Malta Further and Higher Education Authority

Follow Up External Quality Assurance Review Report

College of Remote and Offshore Medicine Foundation

November 2025

1 Introduction

This follow up review evaluates progress made by the College of Remote and Offshore Medicine Foundation CoROM in addressing the recommendations issued during the 2024 External Quality Assurance Review. The review process commenced with a preliminary online meeting with the provider on 5 November 2025, followed by an onsite visit to the institution's premises in Malta on 18 and 19 November 2025. To accommodate the institution's global footprint, the panel conducted hybrid interviews, meeting with the leadership team, academic and administrative staff, students, alumni and external stakeholders both in person and via video conference.

CoROM is a specialised international higher education institution dedicated to remote, offshore and austere medicine. It serves a global community of medics, paramedics and health professionals working in demanding and often unpredictable environments. Since the previous review, the institution has focused rapid policy development, the consolidation of governance structures and the enhancement of administrative procedures.

The purpose of this follow up review was to evaluate the degree to which CoROM has addressed the Main Recommendations and Key Recommendations issued in 2024 and to assess the effectiveness of its evolving internal quality assurance system. The panel acknowledges the openness, professionalism and willingness to improve that was consistently demonstrated across staff and student groups.

2. Methodology

A panel comprising of two of the original review team was formed. These were:

Andy Gibbs (Chair) Independent QA Expert

Anita Līce (Peer reviewer) Independent QA Expert

CoROM provided a progress report which the panel reviewed prior to the site visit. The panel met online with representatives of CoROM on 5 November 2025 to discuss expectations and outcomes of the visit, as well as to clarify any issues outstanding form the progress report.

The panel requested updated documentation from CoROM in advance of and during the visit. This included the Internal Quality Assurance policy, updated Policies and Procedures (such as the Financial Risk Assessment Protocol and Succession Process), governance and organisational documents, programme design and approval documentation, evidence of curriculum review, student and staff records, information management documentation, the new complaints and appeals policy and access to online learning environments. CoROM was able to produce all requested documents without delay and in a well-organised fashion.

During the visit, the panel met senior leadership and governance representatives, programme leads and teaching staff, support staff, undergraduate and postgraduate students, alumni and external stakeholders. The panel reviewed Moodle, Google Classroom and the DreamClass Student Information System and sampled tracking tools used by programme managers. Discussions explored both the intentions behind the new policies and the extent to which they were operationalised and embedded in practice.

The panel used the following terms, established in previous MFHEA follow up visits to assess progress.

Action completed: The recommendation has been fully addressed. Relevant policies are approved, and there is clear evidence that they are operational and effective in practice.

Significant progress made: Significant progress has been made (e.g., a policy has been drafted or approved), but full implementation is not yet evident, or specific operational gaps remain.

Still work in progress: Work on the recommendation has commenced and is ongoing, but it is not yet sufficiently advanced to be assessed as partially or fully met.

No significant progress made/Action not addressed: There is no evidence of significant progress, or the actions taken do not adequately address the core requirements of the recommendation.

Findings and judgements are aligned with the National Quality Assurance Framework.

3. Progress Against Standards

STANDARD 1 Internal Quality Assurance – Significant progress made.

CoROM has now published an Internal Quality Assurance policy and a full Policies and Procedures suite on its website, covering governance, programme design, student policies, admissions, examinations, research, RPL, student records and retention, risk management and more. Policies are versioned, dated and centralised which represents a major advance. QA roles are described in narrative form and staff show growing awareness of these responsibilities, though the QA Committee is currently non-functional and operates "ad-hoc". Staff confirmed that a QA calendar is being developed for implementation in January 2026. Policy discussion and

approval flows are emerging through the Board of Regents, with students confirming involvement in Board meetings. Programme leads, faculty and managers shared examples showing improving understanding of QA expectations. The College outlined plans for the appointment of a dedicated QA lead in the early part of 2026.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR1	Develop, publicise and operationalise a comprehensive QA policy that clearly defines roles, responsibilities, and processes, ensuring strategic alignment and consistency.	Within 26 weeks of publication.	**Significant progress made**	IQA published; full policy suite online; roles described. Operationalisation is pending (no QA calendar, ad-hoc meetings). QA Committee not yet gathering formally. Evidence of informal training and role definition provided.
MR2	Clarify stakeholder roles in QA: define and formalise the roles of faculty, staff, and students to ensure structured involvement and accountability.	Within 16 weeks.	**Action completed**	Staff roles clarified in IQA Section 10.4; Student Union Policy defines student role; academic responsibilities evidenced through contracts.
MR3	Systematise external stakeholder engagement: establish regular mechanisms for external stakeholder feedback in the QA process.	Within 26 weeks.	**Action completed**	Programme design policy includes external input; MSc review evidences stakeholder engagement.
KR1	Enhance policy documentation: improve documentation and communication	Within 16 weeks.	**Action completed**	Good Academic Practice, Ethical Engagement and Generative AI policies published

