peer Review Group. The QAM reviews the SAR and its appendices and liaises with the director / manager of the service regarding any additions, clarifications or amendments that are recommended.

6.1.15 The Quality Office shares the SAR and its appendices with the member of senior management to whom the professional service reports seeking permission to send them to the Peer Review Group.

6.1.16 Once permission is granted, the Quality Office shares the SAR and its appendices with the members of the Peer Review Group (PRG). The PRG must receive the SAR at least six weeks before the Peer Review Visit.

6.2 The Peer Review Group (PRG)

6.2.1 Selection and Appointment of the Peer Review Group (PRG)

6.2.1.1 MIC takes due care to ensure that the members of the PRG are independent and impartial and, accordingly, attributes particular importance to the independence and impartial nature of the Peer Review Report. In the early stages of the SAR process, the QAM identifies potential peer reviewers through consultation with the service under review, relevant MIC staff and contacts within other institutions and organisations.

- The PRG typically comprises three persons, a chairperson and two other members all of whom must be external to the College and may include national, international, employer and student representatives. Peer Review Groups are not comprised of persons of one gender only.
- The members of the Peer Review Group are typically directors / managers or senior members of a similar service in another higher education institution or public or private organisation.
- Where appropriate, a student representative is chosen to represent the students served by the service under review. Selected based on their experience, the person must be an Alumnus and external to MIC.
- A Chairperson is selected from within the members of the group. The Quality Assurance Manager seeks to appoint the Chairperson prior to commencement of the Peer Review phase to assist with the efficient management of same.

6.2.1.2 The Quality Assurance Manager consults with the director / manager of the Service and/or independently identifies potential candidates. The Quality Assurance Manager takes due diligence in relation to the suitability of all potential Peer Review Group members including seeking the support of the member of senior management to whom the service reports in bringing the recommendation on the composition of the Peer Review Group to the Executive Team, who have responsibility to approve Peer Review Group panels.

The Peer Reviewer Nomination Form (QF-005) must be completed and signed by the director / manager of the Professional Service and the member of senior management to whom the service reports prior to submission to ET.

6.2.1.3 In the case of a late withdrawal of one member of the group, it may be possible to co-opt a replacement or to continue with the remaining members; this decision is taken by the Quality Assurance Manager in consultation with the Peer Review Group chairperson.

6.2.1.4 Once the peer reviewers have been approved by Executive Team, a formal letter of appointment is issued by the Quality Office that confirms the dates of the review. Once appointed and prior to the commencement of the Peer Review, any necessary communication between the Professional Service and members of the Peer Review Group is facilitated by the Quality Office.

Peer Reviewers are asked to sign the MIC Non-Disclosure Agreement which represents an undertaking by such persons to safeguard any confidential corporate data or other information shared with them during the peer review process.

6.2.2 PRG Roles and Responsibilities

6.2.2.1 Roles and Responsibilities of all members of the PRG

- Read the SAR and supporting documentation prior to the site / virtual visit;
- Participate in online preliminary meeting(s) to plan the visit;
- Prepare the Pre-visit summary of Initial Findings for sections of the SAR allocated to them;
- Participate in either a site or a virtual visit depending on the prevailing circumstances (e.g. COVID-19 restrictions). The site visit requires the Peer Review Group to spend 2-3 days in MIC (depending on the size of the service under review) The virtual visit requires the Peer Review Group to conduct the review remotely via online meetings;
- Write the Peer Review Report (PRR) containing both commendations and recommendations corresponding to each section of the SAR and provide a rationale for each;
- Respond in a timely manner to follow-up communications after the site / virtual visit and complete and submit the PRG feedback survey;
- Make their own travel arrangements to Limerick and submit their *Expenses Claim Form* and *Honorarium Claim Form (QF-002)* to the Quality Office in a timely manner after the review;
- Treat all documentation and knowledge shared with and by the PRG in strict confidence;

