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DH Department of Health

Final review trends report
2003-06

Major review of NHS-funded healthcare programmes in England

QAA

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Overview

The Quality Assurance Agency for Higher Education (QAA) was awarded the contract by the Department of Health (DH) and its partners, to develop, implement and manage Major review. A quality assurance review method that looked at all National Health Service (NHS)-funded healthcare education in England from 2003 to 2006.

Major review was developed in partnership with the DH, the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC) and Strategic Health Authorities (SHAs)/Workforce Development Confederations (WDCs) with input from higher education institutions (HEIs), NHS healthcare trusts and the voluntary and independent health sectors.

This overview highlights the key findings from the analysis of outcomes from each Major review and the evaluation of the process itself. Further details are captured in the Executive summary and the report that follows.

Outcomes of Major review

- Evaluation of the reviews showed that 95 per cent of all those involved in Major review were satisfied that the reviews were conducted well and according to due protocols (section 3.2.5).
- Major review teams had confidence in the academic and practitioner standards achieved across all 90 reviews. Only one programme received a judgement of no confidence, and one programme received a judgement of limited confidence (section 4.1).
- The reviewers found that the quality of learning opportunities was commendable in more than 90 per cent of the provision. The quality of the remaining programmes was approved. No programmes were found to be failing (section 4.1).
- Major review confirmed that students[1] who successfully completed programmes were fit for practice, purpose and award (section 4.2.1.4).

Key **strengths** found in the provision reviewed

- HEIs and their partners work effectively together to plan, develop and implement the curriculum (section 4.2.1.2).
- Graduates and diplomates achieve their learning outcomes, are fit for purpose and are well prepared for employment in the NHS (section 4.2.1.4).
- Teaching and assessment methods are effective in promoting the integration of theory and practice using some innovative methods (section 4.2.2.1).
- Interprofessional learning is well supported in practice (sections 4.2.1.2 and 4.2.2.1).
- There is a vast array of high-quality resources to support learning and teaching (section 4.2.2.3).

Some aspects of **good practice**

- Post-registration and CPD curricula are well designed and effectively incorporate work-based learning (section 4.2.1.2).
- Practice placement facilitators[2] perform a significant role in supporting mentors, practice educators and assessors in placement areas (Sections 4.2.1.1 - 4.2.1.3, and 4.2.2.1 - 4.2.2.3.

[1] In this report 'students' is used as a generic term for those undertaking programmes of study and includes trainees.

[2] 'Practice Placement Facilitator' is used here as a generic term for a number of similar roles, also known commonly as clinical placement facilitators or placement learning facilitators.

- There is widespread use of problem-based and enquiry-based teaching methods to develop students' and trainees' critical and analytical skills (sections 4.2.1.2 and 4.2.2.1).
- Some providers offer unusual or innovative placement opportunities on campus or in non-traditional settings (sections 4.2.2.1 and 4.2.2.3).

Frequently occurring **weaknesses**

- There are limited opportunities in some disciplines for service user and carer involvement in curriculum development and/or delivery (section 4.2.1.2).
- There is a lack of sufficient mentor or practice assessor training, updating or support in some provision (section 4.2.2.2).
- Feedback to students on assessment is not always timely, consistent nor useful (section 4.2.1.3).
- Strategies for programme monitoring and placement audit are not always thorough nor consistently applied (section 4.2.3)
- There are high attrition rates on some programmes and strategies to improve retention are not always effective (section 4.2.2.2).

Positive features of Major review

- Major review was a success: it achieved its aims fully and numerous areas of strength and good practice have been identified (chapters 1, 4, and 5).
- Major review promoted and strengthened partnership working between HEIs, SHAs and placement providers (sections 3.2.5.3/ 3.2.5.9/ 3.2.5.11/ 4.2).
- Major review stood the test of time and was able to adapt to the changing environment, while ensuring consistency across all reviews (chapter 2, section 3.2.5.3, chapter 5).
- Major review recognised that 50 per cent of learning takes place in practice, and raised the profile of quality assurance of education in placement areas (sections 3.2.5.9 and 3.2.5.11)
- The ability to differentiate judgements ensured that not all the provision was penalised if, for example, there was a difficulty in one programme, mode of delivery or level of award (section 3.2.5.10 and 4.1).
- Bullet points enabled strengths and good practice to be celebrated as well as to identify weaknesses (section 4.1).
- Some streamlining was possible: incorporating NMC annual monitoring; sharing evidence with the HPC and British Psychological Society in relation to their monitoring and approval processes; and coordinating schedules with other QAA review methods (section 2.1).
- The roles of the Review Coordinator, Major Review Facilitator and Practice Review Facilitator were pivotal in managing the reviews (section 3.2.5).
- Review teams consistently adopted an open, friendly and professional approach to the reviews (section 3.2.5).
- Major review encouraged interprofessional team working in conducting the review and in writing the report. The teams found it highly beneficial to learn from other professions in this way (sections 3.2.5.9/3.3.1).

Challenges in Major review

- Five days of review spread across a six-week period was demanding both in terms of travel and balancing review work with the day job (section 3.2.5.12 and 3.2.5.13).
- The review model had limited ability to take account of differences in size and complexity - all providers reviewed with common intensity (section 3.2.5.12 and 3.2.5.13).
- Providers made a large amount of evidence available, which was not always well signposted, focused or targeted on the claims made in the self-evaluation document (sections 3.1.7/3.2.3/3.2.5.5).
- The lack of common definitions and presentation of data on student progression, achievement and employment (sections 3.1.7/ 3.2.5.8/ 3.2.5.12/ 3.2.5.13).
- Post-registration and continuing professional development programmes were often less visible in the review reports (section 4.4).
- The differences in terminology between the professions reviewed created some difficulties in writing the reports (section 3.2.5.13).
- The rapidly changing healthcare context in which Major review took place (chapter 2).

Thoughts for the future (chapters 5 and 6)[3]

- It is important to build on the success of Major review, to retain effective quality assurance processes that include an appropriate amount of externality (paragraphs 393, 395, 413, 430).
- Major review has helped to establish strong partnership working between providers which should be supported by the new quality assurance processes (paragraph 418).
- There is now an opportunity to develop a review process that is proportionate to the size of the provision, level of risk and previous performance identified in Major review reports and from other sources (paragraph 431).
- Any new review process should ensure that academic and practice elements continue to be reflected equally, and recognise interprofessional programmes which span a number of different subjects (paragraphs 401, 422)
- Judgements need to be expressed in language which is more commonly used and understood (paragraphs 406, 407)
- Major review has trained a large number of reviewers and facilitators from HEIs, SHAs and practice areas who now have considerable expertise which should not be lost (paragraphs 397, 400, 402, 425, 428).
- There should be continuing work with professional statutory and regulatory bodies, SHAs and SfH to strive towards a more streamlined quality assurance process (paragraph 431).

[3] These thoughts are derived from the evaluation of the Major reviews and reflect the views of those who participated in the review method

Chapter outlines

Executive summary

The executive summary provides a detailed synopsis of the annual trends report and is designed to give readers a complete overview of Major review before they consider the detailed sections of the main report.

Chapter 1 Introduction

This chapter provides some background and context to the Major review of healthcare programmes in England. It outlines the purpose and scope of Major review, and charts its development.

Chapter 2 Healthcare organisational structures underpinning Major review

Chapter 2 describes how QAA has worked with partners and stakeholders to streamline quality assurance of healthcare education within the changing landscape of the NHS and national policy.

Chapter 3 Processes

Chapter three outlines how Major review was planned, implemented and evaluated. Each step of the review process is considered, from the scoping and scheduling of the reviews through to the publication of the reports. It highlights the particular strengths and challenges for the review method and suggests some improvements for the future.

Chapter 4 Outcomes

This chapter details the judgements arising from Major review before discussing the strengths, good practice and weaknesses that were identified by the review teams. It also considers how providers have responded to these in their action plans. The final part of the chapter includes a statistical analysis of the student achievement, progression, employment data recorded in Major review reports.

Chapter 5 A summary of key learning points from Major review

Drawing on the earlier sections of the report, this chapter lists the learning points identified from the implementation and evaluation of the reviews.

Chapter 6 Conclusions

The final chapter provides a summary of the key outcomes from Major review, and points to note in relation to the development of any future quality assurance of healthcare education.

Executive summary

Introduction

This report covers all the Major reviews of healthcare education undertaken by the Quality Assurance Agency for Higher Education (QAA) during the period 2003 to 2006 and follows the two annual trends reports for 2003-04 and 2004-05. QAA has been contracted by the Department for Health (England) (DH) and, latterly, by Skills for Health (SfH)[4], to review all National Health Service (NHS)-funded healthcare education programmes in England. Major review was developed in partnership with the DH, Nursing and Midwifery Council (NMC), Health Professions Council (HPC), Strategic Health Authorities (SHAs) (formerly Workforce Development Confederations), and with input from higher education institutions (HEIs), healthcare Trusts and the voluntary and independent health sectors. To reduce the quality assurance burden placed on HEIs the method incorporated NMC annual monitoring for the year that Major review took place with the inclusion of a member of the review team who was also an NMC Visitor (see sections 2.1, 3.1.2, 3.1.3). QAA also ensured that those undergoing Major review would not also be subject to a discipline audit trail in NHS-funded healthcare programmes during any institutional audit that took place during the period 2003 to 2006 (see sections 2.1; 3.1.1).

The purpose of Major review was to provide the public with the assurance and confidence that the students who successfully complete healthcare programmes are competent and safe practitioners, who are fit for purpose. The review method and subsequent reports consider, with equal emphasis, practice and campus-based learning. This was a significant development from previous review methodologies, which only considered campus-based activity, and did not recognise that 50 per cent of the students' learning takes place in practice.

The main purposes of the annual trends reports are to record the findings of review teams; promote good practice, focusing on learning gained about academic and practitioner standards, and the quality of learning opportunities; log the developments in the review process and procedures, and the changing context in which the review method operates; and highlight learning points that could helpfully feed into other future methodologies (see section 1.1).

The judgements

Of the 90 reviews undertaken, the majority of the judgements in academic and practitioner standards were 'confidence', with only two programmes receiving different judgements - one of 'limited confidence' and one of 'no confidence'. In the quality of learning opportunities, there were 87 commendable judgements in learning and teaching, 89 in student progression and 86 in learning resources and their effective utilisation. The largest number of approved judgements relating to the totality of the provision reviewed was in learning resources and their effective utilisation, although this was still a small proportion of the judgements made (see section 4.1).

The process

Evidence confirms that Major review has worked well, particularly considering the complexity and breadth of the provision being reviewed with some 15 disciplines and a broad range of awards. It met fully its stated aims and outcomes as listed in the Handbook for major review of healthcare programmes (the Handbook). It is now a tried, tested and refined review methodology. This is in no small part due to the reviewers and facilitators

[4] Responsibility for the Major review contract transferred to SfH, a sector skills council, under a service-level agreement from DH on 1 October 2004

The process of Major review and other variations to contract work related to the partnership quality assurance framework was managed by a dedicated Health Team at QAA. Contract reviewers (CRs), more commonly known as Review coordinators, managed the review teams and coordinated the writing of the reports.

Reviewers, who were specialists in one of the disciplines under review, were drawn from both academic and practice backgrounds. The reviews were facilitated on behalf of the providers by a nominated Major Review Facilitator (MRF) from the HEI and a Practice Review Facilitator (PRF) from the lead SHA. All of these were fully trained and briefed by the QAA Health Team before taking part in the process.The process and criteria for the selection of individual reviewers were agreed in advance by all stakeholders. A total of 438 nominations were received. Equal opportunities were an important part of the reviewer nomination and selection process, and the profile of reviewers matches that within the NHS. Normally, the review team consisted of a pair of reviewers from each discipline under review, one drawn from an academic post and one from practice. After the experience of a very large and complex review early in the cycle, the number of reviewers was limited to 10 for a six-discipline review, and reviews with five disciplines were limited to eight reviewers. Four disciplines or less were allocated two reviewers for each discipline (see section 3.1.2).

From the 373 reviewers who were trained between 2003 and 2005, 269 (72 per cent) have been used as reviewers on a Major review. Each intensive three-day reviewer training event followed the broad pattern of the Major review visit. The provider's self-evaluation document (SED) was the cornerstone of each visit. Having evaluated this, reviewers sought evidence from documentation, meetings with academic and practice staff and students to verify the claims made in each SED. The reviewer training materials developed by QAA were designed with this process in mind. Twenty-four training events were conducted. All were very positively received by reviewers, with many comments on the high quality of tuition, the effective structure of the training, and the success of these events in preparing for the reviews. The role of the NMC Visitor was included from the start of the training (see section 3.1.3).

Evaluation

Major review was evaluated with care and consistency to determine how well it worked. Following each of the 90 Major reviews, evaluation questionnaires were disseminated to the review teams, the CRs, MRFs, PRFs and the relevant NHS placements and other independent placement providers, through the PRFs. These evaluations focused on the stages of the Major review process. Fourteen focus groups, carried out through the period 2004 to 2006, were attended by 238 people, including reviewers, CRs, MRFs, PRFs, subject and practice staff (see section 3.2.5.1).

Overall, these evaluations show that responses throughout the cycle were consistently positive, with an average of 95 per cent satisfaction rate across all participants. Communication between all those involved in the reviews was predominantly seen as effective. From the perspective of providers, one of the benefits of Major review was considered to be the opportunity it afforded them to ensure that appropriate processes and procedures were in place for quality assurance, while formalising and embedding partnership working, which was also seen as a very positive output.

Preparatory meetings were useful for both the CR and providers in preparing for the review. The majority of PRFs involved were also very satisfied with the visits. Placement staff involved in visits to practice also found the process beneficial. Placement respondents welcomed the opportunity to strengthen the relationship between themselves and their partner HEIs. Evaluations also indicated that the role of the CRs was one of the most positive features of Major review. The CR was regarded as pivotal to managing the process successfully. They demonstrated three key skills - organisation, facilitation and communication. The review teams were noted as a positive feature as well, with judgements made by them found to be consistent with the dialogue during the review (see sections 3.2.5.3 to 3.2.5.11).

A fundamental underpinning of Major review was the need to acknowledge at every level that the education provided was shared equally between academic and practice learning. For logistical reasons, the number of placement areas visited was in most cases still small in relation to the total number used by the educational providers. Nevertheless they provided a legitimate cross-section that contributed significantly to the evidence base. The geographical spread of practice locations, frequently far removed from the HEI, provided serious logistical challenges. Reviewers visited each placement area in pairs. They found that visiting placements was a very beneficial aspect of the process and greatly valued the experience. CRs also commented positively about visits to practice (see section 3.2.5.9).

From the qualitative evaluations it can be seen that less positive aspects of the reviews tend to be related to process, with the most frequent references being to the timescale of reviews, the quality of the SED prepared by the institutions, and the student work and statistical data provided as evidence. Across all responses to the evaluation questionnaires, the most frequent area of dissatisfaction was in relation to the adequacy of student information and reviewers' access to it. Where issues arose, the QAA Health Team was able to respond to and resolve them, and offer further guidance, briefings or discussion forums where appropriate (see section 3.2.5.12).

Major review encouraged review teams to work interprofessionally in conducting the reviews and in writing the reports. Therefore, in each of the main sections, the reviewer responsible needed to write, on behalf of the team, about all the professions represented in the review. In turn, this meant that throughout the review visit there was a premium on interprofessional dialogue within the team. It was often challenging for the reviewers to write across disciplines, but the benefits in terms of interprofessional working far outweighed the difficulties. The rigour and accuracy of the review report are paramount, as the reports are public documents (see section 3.3.1).

Strengths, weaknesses and good practice

Each published Major review report includes key bullet points about the strengths, good practice and weaknesses of the provision as identified by the review team. Taking the 90 reports together, there were 2,686[5] bullet points. These were analysed to identify key themes arising across the whole provision, and any trends across the reviews through the review cycle or within disciplines (see section 4.2).

Key **strengths** indicated by the summary bullet points in the Major review reports include the following: intended learning outcomes (ILOs) are communicated effectively to academic and practice staff and students, emphasising the strength of partnerships between the HEIs and placement areas. Partnerships work together with stakeholders to develop the curricula, demonstrating effective planning, design and approval processes. The security, integrity and consistency of assessment procedures, in setting, marking and moderating, are also common areas of strength. Graduates and diplomates are achieving their ILOs, are fit for purpose and are well prepared for employment. The most frequently occurring area of strength in learning and teaching is the effectiveness of teaching methods in promoting the integration of theory and practice. Most frequently identified strengths in student progression are recruitment, admission and induction processes, closely followed by processes for student support. In learning resources and their effective utilisation, the most common area of strength is in the quality of material resources. The effectiveness of partnership arrangements in all aspects of programme planning, delivery and monitoring are notable in the maintenance and enhancement of standards and quality (see sections 4.2.1.1 to 4.2.3).

[5] Some bullet points in academic and practitioner standards were repeated verbatim across the disciplines under review, and have only been counted once in this total, but were considered under each relevant discipline in the thematic analysis.

Good practice is demonstrated across the sector and follows similar themes to those in strengths. These include the effective communication of ILOs, stakeholder involvement in the development of ILOs; partnerships, curriculum design and interprofessional learning. Good practice in assessment focuses on the range and appropriateness of methods, integrity and security of procedures, practitioner involvement and mentor support. In learning and teaching the effectiveness of learning opportunities in placements, of teaching, and of the use of learning resources is noted. The majority of good practice in student progression centres on the theme of student support. In learning resources, good practice follows similar themes to strengths, with the most frequently occurring areas being the quality of material resources, the quality of access to resources, teaching staff and partnership working. In the maintenance and enhancement of standards and quality, the operations of committees or groups involved in quality monitoring, including stakeholder representation through a student council or placement learning unit, are highlighted. Several of these bullet points focus on practice areas (see sections 4.2.1.1 to 4.2.3).

Weaknesses identified in ILOs, curricula and assessment of some provision are often in the same areas identified as strengths in other reviews. For example, in curricula, the lack of interprofessional learning becomes less evident later in the cycle of reviews. Limited opportunities for service-user and carer involvement in curriculum development were noted in some disciplines while, in assessment, the need to strengthen the consistency of feedback given to students is a common theme. There were no consistent weaknesses in student achievement. Weaknesses in learning and teaching are almost identical to areas of strength and good practice, and cover learning opportunities on placements, interprofessional learning opportunities, learning and teaching methods and the effective management of learning and teaching. In student progression, the majority of weaknesses relate to attrition rates and work undertaken to reduce them. Weaknesses identified in the learning resources of some providers include the resource of academic and practice staff, material resources, and placement provision. Strategies and processes for monitoring and placement audit are not thorough in the maintenance and enhancement of standards and quality of some provision (see sections 4.2.1.1 - 4.2.3).

Student data

Three standard data tables were included in all Major review reports: achievement, employment and progression statistics for the last three completing cohorts. These provided some useful trends although were challenging to construct. Three-quarters of all students were enrolled on pre-registration programmes. Forty-three per cent of all students were studying on diploma programmes: the majority of these were nursing students, with the remainder taking programmes in midwifery, operating department practice (ODP) and radiography. Within allied health profession (AHP) disciplines, the highest enrolment rates are in physiotherapy. Completion and achievement statistics show that, in general, the pass rate across all disciplines of pre-registration programmes was similar to post-registration programmes (96.9 and 97.5 per cent respectively). The average degree classification profile for all disciplines was similar to that for all higher education degree students studying at HEIs in England. Of the nursing, midwifery and health visiting disciplines, the achievement level is highest in health visiting. Among the larger AHP disciplines, the achievement rate is good, with 98.8 per cent achievement in physiotherapy and 97.5 per cent in occupational therapy (see section 4.4.1).

The largest proportion (22,974 students, 56.6 per cent) of students who completed programmes successfully, across all discipline areas, were employed (within six months of leaving) by employers local to the providers. The employment data revealed emerging patterns of mobility after graduation in relation to both discipline and level. It is probable that these are related to the local economic conditions and the demand for skills or employees within specific sectors at a certain skill level, or to the spatial mobility of individual

students. The overall average for unemployment within six months of graduation across all disciplines during the period was 4.4 per cent (see section 4.4.2).

The average withdrawal rate across all programmes within the scope of the review was 10.2 per cent of the initial recruitment. There are six disciplines with a higher than average withdrawal rate: midwifery, ODP, podiatry, prosthetics and orthotics, radiography and orthoptics. Physiotherapy and health visiting have notably lower than average levels of withdrawal. Considered by level of award, withdrawal rates were highest for diploma programmes (11.2 per cent), compared to 9.9 per cent for bachelor's degrees (see section 4.4.3).

Action planning

The identification in the Major review report, in bullet-point form, of key strengths, weaknesses and good practice within the provision forms the basis of an action plan which is completed by the HEI/SHA and published as part of the report. The action plan addresses all the summary bullet points. Action plans have been a significant and important part of Major review and raised a number of learning points. The action plan should be an active, useable document. SMART (specific, measurable, agreed, realistic and time-bound) responses to the bullet points are vital. Some providers were unsure how good practice should be actioned where it is included in the action plan. Focus groups reported that the process of completing the action plans has continued to enhance partnership working. However, responsibility for undertaking the actions continues to lie predominantly with the HEI. The kinds of action taken can broadly be categorised as follows: production of new or enhancement of existing documents and strategies; specifically designed events, either one-off or more regularly instituted; use of information technology to enhance communication or share information; use of committees, working groups or liaison and collaboration between different groups or organisations; dissemination, particularly of strengths and good practice, across a range of groups and bodies; staff development activities; resources; scoping and evaluation (see sections 4.3.1 to 4.3.8).

Streamlining the quality assurance of healthcare education at a national level has been an underlying aim throughout Major review. There has been a series of developments enabling more sharing of evidence across review processes, working closely with the NMC, HPC and British Psychological Society (BPS). A significant advance in streamlining, noted in the DH 'streamlining' document[6], was the production of the healthcare benchmark statements, providing a uniform expectation of standards to be reached for each discipline. The emerging health professions framework which led to the publication of the statement of common purpose for health and social care is a further streamlining development (see section 2.1).

Partnership working

The QAA Health Team has developed close working partnerships with stakeholders involved in Major review, and with other organisations that may use the outcomes of Major review as evidence for their quality assurance processes. Regular meetings were held with other stakeholders, including joint meetings with SfH and the BPS, the Commission for Health Improvement, which later became the Commission for Healthcare Audit and Inspection (more commonly known as the Healthcare Commission). The process of Major review itself has been able to adapt throughout the review cycle to respond to changes and developments in the healthcare environment, while still working within the protocols agreed by all partners at the start, to ensure consistency across all reviews. The number of students commissioned by SHAs has varied through the cycle due to workforce demand, leading to difficulties for HEIs running programmes with either very few or very large numbers of

[6] 'Streamlining quality assurance in healthcare education', DH 01 March 2003

students. This has had an impact on the availability and suitability of placements, and placed strain on mentors and practice assessors dealing with larger numbers of students. Major review has also responded to national policies and initiatives that have been introduced during the cycle. QAA has ensured that reviewers understood and were up to date with these developments (see sections 2.2 to 2.4).

The trends report highlights a wealth of invaluable learning points, of which the Executive summary provides a flavour. It is hoped that the experience of, and lessons learned from Major review will contribute significantly to any future quality assurance processes, and that the Major review reports, including the action plans, provide a robust baseline on which a risk-based and proportionate quality assurance approach can be developed.

List of acronyms

AHP	allied health profession
APEL	accredited prior experiential learning
ARCS	QAA Academic Reviewer Communications Service
BPS	British Psychological Society
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Health Improvement
CPD	continuing professional development
CR	review coordinator (contract reviewer)
DH	Department of Health (England)
ECR	editing contract reviewer
FEC	Further education college
FHEQ	The framework for higher education qualifications in England, Wales and Northern Ireland
HCC	Healthcare Commission
HEI	higher education institution
HESA	Higher Education Statistics Agency
HERRG	Higher Education Regulation Review Group
HPC	Health Professions Council
ILO	intended learning outcome
IPL	interprofessional learning
IT	information technology
KSF	Knowledge and Skills Framework
MESQ	maintenance and enhancement of standards and quality
MPET	multiprofessional education and training
MRF	Major Review Facilitator
NHS	National Health Service
NMC	Nursing and Midwifery Council
NMH	Nursing, midwifery and health visiting
ODP	operating department practice
OQME	ongoing quality monitoring and enhancement
OSCE	objective structured clinical examination
PDP	personal development planning
PQAF	Partnership Quality Assurance Framework for Healthcare Education in England
PPF	Practice Placement Facilitator
PRF	Practice Review Facilitator
PSRB	professional and statutory regulatory body
QA	quality assurance
QAA	Quality Assurance Agency for Higher Education
SED	self-evaluation document
SfH	Skills for Health
SHA	Strategic Health Authority
SLT	speech and language therapy
VLE	virtual learning environment
WDC	workforce development confederation

Chapter 1 Introduction

1.1 Purpose and scope

1 This is the third and final trends report for the Major review of healthcare education. It covers all the reviews undertaken in the period 2003 to 2006[7] as part of the contract between the Quality Assurance Agency for Higher Education (QAA) and the Department of Health (England) (DH), later passed to Skills for Health (SfH)[8], to review all National Health Service (NHS) funded healthcare education programmes in England.

2 The main purposes of the annual trends reports are to:

- record the findings of the reviewers
- promote good practice, focusing on learning gained about academic and practitioner standards, and the quality of learning opportunities
- log the developments in the review process and procedures and the changing context in which the review method has operated
- highlight learning points that could helpfully feed into any future quality assurance methodology.

3 This final report presents the key themes and lessons learned during whole cycle of Major review.

4 A range of data sources has been used in producing this report:

- the 90 Major review reports and action plans (including the prototype reviews) published between December 2003 and December 2006
- the analysis of evaluation questionnaires sent to the participants in each of the Major reviews: review coordinators (CR), reviewers, subject staff (both academic and clinical) and Strategic Health Authority (SHA) staff. The evaluations of the latter two groups are coordinated by the major review facilitators (MRFs) and the practice review facilitators (PRFs) respectively
- the 14 focus groups held during 2003 to 2006, attended by 238 participants from each of the constituencies involved in the reviews
- the evaluations for all of the reviewer training events, facilitators briefings and self-evaluation document (SED) workshops
- the reflections from the QAA officers recorded through 113 days of visit support for preparatory meetings (40 days), judgement meetings (55 days) and 18 'call outs' for additional support.

5 Major review was developed in partnership with the DH, the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC), SHAs (formerly workforce development confederations (WDCs)), with input from higher education institutions (HEIs), NHS healthcare Trusts, and the voluntary and independent health sectors. The review methodology was piloted in 2001-02 by six providers and evaluated by QAA and an external evaluator commissioned by the DH. The method was refined in the light of these experiences. The six Major review prototypes were converted to the agreed Major review report format in autumn 2003[9]. The first non-pilot review took place in January-February 2004 and the last review was completed in November 2006, with the final reports published in March 2007.

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[7] The 90 reviews includes the conversion of the Major review pilots into final review reports that were published in autumn 2003 (see section 2.2)

[8] Responsibility for the Major review contract transferred to SfH, the UK sector skills council for health, under a service-level agreement from DH on 1 October 2004

[9] The full evaluation report on the pilot reviews can be found at www.qaa.ac.uk/health/archive/evaluation/evaluationshort

6 The purpose of Major review was to provide the public with the assurance and confidence that the students and trainees who successfully complete healthcare programmes are competent and safe practitioners. The aims of Major review were:

- to promote continuous improvement and to facilitate enhancement of the quality and standards of the education provided
- to test accountability, through demonstrating that the needs of the key stakeholders were being met, including contributing to fulfilling the requirements of the professional statutory regulatory bodies (PSRBs)
- to provide clear, effective and accessible public information on the quality of higher education in the healthcare professions.

7 The method was also designed to review the theoretical and practice elements of healthcare education and the integration of these two aspects in order to:

- meet the requirements of commissioners in ensuring students were fit for purpose
- meet the requirements of PSRBs in ensuring registrants were fit for practice
- meet the requirements of the HEIs in ensuring diplomates and graduates were fit for award.

8 The outcomes of Major review were expected to confirm the standard and quality of the provision, identify shortcomings and inform funding decisions through the judgements made on the provision; to share good practice across disciplines and across the sector; to provide public information; to inform ongoing quality monitoring processes; and to inform the review process of the Healthcare Commission (HCC). All of these outcomes have been achieved through the production of 90 reports on all of the NHS-funded healthcare provision in England and the positive judgements that have been made on the programmes reviewed. Good practice has been identified in these reports and has been disseminated across the sector through evaluation forums, conferences and the quarterly newsletter produced by QAA on behalf of SfH for the duration of the Major review cycle.

9 The review and subsequent reports consider, with equal emphasis, practice and campus-based learning. Major review initially included 11 disciplines, with a further four added early in the cycle. The 15 disciplines were:

- Audiology
- Clinical psychology
- Dietetics
- Health visiting
- Midwifery
- Nursing
- Occupational therapy
- Operating department practice (ODP)
- Orthoptics
- Paramedic science
- Physiotherapy
- Podiatry
- Prosthetics and orthotics
- Radiography (diagnostic and therapeutic)
- Speech and language therapy (SLT).

The scope of each review was confirmed with the providers prior to the start of the review. In the light of an early review experience, for the most part, reviews were limited to six disciplines. Where the number of disciplines offered was greater, two reviews took place.

10 Major review considered mainly NHS-funded programmes at a range of levels from certificate of higher education to professional doctorate, and included those regulated by PSRBs. Continuing professional development (CPD) modules and programmes also formed a significant part of Major review.

11 Major review did not take place in isolation. It was an integral part of the Partnership Quality Assurance Framework for Healthcare Education in England (PQAF) that has been developing since 2003 led initially by DH and latterly SfH. Although Major review was the first part of this framework to come to fruition, prototyping of two other elements of the PQAF; OQME and approval; took place in 2004-05[10] and was managed by QAA. Following evaluation of the prototypes[11] by QAA and HSHS [Homerton School of Health Studies],who were contracted by SfH to provide an external evaluation), stakeholder forums and reference groups were convened to discuss the recommendations raised. Interim standards were subsequently published in May 2006 for use in the quality assurance of healthcare education in England on a voluntary basis, while the final framework is currently envisaged to be agreed and implemented during the academic year 2008-09.

1.2 The development of Major review

12 The Major Review Working Group, chaired by QAA, was established to oversee the initial development of the Major review process, including agreeing the methodology and the Handbook for major review of healthcare programmes (the Handbook). It included representation from the partners (DH, WDCs/SHAs, NMC and HPC) and HEI, Trust and voluntary and independent sector representatives as key stakeholders. This group met to discuss a wide range of operational issues, including potential no confidence or failing outcomes and the follow-up responses to these, and the then imminent publication of the national minimum dataset (finally published in April 2006 as part of the Multi-professional education and training (MPET) national standard contract). Following the implementation of the Major review pilots, the working group was re-formed as the Major Review Steering Group, which included the previous members together with further representation from HPC, the British Psychological Society (BPS) and from SHAs and partner HEIs with specific experience of implementing the prototype reviews.

13 **The working group and subsequently the Steering Group provided excellent help and guidance to the Health Team at QAA** who led the management and implementation of the Major reviews. The group provided a constructive forum to discuss any issues arising from the reviews and proposals for varying the contract to undertake additional work (see section 1.3). The Group was also instrumental in promoting Major review and encouraging nominations from the professions to become reviewers. It also agreed the format for the first annual review trends report. The last Steering Group meeting was held in November 2004, following the move of the DH quality assurance (QA) team to SfH. Following the transfer of responsibilities from DH, SfH intended to establish a Quality Assurance Key Stakeholder Advisory Forum to provide stakeholder engagement and to advise SfH about future policy direction and priorities. Following a review of steering and advisory groups, this group was established later as a **Partnership Summit**, the first meeting of which was held in February 2006 to bring a wider range of potential partners into the process and to establish a formal partnership agreement on the quality assurance of healthcare education. No formal partnership has been established, but

[10] Prototypes took place in seven HEIs; three partner organisations undertook the approval process and four the OQME process; one HEI/SHA participated in both the approval and OQME processes.

[11] The evaluations of the approval and OQME prototypes can be found at www.qaa.ac.uk/health/framework/evaluation/default

the group continues to meet as a Partners' Forum to discuss and comment from their different perspectives on quality assurance in healthcare education, including developments towards the new framework and the agreement of shared principles.

