Curriculum Innovation in Response to
'The Future Pattern of Basic General Student Nurse Training/Education'
(ENB 1984)

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ABSTRACT

The focus of the research is on the process of implementing curriculum innovation in six English nursing schools in response to the invitation from the statutory body - the English National Board for Nursing, Midwifery and Health visiting - for collaboration between nursing schools and institutions of higher or advanced further education. The thesis begins with a review of the historical background, and the events leading up to the Board's call for experimentation in September 1984; the first two chapters, which are largely descriptive, recording previous attempts to reform the pattern of initial preparation nursing.

Content analysis of the submissions reveals differences and similarities in the proposals from the six schools. One scheme, in a rural area, makes no external educational linkage; one nursing school links with a college of education, one with a tertiary college, two with polytechnics and one with lecturers from the extra-mural department of a university. Five of the schemes propose a change in curriculum context and in the status of the student - with supernumerary status for six months, one year or two years. One does not propose to alter the context of the curriculum, but proposes major changes in curriculum content teaching/learning strategies and assessment.

An interpretive approach is then adopted to elicit the view of those planning and preparing to introduce change. Visits between July 1986
and July 1989 were made to each school for discussion with individuals and groups, and open interviews with participants and others.

Factors influencing the implementation, modifications, and educational or organisational changes in the collaborating institutions are discussed - revealing differences in each social milieu. Issues raised in the six schemes include; the issue of time - the time-scale for adoption of plans, preparing and introducing change, time for preparing everyone involved for changing roles, and the difficulties of time spent travelling between two sites; developing the infrastructure and communication system; the workload for innovators and implementors; maintaining support networks, and the complexity with large, or frequent annual intakes of students. The evidence points to the need for assessment and evaluation to be an integral part of the planning procedure within parameters agreed by the statutory bodies - the UKCC and ENB. The issues raised in the research are relevant to those planning nursing courses for Project 2000.
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Glossary

A.D.N.E.  Assistant Director of Nurse Education
Briggs'  Report of the Committee on Nursing
C.N.O.  Chief Nursing Officer
D.E.S.  Department of Education and Science
D.H.A.  District Health Authority
D.H.S.S.  Department of Health and Social Security
D.N.E.  Director of Nurse Education
D.O.H.  Department of Health
E.A.G.  Education Advisory Groups
E.C.  European Community
E.N.B.  English National Board for Nursing, Midwifery and Health Visiting
G.N.C.  General Nursing Council for England and Wales
I.C.N.  International Council of Nurses
Judge  The education of nurses: a new dispensation, Commission on Nursing Education
N.H.S.  National Health Service
Project 2000  A New Preparation for Practice
Rcn  Royal College of Nursing
R.G.N.  Registered General Nurse
R.H.A.  Regional Health Authority
R.M.N.  Registered Mental Nurse
R.N.M.H.  Registered Nurse for the mentally handicapped
R.S.C.N.  Registered Sick Children's Nurse
U.K.C.C.  United Kingdom Central Council for Nursing, Midwifery and Health Visiting
W.H.O.  World Health Organisation
Introduction

In September 1984 the English Board for Nursing, Midwifery and Health Visiting, the statutory body set up under the Nurse Midwives and Health Visitors' Act 1979, called for pilot studies in the initial preparation for general student nurse training/education. The letter was addressed to the District (Chief) Nursing officers and Directors of Nurse Education in the English schools of nursing, and to the

Official Correspondents at Institutions of Further/Higher Education approved by the English National Board

A background paper, accompanying this invitation, discussed the differing views amongst Board members regarding the locus of courses leading to registration as a nurse, indicated areas where curriculum innovation would be welcomed, and offered opportunities on an experimental basis, stating that

central regulation/control will be kept to a minimum to allow maximum local creativity and flexibility.

The Board's intention, expressed in the paper, was to call for courses which would provide a sound knowledge base, develop enquiry and critical thinking, and foster the vocational aspects of commitment and caring in a practice based discipline. In nursing, as in other forms of professional education this calls into question not only the locus of the course, but the relationship between curriculum design and curriculum content, and between the creation of learning environments and methods of assessment in the curriculum process.
This research project is an independent study, prompted by the Board's failure to attract funding for a larger research project from the Department of Health. The aim is to record the contribution to the development of nursing education in England made by the six schools, and to raise issues which are relevant to those developing The Project 2000 courses.
CHAPTER ONE

THE BACKGROUND TO THE ENGLISH NATIONAL BOARD’S CALL FOR EXPERIMENTATION

This chapter reviews some of the events which led up to the invitation by the English National Board (ENB) to schools of nursing and institutions of higher and advanced further education in England, for experimentation in nursing education in September 1984.

The battle for state registration for nurses during the late nineteenth, and the early part of the twentieth, century is recorded by Abel Smith (1960), Bendall and Raybould (1969) and Hector (1973). The reports of select committees of the House of Lords provide the evidence of this struggle. Abel-Smith (1960) draws attention to the terms of reference of the Select Committee on Registration set up in June 1904:

to consider the expediency of providing for the Registration of Nurses

(Select Committee on Registration 1905 iii in Abel-Smith (1960) p.78)

The Select Committee on Registration (1905 p.iv) recommended:

It is desirable that a Register of Nurses should be kept by a Central Body appointed by the State, and that, while it is not desirable to prohibit unregistered persons from nursing for gain, no person should be entitled to assume the designation of "Registered Nurse" whose name is not upon the Register.

(Abel-Smith (1960) 79)
Debate and discussion at that time, in common with all subsequent debates on nursing and midwifery education and training, hinged on the issues of quality and quantity. There has always been tension, when those learning to become nurses form a large part of the workforce, between the need for a form of preparation which lays the foundation for present and future professional competence in nursing, and the need to estimate and provide sufficient nurses for the work to be done. Owen (1986) in a paper prepared for a Conference of Fellows of the Royal College of Nursing, identified six phases in the development of nursing; the professional progress from the Nightingale era, the struggle for registration 1900-1925, the period of consolidation 1925-1945, the Nurses' Act 1949 making experimental courses possible, from the late 1950's onwards the establishment of degree courses in higher education, and the sixth phase of progress ushered in by the 1979 Nurses, Midwives and Health Visitors Act.

In the Nightingale era, 1896-1910, nurse training in hospital was established, and courses of training for a hospital certificate were offered in many hospitals in England. These were rigorous, demanding hard work and good health. Baly (1986) throws fresh light on what became known as the Nightingale system:

> the compromise between the hospital authorities who wanted to use probationers as pairs of hands, the doctors who wished to keep nurses accountable to them, and the (Nightingale Fund)* Council who wished to instigate a system of planned training with nurses accountable to trained nurses.

* Researcher's note (Baly 1986 p.4)
The struggle for registration, according to the literature, was overshadowed by personal antagonism between factions in nursing, and nursing organisations, leading to a failure to achieve a common purpose. Polarisation led to the College of Nursing supporting a Bill in the House of Lords in May 1919, and the Royal British Nursing Association supporting a different Bill in the House of Commons in June 1919. Each reflected different perspectives from which these two organisations viewed the proposals for registration - either that standards of nursing and training should have regard to the staffing of the hospitals, or that standards of nursing should be based on education and an educational elite. As a result the Minister of Health put forward his own Bill to appoint a provisional council to set up a register, arrange for an election and determine criteria for admission to the register of those 'who were bona fide engaged in practice as those nursing the sick', and in future by examination. The Act was passed in 1919 and the two General Nursing Councils - for England and Wales, and for Scotland - and a Joint Nursing and Midwifery Council for Northern Ireland, were appointed.

Although the first step had been achieved, dissension continued over the interpretation of the Act, conditions of entry to the register were strictly applied and progress towards an election was slow. The concern of nurses and members of the public and voluntary associations, many of whom had played an important part during the First World War, for the provision of a qualified professional nursing service was at issue, in addition to the aspirations of nurses for professional status through
education. In consequence, there was a dilemma for those in government when conflicting claims for the provision of a service were offered as advice. As a result, the Minister of Health formulated the rules, and Parliament determined the outcome. In 1925, the General Nursing Council's original intention to make a syllabus of training obligatory was not agreed - the Minister insisting that it should be advisory only.

Nevertheless, as Owen suggests, this phase from 1925-1948 in the development of nursing, may be seen as a period of consolidation. Approval of training schools - including the size and type of clinical experience available, sufficient suitable living accommodation for probationers and the provision of nurses to teach them - rested with the Council. Lectures, demonstrations with identified topics were required to be recorded, the age of entry to training was determined and the length of training for registration was to be three years. During this phase, it may be deduced, a 'collection-type' curriculum was introduced, and inspectors of the Council visited training schools - although at infrequent intervals.

There were, however, signs that further reform was necessary in the years between 1932 and 1949, as indicated in a number of reports e.g. The Lancet Commission Report 1932, and an Interim Report from the Inter-Departmental Committee, on Nursing Services 1939. This committee under the chairmanship of the Earl of Athlone, was set up in 1937 by the Minister of Health and the President of the Board of Education but was postponed owing to the outbreak of war. (See Appendix I). In 1941 the Royal College of Nursing (Rcn) set up the Nurses' Reconstruction Committee under the chairmanship of
Lord Horder and a series of reports were published between 1942-1949, e.g. on the assistant nurse, and on education and training with a wide remit including post-certificate training (See Appendix i).

After the war, a working party was set up by the Minister of Health, Secretary of State for Scotland, and the Minister of Labour, under the chairmanship of Sir Robert Wood, then Principal of University College, Southampton, to make a comprehensive review of the whole nursing service in the light of the impending establishment of the National Health Service (See Appendix i). The report, published in 1946, pointed out that no attempt had been made to formulate interim proposals to remedy present difficulties but the object should be rather to assess, if possible, what nursing force, in terms of quantity and quality is likely to be required in the future... and to suggest how best that force can be recruited, trained and deployed.

Wood (1947, p.iii, para.2)

In his introduction to the Report, Sir Robert reported that the ground we have to cover is by no means unexplored; we are in no sense pioneers in new territory.

Wood (1947, p.iv, para.4)

This report envisaged Nurse Training Committees for each region in England to plan and oversee nursing courses - powerful bodies with representation from NHS Regional Hospital Boards, Board of Governors of teaching hospitals, the General Nursing Council for England and Wales (GNC) and Central Midwives Board, local authorities, local education...
authorities and the universities. These committees would co-ordinate facilities for training, form advisory centres and encourage experimentation. The training courses would be under the control of a Director of Nursing Education (DNE), students would have training grants and a reduced period of training - 18 months, plus 6 months as an elective prior to registration.

White (1982) in a paper for the Royal College of Nursing (RCN) Research Society, reflects on the reaction of nurses to these reports - contrasting the different reactions of nurses, matrons and the RCN Council - and analyses the different approaches each committee made to the need to provide for a qualified nursing service and a cadre of nurse leaders and policy makers. Changes in the Nurses' Act 1943 had provided for an assistant nurse, a second level nurse, and the 1949 Nurses' Act provided for Training Committees to be set up in each region, and for experimental schemes. These Area Nurse Training committees were, however, given very limited powers under the Act, mainly acting as a channel for the distribution of monies from the GNC to the schools of nursing for the payment of teachers' (and later clerical staff) salaries, for teaching equipment, lecture fees, books and travelling expenses. The provision in the Act for experimental courses, as Owen points out, led to the establishment of diploma and degree courses in England - another route to registration as a general nurse. Other experimental courses provided for a nursing course associated with studies in another discipline - sociology, economics, social science and psychology. Later, under the same experimental course rule courses were
developed for registration on two parts of the register, or courses for registration combining a district nursing or health visiting certificate. All experimental courses had to be approved by the GNC - and then referred to the Minister of Health for his approval - a lengthy process. However, progress was made slowly, and the process quickened as polytechnics became established.

By 1969, it was clear that the changes put forward by all these committees and working groups were becoming urgently needed. The entrants for general nursing were fewer, and in its annual report for 1969/70 (GNC Report, p.8) the Council drew attention to its concern, and the responsibilities of the professional organisations, the Department, Minister and the general public for recognising the situation.

In 1970, the Nurse Tutor Working Party under the chairmanship of Dame Kathleen Raven, Chief Nursing Officer, DHSS, was formed by representatives of the GNC, the RCN, the DES and the medical profession. (See Appendix i). They examined the difficulties experienced by students and nurse teachers in planning curricula, recommended a ratio of one qualified nurse to three students in clinical areas, and one student to not more than eight patients in any span of duty. Modular courses, providing practice related to knowledge and skills were also advocated.

In 1970, plans for the re-organisation of the Health Service to provide for integration between hospital, general practitioners and community
services were at the discussion stage - and the organisational framework of 1974/75 was at the planning stage. Concern again hinged on the manpower needs of an integrated service - and the Committee on Nursing, under the chairmanship of Professor Asa (now Lord) Briggs was set up in 1970:

1.8

to review the role of the nurse and the midwife in hospital and in the community, and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.

(Report of the Committee on Nursing - Briggs' - 1972 p.1)

The committee worked for two years, supported by a team of civil servants and research workers, studied evidence from nursing, medical and paramedical organisations, from educational and managerial groups in the four countries of the U.K. The Report was published in 1972 (See Appendix i) and it was made clear that the recommendations were:

for educational and other policies in nursing and midwifery to be thought of as parts of a strategy within the overall context of the NHS policy as a whole, not as piecemeal expediency. They should be feasible of implementation...... those responsible for the strategy should not ignore demographic, educational or social factors outside NHS administration.

(Briggs' 1972, p.14, para.49)

The Report recommended that dual entry to registration and enrolment should disappear, greater emphasis should be placed on basic nursing education, on the capacity to see the patient as a whole person in relation to his family and society, and on further provision for development in specialised nursing, an increasing involvement of higher
education in nursing courses, with an increasing element of continuing education being built into the system.

By recommending the framework of a Central Council for registration, professional standards and discipline with Education Boards in each country, and colleges of nursing and midwifery financed through Area Committees for nursing and midwifery education, the Briggs' Committee hoped to prevent fragmentation and overlap in function due to the many controlling or regulatory bodies concerned with nursing and midwifery education. At that time there were six statutory bodies, and more than sixteen Boards and associations involved in nursing and midwifery education and research granting certificates to nurses, midwives and health visitors in the U.K. (See Table 1) page 1.20. A modular pattern, broadly based for all entrants, was proposed -

- to provide experience and related teaching in the nursing of patients with physical, mental and behavioural disorders and in the nursing of different age groups and levels of dependency and, of equal importance, in the nursing of patients in both hospital and community settings.