6.2.2.2 Role the of Chairperson

The primary roles of the chairperson are:

- To manage the PRG site / virtual visit meetings and reporting process;
- To ensure that the PRG review and reporting process is conducted in accordance with the MIC Professional Service Quality Review Process (this document) and that the review is independent, impartial and evidence-based;
- To act as a liaison person between the PRG and the Quality Office or other stakeholders;

On a practical level, the chairperson typically carries out the following tasks:

- Coordinate the site / virtual visit: ensure that all meetings are conducted according to the schedule;
- Encourage reviewers to draft their commendations and recommendations after each session;
- Write the introductory section of the PRG report;

- Facilitate the completion of commendations and recommendations (with a rationale for each) for the PRG report;
- Read out in its entirety the PRG report or assign sections of the report to members of the PRG to read out at the end of the site / virtual visit;
- In the days following the visit, read and approve the PRG report;
- In the days following the visit, communicate any suggested changes in the report to the PRG (if necessary).

6.3 Peer Review (PR)

The members of the Peer Review Group (PRG) read the Self-Assessment Report and either spend a number of days in the College or conduct the review remotely depending on the prevailing circumstances (e.g. COVID-19 restrictions).

The review group completes a Peer Review Report (PRR) on its findings that comprises both commendations and recommendations using *QT-005 Professional Service Peer Review Report Template*. These are communicated verbally to the professional service at the end of the site / virtual visit. After the visit, the Peer Review Report is shared with the Quality Office, which shares it with the director / manager of the professional service to check for factual errors. Once this is complete, the Peer Review Report is finalised. The Peer Review phase takes approximately 3 months.

6.3.1 Peer Review Visit Organisation

6.3.1.1 Once the SAR has been sent to the PRG, the Quality Office drafts a proposed Peer Review Visit Schedule based on the SAR. Site Visit Schedules are created using *QT-007 Professional Service Peer Review Visit Schedule Template*, Virtual Visit Schedules are created using *QT-016 Peer Review Virtual Visit Schedule Template*. The Quality Office shares the draft schedule with the service staff for review and feedback. The Quality Office then sends the draft schedule to the PRG for review and feedback.

6.3.1.2 Once the Peer Review Visit Schedule is finalised, the Quality Office sends invitations to relevant staff and stakeholders to meet with the PRG. The Quality office makes all the other necessary arrangements as outlined in *QF-003 Peer Review Visit Preparation Checklist*.

6.3.1.4 The PRG visits the college for two to three days or conduct the review remotely depending on the prevailing circumstances (e.g. Covid-19 restrictions). During the site / remote visit, the PRG meets with staff and stakeholders in accordance with the agreed peer review schedule.

6.3.1.5 The visit to MIC usually commences at 09h00 on a Tuesday morning and concludes on either Wednesday or Thursday evening. A sample visit schedule is provided in *QT-007 Professional Service Peer Review Visit Schedule Template / QT-016 Peer Review Virtual Visit Schedule Template*. A briefing session is given by the Vice- President Governance and Strategy on the Tuesday morning to provide a comprehensive overview of the governance structures within MIC.

6.3.1.6 The review group completes a Peer Review Report (PRR) on its findings, which comprises both commendations and recommendations (and the rationale for these), which are communicated verbally to the professional service at the end of the site / virtual visit. No

new items may be added once the Peer Review Group has verbally communicated the Peer Review Report to the professional service.

6.3.1.7 For security of data purposes a copy of the draft report is made available to the Quality Assurance Manager via MS Teams. The copy of the report is held securely until the finalised draft is completed by the Peer Review Group.

6.3.2 Alternative Virtual Visit Schedule

In exceptional circumstances the site visit may be replaced by a virtual review, for instance, due to travel restrictions (e.g. COVID pandemic), or may be conducted in a hybrid fashion to allow for the inclusion of Peer Review Group members who cannot travel for other reasons.