14 The Major Review Steering Group included an ongoing quality monitoring and enhancement (**OQME) and Approval Sub-group**, established to advise on the development and implementation of the pilots for these two elements of the proposed framework. These groups were reformed into an integrated **Quality Assurance Framework Management Group** that first met in June 2005, chaired by SfH. This group was to provide advice on the implementation of the proposed Partnership Quality Assurance Framework for Healthcare Education in England (PQAF) elements, and formulate proposals and recommendations for change. To clarify its scope it was renamed at the second meeting in September 2005 as the **QA Stakeholder Development Group.**

1.3 Variation to contract

15 Variations to the contract were introduced in February 2004 in the light of a lower than expected number of reviews due to take place over the whole cycle. These variations included a regular newsletter, annual trends reports, consultations, roadshows, conferences, evaluation activities and the management, delivery and evaluation of OQME and Approval pilots. Details of variations to the contract between the DH/SfH and QAA are given in Appendix 1.

Chapter 2 Healthcare organisational structures underpinning Major review

2.1 Streamlining

16 In 2003, the DH produced a document entitled Streamlining quality assurance in healthcare education: purpose and action[12], which set out the 'context for, and Departmental approach to streamlining quality assurance of NHS-funded programmes of professional education and further development' while further developing the PQAF. The starting point for this work was noting that the three groups of key stakeholders, WDCs, PSRBs and education providers, employed **different approaches to quality** assuring programmes. Different evidence was used and different definitions of the same evidence, for example of attrition, were employed across the disciplines, with diverse QA approaches of the various stakeholders.

17 Major review has been successful in contributing to streamlining through a number of mechanisms, including building on existing HEI and SHA internal QA processes, making use of existing documents and data wherever possible in order to reduce the burden on providers, ongoing dialogues with partners and stakeholders - for example, the invaluable contribution of NMC and HPC on the Major Review Steering Group, sharing review scheduling information, sharing evidence and integrating processes where possible. A key example of this is the inclusion of reviewers on teams who are trained for Major review but are also qualified as NMC Visitors who, once the Major review visits are completed, use the same evidence base to produce the annual monitoring report for the NMC. In addition, in the year that Major review took place the provider's SED was accepted by NMC as the provider's annual monitoring report. A copy of the SED was forwarded by QAA to the NMC for its records.

18 QAA is also an associate signatory to the healthcare Concordat, which is designed to bring about further streamlining in the audit, inspection and review of healthcare practice.

19 Another **advance in streamlining** was the production of the NHS-funded **healthcare benchmarks statements**[13] (DH 2003)[14], which provide a uniform expectation of standards to be reached for each discipline. Prior to the publication of the benchmark statements, there were no shared overall outcome standards for healthcare programmes. Eleven benchmark statements were produced in 2001, prior to the start of the cycle, with a further five published during the cycle to cover all disciplines that fell within the scope of Major review. QAA commits to review all of its benchmark statements after five years. The DH-contracted benchmark statements for the health professions, in the context of Major review, are to be evaluated by SfH shortly, with consideration given as to whether they will need to be revised. As most of the health professions statements were published in 2001, it is timely to consider whether they should be reviewed and updated in order to maintain their currency and usefulness in providing a baseline expectation of standards to be achieved in each discipline as part of the student learning experience.

20 A related development is the emerging health professions framework, published in each health professions benchmark statement, which led to the **statement of common purpose for health and social care**. As benchmark statements were published, considerable overlap between disciplines was noted, from which the common framework began to emerge. This

[12] Document available at: www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4072928&chk=SXJX0J

[13] The health benchmark statements are published by QAA as part of the academic infrastructure and available on the QAA website at www.qaa.ac.uk/academicinfrastructure/default.asp

[14] The role of benchmark statements is outlined in the DH (2003) publication 'streamlining quality assurance in healthcare education'

provides the shared context in which the different professions operate and helps to define the competencies and proficiencies, as defined by the PSRBs, expected and reflected in the intended learning outcomes (ILOs) of the programmes. The statement of common purpose was developed to emphasise the shared values and principles that underpin the wide spectrum of health and social care practice, and QAA was commissioned by the DH to work with stakeholders to further the development of the framework and, in turn, the statement.

21 The DH's National standard framework contract, introduced in April 2006, provides generic guidance about **a national dataset** and will incorporate a standard framework for QA to be used by education commissioners. The detail of this framework is still to be worked out. However, there is room within it for local variation in order to suit the needs of particular commissioners, education providers and professional requirements. SfH are currently developing quality arrangements which may be adopted nationally, when finalised.

2.2 Working with partners and stakeholders

22 In implementing the Major review, **QAA has worked closely with partners and stakeholders** and a variety of representatives through regular contract monitoring meetings, working groups, steering groups, advisory and development groups. QAA has also contributed to statutory regulatory body and professional body events. QAA has worked closely with the HPC, NMC, DH and SfH in managing all aspects of Major review and associated work, and has taken account of its own schedules for audit and review to ensure a coordinated and integrated approach between QAA methods and other inspection and review processes. Major review and all other PQAF-related activities have been **led by the Health Team at QAA**, working with support teams within the QAA Reviews Group and, for the analysis of evaluation activities, the QAA Information Unit. The Health Team has managed all aspects of the reviews.

23 A key principle underpinning QAA reviews is that they should be conducted in a **spirit of dialogue and cooperation** between the HEIs, practice placement providers, their staff and the review teams. The process is one of **peer review** and is carried out by specialist teams of peers, drawn from both academia and practice. Peer review enables judgements to be made by those who understand the healthcare programmes under scrutiny and who are familiar with teaching and learning processes. It enables judgements to be credible to subject providers, and to command their respect. For a peer review process to have credibility with external stakeholders, such as PSRBs, NHS Trusts, SHAs, other health service providers and potential students, **judgements** must be **made in a rigorous and transparent manner and reported publicly.**

24 Meetings between the QAA, DH, NMC and HPC in summer 2004 considered Approval and OQME prototypes and the involvement of the PSRBs. Further consideration was also given to how the HPC might link more closely with Major review. A briefing session was arranged for HPC and NMC Visitors involved in the Approval and OQME prototypes. Regular meetings were also held with other stakeholders, including joint meetings with SfH and the British Psychological Society (BPS), the Commission for Health Improvement (CHI), which later became the Commission for Healthcare Audit and Inspection (CHAI) (known now as the Healthcare Commission). Work continued on developing and enhancing communications between the DH, SfH and QAA.

25 During the Major review cycle significant changes and developments have taken place for the partners including the move of responsibility for the development of the quality assurance framework for healthcare programmes, of which Major review is one element, from DH to SfH under service-level agreements. This saw the QA team responsible within DH also move across to SfH. HPC has rolled out, after consultation, its QA processes and related documentation including its approval process, and annual monitoring process. NMC has also undergone considerable change for example the change to the Register (on 1 April 2004)

from its previous 15 parts to three: nursing, midwifery and specialist community public health nursing, the implications of which will be discussed later in this report in sections 2.4.1 and 3.17.

26 Significant developments have also taken place in the WDCs/SHAs to which Major review has had to respond. In 2004, the WDCs merged with the SHAs, forming 28 regional bodies. Some WDCs retained their identity within the SHA, and others were subsumed into directorates or departments. This saw a significant change in personnel and meant that a number of additional briefing events for PRFs were needed often at short notice. In July 2006, the SHAs were further reconfigured and reduced to 10 organisations. This created some difficulties for publishing the reports in the 2005-06 part of the cycle, for example, in identifying the appropriate contacts to continue developing the action plans and to sign off the final published version. The destination of the responsibility for the quality assurance of healthcare education within the new SHA structures is as yet unknown but a notable reduction in resources available to support Major review and its related activities has been seen. An example of this is the PRF network; this network was established in September 2004 and met every three months across England to share experience and good practice gained from PRF involvement in the Major reviews and other elements of the PQAF. Its future is in doubt because of the movement of personnel within the SHA, the loss of the existing PRFs and funding to host the meetings.

27 Throughout the cycle the Health Team also liaised with professional bodies such as the British Paramedic Association, Association of Operating Department Practitioners and the British Academy of Audiology to attract further reviewer nominations from these disciplines and to provide information on and updates about Major review and Approval/OQME prototype processes. A member of the Health Team also attends as an observer at HPC Education and Training committee meetings and at NMC Council meetings in order to maintain currency of knowledge about the latest developments.

2.3 Healthcare education commissioning

28 **A number of different patterns of commissioning have been observed** through Major review. In some regions, SHAs worked together to commission by discipline, for example, in London. Rather than each SHA commissioning every discipline required, they would specialise in commissioning a few disciplines each and spot purchasing extra provision where necessary. Many HEIs developed partnerships with a number of different SHAs, which led to variations in contract monitoring as each SHA adopted a slightly different approach. Cross-commissioning was also observed, where one SHA commissions provision usually from a local provider on behalf of another SHA. Where this took place, it was included within the lead SHA for the review. In one instance an HEI did not have a 'traditional' contract with an SHA, rather it had spot purchasing arrangements with a number of SHAs. This had implications for the PRF role.

29 **The number of students commissioned by SHAs has varied through the cycle due to workforce demand,** leading to difficulties for HEIs running programmes with either very few or very large numbers of students. This has had an impact on the availability and suitability of placements, and placed strain on mentors and practice assessors dealing with more and more students. In the current financial climate, following a period of significant investment by HEIs in new buildings and equipment to train healthcare professionals, considerable cut backs have been made in the number of students commissioned, especially now that the MPET funding for pre-registration training is no longer ring-fenced and centrally held by the DH, but has been distributed to the SHAs.

2.4 Responding to national policy

30 **Major review has also responded to national policies and initiatives which have been introduced during the cycle.** The Knowledge and Skills Framework (KSF), which forms part of the Agenda for Change, has had an impact on the way healthcare professional roles are defined and developed. In turn, this has had impacted on curricula, with new expectations for competencies and skills to be gained by newly-qualified staff. National service frameworks and national occupational standards have also influenced the development of curricula. **QAA worked to ensure that reviewers understood and were up to date with these developments** and could identify how HEIs are able to respond to the rapidly-changing health environment. The Skills Escalator and, more recently, policy on Commissioning a Patient-led NHS have also impacted on training and development for both pre and post-registration students, with the emergence of new roles which cross traditional boundaries between disciplines, and new career development pathways, particularly for practitioners in primary care. Again the Health Team has ensured that the reviewers were aware of these developments and their relevance to the Major review process.

Chapter 3 Processes

31 The 2004-05 review trends report discussed each stage of the review process from early planning and preparation for review, to the production of the report and the action plan. This report also noted changes to the process during the cycle in response to modifications in scope or to evaluation feedback.

32 This 2003 to 2006 report examines in more detail the processes for nominating, selecting and training reviewers, noting issues of diversity and equality of opportunity, and the challenges associated with maintaining a sufficient pool of reviewers from a wide variety of backgrounds and disciplines to make up the review teams. It also considers the training and briefing workshops provided by QAA to prepare reviewers, review facilitators and education providers for Major review, drawing on the data from the evaluation questionnaires given out at each training or briefing event. This is followed by a section on evaluation of Major review from the early planning stage, through to the final day of the review (normally day 5), when the reviewers reached and delivered their judgements on the provision.

33 QAA evaluates all its review methodologies according to its evaluation strategy (see paragraph 90). This strategy utilises a combination of questionnaires and focus groups. Questionnaires are returned by the CRs, review facilitators, placement areas and reviewers. They are analysed along with feedback from focus groups, which test the questionnaire data and to provide further information and discussion about the issues raised, including areas of good practice and recommendations for the development of the process. These have been used to inform the final two chapters of this report. This chapter concludes with a discussion of the action planning process, using evidence from the four discussion forums that were held in 2005-06 to give education providers, SHAs and placement areas the opportunity to feed back on their experience of action planning and the opportunities and challenges associated with its implementation.

3.1 Pre-review

3.1.1 Scoping and scheduling

34 WDCs/SHAs that commissioned programmes within the scope of Major review and their partner HEIs were sent a **scoping and scheduling form** in March 2003, asking for a joint response. Following clarification of the programmes in scope, criteria were developed by the QAA Health Team for scheduling the reviews, which gave the providers two preferences of term and academic year. These also took account of NMC and HPC requirements for annual monitoring or approval, where known, and previous QAA activity with the HEI.

35 During the Major review cycle, the scope of provision at a number of institutions needed to be amended as programmes were closed, transferred to other providers or new programmes started. This affected reviewer recruitment and team composition as well as the schedule of reviews. An initial communication problem with WDCs arose in cases where the letter did not reach the appropriate person in the organisation. Following feedback from the WDCs themselves and assistance from the DH in identifying the appropriate contacts, this issue was resolved. A number of providers queried the dates they were offered, which led to negotiations with the QAA Health Team to amend the schedule. This resulted in considerable extra work. The scope of provision also needed to be verified by the WDC to confirm that all commissioned programmes were included in the reviews.

36 In August 2003, after the publication of the Handbook, containing the list of disciplines to be reviewed (Annex A), four further disciplines were added to scope by the DH, which created further challenges for scoping and scheduling. The review schedule was finalised in December 2003 with the number of reviewers, year and term agreed. Specific dates were agreed for each review between six months to one year in advance. Further scheduling revision was required due to two HEIs taking on additional provision, and a few reviews being postponed to later terms for a variety of reasons.

37 Normally, **the review team** consisted of a pair of reviewers from each discipline under review, one drawn from an academic post and one from practice. However, it was not always possible to achieve this balance. One review that took place in autumn 2004 covered seven disciplines and involved two CRs and a team of 13 reviewers; in the light of this experience and after discussion with the Steering Group it was agreed that the number of disciplines for each review would be limited to six and the team size limited proportionately. This resulted in **some providers needing two reviews**, creating further scheduling issues.

38 The high number of reviews in the autumn term 2005 led to a minor revision of the protocol for agreeing review dates, with the partners being offered only one set of dates instead of two. However, the partners were still able to negotiate jointly for alternative dates if necessary, and many took the opportunity to do so.

39 **QAA internally undertook to coordinate Major review activities with institutional audit.** This ensured that no HEI undergoing Major review would also be subject to a discipline audit trail in any NHS-funded healthcare programme, for the duration of the Major review cycle. QAA also ensured that audits referred to Major review reports and vice versa, to share the evidence gained from each process, and reduce the burden on the HEIs[15] or the potential to duplicate evidence.

3.1.2 Reviewer nominations

40 Evidence confirms that **Major review has worked well**, particularly considering the complexity and breadth of the provision being reviewed. It is now a tried, tested and refined review methodology. This is **in no small part due to the reviewers**. The quality and standard of their work has ensured the successful completion of 90 reviews over the three-year cycle. A considerable amount of work has ensured that the process of nomination, selection and training of reviewers has been fair and monitored closely. This was not only to ensure that the methodology was being systematically followed but also that the necessary number of reviewers, against predicted requirements, were trained for each of the disciplines, thus ensuring the review teams reflected the size, range and complexity of the provision being reviewed.

41 **Major review is a peer review process.** The nomination, selection and training of reviewers from both academic and practice settings were an important part of ensuring that the peer process works. Review teams which include peers from HEIs, SHAs and practice settings were a central tenet of Major review. The process and criteria for the selection of individual reviewers were agreed in advance by all stakeholders through the Major Review Steering Group.

42 The reviewer nominations were initially acquired through the work of the Major Review Working Group, the DH QA reference groups and the QAA Health Team. Further reviewers were attracted by advertisements placed in professional journals in the first year. **A high level of interest in becoming a reviewer was noted** at the start of the process in May 2003.

43 A large amount of additional work needed to be undertaken to attract reviewers from some smaller disciplines. **The WDCs had a key role in promoting nominations.** The advertisement on the QAA website was adapted to reflect exact requirements. NHS computer firewalls prevented a number of targeted emails from being received. This problem was solved with the help of DH and WDC colleagues in further disseminating information. A second round of advertising was conducted in November 2003 as the number of applications dropped. **Targets were reached quickly for adult nursing,** and recruitment to this discipline was closed in November 2003. Occupational therapy and podiatry numbers were reached by June 2004. Recruitment for prosthetics and diagnostic radiography also closed in November 2004.

[15] The 2002-05 Institutional Audit handbook can be found at: www.qaa.ac.uk/reviews/institutionalAudit/handbook/audit_handbook

44 **In the majority of disciplines, more academics than practitioners were trained.** However, this was not the case in three of the allied health professions (audiology, orthoptics and paramedic science). Although more academic nominations were received in most disciplines, therefore resulting in more academics trained, the work to boost the practice figures did reduce the gap significantly, particularly in the second year of the Major review cycle (2004-05). Disciplines in which it remained difficult to recruit sufficient reviewers included audiology, clinical psychology, podiatry, occupational therapy (practitioner reviewers only), ODP, paramedic science and SLT. The relevant professional bodies assisted in attracting more nominations, along with continued work by the QAA Health Team, DH, SfH, WDCs and SHAs. Further calls for reviewers were also placed in the QA newsletter and on the DH website.

45 Good progress was made in attracting sufficient nominations from all disciplines, with the only areas of concern for the 2005-06 year being audiology, clinical psychology and ODP. Although a sufficient number of reviewers had been trained, availability of reviewers to take part in reviews was particularly difficult in these and other small disciplines. However, further nominees from these disciplines were trained at the final training event in November 2005.

46 A total of 438 nominations were received. **QAA is committed to the principle of equal opportunities in its approach to selection.** Therefore, equal opportunities were an important part of the reviewer nomination and selection process. Great care was taken in designing the nomination form to be user friendly and ensuring fair and equal selection criteria for all. As part of the monitoring process, nominees were asked to complete an equal opportunities form.

47 **All nomination forms were screened anonymously** by one QAA officer, thereby ensuring that the screening protocol was applied consistently. Prior to the screening and as part of the selection process, it was necessary to check that the nominees' registration with their PSRB was current and relevant.

48 **The proportions of gender and ethnicity of reviewers were in line with national healthcare workforce statistics for the professions.** The majority (74 per cent) of reviewers were white females across a wide age range. Approximately 7 per cent of NHS-employed, non-medical healthcare practitioners are from ethnic minority groups. This closely matched the nominations received for Major review in which 91 per cent were white and 8.7 per cent were from ethnic minority groups.

49 **Allocation of reviewers to teams posed some problems in 2005-06** due to the large number of reviews taking place in that year, and with reviewers, particularly from practice, unable to make themselves available. However, all teams were allocated according to the agreed protocols in the Handbook.

50 From the 373 reviewers who were trained in the period 2003-05, 269 have been used as reviewers on a Major review, across 90 reviews. In percentage terms, **72 per cent of trained reviewers have undertaken a Major review** (see Tables A and B below). It was the intention to try and utilise as many of the reviewers as possible. The majority took part in more than one review; the average number undertaken by each reviewer was two reviews.

51 Of the 269 reviewers who have undertaken a Major review, 162 (60 per cent) were from an academic background and 107 (40 per cent) were from a practice background. Even though these percentages show a higher number of academic reviewers, there are a number of disciplines where more practice staff have undertaken reviews. Some of the smaller professions show this to be the case (for example, audiology, ODP and health visiting).

52 The aim was always to ensure that the number of reviewers on each team reflected the size, range and complexity of the provision being reviewed, normally with up to a maximum of eight reviewers in a team. Review teams normally included at least one member who was a registered practitioner for each of the subject areas to be reviewed. As far as possible, within the resources available, **QAA has matched the expertise of the team with the broad**

specialisms of the subject provision being reviewed. The precise number of reviewers was dependent on the number of professions represented in the provision under review, and the breadth and complexity of programmes offered. Reviewers were required to declare any conflicts of interest with providers, and HEIs/SHAs were also able to consider this before the team was confirmed.

53 The number of reviewers in a team was limited to 10 for a six-discipline review, and those with five disciplines were usually limited to eight reviewers. Four disciplines or less were normally allocated two reviewers for each discipline. At times, it was not always possible to appoint an academic and practice pair of reviewers for each discipline, and there were instances when two academic or two practice-based reviewers for a discipline were allocated to a team. However, all teams were appointed according to the protocols agreed by the Steering Group. Major review also made provision for a specialist adviser[16], drawn from the pool of trained reviewers, who could, if required, provide additional specialist advice to the team on a specific matter, but they did not become a full member of the team, and withdrew after advice was given. This facility was only used in a very small number of cases across the review cycle.

54 Of the 114 **adult nurses** trained, 52 were used on a review (Table A). This figure is low in comparison with other disciplines, due to the significant number of nominations received and the need to use reviewers who were also trained NMC Visitors in order to accommodate the NMC annual monitoring requirements within a review team. The number of **mental health nurses** used on review is also low in comparison, and again this can be attributed to the need to use those who were also NMC Visitors. The limited availability of these reviewers was also a contributing factor to the comparatively low number used.

Table A: Comparison of nursing, midwifery and specialist community public health nursing reviewers trained and used

Discipline	Trained	Used on reviews	
		Number	%
Adult nurse	114	52	45.6
Children's nurse	20	19	95
Learning disabilities nurse	11	8	72.7
Mental health nurse	30	17	56.6
Midwifery	30	27	90
Specialist community public health nursing (health visiting)	22	21	95.4
Totals	**227**	**144**	
Average			**63.4**

55 A total of 146 reviewers were trained in the AHPs. This may seem small in comparison to the nursing, midwifery and health visiting numbers. However, of these, 125 reviewers have been used on reviews (85.6 per cent) (Table B).

[16] See Annex F of the Handbook for major review of healthcare programmes

Table B: Comparison of allied health profession reviewers trained and used

Discipline	Trained	Used on reviews	
		Number	%
Audiology	5	5	100
Clinical psychology	19	18	94.7
Dietetics	5	5	100
Occupational therapy	13	13	100
ODP	12	12	100
Orthoptics	5	4	80
Paramedic science	7	3	42.8
Physiotherapy	26	22	84.6
Podiatry	13	10	76.9
Prosthetics and orthotics	1	1	100
SLT	12	10	83.3
Radiography	28	22	78.5
Totals	**146**	**125**	
Average			**85.6**

3.1.3 Reviewer training

56 If accepted, nominees from both academic and practice backgrounds were invited to attend a **three-day reviewer training event.** In 2003-04, 245 reviewers were trained, with a further 128 trained in 2004-05. The first reviewer training event took place in September 2003, with a further 23 events following, the last of which took place in November 2005. During 2004-05, there was an increase in the number of last-minute trainee withdrawals due to work pressure or personal circumstances. Efforts were made to fill all available places on training sessions, and withdrawals were monitored to determine whether nominees were repeatedly failing to attend training.

57 There were set criteria for the allocation of reviewers to training: a maximum of 18 trainees at each event, with a **mix of disciplines** and a **mix of academics and practitioners.** The event was **designed to simulate a review visit,** with up to six participants allocated to one of three teams, each led by a CR. The training covered all aspects of the review process, from preparatory work to report writing.

58 In Major review, the **SED is the foundation of the review activity.** Having evaluated the SED, the reviewers seek evidence from documentation, meetings with academic and practice staff and students, and visits to practice placements to verify the claims made in it. The training materials developed by QAA were designed with this process in mind. Feedback from the first training session in June 2003, for the reviewers on the prototype reviews, informed and helped to finalise the materials. An SED, other relevant documents such as external examiners' reports, completed student assessed work notes and meetings notes, were created for programmes at the fictional University of Beeston by a group of CRs, with guidance from the QAA Health Team and the Major Review Working Group.

59 Each training event followed the broad pattern of the Major review visit up to and including the judgement meeting, at which the review team determines the extent of its

confidence in academic standards and whether the components of the quality of learning opportunities are commendable, approved or failing. The **training was intensive,** like a review visit, with simulated meetings with subject staff and students and preparation for them, briefing presentations from QAA officers and team meetings. There was a premium placed on **evening written work** to provide first-draft Major review report sections. This gave the reviewers **a realistic experience of reviews** and feedback on their commentaries.

60 Each training event was delivered by members of the Health Team and three CRs. While those presenting from QAA remained constant, with one of two leading each event, all the CRs involved in Major review participated; therefore, comprehensive tutor notes were also developed to ensure consistency between training sessions.

61 Thirteen **training events** were conducted in 2003-04, followed by nine in 2004-05 and two final sessions in 2005-06. All **were very positively received by the reviewers, with many comments on the high quality of tuition, the effective structure of the training and the success of these events in preparing for review.** Key messages from trainees were that the training was intense and hard work but **invaluable preparation for reviews**, and that the quality of learning resources was excellent. Key highlights from training were the structure, knowledge and friendliness of tutors, and the varied professional composition of trainee groups, **in line with the commitment to promote interprofessional learning (IPL).**

62 Although the training materials were found to be appropriate, following the first three training sessions, the opportunity was taken to add a briefing to outline in more detail what was required from the overnight work to enable trainees to understand fully their written tasks. A need to monitor the use of the practice placement form on training was identified, as some trainees found it confusing. This form, along with some other training materials, was revised in summer 2004. The practice placement form was maintained in the training session and examples of completed forms were included in the training pack. The reviewers found it helpful to see examples of well and inadequately completed forms and how this affected the evidence base of a review. The materials were also amended as the context in which Major review was operating changed.

63 **The role of the NMC Visitor was included from the start of the training.** Normally, one Major review team member, for reviews which contained NMC-approved programmes was an NMC Visitor. This reviewer drew the material for the separate NMC monitoring report from the Major review report. Where the NMC monitoring sample covered more than one part of the register, further NMC Visitors needed to be included, which occasionally led to more than two nursing reviewers on a team.

64 At the start of Major review it was anticipated that there might have been an opportunity for some HPC QA activities to be incorporated into Major review. In the event, this did not take place because of the different time frames for the development of Major review and HPC's approval and monitoring processes. However, once confirmed, the HPC processes used Major review reports as a verified source of evidence.

65 Training sessions were observed by QAA staff involved in supporting Major review, by the DH QA team and by NMC observers to enable them to familiarise themselves further with the process. HPC observers were also invited to attend but were unable to do so.

3.1.4 Review coordinator briefings

66 The **CRs are contracted by QAA for the purpose of leading each of the Major reviews.** Their role is to be the independent chair of the review team, to manage each review from its start, with a preparatory meeting at the HEI, through to its completion with the editing and eventual publication of the report. They also contribute to reviewer training and other activities related to Major review. CRs are mainly independent consultants, while a small number are seconded from HEIs or further education colleges (FECs). **They gave consistent and unqualified support throughout the Major review process.**

67 The first CR briefing was held in May 2003 for 12 CRs who would coordinate Major reviews in the first year of the cycle. The evaluation showed that CRs considered that the training fulfilled the stated purposes in briefing them both on managing the reviews and acting as tutors for reviewer training events. CRs requested further briefing on training reviewers, and two more workshops were organised for July 2003 to meet this request. These two workshops were well received and enabled the CRs to contribute fully to the content of the tutor notes as well as being able to see the training materials in full.

68 **An operational pack was introduced** for CRs and QAA staff in February 2004 to support the review processes. This pack included forms, guidance and protocols. All of the forms for a review were also available to the CRs and the reviewers through a web-based platform, the QAA Academic Reviewer Communications Service (ARCS).

69 Two CR workshops were held in 2004 for new CRs, and annual CPD sessions were held in 2005 and 2006, providing updates to the operational pack and giving CRs the **opportunity to share good practice of reviews** and to discuss how best to allocate elements of report writing to the reviewers, or approaches to formulating good practice bullet points in the provision reviewed.

3.1.5 WDC workshops

70 It was agreed between the DH and QAA that it would be beneficial to DH, QAA and the WDCs to hold workshops specifically to brief commissioners. These workshops were designed to brief them on the Major review process and give them the opportunities for further clarification and to raise any issues specific to the partners, and were held during July and August 2003. There were 76 attendees at these workshops in total. **The workshops were deemed to provide a useful overview of the Major review process** and were positively evaluated, with the majority of participants welcoming the opportunity to: raise and clarify issues in an open forum; gain a good overview of the process and its partners, and network with colleagues from the other WDCs, QAA and the DH. Participants also appreciated the materials that were circulated, both before and during the workshops, particularly the opportunity to read through the Handbook.

71 In April 2004 the WDCs merged into 28 SHAs, and all Major review documentation was updated. A number of personnel changes at this point led to further briefings for new PRFs as part of the review facilitator workshops.

3.1.6 Review facilitator workshops

72 Workshops were held for MRFs and PRFs to brief them on their roles in the Major review process. Five took place in 2003-04. The first two were aimed at those completing a review in the first year, but high demand led to inclusion of those with reviews in the second and third years. The first event raised areas for consideration by QAA, which were subsequently acted on, with the success being reflected in feedback from the second event. The revised programme included interactive group work in both the morning and afternoon sessions. Key positive features of the workshops recognised by MRFs and PRFs included the opportunity to work together and to clarify issues with QAA staff. They **valued being able to discuss the two roles and to plan their implementation jointly**. Feedback from these events stated that they had provided the opportunity to clarify any areas of confusion, reinforce the methodology, raise awareness of the amount of work to expect and the timeframe for the various stages of the process, and provided an invaluable chance to meet colleagues from other HEIs, WDCs/SHAs and to network. The briefing sessions were found to be both useful and informative, with valuable handouts providing a clear step-by-step guide through the method. Some PRFs repeatedly attended these briefings with different HEI partners and found that they benefited, despite some repetition, and commented that the briefings were well organised and appropriate.

73 Further briefing events were held during the academic years 2004-05 and 2005-06. The later events were organised to train replacement facilitators, reflecting the turnover of staff, particularly in SHAs, following the reconfiguration of the WDCs. All attendees said that their expectations were met and they were better informed following the workshop. A final review facilitator briefing was combined with an SED-writing workshop in October 2005, due to insufficient numbers to run two separate events. This worked well and delegates found it useful to hear about the processes they were not directly involved in. All MRFs and PRFs who took part in a Major review were briefed by QAA before they took on the role.

3.1.7 Self-evaluation document workshops

74 The first SED workshop took place in July 2003. This provided a valuable opportunity for HEI and WDC colleagues to work together to consider the logistics involved. Five further workshops took place in 2003-04. They continued to be valued by all delegates attending. Increased attendance at later events was considered to be due to the delegates' desire to benefit from the experience of the QAA Health Team and CRs up to this point. In February 2004, **further guidance on the quantitative data required** as an annex to the SED was produced and disseminated following feedback from providers. Participants in the evaluative focus groups acknowledged that, although there was some guidance provided, there were **no nationally agreed definitions** and providers often used their own interpretation of the categories when completing the tables, making **further analysis problematic.**

75 During 2004-05, the **SED workshops continued to be evaluated positively,** and delegates found it helpful to consider issues around ownership of the action plan and the relationship of this to OQME. Other factors which contributed to the success of SED workshops, identified from the evaluation questionnaires, were the helpful and supportive atmosphere, provision of real-life examples, the skills and personalities of the QAA tutors, interactive sessions and networking opportunities.

76 Despite representatives from all HEIs and SHAs attending the SED workshops, in 2004-05 **some SEDs were submitted that did not follow the structure required**, as outlined in the Handbook. This created further challenges for the review teams. Feedback from providers at focus groups held in 2004-06 suggested that **writing the SED had been beneficial for those involved,** and provided the opportunity to review processes across disciplines. While the time and staff resource required to produce the SED had been considerable, **the benefits from interprofessional working were considerable.**

77 Additional guidelines on the structure of the SED were issued during the summer of 2005 in response to this variability. It was also made clear that any SED received in an inappropriate format would be returned to the HEI/SHA for amendment. However, following this guidance, no SED needed to be returned and only one provider was asked to provide additional material.

78 **A difficult challenge** for both providers and CRs leading reviews was **identifying an accurate list of programmes** using the correct terminology. In Major review reports, the listed provision is divided between pre-registration and post-registration or post-qualifying programmes. In relation to post-qualifying and post-registration, the NMC uses the latter term while AHPs use the former. Return to Practice, an NMC-approved programme, is a pre-registration one, despite the insistence of some institutions that they designated it post-registration. In addition, it needed to be made clear which programmes were also to form the NMC annual monitoring of 20 per cent of the provision as part of Major review, and which programmes were approved by the HPC or BPS. The changes to the NMC register and the development of interprofessional programmes also posed challenges for providers in determining under which discipline a particular programme should be cited. For example, health visiting needed to be separated from the rest of the specialist community public health nursing provision. To ensure greater consistency across the reports, including the list of programmes, all reports were edited by the Assistant Director leading Major review and an editing review coordinator (ECR).