	of policies, particularly around academic integrity and technological infrastructure.			and oriented to staff.
KR2	Implement ongoing training in QA best practices for faculty and staff.	Within 16 weeks.	**Action completed**	Training is informal and mentor based. There is an evidence trail of independent training input.
KR3	Integrate learning analytics for monitoring and analysis of educational processes and outcomes.	Within 52 weeks.	**Action completed**	DreamClass/Moodle used; no integrated analytics reports evidenced, however analytics are undertaken on a case by case basis as aggregating would lose nuance and validity.

STANDARD 2 Institutional Probity and Administration – Action completed

Leadership succession is now documented and staff explained the planned transition with clarity. Revised contracts and pay structure have been introduced and staff confirmed that contracts are in place and the panel saw examples. Financial risk protocol is published and Risk Register was demonstrated. Organisational map is published on the website. Evidence of reconciliation of past remuneration discrepancies and the CVO and Commissioner for Revenue documents are still outstanding.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR4	Clarify employment and remuneration structures for key roles (e.g., Executive Dean, registrar) and resolve any discrepancies between reported and actual compensation.	Within 26 weeks.	**Action completed**	Revised contracts supplied, Executive Dean role formalized via ASMG contract; past remuneration discrepancies reconciled.

MR5	Develop a clear leadership continuity succession plan for key positions.	Within 26 weeks.	**Action completed**	Succession plan documented in governance policies and roles of Board/Dean Emeritus clearly defined.
MR6	Institute a formal financial risk assessment protocol.	Within 26 weeks.	**Action completed**	Financial risk protocol published; Risk Register and quarterly review process confirmed by staff.
MR7	Review and formalise administrative arrangements to ensure clarity in roles, responsibilities, and compensation.	Within 26 weeks.	**Action completed**	Contract templates provided; need full HR file with workload model.
KR4	Submit: (1) declaration of compliance (or otherwise) from the Commissioner for Voluntary Organisations; (2) compliance certificate from the Commissioner for Revenue.	Within two months.	**Still work in progress**	Annual Return filed; CVO and Revenue certificates still outstanding.

STANDARD 3 Design and Approval of Programmes – Action completed

A strong programme design and approval policy is now published and aligned with NQAF requirements. Programme leads described detailed benchmarking against international curricula. Extensive stakeholder engagement was demonstrated including LinkedIn surveys, international partners, employers, paramedic associations and external experts. Tools and templates for design, approval and review are in place. Annual review is developing though not yet fully formalised.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR8	Review policies on course design, development, validation, and review to include engagement of internal and external stakeholders.	Within 16 weeks.	**Action completed**	Updated design and approval policies published; stakeholder input embedded.
MR9	Develop processes to implement and record multiple internal and external stakeholder involvements in design and approval.	Within 16 weeks.	**Action completed**	Stakeholder inputs recorded in programme development (e.g., BSc feedback form, LinkedIn survey results); processes described.
KR5	Update the policy on programme design and review to include all elements required by MFHEA standards and give proper guidance to staff.	Within 26 weeks.	**Action completed**	Policy aligns to MFHEA S3 (explicitly lists 12 required characteristics in Section 3.3); mapping checklist still required.
KR6	Update the IQA document to align with official internal policies regulations and avoid contradictions duplications.	Within 16 weeks.	**Action completed**	Updated IQA alignment present in published documents.