The review process and its relevant guidelines for drafting the self-assessment report (SAR) remain unchanged. It is anticipated that stakeholder feedback for the SAR will be sought using electronic means such as survey, email, MS Teams meetings, and online focus groups. The College will retain its guidelines for panel composition.

6.3.2.1 Online Meetings

The site visit is replaced with a series of online meetings held over a period of 5-10 (max) days. The elapsed time is suggested due to the more intensive nature of online meetings and to allow combination of enhanced desk review and targeted meetings.

Initial Review Meetings
These meetings ensure that the PRG have sufficient information and background from the College perspective on which to base their review. These meetings allow the reviewers to ask clarifying questions of the members of Quality Office, Senior Management and the Department/Service under review.
Stakeholder Meetings
Stakeholder meetings are held with both internal and external stakeholders.
Peer Review Report Meetings
Peer Review Report meetings facilitate writing the Peer Review Report and may be a combination of online and offline activities.

6.3.2.3 Considerations

The scheduling of meetings may depend on time zones of PRG members.

The Quality Office will be required to moderate the meeting, facilitate connections should broadband drop etc. and give guidance on how to conduct the online meetings.

Technical backup will be needed from ICT Services.

6.3.3 After the Peer Review Visit

6.3.3.1 After the visit, the Peer Review Report is shared with the Quality Office, which shares it with the director / manager of the service so that they and their team can (i) check for factual

errors and (ii) verify that the recommendations fall within the scope and purpose of the quality review process. Should issues arise as a result of the verification process, the Quality Office brings these to the attention of the Peer Review Group chair, who then works with the Peer Review Group to respond or amend the report appropriately.

6.3.3.2 Once the Peer Review Report is finalised it is sent to the director / manager of the service and the member of senior management to whom the service reports.

6.3.3.3 The Peer Review Report is submitted to the Quality Committee for discussion and noting and then to An tÚdarás Rialaithe (Governing Body) for noting and permission is sought from An tÚdarás Rialaithe to make the report publicly available. Once permission is granted, the Peer Review Report is made publicly available via the MIC Quality Office website.

6.4 Quality Improvement (QI)

The Quality Improvement phase comprises the following stages:

- Consideration of recommendations by the professional service and formulation of a Quality Improvement Plan (QIP)
- Identification of SMART (specific, measurable, achievable, realistic and timed) action items necessary to implement the recommendations
- Ongoing implementation of recommendations
- Interim progress report to Quality Committee

The development of the QIP takes approximately 3 months.

6.4.1 The QAM populates the Quality Improvement Plan template (QT-006) with the Peer Review Report recommendations and shares this with the service staff via the Dropbox folder.

6.4.2 The QAM meets with the service staff to develop the Quality Improvement Plan (QIP). The first step in the development of the Quality Improvement Plan is the categorisation of the Action Items based on the level at which action is required (e.g. service under review, other Professional Service, College Body e.g. Executive Team, An Chomhairle Acadúil,). The department then completes the QIP for Action Items categorised at the level of their service by identifying the necessary actions / sub-actions, allocating these actions and setting appropriate target dates.

6.4.3 The Quality Office organises a meeting between the director / manager of the service, Quality Office and the member of senior management to whom the professional service reports to discuss the QIP, in particular in relation to recommendations that fall outside of the department's remit.

In the first instance, recommendations that align with priority objectives within the Annual Operating Plan (AOP) are matched to the relevant action item and the lead for that action item will be contacted for approval to map the AOP action item and the QIP recommendation. Both the AOP and the QIP are updated to reflect this mapping.

Action items for recommendations that do not form part of the AOP but do reside at Senior Management level are agreed with the relevant Senior Manager.

When all recommendations have been discussed and action items agreed, the QAM seeks the approval of the member of senior management to whom the professional service reports to submit the QIP to Executive Team (ET) for their consideration. The QIP is

submitted to the ET for consideration and approval. In the event that there are any issues which ET decide need further consideration, these are conveyed to the QAM and the director / manager of the service by the Senior Manager with overall responsibility for the service area.

