



# Quality assurance for nursing and midwifery education: an analysis of the approach in England

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The main purpose of this paper is to discuss conceptual and policy developments for external quality assurance for nurse and midwifery education in England. The current framework was implemented in the academic year 1998/99, and is the subject of a three year evaluation commissioned by the English National Board for Nursing, Midwifery & Health Visiting (ENB). The methods which are being used to evaluate the quality assurance arrangements will be discussed within the context of nursing and midwifery education and practice. The ultimate aim of professionally accredited nursing and midwifery education is to ensure the development of practitioners who are fit for purpose, practice and award. It follows that the quality assurance processes should have the capacity to demonstrate the extent to which professional education meets this aim. This paper will discuss this issue, with particular emphasis on the collaborative review process which is being undertaken by the Quality Assurance Agency and the statutory body for nursing, midwifery and health visiting education. The paper concludes with a discussion of the changes proposed by the government for nursing and midwifery education, and considers the potential impact for quality assurance of health care education.

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## Introduction

The main purpose of this paper is to discuss conceptual and policy developments for external quality assurance for nurse and midwifery education in England. The current framework was implemented in the academic year 1998/99, and is the subject of a three year evaluation commissioned by the English National Board for Nursing, Midwifery & Health Visiting (ENB).

The paper will focus primarily on nursing and midwifery education as the move into higher education is one of the main issues which has affected the development of the quality assurance processes, particularly in relation to the outcomes for initial professional registration. Health

visiting education, although subject to similar quality assurance processes, is concerned solely with a post-registration qualification, and has traditionally been located within the aegis of further/higher education. Health visiting education will therefore only be included within this paper in broad terms in relation to the quality assurance framework which is being implemented nationally for all three disciplines of nursing, midwifery and health visiting. In addition, the paper will not specifically address the quality assurance processes which are in place in the other countries of the UK, (Scotland, Wales, Northern Ireland), as they each have their own statutory frameworks as determined by the relevant National Board.

However, as nursing and midwifery education and practice in the UK are ultimately subject to the regulatory process of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), there will inevitably be issues of commonality across the UK; and the wider mechanisms for the quality assurance of higher education within the UK will also apply (see Quality Assurance Agency 1999).

The methods which are being used to evaluate the quality assurance arrangements will be discussed within the context of contemporary policy developments in nurse education and practice, with the key focus on quality assurance in nurse *education*, not professional practice (although there should inevitably be a relationship between these processes).

The National Health Service (NHS) in the United Kingdom has undergone substantial change within the past 15 years. The drivers behind change have been: efficiency, accountability and a renewed emphasis on meeting patient/customer needs. Reform was initiated by the then Conservative government as part of wider plans to fundamentally alter the relationship between government and public services. It was the view of the government of that time that much public sector activity offered poor value for money, was insufficiently accountable to stakeholders, and was primarily provider rather than client oriented. There was also a desire to contain the ever-increasing pull of public services on public funds (or even reduce reliance upon public funds in the first place).

The way forward was seen to be a complicated mix of marketisation (to various degrees) and increased regulation of public services (e.g. Department of Health and Social Security 1983, 1989; Department of Health 1990). Since 1997 the new Labour government has been outlining its vision for the future of the NHS, which has included the abolition of the internal market, which is to be replaced with a system of 'integrated care, based on partnership and driven by performance' (Department of Health [DOH] 1997).

The word 'quality' is often key to rationalizing such developments (i.e. to stress 'efficiency' over 'cost-cutting'), with quality being described by the current government as the 'driving force of decision making at every level of service' (DOH 1997).

## Developments in nursing and midwifery education

Nursing and midwifery practice and education have been the focus of much debate and change during the time the NHS reforms have been ongoing throughout the 1980s and 1990s. The history of nursing can be viewed as a continual process of rethinking the role of the professional nurse – from kindly presence at one extreme, to formally trained, highly skilled, clinically adept professional at the other. Recent years have seen the process of professionalization gather apace, and the language of quality assurance is now firmly a part of nursing practice (Marr & Giebing 1994).

The Judge Report (RCN 1985) concluded that the link between nurse education and nurse employment was problematic. Too often student nurses were found to be utilized as cheap NHS labour (above and beyond notions of professional practice as part of an educational programme). This situation was linked to student wastage rates which were found to be unacceptably high (such a state of affairs had been well-known for some time, e.g. RCN/NCN, 1964). The report recommended that nurse education be moved into the mainstream of higher education, thus placing educational control in the hands of independent educationists rather than educationists employed in schools of nursing tied to the then District Health Authorities (DHAs), and changing the status of trainee nurses from NHS employees to bursaried students (on a par with other trainee professionals).