STANDARD 4 Student centred Learning, Teaching and Assessment – Action completed

Students reported high satisfaction with accessibility and responsiveness of faculty. New complaints and appeals policy is published and operationalised. Academic integrity and ethics policies are available and understood. Engagement tracking on Moodle and Google Classroom is

active. Assessment records remain on generic cloud systems (DreamClass/Google) with no evidence of Malta-based storage, however there are no physical records to store. Student support and success functions exist but require formal documentation.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR10	Formalise procedures for student complaints and appeals.	Within 26 weeks.	**Action completed**	Complaints & Appeals Policy approved. Informal mechanisms in place as well as formal procedures. Admissions appeals now explicitly permitted.
MR11	Keep records of assessment and grading and ensure compliance steps.	Within 26 weeks.	**Action completed**	Assessment data stored on secure servers (DreamClass). Hosting/archival agreements were shared with panel.
KR7	Formalise agreements with partners involved in course delivery and mobility.	Within 52 weeks.	Partially	Some formal agreements and MoU with delivery/mobility partners provided but no consistent due diligence policy.

STANDARD 5 Student Admission, Progression, Recognition and Certification – Action Completed

Progression tracking policy exists and trackers are used actively. DreamClass, Moodle and Google trackers were demonstrated during meetings. Published admissions policy now exists with weighted criteria. Admission criteria published on website and admission processes tracked on DreamClass. Student progress tracked via Moodle, Google and DreamClass. RPL policy in place.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR12	Establish formalised procedures for tracking student progression through the QA system.	Within 26 weeks.	**Action completed**	Progression tracking evidenced via DreamClass and Programme Manager trackers; policies in place.
KR8	*Ensure all data on admission, progression, recognition and certification are securely stored.*	*Within 24 months.*	**Action completed**	*Secure storage agreements evidenced.*
KR9	Develop procedures to validate non formal and informal learning.	Within 32 months.	**Action completed**	RPL cases available; formal RPL procedure that includes procedures to validate non formal and informal learning published on website
KR10	Make selection for admission more transparent, using clear criteria beyond basic eligibility.	Within 32 weeks.	**Action completed**	Admissions criteria published with specific weighting (e.g., 30% interview, 30% experience) in new policy.

STANDARD 6 Teaching Staff – Significant progress made

Recruitment policy is published and operational. Faculty confirmed contract arrangements and positive working relations. CPD policy exists and needs-based CPD is occurring, guided by Personal Development Plans (PDPs). No formal CPD budget line yet established, with reliance on staff's external employment. No written research strategy though priorities are listed online. No formal workload model for research, but participation in international networks is present. Internal communications are effective via new stakeholder update protocols.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR13	Develop an internal policy for continuous professional development (CPD) based on staff evaluation and identified needs.	Within 26 weeks.	**Action completed**	Faculty PDP policy present and evidence of implementation provided via the "Faculty Development and Quality Policy" and sample PDPs.
MR14	Ensure legally correct contractual relationships with all staff, including clear contracts and defined responsibilities.	Within 6 weeks.	**Action completed**	Contract templates provided and staff confirmed during interviews that everybody has a standardised contract.
KR11	Ensure transparent and fair recruitment: publish vacancies consistently and use official selection procedures against set criteria.	Within 26 weeks.	**Action completed**	Recruitment adverts provided (published on LinkedIn to 12k+ followers); shortlisting matrices & decision records required.
KR12	Allocate specific funding for general CPD of staff.	Within 52 weeks and in next year’s budget.	**Action completed**	CPD is needs based, uses free resources however there is no dedicated budget line. The College admits relying on free resources and external employment.
KR13	Formulate and implement a comprehensive research strategy integrating research as an essential HE activity.	Within 52 weeks.	**Still work in progress**	Research priorities published; formal "Research Priorities Institutional Strategy 2024-2028" and "Ethical Engagement Policy" provided. Strategy

				implementation is ongoing but limited by lack of internal funding.
KR14	Allocate specific resources and workload for research; encourage participation in international research networks.	Within 52 weeks.	**Still work in progress**	No research workload allocation in contracts. Participation in the European Prehospital Research Network has been mentioned. Memorandum of Understanding with University of Bern has been confirmed.
KR15	Facilitate regular information exchange so all staff understand internal processes, procedures, and roles effective online comms.	Within 26 weeks.	**Action completed**	Internal comms framework demonstrated.