6.4.5 The Quality Improvement Plan is submitted to the Quality Committee for comment and noting.

6.4.6 The QIP Action Items are transferred to the QIP Tracker Database by the Quality Office. The Quality Office liaises with the director / manager of the service and relevant leads / senior management each semester to update the status of the action items. The Quality Office and the director / manager complete *QT-019 QIP Interim Progress Report*. The Quality Office submits the report to the Quality Committee for comment and noting.

6.4.7 A meeting takes place between the director / manager of the service, the member of senior management to whom the professional service reports and Quality Office 18 months after ET approval of the QIP , with the express intention of closing out the QIP.

The Quality Office and the director / manager of the service completes *QT-020 QIP Final Progress Report* detailing the status of each recommendation. The Quality Office submits this to the Quality Committee.

The director / manager of the service attends the next Quality Committee meeting to discuss the Final Progress Report with the Committee.

The Quality Committee must satisfy itself that the service has implemented the QIP to the best of its ability. The Quality Committee, once satisfied, signs-off on the completed QIP. The Final Progress Report is submitted to An tÚdarás Rialaithe (Governing Body) for noting and permission is sought from An tÚdarás Rialaithe to make the report publicly available. Once permission is granted, the Final Progress Report is made publicly available via the MIC Quality Office website.

7. Change History

The MIC Professional Service Quality Review Process is approved by the Quality Committee. This document is maintained by the Quality Office, and periodic minor updates are approved by the Quality Assurance Manager. Updates that reflect major changes to the quality review process require approval by the Quality Committee. The most up-to- date version of this document can be downloaded from the Quality Office website.

Revision	Document History	Approved By	Date
0	Initial Release	Quality Committee	01st October 2019
1	Incorporation of the provisions for Alternative Management of Peer Review Group Site Visit (Virtual Site Visit) throughout the document. Introduction of QT-016 *Peer Review Virtual Visit Schedule Template*. **5.0 Responsibilities**	MIC Quality Committee QC2020#03	15th September 2020

	Created section 5.3 *The Professional Service's Obligations*. Moved text from 6.4.8 and 6.4.9 in Rev. 0 under this heading. **6.2 The Peer Review Group (PRG)** Added guidance on the selection of the Peer Review Group including guidance on gender. Changed the appointment process of Peer Review Group. Introduction of form *QP-005 Peer Review Nomination Form*. Added guidance on the handling of the late withdrawal of a member of the Peer Review Group. **6.3 Peer Review (PR)** Added briefing session by VPGS at the beginning of the Peer Review Visit Added request for rationale for PRG recommendations (ADM Recommendation) Added the retention by the Quality Assurance Manager of a copy of the draft PRR until report is finalised to mitigate against the risk of data loss. Introduction of QF-002 Peer Review Honorarium Claim Form **6.4 Quality Improvement (QI)** Added the submission of the QIP to UR for noting and to seek permission from UR to make the QIP publicly available.		
1.1	Removed reference to Technical Writer throughout the document as Quality Office will not be availing of the services of a technical writer. The final review of the SAR will be completed by the QAM instead.	Emma Barry Quality Assurance Manager	12th October 2020
1.2	Revised guidance on the composition of the Peer Review Group and selection of the Chairperson of the Peer Review Group.	Emma Barry Quality Assurance Manager	23rd November 2020
1.3	Insertion of revised QIP Process approved by ET (June 2021)	Emma Barry	19th October 2021