Project 2000, as developed by the UKCC, took the professionalization process further when it got underway in the 1980s. The UKCC put forward a vision of the nursing profession without the (lower) level Grade 2 (enrolled) nurses, and concentrated instead on a single level of pre-registration education (to be increasingly at degree rather than diploma level), and the promotion of new post-registration qualifications for nurses with particular specialist or managerial roles. The UKCC also set out requirements for regular Continuing Professional Development (CPD) on the part of all practising nurses, midwives and health visitors – developed in the Post-Registration Education & Practice initiative (PREP) (UKCC 1995).

The Government accepted the UKCC proposals for pre-registration nursing and midwifery education (after much internal politicking, e.g. the recommendation of the Peat Marwick McLintock [1989] report that the four National Boards should take over full responsibility for funding and managing schools and colleges of nursing and midwifery), and the move into higher education was agreed. From 1992, the NHS Management Executive encouraged Regional Health Authorities (RHAs) to facilitate the integration of schools of nursing and higher education institutions (HEIs), and in 1996 the last School of Nursing and Midwifery achieved integration.

Humphreys (1996) has argued that this shift into higher education allowed the aspirations of the nursing profession to be fulfilled, while at the same time (following *Working Paper 10: Education & Training* [DOH 1989] and later developments) including nurse education as part of the NHS internal market. Regional Health Authorities were charged to select education providers on the basis of various criteria, and commission nurse education on a limited contractual basis. The process of contracting non-medical education and training from the HEIs has continued apace, and locally based education and training consortia are now in place nationwide, largely with devolved responsibility from RHAs to purchase nursing, midwifery and health visiting education on behalf of the NHS.

It is important to note that this path to greater professionalization has not been accepted entirely without comment. For example, the nursing literature is replete with debates concerning the value or otherwise of functional analysis/competence and National Vocational Qualifications (NVQ), e.g. Ashworth & Morrison 1991. Such an approach stresses the core competencies of nursing practice and demands far greater advance written specification of the nursing role and relies less on the professional judgement of individuals. Project 2000 has been criticized as overly theoretical in scope, and reference has been made to the 'professional preciousness' of many in the nursing profession in their rejection of competence as overly narrow and conservative (Storey 1998). Other issues relate to claims that nurse educators in higher education are out of touch with day-to-day NHS management (Clifford 1999) and the charge that the professionalization ambitions of Project 2000

fail to socialize nursing students for the alleged continuing second-class status of nurses in the NHS (Casey 1996).

It is interesting to note at this point the recent changes which are being proposed by the government (DOH 1999) and the UKCC (UKCC 1999b). Of particular interest in the light of the above discussions is the move towards a competency based outcomes approach to pre-registration nurse education, with agreed outcomes for the end of each year of the three year programme in England (DOH 1999). The first draft of 'examples of outcomes' for the end of year one of the pre-registration nurse education programme were published in a Health Service Circular (1999/219), and are based on NVQ competencies – thus raising questions about concerns which have previously been voiced by some commentators that official prescriptions for professionalization are often in tension with the development of students as critical individuals (Purdy 1994). The critical issue for nurse educationists and practitioners relates to the extent to which such a framework will facilitate the development of practitioners who will be fit for practice within the broad context of the professional role of the nurse.

### **Developments in quality assurance processes for nursing and midwifery education**

Quality assurance in nurse education displays many similarities with quality assurance in higher education generally (e.g. the activities which make up a higher education experience such as teaching methods, assessment, student support mechanisms and resources; and academic expectation and student attainment). However, there are also a number of important differences. As education in preparation for professional practice, nurse education has always been subject to some form of professional oversight. The emergence of nursing and midwifery as professions in the nineteenth century was enabled precisely through the promotion of various criteria to attempt to standardize nurse education and practice.

A national register for nurses, following various voluntary and localized attempts to introduce professional discrimination, was first instituted under the 1919 Nurses Act (although the first piece of national legislation concerning

midwives came into force in 1902). This began a long struggle (continuing to this day) between government and profession over control of nursing. For example, the Royal College of Nursing (founded in 1916) desired stricter entry criteria than government.

In 1972, the Briggs Committee recommended the formation of a single statutory body for nursing. After much delay, 1979 saw the Nurses, Midwives and Health Visitors Act involving a rationalization of the various nursing and midwifery statutory bodies and the creation of the UKCC and the four national boards.