(Briggs' 1972, p.86, para.270)

This course, lasting eighteen months, would lead to a Certificate in Nursing Practice. For those wishing to proceed to registration as a general nurse, or for specialised forms of nursing, a further 1½ year course would be required.

There was a positive response to the report, and the profession accepted many of its recommendations, but there were widely divergent views
regarding the generalist/specialist issue, and differing opinions amongst midwives, health visitors and district nurses. As a result, health ministers consulted widely for seven years from 1972-79, seeking views of the existing statutory bodies, professional organisations and trade unions regarding the proposed framework. A Briggs' Co-ordinating Committee was set up by the health ministers to consider the issues and proposals for a Bill. The signing, by the U.K. of the E.C. directives on the nurse for general care (1977) gave further impetus and the Act reached the statute book in 1979.

The Nurses, Midwives and Health Visitors Act 1979

This Act provides for a Central Council for nursing, midwifery and health visiting for the UK (the UKCC) which is charged with establishing and improving standards of training and professional conduct for nurses, midwives and health visitors. To this end, the UKCC formulates rules (to be approved by the health ministers) regarding admission to training, the kind and standard of training to be undertaken for registration, and the kind and standard of further training to be available for those already registered.

Section 6.1 of the Act provides for four National Boards, one for each country in the U.K. with the following functions:

(a) provide, or arrange for others to provide, at institutions approved by the Board.
(i) Courses of training with a view to enabling persons to qualify as nurses, midwives or health visitors or for the recording of additional qualifications on the register.

(ii) Courses of training for those already registered.

(b) ensure that such courses meet the requirements of the Council as to their content and standard.

c) hold, or arrange for others to hold, such examinations as are necessary to enable persons to satisfy requirements for registration or to obtain additional qualifications

d) collaborate with the Council in the promotion of improved training methods, and

e) carry out investigations of cases of alleged misconduct with a view to proceedings before the Council, or a committee of the Council for a person to be removed from the register.

(Nurses, Midwives and Health Visitors Act 1979, Section 6.1)

In 1979, membership of the National Boards was by appointment, by health ministers - nurses, midwives, health visitors, health service administrators, members of the medical profession and the public, and educationalists. Each of the four National Boards then elected four members to serve on the UKCC, and other members were directly appointed to the Council - these included educationalists, doctors, and experts in finance. Members were appointed for four years, during which time the Council (like its predecessor in 1919) was to determine the method of election of their successors in 1983, and was charged with forming rules, and forming one register from the existing data. Considerable negotiation was inevitable - to establish the relationships between these five new statutory bodies created under the Act, and to meet the expectations and concerns of all the outgoing, or subsumed bodies, and to determine a framework to carry out future functions. Seven working
groups were each charged with a specific task, and UKCC Working Group 3 was to prepare a consultation paper on the philosophy which might govern future nurse training and education.

**UKCC Working Group 3 - Education and Training**

The group consisted of the Chairman of Council, who served on all committees, and seven Council members, six of whom were in nursing or midwifery education in either the N.H.S. or higher education, and were members of the National boards, one Council member from higher education and one non-member of Council who was a District Nursing Officer from a health authority in England, to provide expertise from nursing management in the N.H.S.

The Working Group 3, in its first report, January 1982, (See Appendix ii) after consultation with the four national boards, stated that

> the present and previous patterns of nursing training cannot be continued indefinitely. Changes in the programmes for registration are essential in order that the nurse may be able to promote health in the home, at school, and at work; to prevent illness and also to give supportive care at home as well as in hospitals and other institutions.

(UKCC Working Group 3, p.1.)

Whilst accepting many of the Briggs' Report's recommendations, UKCC Working Group 3 rejected the concept of a certificated nurse, because it was believed that registration marked the point of entry to the
profession. It made a significant comment, however.

There would, however, be a variety of routes to this single point of registration, and varying time scales to achieve this goal.

(UKCC Working Group 3, p.2.)

Furthermore, it was contended that each National Board should make courses available for those enrolled nurses wishing to proceed to registration.

In pointing to the need for change, the Report drew attention to the reports giving testimony to this need (from 1932, 1938, 1942-48, 1947, 1953 and 1964) as well as the Report of the Committee on Nursing 1972. Appendix I. It drew attention to the factors contributing to the current needs - the fragmentation, duplication and overlap in various nursing, midwifery and continuing education courses and programmes, the inadequacy of

the impoverished 'apprenticeship system' on which much nursing training was based has been increasingly highlighted by the rising expectations of the public .......

(UKCC Working Group 3, p.3.)

and

the nursing student has never been a true apprentice under the supervision of trained nurses. The imbalance in numbers of supervisors to learners, and the misuse of untrained nursing auxiliaries and assistants has constantly bedevilled any attempt at true apprenticeship for nursing students.

(UKCC Working Group 3, p.4.)
Although the group do not enlarge on this issue, the report referred to insufficient numbers of trained staff for personal supervision, and the organisational patterns of care which, in many places, relied on task-centred approaches to getting the work done, rather than on individual responsibility for nursing care of the individual wherever that care took place. Therefore, it proposed that all courses for registration should encourage the promotion of health, the prevention of illness, as well as the supportive care given by nurses in the home and in the hospital. A common core was suggested for all courses (not a common portal of entry) to focus on human development, the nature of care, and an understanding of the support services available in the social setting.

Past achievements by the existing statutory bodies should not be lost, but the development of a variety of courses for special needs and for changing patterns of care is vital if the purpose of the Act is to be achieved..... continuing change is essential in the courses of preparation for those qualifying for professional service in the health, social and welfare fields.

(UKCC Working Group 3, p.7.)

The report envisaged that, since the art and science of nursing could be learned only where there was a need for this by patients and clients, a controlled learning situation for nursing students was essential - one wherein the motivation and commitment of the student was matched by the professionals' motivation and commitment to provide an environment where learning can grow and flourish.
Theoretical learning... newly acquired knowledge needs to be shown to be of value in the settings where patients and clients are to be found.... It would be idle to suggest that there will never be any degree of conflict between the training needs of students and the demands of the service in the clinical setting.

(UKCC Working Group 3, p.9)

Recognising that the ideal must be matched in the reality, and emphasising that service and training must be linked, the group advised that administrative arrangements be provided for identifying the educational function with a budget separated from the nursing service budget of the health authorities, with colleges of nursing and midwifery with governing bodies responsible to the National Boards and a director responsible to the governing body. The report acknowledged that there would be implications to be addressed for replacing the nursing service given in the past by students -

it is indefensible that first year nursing students have had laid upon them responsibilities far beyond their level of preparation

(UKCC Working Group 3, p.13)

The implementation of the Group's proposals will require a substantial and continued commitment by all in the health service.

(UKCC Working Group 3, p.13)

In its conclusion, it comments that closer links between nursing, midwifery and health visiting and higher and further education, and greater flexibility and interchangeability in the professional workforce should help to offset these effects.

for more than a hundred years the greatest constraint that has been placed on nursing training has been the pressure of the service demands in various clinical settings. These demands have given rise to piecemeal developments in courses of training in response to
crises rather than by the planned development of innovation.

(UKCC Working Group 3, p.12)

In January 1982 the UKCC accepted this Report of the Working Party but decided to refer it to the newly formed Council which would meet in 1983 - after the first elections to the National Boards had provided for the election of members to the UKCC. This decision was expedient, because the existing Council had a heavy programme - work was proceeding slowly on the formulation of rules, the competencies to be achieved for registration and with forming policies related to professional conduct and discipline. The decision was also influenced by views expressed strongly by organisations, including the RCN, that an appointed body should leave such decisions to the newly elected Council in the following year. The ENB had also expressed concern that the time scale for decisions on education and training was not as crucial as that for other matters, and there was some concern amongst Board members that Working Group 3's work related directly to the work of the ENB. In this respect the scenario was somewhat similar to that of 1919-25.

The ENB had set up its own working group at the fourth meeting on February 24th 1981 to

identify the main education principles stemming from the major function of the Board as defined in Section 6 i of the 1979 Act and to indicate those which appear most critical before the Board assumed its main responsibilities.

(The End of the Beginning, ENB. 1980-83)

There was agreement that Colleges of Nursing and Midwifery would be acceptable in England, and a comment appears in the report that
the nature of their governing committees, or Boards, needs careful review, as does the long term possibility of education for the three professions being within the general sector.

(The End of the Beginning, ENB. 1980-83)

Continuing education for nurses to improve clinical practice and to maintain professional competence, and the provision of further resources to meet these needs, were also accepted as objectives by the Board, together with a commitment to undertake a review of existing criteria and guidelines to training institutions. All such institutions were requested to establish a course planning/curriculum development team for each course, and to inform the appropriate professional officer of the Board about how significant curriculum changes would be implemented.

These events led to the ENB's invitation in September 1984 to schools of nursing and institutions of further and higher education approved by the Board for the submission of programmes as pilot studies in basic general student nurse training/education which is discussed in Chapter 2.

Increasing professional pressure for change also led to the setting up of the Commission on Nursing Education by the RCN in April 1985 under the chairmanship of Dr. Harry Judge. The report one year later entitled The Education of Nurses: a new dispensation recommended that

All schools of nursing designated for development in a more concentrated and effective system should become integral parts of Polytechnics or Colleges of Higher Education.

(Judge p.18, para 2.11)
In addition, the newly formed UKCC, with its newly elected members, following the National Boards' elections in 1983, set up Project 2000 - a group to face the deficiencies in the current arrangements of initial preparation and the changes needed in the future - and a series of consultative papers, widely researched and supported by evidence, were produced between 1983-86. These were incorporated in the P.2000 report in May 1986 with recommendations providing for a common foundation programme, followed by branching programmes to meet specialised nursing needs. The three year programme should emphasise health promotion and health care, and the students would have supernumerary status throughout the period of education and training, although with a proposed service contribution of twenty per cent (20%).

Although these recommendations include an improved teacher student ratio of one to twelve (1:12) appropriate education for teachers and those supporting students in practice-settings, and joint professional and academic validation, they do not, however, indicate the locus of education and training, although the proposal is made in Paper 9 (February 1987) that

(e) N.H.S. facilities provided for education and training should reflect the better standards in higher education.

(UKCC P.2000, Paper 9, p.8, 1987)

The National Boards are left to consider how to implement the UKCC proposals
inviting the parties to be involved as appropriate and necessary.

(UKCC P.2000, Paper 9, p.9, 1987)

The ENB's call for experimentation in September 1984, which may therefore be seen as a precursor to the UKCC's P.2000 Paper 9, is the topic discussed in Chapter 2.
## Table 1

<table>
<thead>
<tr>
<th>Statutory bodies, and associations or boards granting certificates or opportunities for education to nurses and midwives in 1970</th>
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<tr>
<td><strong>Statutory bodies</strong></td>
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<tr>
<td>General Nursing Council for England and Wales</td>
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<td>General Nursing Council for Scotland</td>
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<tr>
<td>Northern Ireland Board for Nursing and Midwifery</td>
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<td>Central Midwives Board for England and Wales</td>
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<td>Central Midwives Board for Scotland</td>
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<td>Council for the Education and Training of Health Visitors</td>
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<td><strong>Bodies receiving support from the DHSS or the Scottish Home and Health Department</strong></td>
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<td>Joint Board of Clinical Nursing Studies</td>
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<td>Panel of Assessors for District Nurse Training</td>
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<td><strong>Others</strong></td>
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<td>Royal College of Nursing</td>
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<td>British Orthopaedic Association and Central Council for the Disabled - Joint Examining Board</td>
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<td>British Thoracic and Tuberculosis Association</td>
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<td>Family Planning Association</td>
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<td>King Edward's Hospital Fund for London</td>
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<td>National Association of Theatre Nurses</td>
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<td>Ophthalmic Nursing Board</td>
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<td>Queen's Institute of District Nursing</td>
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CHAPTER TWO

THE ENGLISH NATIONAL BOARD'S INVITATION - CHALLENGE AND CHANGE

The ENB invitation, September 1984, is set out in full in Appendix III(a). The background to the call for curriculum innovation was discussed in Chapter 1, but two other significant pointers towards this experimentation are noted. Firstly, the newly appointed ENB's interpretation of its function in education under Section 6 paras a - d of the 1979 Act was determined at a Selsdon Park Conference in December 1980, and its definition of the basic philosophy of nursing includes -

all should be responsible in association with their peers for their own standards of practice. This philosophy requires a collegiate approach to setting standards for education and practice so encouraging established practitioners, learners, teachers and educational bodies to take that substantial measure of responsibility necessary to promote innovation and standards of excellence. It requires also that the Council and the Boards should have a collegiate, rather than a prescriptive, hierarchical approach to the supervision and provision of education.

(The End of the Beginning, ENB, Sept.1980-83, para.4.)

Secondly, the GNC's circular on Educational Policy issued in June 1983 (paper 83/13 and enclosure 83/13/A) which is included as Appendix III(b). This circular, issued in the year when the ENB, as the new statutory body, would take over the GNC's functions, called for a new approach to curriculum planning and development

nursing education is a process concerned inter alia with providing the foundation for nursing practice. In this context the caring role, which is central to nursing practice, may be seen as working towards the physical, psychological, social and spiritual well being of the patient. It encompasses all age groups of differing
cultures whether well or sick and includes teaching and educating towards health.

The initial aim of nursing education is to provide for learners an appropriate balance between theory and practice......

While training is concerned with the mastery of skills (practised under supervision)...... it forms only part of the broader educational issues with which the nursing profession is concerned.

(GNC E/W. 83/13/A. para.1.2)

The newly elected ENB's invitation, in September 1984, to schools of nursing and institutions of further and higher education to submit proposals for experimentation in initial general student nurse training/education may be viewed as a collegiate approach to innovation. It demonstrates a willingness by the statutory body to consider schemes prepared by those actively involved in nursing education, by offering the possibility of partnership or linkages between schools and colleges to encourage maximum creativity and flexibility. In calling for new methods of preparation to be devised, tested and evaluated to meet future needs in patterns of health care, central regulations/control would be kept to a minimum provided that the legal requirement and framework of the UKCC training rules and European community directives were fulfilled. See Appendix III(a) (ENB Appendix B, C and D).

A critical analysis of the content of the ENB's invitation and its accompanying appendices reveals general agreement with the GNC's June 1983 policy statement that an initial foundation course should include the concept of health, the prevention of disease and that the core of initial professional education is learning through caring for
There are three stages:

(i) The competencies set out in the new rules must be acquired during a period under close, direct supervision with concurrent assessment and with well prepared trained nursing staff as role models/supervisors* (Researcher's emphasis)

(ii) There should be a period of consolidation, still under supervision

(iii) Finally, there should be an 'intern' period leading to independence, self determination and registration.