		Quality Assurance Manager	
1.4	Annual Review: 6.1.1 Removed reference to commencing reviews at beginning of year, reviews commence in the year that they are scheduled and start dates are staggered based on the operational demands of the services under review and the Quality Office. 6.1.6 Change to one email at the beginning of the academic year which lists the reviews due to commence in the coming academic year and a link to previous peer review reports. Added e-mail to inform relevant senior management of commencement of review. 6.2.1.4 Addition of MIC Non-Disclosure Agreement for PRG members. 6.2.2.1 Addition of preliminary online meetings and completion of pre-visit finding to roles and responsibilities of the PRG. 6.3.1.7 Change to MS Teams for data security. 6.3.2 Addition of hybrid PRV in cases where a PRG member cannot travel. 6.3.3.3 Added discussion to submission of PRR to QC as per revised QC Terms of Reference. 6.4.5 Added comment to submission of QIP as per revised QC Terms of Reference. Submission of QIP to UR removed. 6.4.6 Change frequency from quarterly to each semester. 6.4.7 Added QIP Interim and Final Progress Reports and references to templates QT-019 and QT-020. Added submission of final QIP Implementation Report to UR.	Quality Committee QC 2022#03	13th September 2022

BRIATHAR DÉ MO LÓCHRANN

MIC

MARY IMMACULATE COLLEGE
COLÁISTE MHUIRE GAN SMÁL

Self-Assessment Report

Professional Service

Month, Year

Instructions

The purpose of this template is to provide guidance on the content of a Self-Assessment Report (SAR) for a Professional Service Quality Review.

Instructions: Remove this instructions page before finalising this document.

Cover Page: Document the following on the first (cover) page:

- The Name of the Professional Service(s)
- The month and year that the SAR is finalised.

Header/Footer: Update the footer with the Professional Service Name.

Table of Contents: Remember to update the Table of Contents (TOC) section. To update the TOC: Put cursor on TOC table and right click on the mouse, choose *Update Field* – choose *Update entire table.*

Template Sections: The document template consists of recommended headings and content guidance for each section. The content guidance should remain in the document to aid the Professional Service whilst compiling the Self-Assessment Report and then removed prior to finalising the Self-Assessment Report.

Text in *red italics* indicates that information needs to be inputted in its place e.g. the Professional Service name. The formatting of this text should be changed to that of the remainder of the paragraph prior to finalising the Self-Assessment Report.

Self-Assessment Report: The report should be short (30 - 50 pages) and should focus on the performance of the Professional Service. It should be supported by numbered appendices which will be provided to the Peer Review Group electronically along with the Self-Assessment Report. The purpose of an Appendix is for adding detailed or supplemental information that would otherwise interrupt the flow of the document.

The SAR is sent by the Quality Office to the Peer Reviewers 6 weeks before the Peer Review Group Visit.

Table of Contents

List of Appendices

Insert list of appendices here.

List of Figures

Insert list of figures here.

List of Tables

Insert list of tables here.

Foreword

Insert a brief introduction (no more than one page) to the report here. Although this section is located at the beginning of the document it is usually written at the end when the rest of the document is complete.

1.0 Introduction

The text for all of section 1 will be provided by MIC Quality Office
The purpose of this section is to introduce the peer review group to MIC and will contain general information on MIC for context. It will also provide information on Quality at MIC and the steps taken in the Self-Assessment process.

1.1. Mary Immaculate College

General information about MIC including history and development of the college, organisational structure and key facts and figures.

1.2 MIC Mission

MIC Mission Statement

1.3 MIC Strategic Plan

An introduction to key institutional strategies and link to the current MIC Strategic Plan.

1.4 Quality at MIC

Overview of Quality at MIC including:

- The governance and management of quality at MIC
- The Quality Office
- The Quality Review process

1.4.1 Self-Assessment Process

Give a description of the self-assessment activities undertaken. Include a list of activities carried out by the Professional Service such as Surveys, Focus Groups, SCOT Analysis, Benchmarking etc. using the table template below

A range of methods may be used to gain feedback from users / stakeholders. Where large numbers of users are involved surveys may be appropriate. With smaller numbers other techniques such as interviews or focus groups may be more appropriate.