The UKCC was charged with establishing and improving the standards for nurse education and professional practice and keeping a national register of qualified nurses, midwives and health visitors. The national boards were given responsibility for approving institutions wishing to educate nurses, midwives and health visitors, and the programmes of study involved. A review of the 1997 Nurses, Midwives and Health Visitors Act has recently been conducted and it was recommended that the UKCC and the national boards merge in some form with a view to a more streamlined and less complex system of statutory oversight (including the joining of the functions of educational standard setting and implementation). The details of such a move are now being considered (UKCC 1999).

The development of the current system of external quality assurance must be placed in the context of the process of enhanced professionalization and shift of nurse education into higher education outlined above-plus the general climate of increased demands for accountability from public services, and the impact of the internal market in health care and education.

In one sense, nurse education today is subject to less statutory regulation than in the past. The UKCC, unlike one of its predecessors the General Nursing Council, does not set syllabi. Initially the 1983 Nurses, Midwives and Health Visitors Rules Approval Order (partly developed by the newly formed statutory bodies - and containing a short list of nursing competencies) formed the basis upon which UKCC standards, institutional curricula and ENB audit were built. European Community (EC) directives on cross-European standards for professional education/ practice in nursing (in the context of freedom of movement clauses in EC law) and the policy on quality

assurance of the International Council of Nurses (ICN 1985) were also taken into account. The ICN identified the overriding purpose of the statutory regulation of nursing as service to the public and protection of the public.

Alongside government demands, the rapid shift of nurse education into higher education, complicated external quality assurance still further. In 1993 the Higher Education Quality Council (HEQC) and NHS Executive began a review of how external quality assurance of nurse education might be rendered more streamlined and effective, while still meeting the needs of the various stakeholders. A report, *Improving the Effectiveness of Quality Assurance Systems in Non-Medical Health-Care Education and Training* (HEQC/NHE), was published in 1996. It was recommended that the statutory bodies, HEQC, the NHS Executive and Committee for Vice-Chancellors and Principals (CVCP) sign up to a 'core quality specification covering those areas where there is a shared need for evidence' (HEQC/NHSE 1996 p5). This specification was divided into 19 input, process and output issues (e.g. management, staff development, curriculum and student performance and progression (pp7-11).

In the light of the HEQC/NHSE work, and the subsequent creation of the Quality Assurance Agency (and the decision that it should review all provision, even if funded by the DOH), and in response to wider changes affecting nursing practice and education, the ENB undertook a review of its activities. The end result, following extensive consultation, was the publication of the ENB's *Quality Assurance Manual* (1998) in which its Quality Assurance Framework (QAF) is outlined. The QAF adheres to the general recommendation of the HEQC/NHSE report that there should be a rationalization of the evidence HEIs are required to produce to satisfy external stakeholders regarding quality, and that quality is a matter of input, process and outcome. The QAF was implemented in all HEIs in England from October 1998, and incorporates the requirement of institutional approval for any HEI wishing to offer nursing, midwifery or health visiting education.

A key element of changes embodied in the QAF is the removal of the fixed period of approval for a programme. A central feature of the new framework is annual monitoring and



review (AMR) at existing programme level (with more reliance being placed on internal HEI validation processes [ENB 1998 p51]). In respect of AMR, the Designated Education Officer (DEO – an ENB representative who leads the process on behalf of the ENB) is charged to produce a report to the ENB and feedback for the HEI. A system of quinquennial reviews is in place for re-approval at institutional level consisting of HEI self-assessment report, visit by DEO/peer review team, perhaps observation of teaching and learning, and AMR evidence gathered over preceding years plus formal structured feedback to the HEI (ENB 1998 p9). The emphasis on the gathering of the *evidence* to inform decision making is one of the key principles underpinning the QAF. The ENB will review all reports and publish an overview of national strengths and weaknesses.

### Process for determining the quality of nursing and midwifery education

As part of its review of the quality assurance process, the ENB reviewed its former regulations and guidelines document, which led to the development of 18 standards (ENB 1997). The standards have been formulated using a systems approach designed to capture the complexity of inter-related processes within HEIs which relate to nursing, midwifery and health visiting education. The headings used follow those in the core quality specification contained in the report *Improving the Effectiveness of Quality Assurance Systems in Non-Medical Health Care Education and Training* (HEQC/NHE 1996). The ENB proposed this approach in order to facilitate the implementation of the core quality specification by HEIs and education consortia, and reduce duplication. Each standard has a set of associated criteria, and the standards have been developed to take account of all 'aspects of human, physical and learning resources, which are necessary for the creation of a stimulating teaching/learning environment' (ENB 1997).