3.2 The reviews

3.2.1 Prototype Major reviews

79 Six HEIs/WDCs volunteered to pilot the Major review process in 2002-03. The payback for this commitment was that each review report remained confidential until the Major review methodology was finalised, after which those in the pilots had the option to be reviewed again if they wished or if the methodology had changed significantly. None of the providers elected to be reviewed again and, as only minor amendments to the methodology were required before roll-out, the pilot review reports were 'converted' to full Major review reports in December 2003.

80 The prototypes allowed all aspects of the Major review process to be carefully evaluated by QAA and an external consultant commissioned by the DH[17]. Most importantly, they provided 'road tests' for the draft handbook, for the pattern of visit days, for protocols around review team composition and management, and for a developing report format. The outcomes of both evaluation reports were positive and provided helpful suggestions in relation to the operation of the methodology. This led to the publication of the Handbook in November 2003 and the rolling out of the reviews from January 2004.

3.2.2 The timeline for a Major review

81 The majority of the Major reviews have been conducted using the same pattern of review teams visiting the providers for five days. In all but three of the reviews, a 2+2+1 model was used, where two consecutive days are spent on site, followed by a break of usually two weeks before the reviewers return for a further two consecutive days, followed by a further break of one or two weeks before they return for the final day (see Table C). Days 1 and 4 were usually spent at the HEI, meeting staff and students, and looking at documentation and learning resources. Days 2 and 3 were spent visiting a range of practice placements, and day 5 was spent with the reviewers discussing and deciding on overall judgements, and discussing an early draft of the review report (see appendix 3 for a more detailed timeline for Major review).

Table C: Pattern of visits for Major review

Day 1	Day 2	Interim of 10-14 days	Day 3	Day 4	Interim of 10-14 days	Day 5
Review team based on campus Meetings with staff and students Scrutiny of documentation	Visits to practice		Visits to practice	Review team based on campus Meetings with staff and students Scrutiny of documentation		Clarification of any matters outstanding Team meet to discuss draft report and to reach judgements

82 Early in the review cycle, one review followed a 2+3 visit model and two small reviews followed a 2+2 model. In each of these instances there was no period of reflection before the final day and the judgements. The CRs and reviewers deemed that this lack of reflection was unhelpful and the model was time constrained, a view consistent with the first annual review

[17] The QAA evaluation can be found at: www.qaa.ac.uk/health/archive/evaluation/Evaluationintro
The DH commissioned external evaluation can be found at:
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4128061&chk=NH/G0O

trends report (2004). The remainder of the reviews have followed the 2+2+1 model. On the whole, the standard model was welcomed by the HEIs, SHAs, Trusts and the reviewers. For the HEI/SHA, although it could provide some logistical challenges in relation to the setting up of the room(s) where the reviewers were located, the pattern of days facilitated reflection and enabled preparation before a visit, including responding to the reviewers' queries. What was crucial, however, was the continued communication between the CR and the facilitators. For some reviewers, these benefits have to be set against the additional travelling and time away from work and home commitments that the model requires. For many reviewers, the key to maintaining engagement with the review during the periods away from the providers was continued communication with the CR and other team members through ARCS.

83 A consistent comment through all the evaluation was that the time available for Major review can be pressured, particularly given the complex structure of healthcare education provision. QAA wishes to acknowledge the level of commitment and workload that the reviewers, CRs and facilitators have undertaken in preparing for, during and following the reviews.

3.2.3 The SED

84 The SED provided the basis of the review on which reviewers based their initial lines of enquiry. Reviewers were encouraged to comment on the quality and usefulness of the SED in preparing for the review, in the maintenance and enhancement of standards and quality (MESQ) section of the report. Almost half the reports have only positive comments to make on the SED. Nine reports lack any comment on the SED, four of which were of prototype reviews. Only four reports had no positive comments to make.

85 More than half of the SEDs were considered to be evaluative, with one-fifth substantially lacking in evaluative comment, tending towards description for the large part. Similarly, around one-third of SEDs were noted to be honest, open and self-critical, identifying weaknesses in the provision and action taken to remedy them.

86 Eleven SEDs were considered to be detailed and informative, and an equal number were noted for their lack of detail, either in part or in whole. Six SEDs were noted for their well-organised structure, whereas 11 were noted for not conforming to QAA guidelines, with some disregarding the recommended structure throughout and some in part. Where SEDs did not conform to the appropriate format or were too generic throughout, the reviewers needed to request substantially more documentary evidence to inform their judgements, than on reviews where SEDs were detailed and well organised. Twenty-four reviews noted a well-referenced SED, and three commented on poor references.

87 Over half of SEDs showed that they were produced collaboratively, with only five lacking any evidence or detail of collaboration. The remaining reports made no comment as to who had contributed its production.

3.2.4 Visit support

88 Visit support for Major review served a number of purposes, including allowing the tracking of preparations and progress of a review. A QAA officer normally supported each review. **One purpose was to monitor the process,** by observing the ways in which the published review method was being implemented, giving advice and consistent interpretation of the method to the review team and subject providers, testing the evidence base, conclusions and judgements of the team during the final judgement meeting, and to provide specific support when requested. The CR could request the attendance of a QAA officer if there are any emerging concerns, for example, a potential 'no confidence' or 'failing' judgement. The QAA officer met the CR, review team, MRF and PRF, and could observe their meetings with subject staff, students and employers. On a few occasions, where a review had been deemed sensitive, the QAA officer met with the providers before the start of the review

to discuss any concerns. The QAA officer was able to access supporting papers and the ARCS folder used by the review team. This additional support was welcomed by the providers and reassured them that due process was being followed in all cases.

89 The QAA officer completed a support log for each visit. The purpose of the visit largely defined the information noted, depending on whether it was a preparatory meeting, during the review itself, or at the judgement meeting. One hundred and thirteen support logs were completed for Major review: 19 for the prototypes and 94 for the reviews following roll out. Data from these logs are included in the evaluation analysis below.

3.2.5 Evaluation: how well did Major review work?

3.2.5.1 Collecting the data

90 The evaluation of the Major reviews followed QAA's evaluation policy[18] and took the form of evaluation questionnaires complemented by focus groups. Following each of the 84[19] Major reviews between May 2004 and November 2006, **evaluation questionnaires** were disseminated to the review teams, the CRs, MRFs, PRFs and the relevant NHS placements and other independent placement providers through the PRFs. The primary aim of the questionnaires was to evaluate perceptions of the Major review process from the experience of the institutions, the partner SHAs, NHS placements, the review teams and the CRs.

91 During the period between November 2004 and November 2006, 14 **focus groups** were conducted. Each was structured in order to include participants across all roles and included reviewers, CRs, PRFs, MRFs, and academic and practice staff. Across all focus groups, a total of 238 attendees took part. For each role there were:

- 79 reviewers
- 21 CRs
- 31 PRFs
- 32 MRFs
- 40 academic staff
- 35 practice staff.

92 Questionnaires were analysed on a termly basis. The focus groups were used to explore and verify the themes and issues identified though the evaluation questionnaires. Participants were also given the opportunity to raise other areas of interest or concern.

3.2.5.2 Analysis of evaluation data

93 The **evaluation questionnaire** (see appendix 5a) largely focused on the stages of the Major review process: the initial contact and ongoing support from QAA, including briefings and workshops; the review team; early review activity, including the preparatory meeting; the review period; communication between the team, the CR, the review facilitators and all subject, practice staff and students involved in meetings, and the judgements given in oral feedback at the end of day 5 of the review. All questionnaires contained three qualitative questions at the end, which asked respondents for the most positive and least positive aspects of the review and any suggestions for how the process could be improved. The most frequent themes arising are summarised in sections 3.2.5.3 to 11 below. Some questions are only completed by a particular type of respondent; for example, some questions are addressed only to CRs or only to review facilitators. Placement providers received a separate questionnaire containing six qualitative questions (see appendix 5b).

[18] The QAA evaluation policy can be found at: www.qaa.ac.uk/aboutus/policy/evaluationPolicy

[19] This evaluation excludes the prototype reviews, which were evaluated separately. The prototype evaluation can be found at www.qaa.ac.uk/health/archive/evaluation/evaluationshort

94 Over the two-year period, the evaluation questionnaire was disseminated to 516 team members, 84 MRFs, 83 PRFs at the SHAs (and through them to a wider number of placement areas) and 85 CRs[20] (see Table D below). Most PRFs collated the responses from practice placement areas and, therefore, the number responding overall was higher than the number of questionnaires returned. Review teams make up the largest respondent group, with a minimum of two and a maximum of 13 reviewers on each team. The questionnaires received from them make up 66 per cent of all questionnaires returned. Of those who specified their current background on the questionnaire, 40 per cent were practitioner reviewers and 60 per cent academic reviewers. There are no notable differences in response between the reviewers from each category. The response rate was the highest of all QAA review methods during the last three years, due in no small part to the work of the QAA Information Unit in chasing responses and the work of the PRFs in encouraging more responses from placement areas.

Table D: Overall response rates to questionnaire survey by respondent group

Respondent group	Sent	Received	Response rate %
Team	516	503	97
CR	85*	82	96
MRF	84	71	85
PRF	83**	62	75
Placements	84	58	69
Total	**852**	**776**	
Average			**91**

*For one review there were 2 CRs, due to the large size of the provision

** For one review there was no PRF

95 A total of 40,860 responses from the questionnaires returned have been recorded. A breakdown of the number of these responses is given below.

Total valid responses

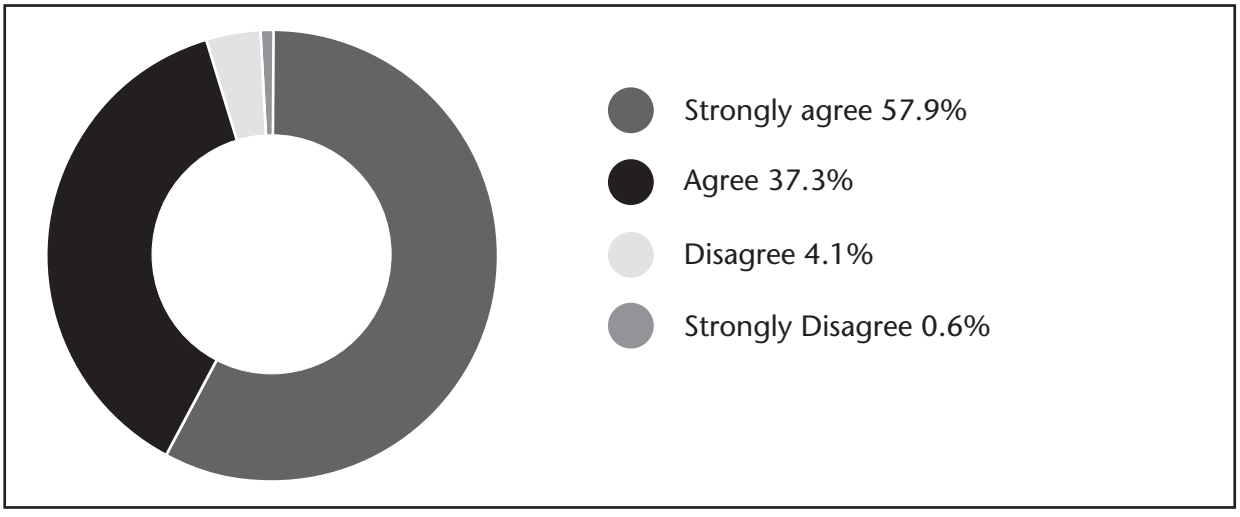


Figure 1 Total number of responses to the Major review questionnaire by type of response

[20] These numbers relate to the amount of forms sent to each group, rather than to the number of those involved. Some MRFs, several PRFs and most of the CRs participated in more than one review.

96 Across all questionnaires, **95 per cent of responses were 'agree' or 'strongly agree'**, indicating a high level of satisfaction among all participant groups throughout the review cycle.

3.2.5.3 The process overall

97 Overall, **HEIs**, represented by the MRFs, **were very satisfied with the Major review process**. There have been few responses of 'strongly disagree' and 95 per cent of the responses from this group were 'agree' or 'strongly agree'. The level of satisfaction felt by the HEIs involved has risen by 5 per cent since the start of the process. The highest level of satisfaction was found to be in relation to the reviews that took place in summer 2005, when a total 98 per cent of responses from HEIs were 'agree' or 'strongly agree'.

98 The majority of **PRFs involved in Major reviews were very satisfied with the visits**, with a 'disagree' response level of only 5 per cent. PRFs who have been involved in more than one review do not tend to show higher levels of satisfaction as the number of reviews increases.

99 The most positive element of QAA involvement was the briefing for the MRF and PRF. All but two MRFs (97.2 per cent) agreed that the briefing proved helpful during the review. The Handbook was also considered by most respondents (91 per cent) to provide clear guidance about the information to be included in the SED. Support for the reviews from the QAA office was viewed as effective by all but three of the MRFs (4 per cent).

100 **Interactions with QAA were viewed positively by the PRFs**, with all but one of the respondents agreeing that QAA supported the review in an effective way. The Handbook was said to have provided clear guidance about information to be included in the SED by all but eight of the respondents (87 per cent). The support logs have noted that the MRF and PRF also find the reviews to be open and transparent and, if concerns or complaints have been raised, they have been resolved promptly and efficiently.

101 **The placement areas involved in visits by the reviewers to practice found the process beneficial.** In general, visits to practice placements were seen as 'positive', 'well received' and 'very useful', comments that have been made right from the start of the process. One respondent was pleased that 'the reviewers were able to ask pertinent questions and had obviously tuned into issues which were also of concern to the practice educators'. One respondent from a later review stated 'I think visits to placement areas are crucial as these areas are central to the education of healthcare professionals'.

102 **A large number of placement respondents highlighted the fact that being involved in a review has benefits for them, through the reflection involved and the highlighting and sharing of good practice.** They also welcomed the chance to 'demonstrate the quality learning environments that they have developed'. One placement respondent was pleased that the reviewers 'were mindful and considerate of the needs of the clients and that the work needs to continue'. Other placements commented that a positive part of the review for them was the 'acknowledgement of the partnership between HEI and placement provider, that we play an important role in the education of students', 'recognition of joint responsibility, practice and HEI' and that it 'highlighted the importance of partnership working between HEIs and practice'.

103 Many placements also mentioned that a positive aspect of the reviews was the 'feeling that **a lot of what we do is OK and to have it evaluated formally by external bodies ratifies what we do'.** Other comments included the 'reassurance that we are doing a good job', the 'opportunity to review practice in line with NMC and QAA requirements', the chance for the HEI to 'view practice placements and receive feedback from QAA', and that 'the positive feedback received confirming that current practices and education provision within the workplace were very good'.

104 **Placement respondents welcomed the opportunity to strengthen the relationship between themselves and the HEIs.** Positive elements given by respondents include 'the opportunity to contribute along with other stakeholders to the SED', 'partnership working between all placements and university staff, with involvement of clinicians at all levels', 'partnership working between placements, WDC and working more closely with the University' and 'university and practice staff working together to promote excellent learning environments for students'.

105 From the perspective of **providers** in focus groups, one of the **benefits** of Major review was considered to be the **opportunity it afforded them to ensure appropriate processes and procedures were in place for QA.** It was also noted that, through the Major review process, recognition of **partnership working was a very positive output**, and the preparation required prior to the review visits helped build and strengthen partnership relationships. The involvement of clinical staff in the process was also considered to be very beneficial. Through the interactions that took place as part of the process, awareness was raised among all partners of the work that was carried out in other areas. This also allowed for greater understanding between the HEI, the placement providers and the SHA. However, it was noted that tensions existed where professional bodies worked together with regulators.

106 It was stated by some members of focus groups that the **Major review process did not serve post-registration provision well.** Some considered that the process was not sufficiently flexible to cope with the reality of provision delivery, particularly with respect to placement visits.

3.2.5.4 The work of the CRs

107 **The MRFs expressed satisfaction with the work of the CRs**, with 89 per cent of MRFs agreeing that CRs had demonstrated facilitation, communication and organisational skills. Many MRFs commented that the **CRs were one of the most positive features of the reviews for them.** Comments about the most positive aspects of the review include: 'facilitation provided by the CR', 'the responsiveness of the CR and panel to the particular circumstances of the University's (untypical) healthcare provision' and the 'professionalism and courtesy of the CR'. Another MRF noted that 'the CR was very effective in his role and established a constructive atmosphere in the meetings with staff'.

108 Equally, one area of the reviews that the **PRFs were most content with was the CRs.** This is shown by comments such as 'the CR was very organised and structured but also very caring of his team and all the stakeholders', 'CR was meticulous in his approach to detail, ensuring a fair review was undertaken' and 'excellent chair, thorough but well planned and organised approach'. Ninety per cent of PRFs were highly positive about the CRs' skills, with 73 per cent of the 'agree' responses being 'strongly agree'. Comments from PRFs about the CR include: 'the CR organised the review in such an effective way that there was no uncertainty for HEI and practice staff', and 'the excellent facilitation and negotiation skills of the CR who offered support and encouragement to all involved throughout the review'. The PRFs agreed strongly that 'effective communication was maintained between the CR and the PRF'.

109 Like the MRFs and PRFs, **the reviewers considered the CRs a positive aspect of reviews.** The majority of team members agreed that for their visits the CRs demonstrated facilitation, communication and organisational skills. Communication between the CR and the reviewers was perceived by most of the team members to be satisfactory, with a very small number of respondents (8 per cent) disagreeing.

110 It was evident from the support logs that **the CR was pivotal to the process.** The CR provided a consistent channel of communication between the different parties - HEI, SHA, review team and QAA. The CR also provided essential guidance to the reviewers throughout the process, keeping them focused and clear of the team's objectives. It was clear that the

CR's meetings with the MRF and PRF at the end of each review day, to inform them of any lines of enquiry and those that have been closed down or make further requests for documentation or clarification, is essential. They also discussed concerns from the subject providers, for example, the progression of the review. This enabled the process to be open and transparent.

3.2.5.5 The work of the review teams

111 **MRFs were also satisfied with the review teams**, mostly indicating that they demonstrated a clear understanding of the review method, applied skills and techniques appropriate to verifying the evidence base, and adopted an open and flexible approach to interactions. Across all institutions, negative responses to the five statements regarding the review team amounted to 7.6 per cent, from 22 per cent of MRFs. The largest number of 'disagree' responses regarding the teams came in relation to the range of expertise within the review team and whether this reflected the practice and academic context of the provision being reviewed.

112 The **PRFs felt that the review teams were a positive feature of the reviews.** Most respondents agreed that the teams demonstrated clear understanding of the method and of the significance of developing a dialogue with the HEI and the SHAs. It was also widely noted that the reviewers applied skills and techniques appropriate to verifying the evidence base. The main area of dissatisfaction among PRFs was the same as for MRFs, with 13 per cent of MRFs and 28 per cent of PRFs questioning the range of expertise and whether this reflected both the practice and academic context. However, most respondents were satisfied with the composition of the review teams, stating that 'the reviewers were knowledgeable in their subject area and reflected this in the professional manner in which they conducted the review'.

113 Sixteen per cent of **PRFs** did not feel that lines of investigation that had been closed by the reviewers were communicated clearly, but **93.5 per cent agreed (69 per cent of them strongly) that the judgements made by the review team were consistent with the dialogue during the review.** A concern that was frequently expressed by some review facilitators and reviewers was in relation to the time available for the reviewers to examine the documentation provided. The reviewers based their agenda on the claims made in the SED, and this agenda was shared with the providers prior to the start of the review. Where providers limited the evidence to that which clearly supported the claims in the SED, teams found it easier to work through the documentation provided. However, some providers made a considerable amount of wide-ranging evidence available, and in many cases it was not possible for all the reviewers to read all the documentation. They needed to take a more focused approach to consider the complete set of evidence available. In the evaluation questionnaires, 89 per cent of the reviewers note that they had received sufficient evidence in all areas to form their judgements.

114 It was suggested in focus groups that there had been a perceived variation in how different review teams worked and shared information, although all teams followed the same method of visits and meetings for each day of the review. Variations occurred due to lines of enquiry that were raised and the evidence, be it from staff, students or documentation, which was needed to follow them through. It was also noted that providers often had difficulties in deciding who should attend meetings, as there was a large range of stakeholders involved. The guidance from QAA was that the number present at each meeting should be kept to a minimum of those who were most able to answer the specific lines of enquiry posed by the reviewers.

115 The QAA officer support logs also note that the CR constantly referred the review team back to the Handbook, especially annex D, and to the SED to ensure a focused approach. **The review team was regularly reminded of the process and protocols to be followed to ensure that the published methodology has been implemented throughout.**

116 **Team members were satisfied with the training given,** with 95.5 per cent agreeing that the training had helped to prepare them for the review. There were very few 'disagree' responses, but most of these related to the composition of the teams (7 per cent) or the allocation of work within them (6.4 per cent). Team members, especially those with less experience of Major review, preferred to write sections of the report on their own discipline only. However, in order to encourage teamworking across disciplines, the protocol was to allocate an 'element' or section of the report to each reviewer. For example, a reviewer responsible for drafting report text for student achievement wrote this section for all disciplines. In evaluations and focus groups, many **team members commented that they had greatly valued working in interdisciplinary teams**, and that by writing about other disciplines they became more aware of the different professions and relationships between them.

117 The CRs feel on the whole that the **training helped to prepare the reviewers satisfactorily** for the review and that they undertook most activities as the training indicates. A large proportion (95 per cent) of the CRs noted that the teams were well balanced, in terms of expertise, for the reviews they undertook. The one area where CRs deemed that the team did not undertake activities as the training indicated was in writing their initial commentaries on the SED. Twenty per cent of the CRs did not agree with this statement.

118 **All teams had satisfactory access to the ARCS website** across the 84 reviews, with only 3.4 per cent of respondents feeling that they did not. As the main communication tool for the reviews, the reviewers need to be able to download material and communicate effectively with each other and the CR through ARCS. The reviewers in focus groups generally found that it had been a useful tool for accessing information and communicating securely with other team members. Only 6.4 per cent of the reviewers found that they could not download material from ARCS satisfactorily. Team members generally find ARCS to be 'very useful and easy', 'excellent' and 'user friendly', and any problems with the system are related to attachment formats or document size. One team member commented that one of the most positive features of the review was 'using the ARCS/QAA website'.

3.2.5.6 The preparatory meeting

119 **Preparatory meetings between the HEIs and CRs are seen as constructive,** with 97 per cent of MRFs indicating that they were useful in preparing for the review. All but one of the MRFs agreed that the timing enabled the HEI/SHA to make the necessary arrangements for the review. One of the aims of the preparatory meeting was to **establish a clear and shared understanding** about various elements of the review. Most responses in this section agreed that such an understanding was effectively established. The areas where the situation was less clear were the scope and focus of the provision to be included in the review, and the arrangements for practice visits for day 3 of the review, which were not firmly decided until after day 2. In 13 per cent of reviews, the sample for NMC monitoring had not been confirmed by the time of the preparatory meeting. Nine per cent of MRFs did not feel that there was a clear and shared understanding established in relation to the practice placements to be visited on day 2, as preliminary arrangements made had not taken into account that the reviewers would work in interdisciplinary pairs.

120 **The preparatory meeting** was an important part of the process and **was viewed positively by PRFs**, with 97 per cent agreeing that it was useful in preparing for the review. The timing of the preparatory meeting was also viewed positively by the PRFs involved, with only three of them disagreeing that the timing enabled the HEI/SHA to make all the necessary arrangements for the review. Other PRFs commented that 'the preparatory meeting offered a useful tool whereby all those involved could check on progress and ensure they understood the requirements for the actual review visit' while another commented positively on 'the developmental outcomes achieved as part of preparation process'.

121 **Preparatory meetings were useful for both the CR and providers in preparing for the review.** All but one CR (99 per cent) felt that the preparatory meeting was useful in preparing for the review, and 72 per cent of all respondents agreed strongly. The main area where a clear and shared understanding has not always been established at the end of the preparatory meeting was in relation to the sample of students' work that would be provided; in total, 10 per cent of CRs disagreed that the sample to be provided was clearly defined or agreed.

3.2.5.7 Communications

122 **Communication between all those involved in the reviews was predominantly seen as effective.** Communication between the CR and MRF, CR and PRF, and CR and the reviewers was perceived as satisfactory by the MRFs, with only 4 per cent 'disagree' responses to the three statements relating to the quality of these communications. The majority of MRFs considered that changes to the agreed review events were clearly communicated and reasons given. 'Disagree' responses were found to be spread across the whole cycle, and so cannot be attributed to a particular issue with the process. Throughout the reviews, communication has been consistently highlighted as one of the most positive aspects. Comments from MRFs include: 'communicating using IT (information technology) with the review chair and review team worked very well indeed'; 'excellent communication between the CR and the University'; 'the review team and especially the review coordinator were excellent in communicating the process'; and the 'openness of CR and communication with MRF/PRF'. The most frequent area of concern was with the clarity with which lines of investigation that had been closed were communicated. Twenty-five per cent of MRFs disagreed with this statement. However, at the end of the review, 95 per cent of MRFs thought that the judgements were consistent with the dialogue throughout the review.

123 **Communication between the CRs and the MRFs was seen by the CRs as effective, and openness was maintained throughout.** Ninety-five per cent of CRs also noted that communication between themselves and the PRFs was effective and maintained, and considered that 'communication between the review coordinator and the reviewers was satisfactory'. All of the CRs indicated that there was a clear and shared understanding established at the end of day 1 regarding issues being investigated and further evidence required for day 2, and 91.5 per cent were clear at the end of day 2 about the lines of enquiry for day 3.

124 **The MRFs and PRFs are described by the CRs as 'strong', 'sound' and 'very knowledgeable'.** One CR stated that the most positive aspect of the review was the 'excellent PRF - who worked across four HEIs and knew what was going on!'. Other CRs positively noted the 'willingness of the MRF and PRF to provide the review team with information and support'.

3.2.5.8 The evidence base

125 **The reviewers found** that, in the majority of cases, the access to materials, documentation, meetings on campus and visits to practice provided them with **sufficient evidence to inform their judgements.** Team members found that the documentation supplied by the HEI was 'highly organised and presented well' and 'very ordered and therefore easy to access', while one reviewer thought that the 'organisation of material on a memory stick was excellent and facilitated cross-checking paper evidence very effectively'. Ten per cent of the reviewers disagreed that the provision of materials and documentation (excluding student work) was adequate, with some quoting 'despite repeated requests from coordinator, the documentation provided was patchy and incomplete', 'some information was slow in being produced', and 'some resistance by HEI to provide satisfactory statistical data'. Student work was another area of discontent for some reviewers, with 13.5 per cent of the reviewers disagreeing that the sample of work provided was adequate to inform their judgements.

3.2.5.9 Visits to practice

126 A criticism of earlier subject reviews of Nursing, Midwifery and Other Subjects Allied to Medicine was that the reviewers did not have access to practice learning. Therefore, a **fundamental underpinning of Major review was** the need to acknowledge at every level **that the education provided was shared equally between academic and practice learning**. Not only was review team membership designed to reflect this, but also the visits to practice placement areas occupied half the visit time in days 1 to 4.

127 **The number of placement areas visited was in most cases small in relation to the total number used by the educational provider.** However, PRFs ensured that a representative sample of placements was visited that reflected the breadth of practice learning environments. In most cases, due to the consistency of the providers' placement management processes, the reviewers gained a clear impression of the effectiveness of all aspects of practice learning from a small sample of visits. Occasionally, this led the reviewers to criticise the need to spend more than a single day out in practice, but the majority view from all respondents was that the two days were highly valuable and that more time spent at individual placements would be beneficial.

128 **The geographical spread of practice locations**, often far removed from the HEI, **provided serious logistical problems** for visits to practice. At first, some unrealistically heavy visit programmes were created, which resulted in time pressures on both the providers and the reviewers. However, in general, PRFs and HEI subject leads worked hard to provide effective timetables and organise the management of the visits to practice in such a way that enabled the reviewers to talk to students, mentors and managers to gain sufficient evidence to answer their lines of enquiry.

129 An effective approach adopted to address geographical challenges has been, where necessary, to locate the team or part of the team at a different hotel closer to the placements to be seen the following day, either day 2 or more usually day 3. This ensured that placements were visited because they provided appropriate evidence in the verification of the SED, not because they are conveniently placed. Similarly, where providers had a specific 'satellite' provision, often highly specialised and geographically distant, reviews were organised so that a small number of the reviewers visited the satellite prior to day 1 and provided a report of the meetings with staff, students and the resources available, ready for the whole team on day 1.

130 **Many practice areas are used by more than one educational provider.** It was therefore important to ensure that no area was visited twice, to avoid additional burden on practice staff. To enable this, the QAA Health Team maintained a database of all the visits to practice that took place, together with the nature of the engagement and whom the reviewers met. In spite of a large number of practice placement providers, covering every kind of healthcare provider from General Practitioner surgeries and day care centres to acute hospital wards, because of the timing of some reviews it was sometimes difficult to arrange visits. This was often because of the cycle of the academic year, staff holidays, or the daily work pressures of mentors or students.

131 **The reviewers visited each placement area in pairs.** Normally, each pair represented two professional disciplines. This was part of the commitment to IPL throughout the reviews. Initially, some reviewers felt somewhat de-skilled visiting areas in which they had no professional expertise, although the protocol around each pairing was made clear at their training. While the reviewer whose profession was the focus of the visit would be the lead questioner, the second reviewer acted as note-taker and lay questioner, providing an alternative view of the quality of the provision. Day 3 pairings were different from those on day 2 to ensure that the reviewers were exposed to a variety of professional cultures. This arrangement worked well, with the **reviewers greatly valuing the experience** not only of interprofessional working but of visiting areas of practice they would not otherwise have the

opportunity of seeing. On each visit to practice, a form was completed, later to appear in electronic form in the reviewers' ARCS folder so that all team members had access to the evidence provided to inform the report.

132 **Visits to practice were seen to be a very beneficial aspect of the process**, and were considered necessary by the reviewers and CRs in order to triangulate evidence from the academic learning environment. These visits also provided the opportunity for placement areas to demonstrate good practice. In some cases, the reviewers asked for further clarity on whether placement visits were to examine strategies, processes and/or students and/or resources. The visits could incorporate all these aspects, depending on the lines of enquiry being followed. Discussions at facilitator briefings and preparatory meetings helped reinforce the purpose and protocols for the visits. Some reviewers initially questioned **the value of visiting placements** where there were no students present, or where very similar types of placement were scheduled. It became apparent that all visits contributed effectively to the evidence base to draw upon in coming to judgements and drafting the report.

133 Annex H of the Handbook provided guidance on the choice of placements to be visited, and the reviewers were able to suggest additional areas they would like to visit following day 2 of the review. Some providers found it helpful to prepare placement areas for the review before the schedule of visits was confirmed. However, managing placement staff expectations was an important consideration as those initially involved and then not visited might feel disappointed. Once a placement visit had been arranged it was difficult to change it, as staff had given a commitment and dedicated time for the visit. Some practice respondents also considered that more support, and more time preparation time for review visits was needed.

134 **Access to placements was rated highly by the reviewers**, with 94.5 per cent of the reviewers agreeing that visits to placements and discussions with students and staff in placements were productive as a source of evidence. Most of the reviewers agreed that the staff within the HEI/SHA/placements responded to their enquiries in an open and informative way.

135 The placements involved in the reviews through the visits to practice found the process to be beneficial. In general, practice placements are seen as 'positive' and 'very useful' - comments that have been made from the start of the process. One respondent was pleased that 'the reviewers were able to ask pertinent questions and had obviously tuned into issues which were also of concern to the practice educators'.

136 **A large number of placement respondents highlighted the fact that being involved in a Major review has benefits for them**, through the reflection involved and the highlighting and sharing of good practice. They also welcomed the chance to 'demonstrate the quality learning environments that they have developed'. Placement respondents commented that a positive part of the review for them was the '**acknowledgement of the partnership between HEI and placement provider** - that we play an important role in the education of students', 'recognition of joint responsibility - practice and HEI' and that it 'highlighted the importance of partnership working between HEIs and practice'.

137 Many placements also mentioned that a positive aspect of the reviews was the 'reassurance that we are doing a good job', the 'opportunity to review practice in line with NMC and QAA requirements', the chance for the HEI to 'view practice placements and receive feedback from QAA', and that 'the positive feedback received confirming that current practices and education provision within the workplace was very good'.