STANDARD 7 Learning Resources and Student Support – Significant progress made

Accessibility and inclusive learning policy is published and based on international best practice ("THRIVES" model). Students praised approachability of staff and peer support. ICT continuity, backup and disaster recovery plan policy exists in the IQA document but operational testing (e.g., failover test) was not demonstrated. Student Success Officer function exists and is operational via a new Help Desk system. Staff development for support roles is not systematically captured.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR15	Enhance ICT infrastructure with continuity backup procedures to ensure reliability of services.	Within 52 weeks.	**Action completed**	ICT agreement and continuity plan evidenced in IQA Document (Section 8). " The panel verified via demonstration that the DreamClass

				system ensures robust data safeguarding and backup.
MR16	Formalise inclusive policies for diverse student needs accommodations adaptive materials tailored support.	Within 26 weeks.	**Action completed**	Inclusive learning policy published ("Accessible and Inclusive Learning Policy") and active.
KR16	Formalise student support systems with clear access guidelines for tutors counsellors advisers.	Within 26 weeks.	**Action completed**	Student support structures evidenced via Director of Student Success and Help Desk ticketing system. Students confirmed "faculty are always approachable". Full framework still needed.
KR17	Formalise professional development for all staff.	Within 26 weeks.	**Action completed**	A needs-based system is in place. Provided evidence of training. General PD noted; no institution-wide PD plan. While no specific budget line exists for non-academic staff, access to needs-based funding and internal training resources was confirmed.

STANDARD 8 Information Management – Action completed

Engagement monitoring templates are in use via the DreamClass system. A "Policy on Student Records and Retention" (2025) has been introduced to define retention periods. Formal data retention and archiving specifically in Malta is not yet established. No restore test, retention schedule, physical archival system or Malta-based server hosting evidence provided. However the panel saw evidence of secure data retention and archiving with secure back up.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR17	Put formal arrangements in place for systematic collection, analysis and evaluation of key student staff information.	Within 26 weeks.	**Action completed**	Collection systems exist and are operational (DreamClass tracking demonstrated); Programme Managers actively monitor individual progress, though aggregate analytics and the formal evaluation cycle are still developing.
MR18	Develop a formal system to maintain, retain and archive student records in Malta for prescribed durations.	Within 52 weeks.	**Action completed**	Policy on retention duration exists and explicitly references the "Malta Information and Data Protection Commissioner". No Malta-based retention/archiving system was evidenced, however the secure systems are accessible in Malta.

STANDARD 9 Public Information – Not Applicable

Policies and procedures are clearly published. Programme information is accessible. Institutional governance is more transparent than previously.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
–	Maintain accurate public information		**Action completed**	Website accurate and comprehensive with accessible policy suite.

STANDARD 10 Ongoing Monitoring and Periodic Review of Programmes – Judgement Partially Met

Programme leads described weekly review of progress. Integrated review strategy is published. Plans for annual review are in place but require evidence of systematic use across all programmes. Change logs are managed via the Stakeholder Update Policy. External stakeholders and alumni confirmed positive involvement.

Code	Recommendation	Timeline	Follow up status	Issues notes and evidence required
MR19	Establish a formal, proactive schedule for periodic review of programmes aligned to internal QA policy standards.	Within 26 weeks.	**Action completed**	MSc review dossier provided; other programme reviews needed.
MR20	Introduce a systematic, structured approach for collecting and incorporating stakeholder feedback to inform programme development.	Within 26 weeks.	**Action completed**	Student feedback collected via Google Forms. Employer/external input evidenced by a sample of "Stakeholder Curriculum Feedback Form" and survey results. At the same time, limited evidence was provided of systematic employer/alumni input in 2025–26 cycle.
MR21	Develop a transparent documentation process recording recommendations, actions taken, and communications to stakeholders.	Within 26 weeks.	**Action completed**	Change log and stakeholder communication of revisions not yet evidenced.
KR18	Implement an integrated review strategy that	Within 26 weeks.	**Action completed**	Integrated review framework documented in

	holistically incorporates input, process, and outcome standards.			"Holistic Approach to Programme Effectiveness" policy; implementation evidenced by BSc benchmarking against QAA standards.
KR19	Ensure decisions to revise replace programmes are transparent with clear documentation and rationales to stakeholders.	Within 26 weeks.	**Action completed**	Process defined in "Course Design and Validation Policy"; transparent decision making evidenced by Board of Regents minutes and "Stakeholder Update" communications; decision logs or published change notices missing.

4. Overall Conclusion

CoROM has made sincere and meaningful progress since the previous review. The publication of a comprehensive policy suite and consolidated Internal Quality Assurance framework is a major achievement that addresses the majority of previous governance recommendations. Remaining gaps relate mainly to operationalisation, documentation and evidencing practice rather than intent or capability. With continued focus on embedding systems, allocating specific resources, and producing live evidence of QA activity, CoROM is well positioned to meet all MFHEA standards in the next evaluation cycle.