The standards form a core element of the QAF as they have been categorized for application and assessment within approval of the HEI, approval of the programme, annual monitoring and review, and quinquennial review/re-approval of the institution. Institutions are required to provide *evidence* to demonstrate that specified

standards have been met prior to approval (and in order to retain approval), of the HEI and programmes. (For example, in order to obtain approval for a new programme, standards 8–12 must be met. These broadly relate to the quality of practice experience, lecturers' involvement in practice, student admission procedures, curriculum design and development, and assessment.) The final standard, 18, relates to the extent to which educational provision leads to the ultimate achievement of fitness for purpose, practice and award.

One of the issues which has, and continues to, generate much debate amongst the range of stakeholders for nursing, midwifery and health visiting education is the process by which it will be determined whether the standards have been met; in particular, the balance between qualitative and quantitative judgements. These debates mirror those which are already well rehearsed within the higher education sector. In essence, the debate focuses around the extent to which complex social phenomena can be adequately represented in numerical terms, or how complex data are judged.

The extreme example of the quantitative approach in higher education is the 'league table' whereby HEIs are ranked against various 'indicators of quality'. Examples of such indicators may include library spending per student, or student retention rates. The challenge to this approach arises from the relationship between such indicators and outcomes of the education process, such as student achievement, or the extent to which they are fit for purpose and practice on qualifying from the course. Direct links between complex factors within the education process may not be accessible to simple measurement.

Furthermore, there may be a range of factors which will impact on the provision offered at local level by HEIs, including available resources, and ease of recruiting students with a strong educational profile, which may well vary widely across the country, having a potential effect on the outcomes of the education provided.

One quantitative approach which is well known within the HEI sector is the graded profile awarded to the HEI following the QAA Subject Review process (SR). A grade between 1 and 4 (where 1 denotes the lowest and unacceptable level of provision) is awarded for each of the six aspects of provision which are reviewed within

the SR process: Curriculum, Design, Content and Organization; Teaching, Learning and Assessment; Student Support and Guidance; Learning Resources; Student Progression and Achievement; Quality Management and Enhancement. It is not part of the QAA methodology to aggregate the grades from each of the six aspects of provision, but all of us who are associated with higher education provision are familiar with the widespread use of aggregate scores, both by HEIs and others associated with the sector, such as employers.

There has been a long (and continuing) struggle between the QAA and the CVCP about the continuation, or otherwise of a graded profile within the post Dearing revised QAA methodology (Baty 1999). This debate clearly has resonances for the approach adopted for assuring professional health care education which is based within the higher education system.

Of particular relevance is the proposal of the ENB to consider both qualitative and quantitative approaches to assessing the extent to which the standards have been met (ENB 1998). It is proposed that over time 'benchmark' standards will emerge, where benchmarking is defined as 'the identification of a level of best performance and is characterized by a commitment to achievable measurable continuous improvement through a desire to learn from the best' (ENB 1998).

There will be a pilot process for considering the quantitative approach, which will include an evaluation of the award of a grade for each standard. This approach is being adopted as the ENB has agreed in principle to work towards the implementation of a valid and reliable system of grading the standards in the light of:

- (a) the need to have a transparent and reliable means by which to judge the extent to which a standard has been met
- (b) the importance to the Board (ENB) and to all stakeholders in NHS and higher education of obtaining a national overview annually on performance against the standards (ENB 1998).

The pilot process which is being undertaken will be included within the Evaluation of the Implementation of the Quality Assurance Framework, which will consider the range of issues related to the assessment of the standards, (including potential advantages and disadvantages of the quantitative method), and

their impact within the broader quality assurance frameworks within higher education. (Further information regarding the evaluation is included below).

The need to develop and implement a strategy to work collaboratively with other agencies was one of the aims of the ENB when developing the Quality Assurance Framework. In this respect, the ENB and QAA have worked together over a period of some years to agree a collaborative approach to the Annual Monitoring and Review and Subject Review processes (AMR/SR). The review processes are similar in many respects, with the standards which are assessed within the AMR process being developed to fit within the six aspects of provision which form the core of the SR process. The main difference between the two processes is that the Subject Review only takes place once every five years, whereas AMR is a continuous process of monitoring and review in which 20% of the programmes offered by the HEI are considered by the designated ENB Education Officer each year. In the year when the Subject Review is undertaken, the main data collection for AMR in that year is undertaken at the same time as the Subject Review. During the academic years 1998/1999, and 1999/2000, all HEIs in England which provide nursing, midwifery or health visiting education will be having a collaborative review visit from the QAA and the ENB.