138 Placement respondents welcomed the opportunity to strengthen the relationship between themselves and the HEIs. Positive elements given by respondents include 'the opportunity to contribute along with other stakeholders to the SED', '**partnership working between all placements and university staff, with involvement of clinicians at all levels**' and 'university and practice staff working together to promote excellent learning environments for students'.

3.2.5.10 Judgements and the oral feedback meeting

139 One of the lessons learned is that the final day of the review, which is for the judgement meeting, progressed better if the team had created an initial draft report of the review. This enabled the team to: clearly identify strengths, good practice and weaknesses; test the evidence base fully; agree the content of the report; and be confident that the judgements reached were robust.

140 All **CRs agreed that the judgements made by the review team were consistent with the dialogue during the review**. All but one of the 503 reviewer responses agreed that the judgements made by the review team were consistent with the dialogue during the review.

141 The CRs provided **oral feedback at the end of their day 5** visit, giving only the judgements agreed by the team. Some MRFs commented that they would like more detailed feedback at the end of the review, that could include 'some indication of identified good practice and any recommendations for improvement' enabling them 'to give immediate feedback to the HEI and SHA and keep up their momentum'. It was said by one MRF that 'there was a sense of anti-climax following the practice visits because of a lack of feedback'. Another MRF thought that a less positive element of the process was the 'length of time between the verbal feedback on the judgements and when the institution and the team can make them public' that is, when the report is published some 20 weeks later. The timescale enables the team to reflect on the working of the report and bullet points to ensure accuracy. It also avoids potential adversarial exchanges between the review team and staff at the end of the review.

3.2.5.11 Most positive themes about the Major review process

142 Respondents were given the opportunity to respond to open questions at the end of the evaluation questionnaire. The most frequently recurring positive theme relates to the approach of the key people involved in the reviews: the **CRs, the review teams and the review facilitators.** Other themes which frequently arose were around **placement visits** and **partnership working.**

143 The **CRs** are consistently highlighted as a positive feature of the reviews. The reviewers members feel that CRs have 'excellent organisation skills' and are 'very able and experienced', 'excellent', 'organised' and 'supportive'. MRFs comment on 'the professionalism and openness of the CR'. Focus groups noted that CRs were essential in ensuring that schedules were maintained and in explaining issues and lines of enquiry as they arose. The CR's role in directing the reviewers and triangulating the evidence available was also considered to have been central to the effectiveness of the process.

144 **The reviewers are also frequently cited as the most positive feature of reviews,** by CRs, MRFs and PRFs. The CRs commented that they were 'cheerful and efficient', 'individually consistently effective' and 'highly professional and committed'. MRFs were impressed by the 'professional approach of the review team', the 'constructive attitude and professionalism of the reviewers', while PRFs and placements commented on the 'dialogue and consistency of the review team', 'discipline of team', and 'friendly, approachable reviewers'.

145 **The review facilitators also play an important role in the reviews.** The CRs and team members recognise the 'helpful MRF/PRF' and the 'quick response from the PRF and MRF when supplying additional evidence' to be a positive element of the reviews. One team member found that the 'professional attitude of CR, MRF and PRF facilitates gaining evidence, allowing informed views to be developed' was a positive element of the review, while another commented on the 'helpfulness and openness of MRF and PRF'. Focus groups also noted that the working relationship between the MRF and PRF was also considered to have been crucial to the effectiveness of the process. The facilitators' role was seen to have enabled the process to be 'open' and 'transparent'.

146 There were many positive comments on **practice placement visits**. CRs thought that they were 'well organised', 'well managed' and 'enjoyed by the team'. Team members commented positively about 'experiencing the partnership working' and 'the opportunity to view the practice placements across primary and secondary care'. They also found that 'visiting placements often prompted additional supportive information which might otherwise have been omitted from dialogue on campus alone'. One PRF commented that a key strength of the process was 'the enhancement of practice through preparation [for Major review]'. Good practice repeatedly highlighted during focus group discussions was **the involvement of clinical staff**. It was considered essential to the process that the views of clinical staff should be heard. Involvement of clinical staff was also thought valuable in raising the profile of practice with the HEI and other stakeholders and highlighted the work undertaken in practice. Additionally, the involvement of practice in the review process served to validate the work undertaken in practice to both clinical staff and the HEI. The focus on practice in the action plans was also seen as an important aspect of the process.

147 **The engagement and development of links with partnerships** was also considered to be an area of good practice by focus groups. Throughout the process, it was generally considered that links with partners had been strengthened and communication between partners had been enhanced and improved. It was suggested that the support that had been provided by the SHAs throughout the process had been a very positive aspect of the process, and that this could have been highlighted more in the published reports.

3.2.5.12 Least positive themes about the Major review process

148 Themes that arose as **less positive aspects** of the reviews tend to be process-based, with the most frequent references to **the timescale of reviews, the SED, statistical data and student work provided** as evidence for the reviews. Focus groups also highlighted the minimal **oral feedback** on the judgements as a less positive feature of the process.

149 **The issue of time** remained constant throughout the two years of the process. Two early reviews were only four days in length, as the provision was very small, but this caused some issues with team members, one CR and one PRF. The two team members commented that they felt rushed by the 'lack of time', and one CR noted that 'the **four-day review model** left reviewers with little or no opportunity for reflection before having to make judgements'. Following these experiences, the review visits were standardised at five days, following the 2+2+1 model. A number of the reviewers considered that the gap between days 2 and 3 created difficulties in maintaining momentum and following through lines of enquiry. Other respondents would prefer more time between visits to read more material and to prepare their sections of the report. Some respondents commented that 'a more condensed period might have been useful' but others noted that 'the time given to the reviewers themselves to complete all the tasks on site was very short'. A number of review facilitators would prefer the review days to be consecutive, as they found it time consuming to 'set up and then dismantle the work room on three different occasions', while another commented that 'the academics leading the programme teams…did complain of the time and effort involved which they felt detracted from their normal activities'.

150 Another area of concern that arose was that of the **quality of the SEDs** presented by the providers being reviewed. Comments about the format of the SED were more frequent in earlier reviews where not all providers had followed the format outlined in the Handbook. Again, QAA issued further guidelines in response to feedback from the review teams and, in later reviews, negative comments about the SED were far less frequent, noting a lack of evaluative commentary, rather than problems with the format. In one case, the reviewers commented that the SED 'made the provision appear considerably weaker than it actually was' and another noted 'the lack of detail given to one of the subjects within the SED'. However, 92.5 per cent of MRFs and PRFs noted that the QAA workshop(s) helped in preparing the SED, and 94 per cent agreed that the Handbook provided clear guidance on the information to be included in the SED.

151 Regarding **statistical data**, MRFs stated that 'quantitative data templates did not help provide the required information effectively' and would like to see 'clearer guidelines on the information required in support'. Other MRFs reflected that there was 'confusion and lack of clarity about the nature and presentation of the progression statistics required'. The main issue here was the lack of the national standard dataset, which it was anticipated would have been published at the start of the review cycle. Had this been available, it is likely that there would have been fewer problems in organising, presenting and interpreting these statistics. Section 3.2.5.13 below offers further discussion and responses to this issue.

152 The reviewers noted variously that, on some reviews, **the sample of student work available was limited**, or there was little time to consider the work provided. The reviewers on other reviews also indicated that they would prefer to see more longitudinal samples of work, as these were more useful than module samples.

153 In line with written evaluations, focus groups indicated that perhaps one of the least satisfactory parts of the Major review process was the minimal nature of the **oral feedback.** Both HEI and SHA staff considered that more detailed feedback at the end of the review visit would have been welcomed. Many considered that the end of the process was an anticlimax after the intense build up in preparation for Major review. Not receiving more detailed feedback of the strengths, good practice and weaknesses until the draft report had been received had been disappointing. Institutions described being left in a state of 'limbo' from day 5 until the bullet points necessary for them to prepare the action plan were received.

3.2.5.13 Suggestions for improvement

154 A final element of the questionnaires gives respondents a chance to suggest how the Major review process could be further improved. This was also discussed at the focus groups. The main areas highlighted by respondents are to **provide greater guidance to HEIs about data, allocate more time overall for the review and introduce more flexibility in the process.**

155 The CRs would like to see 'more guidance to HEI/placements on the data required', 'clearer specification of the statistics required' and 'ensure providers produce accurate data'. PRFs would appreciate 'more detailed instructions on the statistics required' and 'more in-depth guidelines about preparation of the SED'. The reviewers suggested that the process could be improved with 'more clarity around the review of student work'. Additional guidance was provided by QAA in response to feedback on a number of issues, including data tables, the student work sample, the format of bullet points and writing action plans. Further additional guidance was also offered on the number of placements that can be realistically undertaken in one day.

156 There is little consensus on the appropriate timescales for the review, with MRFs preferring a shorter period, PRFs and placements preferring a greater amount of time to be spent in practice, despite **two out of four days being spent entirely in practice**, and the opportunity for practice and SHA staff to attend meetings on the other two days. The reviewers vary in their responses to the timescales, with some preferring a greater gap between visits: 'too little time between days 2 and 3 to digest the outcomes of the first visit'; and others feeling that a two-week period between visits was disadvantageous, and that travelling time and expense could be reduced with more consecutive days.

157 Regarding **flexibility**, a number of respondents commented that the length of the review could vary depending on the number of disciplines and programmes to be reviewed: 'the level of intensity of scrutiny was out of proportion to the size of the provision' and suggests that 'any new method should be flexible enough to fit the size of provision being reviewed'. However, following experiments with fewer days for smaller provision, the reviewers commented that they felt rushed, and that there was insufficient time to consider all the evidence available and to write the report.

158 The CRs would also like a greater emphasis to be given on training for improving reviewers' **writing skills** and on referencing the evidence. While guidance was given on both of these aspects, the reviewers did not always apply them consistently, resulting in considerable editing being undertaken by the CR, ECR and QAA officers.

159 Developing a more consistent use of language and terminology was also suggested by focus groups. Differences in **language and jargon** used by the different professional groups, by academics and by practitioners created some confusion or inconsistency. A prime example is the use of 'mentors' in nursing and midwifery, and 'practice assessors' or other terms in the AHPs. Another example would be the many titles used for the placement facilitator, the most common of which are 'practice placement facilitator' or 'clinical placement facilitator'.

160 Further comments on improvements and recommendations for the future, drawn from the evaluation of major review and analysis of the reports, can be found in Chapter 5: Learning points.

3.3 Post-review

3.3.1 Preparation of reports

161 A report was produced at the end of each review, describing the findings of the review team. When published, 20 weeks after visit day 5, this marked the end point of the review process. The report provides detailed feedback to the HEIs, SHAs, practice placement providers, SfH and PSRBs. It is also used to inform the public, giving assurance that the education provided is fit for purpose. Potential students can also use it to inform their choices when deciding where to study, giving them confidence in the quality and standards of the provision.

162 Each of the eight main sections of the report, corresponding to the eight elements of the review (see section 4.1), was normally drafted by the reviewer charged with leading on that element on behalf of the review team. **Major review encouraged review teams to work interprofessionally** in conducting the reviews and in writing the reports. Therefore, in each of the main sections, the reviewer responsible needed to write, on behalf of the team, about all the professions represented in the review. In turn, this meant that throughout the review visit there was a premium on interprofessional dialogue within the team. It was often challenging for the reviewers to write across disciplines, but the benefits in terms of interprofessional working far outweighed the difficulties.

163 **The drafting process began very early in the review** because the reviewers could use their initial critique of the SED as a skeleton, building on it through the review visits as they gathered evidence. The CR edited contributions as s/he received them and was responsible for producing a complete initial draft in time for the reviewers to download and print out before the day 5 judgements meeting. By then, the whole text would normally be close in form and content to the final version. This draft was scrutinised line by line during the meeting, ensuring that the content of the report and the evidence base which had been referred to fully supported the judgements made.

164 From the onset, it was recognised that writing a Major review report may be considered to be challenging, therefore **the reviewer training course had a strong emphasis from the outset on developing appropriate report-writing skills.** For some academic reviewers, there was undue emphasis on writing about the academic as opposed to the practice education. On the practice side, some reviewers were confused by academic jargon. In both cases, the CR needed to edit the draft considerably to gain a consistent tone across the report, remove repetition and to ensure that the points being made were sited in the appropriate section of the report. Some reviewers struggled in identifying the differences between achievement and progression, or curriculum and learning and teaching. In general, reviewers from all professions carried out a splendid job in producing the written work required of them under considerable time pressure.

165 **The rigour and accuracy of the report are paramount** as it is in the public domain. This meant that the editing process after day 5 entailed very close working between the CR, the ECR, the Health Team, the QAA Reports Team and the institutions to which the report refers. The quality and consistency of reports clearly benefited from this careful process. Within a week of day 5, the CR produced and sent electronically Draft 1 to the reviewers. They responded with comments and corrections. Over the next 19 weeks, the draft report passed to the ECR, back to the CR for further corrections, on to the institutions for their comments on factual accuracy, and back to the CR to produce the final draft. The ECR also checked the report to ensure the institution's comments and concerns were appropriately addressed. At this stage, the Reports Team proof read and prepared the report for publication, incorporating in it the action plan produced by the providers.

166 Superficially, it may appear that 20 weeks between the end of the review visit and the publication of the report is a long period. However, with many different parties involved, while moving through several drafts, it often proved challenging to stay within this timeframe. Account needs to be taken of this in introducing any new report structures or templates that might arise out of Major review. The time available for completion and return of the action plan was extended with the consequence that an extra three weeks were added to the overall schedule.

167 **The reports can be lengthy,** depending in part upon the number of disciplines involved in the review. The initial template within which the report was written needed some fine tuning and it took CRs time and experience to embed consistency in their practice. **The inclusion of data tables recording student achievement and progression in the reports for the first time in QAA reviews at the subject level proved challenging.** Not only were the data themselves often very difficult to acquire and not always accurate initially, but the formatting of the tables caused some frustration due to varying technological proficiency on the part of both review teams and providers. With regard to the process for production of the report, some CRs thought it to be straightforward. Others, however, found it more difficult to meet the published deadlines. CRs also suggested that it would have been helpful if the Handbook contained timescales for this aspect of the process, although the complete timeline was included in the CRs' operational pack.

3.3.2 Action plans

3.3.2.1 Key themes

168 The **completion of the review report** was an important stage in the review process, but it was **not the final stage**. The identification as bullet points in the report of key strengths, weaknesses and good practice within the provision formed the basis of an action plan which was completed by the HEI/SHA and published as part of the Major review report. **The action plan addresses all bullet points** and provided the focus for ongoing quality assurance activities in which the HEIs, practice placement providers, SHAs, PSRBs, DH and SfH will have an interest. For an analysis of providers' responses to the bullet points as set out in the action plans, see section 4.3 above.

169 A premise of Major review was that **the action plan is a useful and useable document.** The action plan should:

- be focused on maintaining and improving the provision
- be clear about the actions required and accountability for the actions agreed
- have clear and measurable outcomes which focus on enhancement of the programmes
- exhibit clarity about the system for monitoring the achievement or otherwise of the agreed actions.

170 The design and structure of action plans for Major review drew on the plans used by the CHI. The plan outlines the actions that providers are committed to undertake, the dates for completion, the constraints preventing delivery, the impact of not delivering the action required, the person or role title responsible for overseeing implementation of the action and the evidence that will demonstrate if change has taken place as a result of the action taken.

171 Providing effective guidance and training to the reviewers and CRs about writing bullet points that could be actioned was initially challenging. In the earlier reviews, the reviewers produced bullet points which were often difficult to action, too numerous to be helpful for the providers, or impracticable in the timescale for the production of the plan. Additional guidance about the definition of strengths, good practice and weaknesses was provided to the review teams in 2004-05 which had the effect of reducing the number of bullet points produced by teams and making them more specific and easier to respond to.

172 **Action plans have been a significant and important part of Major review and have raised a number of learning points.** Following feedback from the providers during the first full year of reviews, a key area for discussion which had been highlighted was around action planning. The QAA Health Team made a commitment to provide at least two days in the academic year 2005-06 to focus on this area to address the need of providers for a forum for discussion, debate and sharing of good practice, in addition to the scheduled contracted evaluation events. The first session on action planning was included in a combined workshop for review facilitators and for SED preparation in October 2005. Delegates found this session particularly useful as an opportunity to discuss and evaluate processes and identify issues and solutions.

173 Following this session, **four dedicated action planning forums** were organised throughout the academic year 2005-06. Delegates commented that the events exceeded their expectations, and they found it useful to share experiences or inform their own processes in preparing for and completing the action plan.

174 The issue of resources in relation to providers developing, contributing to and completing the action plan was a prominent theme during the forum discussions. This includes people, equipment and IT access. For a substantial number of providers, the lack of resources in terms of people, equipment and funding was an ongoing issue which affected the completion of the action plan. Tensions arose because some actions leading to quality enhancement needed both investment and resources to be achievable. Other **key themes emerging** from the forums included:

- the importance of setting key dates and timeframes to ensure successful completion of action plans
- the need to have the right personnel involved. The problem facing many providers, particularly in practice, was how to get the importance of action planning high enough up the agenda at board level. In some organisations there was sometimes little or no awareness of the action planning part of Major review at executive or board level
- SMART (specific, measurable, agreed, realistic and time-bound) responses to the bullet points were vital
- the importance of the 50:50 partnership balance in the reports and action plans
- the need to have mechanisms for monitoring progress, reviewing and feeding back to the placement providers; a danger that, post-review, the momentum gained during the review would slow and actions identified would not be completed and that the relationship built with partners would decline
- the value of action planning in developing and enhancing interprofessional working.

175 Those attending the forum also maintained that action points could easily be taken out of context because they are bullet points taken from the text, and that they should always be read in conjunction with the full text of the report to ensure that they are not misinterpreted. Some stated that they found action plans containing both strengths and weaknesses to be confusing, as these two areas are considered and dealt with very differently. **Some were unsure how good practice should be actioned where it is included in the action plan.**

176 Action planning forum groups reported that the process of completing the action plans has continued to enhance partnership working. However, **responsibility for undertaking the actions continues to lie predominantly with the HEI**, although more examples of explicit joint responsibility are now more frequently seen in the action plans.

177 Despite the underpinning principle of Major review being that academic and practice learning should be given equal weight, some participants in action planning forums considered that the reports were unbalanced. It was also thought by some that the outcomes were **too focused on the HEI**, with insufficient reference to practice. It was also stated that the report content could be **repetitive** in the sections covering strengths, weaknesses and good practice. One comment referred to the balance of strengths and weaknesses in the report, and considered that there were **too many strengths** listed, and that there should be more focus in the report on the weaknesses. In the early part of the cycle, the reviewers identified a large number of strengths as bullet points, which created difficulties for the providers in responding to so many in the action plan. This matter was addressed in the additional guidance provided by QAA to the reviewers.

178 There was some lack of clarity expressed regarding the **judgements** used. Use of the term 'commendable' for practices or processes that include some weaknesses was thought to be confusing, and many providers interpreted this term in the common usage sense, rather than as defined in the Handbook.

179 In the final forum, the concern regarding the forthcoming reconfiguration of SHAs and the effect this would have on the sign-off of action plans for the summer 2006 reviews was evident. The bullet points from the discussion groups were recorded and analysed, and feedback provided to SfH for their consideration in planning further developments.

3.3.2.2 Analysis of lead responsibilities

180 The lead responsibility column in the action plan identifies the person(s) or role title(s) responsible for overseeing implementation of the actions. Analysis of the action plans arising from Major review was undertaken to determine if there was any pattern of how responsibility for implementing actions was distributed, whether it varied over time, and which organisational levels were involved.

181 In order to conduct this analysis, a table was created, listing strengths, weaknesses and good practice against the lead responsibility for each action. The data were grouped by year, coded and analysed, identifying trends and the frequency of the level of involvement of HEIs, SHAs and Trusts in implementing action plans.

182 Providers have tended to list **a number of actions against each bullet point,** identifying a lead responsibility for each. This trend has increased over the review cycle, reflecting the increased specificity of the actions outlined in the plans (see section 3.3.2.1 above).

183 Table E highlights the number of times the different organisations appear in the lead responsibility column across the 88 action plans analysed for this report

184 HEIs appear to dominate the action plans, with more than half the actions to be led by them alone. However, it should be borne in mind that, although they are the only organisation listed against these action points, they are only designated as a 'lead' and no consistency has been adopted across all action plans as to how this column has been completed.

185 According to the figures below, partnerships will lead on over nearly two-fifths of action points. This includes SHAs working with practice and HEIs, HEIs working with practice, and all three groups working together.

186 Also included in the 'lead responsibility' column were some actions to be led on by student representatives, service-user representatives, or employers, most often working in partnership with one or more of the main stakeholders. As these numbers are quite small, they have been amalgamated into the 'HEI with SHA and practice' figures.

Table E: Ratio of responsibility for taking forward actions listed in the action plans (2003-06)

Organisation	Total No.	%
HEI only	1,542	58.2
SHA only	31	1.2
Practice only	45	1.7
SHA with practice	12	0.4
HEI with practice	406	15.3
HEI with SHA	267	10.1
HEI with SHA and practice	346	13.1
Totals	**2,649**	**100**

Analysis by year

Table F: Count of lead responsibility by year

	2003-04		2004-05		2005-06	
	16 reviews		30 reviews		42 reviews*	
	No.	%	No.	%	No.	%
HEI only	332	55.4	438	48.3	772	67.5
SHA/practice	13	2.2	47	5.2	36	3.2
Partnership[21]	254	42.4	422	46.5	335	29.3
Totals	**599**	100	**907**	100	**1,143**	100

187 The pattern of lead responsibility shows a similar picture when the data are aggregated by academic year (Table F), but with some increase in practice and SHA responsibility mid-cycle. Interestingly, allocation of responsibilities to 'partnerships' dropped considerably in the final year. This may have been due to providers allocating a more clear lead to an individual to coordinate the action, rather than across several organisations, where accountability for action may be unclear.

3.3.2.3 Level of responsibility

188 In addition to looking at the allocation of responsibility by organisation, the analysis examines the level at which responsibility is given. Overall, **a wide range of level of responsibility** was demonstrated in the different organisations (Tables G and H), including senior academic, management or administrative, teaching staff (academic and practice) and encompassing committees and groups consisting of a wide range of stakeholders, although

[21] 'Partnership' in Table F refers to all combinations of two or more organisations working together

some plans just referred to the organisation rather than identify a named individual, group, or committee. Within the practice settings it was evident that senior Trust staff were involved. The number of responsibilities allocated to committees or groups also indicated a high level of shared responsibility between all stakeholders.

189 Examples of the breadth of role identified are given in Tables G and H. Individual role titles were mainly identified in the action plans, although teams or groups of people have also been recorded frequently in the plans.

Table G: Level of responsibility within HEIs for taken forward the actions

Level of responsibility	2003-04 %	2004-05 %	2005-06 %	Average %
Senior level	38.3	30.7	34.7	34.6
Management level	35.0	33.4	38.2	35.5
Staff level	15.7	18.7	13.7	16.0
Committees/groups/boards	8.2	10.3	9.6	9.4
Not specified	2.8	6.9	3.8	4.5
Totals	**100**	**100**	**100**	**100**

190 Table G shows that, within HEIs, the majority of action points are to be led by senior staff, with academics and committees taking a lesser role. Conversely, Table H shows that, within SHAs and practice placements, the majority of roles specified are at a lower level, reinforcing the many comments from placement areas in evaluations and focus groups that the action plans need greater involvement from more senior staff to ensure effective action and change.

Table H: Level of responsibility within Trusts and SHAs for taking forward actions

Level of responsibility	2003-04 %	2004-05 %	2005-06 %	Average %
Senior level	6.3	5.9	10.0	7.4
Management level	6.0	15.8	16.3	12.7
Staff level	34.2	35.6	54.0	41.3
Not specified	53.5	42.7	19.7	38.6
Totals	**100**	**100**	**100**	**100**

Chapter 4 Outcomes

4.1 Judgements

191 In Major review, judgements are made by the reviewers about academic and practitioner standards and about the quality of learning opportunities. In coming to judgements about **academic and practitioner standards**, the reviewers consider four elements: learning outcomes, curricula, assessment and student achievement. A separate judgement was then made for standards in each discipline.

The judgement categories are:

Confidence - a judgement that was made if the reviewers were satisfied with current standards and with the prospect of those standards being maintained into the future

Limited confidence - a judgement of limited confidence was made if standards are being achieved but the reviewers had doubts about the ability of the HEI and partner placement providers to maintain them into the future

No confidence - a judgement that was made if arrangements are inadequate to enable standards to be achieved or demonstrated.

192 For **quality of learning opportunities**, in contrast, single judgements were made across all of the provision for each of the following elements: learning and teaching, student progression and learning resources and their effective utilisation. The judgement categories are:

Commendable - the provision contributes substantially to the achievement of the intended outcomes, with most elements demonstrating good practice

Approved - the provision enables the intended outcomes to be achieved, but improvement is needed to overcome weaknesses. The review report will set out the areas where improvement is needed

Failing - the provision makes a less than adequate contribution to the achievement of the intended outcomes; significant improvement is required urgently if the provision is to become at least adequate.

193 In both academic and practitioner standards and the quality of learning opportunities, Major review enables specific programmes and/or levels of study (undergraduate or postgraduate) and/or modes of study to be given a different judgement from the rest of the provision - that is, differentiated judgements can be made.

194 No judgement was made in relation to the maintenance and enhancement of standards and quality although the reviewers comment on the degree of confidence they have in the providers' ability to maintain these[22].

195 Table I lists the judgements reached over the Major review cycle 2003 to 2006, both in totality and by type of provision reviewed: AHP only, nursing, midwifery and health visiting (NMH) only, or mixed AHP and nursing and/or midwifery.

196 **Of the 90 reviews undertaken, the majority of the judgements in academic and practitioner standards were confidence, with only two programmes receiving differentiated judgements - one limited and one no confidence judgement.** In the quality of learning opportunities, there were 87 commendable judgements in learning and teaching, 89 in student progression and 86 in learning resources and their effective utilisation. The remaining judgements were all approved. No programmes were found to be failing.

[22] 'QAA Institutional Audit makes a judgement on the effectiveness of institutional processes to maintain quality and standards.

197 From Table I below it is apparent that differentiated judgements were made on 24 reviews, and applied to specific programmes on each review. For academic and practitioner standards, these occurred in clinical psychology and occupational therapy (one limited confidence and one no confidence respectively). For the quality of learning opportunities, they occurred in audiology (one programme), clinical psychology (three programmes), health visiting (one programme), midwifery (two programmes), nursing (10 programmes), occupational therapy (two programmes), ODP (two programmes), paramedic science (one programme), physiotherapy (one programme) and radiography (three programmes).

198 A greater number of differentiated judgements were seen in student progression, with 10 approved judgements across six disciplines: midwifery, nursing, occupational therapy, ODP, paramedic science and radiography.

199 There was little difference in the pattern of judgements made when analysed by type of provision (AHP only; only; mixed). All three had positive outcomes in the majority of cases, with either confidence or commendable judgements (see appendix 2).

200 Reviews of entirely AHP provision found one no confidence judgement in one occupational therapy programme; one provision approved and one with a differentiated judgement in learning and teaching; one differentiated judgement in student progression, and three provisions approved and two differentiated judgements in learning resources.

201 Reviews of provision found confidence in all academic and practitioner standards; one approved provision and two differentiated judgements in learning and teaching; one approved provision and three differentiated judgements in student progression, and one differentiated judgement in learning resources.

202 Reviews of mixed provision found one limited confidence in one clinical psychology programme; one approved provision and one differentiated judgement in learning and teaching; six differentiated judgements in student progression, and one approved provision and five differentiated judgements in learning resources.

203 On these mixed provision reviews, the total number of programmes receiving approved judgements in the quality of learning opportunities was eight in AHP disciplines and six in nursing disciplines.

204 Of all reviews, the total number of all programmes receiving approved judgements in the quality of learning opportunities was 13 for AHP programmes and 14 for nursing programmes.

Table I: Outcomes from the Major reviews undertaken 2003-06

Report section	Judgement
Academic and practitioner standards	**Confidence** judgements in all 90 reviews Differentiated judgements within two of these reviews **Limited confidence** - one x clinical psychology programme **No confidence** - one x occupational therapy programme
Quality of learning opportunities	
Learning and teaching	**Commendable** judgements in 87 reviews Differentiated judgements within four of these reviews: **Approved** - one x health visiting programme - two x nursing programmes - two x radiography programmes **Approved in all provision** - three reviews
Student progression	**Commendable** judgements in 89 reviews Differentiated judgements within 10 of these reviews: **Approved** - two x midwifery programmes - eight x nursing programmes - one x occupational therapy programme - one x ODP programme - one x paramedic science programme - one x radiography programme **Approved in all provision** - 1 review
Learning resources and their effective utilisation	**Commendable** judgements in 86 reviews Differentiated judgements in eight of these reviews **Approved** - one x audiology programme - three x clinical psychology programmes - one x nursing programme - one x occupational therapy programme - one x ODP programme - one x physiotherapy programme **Approved in all provision** - four reviews

4.2 Strengths, good practices and weaknesses

205 **A total of 90 reviews** have been undertaken in the 2003 to 2006 cycle, with 21 reviews of NMH group disciplines, 28 of AHP disciplines and 41 covering both groups. Following the experience of one early review, which had seven disciplines and was supported by two CRs, each review was limited to a maximum of six disciplines. Where the provision exceeded this number, two reviews were undertaken, generally divided into nursing professions and AHP.

206 In each published Major review report, key points about the strengths, good practice and weaknesses of the provision are identified as bullet points. With the benefits of hindsight, **areas for further development** might have been a more appropriate term than **weaknesses**, especially as many institutions were already aware of and taking action on these areas.

207 In total the 90 reports listed **2,686**[23] **bullet points**. These **have been individually coded to identify key themes** arising across the whole provision, and any trends across the reviews through the review cycle or within disciplines (see appendix 4).

208 In each Major review report, there are three sections - **Academic and practitioner standards, Quality of learning opportunities and MESQ**[24]. The first section contains four elements, which are reviewed for each discipline:

- ILOs - in relation to the overall aims of the provision, relevant subject benchmark statements and other external reference points
- curricula - the content and design of curricula in enabling the ILOs to be achieved
- assessment - measuring the achievement of the ILOs
- achievement - the extent to which the students achieve the ILOs set.

209 The second section contains three elements, which are reviewed across all provision:

- learning and teaching - of theory and practice in relation to programme aims and curriculum content
- student progression - support mechanisms, on campus and in practice placements, to enable students to progress through their programmes and to achieve the learning outcomes
- learning resources and their effective utilisation - the adequacy of resources provided and how they are used.

210 The final section deals with MESQ, looking at how effective the partners' quality assurance processes are.

211 Every bullet point from each of these sections has been coded thematically and by discipline group. NMH are grouped together and referred to below as the 'NMH group' for ease of reference, while the 12 AHPs under review are referred to as the AHP group. Where it has been possible to identify themes by an individual discipline, this is noted below. Each Major review report is structured to deal separately with each discipline under academic and practitioner standards (standards) and collectively under quality of learning opportunities (quality).

212 **Themes have been identified using Annex D of the Handbook** for reference. This annex guided the reviewers by providing prompts to assist their analysis of the SED prior to the review, the collection of evidence during the review, and in writing the review report.

4.2.1 Key trends - Academic and practitioner standards

213 The division of bullet points across each discipline group was remarkably even, with 686 for the NMH group, and 627 for the AHP group. The count of bullets by type (strength, good practice or weakness) shows a similarly even distribution, as shown in Table J below.

[23] Some bullet points in academic and practitioner standards were repeated verbatim across the disciplines under review, and have only been counted once in this total, but considered under each applicable discipline in the thematic analysis.

[24] Judgements are only made in relation to academic and practitioner standards and the quality of learning opportunities. The section on MESQ provides commentary only.

Table J: Count of bullet points by discipline group and section of report for Academic and practitioner standards

	AHP group					NMH group				
	ILOs	Curriculum	Assessment	Achievement	Total	ILOs	Curriculum	Assessment	Achievement	Total
Strengths	47	153	105	61	**366**	48	183	132	49	**412**
Good practice	10	35	17	3	**65**	5	38	21	4	**68**
Weaknesses	18	57	113	8	**196**	22	56	119	9	**206**
Totals	**75**	**245**	**235**	**72**	**627**	**75**	**277**	**272**	**62**	**686**

214 An analysis of the key bullet point themes, by heading section of the report and by discipline group, is given below. The top three themes identified are noted in all cases and, where considered significant, further themes are discussed. The proportion of bullet points identified for each theme within each section and group is given as a percentage for ease of comparison, and is presented as '(AHP group/NMH group per cent)', unless the figure for each group is the same. Quotes from the reports have been included to demonstrate key points. All quotes from reports have been anonymised.