(ENB. Sept.1984 (Appendix A, p(ii) in Appendix iii(a))

It is contended that some degree of concern may be inferred in the report of this debate regarding how and where such preparation should occur, and about what constituted initial or basic primary preparation and what constituted post-registration courses or continuance.

It was generally agreed that for the future, the present pattern of building one training on another so that it could, for example, take in excess of seven years to become a health visitor, should not continue.

(ENB 1984, Appendix A, p(ii))

However, only three out of six groups of Board members participating in the debate felt that

the Board should explore the use of institutions of further/higher education to provide the theoretical base for primary nurse education. Many stressed that there is a need to explore the effects of changing the present
status of the nurse learner.

(ENB 1984, Appendix A, p(ii) in Appendix iii(a))

These differing perspectives are reflected in the report of the debate, and in the preamble to the ENB Invitation, regarding the locus of nursing education.

Many of those who work in, or have been educated through the further/higher education system, believe that a sound knowledge base, the development of critical thinking, the need to be in contact with a variety of attitudes and approaches and the motivation to 'find out' are more likely to be acquired in an intrinsically educational establishment than in a monotechnic institution accountable to and funded by those responsible for service.

(ENB Invitation, Sept.1984, para 1.2 in Appendix iii(a))

Further light on the arguments put forward is revealed in an article by Bendall (1987) entitled "Raising the Siege" - an edited version of a keynote speech delivered in April 1987 at a conference on piloting the project - i.e. the pilot schemes. In this she refers to education for the professions, many of whom share similar problems of central control, gatekeeping, and difficulties with the search for competencies in the face of the explosion of knowledge; she argues that education should prepare individuals to recognise good practice and strive to attain that, rather than to be expected to become competent by being taught ideal practice which hardly ever exists.

(Bendall 1987 p.8)

She also contends that effective training for the skills the patient needs the nurse to carry out (both task-related and interpersonal/social) requires a degree of supervision, facilitation and freedom from work pressures that cannot currently be provided. She urges that
present planning should prepare for future possibilities with the help of occupational psychologists and industrial trainers. The choice of title for her article reflects her belief that there was a do-it-yourself mentality - isolationism, or siege mentality, and proposes that -

the attitude is a symptom of something much deeper - defensiveness as a reaction to fear, fear of control by others and fear that springs from an inability to define what nursing is.

(Bendall, 1987, p.6)

She reached this conclusion because, in the discussions which led to the decision to invite experimentation when the flexibility and the 'permissive' framework for linked schemes was mooted - one Board member pointed out that

with that amount of educational control we do not need to link with any other establishment - a school of nursing could do perfectly well on its own and produce just as good results

(Bendall, 1987, p.6)

This opinion, untried and untested at that time, may have influenced the Board's initial choice of the six schemes - three of which were offering links between DHA's and educational establishments, and three were from DHA's alone; later two of the latter schemes developed links with educational institutions.

The inference, from Bendall's paper, is that sharing expertise between disciplines, and a variety of approaches may offer help or solutions with mutual problems, and that the pilot schemes may illustrate this.
She challenges those preparing future practitioners to define nursing:

the unique thing which requires an amalgam of knowledge, skills and experience unlikely to be found outside the occupational group whose title is protected by statute

(Bendall, 1987, p.6)

Failure to define this, she argues - the unique whole (which is greater than the sum of its parts) - has led to off-loading to others tasks which were at the core of a training in skilled physical care (e.g. nutrition, cleanliness of the environment) and to filling the gap with activities requiring cognitive skills - assessing, planning, evaluating, whilst failing to reflect this fundamental change in educational terms.

Bendall offers this view, formed in the light of her personal experience, with a long career in nursing education, and as a former Chief Executive Officer of two statutory bodies - the GNC for England and Wales, and the English National Board. It deserves careful consideration. It raises questions about the generalist/specialist issue in nursing, about central versus local control, about the nature of innovation and constraints. It challenges the practitioner and the educator to face the issue of the locus of the curriculum, and to demonstrate whether nursing theory does arise from practice, and whether it is founded in reality.

Bendall's article suggests that the Board member, who articulated a
belief that nursing schools would benefit from the same parameters proposed for the pilot schemes, was being defensive. This may be true, but it may also be interpreted as a plea for a critical reappraisal of the resources and constraints in current nursing education and for an approach to educational accreditation for some, if not all, existing nursing courses. Bendall's challenge to define what nursing is - the unique amalgam of knowledge, skills, attitudes and experience - is addressed by Stevens (1979) who suggests that a broad label - the domain of nursing - should be used to cover a general arena of events since precise definition of the term nursing will vary according to different theorists. She maintains that for most theorists the locus of nursing is a mental construct, and argues that it is detrimental to search for one universal unitary nursing theory:

it is conflict and diversity amongst theories that account for much of the progress in any discipline. A search for conformity is to stultify the growth of a profession.

(Stevens, 1979, p.xiii)

She raises the question whether the unique contribution of the nurse identified by Henderson (1960) arises from the use of knowledge rather than from knowledge per se?

McFarlane and Castledine (1982) identified the nature and characteristics of nursing in twelve statements from which four inter-related elements were brought together in a conceptual framework - man, society, health and nursing; in contrast to Katz (1969) in
Etzioni pp. 74-76. who argues that the incorporation of behavioural sciences into the nursing curriculum is part of the effort to gain professional respectability.

Many professionals, other than teachers and nurses, are critical about the form that their education has taken e.g. the Report of the Committee of Enquiry into the Engineering Profession, "Engineering our Future" (Finniston 1980).

Teaching is an example where arguments against monotechnics were used ten years ago with moves towards an all graduate profession. Social work, physiotherapy and nursing have established some programmes in higher education during the past twenty five years, but debate continues about the locus of future preparation for nursing in England and the rest of the United Kingdom.

The ENB'S Challenge

The Board's invitation was addressed to two disparate groups, nurse managers of education and service in the N.H.S. and official correspondents at institutions of further/higher education approved by the ENB. The latter are in colleges where courses in nursing specialities for registered nurses have been established, e.g. occupational health, district or community psychiatric nursing or health visiting, and therefore where there are nursing lecturers in departments of nursing or community studies. In schools or colleges of nursing there are also nurses whose preparation for nurse teaching has taken place in higher educational institutions, and many whose
education has been at graduate or postgraduate level, or who are currently studying for a first degree, or undertaking studies at the master's or doctoral level. The ENB data synopsis - (Basic Nurse Education and Training Schools of Nursing Teacher Returns and Student Statistics on 31st March 1988) reveals that 42.74 % (one thousand, six hundred and twenty) nurse teachers in England hold or are studying for degrees - of whom thirty-two are studying at doctoral level, and two hundred at the master's level - and that these numbers have risen by 2.62% on the 1987 figures. It may therefore be argued that there are nurse educators in both the settings - schools of nursing and higher/further educational institutions - with an awareness of the differences and similarities between each, to participate in planning the submission for a pilot study.

The two types of institution are, however, different organisations, with differing structures, functions and control mechanisms. Whilst nurses who had studied or who are studying in polytechnics or universities might be expected to have knowledge of both settings; their own roles and, therefore, functions differ in each setting. Similarly, nursing lecturers in colleges, even if they are aware of changes in the nursing schools in the NHS by virtue of their supervision of post-registration students and their own past experience, are not necessarily aware of the dynamic day-to-day activities currently involved in teaching and management in a school of nursing. It is contended here that this knowledge gap (and possibly attitudinal gap) needs to be bridged by goodwill and much
effort between nurse educators from both organisations if they are to share their experiences and develop understanding. This, it is suggested, is necessary so that lecturers from disciplines other than nursing in further or higher education may be apprised of the complexity of nurse education programmes before planning the innovative curriculum before experimentation begins. It is equally important to prepare all those currently teaching student nurses for the changes they will be called upon to implement. These will include registered and enrolled nurses in the hospital and in the community services, medical and paramedical staff and others in the NHS and voluntary services.

The challenge from the ENB to innovate, to create a new organisational framework for nursing education, calls for collaboration in planning, introducing, implementing and evaluating changes in the nursing curriculum between individuals in two social systems. These issues are explored further in the current research project.

**Change and Changing**

Schön (1983) maintains that significant organisation learning is necessary to effective organizational adaptation — but it disrupts the constancies on which manageable organizational life depends

(Schön, 1983, p.328)
Social systems provide a framework within which individuals act, and, as Berger and Luckmann (1967) argue, make sense of their lives by their social constructs of reality. Change presents a threat to this framework, and to individuals with their own personal constructs of reality.

Change disrupts the pattern of events, altering roles and expectations, and forming new inter-relationships between individuals and between social systems interacting in a the changing situation.

Chin and Benne (1976) point out that every system has boundaries, where connections between the systems may be conjunctive - effective - or disjunctive - negative and leading to conflict. They emphasise that these relational issues are very important in introducing planned change and that a feedback mechanism is essential in a dynamic situation in order to maintain equilibrium. Tension, stress and conflict are inevitable - setting goals to achieve their reduction may represent the price to be paid for facilitating planned change. They refer to the work of Havelock and Benne (1965) who point out that role conflicts at inter system exchange are important because they call for transactional and collaborative exchanges across lines of varied interests - between basic researchers and applied researchers, between applied researchers and teachers/administrators, and between teachers and students. This raises the question of communication difficulties between different groups, with normative issues at stake, which may occur during collaboration in curriculum innovation in the pilot schemes, and will be
Bennis et al (1985) discuss general strategies for introducing change in current use - empirical-rational, normative re-educative and power coercive. They suggest that empirical-rational strategies work best in areas where research extends knowledge and diffusion of that knowledge through new technology; but question the view that rational self interest assumes the adoption of change. They suggest that this strategy is less successful in complex social settings than in the natural sciences.

This is further questioned by Cohen and Manion (1985) who point out the difficulties of the positivist approach in education and the study of human behaviour

> where the immense complexity of human nature, and the elusive and intangible quality of social phenomena contrast strikingly with the order and the regularity of the natural world

(Cohen and Manion 1985, p.13)

Normative or re-educative strategies for change build upon motivation and commitment and are supported by social cultural norms, and the individual's commitment to these norms. Bennis et al (1985) argue that changes in patterns of practice or action, according to this view, involve changes in attitudes, values, skills and significant relationships, as well as changes in knowledge and information as the rationale for action. It is suggested that this approach requires openness and trust. Power-coercive strategies may be used to introduce
change - and as power is an ingredient of all human action it may be exercised to induce compliance by law or legitimate authority, when external agents require change to occur. Compliance may also be required by in-house changes, when pressure is brought to bear by an employing authority; the managers or executives, or by influential individuals within the organisation exerting pressure on others, to achieve change.

Power coercive strategies may be used to limit, or directly alter, proposals for change; for example, by limitation of the resources required to support change. Owen (1988) discussing nursing in higher education, and complexity of social change, refers to definitions of change by Smith (1976) and Nisbet (1969) using the term 'succession'.

A succession of events which produce over time a modification or replacement of particular patterns or units by other novel ones.

(Smith in Owen 1988 p.7)

A succession of differences in time within a persisting identity

(Nisbet in Owen 1988 p.7)

A developmental model such as this which assumes growth and noticeable differences between the state of an organisation or system at different times, may reveal increasing value or growth to a new state - a step up - or it may reveal a downward step or subvalue in the actor's judgement. For example, there may be a change of role, promotion for the innovation and the individual may suffer role loss - deprivation or less satisfaction, or another may find the role loss made up for, on balance, by the gains in this process of change.
Chin and Benne (1976) remind us that progression in a developmental model may be linear, curvi-linear, spiral or occurring in phases or recurring cycles; or it may lead to branching with different forms and processes; e.g. specialising leading to autonomy.

They argue that the developmental model has an advantage over the systems model in that, whilst it sets time limits, it develops a time perspective beyond the systems analysis model. It has the advantage of clarifying thought, aims, steps towards a goal achievement, and provides for the practitioners' intervention to become strategic rather than merely tactical, and thus part of the theory of changing the system. Chin and Benne contrast the focus of the practitioner on theories of changing, and the focus of the social scientist on the theory of change.

Bennis et al (1985) discuss the collaboration required when introducing planned change - which is a

> conscious, deliberate and collaborative effort to improve the operations of a human system, whether it be a self-system, social system or a cultural system, through the utilization of knowledge.

(Bennis et al, 1985, p.4)

This raises questions of validity and values - the value framework within which there is the intention to collaborate to introduce change, and the ethical issues arising in the choice of goals, the means of introducing and implementing changes, and in the assessment of consequences of the intervention.
Warwick and Kelman (1973) examine these issues, and point out that conflicts of values between individuals and groups involved in the process of change may occur at any stage as choices have to be made between alternative policies and courses of action. They pose the question:

what values are we prepared to sacrifice for a valued social change?

Warwick and Kelman (1973) in Bennis et al (1976) Kelman (1968), examining the value framework when introducing change, asks

How can social intervention be introduced without destroying the existing culture patterns..... provide meaning and stability to people whilst helping to build the new patterns and values that a changing society requires if it is to remain human?

(Kelman, 1968, p.63)

Warwick and Kelman (1973) conclude that the goals may be confused with predictions - confusion between what will happen and what should happen according to the value judgement of the formulator. They suggest that choices of goals should reflect the needs of individuals, should not be introduced as abstract notions, and that the institutional arrangements should be such that they encourage participation, gain legitimacy and show respect for traditional values.

These are important issues that will be explored further in this study of curriculum innovation.
'Managing change in Nursing education, Pack One: Preparing for change',

(ENB 1987) makes the following statement:

Change in nursing education over the last decade has been held back, not by a lack of innovative ideas, but by a failure to understand and manage the process of change.

The present research project explores whether the pilot schemes illustrate any of the issues raised in this section of Chapter 2.