Step	Date	Purpose
Initial Meeting		Meeting between Quality Assurance Manager (QAM) and Head of Service.
Briefing Meeting		Briefing meeting between QAM and the members of the Professional Service under review.
Facilitated Workshop		Mission and Strategy Aims and Objectives Stakeholders SCOT Analysis – Strengths, Challenges, Opportunities and Threats Delegation of SAR content and other tasks Decision on the most appropriate feedback mechanism – survey, focus group etc. Setting of SAR timeline including key targets and meetings Supports required
Feedback Planning Meeting		Meeting re arrangements for stakeholder feedback.
Feedback		Gather stakeholders' opinions on all aspects of the service with a view to resource allocation & future planning. Who was surveyed / interviewed, what was the response rate? Provide a copy of the survey / interview questions and resultant reports as appendices to the report.
Benchmarking		Benchmark service against appropriate service based on defined indicators. Provide a report which includes a rationale for your choice of benchmark service / institution the indicators examined and the outcome as an appendix to your report.
Feedback / Benchmarking Review Meeting		Review feedback and benchmarking and add it to relevant sections of SAR. Generate planned improvements based on feedback.
SAR Meeting		Workshop to review the SAR prior to sending to Quality Office.

Table 1: Steps in the *Professional Service Name* Self-Assessment Process

2.0 Structure, Governance & Mission

2.1 Overview

Provide a brief overview of the service – this can be extracted from the service QMS document.

2.2 Users / Stakeholders

Identify key service users and stakeholders, the individuals, departments, services and organisations to whom the Professional Service provides a service. This may consist of a wide range of clients, both within the institution and external to it? Briefly describe the nature of the relationship. *This will be explored in the workshop.*

2.3 Service Structure and Governance

- Insert an organization chart(s) depicting the structure of the service, how it reports to senior management and how it interacts with the governance of the college.
- Insert descriptive text to provide further explanation where necessary.
- Provide information on relevant developments in recent years.
- Consider the effectiveness of the current organisational structure and reporting lines. Does it support your mission, aims and objectives?

2.3.1 Staff Profile

- Provide details of service staff as an appendix which includes the following information:
- Grade;
- whether the staff member is permanent or temporary;
- whether the staff member is full-time or part-time;
- the number of years the staff member has worked in the service and / or MIC;
- contract length (for staff members with temporary contracts);
- gender balance across all grades of staff;
- Consider whether your staff profile is appropriate for your service.
- Are there any potential difficulties related to succession planning, contingency planning or gender balance that need to be addressed?

2.4 Mission

What is the mission of the service?

This will be explored in the workshop.

- How does your mission align with and support the MIC Mission Statement and Strategic Plan?

2.5 Aims and Objectives

What are the aims and objectives of the service?

This will be explored in the workshop.

- What are the aims and objectives of the service? How are they determined?
- How do the aims and objectives relate to the MIC Mission Statement and Strategic Plan?
- How well do the aims and objectives reflect the needs of your stakeholders and service users?
- What provisions exist for the long-range planning and development of your service?
- What factors have influenced the implementation of your aims and objectives over the past three years?
- How do you know that the implementation of your aims and objectives has been successful? What measures, either qualitative or quantitative, support / provide evidence of success?

2.7 Planned Improvements

Summarise improvements to be implemented based on analysis of feedback from stakeholders.

-

3.0 Professional Service Name Key Functions

Provide a summary of the key functions of the service (as per service QMS).

3.1 Function 1

The sections to follow give a breakdown of each of the functions listed above. Feedback from SCOT analysis / surveys / interviews / focus groups and benchmarking relevant to each function should be included in the section related to that function.

When completing the sections consider:

- The extent to which these functions reflect the mission, aims and objectives of the service?
- Whether some functions have primacy over others?
- Is this function shared or partially dependent on another service or department? For shared / dependent functions, are ownership and responsibilities clear?
- What users / stakeholders are served by the functions provided?
- What approaches are used to measure the quality and impact of your activities?