215 **It can be seen from Table J above, that the number of strengths identified in the provision overall considerably outweighs the number of weaknesses, which supports the dominance of confidence judgements made.** Assessment is the only element where weaknesses identified balance the number of strengths, showing that this element was the area where most concerns are raised; this is discussed in more detail in section 4.2.1.3 below. The element with most good practice noted is curricula, detailed in section 4.2.1.2 below. There is little difference in the number of strengths, good practice and weaknesses between the two discipline groups.

4.2.1.1 Intended learning outcomes

Strengths

216 The top three strengths identified for each discipline group were the same, with the **effective communication of ILOs to academic and practice staff and students** being the most frequently identified (38/27 per cent). The reviewers comment that ILOs are clearly articulated in programme and module handbooks, and effectively disseminated to all staff and students, so that all know where to find them, what they mean and how to achieve them. Where undertaken, repeated iteration of ILOs, in order to reinforce their importance and to ensure that all students have a clear understanding of them, is also highlighted as a strength:

> 'Learning outcomes have been made more explicit during induction and at regular intervals because of the non-traditional nature of the student group…'.

217 **Effective communication** also emphasises the strength of partnerships between the HEIs and placement areas:

> 'There are strong links between the University and...practice placement providers and this ensures that practice intended learning outcomes are appropriate and clearly understood by clinical educators'.

218 **Link lecturers and practice facilitators** are also highlighted as key to effective communication and understanding of ILOs:

> 'The role of the link lecturer and the posts...such as the practice placement facilitators, are significant factors in enabling the...intended learning outcomes to be communicated effectively and to inform practice learning'.

219 The second most frequent strength was **that ILOs meet the programme aims and regulatory requirements, and appropriately reflect external reference points** (21/23 per cent). This could be interpreted as an expectation, rather than a strength, but the reviewers have highlighted where documents have been clearly mapped and presented, and embedded fully into the programmes:

> '...the ILOs are clearly stated in handbooks, refer to a wide range of internal and external reference points and are regularly updated'.

220 This theme was also considered a strength where it shows that the **programmes are regularly updated** in order to be responsive to changing service needs:

> 'ILOs reflect contemporary...practice, with practitioners reporting high degrees of satisfaction with the currency of the provision and the degree to which they are able to assist the [HEI] in maintaining contemporary relevance against the evolving public health agenda'.

221 The third theme most commonly identified as a strength was **stakeholder involvement in developing ILOs** (30/27 per cent). Like effective communication, these strengths reflect the strong collaborative nature of the partnerships between providers and stakeholders, in some cases, including students and service users in the development of ILOs:

> 'The intended learning outcomes...were carefully devised, following extensive involvement of employers, consortia representatives, [students], supervisor representatives and members of the programme team'

and elsewhere:

> '...the use of the partnership in the development and refinement of intended learning outcomes, and strategies to involve non-statutory services and service users in the development of learning outcomes are effective'.

Good practice

222 **Effective communication** also tops the list of **good practice** bullet points for both discipline groups (40 per cent), focusing on communication methods such as a newsletter or CPD activities to support practice staff, and having academic staff clearly referencing ILOs in their lectures. Clear mapping of ILOs in programme and module documents was also highlighted as a feature of good practice:

> 'The mapping of trigger learning outcomes...against module outcomes is an example of good practice in ensuring that course outcomes are met'.

223 The second area of good practice most commonly identified was different for each group. **Achievement of ILOs in practice** was highlighted particularly for the NMH group (40 per cent), with practice facilitators supporting assessors to promote achievement:

> 'The practice educators have proved to be an invaluable underpinning to both students and mentors in ensuring that students in all professions are able to achieve their intended learning outcomes'.

224 For the AHP group, **stakeholder involvement** was highlighted as the second most frequent theme (20 per cent), with good networks established across discipline groups with a wider membership than the local provider partnerships:

> 'Clinical practitioners...have been involved in developing the learning outcomes through the [pan-region] sub-group, a group that addresses workforce requirements for the NHS across the [region's] SHAs on behalf of them all'.

Weaknesses

225 Weaknesses highlighted show similar thematic trends, with **communication, stakeholder involvement,** and **meeting the programme aims and PSRB requirements** reaching the top three most frequently stated in each discipline group.

226 A **lack of thorough communication of ILOs** forms 33 per cent of the weaknesses in the AHP group and 32 per cent in the NMH group. Particular issues highlighted include practice assessors and facilitators not being familiar with the ILOs:

> 'Although some practitioners were involved in their development, not all mentors are sufficiently familiar with the intended learning outcomes…'

or students not understanding them, not knowing where to find them, or finding them difficult to understand:

> 'Some...students and practice educators think that the professional practice portfolio learning outcomes are complex and difficult to interpret'.

227 A significant number of weaknesses relating to **mapping against aims, requirements and external reference points** were identified in the NMH group (55 per cent), and to a lesser extent in the AHP group (33 per cent). For the AHP group, particular issues relate to insufficient differentiation between levels of ILOs, with level descriptors inconsistent with the FHEQ[25], or not clearly mapping to the statutory regulatory body's standards of proficiency. For the NMH group, a lack of clear mapping against current external reference points was noted in some provision, with some programmes being mapped to obsolete references such as old regulatory or professional body requirements that have been superseded. Lack of clear differentiation between levels of study was also cited as a weakness for another provider in the NMH group.

4.2.1.2 Curricula

Strengths

228 Key strengths identified in the curricula sections of reports largely focus around **partnerships working together with stakeholders** to develop the curricula (33/26 per cent), closely followed by the **planning, design and approval processes** (20/26 per cent). **User and carer involvement** (11 per cent for the NMH group) and **IPL** (8 per cent for both groups) can also be identified as recurring themes in a smaller proportion of reviews.

229 **Close relationships between academic and clinical staff and strong partnership engagement** in planning, developing and delivering the curricula are highlighted as strengths in many reports. Strong links between practice and academic staff help to promote the integration of theory and practice elements of the curricula. Working groups are established in many areas to involve a wide range of stakeholders in curricula development:

> 'There is systematic collaboration between supervisors and the University through Special Interest Groups, the Liaison Committee and the Curriculum Coordinating Committee in the development and monitoring of the programme'.

[25] The FHEQ is published by QAA as part of the academic infrastructure and available on the QAA website at www.qaa.ac.uk/academicinfrastructure/default.asp

230 **Wider networks** are created across regions in some disciplines:

> 'There is close cooperation between the three universities…The sequencing of specialist modules arranged over different years helps the management of the demand for clinical placements in specialist areas that are shared with other universities'.

231 **Communication strategies** are also highlighted as enabling or promoting partnership working, for instance through websites:

> 'The...practice educators' website...is a promising tool in increasing communication and the involvement and participation of practitioners in curricular planning'.

232 **Involvement of other stakeholders** in delivery of curricula is also highlighted as a way of strengthening partnerships:

> 'The use of visiting lecturers and joint appointments strengthens the involvement of stakeholders in delivery of the...curricula'.

233 **Ways of developing specialist skills** were identified as strengths in the curriculum design of a number of programmes, through opportunities for shared learning, specially designed units or a particular emphasis throughout the curricula:

> 'The innovative social constructionist model adopted within clinical psychology is a very positive feature of the curriculum', or
>
> 'The introduction of the Capability Building unit into the health visiting programmes is particularly appreciated by students who have no previous experience of working in the community'.

234 **Flexible modes of delivery**, such as in-service programmes or part-time routes, are also highlighted as positive features of curriculum design. These enable students already in employment to manage their studies effectively alongside other commitments.

235 **User and carer involvement in curriculum delivery** was most frequently identified in learning disabilities and mental health branches of nursing and in clinical psychology. However, it is becoming more frequently used in midwifery programmes as well:

> 'The midwifery curriculum is well informed by users and lay members, who actively participate in curriculum development forums'.

236 Eight strengths around user and carer involvement in either curriculum development, delivery or both are identified in midwifery provision, compared to 10 in nursing provision. For the AHP disciplines, the strengths within this theme are spread across more disciplines, with one strength for audiology, two for clinical psychology, two for occupational therapy and one each for physiotherapy and SLT:

> 'the patient focus in the programmes in speech and language therapy is strengthened by the inclusion of client experiences of care in the Introduction to Clinical Studies and Communication Impairment modules'.

237 **IPL** features in a number of strengths across a range of disciplines, but more frequently in occupational therapy and physiotherapy for the AHP group, and in nursing curricula. Some providers offer well-structured programmes providing opportunities for IPL across a large number of disciplines:

> 'The opportunity to learn and study with students from nursing, midwifery, occupational therapy, physiotherapy and social work departments enhances the operating department practice curriculum'

and elsewhere:

> 'interprofessional learning is well developed in pre-registration programmes…Client-focused learning pathways, available on-line, are being developed with practice partners to aid integration into practice'.

Good practice

238 Similar thematic trends can be seen in the good practice bullet points for curricula, with most focusing on **partnerships, curriculum design** or **IPL**. Most bullet points on partnerships comment in a general way about the effective nature of partnership contributions to curriculum development, with some outlining specific mechanisms to allow particular groups to contribute, for example, practice educator days, or user-liaison and consultation groups. A strong element of this theme is the involvement of practitioners in curriculum development, identifying the approach as one of equal partnership between the HEI, placement partners and SHA commissioners:

> 'The evidence of strategic partnership working and the extent of focus-group activity by the Curriculum Review Project Group, to inform the...curriculum, is impressive'.

239 **Work-based learning** is a recurring good practice element of curricula design, particularly for post-registration and CPD programmes:

> 'An innovative continuing work-based learning module, running throughout the BSc (Hons) Community Specialist Practice programme, allows students to identify and develop skills and knowledge within a chosen area of practice, appropriate to both student and local need'.

240 Learning approaches such as case-loading in midwifery, case presentations or **problem-based learning**, used across a range of disciplines, are also prominent:

> 'The problem-based learning developments in radiography have influenced the School's approach more widely and have been shared as good practice with other healthcare disciplines'.

241 For **IPL**, a trend can be identified which develops through the review cycle. In earlier reviews, IPL is noted as innovative and impressive and, in later reviews, it is more likely to be identified as a weakness where it is not so well developed, indicating a shift in expectations (see paragraph 245). Features in curriculum note a range of developments from a primary focus on IPL in practice:

> 'Practice placement facilitators in some Trusts have introduced structured interprofessional learning opportunities in practice settings…'

to integration into part of the curriculum:

> 'the BSc common foundation modules in year one...represent an impressive regional initiative to promote interprofessional learning'

to fully interprofessional programmes:

> 'The BSc (Hons) Interprofessional Learning programmes provide a relevant and forward-looking environment designed to give all students an understanding of other professional perspectives'.

Weaknesses

242 The most frequent theme arising from the weaknesses for both discipline groups under the curricula heading, however, is also **IPL** (35/34 per cent). As suggested above, this trend varies through the cycle, with only five bullet points from reports from 2003-04, 19 from 2004-05 and 15 from 2005-06. Bullets at the midpoint of the review cycle show that, while IPL is taking place in practice areas, there are limited opportunities formalised within the curricula:

> 'There are few structured opportunities for midwifery students to engage in interprofessional learning built into the curriculum design'.

243 The **decrease in weaknesses towards the end of the cycle** would indicate that IPL has been more fully integrated and embedded into programmes, and the weaknesses highlight exceptions, rather than a more general lack across providers:

> 'The March intake of nursing students have more limited opportunities for sharing with other disciplines in the interprofessional learning modules'.

244 For weaknesses, there are **no clear trends by discipline.** However, in the NMH group, health visiting receives only one bullet point:

> 'While there are some examples of potentially fruitful opportunities for interprofessional learning, it is not yet widely embedded within the health visiting curricula'.

245 For the AHP group, disciplines that have more traditionally embraced interprofessional opportunities, such as clinical psychology, begin to be highlighted in later reviews:

> 'Although healthcare professionals do contribute to teaching on the Doctorate in Clinical Psychology, the programme lacks an active involvement in interprofessional learning opportunities'.

246 The second most frequently identified weakness is again the same for both groups, **curriculum design** (21/27 per cent). The issues raised within curriculum design vary, with no common strand emerging. They include **length of placement, academic and/or practice staff allocated to teaching or assessing,** and **opportunities for independent reflective study:**

> 'Orthoptics students are heavily timetabled with little independent private study within the week'.

247 Another issue raised is a **lack of equity in the discipline focus of common foundation programmes or modules:**

> 'Students on nursing branches, other than adult, reported that the focus in the Common Foundation Programme is too adult-specific'

or, in another example:

> 'Curricular developments and structures in radiography are not always sensitive to the needs of therapeutic radiography, the smaller part of the provision'.

248 **Limited opportunities for service-user and carer involvement in curriculum development** are also a recurring weakness across both groups (19/11 per cent]). Although users are more frequently being used in programme delivery, there are relatively few initiatives to incorporate user involvement fully in programme design:

> 'The...programme has not considered ways in which users and carers might contribute to the design and delivery of the curriculum'.

4.2.1.3 Assessment

Strengths

249 The most frequently identified theme for assessment strengths is the same for each group, focusing on the **range and appropriateness of assessment methods** (31/33 per cent]). Bullet points note the variety of methods that help students to integrate theory and practice, and innovative methods that have been developed on some programmes. An example is the use of actors instead of service users in formative assessments, or the use of objective structured clinical examinations (OSCEs) and skills laboratories, again as substitutes for patients while students are learning new skills. Common assessment tools across placements and regions are highlighted as strengths for many providers. The use of logs and diaries is also noted as a strength, enabling students to develop critical and reflective skills:

'The module...which requires students to complete a reflective log during their practice placement is noted as particularly effective in enabling students to demonstrate their development of skills and practice'.

250 **Use of portfolios,** which particularly features in the NMH group, is also commented on frequently:

'The portfolio of evidence from practice contributes substantially to the assessment strategy in utilising the formative assessment and ensuring integration of theory and practice'.

251 **Security, integrity and consistency of assessment procedures, in setting, marking and moderating** are also a common area of strength across both groups (11/17 per cent). Strong internal moderating, good use of external examiners, and tripartite practice assessment, involving student, practitioner and lecturer, are frequently noted as strengths. Involvement of external examiners in practical assessments is rare, and lack of external verification of practice assessments is more frequently identified as a weakness, however such involvement is highlighted in two strengths:

'External examiners participate in the objective structured clinical examinations which assess operating department practice skills'

and also:

'the contribution of the external moderator across a range of activities linked to clinical assessment'.

252 **Practice placement facilitators** (PPFs), where in place, **are also able to contribute to assuring consistency of practice assessment:**

'the PPFs and Practice Experience Coordinator play a positive role in maintaining the standards and consistency of practice assessment for nursing'.

253 **Feedback to students on assessment** is another theme which is raised frequently (17/16 per cent]), both as a strength and a weakness. The strengths relate to the clarity, timeliness, regularity and helpfulness of the feedback:

'clear, comprehensive and supportive feedback on campus and practice-based assessments…'.

254 Some assessment feedback processes are identified as having **added-value,** for example, by providing the basis for tutorials, by breaking down the overall mark for each element of the assessment and, in one case, daily written feedback on placement activities:

'Students and clinical educators find that [daily feedback forms] encourage reflection, help to ensure that feedback is given and received at the end of every day, and can be used to assist in debriefing students on their return to the University'.

255 **Strong partnerships in developing assessment strategies and methods** are noted in many reports, with frequent practitioner involvement in developing methods and tools:

'There is a proactive relationship between university and clinical staff...to enhance practice assessment'.

256 **Practice staff** are also highlighted as strengths in many reports. Appropriate training and updating of assessors is noted, but systems for their support are identified as strengths, for instance, in written communications such as assessor handbooks, and also through the support of other colleagues, such as link lecturers or PPFs:

'Practice Learning Facilitators provide an excellent mechanism for supporting mentors in the assessment of practice'.

Good practice

257 Good practice in assessment **focuses on similar themes,** including the **range and appropriateness of methods, integrity and security of procedures, practitioner involvement** and **mentor support.** Specific assessment methods which have been well designed are highlighted, for example, electronic assessments or assessed 'conversations'. **Tripartite assessment arrangements,** particularly frequent in the NMH group, are also extolled:

> 'In midwifery and health visiting, the triangulation interview between the student, mentor and link tutor...was cited by students as a particularly effective way of verifying achievement at each stage'.

258 **Support for mentors** is another area of good practice highlighted through the bullet points, particularly different ways of supporting assessors by, for example, providing training materials:

> 'the midwifery mentor preparation pack, including a worked example of assessment'.

259 **PPFs and link lecturers** are also highlighted throughout the reviews as providing vital support for mentors.

Weaknesses

260 Weaknesses for assessment again identify **similar themes**, most frequently the **poor quality of feedback to students** (35/30 per cent), a **less-than-adequate assurance of the integrity of procedures** (26/16 per cent), and the **quality of assessment documents,** including strategies, policies and guidelines in handbooks (14/13 per cent).

261 The most frequently highlighted issue with **feedback**, particularly written feedback, is the delay in returning it to students, in some cases with them not receiving it on one assignment before completing the next:

> '…[students] raised further concerns over the delay in receiving feedback which was too late to help in progression'.

262 Other weaknesses note poor quality of feedback, in content or legibility:

> 'Not all feedback is sufficiently detailed and extensive enough to be useful for student learning'

and elsewhere:

> 'Written feedback is sometimes difficult to read and uses inconsistent formats'.

263 **Interassessor reliability** was often a concern in relation to the integrity of procedures, with a **lack of appropriate internal moderation** by a number of providers. This is a particular difficulty in practice assessments and, as outlined above, has often been overcome by the tripartite method. Variability or a lack of clearly-documented evidence also led to the reviewers questioning the robustness of marking and moderation procedures:

> 'There is a lack of documented evidence of consistency in respect of the second marking and moderation of assessment…'.

264 **Grading of practice** was also an area of concern, where interassessor reliability is also key:

> '…both practice educators and students expressed some concerns about the variation in the use of the practice assessment form and grading criteria, which they felt were open to different interpretations'.

265 **A lack of appropriate guidance in assessment documentation** was highlighted as a weakness:

> 'The School does not currently have a written assessment policy or generic guidance on assessment procedures for use by academic and practice staff…'

although, in most cases, it is lack of consistency, clarity or helpfulness that is commented on:

> 'There is ambiguity within the...programme documents relating to percentage grading and statements of pass, refer and fail, which requires clarification'.

266 **A lack of communication of policy and guidelines** is also noted, most often with practice staff not being aware of or fully understanding protocols:

> 'There is a lack of awareness amongst some clinical staff in the Trusts about the assessment policy for the retrieval of placement failures, despite the published guidance available in clinical handbooks'.

4.2.1.4 Student achievement

267 For the section on achievement, reviewers are asked to comment on whether students have achieved the ILOs, and to judge whether appropriate standards are being achieved. Bullet points in this section are of a similar number to those on ILOs. However, in achievement, more than in any other section of academic and practitioner standards, **there is a considerable majority of strengths, with very few weaknesses (Table J).**

Strengths

268 Most strengths relate to achievement of the ILOs (25/31 per cent). The quality of students' assessed work, clearly showing a high level of academic and skill attainment, is frequently the subject of comment:

> 'student achievement levels in all subjects are high, demonstrate good subject knowledge, skills and the ability to integrate theory and practice'

and elsewhere:

> '…students have strong clinical skills, consistently produce high-quality output and have a comprehensive understanding of the relationship between theory and practice'.

269 The reviewers are also asked to comment in this section on whether there is evidence that students are fit for purpose, practice and award. A significant number of strengths identified here relate particularly to fitness for purpose, often as quoted by employers:

> 'Key strengths identified by employers are their level of confidence and good knowledge of the real world working situation'.

270 A number of bullet points confirm that students are well prepared for employment, and that employers value students from these programmes (21/25 per cent).

271 Another theme noted in achievement is progression to either a successful health career or to further study (11/10 per cent), where providers can demonstrate high employment rates following graduation:

> 'an excellent record of over 95 per cent of students taking up their first post in the National Health Service'

and through having developed a high level of academic ability:

> '…students demonstrate a commitment to a lifelong learning strategy by going on to undertake research, publication and PhD study'.

Good practice

272 Good practice bullet points for achievement are few, numbering only seven overall. No specific trend is identifiable, with each bullet point being different. These cover preceptorships, published student work, preparation for lifelong learning, suitability for the local workforce, high levels of staff to promote achievement, and programmes offered at different levels to suit individual academic ability.

Weaknesses

273 Weaknesses for achievement follow similar themes to strengths, focusing on achievement of ILOs, and fitness for purpose, practice or award. The small number of bullet points (only 4 per cent of all weaknesses identified in all sections of standards) shows that levels of achievement overall are very high. Most of these bullet points relate to specific weaknesses on individual programmes, rather than across the provision, with a few general comments related to employment issues, such as:

> 'preparation for employment in the NHS needs to be strengthened'

or elsewhere:

> 'The level of employment among nurses completing pre-registration programmes gives some cause for concern'.

4.2.2 Key trends - Quality of learning opportunities

274 Sections of the report under this heading are not separated out by discipline, unlike academic and practitioner standards, but refer to the provision as a whole, unless the bullet point explicitly mentions a programme or discipline type. Therefore, for analysis by discipline group, the bullets have been treated as follows. Reviews that contain only either NMH group or AHP group disciplines have been counted under their respective groups, along with bullets from the 'mixed' reviews that refer to a specific programme or discipline. Bullets from reviews that contain a mixture of disciplines and make no specific reference to a programme or discipline have been reported separately in Table K below, but for the data that appears in the text they have been divided equally across both groups, as the assumption is that they apply to the whole provision.

Table K: Count of bullet points by discipline group and section of report for Quality of learning opportunities

	Learning and teaching				Student progression				Learning resources			
	AHP	NMH	Mixed	Total	AHP	NMH	Mixed	Total	AHP	NMH	Mixed	Total
Strengths	76	69	99	**244**	77	60	82	**219**	66	52	89	**207**
Good practice	17	29	25	**71**	10	11	9	**30**	15	10	15	**40**
Weaknesses	39	39	41	**119**	23	36	12	**71**	52	24	31	**107**
Totals	**132**	**137**	**165**	**434**	**110**	**107**	**103**	**320**	**133**	**86**	**135**	**354**

275 The number of bullet points for each discipline group within the quality of learning opportunities is rather more uneven than for academic and practitioner standards, with **more strengths and weaknesses overall for the AHP group** and **more good practice bullet points for the NMH group (Table K).** However, the number of **strengths overall is more than double that of weaknesses, again confirming the high quality of the provision.** Most strengths and areas of good practice are to be found in learning and teaching, and weaknesses are spread more or less evenly across all three elements.

4.2.2.1 Learning and teaching

Strengths

276 The most frequently occurring area of strength in learning and teaching is the **effectiveness of teaching methods in promoting the integration of theory and practice** (29 per cent of all learning and teaching strengths), with more bullet points relating to the NMH group than to the AHP group (59/41 per cent). Bullet points note variously the

breadth, depth and variety of teaching methods, together with the **teaching of specific skills** such as critical reflection, reasoning and problem-solving to ensure students become competent and safe practitioners. **Problem-based and enquiry-based learning** are two approaches frequently cited to facilitate a well-rounded approach to integrate theory and practice:

> 'A range of teaching approaches is used, from traditional methods such as lectures and tutorials to innovative self-directed initiatives such as problem-based and enquiry-based learning…'.

277 Other teaching methods, such as action-learning groups, mock ward rounds (with nursing and medical students), video-recording, case-studies, special interest groups and student-led conferences, demonstrate that a **wide variety of innovative and creative methods for learning and teaching are being employed.** The effective support of link lecturers and practice facilitators is also identified as central to the promotion of integration of theory and practice:

> 'The use of learning contracts, portfolios, and lecturer-practitioners helps to integrate academic theory and professional practice'

and elsewhere:

> '…student learning on placements is well supported…with link lecturers and placement facilitators encouraging the integration of theory and practice'.

278 The second most frequent strength is the **effectiveness of learning opportunities on placements** (19 per cent), with slightly more relating to the NMH group (48/52 per cent). A number of these bullet points relate particularly to the high quality of practice learning environments seen, for example:

> 'The reviewers were impressed with the variety of clinical practice areas available that offer excellent, sometimes unique, learning experiences'.

The management of placements, often by dedicated units, is also highlighted:

> 'The Placement Learning Unit...is highly effective in coordinating, planning and managing placements, and balancing each programme's placement needs, and is a central point of contact for students'.

279 **Student support on placements,** particularly from mentors, practice educators and facilitators, is reported as being highly effective and valued by students:

> 'all students reported positively on the support they receive from practice placement facilitators who are universally praised for helping them achieve their learning outcomes in practice placements'.

280 **IPL opportunities** are another frequently-identified strength, with a greater proportion of strength bullet points in the nursing disciplines (44/56 per cent). The reviewers note that **many providers are working well in this area, with enthusiasm, diligence and strong partnership working evident in many reviews.** IPL can be seen at a variety of different stages, from being evident only in placement settings, to being fully embedded in the curriculum. IPL is also identified as a frequently-occurring weakness (see paragraph 294) where it is not formally available within the curriculum. IPL opportunities are identified in only four reports from 2003-04:

> 'There is successful implementation of multidisciplinary and interprofessional learning'.

In 2004-05 more formal arrangements are being highlighted:

> 'Both programmes are participants in the interprofessional education...project which will incorporate all health students in three local higher education institutions'.

In 2005-06, with IPL more fully incorporated into curricula, further developments can be observed:

> 'Interprofessional learning is integrated into the radiography curriculum at all stages, comprising a full module in year one, followed by bespoke study days in years two and three'.

Good practice

281 Good practice bullet points focus on very similar areas to strengths, with the **effectiveness of learning opportunities in placements** (27 per cent), **the effectiveness of teaching** (18 per cent) and **the effective use of learning resources** (14 per cent) the most frequent themes.

282 For **learning opportunities on placement,** areas of good practice relate to student support from practice staff, and also support for practice staff in their education roles:

> 'the role of the department and the Trusts in developing and supporting the clinical facilitator role and the contribution of the clinical facilitators to student learning in placements'.

283 Unusual placement opportunities, some of which are developed on campus, are also noted as good practice:

> 'The Communications Disorders Clinic on the University campus provides an effective additional placement experience for students'.

284 Placement learning methods such as portfolios, specialist learning materials, and hands-on work are also highlighted.

285 **Specific teaching methods** are highlighted in many of the good practice bullet points, for example, the use of a learning styles questionnaire, module learning packs, clinical simulations (with manikins, actors or videos) and community-based projects. The wide variety of teaching methods employed helps to promote further the integration of theory and practice:

> 'Projects by students...demonstrated their ability to integrate policy, evidence, theory and practice and to communicate health information to a wide range of potential recipients in imaginative formats such as story-lines, interactive board games, and videos'.

Weaknesses

286 The thematic areas highlighted as weaknesses are **almost identical to those outlined above,** and cover **learning opportunities on placements** (27 per cent); **learning and teaching methods** (18 per cent); the **effective management of learning and teaching** (18 per cent) and IPL opportunities (16 per cent).

287 Bullet points relating to **placements** focus primarily on **practice educator/mentor arrangements and support.** Two key issues are highlighted in particular: variable availability, and insufficient support and updating. Mentors/educators may be in short supply due to staff shortages or high numbers of students on placements, and so some may not have received timely updating or preparation:

> 'The mentor database for nursing currently includes some who have not undertaken recent updating'.

288 Some confusion also arises through complex programme documentation, or differing requirements in the same placement areas from different HEIs:

> 'Some mentors reported that it is difficult to keep abreast of the different documentation provided to support student learning from various HEIs using the placements'.

289 The number of bullet points for each discipline area is again comparable, with 50 per cent for each group.

290 Issues highlighted around **teaching methods** mostly relate to specific programmes, rather than throughout the provision. Weaknesses highlighted relate to errors and inconsistencies in programme documentation, a lack of a full understanding by students of teaching methods used, or a lack of evidence of strategies being fully implemented in teaching:

> 'One aspect of the strategy that was not clearly evident across the provision was the use of professional development profiles to develop and facilitate lifelong learning and employment skills'.

291 Regarding the **management of learning and teaching,** areas of weakness highlighted include a lack of strategies or strategic direction:

> '…the lack of the implementation of a coherent and well-planned learning and teaching strategy meant that students had some unsatisfactory learning experiences'

or poor organisation of some placement allocations:

> '…the rationale for some placement decisions is not always transparent…'.

292 Weaknesses in IPL largely focus on lack of campus-based opportunities, or where it is not sufficiently embedded in the curriculum. In earlier reviews, comments were also made about students not understanding the significance or relevance of IPL until later in their programmes:

> 'IPL is yet to be systematically incorporated across all disciplines and the strategy for its development needs to make the student learning experience more explicit'.

Mid-cycle, most comments related to lack of formal opportunities:

> 'The under utilisation of the opportunities for formal interprofessional learning across the provision…'.

293 **Towards the end of the cycle there are fewer weaknesses relating to IPL** as it has been more widely developed. Bullet points in later reports refer more to operational difficulties, such as **larger discipline groups dominating smaller ones**, or **unequal student experiences across different placement settings.**

4.2.2.2 Student progression

294 In student progression, a large number of strengths are identified with limited examples of good practice and few areas of weakness. The overall number of bullets split across discipline groups is again even.

Strengths

295 More strengths are identified for AHP group programmes (54 per cent) than NMH group (46 per cent), and the most frequently identified themes are **recruitment, admission and induction processes** (23 per cent), an equal number for **student support**, then followed by **support for learning and teaching** and **retention and attrition strategies** (both with 16 per cent).

296 In relation to strengths in **recruitment and induction processes,** the **focus is on partnership working**, with practice staff involved at each stage, and successful widening participation schemes resulting in the recruitment of students from diverse and non-traditional backgrounds. Taster sessions offered by some providers to give potential students a better idea of the profession are seen as particularly useful, especially in smaller disciplines such as podiatry and dietetics. Information packs provided to prospective students at open days or interviews are also seen as a positive aid to recruitment:

'The University and its partners have a clear marketing policy and comprehensive materials and activities to recruit students from a wide range of backgrounds'.

297 Strengths around **student support** note some **effective mechanisms** to identify individual learning needs and ensure appropriate support:

'The University and its partners have a well-developed structure for pastoral and academic support, including information and advice on financial issues, health matters, careers and disability support which is highly valued by students'.

298 A number of bullet points also note good support for students **in placements:**

'Students from all professional areas comment that they are well prepared for practice and feel well supported by clinical staff'.

299 Other strengths which highlight **support for learning and teaching** cover tutorials on campus, with good support from personal tutors. The support of mentors or practice educators in placements is also highlighted, with comments on effective links between placement and campus, providing effective all-round support:

'Students and practice staff across the range of provision indicate that the quality of the pastoral care and academic support from the University during assessed practice placement is effective and supportive'.

and for distance and open-learning students:

'The role of the open learning tutor is a particular strength when a student is struggling with the demands of the programme. This is pivotal to the success of the distance-learning approach to study'.

300 Placement facilitators who support mentors and assessors in practice are also considered to be a strength. As well as providing a mechanism to assure consistency between assessors, they also provide support for students in enhancing the quality of placement experiences:

'Practice placement facilitators are valued in both the work done to identify learning opportunities for students and their support role to mentors'.

301 Eleven reports comment on low attrition rates, or evidence of work on the part of the partners to reduce attrition:

'Attrition rates...are dramatically improving as a result of the attention paid to the admissions process'.

302 **Support for progression** through the programme or into employment are also highlighted, with a number of support schemes in place for newly-qualified practitioners, such as transition workshops, preceptorships, or internships.

Good practice

303 There are fewer good practice bullet points for student progression than for other elements in the quality of learning opportunities. The majority of these are around issues of **student support** (37 per cent), citing processes such as effective review boards, accessible tutors, or schemes for pastoral support, such as access to counsellors or other professionals. Other bullet points note **comprehensive guidance** for student support in handbooks or on websites.