**Changing the Organisational Framework**

Organisational change, such as the introduction of a pilot scheme into a school of nursing, is a form of social intervention. It is an activity planned to alter the pattern of activities and the pattern of relationships between individuals. This process may be affected by both internal and external factors. All nursing schools have to fulfil the current requirements of the statutory bodies by which their processes and their products are legitimised; but in so doing they may be affected by the historic, traditional and cultural patterns from which they have arisen, as well as by the organisational structure within which they function at the time. Cox (1983), looking to future changes in nursing education, warns against commitment to change causing the overthrow of old values and traditions which have stood the test of time.
Each of the schools of nursing in the six pilot schemes is a social
organisation operating within the bureaucratic structure of one NHS
health district - or across two health districts. Financially, in
common with all nursing schools based in the NHS, they are supported
by exchequer funds from within the district budget to provide training
allowances for nursing students, continuing and in-service training of
qualified nurses, personnel services and for the provision and
maintenance of buildings, class and study rooms, libraries and so on.
The cost of salaries of teachers of nursing, educational equipment,
books and travelling expenses incurred for educational purposes by
students and teachers, and salaries, fees and expenses for nurses on
teaching courses, are met from exchequer funds which are channelled to
the ENB from the DOH and distributed through ENB educational advisory
committees at regional level. Accountability for the use and
dispersal of these ENB funds within the district rests with the DNE.
At the 1974 NHS re-organisation the DNE was accountable to the Chief
Nursing Officer of the authority (either a district or an area at that
time). When the organisational structure of the health service
underwent further management changes following acceptances by
government of the recommendations of the NHS Management Inquiry
(Griffiths 1983) this accountability changed. The DNE's managerial
accountability varies from district to district, either to a district
general manager, to the personnel manager, or to the chief nursing
adviser to the district management team/authority. The professional
accountability of the DNE, however, remains more complex. He/she is
responsible to the UKCC and ENB for the school's regulatory and
disciplinary function, to the ENB for the management of the school's educational functions, and to the employing authority for educational advice. These activities and other internal factors may affect the response of all those involved to the organisational changes which accompany curriculum change. Schön (1983) maintains that stability and predictability are needed for organisational life and that learning which involves significant change in underlying values and knowledge structure is always the subject of an organisational predicament

(Schön, 1983, p.328)

Some of the internal factors which may accompany curriculum innovation include - the size of the school, the provision of resources - manpower, money, materials - the type of management structure, and the distribution of power, or delegation of authority.

External factors affecting all nursing schools and the nursing curriculum include social, political, statutory, professional, educational and technological factors, and in addition, any situational or cultural variants affecting each particular school. Social factors may include the expectation of candidates, the demographic changes affecting the numbers, or the age, of entrants, the proportion of dependent young and old in the local population requiring nursing care, local or national client/patient pressure groups highlighting special needs, the economic conditions affecting housing provision for staff and patients, and the transport provision in the locality. Political and
managerial factors include the provision of resources in the district for care of patients and clients - for the standards and availability of equipment and the attitudes and norms of the prevailing political climate. ENB Managing Change in Nursing Education - Pack One Section 3 addresses the issues of power and control in relation to nursing education in the NHS, when power is invested in position rather than individual expertise, citing Webb (1981) and Keyzer (1985)

Legal and statutory factors include the functions of the statutory bodies controlling the practice of nurses in the UK, and the training and education of nurses in England - the ENB - and the directives for the nurse for general care of the European community. District health authority policy on health and safety at work, on employment protection and other aspects of employment practice will also play a part as factors affecting the nursing curriculum. Professional practice requires the nurse, in law, to be accountable for her/his actions as a nurse, and the statutory bodies are charged with carrying out investigating and disciplinary functions - other professionals being competent to question and determine the professional's judgement and competence. In this context Hall (1972) discusses this attitudinal aspect of autonomy - having gone through the process, met the structural requirement the assumption is that there will be some correspondence between attitudes and behaviour. This attitudinal approach to practice, he suggests, rests on the vocational aspect - the belief in service to
the public, the use of the professional organisation as a major source of reference and colleagues or peer groups regarding the judgement of work. Autonomy, then, he argues, is the individual's self regulation, without external pressures. National and international nursing organisations influence professional development and education, encouraging research and the dissemination of nursing knowledge - for example, the RCN, the ICN and WHO.

Educational factors affecting nursing schools include the availability of continuing education or distance learning, the provision of nursing courses in higher education and further education, and the studies undertaken by the nurses in the school and in the district. Provision of resources to release staff for study leave includes the provision of their replacement in the service.

Technological and scientific advances affect all nursing schools, and have been the cause of additional material in the nursing curriculum. Such review of the curriculum to meet urgent requirements locally in medical or surgical specialities may cause overloading of the existing syllabus and timetable. Benne (1985) argues that there are real epistemological differences between actionists and academics about the utilisation of knowledge in field experience, as well as differences between these groups in norms and attitudes. In addressing the relationship of theory and practice in education, he argues that these differences require negotiation between different cognitive worlds, so that both may cope with the exigencies of reality. Benne advocates
bridging, or intellectual linkages, between theory and practice to 
explore the social processes that lead to action and policy decisions.

He raises the issues facing students engaging in a combination of 
academic instruction and field experiences, and quotes the experience of 
student nurses and student teachers and similar groups of students, 
wherein academics want students to add to, and widen and deepen 
professional knowledge whilst for

field supervisors, student's learning is subordinated to the 
management of quality service.

Bennis et al (1985 pp.118-119)

He suggests that potential conflict may arise between these priorities, 
since the student is in a position of a linking, or bridging agent in 
two distinct social systems within the chain - of using knowledge. The 
students, he maintains should be encouraged by teachers to see field 
experience not simply as the application of theoretical knowledge, 
finding concrete examples in the field to illustrate and clarify 
academic studies, but as a two-way flow with the practice setting 
raising issues to be explored mutually between academics and 
practitioners.

The stereotype - a popular concept - of an academic possessing real 
knowledge, the scholar removed from the push and pull of practical 
affairs - he suggests is drawn from a normative model. He further
suggests that it is often difficult for practitioners to defend and affirm their practical knowledge, and indicates the value of sharing assumptions and discussing issues at joint seminars with students to utilise the benefits of both worlds.

Educational institutions like all social organisations are also subject to change in a changing world. Jarvis (1987) refers to the change in direction in higher education.

Traditionally in the U.K. higher education has been didactic, subject-centred and orientated towards young adults. But the clientele of higher education is also changing and so its approach to education must respond to this change...

(Jarvis 1987 pp.49-51)

Collaboration between educational institutions and schools of nursing in the pilot schemes will call for changes in organisation, and in approaches to teaching in subject specialisms or different disciplines in the particular social milieu in each pilot scheme. The advantages each can share with the other, the contributions to curriculum content, design and evaluation, will be explored in this research project, which focuses on curriculum innovation and curriculum process. Nisbet (1975) discussing the dynamics of change lists three essentials for successful implementation of curriculum innovation - organisational support, teacher involvement and evaluation. He also points to five potential problems encountered during this process - increased teacher workload, some degree of loss of self-confidence, strained relationships with colleagues, a period of confusion and a period of backlash. These are aspects to be examined during this research project. Fullan (1982)
contends that different skills are needed for innovation and implementation, and that planners of change cannot rely solely on rational argument, - the goals, the means, the evidence, - and ignore the personal and social conditions of the proposed change. Implementation makes further policy, it does not simply put defined policy into use - we never fully know what implementation is, or should look like, until people in particular situations attempt to spell it out through use.

(Fullan 1982 p.79)

The following chapters explore the proposals for curriculum innovation, and the process of introducing change in the nursing curriculum.
In 1985, when the pilot schemes were being selected by the ENB there was a growing feeling of urgency within the nursing profession regarding the need for fundamental changes in the process of preparing nurses to meet changing needs - both during initial courses and in continuing education. Debate centred on the Report of the RCN Working Party on the preparation of nurse teachers, 1983, which addressed the teaching role of ward sisters, and their preparation for the role, the preparation of teachers for management roles in nursing education, and the management of environments conducive to learning - at the micro level - and conducive to education - at the macro level. Clay (1984) in an article in Senior Nurse reviewed the pointers to opportunities for change, and encouraged nurse teachers to seize these opportunities. Gott (1984) and Reid (1983) and 1984) as a result of their respective research reports also illustrated the need for change.

3.1 Continuing Professional Education

Teaching became an all-graduate profession, moving from isolated teacher training colleges. Changes had occurred in other professions, e.g. among physiotherapists, occupational therapists and other paramedical groups. Opportunities were becoming more widely available for qualified professionals to study, on a full or part-time basis for
first or higher degrees. Courses offering nursing studies in depth at diploma or degree level in established departments of nursing in universities and polytechnics were becoming more widely available for registered nurses. In addition, nurses could choose to study with the Open University, or to undertake full or part-time studies to broaden their experience in disciplines fundamental to nursing, such as the natural or human and behavioural sciences. An increasing number of courses preparing teachers of nursing in the English regions, and a growing awareness of the need for adult and continuing education, raised the level of expectation of both qualified nurses, and entrants to nursing courses, for major curriculum change in nursing.

Allen (1987) contends that the opportunities and challenges for development of the nursing curriculum arise from the increasing knowledge of the nurse teacher. The results of her study, 1981 showing that 34% of the respondents - nurses, health visitors and midwives in the U.K. holding a teaching qualification - had undertaken additional educational studies, may be compared with the 42.74% of nurse teachers in England in 1988 (See Chapter 2 p.2.9)

3.2. Student Status

The necessity, as well as the desirability, of changes in the status of the student, in the learning environment and in the planning of initial nursing courses was widely accepted in 1985 - not only by students and teachers of nursing but also by their clinical and
community nursing colleagues and those responsible for providing and managing the nursing service. This was borne out by the RCN Commission on Nursing Education - a new dimension (the Judge Report 1985), by evidence to the UKCC's proposals for consultation regarding Project 2,000, and subsequently since 1987 by public concern regarding the need to recruit and retain sufficient nurses for the nation's needs.

3.3. The Learning Environment

In conventional, or traditional, courses in general nursing in England, the learning environment for the student is heavily weighted towards nursing service - the students providing the major part of the workforce in most instances. In a course lasting 146 weeks, between 24-28 weeks is allocated for full-time studies. Within the remaining 118-122 weeks service, periods of 4-6 weeks experience in maternity nursing and in community nursing, and periods of 8 weeks experience in the care of the mentally ill, the elderly, and children, have to be included. The student, an employee of the health authority, has therefore 32-36 weeks service to give, and experience to gain, in nursing acutely ill men and women in medical and surgical wards - including trauma and accident and emergency settings, with a short period of night duty experience. The movement of learners to fill gaps in the workforce has been discouraged by officers of the G.N.C. and the ENB and is a major factor in the proposed, or actual, suspension of nurse training in some health districts. This complex
situation placed increasing demands on nurses responsible for the delivery of care; e.g. ward sisters and nurse managers, and provided a dilemma for nurses responsible for the allocation of learners to wards and departments on a continuing basis. Developments in the design of nursing curricula have been tried in many schools. Changing trends can be traced from the early 1970s when experimental modular schemes were introduced to provide integration of theory and practice by replacing a topic based syllabus and schedules of practical skills.

A more recent example is the move, influenced by developments in psychiatric nursing, towards the replacement of a collection-type plan of training based on a disease-dominated medical model by a humanistic approach involving experiential learning and a student-centred curriculum. Salisbury (1987) described twelve steps in planning a new curriculum based on the 1982 syllabus and guidelines for psychiatric nursing. These developments were hampered in general nursing by the existing limitations, and the need for students to provide a high proportion of service. Conventional courses were unable to alter the context in which the course was based. They were, therefore, unable to utilise the experience gained in undergraduate nursing courses in higher educational institutions in the United Kingdom, where the search for a definition of nursing and a body of nursing knowledge continues.
3.4 Future Preparation of the Nurse

The UKCC's Project 2,000, given conditional approval by the then Secretary of State for Health and Social Services in April 1988, is now accepted, plans to introduce a core curriculum and consequent changes are now being considered in each region in England, and thirteen demonstration districts were announced in April 1989.

Curriculum innovation in the six English pilot schemes, the evidence they offer about forging links between the schools of nursing and higher education, and this research project regarding how change in the curriculum is implemented, may assist schools facing such changes. Any nursing curriculum, it is contended, is influenced both at the planning stage, and during implementation, by the philosophy of nursing, or policy of the nursing school, the social milieu and organisational change. It is also influenced by the innovators' awareness of research into the curriculum and by their knowledge of educational theory.

These factors are addressed during the research project in the following chapters.
3.5 **The Research Project**

3.5 (i) The context of the nursing curriculum

The ENB invitation to schools and colleges offered an opportunity to make major changes in the nursing curriculum - in context as well as in design. See Appendix III(a). It called for diversity and creativity and indicated a flexible approach to the limits set by the Board within which experimentation might occur. The present research project seeks to highlight the proposals for change contained in the submissions to the Board - by content analysis - and to show the process of implementing change through interviews with participants, by discussion on visits to the six schools over a three year period, by analysing articles written by participants and collating annual reports to the ENB from each school.

In the Spring of 1986 permission was sought and obtained from DNE's in the six schools for the researcher to approach the Chairman and Chief Executive Officer of the ENB to allow this project to be undertaken. In June 1986 these proposals were welcomed, and the independent status of the researcher was agreed. The original plans for research to be commissioned by the Board with funding from the Department of Health had not been fulfilled. The researcher was given freedom of access to the submissions and reports from the schools, and the Board's officers readily agreed to give assistance if required. The research was then planned in six phases.
3.5 (ii) **Phases in the Research Project**

**Phase 1**

A brief description of each school was compiled from the records - its size, locality, courses offered and any other relevant matter in the reports to the statutory body, noted in Chapter 6.

The submission documents from each school were subjected to content analysis (Chapter 5) and similarities and differences between the proposals, and any omissions in the documents, were noted. Publications in nursing journals by participants in the schemes were also studied, and are referred to in the following chapters as appropriate.

**Phase 2**

Visits by the researcher were made to each school for discussion with course tutors and others participating in the pilot course to clarify the material in the submission and to discover the initial progress of the scheme up to November 1986. The starting date, subsequent entry dates, and numbers of students, and the curriculum design proposed for each pilot course are illustrated in Table 5.2, 5.3 and 5.3 (a), in Chapter 5.
Phase 3

Discussions with the education officers of the Board took place and interviews regarding their views on the nature of the changes proposed by the ENB, and of the changes proposed in the pilot schemes approved in schools of nursing in their regions. A two-day conference "Piloting the Project", arranged by Senior Nurse and PNK Associates in April 1987, with two speakers from each of the six schemes explaining to an audience of over one hundred of their peers and interested colleagues from higher and further education, provided further insight into the progress of implementation.

Phase 4

Visits to each school by the researcher during the remainder of the three-year course were made, at intervals, to interview participants about the changes and about any modifications or adaptations to the original proposals. These open, unstructured interviews were recorded on tape, or immediately following the interview, and are discussed in Chapter 7.

Phase 5

Meetings of representatives from each course were held at the Board in October 1986, January 1988 and February 1989. Each scheme was
reported on at these meetings, and discussions on mutual concerns and issues were addressed. An annual report from each pilot scheme to the Board was agreed in January 1988, and the researcher offered to collate these findings for the ENB. These data have been included in the findings in this research. Further discussion with the education officers took place as each pilot course approached the end of the three year period. A detailed diary of events in this research project appears in Table 4, on page 4.19

**Phase 6**

Analysis of the findings, and discussion regarding issues raised in the project and suggestions for further research are reported in Chapter 8.