It is perhaps important at this stage to note that nursing, midwifery and health visiting education will continue to be subject to the national frameworks for quality assurance as determined by the QAA. In this respect, current collaboration between the statutory professional organization (the yet to be formed UK Council) and the QAA will need to be reviewed once nurse education becomes subject to the QAA's post-Dearing quality assurance framework, which will include Subject Benchmarking (QAA 1999). Threshold standards will be set in respect of student attainment on graduation (it has yet to be decided how sub-degree provision will be managed. This will continue to be an important issue for nursing and midwifery education in the light of current plans to have defined competencies to be attained by the end of the first year of pre-registration nurse education, and to have more formally managed 'stepping on and off points' during the education process [DOH 1999, UKCC 1999]).

The ultimate aim of professionally accredited nursing and midwifery education is to ensure the development of practitioners who are fit for purpose, practice and award (ENB 1998). It follows that the quality assurance processes should have the capacity to demonstrate the extent to which professional education meets this aim.

It is for this reason that the Quality Assurance Framework will be the subject of a three year evaluation which is currently underway. The next section will briefly discuss the aims and methods of the evaluative process, and conclude with some thoughts on issues which will need to be considered in the light of planned changes to the frameworks for nursing and midwifery education.

### Evaluation of the implementation of the Quality Assurance Framework

The three year evaluation (1999–2001) has been commissioned by the ENB, and is supported in principle by the QAA.

The following aims have been identified for the evaluation:

- Effectiveness of the preparation of all stakeholders for the implementation of the standards within the QAF
- Effectiveness of the standards as audit tools for assessment of educational quality
- Validity and reliability of the data collection methods in each section of the framework
- Validity and reliability of the grading matrix
- Perceptions of key stakeholders regarding the implementation of the standards and the framework
- Effectiveness of the process and outcomes of collaborative Annual Monitoring and Review with Subject Review.

In order to provide comprehensive information in relation to the aims outlined above, a multi-method approach is being used including: the collection of national datasets regarding the extent to which standards are assessed as having been achieved; survey data from the range of stakeholders (including HEIs, NHS staff, consortia, students, professional and statutory bodies) regarding implementation of all aspects of the QAF; in-depth information from eight case study sites including observation of the

collaborative AMR/SR process; a pilot of the approach used to grade the standards in a sample of HEIs across England.

This range of approaches will allow for many of the issues discussed in this paper regarding the quality assurance processes to be investigated. It will be of particular interest to consider the extent to which the national quality assurance processes are appropriate for programmes of professional education, and have the capacity to encompass the changing context for education which has been set out for the new millennium.

For example, the current QAA methodology is primarily focused towards the direct review of the theoretical component of teaching (classroom teaching is observed by the reviewers) whereas 'indirect' methods of data collection for the teaching of practice are used (e.g. the use of audit trails, reference to ENB reports, questioning of students and practice placement staff). As there is a requirement for pre-registration nursing and midwifery programmes of education to have equal emphasis on the teaching and assessing of theory and practice, questions may be raised in relation to a review system which uses differential review methods for these components.

In addition, current systems of quality assurance have tended to focus on 'complete courses/programmes', and the associated processes and outcomes. In the light of proposed changes for nursing education, there will be a requirement to identify specific outcomes which are to be attained part-way through a course of study (e.g. at the end of the common foundation programme, and subsequently at the end of each year of study).

Other complexities will arise as changes are implemented, such as the more formal management of 'stepping on and off' points whilst completing a programme of study, and the need to take account the needs and achievements of students from a much wider entry gate (DOH 1999). This will inevitably increase the need for considering issues such as the 'distance travelled by the student' (a student with no formal qualifications who achieves a diploma qualification may be considered to have achieved at a greater level than one who achieves an honours degree following entry to the programme of study with good A level grades).

A further challenge will be to consider the quality assurance processes which will be

required to encompass moves towards the specification of outcome standards based on a system of student attainment at exit (UKCC 1999), which may have some similarities with the current QAA thinking about setting threshold standards.

Whether the current arrangements meet (and are seen to have met) the needs of the range of stakeholders, especially the NHS, will be a crucial question – as will the view of the HEIs regarding the validity and reliability of information used by the NHS as a measure of the quality of the education provided. Townsend (1992, cited by Marr & Geibing 1994 p72) comments in relation to nursing that 'New systems of standard setting and inspection will be adapted readily while the necessary attitudes, skills and working relationships go largely ignored and undeveloped'. It is perhaps timely to reflect on such sentiments as we work our way through implementing the vast array of changes which are about to become part of the future direction for nursing and midwifery education.

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