304 A smaller number of good practice bullet points (17 per cent) relate to **recruitment strategies,** highlighting those that are effective at recruiting students from diverse and non-traditional backgrounds, or providers that use devices such as recruitment packs for prospective students or CD-ROM packages. Another provider exploits partnership arrangements with local to promote recruitment.

305 A similar number of **good practice** bullet points highlight **support for learning and teaching,** including buddy schemes, where second-year students can provide guidance and help to new students, and good academic support from teaching staff:

> 'academic support...is effective, with students valuing a consistent commitment from academic staff'.

Weaknesses

306 The majority of weaknesses relate to **attrition rates** and work undertaken to reduce these rates (38 per cent). High attrition rates in individual programmes are commented on, especially where numbers of students remaining affect the viability of the programmes. Just over half of these bullet points relate to nursing programmes, most of which are pre-registration. Of AHP programmes, the most frequently occurring are in ODP and radiography. Weaknesses are also cited where the providers have undertaken action to address high attrition rates but have not so far been effective. Attrition rates are also set in the context of national averages, as withdrawal rates in some disciplines are high across England, and not unique to particular providers.

307 **Student support mechanisms, largely on placement account for 24 per cent of weaknesses,** where there is limited evidence of support from link lecturers or academic staff who are not visiting students on placement:

> '…there is only limited evidence that module leaders follow the [School] policy of visiting placements'.

308 **Lack of preparation of students for placements** is also cited as an area of weakness. Support for placement assessors is deficient in some provision, through a lack of assessor preparation, updates or feedback from the HEIs on the student experience:

> 'The clinical staff reported that they received insufficient formal feedback from the University…, including the views of students'.

309 **Support for learning and teaching** is the third most common area of weakness, (10 per cent). These bullet points cover inadequate mentorship arrangements, where there are too few prepared and updated mentors/practice assessors to cope with rising student numbers, resulting in an unequal student experience across placements. Difficulties for students in obtaining access to academic staff while on placement is also highlighted in some cases, where again the student experience is variable across placement areas, particularly in those more distant from the campus.

4.2.2.3 Learning resources and their effective utilisation

Strengths

310 The most common area of strength is in the **quality of material resources**, such as discipline-related equipment, IT facilities, library stocks and teaching accommodation (29 per cent). Library and IT facilities are mentioned particularly frequently, with comments on the effective use of virtual learning environments (VLEs) and ample library collections. Specialist skills laboratories are available where required, covering a wide number of disciplines from both groups:

> 'The development of the purpose-built, state-of-the-art, clinical skills suite provides superior teaching and learning facilities for the Faculty'.

311 Support from library staff for students using IT and library facilities are also highlighted frequently.

312 The **quality of teaching staff** is another recurring strength (22 per cent). Well-qualified and experienced staff who provide a high level of teaching and student support are identified

in many reviews. The appointment of research staff who enhance their teaching through their research is also highlighted:

> 'The School fosters research and scholarship that impacts directly on the quality of student learning'.

313 **Link lecturers and practice facilitators** are considered a strength in learning resources as well as where previously mentioned above. Staff development and CPD programmes are highlighted as strengths in both academic and practice settings:

> 'A wide range of targeted CPD programmes helps to maintain the currency and skills development of all staff'.

314 The **provision and monitoring of placement areas** is another area of strength identified (11 per cent). This theme covers strategies for allocating and managing placement opportunities, and placement facilitators are again identified as playing a key role:

> 'Practice educators have a positive strategic role and provide contacts within the Primary Care Trusts'.

315 Effective partnerships between HEIs, placement areas and the SHAs are also highlighted as working together to provide appropriate placement experiences for students:

> '…a collaboration between the SHA, local Trusts, the independent sector, Social Services and education providers, has been set up to address the problems of finding sufficient placements in a wide range of settings and to meet the challenge set out in Working Together-Learning Together…'.

Good practice

316 Areas of good practice for learning resources follow **similar themes to strengths**, with the most frequently occurring areas being the quality of **material resources** (23 per cent), the **quality of access to resources** (18 per cent), **teaching staff** (18 per cent) and **partnership working** (15 per cent).

317 For **material resources**, examples of good practice cited focus on the use of VLEs for interactive projects, rather than simply as a means of disseminating information, including subject specialist software and 'virtual tutor groups'. Regarding access to learning resources, good practice highlighted includes free organised transport between the campus and main placement sites, book delivery services to placements, and 24-hour library access.

318 Good practice for teaching staff focuses on **staff development and training** opportunities, for both academic and practice staff. Approaches cited include peer observation and the use of action plans following staff appraisal.

319 Half of the good practice bullet points on **partnership working** highlight relationships that are wider than the commissioner-HEI-placement triad. A number of providers work collaboratively with other providers in the region to enhance the resources for all their students. Examples include joint regional placement allocation systems for some AHP disciplines, and SHAs within one region working together to fund education posts in placements:

> 'Proactive strategic and operational support from the three SHAs, for example, in funding initiatives such as the establishment of clinical placement development manager posts throughout the region...and collaboration with other education providers, practice managers, mentors and assessors, contributes to the efforts being made to enhance placement provision and to assist practice educators and mentors'.

Weaknesses

320 Weaknesses again follow **similar themes:** the resource of **academic and practice staff** (30 per cent), **material resources** (26 per cent) and **placement provision** (21 per cent). AHP programmes give rise to a greater proportion of weaknesses in learning resources (63 per cent) than NMH group programmes (37 per cent).

321 Weaknesses around **staffing** are concerned with time pressures on practitioners to fit in adequate supervision time and to manage their support and education roles with their clinical responsibilities. In some practice areas, there are difficulties for mentors finding sufficient time to attend update sessions, and a lack of integration of practice assessors with campus-based staff. Shortages of campus staff in some areas compound with financial restrictions in both academic and practice environments to put further pressures on staff time and resources.

322 **Inadequate accommodation for students in practice areas** is a recurring theme, with no dedicated space for student learning in some areas and restricted facilities in others (26 per cent). This seems to be more of **an issue with clinical psychology**, with 46 per cent of the bullet points on material resources relating to accommodation difficulties in this discipline. Access to IT and library facilities in some placement areas is also highlighted, with some students not being able to use IT facilities on placement nor access campus facilities during that time:

> '…concerns recurring across the provision about the standard and adequacy of the space available to students and trainees for study and placement learning purposes'.

323 Weaknesses relating to **placement provision** vary in focus, from geographic distance and transport problems, to placement organisation and facilitation, especially where student numbers have increased:

> '…some clinical placements are oversubscribed, placing heavy burdens on mentors. Students are sometimes allocated to placements far from their homes'.

324 The lack of robust placement allocation strategies or policies and the resulting pressure on placements or students is identified in several reports. Incomplete, inadequate or ineffective audit of placement documentation is also highlighted in some reports.

4.2.3 Key trends - MESQ

325 The themes identified across strengths, weaknesses and good practice are similar for this element of the reports. Below, therefore, a comparative style has been adopted to highlight differences across the provision.

326 The number of bullet points across discipline groups is more variable in this section of the report. There are both more strengths and more weaknesses in AHP provision, with slightly more good practice in NMH group programmes. **Overall, there are more than twice as many strengths as weaknesses, with few items of good practice** (Table L).

Table L: Count of bullet points by discipline group for MESQ

	Strengths	Good practice	Weaknesses	Totals
NMH group	39	9	22	**70**
AHP group	55	7	26	**88**
Mixed provision	73	3	31	**107**
Total	**167**	**19**	**79**	**265**

327 Themes that can be identified in this section are the same across each discipline, relating to **partnership working, internal quality assurance mechanisms, internal evaluation and feedback processes,** and the use of **internal evaluation for enhancement.**

328 Bullet points on **partnerships** are the most frequently occurring strength (40 per cent), and comment on the effectiveness of partnership arrangements in all aspects of programme planning, delivery and monitoring. Extensive networks of partnerships and clear lines of responsibility are highlighted, along with positive and close working relationships:

> 'A clear sense of partnership is evident in the annual contract review process, involving the HEI, Strategic Health Authorities and placement providers, in ensuring and enhancing the quality of commissioned programmes'.

329 A small number of good practice bullet points also relate to partnerships (26 per cent of all good practice in this section). These describe partnership and collaborative arrangements as 'effective', 'innovative' and even 'visionary', and include reference to the transparent lines of communication, a sense of shared stewardship of the provision and the effectiveness of the providers in working with a range of diverse and geographically widely-distributed stakeholders.

330 Weaknesses in partnership arrangements relate to less effective communications between partners (particularly between HEIs and Trusts), and inconsistencies and lack of clarity in processes for contract monitoring and evaluation:

> 'There is a lack of evidence of a robust mechanism for the SHA monitoring of the contract and a lack of clarity in the operation of the Integrated Assessment Process'.

331 The second most prominent theme is the use of **internal quality assurance mechanisms** for enhancement purposes (28 per cent). Strengths include arrangements for internal monitoring and enhancement processes, which are described as 'thorough and effective', 'robust', or 'careful and constructive'. Systematic and comprehensive strategies are in place, and are implemented effectively. One example of an innovative approach is:

> 'A Cross-Faculty Quality Task Force [which] is an evolving and potentially powerful mechanism for enhancing quality within the Department'.

332 Other reports highlight opportunities for all stakeholders to contribute to improving the student learning experience through programme development, monitoring or review committees.

333 Good practice bullet points highlight the operations of committees or groups involved in quality monitoring, including stakeholder representation through a student council or placement learning unit. Several of these bullet points **focus on practice**, commenting on effective audit and monitoring systems, learning in practice projects or frequent liaison between academic and clinical staff:

> 'The Faculty Placement Learning Support Unit works in conjunction with the Placement Partnership Strategy Group, utilising both qualitative and quantitative data to increase placement capacity and the capability of those who support students'.

334 There is a higher number of weaknesses for this theme (33 per cent of all weaknesses in this section). These find that strategies and processes for monitoring and placement audit are not thorough or they demonstrate inconsistencies across the provision:

> 'Lack of rigour in the application of some monitoring systems results in lapses…'.

335 In one or two cases there are no clear formal or systematic processes in place. Other issues highlighted include the follow-up of action plans, with a lack of clarity around lines of responsibility and of informal processes that need further clarification:

> 'The formal auditing of placements...remains unclear'.

336 The third most frequent theme in MESQ is the use of **internal evaluation and feedback mechanisms** (17 per cent). The numbers of strengths and weaknesses are equal, with no examples of good practice.

337 Strengths focus on mechanisms for capturing and responding to student views and also highlight student satisfaction rates. Representation from students and other stakeholders on HEI committees and student-staff liaison committees ensure that the student voice is heard and acted upon:

> 'There is open and constructive dialogue between students, faculty and practice staff. A proactive approach is taken to managing emerging issues affecting students, facilitating timely actions and responses as problems arise'.

338 Systematic collection of **student feedback for annual monitoring purposes** is also noted.

339 Weaknesses highlight the opposite: the lack of systematic collection of feedback, and poor dissemination of feedback to placement areas or the responses from feedback to students. Bullet points range from 'no formal mechanisms' to 'limited opportunities' to 'variable experience'. Engaging part-time or geographically-dispersed students is also noted as a difficulty in one report and, in three other reports, the bullet points note the quality of feedback from external examiners' reports as 'variable', or lacking substance:

> 'Not all external examiners' reports are sufficiently detailed, especially with reference to specific modules or levels, and they do not all indicate the sample of student work received for scrutiny or refer to practice assessments'.

340 A related theme is the use of such **internal evaluation and feedback processes for enhancement** (13 per cent). Here, there are again more strengths (48 per cent) than weaknesses (40 per cent), and also a few good practice bullet points (12 per cent).

341 Strengths identified involve providers responding in a timely and effective way to feedback from all stakeholders, including **students and external examiners**, with clear evidence of actions taken in response to recommendations. For one provider, the Student Council was highlighted as an effective means for providing feedback to students about their concerns, and two other reports note the feedback loop extending to practice:

> 'Student feedback is valued by all stakeholders, is comprehensively, constructively and consistently communicated to mentors and managers, and results in action as appropriate'.

342 Items of good practice relay similar messages again to strengths, highlighting good feedback loops, and clear responses to feedback received from stakeholders, and particularly from students:

> 'There is extensive evidence...that the student voice within the academic institution is consistently sought, heard and acted upon'.

343 Weaknesses highlight feedback to which the response is slow, or not disseminated widely. Lack of response to external examiners' comments is noted, especially where such examiners have reported the same concerns in consecutive years. Another recurring area of weakness focuses on the lack of communication of student feedback to practice, which is variable across the provision within partnerships:

> 'The content of student evaluations is not always communicated to placement providers to assist them in improving the student learning experience for the future'.

4.3 Action plans - providers' responses to the bullet points

344 The analysis of the 90 action plans produced in the Major review reports indicates a significant development in their sophistication over the three-year period. As experience was gained, precedence set and additional guidance and support supplied by QAA, providers' responses to the bullet points, particularly the strengths and good practice, moved from the inclusion of bland statements only making reference to 'continuation' and not indicating what the providers did normally, nor how the action was to be delivered, to more detailed responses that followed the principle of SMART (specific, measurable, agreed, realistic and time-bound) objectives more closely.

345 Analysis of the actions proposed by the HEI, SHA and placement providers identified a number of different but interrelated themes, irrespective of whether the bullet point recorded is a strength, an item of good practice, or a weakness. The themes are as follows:

- production of new or enhancement of existing documents (strategies, policies, guidance or other information)
- specifically-designed events, either one-off or more regularly instituted
- use of IT to enhance communication or to share information
- use of committees and working groups, or liaison and collaboration between different groups or organisations
- dissemination, particularly of strengths and good practice, across a range of groups and bodies
- staff development activities
- allocation or improvement of resources
- scoping and evaluation.

346 The range of responses are considered in more detail below under each of these themes. Words in bold type enable cross-reference to the eight elements of each report covering academic and practitioner standards, the quality of learning opportunities and MESQ.

4.3.1 Production of new or enhancement of existing documents and strategies

347 This action appeared throughout each element of the report. It normally involved the evaluation, updating and enhancement of the documentation for students and/or staff of the provision. For example:

- a folder will be developed containing all necessary placement information, including practice **ILOs**, to be sent to all departments
- welcome packs for new staff and students will be produced, containing more detail on **ILOs** to ensure they are adequately communicated and understood
- programme outcomes will be synchronised with practice **ILOs** by working in partnership with other local HEIs to adopt a common practice document
- the development of **curriculum documentation** will include a greater focus on employability skills in teaching, learning and assessment activities
- the coherence of **assessment** paperwork will be enhanced to promote consistency
- an **assessment** handbook will be developed
- the introduction of logs to record practice learning hours, which will then form part of a summative **assessment**, and the promoting of guidance on effective time management strategies with students to ensure study weeks and days on campus are used effectively

- developing standardised documentation that will facilitate consistency of **assessment** practice, for example:
  - providing feedback to students on assessment - the extent to which assessment criteria have been met, identifying areas of quality and areas for improvement
  - developing structured feedback grids for pre-registration programmes
  - producing student module/programme evaluation forms that include opportunities to comment on feedback on assessment, practice placements and ensure that receipt of student feedback can be monitored by providers
  - creating annual monitoring forms that require reference to feedback on assessments
  - providing guidance to practice placements on the provision of feedback and ensuring it is given in a consistent and timely manner
- guidance on the role of **external examiners** will be provided and updated in relation to, for example, the review of practice portfolios, meeting students and mentors, verifying the reliability of practice assessments and the use of external examiner forms
- strategies/policies will be developed for **internal moderation**
- guidance/strategies will be developed to promote the use of daily reflective diaries, tripartite agreements and portfolios as part of the **assessment** process - all identified as good practice
- one provider will run mixed focus groups across disciplines and including academic and practice staff and students to identify and understand the issues around **practice portfolios.** Outcome activities based on the findings will then be implemented
- action will be taken to ensure that the **learning and teaching strategy** continues to promote use of problem-based learning in order to promote student achievement
- additional guidance and activities will be provided to prepare students for **learning in practice**
- **learning contracts** will be developed to improve student achievement and to help with resource planning
- **learning styles** questionnaires for students will be used early in the programmes to inform campus and practice-based teaching
- **IPL** case-studies will be developed to encourage the involvement of other professional groups
- more specific guidance will be introduced for the use of personal development planning (**PDP)** within programmes
- an attendance booklet will be used to monitor student progress to encourage students and staff to publish the findings of their research and promote **student progression**
- a formal mechanism will be established for tracking **career enhancement** of post-qualification students
- guidance on identifying **students at risk** will be provided and evaluated
- additional guidance on **pastoral and academic support** will be available to students at programme level and centrally, including an explanation of the role of the pastoral tutor
- strategies will be developed to address **student attrition** strategies, including the review of contact hours for each module and the development of more self-directed learning
- **mentor** handbooks and **training** will be provided and updated
- documentation will be provided for the mapping of university-wide processes against those of the school to ensure institutional consistency.

4.3.2 Specifically-designed events, either one-off or more regularly instituted

348 A range of events and activities was reported in the action plans, largely for recruitment or induction purposes, although some were for dissemination of policies and guidelines or changes to the curriculum. These include:

- specific **induction** activities, mentor conferences and regular **staff training** to improve/enhance student and staff understanding of processes and procedures, including **ILOs**
- to aid student **recruitment, retention and progression,** the development of enhanced partnership working between HEIs, SHA, local FECs and key placement areas to target specific groups or communities and to promote understanding of minority disciplines to ensure that applicants fully understand the nature of the programmes they are applying for
- the development of creative **recruitment activities,** for example a community-based poster campaign, a preparation-for-study module accredited by the HEI, and subject-specific open days for potential students
- encouragement for academic staff to be involved in **quality enhancement events and seminars** to update them about recent developments and to raise their awareness of government policy initiatives and changes in PSRB requirements which impact on curricula.
- the use of **roadshows** to inform clinicians of key changes to provision
- study days and specific **staff training** in assessment processes offered, along with workshops and other staff development activities to promote interassessor reliability.

4.3.3 Use of IT to enhance communication or share information

349 Many providers committed to increase or make more accessible the use of **VLEs, email and websites** to:

- make documentation available to staff and students
- improve communication with students and practice staff
- provide discussion forums that facilitate communication between students and staff
- enhance **communication** between the HEI and practice partners.

350 Also suggested in the action plans is the further development of:

- **on-line resources,** including distance-learning packages to promote access to geographically-distant students or those living in rural areas. Such developments can be further used to provide greater flexibility in delivering the **curriculum** and to ensure that students gain maximum benefit from virtual resources
- documentation that can be provided on **CD-ROM** for students/practice staff who are unable to access the university VLE/websites easily
- the use of **electronic** mark sheets to be returned to students by email.
- joint databases that can be accessed by HEI administrative and programme staff, and placement facilitators and managers will be developed or further embedded to ensure currency of information on **mentor** preparation and updating
- web-based **feedback mechanisms** to incorporate module and placement feedback and to report on subsequent action.

4.3.4 Use of committees, working groups or liaison and collaboration between different groups or organisations

351 These actions are mostly found in the quality of learning opportunities sections of the reports (learning and teaching, student progression and learning resources), although they also feature in actions around curriculum development. They can be used to disseminate good practice, encourage contributions from stakeholders other than subject staff, update materials, assure standards and consistency, and take forward specific activities. For example:

- **curriculum development** groups will recognise the essential contribution of the clinical tutors and placement educators in programme development
- annual **clinical education planning meetings** will be held to review and update handbooks, and develop ILOs
- **collaboration** between HEIs and placement educators and professionals from other disciplines will take place through committees, review panels, or interaction between health programme teams and a social work practice panel
- the membership of a curriculum and assessment committee and a partnership and quality forum will be reviewed
- working groups such as a disabilities and widening access working group will be established to promote activity in relation to **widening participation**
- in relation to **service-user involvement,** a communication matrix of patient advice and liaison service leaders will be developed in each placement area. It will be the responsibility of relevant committees/working groups to develop, monitor and evaluate schemes to increase service-user involvement
- **discipline sub-groups** will link the HEI with the newly-reconfigured SHA
- HEIs will work with SHAs and practice partners in devising strategies for **improving IPL opportunities** through new working groups or normal contract-monitoring processes
- working groups within schools, across faculties and between HEIs, SHAs and practice partners will **review IPL provision** in academic and practice areas, and explore the potential for creating further opportunities incorporating social work and other related departments. Committee subgroups will also work to review the structure of IPL within programmes and recommend improvements
- providers working with practice managers will ensure **practitioners** are released to attend **training** and updating events. One provider will offer distance learning packs for practice assessors in remote placements, and offer an annual mentor/assessor conference to provide further update and feedback opportunities
- one provider will establish a geographic base for all programme elements to reduce the time students need to spend travelling between multiple locations. Another will review **placement** allocations to ensure that students on part-time routes are placed nearer to home
- committees also take a role in the area of **staff development**. One provider will ensure full representation of mentors and practice educators on programme committees. Another will ensure that termly meetings with practice managers continue to ensure effective communication between academic and practice environments
- **collaboration internally** between programme technical, administrative and library staff will be used to promote best use of **resources** available, and their effective integration into teaching and learning
- **external collaboration** with NHS trusts will be developed and widened to include private practice and industry; monitoring progress will be undertaken through the

contract management group and inviting practice representatives to module development meetings

- HEI/SHA/practice **Major review steering groups** will continue in order to implement the action plans
- regular meetings between quality groups, managers and practice links will enable **effective communication** between organisations and between strategic and operational levels within organisations
- **students** are important **stakeholders** and providers have, or are about to establish or make better use of, for example, student lead networks, student support group meetings and student forums to ensure the outcomes of these meetings feed into the HEI's deliberative structures
- improvement of communication will be achieved by establishing a **student newsletter**
- a '**task and finish**' group will be established to explore issues and make recommendations to a faculty board
- the formal establishment of a **Quality Task Force.**

4.3.5 Dissemination, particularly of strengths and good practice, across a range of groups and bodies

352 The reports provided evidence of a number of different dissemination **mechanisms** and routes. Good practice is shared between providers and practice staff:

- across programmes/disciplines, and schools of study
- between HEIs within a region
- across professional networks through national forums and conferences, including student conferences.

353 Most dissemination took place through institutional deliberative structures or campus-based activities, although providers frequently made use of electronic means, including VLEs, electronic newsletters and good practice websites.

4.3.6 Staff development activities

354 A range of staff development activities has been cited in the action plans but, underpinning these, are mechanisms to identify staff training needs, enabling staff to attend development activities and subsequently to appraise performance. Examples of these staff development activities include:

- in relation to **assessment**:
  - moderators being asked to produce objectives for practice assessors to promote consistency of approach
  - providing more detailed guidance for markers and developing paperwork and procedures to better reflect the needs of students and of service
  - gathering feedback from both staff and students to enhance the marking scheme
  - events for supervisors and mentors focusing on good practice in writing feedback for students
  - providing annual marking and staff development workshops
  - revisiting supervision skills at mentor workshops.
- promoting varied approaches to **teaching and learning** through regular workshops and conferences while supporting the aims of the learning and teaching strategy

through a programme of developmental activities for new and existing staff

- recruiting staff with a commitment to research in order to promote standards of **student research** on a doctoral programme
- supporting **staff development** activities by providing more electronic resources
- encourage and enhancing **IPL** by the integration of staff into mixed discipline offices, including a wider range of disciplines in structured IPL opportunities, and participating in national forums such as the Centre for the Advancement of Interprofessional Education.

4.3.7 Allocation or improvement of resources

355 Although less prevalent, resources are nevertheless an important theme in the action plans, both in terms of human and material resources. For example:

- many providers will review and update their **mentor/practice assessor preparation** and training courses. Some will explore alternative modes of delivery to ensure better coverage and availability of practitioners; others will provide more opportunities for practitioners to attend training workshops with the aim of increasing the mentor pool. Some providers will also undertake surveys to identify specific or individual development needs and formulate strategies to meet these needs
- efforts will be made to ensure adequate **staffing**, and an appropriate mix of academic, clinical and technical staff to support learning. Some providers will recruit to new posts, such as a laboratory technician or placement facilitator. Others will review their recruitment processes to secure staff with appropriate expertise, including those with strong research backgrounds
- additional **practice facilitators** may be employed to meet programme requirements and to promote further the integration of theory and practice in the student learning experience
- in relation to **material resources**, examples include improving skills laboratories to provide more virtual experiences for students to test their skills in a safe environment
- **on-line resources**, including distance-learning packages will be developed to promote access to geographically-distant students or those living in rural areas
- **placement opportunities** will be reviewed in response to changes in service delivery. HEIs will work with SHAs to ensure that an appropriate range of placements and resources within placements are available.

4.3.8 Scoping and evaluation

356 A common theme in the action plans has been the use of scoping exercises and/or evaluation of current processes as a starting point for addressing shortfalls in the provision and to support strengths and identify further areas of good practice. For example:

- in **curricula**, scoping exercises will be undertaken to assess user demand for interprofessional opportunities and for identifying further opportunities to share good practice. Module **ILOs** will more clearly reflect the interprofessional nature of the provision, and strengths relating to **IPL** will be considered and evaluated in annual monitoring or planning for re-approval
- **curricular reviews** will be undertaken to assess currency, relevance, assessment loading, range of clinical experience students receive, learning hours required in practice, and how to maximise accreditation of prior (experiential) learning
- responses to strengths in **service-user involvement** include identifying the level of current involvement and areas for improvement, regular evaluation of service-user

involvement and their contribution to curriculum development and delivery, and developing a communication matrix of Patient Advice and Liaison Service leads in each placement area

- scoping the possibility of greater **practitioner involvement** in campus-based education
- providers will gather feedback from both staff and students to enhance both the marking scheme and **feedback to students on assessments**
- reviewing **assessment schedules** to avoid bottlenecks in submission and return dates
- reviewing current student assessment feedback processes and timescales to improve turnaround time, and devising or developing strategies and policies to formalise arrangements. One provider notes that the university system that only allows the release of final marks following examination board ratification means that they cannot improve turnaround times
- an HEI **learning and teaching strategy** will be reviewed to make more explicit the need to maximise IPL opportunities within the provision and between other schools and institutions
- one provider will review **contact hours** for each module and look to develop more self-directed learning. Another will introduce logs to record practice learning hours, which will then form part of a summative **assessment**. Another will promote effective time management strategies with students to ensure they use study weeks and days on-campus effectively
- evaluating the impact of **teaching methods**, including IPL, on students, staff and clinical practice through the validation/re-approval process
- the **staff roles** of placement facilitators, link tutors and personal tutors will be evaluated to further strengthen them in supporting students
- scoping the feasibility of establishing HEI-wide mechanisms for **student support,** including specialist support and guidance centres, and learning support services, and encouraging school and programme teams to promote the use of appropriate external support agencies
- reviewing **student progression data** and exit interviews to improve retention rates
- drawing from the evaluation by students of learning resources to inform the learning resources strategy and the learning and teaching strategy
- the review of IT access at clinical placements as part of a resource-scoping project in developing the availability of electronic information and potential student feedback mechanisms
- reviewing placement opportunities in response to changes in service delivery, with HEIs and SHAs working together to ensure that an appropriate range of placements is available. Audit systems will be maintained and developed to ensure placements are of a high quality
- reviewing internal QA mechanisms, for example, committee structures and membership, to ensure a clear remit for each and appropriate representation. Responsibilities for action will be clearly identified in minutes and monitoring procedures established to ensure that actions are undertaken. School QA processes will be mapped to university-wide processes to ensure consistency
- annual monitoring processes will be reviewed by some providers to further develop links with professional regulatory and statutory bodies.

4.4 Data arising from Major review

357 In 2002-03, there was an expectation that there would be **an agreed national minimum dataset** in relation to WDC/SHA commissioned programmes. This would enable comparison of data between organisations as it would include definitions of the terms used, for example 'attrition'. The Major Review Steering Group recognised that Major review reports could actively contribute to this data set. In the later stages of the development of Major review, the Steering Group agreed the scope of the data to be published in each report. It was intended that such data would also inform the review teams' judgements on student achievement and progression. **Three standard data tables** were developed:

Table 1: Completion and achievement statistics for all award-bearing programmes

Table 2: Employment statistics for pre-registration programmes and post-qualifying programmes (by exception reporting only)

Table 3: Recruitment and attrition statistics for pre-registration and NMC-recordable qualifications.

358 The national minimum dataset was finally published as part of the MPET national standard framework contract for professional health training (DH, 5 April 2006). However, the Major review reports published after this date have retained the data tables in the format initially agreed by the Steering Group, for consistency across the cycle.

359 During the review cycle, additional guidance was developed by QAA to address the issues of inaccurate or incomplete data and the definitions of terms, queries about which were raised in the early reviews. While there has been a notable improvement in the presentation and reliability of the data provided, it has remained a challenging task for most providers with the amount of work required, being highly dependent upon the systems and terminology agreed between the SHA and HEIs.

360 The following sections explore the **analysis of the data tables**[26] in more detail. However, there is a note of caution: the time period covered by the data within each table varies by programme. It is not always clear if the year given refers to the start date of the cohort, or all the students studying in that year, thus making some comparative analysis unreliable, for example, the comparison of achievement and retention data (Tables 1 and 3). The definition of a cohort may also vary across HEIs and SHAs.

361 It is important to understand that a student who **Fails** is defined as one who did not successfully complete the final assessment. One who **discontinues** is excluded by the institution from their programme of study at some stage, due to a failure to fulfil the programme requirements before the final assessment. This is distinct from a student who **withdraws** for non-academic reasons and therefore is unable to complete the programme.

4.4.1 Completion and achievement statistics

362 Table 1 in the Major review reports captured information about the achievement of 61,055 students on a diverse range of award-bearing programmes at both undergraduate and postgraduate levels. These data are summarised in Tables M and N below.

363 Classifying students according to level of achievement, the following is apparent:

- 25,400 were recorded on degree programmes, 71 per cent of whom were on pre-registration programmes
- 26,311 were recorded on diploma programmes, 89 per cent of whom were on pre-registration programmes
- 4,561 were recorded on postgraduate programmes, 35 per cent of whom were on pre-registration programmes (including professional doctorates)

[26] All data related to head count of students and not full-time equivalents.

- 760 were recorded on conversion programmes
- 1,523 were recorded on Return to Practice programmes
- 2,064 were recorded on 'other' programmes, including short courses and CPD programmes, 60 per cent of whom were on supplementary prescribing programmes for both nursing and AHPs.

364 It has not been possible to analyse the number of students registering on programmes (recorded in Table 3 of the review reports) compared to those completing (recorded in Table 1 of the review reports) due to a lack of consistency and completeness of information across these two tables. Therefore, the numbers below are based on the achievement statistics, recording those students who completed programmes and received an award.

365 The majority of students are recorded as studying for diploma programmes, with 45.5 per cent of all students noted as either completing a diploma or advanced diploma, and the majority of these students are in nursing (91 per cent of all diplomates). The remainder were taking programmes in midwifery, ODP and radiography. The Pass rate is high, the average across all disciplines being 97 per cent.

366 Nursing continues to have the largest number of students completing programmes of study, of the disciplines covered by Major review. Of all the students for whom data were presented in Table 1 of the review reports, 67 per cent completed nursing programmes. While 65 per cent of these completed diplomas, advanced diplomas, conversion programmes, Return to Practice programmes and certificate of professional studies. Twenty-seven per cent completed degree programmes, and 4 per cent postgraduate programmes, including professional doctorates. The remaining 4 per cent were registered on programmes that fall into the 'other' category. With regard to pre and post-registration programmes, three-quarters of all students recorded in Table 1 were enrolled on pre-registration programmes. Within nursing, students on pre-registration programmes accounted for 68 per cent, with 32 per cent on post-registration programmes. Pre-registration students were more likely to be studying at diploma level than students on post-registration programmes. Conversely, those on post-registration programmes were more likely to have studied at degree and postgraduate level than pre-registration students.

367 Midwifery had the second highest number of students, with 97 per cent of all students completing, of whom just over half took degree programmes. As with nursing, around 4 per cent undertook and completed postgraduate programmes.

368 Health visiting was classed as a separate discipline in order to meet NMC requirements. Following the change to the NMC register from 15 parts to three, it progressively became more difficult for providers to separate health visiting from other specialist community public health nursing programmes. QAA provided a substantial amount of support to review teams and providers in clarifying which programmes and data needed to be considered under this heading. In terms of the overall number of students recorded in the data tables, health visiting constitutes a small discipline, with just over 1 per cent of all students recorded as completing a diploma or degree programme.