This chapter reviews the influences bearing on the ENB's call for experimentation, and the trends towards an educational approach to the initial preparation of the nurse, and to continuing professional development. The researcher's concern to examine the relationship between the context, or locus, in which the curriculum is set - the framework - and the process of implementing curriculum innovation, led to the decision to undertake this research project.
CHAPTER FOUR

METHODOLOGY

The focus of the research project is on the process of implementing change in the nursing curriculum. It is a heuristic study addressing changes in the six pilot schemes over three years - 1986-1989. It offers a contribution to the wish, expressed by the ENB, that the pilot schemes should provide information which can enable debate and discussion. Beattie (1987), discussing how to make a curriculum work, indicates the difficulties in using curriculum design theory in nursing education because of differing and conflicting approaches in the literature. These frequently remain at an abstract level, over-emphasizing theoretical debate at the expense of practical demonstration. He suggests there is a -

shortage of worked examples in the design of nursing curricula. Beattie (in Allen and Jolly 1987, p 15)

These six pilot schemes offer such examples, and reveal the influence of local needs, resources and opportunities, and of external factors on both the proposals and implementation of the plans for changing the framework - the design, content and context of the curriculum.

4.1. **The qualitative or naturalistic paradigm**

The research is both descriptive and interpretive. The choice of framework, or paradigm is qualitative or naturalistic because this fits the phenomenon being studied - the multiple intangible realities which
can only be studied holistically since to dissociate the whole is to alter radically the parts of which it is comprised. Fullan (1982) maintains that an understanding of the meaning of educational change requires -

understanding of what reality is from the point of view of people within the role - an essential starting point for constructing a practical theory of the meaning and results of change attempts.

Fullan (1982 p.130)

The setting or context within which change occurs, the participants' views of the action, and actual changes observed during the process of implementing the proposed plans in the six schools illustrate similarities and differences. It is argued that an interpretive approach offers contextual relevance and a sensitivity to the process which fits the present project. It does not seek to make predictions, but by description of divergent views or concerns, raise issues which might be explored further.

A literature search reveals that in England, in nursing as in general education whilst articles and books have been written about curriculum theory - e.g. planning, modifying and evaluating curricula, criteria for selecting learning environments and field experience - there is a scarcity of information about how the process of major change in the curriculum actually occurs.

This project therefore seeks to reach understanding of how this happens, of the issues that arise for individuals, their interactions and
inter-relationships, and systems of organisation and control within the six pilot schemes. Schütz (1932) concerned with the complex problem of meaning in the social world, differentiates between meaning-establishment and meaning-interpretation. He draws attention to the difference between the meaning of the act for the actor and for the non-participant observer, and by the meaning of the action in progress and the meaning of the completed act. During the research critical attention was given to the underlying assumptions of the researcher, the participants and respondents when exploring issues over a three year period, and to the basic postulates by Woods, quoted by Cohen and Manion (1985).

i. Man acts towards things on the meanings they have for him in the natural world.

ii. Attribution through meaning is a continuous process, emerging and subject to change.

iii. This occurs in a social setting, the individual aligning his action with others, altering his response, taking the role of another, modifying his response.

Cohen and Manion (1985 p.34)

The influence of philosophy and humanistic psychology and the writings of Rogers (1961, 1967, 1969) are acknowledged by the researcher, with the consequent effect on her attitudes to the development of the nursing curriculum at initial and post-registration level over the past thirty years. This influence, with the emphasis on the dynamic nature of social encounters, on the changing nature of groups, and of role-taking, is a further argument for the choice of the paradigm - and the 'fit' with the study.
4.2. **Choice and Values**

The choice of method in any research is always value-based. The researcher’s values are expressed in the choice of the problem to be studied, the framing and focus of the problem, the choice of substantive theory, methods to collect and analyse data, the methods of interpretation of data, and presentation of findings. In traditional, or positivist research where decisions are made at the outset, personal values influence both the subject of study and the parameters within which the methodology is applied. In qualitative or interpretive research the inquiry is influenced not only at the outset, but throughout the process by personal values - of the researcher and of those held by the actors in the setting where the study is conducted which are an essential part of the format.

In this research, where the views of those involved in the action are sought, interaction between the respondent and the researcher is inevitable - it is a central point of inquiry. Equality between these individuals is therefore important, and this is reflected in the design of interviews and discussions. The researcher sought to facilitate the response, in open interviews, using a tape-recorder only when the respondent wished, and in a relaxed informal setting. The former status of the researcher - as a nurse teacher and member of the Committee on Nursing (Briggs' 1972) was known to many of the respondents - but the current status of the researcher and the aims of
the project were clarified at an early stage and before each interview, as indicated in Chapter 7.

Safeguards to prevent misunderstanding during interviews included tape-recordings, checking statements, introducing questions in another form, or at another time in a different setting, probing to prevent bias in reporting. Independent readers were asked to check accuracy of the content analysis of material written by participants, e.g. submissions, articles, and the annual reports to the ENB, which the researcher collated. Simons (1981), discussing interpretive approaches to process evaluation in schools, considers the issues of subjectivity and values in decision making -

Subjective judgements are an important part of the process......these professional judgements are an integral part of classroom transactions and policy decisions ..... in evaluating the process of teaching, learning, the judgements of people are an important source of data which it would be foolish to ignore if understanding of complex processes is sought.


Guba and Lincoln (1982) describe criteria to judge naturalistic research - credibility, transferability, dependability and confirmability. Credibility of the present research depends on whether the realities of the respondents have been appropriately represented - on the truth of the findings for respondents in the context of the inquiry. The reader of the report will determine its value as a pointer to further research - in another context at another time. Transferability depends on
whether the description gives sufficient information about the timing and context of the inquiry to allow judgements to be made about the use of its findings in another similar context. Guba uses the term "thick" description to indicate that such information should provide grounded theory which facilitates judgements about whether, or the extent to which, working hypotheses from the context may be transferred to a similar context.

These six pilot schemes offer rich sources of data - but the naturalistic setting is part of the phenomenon - the research findings are relevant only within the setting at a point in time.

4.3. The Research Design

Field and Morse (1985) remind readers that theory is a systematic explanation of an event - the researcher's perception of reality, and that inductive theory is directed towards bringing knowledge into view. Dependability, in Guba's view, rests upon the researcher's description of the research design, and the changes in design that occur during the process of searching for meaning of factors and events, and patterns of events in context. The provision of references, of all material collected, including unanalysed data, should allow other researchers to test the interpretations made in the analysis in this study, and to choose different ways of using from the same data. Confirmability is a safeguard to establish validity, and Guba suggests that sufficient time should be spent at the site to allow salient characteristics of the
context, and the phenomenon to be uncovered. This is considered also by Field and Morse (1985) who warn that the issue of time and place needs to be carefully planned - for, whilst rapport and closeness to respondents and situations may lead to greater accuracy in reporting, the researcher must avoid loss of objectivity by becoming a 'member of the group'. This was taken into account in the research design by the timing of visits. Interviews and discussions were conducted during the first year of the pilot schemes within the six schools. Subsequent visits during this three year study, as the pilot courses progressed, were limited to one day at each site, and were arranged at a time convenient for the school. Each visit was timed at similar points in each pilot course, i.e. mid-second year and towards the end, or at the end of each course. At these visits, discussions and interviews with participants and others took place, and additional interviews were conducted at professional meetings on other sites.

The research project concerns the meaning of the changes for individuals, involved in the activities - the actors - their inter-relationships, systems of control and organisation, and an understanding of the different issues arising from subjective experience. Rex (1974 in Cohen and Manion) argues however, that whilst actors may define situations and patterns of social reactions, it is possible that

those actors might be falsely conscious and sociologists have an obligation to seek an objective perspective which is not necessarily that of the actors at all.

Cohen and Manion (1985 p.37)
This view was addressed by interviewing individuals who were not involved in the pilot scheme (either at their own request, or by force of circumstances) for their views about the proposals and the introduction of a new curriculum into the school. Examples are documented in Appendix VI - transcripts of interviews.

Education Officers of the ENB, in the regions where the pilot schemes were being conducted, were interviewed at an early stage and again, towards the end of the third year in order to gain their perceptions of the pilot schemes and the implementation of changes.

Although Stenhouse (1975) sees the role of the teacher as researcher - since the individual's frame of reference needs to be shared by the researcher if his behaviour is to be understood - Cohen and Manion (1985) refer to Bernstein's critical comment that the very process whereby one interprets and defines a situation is itself the product of the circumstances in which one is placed. Field and Morse (1985) discuss the effects of interaction between the observer and respondent, or interviewer and interviewee. They draw attention to the problems which may arise in nursing research when the client/patient knows the researcher is a nurse and casts her in the role of care-provider, as discussed by Kratz (1974).

In the early phases of this project the researcher found that some participants sought to put her in the role of educational consultant. This factor was addressed by making clear the aim and purpose of the
research, and the status of the researcher, both to maintain the integrity of the research and to gain the participants' trust. This was re-iterated in future visits and interviews, to prevent mis-understanding. Parlett and Dearden (1981) suggest that in illuminative or interpretive studies an evaluator needs to be supportive without being collusive, and non-doctrinaire without appearing unsympathetic. It is contended that the researcher's previous experience of introducing change in nursing education provided the insight required to weigh and sift a complex array of human evidence and draw conclusions from it -

(Parlett and Dearden, 1981 p.22)

According to Stenhouse (1983) innovation and change in the curriculum and action research in educational contexts should not only contribute to practice but to a theory of education and teaching which is accessible to other teachers. This project, which is reality-based, illustrates the complexity of implementing change in the nursing curriculum, focuses on the learning milieu, and the meaning of change for the individuals in each context. It offers vicarious experience - Stake (1975) quoted by Parlett and Dearden (1981), suggests that:

the best substitute for direct experience is probably vicarious experience .... conceptualised in terms of persons, places, events. We need a reporting procedure for facilitating vicarious experience. We need to portray complexity. We need to convey holistic experience - the mood, even the mystery of the experience.

Parlett and Dearden (1981 p.155)
This research project, it is argued, offers a contribution in a number of areas that have not, as yet, received wide attention, by exploring the changes in the nursing curriculum from conventional courses to pilot schemes and the issues that arise when schools of nursing form links with institutions in the higher educational sector.

4.4 The Open Interview Method

Open, or unstructured, interviews formed a large part of the project. This method was chosen because it helps to explore the meaning of changing the curriculum for participants involved in that process. The views, opinions and professional judgement of those involved in the action, and of those not directly involved but observing the activities, were collected and recorded or noted at different points in the three year study.

Structured interviews and questionnaires were not chosen. In a complex project a positivist approach, with answers to specific questions being sought, might lead to over-simplification, failing to find differences, or difficulties, the unusual or atypical event. An advantage, in this project, of the open interview is that respondents talked freely in a relaxed setting about the changes, how these were initiated and the meaning of the changes for them. Frank and critical comments from respondents were then explored in more depth, and form part of the data. It is contended that such information might not
have been elicited from a questionnaire, even if open-ended questions were included.

The open interview method may be viewed as a disadvantage as it is prone to subjectivity and bias on the part of the interviewer, and relies on the ability of both interviewer and interviewee to make a mutual commitment to search for meaning in their communication. To encourage trust and understanding, at the outset of each interview the purpose of the data collection was clarified. Confidentiality was assured for individual views and for personal information. However, in a research project centred on the ENB experiment, where participants are known, with some knowledge of the pilot schemes already in the public domain, it would be impossible to assure complete anonymity.

The setting for informal discussion to gain information is an important consideration, and much valuable data were obtained in staff common rooms over tea and coffee breaks, at lunch in dining rooms, cafe or pub, as well as on car journeys between school and college, hospital or community, and the railway station. In these encounters, individuals showed great freedom of expression, and offered opinions without prompting, and their views were noted immediately after the encounter. Appointments were made for interviews which were to be taped and their setting was also considered carefully. The use of a small discussion room for privacy and in order to prevent distraction was preferred rather than an office setting, and a ward teaching room
or a sitting room, rather than the ward itself. In order to offer the respondents freedom to express what they wished to say the major part of the interview consisted of the researcher listening, noting and clarifying the statements being made. The sequence in which the information was gathered in the interview was not interrupted. After this initial part, any remaining information the researcher intended to discover was elicited by questions, and probing for meaning. At the end of each session, the respondent was asked to reflect on the interactions and to ask any questions, raise issues or comment in any way on the conduct of the interview by the researcher. The length of the interviews varied, according to the setting, the interactions and the individual's desire to 'tell all' and to 'tell it as it is'. (Melia, 1982 and 1987).

Each interviewee was asked to spend half an hour in discussion for taped interviews. The researcher's agenda was covered without difficulty by all respondents; two of whom preferred not to be taped (both in the older age group!) and only one respondent was prevented from giving up a full half hour due to the pressure of work in a surgical ward with a long 'operation list' and operations in progress. Cohen and Manion (1985) quote Cicourel (1964) who listed the unavoidable features of the interview situation, suggesting that it is impossible to bring every encounter of everyday life under rational control. Therefore, it should be accepted that, even with a genuine desire to communicate, the meaning attached by one person to a statement may be unclear to the other, the respondent may choose to withhold information or may be uneasy with the
interviewer, feeling distanced or put at a disadvantage. The interviewees in this study had volunteered, or agreed, to participate - they were not 'pressed men'; first names were used throughout the research, and any verbal expressions in common parlance were used. The researcher recalls her delight on hearing about 'fixed feasts' - which turned out to be 'an annual programme, or timetable, of immovable lectures' (or lecturers?) - which had preceded the current curriculum changes. The relationship between interviewees and the researcher may be exemplified by the fact that most respondents after they had concluded their sessions, initiated conversation on the topics such as, comments commiserating about the amount of work the research must entail, or spent time discussing their career aspirations, or raised other prevalent professional concerns such as Project 2000! The researcher maintains that this illustrates their feeling of freedom, the rapport achieved, and the interviewees' acceptance of the status of the researcher. It may also indicate the professional's feeling of the need for discussion and support from external sources, or for 'a listening ear' with time and willingness to act as a sounding board.

Interviews during Phase 2 of the research were with DNEs (or Acting Directors) in each school, and with the course tutor and lecturer or principal lecturer in joint schemes. In Phases 3 and 4 a wide range of individuals were interviewed on the six sites including clinical and community nursing staff - mentors, clinical supervisors, ward sisters, staff nurses, nursing managers, nurse teachers, college lecturers, and allocation officers - in addition to the course tutors and DNEs or
ADNEs. The researcher met students for discussion in informal situations and as participants in curriculum committees, and students were interviewed prior to the completion of the course and registration. Interviews were recorded with senior tutors who had chosen not to participate in a pilot scheme, and with tutors teaching in the conventional scheme who wished to join the pilot scheme as soon as it was practicable.