When completing this section remember the four self-assessment questions:

- What do you do?
- How do you do it? (Reference relevant supporting policies and procedures and include them as appendices.
- How do you know it works? What are the Key Performance Indicators for this function? Are you meeting these (information from SCOT analysis / surveys / interviews / focus groups or other measures)?
- How do you change in order to improve? (Implemented or Planned Improvements)
- Repeat until all key functions are documented.

3.X Planned Improvements

Summarise improvements to be implemented based on analysis of feedback from stakeholders.

-

4.0 Environment and Facilities

4.1 Service Facilities

Provide details of the service's current facilities including offices, dedicated rooms, location etc., Include maps and drawings as appendices to illustrate location, layout etc.

Was there any feedback about the facilities from stakeholders?

4.2 Equipment & Systems

Give a description of the key equipment and systems used by staff. This may include information systems, software packages and any other relevant equipment.

Was there any feedback about equipment from stakeholders?

4.3 Staff Facilities

Give a description of the staff facilities both in general e.g. staff room and facilities specific to service staff if applicable. Include maps and drawings as appendices to illustrate location, layout etc.

Was there any feedback about the facilities from stakeholders?

4.4 Opening Hours

Describe the service opening hours and provide any feedback from stakeholders regarding the opening hours.

4.5 Planned Improvements

Summarise improvements to be implemented based on analysis of feedback from stakeholders.

-

5.0 Organisation and Management

5.1 Communication

5.1.1 Staff Communication

Describe the communication mechanisms within the service. When completing this section consider:

- How often does the service hold regular staff meetings and who attends? Do staff have the opportunity to set Agenda items? How are decisions reached? Is there a formal minute record and is there an opportunity for staff to review and agree the minutes?
- How does the service ensure that significant information coming to the service from outside is brought to the attention of all relevant staff members.
- How does the service ensure that staff are made aware of the service's functions, objectives and procedures?
- How are staff kept informed of decisions that affect the work of the service?
- Do you consider there to be effective communication among staff? How do you ensure that there is effective communication?

5.1.2 Communication with Users / Stakeholders

Describe the communication mechanisms with service users / stakeholders. When completing this section consider:

- How does the service make information about its key activities publically available (website & other methods)?
- How do manage communication with your users?
- How are users kept informed of relevant decisions?
- How does the service ensure that user groups understand the service they can expect to receive?
- How does the service ensure that your guidelines / handbooks are useful and relevant to your users? Have users been asked to evaluate their usefulness? What changes have been / will be implemented based on the feedback?
- Based on surveys / focus groups / interviews / benchmarking, what improvements could be made to your current methods of communication?

5.2 Planning

5.2.1 Annual Operating Plan

Provide details of the process for the development of annual operating plans. Who is involved in its development? How does it align with and support the MIC Strategic Plan? Provide a copy of the current AOP as an appendix.

5.2.2 Service Planning

Describe how the service plans its activities (daily, weekly, monthly, and annually) both formally

and informally. How are tasks delegated and responsibilities assigned? How are decisions made?

5.2.3 Financial Planning and Management

- How is the service funded?
- How is money allocated to the service in MIC?
- Provide details of the budget allocation process in MIC.
- How does the service develop its budget each year?
- How does the service monitor its budget to ensure transparency, accountability and best practice?
- If the service manages expenditure from a number of budgets (either budgets within the service or budgets outside of the service e.g. academic departments), how is this managed?
- Reference relevant Finance policies and procedures where applicable.

5.3 Committees

Provide a list of committees, within the service, within MIC and outside MIC that service staff are members ex officio. Provide information on their role in the committee, the terms of reference of the committee (link / appendix) and meeting frequency.

5.4 Risk Assessment and Management

How does the service identify and manage risk? How are risks evaluated, documented, mitigated, managed and monitored?