369 Within AHP disciplines, the highest completion rates are in physiotherapy, with 31 per cent of all AHP students completing a programme of study in this discipline, nearly all of whom completed a bachelor's degree programme. In total, 108 students are recorded as having completed a postgraduate physiotherapy programme. In most cases this is a pre-registration master's-level programme. Occupational therapy is the second most popular AHP discipline, with 22 per cent of all AHP students completing a programme of study, 91 per cent of whom were at undergraduate level and 8 per cent at postgraduate level.

370 Clinical psychology is the only health discipline studied entirely at postgraduate level, with students qualifying with professional doctorates or postgraduate diplomas (PgDip) in related areas such as cognitive behavioural psychotherapy. Among the other disciplines, audiology had the greatest proportion (97 per cent) of students within the discipline taking postgraduate programmes. After audiology, SLT and dietetics have the highest proportion of

students within the discipline studying at postgraduate level, with each having around 30 per cent of postgraduate students recorded.

371 **Of the nursing, midwifery and health visiting disciplines, the achievement rate is highest in health visiting**, with only 0.7 per cent of students recorded as having failed (Table M). The failure rate for midwifery is 2.9 per cent and for nursing is 4 per cent. However, nursing programmes have six times as many students as midwifery and 17 times as many students as health visiting.

372 Within the **AHP professions for pre-registration programmes,** two (orthoptics and prosthetics and orthotics) are recorded as having 100 per cent achievement rates (Table M). However, these disciplines are very small, with only 136 and 67 students respectively. Only one student is recorded as having failed in SLT, giving this discipline the next highest achievement rate. The highest failure rates in an AHP discipline are in ODP (4.9 per cent) and audiology (4 per cent). However, these are also small disciplines, with only 351 and 95 students respectively. Among the larger disciplines, the achievement rate is good with 98.7 per cent achievement in physiotherapy and 97.5 per cent in occupational therapy.

Table M: Student achievement by discipline and pre or post-registration programme

	Pre-registration programmes				Post-registration programmes				Unknown	
Discipline	**No. Pass**	**pass %**	**No. fail**	**fail %**	**No. Pass**	**pass %**	**No. fail**	**fail %**	**No. Pass**	**Pass %**
Audiology	95	96.0	4	4.0						
Clinical psychology	1,036	99.5	5	0.5	67	100.0	0	0.0		
Dietetics	521	99.6	2	0.4	3	100.0	0	0.0		
Health visiting	1,590	99.3	14	0.7	469	99.2	4	0.8	168	100
Midwifery	4,426	97.1	131	2.9	531	98.7	7	1.3		
Nursing	26,732	96.0	1,113	4.0	12,427	97.6	349	2.4	83	100
Occupational therapy	2,670	97.5	69	2.5	134	98.5	2	1.5		
ODP	351	95.1	18	4.9						
Orthoptics	136	100.0	0	0.0						
Paramedic science	141	97.2	4	2.8	20	100.0	0	0.0		
Physiotherapy	3,917	98.7	50	1.3	97	100.0	0	0.0		
Podiatry	661	99.7	2	0.3	25	100.0	0	0.0		
Prosthetics and orthotics	67	100.0	0	0.0						
Radiography	1,360	98.2	25	1.8	393	98.7	5	1.3		
SLT	938	99.9	1	0.1	192	100.0	0	0.0		
TOTALS	**44,649**		**1,443**		**14,350**		**334**		**251**	

373 Students were recorded as studying at bachelor's degree level in all disciplines except clinical psychology. The majority of first-degree students pass with Upper Second class honours (45 per cent); 11 per cent were awarded a First class degree. The discipline that attained the highest proportion of students with a First class degree was midwifery, at 20.7 per cent.

374 **The average degree profile for all disciplines displayed congruence with the degree classification profile for all higher education degree students studying at HEIs within England** (based on Higher Education Statistics Agency (HESA) 2004-05 student data). For all programmes of study for which data were provided through Major review, the average Pass rate was in excess of 98 per cent for all disciplines (Table M). The highest proportions of failures are in pre-registration nursing programmes and ODP, both with failure rates at around 4 per cent.

375 It is not clear whether students who only gain an unclassified Pass are on honours or non-honours degree programmes. Again, therefore, no trend can be observed from these data on the level of achievement.

376 **In general, the Pass rate across all disciplines of pre-registration programmes was similar to post-registration programmes (98.2 and 99.3 per cent respectively)**. However, this trend was not replicated within each discipline. There was also some variation in Pass rates between the different programme types. Diploma programmes tended to have a higher proportion of passes in post-registration programmes than pre-registration, whereas postgraduate ones recorded a higher proportion of failures in post-registration programmes.

377 Students are recorded on postgraduate programmes in 12 out of the 15 disciplines (Table N). These data include the awards of postgraduate certificate (PgCert), PgDip and master's. Doctorates are counted separately. Again, the highest proportion of students taking postgraduate programmes is in nursing, at 45 per cent. Less than 1 per cent of students studying at this level are recorded as having failed, and the majority of these were also on nursing programmes. The majority of postgraduate awards are also post-registration, at 65 per cent.

378 Taught doctorates are awarded in two disciplines, clinical psychology and nursing. The majority (96.7 per cent) of these students are on clinical psychology programmes. Only 0.5 per cent of these are recorded as having failed. No Fails are recorded against the nursing programmes.

Table N: Student achievement by discipline and qualification aim

	Diploma		Degree Classification						Post-graduate[27]		Doctorate		Return to practice		Conversion		Other[28]		Total
	Pass	Fail	1st	2i	2ii	3rd	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail	Total
Audiology			0	1	2	0	0	0	92	4	0	0	0	0	0	0	0	0	99
Clinical psychology	0	0	0	0	0	0	0	0	128	0	965	5	0	0	0	0	10	0	1,108
Dietetics	0	0	48	226	85	3	0	0	159	2	0	0	0	0	0	0	3	0	526
Health visiting	0	0	194	913	658	102	17	11	193	4	0	0	10	0	0	0	140	3	2,245
Midwifery	1,905	77	366	959	835	199	115	47	214	4	0	0	307	9	0	0	57	1	5,095
Nursing	22,971	948	1,197	4,514	3,453	597	943	326	1,555	44	33	0	1,145	52	744	16	2,090	76	40,704
Occupational therapy	0	0	265	1,195	933	86	75	69	235	2	0	0	0	0	0	0	15	0	2,875
ODP	351	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	369
Orthoptics	0	0	11	55	58	12	0	0	0	0	0	0	0	0	0	0	0	0	136
Paramedic science	0	0	8	59	19	3	22	4	10	0	0	0	0	0	0	0	40	0	165
Physiotherapy	0	0	487	2,427	935	31	7	50	108	0	0	0	0	0	0	0	19	0	4,064
Podiatry	0	0	89	250	249	63	8	2	25	0	0	0	0	0	0	0	2	0	688
Prosthetics and orthotics	1	0	16	37	10	2	0	0	0	0	0	0	0	0	0	0	1	0	67
Radio-graphy	38	2	132	470	532	121	7	18	410	10	0	0	0	0	0	0	43	0	1,783
SLT	0	0	100	415	232	9	15	1	359	0	0	0	0	0	0	0	0	0	1,131
Total	**25,266**	**1,045**	**2,913**	**11,521**	**8,001**	**1,228**	**1,209**	**528**	**3,488**	**70**	**998**	**5**	**1,462**	**61**	**744**	**16**	**2,420**	**80**	**61,055**

[27] 'Postgraduate' includes master's, PgDip and PgCert

[28] 'Other' includes Foundation Degrees, graduate diplomas, CPD programmes and short courses

4.4.2 Employment statistics

379 Table 2 in the Major review reports provided information about the employment profile after completing their programme of study. In total, this yielded data for 40,595 students.

380 The largest proportion (56.6 per cent of 22,974 students) of students across all discipline areas was recorded as being **employed by local employers**, with over 67 per cent of these having undertaken a nursing qualification (Figure 2). However, it should be noted that no clear definition of 'local' had been provided, and therefore may have been interpreted differently by providers. However, 'local' generally is taken to mean within the area(s) covered by the commissioning SHA(s). The proportion of students who were recorded as unemployed across all disciplines was 4.4 per cent (1,805 students), with over 80 per cent of these having studied nursing.

381 **The employment data revealed emerging patterns of mobility after graduation** in relation to both discipline and level. It is probable that these are related to the local economic conditions and the demand for skills or employees within specific sectors at a certain skill level, or the spatial mobility of individual students. Following completion of their programme of study, less than 5 per cent of students were known to have been unemployed.

Employment/study status following qualification attainment across all disciplines

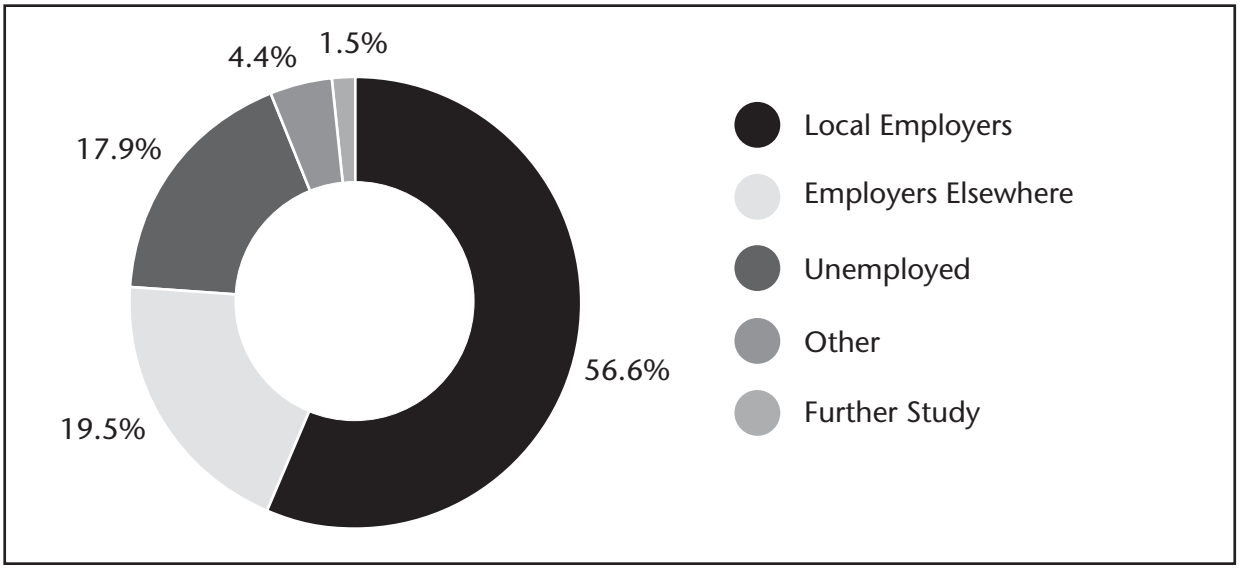


Figure 2 - Employment data

Source: QAA Major review of healthcare programmes reports

382 Local and national commissioning arrangements also have some impact, as students in some small disciplines are recruited by few HEIs, but will find work across the country. **Table O** shows that audiologists, orthoptists, and prosthetists and orthotists are more likely to be employed away from where they were trained, and this is most likely due to patterns of commissioning. Also, more physiotherapists are employed elsewhere than locally. This is most likely due differences in local and national labour markets for some disciplines, and patterns of student mobility when choosing where to study. The most surprising result is that of Return to Practice midwives, the majority of whom are shown below to be employed away from where they were trained.

Table O: Destination of students six months after completing their programme of study by discipline

Subject	Further study	Local employers	Employers elsewhere	Unemployed	Other	Total
Audiology	2	15	67	0	8	92
Clinical psychology	1	627	257	6	79	970
Dietetics	13	155	189	10	58	425
Health visiting	7	990	46	12	100	1,155
Nursing-degree	89	2,234	678	141	930	4,072
Nursing-diploma	317	11,820	2,541	1,248	3,540	19,466
Nursing- other	0	279	23	0	11	313
Nursing-postgraduate	33	595	181	26	260	1,095
Nursing-return to practice	8	271	90	36	78	483
Nursing-conversion	0	216	13	0	8	237
Midwifery-diploma	21	673	159	20	144	1,017
Midwifery-degree	75	1,037	720	151	202	2,185
Midwifery-return to practice	0	42	304	0	2	348
Midwifery-other	0	118	10	0	74	202
Occupational therapy	13	1,082	447	35	629	2,206
ODP	1	172	15	1	73	262
Prosthetics and orthotics	0	3	39	3	4	49
Orthoptics	7	11	71	0	8	97
Paramedic science	0	72	0	0	0	72
Physiotherapy	19	1,264	1,326	65	690	3,364
Podiatry	7	220	52	34	80	393
Radiography	7	660	250	9	145	1,071
SLT	8	418	432	8	155	1,021
Total	**628**	**22,974**	**7,910**	**1,805**	**7,278**	**40,595**

383 The overall average for **unemployment** across all disciplines was 4.4 per cent (Figure 2). Podiatry recorded the highest proportion of unemployment at 8.7 per cent (34 students) (Table O). A relatively high proportion of unemployment was also recorded for students studying on nursing Return to Practice courses, with 7.5 per cent (36 students) stating they were unemployed following qualification. Although the largest number of students recorded as unemployed following graduation had studied nursing at diploma level (1,248 students), this represented only 6.4 per cent of nurse diplomates. It is interesting to note that two institutions recorded well-above-average rates for unemployment within their nursing diploma provision, with one institution recording 45 per cent unemployment following graduation and the other 37 per cent.

4.4.3 Recruitment and attrition statistics

384 **Table 3** of the Major review reports provided data about the recruitment and attrition statistics for programmes. Data were provided for the numbers registering, withdrawing, and for transfers, both in and out of programmes.

385 There are **some inconsistencies between the data** provided in Tables 1 and 2 of the Major review reports (achievement and employment data) on the one hand and Table 3 (recruitment and attrition data) on the other. For example, from the data in Table 3, over 71,000 students should complete their programmes but, according to achievement statistics in Table 1, just over 61,000 students are recorded. The anomalies lie in different cohorts being recorded in each table, due to the availability of data at the time.

386 The data tables indicated that a total of 82,043 students had been recruited to the programmes included within the scope of the reviews (Table P).

Table P: Student progression data across all disciplines

	Number	%
Recruited	82,043	
Withdrawn	8,354	10.2
Transfer In	4,339	5.3
Transfer Out	4,168	5.1
Discontinued	2,621	3.2

NB: All percentages are based upon the recruitment data.

Source: QAA Major review of healthcare programmes reports

387 The average **withdrawal** rate across all programmes within the scope of the review was 10.2 per cent of the initial recruitment. There are six disciplines with a significantly higher-than-average withdrawal rate: midwifery, ODP, podiatry, prosthetics and orthotics, radiography and orthoptics (Table Q). The lowest withdrawal rate is in clinical psychology, and this may be due to the nature and level of the programme. Students will need a greater understanding of the subject and the levels of study required before undertaking it and, therefore, are more likely to complete than students on diploma or degree-level programmes, who may not have experienced work in these subject areas before. The withdrawal rate for nursing is about average, which is unsurprising, as nursing students form around 60 per cent of all students recruited across the 15 disciplines. Physiotherapy and health visiting also have notably lower-than-average levels of withdrawal.

388 Considered by level of award, **withdrawal rates were highest for diploma programmes** (11.2 per cent), compared to 9.9 per cent for first degrees. Postgraduate students show a similar trend to that of first degree students, with the exception of doctoral students, the large majority of whom progress to complete their programme successfully.

389 With regard to the **transfer in and transfer out** of students, it is not known whether transfer was between levels within the same discipline or cross-discipline within or outside of healthcare provision. It is interesting to note that students transferring in to programmes more or less balance the numbers of those transferring out, at 5.3 per cent and 5.1 per cent respectively. The disciplines that show a higher level of transfers in than out are all small, AHPs: dietetics, podiatry and orthoptics. The disciplines that show the most balanced trend between transfers in and out are those with the largest numbers of students: nursing, midwifery, health visiting, occupational therapy, ODP and physiotherapy. The disciplines that show a higher rate of transfers out are also small, AHPs: audiology, paramedic science, prosthetics and orthotics and SLT.

Table Q: Student progression data by discipline

	Recruited	Withdrawn %	Transfer in %	Transfer out %	Discontinuation %
Audiology	412	6.3	0.2	1.7	0.7
Clinical psychology	1,511	1.5	0.9	0.3	0.3
Dietetics	863	6.7	5.8	3.1	3.2
Health visiting	2,909	5.5	0.7	0.9	1.6
Midwifery	6,426	14.8	6.3	7.7	2.1
Nursing	50,351	10.6	6.4	5.9	4.1
Occupational therapy	3,619	9.6	3.8	3.6	3.9
ODP	1,156	13.5	3.2	3.4	4.2
Paramedic Science	294	7.5	3.7	6.5	2.4
Physiotherapy	4,923	4.8	2.8	2.9	1.6
Podiatry	539	18.0	4.1	2.4	1.9
Prosthetics and Orthotics	90	12.2	2.2	8.9	1.1
Radiography	4,360	14.3	4.3	5.6	1.1
SLT	748	6.8	2.5	4.0	0.3
Orthoptics	193	16.1	9.3	5.2	1.6
Other[29]	3,649	5.8	1.4	0.5	0.6

[29] Those programmes listed as 'other' were not set against a programme or discipline area, or had been grouped together and could not be disaggregated.

Chapter 5 A summary of key learning points from Major review

390 Major review, both through its process and its outcomes, has provided much learning to inform all stakeholders about the quality of healthcare education in HEIs and the practice environment over the period 2003 to 2006, and the ways these can be enhanced. It is hoped that these will inform any future QA processes.

391 Major review has been an unqualified success. It has delivered what the partnership of contractors and stakeholders intended through a rigorous peer-review and reporting process. It has assured that HEI providers offer the quality of education necessary to inform the general public that programme graduates and diplomates are fit for purpose, practice and award. Numerous areas of strength and good practice have been identified.

392 The Major review methodology, carefully tested by and in response to prototype reviews, has stood the test of time despite changes in the external environment. The approach has been continuously fine-tuned through the use of responses to evaluative questionnaires and focus groups throughout the period 2003 to 2006. This suggests that a collaborative, partnership and peer review approach serves both to assure and enhance the quality of healthcare education.

393 The Handbook for major review of healthcare programmes has also withstood the test of time. Annex D has provided an effective template of equal value to institutions writing SEDs and preparing for their reviews and to reviewers in maintaining an appropriate focus on key questions. The lack of resources for further fine tuning and reprinting of the Handbook in response to experience of Major review indicates that, in future, such helpful modification needs to be considered. However, where appropriate, QAA has issued additional guidance to all those participating in Major review to ensure that all were briefed fully.

394 The approach to the nomination and selection of reviewers conformed to the QAA's equal opportunities policy and the needs of teams to consist of appropriately-qualified professionals, drawn as far as possible equally from HEIs and practice environments, across all the professions subject to review. Although there was some difficulty enlisting peer reviewers from some smaller health professions, QAA was successful in providing teams appropriate to the spread of professional areas of each provider. Therefore, in spite of the manifold work pressures of busy professionals, the process of peer review proved sustainable, productive and gained the respect of the sector.

395 The QAA Health Team, specifically drawn together to conduct Major review, has provided essential and much-appreciated support both for the reviewers and education providers. Scoping and scheduling of reviews was a moving target, providing a significant challenge and changes to the timing and content of reviews. The support of this Team proved essential to ensuring a process demanding consistent good practice and high standards. Where difficulties arose, the Health Team were the first point of contact and resolved issues effectively within appropriate timescales. Support from the QAA Information Systems help desk was also much valued and much used by reviewers.

396 Internally, QAA undertook to coordinate Major review activities with Institutional audit, ensuring that no HEI undergoing Major review would also be subject to a discipline audit trail in healthcare provision. Also, audits referred to Major review reports and vice versa, so that the evidence gained from each process was shared, thereby successfully reducing the burden of external QA on HEIs. Similarly, the involvement of NMC Visitors in Major review reduced the burden of HEIs' meeting PSRB needs by eliminating the need for a separate sampling visit to an institution for annual monitoring purposes during the year that the HEI had its Major review. The role of the NMC Visitor was included in Major review from the start of the training. This reviewer on the evidence gathered by the review team for the Major review report in order to complete the NMC annual monitoring report. There were positive benefits from this close working partnership between the QAA and NMC, particularly in the context of reducing the QA burden for providers.

397 The MRFs and PRFs have proved vital roles in ensuring the integrity and efficient management of review events, supporting the enhancement of partnership and interprofessional working, and ensuring effective dialogue between review teams and providers. From the perspective of providers at focus groups, one of the benefits of Major review was considered to be the opportunity it afforded them to ensure that appropriate processes and procedures were in place for QA and that, through the Major review process, recognition of partnership working was a very positive output.

398 The 50:50 principle of academic and practice emphasis throughout the Major review process has been upheld and has brought substantial benefits for partnership and interprofessional working. HEIs and their associated practice environments have been brought closer together, often finding new ways of working in partnership to the benefit of both. Similarly, reviewers from academic and practice backgrounds have benefited from working together. Interprofessional working has been fostered and enhanced through the planning and implementation of Major review.

399 A significant number of reviewers from both academic and practice backgrounds have been trained for Major review, and have gained a considerable amount of experience as peer reviewers. They constitute a significant resource which could contribute substantially to any future external QA process and should not, therefore, be overlooked.

400 The model of 2+2+1 days for the visit to the HEI and practice placement providers spread over six weeks was considered, by the majority of participants in the focus groups, to be useful in allowing time for reflection and for the planning of placement visits. It has resulted in a rigorous evaluation of the quality of education. However, it also sometimes resulted in the reviewers, HEIs and SHAs becoming disengaged during the gaps between visits. This model also resulted in a significant increase in the amount of time reviewers' travelled, compared with a single visit over five days, or two visits of two and three days.

401 All review teams had satisfactory access to the ARCS website, that enabled them to communicate in confidence with each other and with QAA officers throughout the review period. Use of this system by MRFs and PRFs, who were able to send documents and emails for the team to read, but not access the team's discussions themselves, was also valued highly. The system was also consistent with the need to reduce the amount and cost of disseminating paper-based documentary evidence and to increase the speed of access to it. The provision by institutions of evidence in electronic form to support the SED and the review was considered helpful. It was provided in a number of ways, including on CD-ROM, memory stick and through the HEIs' intranets. However, teams noted that, where this evidence was not well indexed, a significant amount of their time could be wasted trying to locate specific material.

402 There were problems from the outset in defining the standard dataset required from institutions as essential evidence for Major review. The inclusion of data tables recording student achievement and progression in the review reports for the first time in QAA reviews at the subject level, proved challenging for both reviewers and institutions. There is still much work to be done before such data are produced using standard methods of calculation or presentation, thus enabling the production of rigorous datasets that can be used in comparing performance of students across the sector by professional areas and institutions. However, the tables in Major review reports are a groundbreaking first attempt to provide such comparative data for student retention, achievement and employment.

403 Enabling review teams to make differentiated judgements was a particular strength of the review methodology. It ensured that areas of concern could be identified explicitly and were not lost in the provision as a whole, nor was the provision penalised as a whole for one, usually small area of it. Judgements could be differentiated by programme, mode of study, and level of study (undergraduate and postgraduate), although all (29) differentiated judgements were by programme.

404 Evaluation of the judgement categories indicated that while the teams were able to make robust and evidenced-based judgements, some found disassociating the use of the word 'commendable' in every-day language from the definition given in the Handbook tricky. This was another example of where the CR role was important in managing the review and providing guidance to the reviewers.

405 The quality of Major review reports was an acid test of the success of the whole process. In general, the published reports are very substantial in comparison with previous QAA subject review methodologies. The division of the content into four academic and practitioner standards elements, three quality of learning opportunity elements, and maintenance and enhancement of standards and quality, followed the Handbook and the institution's SED. This was a workable division of content. However, certain themes crossed several elements. It was often challenging for reviewers to determine where to report features relating to practice learning, mentoring, academic staff and the various elements of student support, particularly in the academic and practitioner standards which were written by discipline. Avoiding repetition was challenging. However, the report template stood the test of time. Reports have benefited from rigorous editing that has resulted in acceptable consistency of content and clarity of message. The action plans they contain have been a significant and important part of Major review and raised a number of learning points.

406 The identification of strengths, good practices and weaknesses as bullet points at the end of each of the eight report sections has facilitated action planning for the progression of internal QA and enhancement in the participating institutions. The use of the term 'weakness' was debatable and might have been better changed to 'areas for further development'. Whereas review teams clearly identified some weaknesses that had already been recognised by institutions and were under review or identified as work in progress. However, the action plan in each report successfully formalised areas for development, ensuring that they form an explicit template for ongoing monitoring and enhancement that can be monitored.

407 The action plan addresses all summary bullet point strengths, good practice and weaknesses provided by the review team in their report. To succeed in enhancing quality, they must be capable of being actioned. As experience was developed, precedence set, and additional guidance and support provided from QAA, the bullet points produced by the review teams improved to become more specific and measurable. In early reports, in relation to strengths and good practice, the action plans tend to provide bland statements. Later, they provided more detailed responses that followed the principal of SMART (specific, measurable, agreed, realistic and time-bound) objectives more closely. Four dedicated action planning forums were held to promote this theme and ensure that an action plan was a useable document. Effective action plans were those that were focused on maintaining and improving the provision; clear about the actions required and accountability for the actions agreed; had clear and measurable outcomes which focused upon enhancement of the programmes; and exhibited clarity about the system for monitoring the achievement or otherwise of the agreed actions. The responsibility for undertaking the actions lay predominantly with the HEI, although the actual activity was often undertaken in partnership with practice.

408 The ongoing quality monitoring and enhancement process was designed and piloted[30] in order to provide continuity for all the positive benefits of Major review, while being less onerous, in line with policy emanating from the Higher Education Regulation Review Group. There are real fears in the professions and institutions that all the impetus and the positive benefits derived from Major review will be lost in the current uncertainty over future QA arrangements and in the absence of external input into any new monitoring or review process.

[30] The design of OQME was led by SfH in consultation with a wide range of stakeholders, piloted and evaluated by QAA and externally evaluated by Homerton School of Health Studies

Chapter 6 Conclusions

409 This chapter provides a summary of the key outcomes from Major review, and points to note in relation to the development of any future QA of healthcare education, drawn from all evaluation activities around Major review and analysis of the reports.

410 The results of Major review convey a very strong positive message about the quality of healthcare education in England over the period 2003 to 2006 to the NHS, and to all the partners and stakeholders involved. In the reports, the strengths and good practice far outweigh areas of weakness.

411 Major review confirmed that students successfully completing programmes are fit for practice, purpose and award. The small number of weaknesses identified in the Major review reports that relate to student achievement indicates that standards overall are high.

412 The reviewers comment variously on the breadth, depth and variety of teaching methods, together with the teaching of specific skills such as critical reflection, reasoning and problem-solving, to ensure that students become competent and safe practitioners. Problem-based and enquiry-based learning are two approaches frequently cited to ensure a well-rounded approach to integrating theory and practice. The effective support of link lecturers and practice facilitators is also identified as central to the promotion of the integration of theory and practice.

413 Not only did Major review find much to praise in the development of interprofessional education, but it also fostered the development and enhancement of interprofessional working throughout the process in line with national policy to promote interprofessional learning and working. Wherever more than one professional discipline was involved in a review, colleagues from the different disciplines worked together. This began with the production of the SED and in institutional preparation for the review, continued through the interdisciplinary working of the review team and the production of the report, and was completed in the creation of the action plan, published as part of the review report.

414 In order to encourage teamworking across disciplines and promote IPL, each reviewer was allocated one of the eight elements to lead and to write about for the report. For example, a reviewer responsible for drafting report text for student achievement wrote this section for all disciplines being reviewed. In the evaluations received and the focus groups, many reviewers commented that they had greatly valued working in interdisciplinary teams, and that by writing about other disciplines they became more aware of the different professions and interprofessional working.

415 The evaluations also showed that a key outcome of the process has been the establishment and formalisation of partnership working between HEIs, SHAs and partner placement providers. The strengthening of these relationships has had a positive impact on both the assurance of quality of programmes and the student learning experience. Following the reconfiguration of SHAs there is a risk that there may be a loss of organisational memory of lessons learnt from Major review. This places greater importance on the continuation of strong partnerships.

416 In many of the elements of Major review, key areas of strength, good practice and weakness were very similar. Key areas from which much can be learned include interprofessional education and mentor updating and training. An area of particular challenge in the future may result from the short supply of mentors/practice educators due to staff shortages or high numbers of students on placements, and the uncertain future funding of practice facilitators.

417 Strengths in the recruitment of students and induction processes focus upon partnership working, with practice staff involved at each stage, and successful widening participation schemes resulting in the recruitment of students from diverse and non-traditional

backgrounds. The majority of weaknesses identified relate to attrition rates and work undertaken to reduce them. High attrition rates in individual programmes were commented upon, especially where the reduced numbers of students remaining affect the viability of the programmes.

418 The most common area of strength in learning resources and their effective utilisation was the quality of material resources, such as discipline-related equipment, IT facilities, library stocks and teaching accommodation. The quality of teaching staff is another recurring strength. Well-qualified and experienced staff who provide a high level of teaching and student support are identified in many reviews. Areas of good practice for learning resources follow similar themes to strengths, including partnership working.

419 Visits by the reviewers to practice took up half of the time allocated to each Major review. The placement areas involved found the process beneficial. A large number of placement respondents stated that being involved in a review was beneficial to them. It enabled them to reflect on the educational process and to highlight and share good practice.

420 The SED produced by the education providers was the cornerstone of each Major review. The writing of the SED was beneficial for those involved, providing the opportunity to review the educational process and achievement. The benefits from interprofessional working were manifold, even if the quality of the SED sometimes fell short of what was ideally required by the reviewers, despite comprehensive briefing given in the Handbook and by QAA at briefing events.

421 The Handbook, which identifies the areas to be considered in the SED and by the review team: academic standards (intended learning outcomes, curricula, assessment and student achievement), quality of learning opportunities (learning and teaching, student progression, and learning resources and their effective utilisation), and maintenance and enhancement of standards and quality, provided a template within which the reviewers were able to conduct a rigorous review of the education provided.

422 There was a high level of interest shown by academics and practitioners in becoming reviewers. The WDCs and certain professional bodies had a key role in promoting nominations. In the majority of disciplines, more academics than practitioners were trained. The gender and ethnicity proportions of reviewers were in line with national healthcare workforce statistics for the professions. QAA was largely successful in matching the expertise of the review team visiting each provider with the broad specialisms of the subject provision.

423 The training of reviewers was intensive, with a premium placed on written work; by the end of the training event, attendees had to provide first-draft Major review report sections. Training events were very positively received by the reviewers who found them invaluable, with many comments about the high quality of tuition, the effective structure of the training, the facilitative environment in which they were run and the success of these events in preparing attendees for review.

424 The CRs were regarded by MRFs and PRFs and reviewers alike as pivotal to the process of Major review. MRFs, PRFs and reviewers all saw the role of the CR as one of the most positive aspects of Major review. They considered that CRs consistently demonstrated three key skills: organisation, facilitation and communication, and gave their consistent and unqualified support for the whole Major review process.

425 Review teams were also frequently cited as the most positive feature of reviews by CRs, MRFs and PRFs. The CRs commented that the reviewers were 'cheerful and efficient', 'individually consistently effective' and 'highly professional and committed'. MRFs were impressed by the 'professional approach of the review teams', and the 'constructive attitude of the reviewers', while PRFs and placements commented on the 'dialogue and consistency of the review team', 'discipline of team', and 'friendly, approachable reviewers'.

426 Published reports provide a clear indication of the quality of healthcare education in England 2003 to 2006. They are a valuable chronicle of the richness and diversity of provision for the education and training of NMH and AHP students. The action plans they each contain are proving to be an increasingly effective tool for the promotion of ongoing quality enhancement.

427 Evidence confirms that Major review has worked well, particularly considering the complexity and breadth of the provision being reviewed. It is now a tried, tested and refined review methodology. This is in no small part due to the commitment and professionalism of the reviewers, the facilitators, and the CRs. The contribution of the partners and stakeholders with whom the QAA Health Team has worked over the contract period has also been invaluable.