Commercially-taped proceedings of the April 1987 Conference were also used to check the interview data from course tutors and lecturers.

The collated annual reports were a further source of checking for omissions or misunderstandings on the part of the researcher, and these were clarified during interviews in Phase 4 of the research.

Discussion with education officers at the Board took place in the first year of the experimental schemes, to discover their attitudes to the proposals for ENH pilot schemes, their involvement with the school for advice, and their views of the implementation. This discussion with the officers occurred after the researcher had analysed the content of the submissions and also had made the first visit to the school. It is argued that this independent assessment of the innovation, its early implementation and the questions or issues raised by the researcher clarified some of the categories used in the content analysis, and in the subsequent coding of interview data.
Coding of responses to open interviews presents a considerable problem. At the outset, the researcher proposed basing the coded responses on the categories found by content analysis of the submissions. As the project progressed it became obvious that open interviews yielded additional themes that had arisen during implementation of the pilot course.

Glaser and Strauss (1967) define theory as

> a strategy for handling data in research, providing modes of conceptualisation for describing and explaining.

Glaser and Strauss (1967. p.3.)

They define grounded theory as that which is generated from the data by a process of induction, and which is grounded in the data. Coding and categorising the data by content analysis of the submissions, and reviewing this analysis following the visits, interviews and discussions during this research project, it is argued, bring into view further avenues to be explored in the real world and suggests issues for further research.

4.5 **The method of content analysis of the Submissions**

Holsti (1969) defines content analysis as

> any technique for making inferences by objectively and systematically identifying specified characteristics of a message.

Carney (1972) illustrates the use of content analysis with the aim of improving the quality of inferences in the arts where pattern fitting involves comparing a complex set of inter-related words or views with various other model sets, to identify a mode of perception or reasoning.

Carney (1972. p.25)

He suggest that categories should be created from the data by the researcher without reliance on theories for the construction of categories which may distort, mislead, or misrepresent the process of searching for meaning and argues that because content analysis operates on the finished product, participant observer technique cannot influence the data as they are being produced.

Carney (1972. p.64)

Robottom (1981) contends that content analysis may consist of pattern fitting or identifying more subtle dimensions into which a phenomenon may be analysed - fitting into a meaningful context.

In choosing this method to analyse the communications from the six schools the researcher was identifying specific themes at the manifest level, and then ordering or classifying these by inference, at the latent level, into a conceptual framework as Fox (1982) postulates. Thirty phrases were identified by the researcher in the six submissions, and from these six categories were formed. (Table 4.1.) Polit and Hungler (1987) point out that the search for reliable valid data when analysing qualitative materials, includes not only coding and
categorising, but seeking out themes that occur within, or may cut across, the categories. This may lead to variations, regularities or patterns in the data, relationships to which the researcher must be sensitive.

It is important to reduce bias by the researcher in categorising and analysing qualitative research data. In this project this possibility was addressed by asking a colleague to read the submissions, identify specific phrases or characteristics of the messages, and to determine categories. The outcomes of the independent peer review and the researcher's categorisation were identical - with two exceptions. The sequence of wording in the title of Category I was amended, after discussion and Category 6 was modified to include staff development as well as staff preparation - (Table 4.1).

The full list of phrases, the coding and categorising are, it is argued, inclusive of data in some, or all, of the submission documents. They do not include all that other educators might wish to add and alternative or additional categories might be formulated from these data by other researchers.

Communication is a two-way process, the quality of inference relies on the researcher who, according to Kerlinger.

selects, orders, classifies and categorises messages, and the possible answers to questions that arise.

In this project, the researcher's aim was to gain a fuller understanding, by content analysis of the submissions, of what proposals for curriculum innovation had been approved, and the intentions of the innovators in each pilot scheme. This formed the framework for further discussion on visits and in interviews with staff implementing the proposals - in different ways and in different settings, which are addressed in the following chapters.
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<tr>
<th>Year</th>
<th>Month</th>
<th>Event</th>
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<td>1984</td>
<td>September</td>
<td>ENB invitation to submit pilot schemes for consideration by January 1985.</td>
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<td>1985</td>
<td>April</td>
<td>Six pilot schemes announced.</td>
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<td></td>
<td>September</td>
<td>Sunderland/Newcastle Polytechnic pilot scheme began.</td>
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<td>1986</td>
<td>January</td>
<td>West Dorset/Weymouth College - tertiary education pilot scheme began.</td>
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<td>January</td>
<td>North Lincoln/Bishop Grosseteste College of Education pilot scheme began.</td>
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<td>March</td>
<td>Central Birmingham pilot scheme began</td>
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<td>March</td>
<td>Yeovil pilot scheme began</td>
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<td>April</td>
<td>D.N.E. Conference at Sheffield</td>
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<td></td>
<td>April</td>
<td>South Birmingham/Birmingham Polytechnic pilot scheme began</td>
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<td></td>
<td>July</td>
<td>Researcher's content analysis of submissions</td>
</tr>
<tr>
<td></td>
<td>September</td>
<td>Peer review of researcher's categorisation from content analysis</td>
</tr>
<tr>
<td></td>
<td>Oct 27</td>
<td>ENB Chairman and Officers meeting with representatives of the six schemes, attended by researcher</td>
</tr>
<tr>
<td></td>
<td>Nov 7</td>
<td>Visit by researcher to Dorset School of Nursing at Poole</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Visit to North Lincolnshire School of Nursing</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Visit to Selly Oak School of Nursing at South Birmingham</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>Visit to Somerset School of Nursing</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Visit to Queen Elizabeth School of Nursing, Central Birmingham.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visit to sixth pilot scheme deferred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion with two education officers at ENB</td>
</tr>
</tbody>
</table>
4.20

Dec 9  Discussion with CEO at the Board regarding selection of schemes

1987  January  Discussion with two education officers at ENB
Jan 14  Interview with senior tutor from one pilot scheme – in London

March 6  Discussion with one DNE in London
March 27  Discussion with senior tutor in London

Apr 8/9  Two day visit by researcher to Sunderland/ Newcastle, interviews with course leader, teaching staff and DNE in school of nursing; CNO and DNE, allocation officer in health authority and lecturers and nursing lecturers and students at the polytechnic

Apr 14/15  Two Day Conference – Piloting the Project – at Lincoln with presentations from two representatives from each pilot scheme with proceedings commercially taped.

Inteviews with teachers, nursing officers, and other representatives from pilot schemes, informal discussions.

Dec 1  Visit to West Dorset, interviews and informal discussions with teaching staff and students

1988  Jan 12  Visit to Birmingham Polytechnic, interviews with principal lecturer, nursing lecturers; discussion with staff involved in pilot scheme informally; visit to school of nursing for interviews with teachers of nursing.

Jan 21  Two members of ENB and officers of the Board meeting with representatives of the six schemes attended by researcher

Jan 25  Telephone discussion with course leader – Sunderland

Jan 27  Peer review of research project in London
Discussion with one education officer at ENB.

Feb 15  Telephone discussion with course leader – Sunderland

Feb 19  Visit to Sunderland postponed
Feb 25    Telephone discussion with course leader - Sunderland

Apr 11    Visit to North Lincoln, discussion with course leader and ADNE. Interviews with teachers and mentors

June 23   Visit to Central Birmingham, discussion with DNE, interviews with teaching staff and mentors; informal discussion with community and psychiatric teachers

July 4     Visit to Yeovil; interviews with senior tutor - teaching staff; senior tutor - curriculum development, ward sister, community nursing staff and student at curriculum development committee. Interviewed mentors

Nov 16    Discussion with ENB education officer regarding two schemes

1989

Jan 3     Visit to West Dorset, discussion with DNE and ADNE, and course tutor recently appointed

Feb 3     Representatives of six schemes meeting with education officers (2) at ENB, to discuss annual reports from the schools collated by the researcher

Mar 14    Telephone discussion with one education officer ENB

Mar 16    Visit to South Birmingham to interview staff in school of nursing, informal discussion with students, discussion with CNO, interviews with ward sister, mentor and nursing officers - in hospital and community

Mar 22    Telephone discussion with two education officers ENB

Mar 29    Telephone discussion with course leader - North Lincoln

May-June  Annual reports from the six schemes for 1988/1989 received and collated by researcher

June-July Telephone discussions to clarify items in the reports from four schools
Table 4.1

Categories arising from
Content Analysis of the Submissions

Category 1 Philosophy of Nursing, Curriculum Model and Theories

Themes in the Submission: philosophy of nursing, philosophy of the nursing school, curriculum model, theories.

Category 2 Organisational Structure, Linkage, Institutional Characteristics and Course Control

Themes in the Submission: course control, linkage with higher/tertiary education, course tutor, joint appointment college/nursing school, organisational structure.

Category 3 Curriculum Content/Design/Balance of Theory and Practice, Student Selection, Status and Remuneration

Themes in the Submission: balance college/school, balance theory/practice, curriculum design, curriculum content, pattern/length field and clinical experience, status of the student/remuneration, selection.

Category 4 Assessment Proposals

Themes in the Submission: assessment - student progress - formative and summative continuous assessment, concurrent data and records.

Category 5 Evaluation Proposals, Course Review, Research, Teaching/Learning Strategies

Themes in the Submission: evaluation proposals and research, course review, modification/adaptation, learning/teaching strategies/methods, criteria for selection of field/clinical placements, process evaluation - summative.
Category 6  Planning for Change, Communications, Staff Preparation *and Staff Development

Themes in the Submission

planning team and proposals, communication, joint appointments teaching/practice, teacher/lecturer/student ratio, mentors and clinical supervisors preparation, lecturers and clinical staff preparation for change role change for teaching staff.

* Amendments after Peer Review
CHAPTER FIVE

CONTENT ANALYSIS OF THE SUBMISSIONS

Six categories emerging from content analysis of the submissions were identified in Chapter 4 and are illustrated in Table 4.1. The themes within the written text of the submissions reveal similarities and differences in the approaches to experimentation in the six schemes, and these will now be discussed. The researcher's original intention was to identify each pilot scheme by cypher or code, but as the schemes had been announced publicly, and articles about the proposals by participants and others had appeared in nursing journals in 1985 and 1986 when this research project began, this was not pursued. To simplify tables, and for brevity in the text, the pilot schemes are referred to either by a letter, or by using a short title of the city, town, or health district in the collaborative venture - Tables 5.1 and 5.2 give the full titles of the institutions and the abbreviations used in the project.

5.1 Philosophy of Nursing, Curriculum Model and Theories

The philosophy of nursing, or the nursing model - the approach to nursing - on which the curriculum is based in each submission is summarised in Table 5.1.a
### Table 5.1

**SUBMISSIONS CONTENT ANALYSIS**

<table>
<thead>
<tr>
<th>Pilot Scheme</th>
<th>Collaborating Institutions</th>
<th>Abbreviation in Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Dorset School of Nursing*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(with West Dorset Health</td>
<td>West Dorset</td>
</tr>
<tr>
<td></td>
<td>Authority)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weymouth College</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>South Birmingham Health</td>
<td>South Birmingham</td>
</tr>
<tr>
<td></td>
<td>Authority</td>
<td></td>
</tr>
<tr>
<td></td>
<td>City of Birmingham Polytechnic</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Sunderland Health Authority</td>
<td>Sunderland</td>
</tr>
<tr>
<td></td>
<td>Newcastle Upon Tyne Polytechnic</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>North Lincolnshire Health Authority</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bishop Grosseteste College</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Somerset Health Authority**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- in East Somerset</td>
<td>Yeovil</td>
</tr>
<tr>
<td>F</td>
<td>Central Birmingham Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Authority</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University of Birmingham Extra Mural Department</td>
<td></td>
</tr>
</tbody>
</table>

*Footnotes:*
* West and East Dorset Health Authorities - the school has two circuits (or centres) one in each Health Authority.
** Somerset School of Nursing has 2 circuits (or centres) one in Yeovil, and one in Taunton (West Somerset)
### Philosophy of Nursing – Curriculum/model/theory

| A | Eclectic model of nursing, conceptual approach, a core of professional knowledge, theories and principles.  
|   | Conceptual process model of curriculum, care grounded in nursing theory, biological and behavioural sciences |
| B | Holistic approach to patient care; relationships, life styles, cultural factors using Roper's model.  
|   | Curriculum based on broad and sound theoretical foundation, communication skills, health education, critical thinking and 'research-mindedness', experiential learning. |
| C | Holistic problem-solving activity, based on the activities of daily living model of nursing, the nursing process and a research-based approach.  
|   | Curriculum model centres on the concept of the individual, health and health deviations, an age and dependency continuum and a scientific base developing the psychological and social domains of nursing theory and practice. |
| D | Health model approach emphasising health education, promotion and maintenance, life studies and occupational/community experience in unit one.  
|   | Curriculum based on experiential learning taxonomy, with a process-orientated approach. |
| E | Nursing theory based on the 8 roles of the nurse: assessor of nursing needs, planner of nursing care, practitioner, evaluator, learner/researcher of nursing care, teacher of nursing and health, manager, professional person.  
|   | Process model curriculum, focus on learner as researcher/enquirer, student-needs based; experience – reflection – formulation model; teacher as facilitator. |
| F | Eclectic model of nursing, based on Henderson's definition and Roper's model; care that reflects current knowledge and research.  
|   | Conceptual process model, health, illness, man, nursing, focus on learning styles, seeking practice with theory grounded in reality. |

**Key:**  
A - West Dorset,  
B - South Birmingham,  
C - Sunderland,  
D - North Lincoln,  
E - Yeovil,  
F - Central Birmingham
An eclectic model of nursing is specified in the submissions from West Dorset and Central Birmingham. The latter adopts Henderson's definition (1960) and Roper's (1976) activities of daily living approaches combined with care that reflects current knowledge and research, and is grounded in theory. West Dorset bases the eclectic model of nursing in a core of professional knowledge, theories, concepts, and principles for the development of an appropriate skills' repertoire for the delivery of nursing care, to prepare students to become safe and competent practitioners.

(Submission p.12)

Sunderland and South Birmingham adopt a holistic approach with the latter using Roper's (1976) model of the activities of daily living in the context of differing life styles and cultural factors. Sunderland's submission stresses the research based approach to nursing as a problem-solving activity and

embodies the nursing process within a model of nursing based upon activities of daily living.