5.5 Records Maintenance and Retention

How does the service manage and retain data? How does the service ensure that it is compliant with GDPR?

5.6 Quality Management System

Provide a description of the service Quality Management System (provided by the Quality Office).

- When did the service develop its QMS?
- Who manages it?
- How are staff informed of changes to procedures?
- Will any changes be made to the QMS following the self-assessment process?
- How will the service ensure enhancement of quality on an on-going basis?
- How will you communicate changes made based on feedback to stakeholders (closing the feedback loop)?
- The service QMS document should be included as an appendix.

5.7 Staff

5.7.1 Staff Recruitment

- Describe the processes for staff recruitment.
- Are current staff consulted on upcoming appointments?

5.7.2 Staff Development

Consider the following questions when completing this section:

- What processes are in place to support staff induction within the service?
- How are staff training needs identified in relation to service needs and institutional requirements?
- What are the staff development requirements related to the achievement of the aims and objectives of the service?
- How does the service ensure that staff participate in training programmes?
- What barriers might exist to ensuring staff have the opportunity to take part in training and development courses? What has your service done to identify and eliminate potential barriers?
- Does your service have a policy of encouraging staff to gain further qualifications?
- How do staff keep up to date as regards the advent of new legislation?
- How do staff ensure that the implications of new legislation are translated into the operating environment?
- What improvements would service staff like to see in relation to training and development?
- How does the service ensure that staff are aware of required College policies and procedures such as Health & Safety, Equality & Diversity, Dignity & Respect and familiar with college-wide development initiatives such as Athena Swan?

Details of staff participation in developmental activities should be provided. These activities might include induction, conferences, workshops, exchange visits and in service training. An indication should be given of the role these activities play in the attainment of aims and objectives of the service.

5.7.3 Staff Appraisal

Provide information on the methods of staff appraisal, both formal and informal.

5.8 Planned Improvements

Summarise improvements to be implemented based on analysis of feedback from stakeholders.

BRIATHAR DÉ MO LÓCHRANN

MIC

MARY IMMACULATE COLLEGE
COLÁISTE MHUIRE GAN SMÁL

Peer Review Report

Professional Service

Month, Year

Contents

Introduction

The Introduction will be completed by the Quality Office and will contain the following sections:

1. Background (to MIC's quality review process)
2. The Professional Service (a brief description of the service)

Peer Review Group Observations

This section is completed by the Peer Review Group.

This section is typically one or two pages in length and provides the Peer Review Group with an opportunity to report upon:

1. The extent to which the service engaged enthusiastically, honestly and effectively in the self-evaluation exercise
2. The Service's openness during the visit
3. The quality of the self-assessment report (SAR)
4. Stakeholder feedback relating to the Service and the extent to which the Service is fulfilling stakeholder needs

Structure, Governance and Mission

Commendations

Recommendations(Please include a brief justification for the Recommendation)

Key Functions

Commendations

Recommendations (Please include a brief justification for the Recommendation)

Environment and Facilities

Commendations

Recommendations (Please include a brief justification for the Recommendation)

Organisation and Management

Commendations

Recommendations (Please include a brief justification for the Recommendation)

Annex 1: Peer Review Group Members

Annex 2: Schedule of Meetings with Stakeholders

MARY IMMACULATE COLLEGE

Quality Improvement Plan

Profession
al Service

Action Item	PRR Reference	SAR Reference	SP Reference	AOP Reference	Recommendation	Level	Action	Allocated To	Status / Target Date

Glossary

VPAA	Vice-President of Academic Affairs
VPAF	Vice-President of Administration and Finance
VPGS	Vice President of Governance and Strategy
DQ	Director of Quality
QAM	Quality Assurance Manager
QO	Quality Office
ET	Executive Team - MIC Management Committee
PRR	Peer Review Report
SAR	Self Assessment Report
SP	Strategic Plan
AOP	Annual Operating Plan