428 This report has highlighted a wealth of invaluable learning points that should contribute significantly to any future QA processes. The Major review reports provide a robust baseline on which to found a risk-based and proportionate approach. It is hoped that the completion of Major review will not see the stalling in the impetus given to the strong partnerships developed between HEIs, SHAs, and practice placement providers that have underpinned Major review and facilitated the momentum for change, and that it will continue into the next iteration of the PQAF processes.

Appendix 1: Variations to contract

Variations to the Major review contract were introduced in February 2004 in the light of a lower than expected number of reviews due to take place over the whole review cycle. For 2003-04, the agreed variations were two editions of a QA newsletter (QA News for Healthcare Education), an annual trends report, a national conference, an investigative project into the existing QA processes of some key stakeholders and a consultation on the OQME and Approval processes. For 2004-05, the variations to contract were four editions of QA News, an annual review trends report, a second national conference, two student and service-user events, and the implementation and evaluation of the OQME and Approval prototypes. For 2005-06, the variations were a retreat event to consider the OQME and Approval prototype evaluation reports, three student and service-user events, a stakeholder conference to consider the outcomes of Major review, four editions of QA News and a third national conference.

For 2006-07, the variations were two editions of QA News and the production of the trends report. The first QA News ran to 7,500 copies, and the print run was increased to 10,000 for the second edition due to high demand and to increase dissemination in practice areas. QA News received positive feedback regarding the ease of access to its content and on the usefulness of this means of disseminating up-to-date information about developments in the partnership framework.

An investigative report was commissioned to provide the DH with an overview of the QA mechanisms for those professional healthcare organisations that fell within the remit of the PQAF. It focused upon: the legal status and powers of these organisations in undertaking their current QA activities, their expressed purpose, the activities themselves, the nature of annual monitoring and the type of data collected, their existing partnerships, any reference to DH requirements within their documentation and the source of funding for these activities. A confidential report was sent to the DH in March 2004.

The first national conference took place in April 2004, with the 300 delegates attending, rating the proceedings highly. Feedback for future conferences suggested a focus on the outcomes of the consultation process on the methods for approval and OQME. Places at the second national conference were increased to 500 due to high demand, were limited for each organisation, and a waiting list was put in place. Like the first, the second conference was a success, with 420 delegates attending. Responses to feedback activities numbered 246. The key message was that developments on the PQAF so far were positive but that further work was needed to refine and progress the framework. The third national conference, of a similar size to the previous year, focused on looking to the future, with a potentially expanded partnership, and a revised framework. Feedback from this event was also largely positive, but with calls for the momentum not to be lost in the interim year before the arrangements for the proposed framework were finalised.

The OQME and Approval consultation went live in March 2004 with four roadshows to promote the consultation in April. These were successful in attracting delegates and feedback responses. In total, 104 returns on the consultation were received. In response to a significant amount of helpful feedback, the OQME and Approval documentation was revised. A two-day briefing event took place in September 2004 in preparation for the prototypes. All partners received copies of the final OQME and Approval documentation and booklets. The Health Team organised a well-received facilitation forum in December 2004 in response to a request from the prototype sites. Observations of prototype activities generated a significant amount of data to be analysed and evaluated, along with questionnaire and focus group responses. The SfH also commissioned an external evaluator to produce a report on the prototypes. The QAA and external evaluations of the prototypes were published in September 2005. The two evaluations contained many shared messages.

Key messages included:

- practice staff who were enthusiastic about their involvement, with partnership working considerably enhanced as a result
- the number of standards which should be reduced and the language modified to be 'less academic'
- students and service users who should also be able to have a more direct involvement in the process.

A retreat event was held in October 2005 to discuss the evaluation findings among a wide range of stakeholders. A report of this event was published by SfH in November 2005.

Two student and service-user events were held in January and February 2005 to make these groups more aware of the purpose of the proposed PQAF and of the prototypes taking place. Attendance at, and feedback on, these events were positive. Three further student and service-user events took place in January to March 2006, and were more interactive, focusing on emerging models of involvement in the developing processes.

A stakeholder conference was held in March 2006 to discuss findings from Major review. This event was successful but feedback from delegates showed that they were keen to hear about the future developments rather than reflect on Major review. However, reflection on HEI and SHA experiences of Major review highlighted to delegates that their own experiences of the process were shared across many reviews, that there had been many positive outcomes from Major review, including real benefits to partnership working and engagement of practice staff, and that it set the baseline for all future QA activities.

Appendix 2: Analysis of judgements by type of provision

Report section	Judgement	Total number of reviews (90)	AHP only reviews (28)	NMH only reviews (22)	Mixed provision reviews (40)
Academic and practitioner standards	Confidence	90	27	22	39
	Differentiated judgement (confidence in all provision except…)	2	(1 review) No confidence: 1 occupational therapy programme		(1 review) Limited confidence: 1 clinical psychology programme
Learning and teaching	Commendable	87	27	21	39
	Approved in all provision	3	1	1	1
	Differentiated judgement (all commendable except…)	4	(1 review) Approved: 2 radiography programmes	(2 reviews) Approved: nursing programmes	(1 review) Approved: health visiting programme
Student progression	Commendable in all provision	89	28	21	39
	Approved in all provision	1		1	
	Differentiated judgement (all commendable except…)	10	(1 review) Approved: 1 paramedic science programme	(3 reviews) Approved: 1 midwifery 4 nursing programmes	(6 reviews) Approved: 1 occupational therapy 1 ODP 1 midwifery 4 nursing 1 radiography programmes
Learning resources and their effective utilisation	Commendable in all provision	86	25	22	39
	Approved in all provision	4	3		1
	Differentiated judgement (all commendable except…)	8	(2 reviews) Approved: 1 clinical psychology 1 ODP programmes	(1 review) Approved: 1 nursing programme	(5 reviews) Approved: 1 audiology 2 clinical psychology 1 physiotherapy 1 occupational therapy programmes

Appendix 3: Timeline for Major review

Start of review minus 8 weeks	Submission of SED and supporting documentation by HEI and WDC/SHA to the QAA
Start of review minus 7 weeks	SED and supporting documentation circulated to review team
Start of review minus 5 weeks	Review team read and analyse SED based on Annex D of the Handbook. Initial comments posted to QAA electronic folders. CR gathers initial comments for discussion at the preparatory meeting.
Start of review minus 4 weeks	CR holds preparatory meeting with relevant subject staff (HEI, Trusts and WDC/SHA), MRF, PRF. Clarification of boundaries, roles and arrangements Placements to visit for day 2 agreed and day 3 visits suggested
Evening before day 1	First review team meeting MRF/PRF can attend
Day 1 - Start of review	Team gathers evidence through: ● meetings with subject team ● meeting with students - identified by providers ● looking at documentation - notes of meetings, external examiners' reports, student work, student and programme handbooks etc ● looking at learning resources on campus. Review team meeting, MRF/PRF can attend
Day 2	Team gathers evidence through: ● visits to practice placements agreed at preparatory meeting ● for each visit reviewers pair up (from different disciplines) ● a practice placement form is completed. Review team meeting at the end of the day - debrief and identify agenda for day 3 and additional placements to visit, MRF/PRF can attend
Time between visits	Review team prepares commentaries
Evening before day 3	Review team meeting, MRF/PRF can attend
Day 3	Review team gathers evidence through: ● Visits to practice placements based on the end of day 2 discussion/documentation Review team meeting at the end of the day, MRF/PRF can attend
Day 4	Review team gathers evidence through: ● second student meeting, ● meeting with practice staff, ● meeting with WDC/SHA staff as applicable ● review of documentation Review team meeting at the end of the day - debrief, identify any issues outstanding, draft agenda for day 5, MRF/PRF can attend

Time between visits	Review team prepares initial draft of the Major review report (draft 0)
Day 5	Review team considers documentation or hold meetings to clarify any matters outstanding before holding judgements meeting CR (only) provides oral feedback to the providers on the judgements only
Day 5 plus 5 to 7 weeks	Major review report sent to HEI/SHA for comment on factual accuracy Action plan containing bullet points sent to HEI/SHA for completion
Day 5 plus 8 to 10 weeks	HEI/SHA returns Major review report with comments
Day 5 plus 18 weeks	HEI/WDC/SHA returns signed-off action plan to QAA
Day 5 +20 weeks Day 5 +20 weeks (+ 2 weeks)	Final review report and action plan published on QAA website Final review report published in hard copy

Note, during the report production process there is an iterative process of editing by the ECR and AD (Health) and proofing by the QAA Reports Team.

Appendix 4: A detailed analysis of themes identified in the bullet points

The following table identifies the distribution of key themes for each element in academic and practitioner standards and the quality of learning opportunities across strengths, good practice and weaknesses. The data is presented by type of provision: allied health professions (AHP) only, nursing, midwifery and health visiting (NMH only), or mixed provision where a review looked at both AHP and NMH programmes.

Academic and practitioner standards	Strengths		Good practice		Weaknesses		Total count	Percentage of element
Theme	AHP	NMH	AHP	NMH	AHP	NMH		
Intended learning outcomes (ILOs)								
ILOs are communicated effectively to staff, students and external examiners	18	13	4	2	6	7	50	33
ILOs reflect programme aims, external reference points and meet regulatory requirements	10	11	3	0	6	12	42	28
Stakeholders (SHAs, Trusts, service providers) are involved in devising ILOs	14	13	2	1	2	0	32	21
Students are achieving the ILOs	0	7	0	2	1	0	10	7
Students negotiate individual ILOs	2	2	1	0	1	1	7	5
Students and service users are involved in devising ILOs	2	2	0	0	1	1	6	4
ILOs address developments in IPL	1	0	0	0	1	1	3	2
Curricula								
SHAs and placement providers are appropriately involved in developing the curricula	51	47	10	8	5	2	123	24
The planning, design and approval process ensures the currency of the programmes	30	47	9	9	12	15	122	23
Curricular content and design are informed by developments in IPL	13	14	3	8	20	19	77	15
Service users and carers are involved in curricula design and delivery	7	21	3	3	11	6	51	10

Academic and practitioner standards	Strengths		Good practice		Weaknesses		Total count	Percentage of element
Theme	**AHP**	**NMH**	**AHP**	**NMH**	**AHP**	**NMH**		
The curricula equip students for self-critical lifelong learning	8	12	3	4	1	0	28	5
The curricula appropriately prepare students for placements	9	6	2	0	5	3	25	5
Curricular content and design are informed by changes in national policy, or relevant occupational or professional requirements	5	8	1	3	0	1	18	3
The curricular design, content and organisation enables students to achieve the ILOs	7	5	1	1	1	0	15	3
Curricular content and design are informed by current research and scholarship	6	4	0	1	1	2	14	3
The curricula are to meet PSRB requirements	6	4	0	1	0	1	12	2
Programme handbooks and related literature provide appropriate information	3	1	2	0	1	3	10	2
Links between theory and practice are promoted through effective learning and teaching methods	1	9	0	0	0	0	10	2
Links between theory and practice are promoted through effective placement opportunities	2	4	0	0	0	3	9	2
There is appropriate academic and intellectual progression within the curricula	5	1	1	0	0	1	8	2
Assessment								
Feedback to students is timely, of sufficient quality, and assists the formative development of students' abilities	18	21	1	4	39	36	119	23
A wide range of assessment methods are used, appropriate to the type and level of work	33	43	5	1	10	12	104	21
There is confidence in the integrity, security and consistency of assessment processes, including setting, marking, and moderating of work	12	23	0	8	29	19	91	18

Academic and practitioner standards	Strengths		Good practice		Weaknesses		Total count	Percentage of element
Theme	**AHP**	**NMH**	**AHP**	**NMH**	**AHP**	**NMH**		
Assessment strategies and procedures are applied consistently on campus and on placement	7	12	3	2	16	16	56	11
Academic and practice assessors are appropriately trained, updated and supported	7	11	2	3	6	14	43	8
Criteria enable assessors to distinguish between levels of achievement and are effectively communicated to staff and students	7	7	0	1	6	15	36	7
Practitioners and practice managers contribute to the development of assessment strategies	12	6	4	1	1	0	24	5
The assessment process enables students to demonstrate achievement of the ILOs	5	4	0	0	5	6	20	4
HEIs, SHAs and placement providers work together to ensure assessment strategies and procedures are effectively implemented	3	4	0	1	0	1	9	2
Assessment strategies enable students to develop critical reflection skills and prepare them for lifelong learning	1	1	2	0	1	0	5	1
Achievement								
Assessed work provides evidence of achievement of ILOs	15	15	0	1	3	4	38	28
Students are competent and fit for purpose	13	12	1	1	3	2	32	24
Standards achieved meet minimum expectations for the award	7	2	1	2	2	0	14	10
Statistics indicate successful progression to careers in relevant health professions or to further study	7	5	0	0	0	2	14	10
Statistics indicate high levels of progression and completion	8	4	0	0	0	0	12	9
Students are equipped for self-critical lifelong learning	4	2	1	0	0	0	7	5

Academic and practitioner standards	Strengths		Good practice		Weaknesses		Total count	Percentage of element
Theme	**AHP**	**NMH**	**AHP**	**NMH**	**AHP**	**NMH**		
HEIs, SHAs and placement providers work together to promote student achievement	5	2	0	0	0	0	7	5
Students are appropriately supported on placements	0	6	0	0	0	0	6	4
Students are prepared effectively for practice and meet PSRB requirements	2	1	0	0	0	1	4	3
Total count							**1,313**	

Quality of learning opportunities	Strengths			Good practice			Weaknesses			Total count	Percentage of element
Theme	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**		
Learning and teaching											
Effectiveness of learning opportunities in relation to programme aims and curriculum content, ensuring integration of theory and practice	27	20	24	4	6	3	6	6	9	105	24
Placements are varied and of sufficient number, and students are appropriately informed and supported	8	10	28	3	11	5	12	12	8	97	22
There is an interprofessional approach to supporting practice-based learning	6	9	10	1	1	3	7	3	9	49	11
There is effective management of learning opportunities, including placement audits	5	7	5	1	1	3	7	11	3	43	10
IT and other learning resources are used effectively to support learning and teaching	10	3	9	3	2	5		1	3	36	8
Partnership arrangements effectively support teaching and learning in academic and practice settings	6	7	8		1	2		1		25	6
Staff development activities, including induction, peer review and team teaching, promote effective teaching on campus and in practice	4	2	2	4	2		5	3	3	25	6
Student feedback is sought and acted upon appropriately	4	4	3	1	2		1	2	4	21	5
Staff scholarship, research and professional activity inform their teaching	4	3	8			1			1	17	4
The client/patient is at the centre of the students' learning experience	2	4	2		3	3			1	15	3
Student workloads effectively facilitate learning							1			1	0

	Strengths			Good practice			Weaknesses			Total count	Percentage of element
Theme	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**		
Student progression											
Strategies are in place to support students on campus and in practice	16	12	22	6	3	2	3	12	2	78	24
Strategies to support progression and reduce attrition are in place and are effective	17	9	9		3		10	12	5	65	20
There are effective arrangements for recruitment, admission and induction	23	14	13	2	2	1	2	2	1	60	19
Appropriate support for learning is provided, including academic support, supervision in practice, and health and safety	10	10	14	1	1	2	4	2	1	45	14
Practitioners and practice managers provide appropriate support and guidance for students with PSRB requirements	3	6	8			1	1	3	1	23	7
Students' special learning needs are appropriately accommodated	4	4	5		2	1	1		1	18	6
HEIs, SHAs and placement providers work together to ensure staff are enabled to provide the necessary support for students	2	4	6	1		2		1	1	17	5
Assessors are appropriately prepared and supported to conduct assessments and meet PSRB requirements	2	1	5				2	4		14	4
Learning resources and their effective utilisation											
There is appropriate provision of material resources, including teaching accommodation, IT, libraries and equipment	24	12	23	2	4	3	19	4	5	96	27
The expertise of academic and practice staff is suitable and available for the effective delivery of the curricula, assessment and achievement of the ILOs	19	11	17	2	4	1	12	12	8	86	24

	Strengths			Good practice			Weaknesses count			Total	Percentage of element
Theme	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**		
HEIs and placement providers ensure the appropriate provision, quality and consistency of placements	9	4	11	3		2	10	4	8	51	14
There is appropriate access for students to all available learning resources	2	8	8	2	2	3	9	3	6	43	12
There is clear and appropriate allocation of responsibilities between partners for securing and managing placement opportunities	3	2	10	4		2				21	6
There is appropriate allocation of resources to support and maintain practice-based learning opportunities	1	4	9			1	1	1		17	5
Students effectively utilise learning resources available to them	2	5	3	2		1			3	16	5
Strategies are in place for the provision and deployment of learning resources on campus and in placements	2	2	7			1			1	13	4
Appropriate technical and administrative support is available	4	4	1			1	1			11	3
Total count										**1,108**	
Maintenance and enhancement of standards and quality											
There are positive and effective working relationships between all partners and stakeholders	22	16	28	1	4		4	2	1	78	29
Internal QA mechanisms in both campus and practice areas are in place and are effective	13	10	19	3	3	1	7	7	12	75	28
There is effective collection, use and evaluation of quantitative data and qualitative feedback from students, external examiners and other stakeholders	8	5	10				6	8	8	45	17

	Strengths			Good practice			Weaknesses			Total count	Percentage of element
Theme	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**	**AHP**	**NMH**	**Mixed**		
Evaluation of data and feedback is used effectively to improve the provision	6	4	6	2	1	1	6	2	5	33	12
Internal review, annual monitoring and audit processes are used to enhance the provision	5	4	8	1	1	1	2	1	3	26	10
The expectations set out in the relevant sections of the Code of practice for the											
assurance of academic quality and standards in higher education[31] are being met							1	2	2	5	2
External reference points are appropriately utilised	1		1							2	1
Management information is accessible and used effectively			1							1	0
Total count										**265**	

[31] Code of practice is published by QAA as part of the Academic Infrastructure and available on the QAA website at http://www.qaa.ac.uk/academicinfrastructure/default.asp

Appendix 5a: List of Major reviews (2003 to 2006) by HEI

HEI (current title)	Review date	Lead SHA (prior to 2006 reconfiguration)
Anglia Ruskin University/ Colchester Institute	Summer 2006	Essex
Anglia Ruskin University	Summer 2006	Essex
Aston University/Matthew Boulton College of Further and Higher Education		Autumn 2005 Birmingham and the Black Country
Bedfordshire, University of (formerly the University of Luton)	Summer 2005	Thames Valley
Birmingham, University of	Spring 2006	Birmingham and the Black Country
Bolton,The University of	Spring 2005	Cheshire and Merseyside
Bournemouth University	Summer 2005	Dorset and Somerset
Bradford, University of	Summer 2004	West Yorkshire
Brighton, University of/ Crawley College	Autumn 2004	Surrey and Sussex
Brighton, University of	Spring 2005	Surrey and Sussex
Brunel University	Spring 2006	North East London
Buckinghamshire Chilterns University College	Autumn 2005	North West London
Canterbury Christ Church University	Autumn 2005	Kent and Medway
Canterbury Christ Church University	Spring 2006	Kent and Medway
Central England in Birmingham, University of	Summer 2006	Birmingham and the Black Country
Central Lancashire, University of	Autumn 2005	Cumbria and Lancashire
Chester, University of	Spring 2006	Cheshire and Merseyside
City University	Summer 2006	North East London
Coventry University	Spring 2006	West Midlands South
Coventry University	Summer 2006	West Midlands South
De Montfort University/The Peoples College Nottingham	Summer 2006	Leicestershire, Northamptonshire and Rutland
Derby, University of	Autumn 2005	Trent
East Anglia, University of	Spring 2006	Norfolk, Suffolk and Cambridgeshire
East Anglia, University of	Summer 2006	Norfolk, Suffolk and Cambridgeshire
East London, University of	Spring 2006	South East London
Edge Hill University	Autumn 2004	Cheshire and Merseyside
Essex, University of	Autumn 2004	Essex

Exeter, University of	Autumn 2006	South West Peninsula
Gloucestershire, University of	Autumn 2004	Avon, Gloucestershire and Wiltshire
Greenwich, University of	Spring 2005	South East London
Hertfordshire, University of	Spring 2005	Bedfordshire and Hertfordshire
Hertfordshire, University of	Summer 2005	Bedfordshire and Hertfordshire
HSHS (formerly Homerton School of Health Studies)	Autumn 2005	Norfolk, Suffolk and Cambridgeshire
Huddersfield, University of	Autumn 2005	West Yorkshire
Hull, University of	Spring 2004	North and East Yorkshire and Northern Lincolnshire
Hull, University of	Summer 2006	North and East Yorkshire and Northern Lincolnshire
Keele, University of	Spring 2005	Shropshire and Staffordshire
King's College London	Spring 2005	North West London
King's College London	Autumn 2005	South East London
Kingston University/St George's Hospital Medical School	Autumn 2003 (prototype review)	South West London
Kingston University/St George's Hospital Medical School	Autumn 2004	South West London
Lancaster, University of	Autumn 2004	Greater Manchester
Leeds, University of	Spring 2005	West Yorkshire
Leeds Metropolitan University	Summer 2005	West Yorkshire
Leicester, University of	Summer 2005	Leicestershire, Northamptonshire and Rutland
Lincoln, University of	Summer 2004	Trent
Liverpool, University of	Spring 2005	Cumbria and Lancashire
Liverpool John Moores University	Summer 2005	Cheshire and Merseyside
London, University College	Summer 2005	North West London
London Metropolitan University	Spring 2006	North Central London
London South Bank University	Spring 2006	South West London
London South Bank University	Summer 2006	North East London
Manchester, University of	Autumn 2005	Greater Manchester
Manchester Metropolitan University, The	Summer 2005	Greater Manchester
Middlesex University	Summer 2004	North Central London
Newcastle upon Tyne, University of	Autumn 2005	Northumberland, Tyne and Wear
Northampton, University of	Autumn 2003 (prototype review)	Leicestershire, Northamptonshire and Rutland

Northumbria at Newcastle, University of	Spring 2006	Northumberland, Tyne and Wear
Nottingham, University of	Summer 2006	Trent
Open University	Spring 2006	West Yorkshire
Oxford, University of	Summer 2004	Thames Valley
Oxford Brookes University	Autumn 2005	Thames Valley
Oxford Brookes University	Autumn 2005	Thames Valley
Plymouth, University of	Autumn 2003 (prototype review)	South West Peninsula
Plymouth, University of	Summer 2004	South West Peninsula
Portsmouth, University of	Spring 2005	Hampshire and Isle of Wight
Reading, University of	Summer 2005	Thames Valley
Royal Holloway, University of London	Autumn 2005	North Central London
Salford, University of	Autumn 2004	Greater Manchester
Sheffield, University of	Spring 2005	South Yorkshire
Sheffield, University of	Spring 2006	South Yorkshire
Sheffield Hallam University	Autumn 2003 (prototype review)	South Yorkshire
Southampton, University of	Autumn 2005	Hampshire and Isle of Wight
Southampton, University of	Spring 2006	Hampshire and Isle of Wight
St Mark and St John, The College of	Summer 2004	South West Peninsula
St Martin's College	Spring 2005	Cumbria and Lancashire
Staffordshire University	Autumn 2005	Shropshire and Staffordshire
Suffolk College	Summer 2005	Norfolk, Suffolk and Cambridgeshire
Sunderland, University of/ New College Durham and Gateshead College	Autumn 2005	County Durham and Tees Valley
Surrey, University of	Autumn 2005	Surrey and Sussex
Surrey, University of	Summer 2006	Surrey and Sussex
Teesside, University of	Autumn 2003 (prototype review)	County Durham and Tees Valley
Teesside, University of	Summer 2004	County Durham and Tees Valley
Thames Valley University	Spring 2005	North West London
West of England, Bristol University of the	Autumn 2005	Avon, Gloucestershire and Wiltshire
Winchester, University of	Autumn 2006	no lead SHA

Wolverhampton, University of	Summer 2005	Birmingham and the Black Country
Worcester, University of	Autumn 2003 (prototype review)	West Midlands South
York, University of	Summer 2004	North and East Yorkshire and North Lincolnshire
York St John University	Summer 2004	North and East Yorkshire and North Lincolnshire

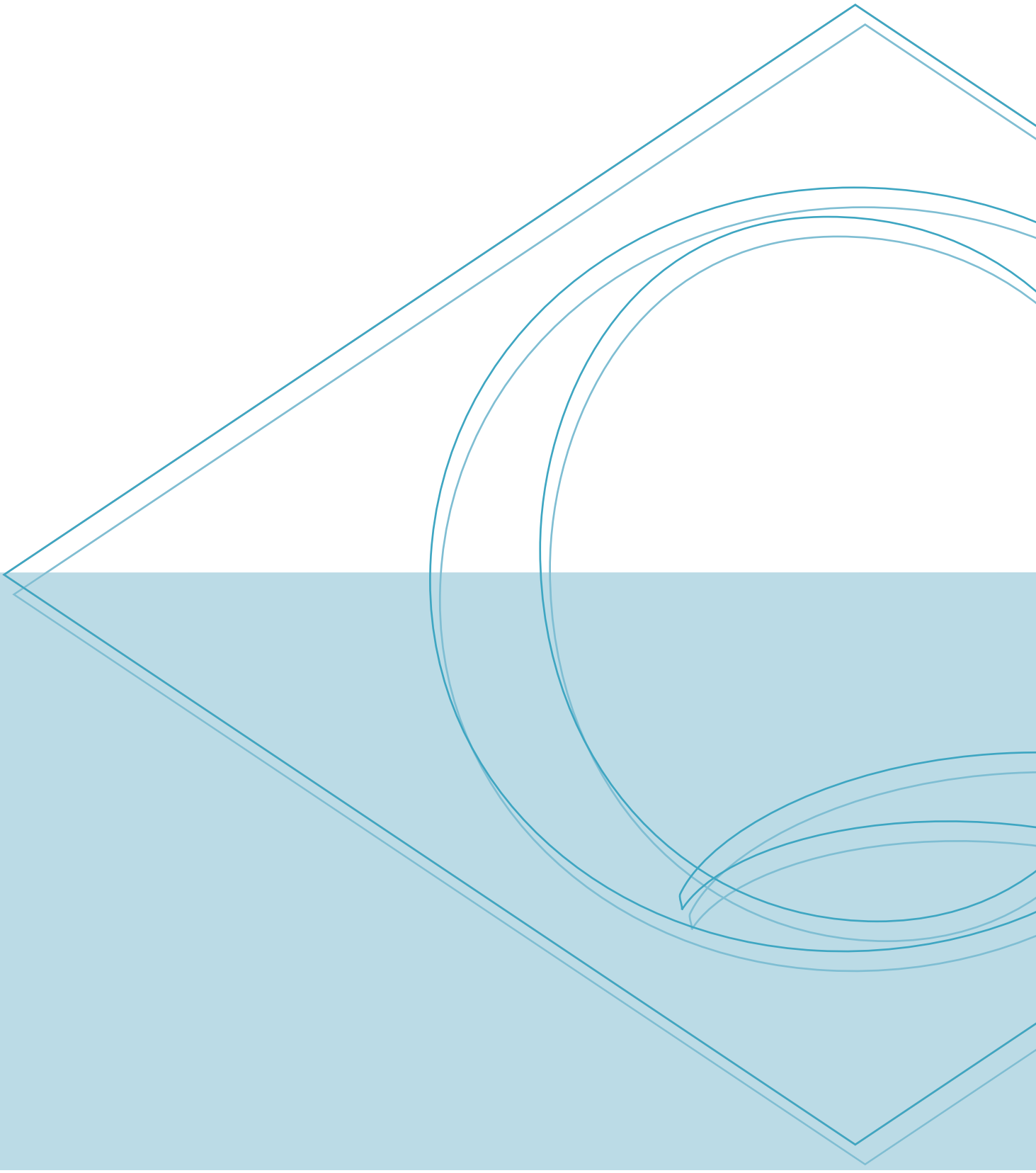
Appendix 5b: List of Major reviews by lead SHA

Lead SHA (prior to 2006 reconfiguration)	HEI	Review date
Avon, Gloucestershire and Wiltshire	Gloucestershire, University of the West of England, Bristol University of	Autumn 2004 Autumn 2005
Bedfordshire and Hertfordshire	Hertfordshire, University of Hertfordshire, University of	Spring 2005 Summer 2005
Birmingham and the Black Country	Wolverhampton, University of Aston University/Matthew Boulton College of Further and Higher Education Birmingham, University of Central England in Birmingham, University of	Summer 2005 Autumn 2005 Spring 2006 Summer 2006
Cheshire and Merseyside	Edge Hill University Bolton, The University of Liverpool John Moores University Chester, University of	Autumn 2004 Spring 2005 Summer 2005 Spring 2006
County Durham and Tees Valley	Teesside, University of (prototype review) Teesside, University of Sunderland, University of/ New College Durham and Gateshead College	Autumn 2003 Summer 2004 Autumn 2005
Cumbria and Lancashire	Central Lancashire, University of Liverpool, University of St Martin's College	Autumn 2005 Spring 2005 Spring 2005
Dorset and Somerset	Bournemouth University	Summer 2005
Essex	Essex, University of Anglia Ruskin University/ Colchester Institute Anglia Ruskin University	Autumn 2004 Summer 2006 Summer 2006
Greater Manchester	Lancaster, University of Salford, University of Manchester Metropolitan University, The Manchester, University of	Autumn 2004 Autumn 2004 Summer 2005 Autumn 2005
Hampshire and Isle of Wight	Portsmouth, University of Southampton, University of Southampton, University of	Spring 2005 Autumn 2005 Spring 2006
Kent and Medway	Canterbury Christ Church University Canterbury Christ Church University	Autumn 2005 Spring 2006
Leicestershire, Northamptonshire and Rutland	Northampton, University of (prototype review) Leicester, University of De Montfort University/The Peoples' College Nottingham	Autumn 2003 Summer 2005 Summer 2006

Norfolk, Suffolk and Cambridgeshire	Suffolk College HSHS College (formerly Homerton School of Health Studies) East Anglia, University of East Anglia, University of	Summer 2005 Autumn 2005 Spring 2006 Summer 2006
North and East Yorkshire and Northern Lincolnshire	Hull, University of York, University of York St John University Hull, University of	Spring 2004 Summer 2004 Summer 2004 Summer 2006
North Central London	Middlesex University Royal Holloway, University of London London Metropolitan University	Summer 2004 Autumn 2005 Spring 2006
North East London	Brunel University London South Bank University City University	Spring 2006 Summer 2006 Summer 2006
North West London	King's College London Thames Valley University University College London Buckinghamshire Chilterns University College	Spring 2005 Spring 2005 Summer 2005 Autumn 2005
Northumberland, Tyne and Wear	Newcastle upon Tyne, University of Northumbria at Newcastle, University of	Autumn 2005 Spring 2006
Shropshire and Staffordshire	Keele, University of Staffordshire University	Spring 2005 Autumn 2005
South East London	Greenwich, University of King's College London East London, University of	Spring 2005 Autumn 2005 Spring 2006
South West London	Kingston/St George's Hospital Medical School (prototype review) Kingston/St George's Hospital Medical School London South Bank University	Autumn 2003 Autumn 2004 Spring 2006
South West Peninsula	Plymouth, University of (prototype review) Plymouth, University of St Mark and St John, The College of Exeter, University of	Autumn 2003 Summer 2004 Summer 2004 Autumn 2006
South Yorkshire	Sheffield Hallam University (prototype review) Sheffield, University of Sheffield, University of	Autumn 2003 Spring 2005 Spring 2006
Surrey and Sussex	Brighton, University of/Crawley College Brighton, University of Surrey, University of Surrey, University of	Autumn 2004 Spring 2005 Autumn 2005 Summer 2006

Thames Valley	Oxford, University of Bedfordshire, University of (formerly University of Luton) Reading, University of Oxford Brookes University Oxford Brookes University	Summer 2004 Summer 2005 Summer 2005 Autumn 2005 Autumn 2005
Trent	Lincoln, University of Derby, University of Nottingham, University of	Summer 2004 Autumn 2005 Summer 2006
West Midlands South	Worcester, University of (prototype review) Coventry University Coventry University	Autumn 2003 Spring 2006 Summer 2006
West Yorkshire	Bradford, University of Leeds, University of Leeds Metropolitan University Huddersfield, University of Open University	Summer 2004 Spring 2005 Summer 2005 Autumn 2005 Spring 2006

* Note, The University of Winchester (autumn 2006) did not, due to spot purchasing arrangements, have a lead SHA.



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