(Submission p.5)

North Lincoln adopts a health model approach to nursing, emphasising health education, health promotion and maintenance, and life studies with occupational and community experience in the early stages of the course. Yeovil also bases nursing theory on a broad approach which includes the role of the nurse as a teacher of nursing and health. Yeovil identifies the eight roles of the nurse as
5.3

assessor of patients' needs, planner of nursing care, practitioner, evaluator, learner/researcher of nursing care, teacher of nursing and health, manager, professional person.

(Submission p.42)

Four of the submissions adopt a curriculum process model; Yeovil basing this on the needs of a rural community, and focusing on the student's needs as a researcher/enquirer. The submission quotes Stenhouse (1975) and the teacher as facilitator using the model - experience, reflection, formulation. North Lincoln takes

a process-oriented approach with the curriculum based on experiential learning taxonomy

(Submission p.1)

and refers to Steinaker and Bell (1979). West Dorset adopts a conceptual process model of the curriculum, and draws attention to the influence of Bruner (1961) Knowles (1973) and Rogers (1969) Maslow (1954). The submission from West Dorset also affirms that on completion of the course the aim is to enable the nurse to provide care which is grounded in nursing theory, and in the biological and behavioural sciences.

(Submission p.13)

Central Birmingham also adopts a conceptual process model of the curriculum, which focuses on the student's need to learn how to learn, with reference to Mezirow (1983) in Appendix 2 of the Submission and theory must be grounded in reality, if it is to be of value

(Submission p.11)
In the process of nurse education the submission affirming that it is anticipated that nurses will become caring, safe practitioners, who adopt a research-based problem-centred approach to all aspects of their professional role, not only to keep abreast of change but also to initiate it.

(Submission. Enclosure 3).

The submission from Sunderland proposes a curriculum model with a scientific base for nursing theory and practice, in order to develop the psychological and social domains of nursing. It centres on the concepts of the individual, and health, and introduces deviations from health on an age and dependency continuum. South Birmingham proposes a broad and sound theoretical foundation including sociology, social psychology, communication skills and health education, the development of critical thinking and 'research-mindedness'. The submissions from these two schemes, with collaboration between schools of nursing and polytechnics, do not discuss the educational theories which influenced the curriculum proposals. This is one aspect which was followed up in visits and interviews later.

This category - the philosophy of nursing, curriculum model and theories - will be explored further during visits to the six schools, as the pilot schemes progress.
<table>
<thead>
<tr>
<th>PILOT</th>
<th>LINKAGE</th>
<th>QUALIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Dorset School of Nursing - West Dorset and Weymouth College</td>
<td>R.G.N.</td>
</tr>
<tr>
<td>B</td>
<td>Selly Oak School of Nursing and City of Birmingham Polytechnic</td>
<td>R.G.N.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diploma in Nursing Studies</td>
</tr>
<tr>
<td>C</td>
<td>Sunderland School of Nursing and Newcastle upon Tyne Polytechnic</td>
<td>R.G.N.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diploma in Nursing Science</td>
</tr>
<tr>
<td>D</td>
<td>North Lincolnshire School of Nursing and Bishop Grosseteste College</td>
<td>R.G.N.</td>
</tr>
<tr>
<td>E</td>
<td>Somerset School of Nursing - Yeovil</td>
<td>R.G.N.</td>
</tr>
<tr>
<td>F</td>
<td>Queen Elizabeth School of Nursing, Central Birmingham</td>
<td>R.G.N.</td>
</tr>
<tr>
<td></td>
<td>Extra mural Department - University of Birmingham</td>
<td></td>
</tr>
</tbody>
</table>

Key: R.G.N. = eligibility to apply to be registered in Part I of the Register - Nurses, Midwives and Health Visitors Rules Approval order 1983 No. 873
5.2 Organisational structure, linkage, institutional characteristics and course control

The proposed linkages between schools of nursing and institutions of tertiary, or higher education, the characteristics of the institutions, and the proposals for course control form a cluster of inter-related themes in the submissions, leaving much to be explored further in visits and interviews.

Table 5.2. previous page summarises the proposed linkages; West Dorset with a tertiary college; North Lincoln with a college of education; South Birmingham and Sunderland with polytechnics; Central Birmingham with the extra-mural department of a university, and Yeovil with no external link.

5.2.(i) Yeovil pilot scheme is based in one circuit of general nurse training of the Somerset School of Nursing, and is sited in the East Somerset part of this single health district. This part of the health district has one general hospital and several small community hospitals, and community services serving a rural community. Proposals for the curriculum design, for monitoring and adjusting the course, and sub-groups to plan and monitor specialised nursing aspects of the course are under the control of the Course Management Team which is responsible to the Nurse Education Committee of the health authority. The Course Management Team, as indicated in the Submission p.3 consists of fifteen members including the DNE, the Director of Nursing Service (DNS Yeovil),
the senior nurse in the community, two nurses managing community hospitals, a children's ward sister, allocation officer, in-service education officer, three senior tutors, three nurse tutors and a clinical teacher. The sub-groups for the foundation unit, community, care of the elderly, mental health, surgical, high dependency, mother and baby and children, and acute nursing units are listed in the submission p.4, their terms of reference include proposals for identifying roles, units of experience, assignments, and evaluation of the reactions to the unit or the need for adjustment.

5.2.(ii) The pilot scheme in Central Birmingham is based in the Queen Elizabeth School of Nursing, in a teaching health district in a conurbation.

The proposed linkage in this course is indicated in the Submission p.43; key and applied teaching sessions are listed including, teaching and learning, health studies, psychology, sociology, research, professional studies and management studies. Key sessions given by lecturers from the extra mural department of the university include sociology, psychology and health studies, with teachers of nursing opting into specialist groups for teaching the applied sessions.

In Appendix 1a in the Submission the membership of the Education Curriculum Policy Committee is set out; it includes eleven members, two lecturers (Further Education/Higher Education), two directors of nursing service, (DNS) the director of midwifery Service, two senior tutors
(basic courses) one senior tutor (part-basic courses) the senior tutor curriculum development, the chief nursing officer and the DNE in the chair. The objectives set for this Committee, which is to advise on the educational policy for the courses within the framework of the philosophy of the school of nursing, are itemised and include educational methodology, evaluation of the courses, the theoretical and clinical experience, and the formulation of principles for assessment and examination to meet the requirements of the ENB. Appendix 1b in the Submission sets out the membership of the Education Manpower Planning Committee with the chief nursing officer in the chair, the DNE, three DNS's, three senior tutors, the senior tutor (allocation) the District Support Nurse, and a health authority member. This committee is to review needs, and make predictions to meet changes in the district strategic plans, to set manpower levels, to monitor statistical information and liaise closely with the Education Curriculum Policy Committee. These appendices are dated 8.1.85 and the structure was revised at a later date during the research project.

5.2.(iii) West Dorset submission p.11 sets out the membership and terms of reference of the Course Planning Team. Team members include the DNE, ADNE, DNS, Senior tutor, tutor, nursing officer, ward sister, senior nurse (allocation) the District Nursing Officer and the principal lecturer from the Department of Humanities, Weymouth College. Their terms of reference include developing a course for entry to part 1 of the Professional Register (RGN) which integrates theory with clinical practice, approving the teaching programme for each stage of the course,
and identifying suitable learning climates for the clinical aspects of the course. Course administration, monitoring and evaluation are addressed in the submission page 34.

The general administration for the course is the delegated responsibility of the course tutor, acting under the structural authority of the Director of Nurse Education (Submission p.34)

The course tutor is required to collect information to enable decisions to be made about the programme, monitoring its effectiveness, and identifying reasons for success and failure in implementing the course. Statistical information on applicants, entrants, withdrawal, discontinuation and initial employment; reports from the Course Committee; examinations/assessments; student evaluations and course resources both human and material are listed, and the course tutor is responsible for co-ordinating the course team and the contribution of placement supervisors. The Course Committee, meeting quarterly, chaired by the ADNE, is to replace the Course planning team when the course becomes operational. The membership includes three students - from each year of the course, the librarian, the DNS, the course tutor, three placement supervisors, and the teaching team. The terms of reference are set out in the Submission page 35, and highlight the evaluation of the course, and of teachers' performance by students; the teachers' evaluation of their own teaching, and the summary evaluation by the Course Committee. The committee will advise the DNE on the learning opportunities, the suitability of all placement settings, and the state
of staff development activity, and put forward suggestions by the teaching team, the DNS, staff in placement settings, students and other bodies regarding any aspect of the course.

5.2. (iv) Sunderland proposes a course jointly planned between a school of nursing in a health district and a polytechnic to lead to registration as a general nurse, and a polytechnic diploma in nursing science. The title page of the submission (January 1985), lists the core planning group for the pilot scheme consisting of six members, three from the health authority - the CNO, the DNE and a tutor, - two from the polytechnic, the Head of School of Behavioural Science and the senior lecturer who is course leader of the Diploma of Professional Studies in Nursing, and the course leader, a senior tutor in the school of nursing, in the chair. The role of the course leader is identified as a key role (Submission p. 79), in all the administrative, organisational and teaching aspects of the course. This includes being responsible to the Course Committee for:

- the effective operation of the course, matters of student admission, registration, welfare, assessment and records as well as matters relating to student discipline and withdrawal
- liaison with polytechnic, health authority staff and personal tutors ...
- liaison with official bodies, external examiners, and assessors
- maintenance of records and the preparation of reports and returns relevant to the operation of the course.

(Submission p. 79)

The submission addresses the criteria for determining educational placements, and the staff preparation required on page 73.
5.2. (v) The submission from South Birmingham proposes a joint submission from a health authority and a polytechnic in a conurbation.

The Polytechnic's Department of Health Sciences and the School of Nursing at S.B.H.A. will be responsible for the management of the course jointly

(Submission p.1)

Course administration is also detailed in the Submission p.53.

The Course Director will be responsible to the Director of Nurse Education and the Head of Department in the Polytechnic for the effective operation of the course through the Course Development Committee, and, later, through the Board of Studies.

The Head of the School of Nursing Studies (Department of Health Sciences) in the Polytechnic will be responsible for the management of liaison between the Polytechnic and the School of Nursing

(Submission p.53)

A joint steering group, and a joint curriculum planning group, set up in October 1984, was succeeded by a Course Development Committee with representation from both institutions, and when the course became operational this was replaced by the Course Board of Studies, with the Course Director as chair person.

The Course Development Committee consisted of seventeen members, eight from the health authority - the DNE, the District Nursing Officer (DNO) and Assistant District Nursing Officer (ADNO), the librarian, two senior tutors a tutor and the senior tutor/course director). Nine polytechnic representatives included the Heads of Departments of Health Sciences; the Head of Department of Sociology and Applied Social Studies; the Head of Faculty, Social Sciences and Arts; the Principal Lecturer in Nursing,
5.11

Studies; the Senior Lecturer in District Nursing; Senior lecturers in the Departments of Health Sciences and Complementary Studies, and the research associate.

The Course Development Committee was to be responsible for the educational programme, management of the course, implementing its aims and objectives, the assessment arrangements, modifications, recruitment and selection of students, monitoring student problems and progress and regular auditing of the course (Submission p.53). The Course Development Committee met every three weeks in the initial planning stages, and the Course Board of Studies took over these responsibilities when the course began, with the additional functions, listed in the submission on page 55:

- the maintenance of contact with appropriate professional bodies
- the maintenance of contact with employers and clinical personnel
- the arrangements for period of placement for students
- recommendations to the Head of Department on the termination of student membership of the course
- nursing students as employees.

(Submission p.55)

The membership of the Course Board of Studies, with the Course Director in the chair, includes the Head of Department of health sciences, the DNE, the Dean of Faculty, all polytechnic staff and all nursing staff in the authority making a significant teaching contribution to the course,
two clinical supervisors for each year of the course, two students, elected by their peers for each year of the course, other members proposed by the department or School of Nursing, or required by external bodies.

(Submission p.55)

The responsibility of the Board according to the submission, is to the Head of Department and the DNE, to monitor all aspects of the course, within the regulations approved, and according to the policies of the academic board of the polytechnic and the ENB regulations for nurse training (Submission p.55).

5.2 (vi) The North Lincoln submission was examined by the researcher in 1986. The submission to the Board in 1985 is in two parts, 1 and 2 each concerned with the design of the course, the model of care, the experiential learning taxonomy, the selection process, and the content and methods of assessment in Units I and II. The goals and objectives for the units that follow are referred to in the list of contents and the submission includes, in the appendices, unit evaluation instruments and ward profiles.

The submission does not record the proposals for course administration nor the name of the college to which reference is made on page 1 of the Submission

- the first unit is totally college based -

The researcher, therefore, at this stage, was unable to include the data for category 2 from the original submission of the North Lincoln
scheme. The first visit to the school, by the researcher was in November 1986 - after a series of articles, by participants in the pilot scheme, had been published in Senior Nurse - Kenworthy (January 1986) Nicklin and Kenworthy (March 1986) Goodchild (June 1986) Snowley (August 1986). These made it clear that the scheme was jointly planned by staff in the School of Nursing and lecturers from the Bishop Grosseteste College of Education, and an article by Bennett (November/December 1986) in the same journal was published shortly after the researcher's first visit.

In August 1987 Part B of the submission from North Lincoln was made to the ENB, and became available to the researcher. The material from the later submission (1987) has been included in this section of the research project, to enable the reader to make comparisons between the six pilot schemes.

There is a core group for curriculum development - the DNE, with the deputy DNE in the chair, the ADNE, two senior tutors and two nurse teachers. An advisory group consists of a nurse manager (hospital) a nurse manager (community) the senior nurse allocations, a student nurse representative, a higher education representative, a medical representative, a ward sister and a community nurse. This advisory group meets with the core group for advice and consultation.

In the light of advice and consultation with the advisory group the core group will amend material to the satisfaction of the advisory group. Such a process hopefully prevents central control of curriculum development and enables a reflective approach to curriculum decisions.

(Part B Submission August 1987 p.10)
Day to day course management is the ultimate responsibility of the Senior Tutor (general).

However, to facilitate this person in the smooth operation of the course, a number of named course co-ordinators support the implementation of the course. This group is collectively referred to as the 'course management team'.

(Part B Submission August 1987 p.10)

The terms of reference of the team, which is responsible to the core group for curriculum development, and of the core group, is to:

- ensure congruence of course design to syllabus guidelines as determined by the ENB(1985(19)ERDB).
- enable wide consultation in the design of the course
- ensure that the concept of health is reflected throughout the course
- safeguard the integrity and internal consistency of the course

(Part B Submission August 1987 p.11)

5.3 **Curriculum content/design/balance of theory and practice - student selection, status and remuneration**

5.3 (i) Curriculum content/design

Curriculum design is illustrated in the six submissions, with varying descriptions, some offering a broad overview and others concentrating on the design and content of the first six months, or first year of the proposed course which is illustrated in Table 5.3 (a) on page 5.47.
### Table 5.3

<table>
<thead>
<tr>
<th>PILOT</th>
<th>LENGTH OF COURSE</th>
<th>STARTING DATE</th>
<th>INTAKES</th>
<th>STUDENT NUMBERS</th>
<th>REMUNERATION</th>
</tr>
</thead>
<tbody>
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<td>A</td>
<td>3 years</td>
<td>January 1986</td>
<td>January 1986</td>
<td>12 x 3</td>
<td>Year 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>June</td>
<td></td>
<td>Pro Rata Training Allowance</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>October</td>
<td></td>
<td>Year 2 and 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full Training Allowance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H/A</td>
</tr>
<tr>
<td>B</td>
<td>3 years</td>
<td>April 1986</td>
<td>April</td>
<td>20 x 2</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>September</td>
<td></td>
<td>Reg. Student of Poly</td>
</tr>
<tr>
<td>C</td>
<td>3 years</td>
<td>September 1985</td>
<td>January 1987</td>
<td>24 x 1</td>
<td>H/A throughout</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>January 1987</td>
<td></td>
<td>Reg. Student of Poly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>January 1988</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>January 1989</td>
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<td>182 weeks</td>
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<td>January</td>
<td>30 x 2</td>
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<td>E</td>
<td>3 years</td>
<td>March 1986</td>
<td>March</td>
<td>12 x 2</td>
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<td>F</td>
<td>152 weeks</td>
<td>March 1986</td>
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<td>50 x 3</td>
<td>H/A throughout</td>
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Content analysis therefore indicates that further exploration is required on visits, and at interviews to identify similarities and differences between the six courses in this respect. Curriculum content in all submissions includes health education, the social context of health, people in society, individualised care, and nursing in a variety of settings - both in hospitals and in the community. The inclusion of voluntary agencies in caring, and the occupational hazards in industrial, commercial and agricultural settings, it is contended, support the aims stated in four of the submissions that these courses are intended to prepare, not only safe and competent practitioners, but responsible members of society able to adapt to changing needs.

5.3.(ii) Student selection, status and remuneration.

The numbers of students in each course, the number of intakes each year, and the timing of the groups entering, show considerable variation, and are illustrated in Table 5.3. Educational entry requirements for pilot scheme students were indicated in Appendix C of the ENB invitation in September 1984; the minimum educational conditions were to meet criteria in 16 (1) of the Nurses, Midwives and Health Visitors Rules Approval order 1983 No: 873. Appendix IIIa in this project. Three submissions - Central Birmingham, Yeovil, and Sunderland do not refer to educational entry requirements. North Lincoln's August 1987 submission refers to the UKCC requirements and makes the following additions:
Applicants during the selection day are required to

1. Write an essay in order that an assessment can be made of the ability of expression in writing.
2. Participate in an informal discussion with a nurse teacher.
3. Participate in a visit to clinical areas.
4. Undertake an individual interview with an interviewing panel consisting of two nurse teachers and a service colleague.

Following interview the applicant is informed of the panels decision immediately. Unsuccessful candidates are offered counselling and advice.

(Part B Submission August 1987 p.5)

West Dorset's submission indicates that in addition to the requirement of 5 passes at GCE ordinary level A, B or C (or CSE grade one) these should include English language and a science subject, and continues

Preference will be given to candidates who have additional passes at GCE Advanced level.

Exceptionally candidates may be admitted following successful completion of the DC Entrance test.

(Submission p.14)

South Birmingham's Submission (pp.26-28) gives detailed information of alternative entry requirements acceptable for candidates entering a course for registration and for the award of a Polytechnic Diploma in Nursing Studies. These include:-
(i) A General Certificate of Education with passes in five separate subjects including English and a science or social science. One pass must be at Advanced level.

or

(ii) Three subjects at ordinary level grades A, B or C with two subjects at advanced level grades A-D. The subjects at Advanced level may be the same subjects as those at ordinary level.

or

(iii) Two subjects at ordinary level grades A, B or C with two subjects at advanced level grades A-D. These must be in different subjects from those at ordinary level.

or

(iv) Three subjects at advanced level grades A-D.

or

(v) Mature students without the minimum entry qualifications if they show ability to complete the course satisfactorily having undertaken the Polytechnic and the ENB entrance tests.

or

(vi) Applicants with other qualifications deemed acceptable by the Polytechnic and the ENB.

(Submission p.26)

Details of the selection process, including the procedure when the Nurses' Central Clearing House system is in operation are given on pages 26-28 of the Submission, and indicate the joint activity of scrutinising application forms, interviewing panels comprised of a polytechnic tutor, a nurse teacher, and a nursing officer, and the role of the admissions tutor who

has the responsibility to ensure comparability in decision making between different panels.

(Submission p.27 para. 6.3.3(iv))

The status and remuneration of the student was one of the areas in which the ENB were hoping for experimentation in the September 1984 invitation. Table 5.3a illustrates the difference in length of the supernumerary period during five of the six courses. This varies from six months in North Lincoln and Yeovil, to one year in Sunderland and West Dorset, and two years in South Birmingham. The proposals in the
sixth scheme in Central Birmingham do not include a period of supernumerary status, although the introductory course is lengthened to ten weeks.

In five schemes, the student receives the training allowance (as paid to conventional scheme students) from the health authority throughout the three year course. In the sixth scheme, West Dorset, a different arrangement for remuneration is made in the first year of the course; the student, who is supernumerary in the foundation year - Stage One of the course - receives a proportion of the full training allowance. The three terms of ten weeks each, and the annual leave entitlement of two and a half weeks are, therefore, recompensed on a pro rata basis - for 32½ weeks in the first year.

There is considerable variation in the data available in the submissions regarding curriculum content and design, and the balance of theory and practice in the proposals. Table 5.3 also illustrates the different approaches to the interpretation of the term 'pilot'. The ENB, September 1984, on page 3 para 2.4 indicates

2.4. It is not intended that the pilot scheme should be for a selected group, but that the whole of the normal group should be included. If, however, it is felt that, for the purpose of evaluation, a proportion of students could be included in the pilot scheme and a proportion could continue under the present training system, details should appear in the submission.

Content analysis of the submissions reveals that this is another aspect to be pursued at interviews and on visits.
Sunderland submission proposed one intake only in October 1985 - with four intakes to the conventional course in that year. Subsequently, further intakes were made to the pilot scheme in January 1987, 1988 and 1989, with four intakes annually to the conventional course.

Two schemes, Yeovil and West Dorset propose pilot schemes in one part of the school - Yeovil, a scheme for twelve students entering twice each year in September and March, and West Dorset, a scheme for twelve students entering three times a year in June, October and January. In both these schemes, there were no other intakes to that part, or circuit, of general nursing when the pilot scheme was in operation.

In North Lincoln, thirty students entering twice in each year, replaced the conventional course entrants, as noted in the August 1987 Submission. Kenworthy (January 1986) comments that the pupil nurse training course was discontinued when the pilot scheme began.

The pilot schemes in Central and South Birmingham also replaced intakes to the conventional courses. The intakes of twenty pilot scheme students to the South Birmingham course, in September and April each year, and intakes in Central Birmingham of fifty students three-times in July, November and March - each year, illustrate the differing dimensions involved.

The size and frequency of intakes are factors to be explored further in the discussions on visits, and in interviews with individuals.
5.4. Assessment Proposals

The ENB invitation September 1984 drew attention to the regulations set out in the UKCC Nurse Training Rules regarding:

Para 2.3 The course must fulfil the overall precepts laid down in the E.C. directives in respect of nurses responsible for general care (appendend D).

Paragraph 2.1. states

The course must provide the student with the opportunities set out in Rule 18 (1) of the UKCC Nurse Training Rules and must include "an examination" as described in Rule 19(1)(C)

Rule 19 (1) To qualify as a person who can apply to be registered in Part I of the Register the student shall

(c) have passed an examination, held or arranged by a Board, which may be in parts, and which shall be designed so as to assess the student's theoretical knowledge, practical skills and attitudes and demonstrate her ability to undertake the relevant competencies specified in Rule 18 of these Rules.

Rule 18 (1) lists the competencies which appear in full in Appendix III (a) in this project.

It was the ENB's intention - set out in para 1.3 (1) September 1984 - in the experiment with the six pilot courses, to minimise central regulations/control to allow for maximum flexibility at local level. The proposals for assessment in the six submissions reflect this intention, and show flexibility, whilst identifying the need for theoretical material to be linked with practical holistic care.
5.4.(i) Central Birmingham's process model of the curriculum involves moving from information-giving to learner independence, according to the Submission, moving away from

the need to acquire information because of the nature of the Final Written Examination, seen as the main gateway to Registration

(Submission p.1.)

The aims of the pilot scheme include

To implement continuous theoretical and practical assessment - the former to occur both in clinical areas and the School of Nursing, deviating from the proposals of the ENB document 21.11.84.

(Submission p.2)

The submission page 58 sets out proposals for assessment, using a variety of methods, and addresses the purposes of assessment - to diagnose difficulties and plan help, to encourage flexibility and personal growth, to appraise knowledge application, to motivate students and to determine suitability for professional registration. Criterion, rather than norm, referenced tests, "contract grading" and negotiated assignments form part of the collaborative approach towards self assessment and independent learning on which the course is based, and which is its stated philosophy. Workshops for 36 ward sisters and nursing officers devised key objectives centred upon patient care, ward organisation and management, and on personal and professional development to enable the competencies in the Rules to be assessed. Detailed examples of the forms for continuous assessment in use in each of the placements of the course, with information for both assessors and learners, are included in the submission in the appendices.
5.4. (ii) The Yeovil submission specifies continuing assessment in clinical placements, and by continuing academic assessment through the completion of assignments for each unit. Marking shared by tutorial and clinical staff. Self assessment exercises discussed with Tutor/Counsellor

(Submission p.41)

These formative assessments will occur in the nine units of the course, and by the tenth unit

The system would allow the final evaluation in unit 10 to be made on complete role fulfilment

(Submission p.41)

The examinations board will be responsible for final evaluation, making use of the external examiner function.

A final grading will be obtained by considering the best five assignments which will be submitted to the Examinations Board.

(Submission p.41)

This submission makes reference to the external examiners, who are members of the Examinations Board, but no other details of membership are given. The point is noted that

A final examination could be included if necessary. Stenhouse argues that although the process model should not be constrained by an examination system, students at the end of the course can do well in final examinations.

(Submission p.41)

5.4. (iii) South Birmingham assessment procedures are set out in the submission on page 33-51, and include course evaluation. The introduction to the assessment and examination system states,
The aim of the Examination Regulations and the Examination Board is to construct, within the ENB and the Polytechnic guidelines, an examination system which is fair and equitable to all candidates. The value of testing a wide range of subjects as well as a range of academic and practical ability is appreciated.

(Submission p.33)

The rationale of assessment is addressed in the Submission p.34 - both academic and ethical ability is to be tested, and assessment is seen as an essential part of the nurse as a safe, competent practitioner. These assessments will be designed to promote the development of confident practitioners, and will take into account likely characteristics of the students on the course.

(Submission p.35)

In Year 1 equal weighting will be given to assessment in supervised practice, course work and written examinations. Achievements in each unit will be assessed. In order to complete Year 1 successfully the student must obtain 40% of the total possible marks available in the placement supervisor's assessment, the examination and the course work.

(Submission p.36)

Assessments will be conducted throughout each full time placement for supervised practice in each year of the course - continuous assessment - and must be passed in order to complete each year. The submission addresses the issue of balancing the loading of course work, which it proposes will be monitored by the Course Board of Studies.
A schedule of assessments for Year 1 is given, and the detailed procedures for setting and marking examination papers. The proposals are for two unseen papers to be taken at the end of each year, which conform to the current ENB requirements for the Final Examination:

(i) One unseen 3 hour essay paper - Paper I
(ii) One unseen 1½ hour essay paper - Paper II

(Submission p.37)

Paper II will offer a choice of three questions for the 1½ hour essay - one question with a clinical orientation offering the opportunity for students to be more questioning, or to offer a wider and deeper approach to the topic, than the shorter time - 35 minutes allowed for five questions in Paper I. The second question, it is proposed may be on health education and promotion, or topical issues in health care, calling for answers which are well-structured, and offer reasoned argument, supported by reference to self-experience, other persons' experiences and research findings; the topics for the question should be more abstract, less clinical, but nevertheless thought-provoking.

(Submission p.38)

The third question should deal with some aspects of the value, relevance, and practical and theoretical applications of research and/or the principles of effective communication in patient care, health promotion and disease prevention.

(Submission p.30)

The composition and functions of the Examination Board are set out on pages 33-34.
5.25

5.4.(iv) The West Dorset submission sets out the scheme of assessments proposed, the regulations and procedures on pages 24-28. The assessment in Stage I, the first year of the course is illustrated in tabular form on page 24. The proposals are for four unseen papers, two context related essays, two essays and the presentation of a care plan, and aspects of its implementation for one patient during a tour of duty.

The proposed weighting is equal for each of these assessments.

Proposals for assessment in year two - the second stage of the course are for care plans in each module of clinical experience to be assessed by the clinical supervisor in consultation with the student's personal tutor. These will require the student to address the patient's need in a holistic fashion, and to demonstrate specific competency during each placement. These are:

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<th>Weighting</th>
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<td>(a) Awareness of health promotion 10%</td>
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<td>(b) Inclusion of the patient in the planning process 10%</td>
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<td>(c) Ability to co-ordinate others in the delivery of care 10%</td>
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<tr>
<td>(d) Demonstration of skills in care evaluation 10%</td>
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<tr>
<td>(e) Capacity to work with medical and paramedical colleagues 10%</td>
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<tr>
<td>(f) Ability to manage a group of patients over a period of time and to organise appropriate support services 10%</td>
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In addition to the care plans, two learning contracts are proposed on specific topics of the student's own choosing, but related to the overall themes of disease prevention and health promotion (20% weighting). One unseen paper - 3 hours - during the last ten weeks of the second year - is proposed (20% weighting). The submission proposes
a variety of methods of continuous assessment of the academic work of students during the third year. These clinically related assignments will, it is suggested, involve learning contracts for learners with their clinical supervisors and tutors. A literature review, or a small scale piece of empirical work, on a subject of the student’s choice, as a research report (5,000 words) is to form a major part of the third year assessment.

The composition of the Examination Board, its functions, the names and duties of the external examiners appear on pages 28-33.

5.4.(v) The Sunderland submission lists the proposals for assessment as a schedule for the three years on page 71.

In Year 1 the focus on models of man and deviations from health is assessed by a literature search, a health care project, a holistic nursing assignment, and an examination. In year 2, when the age continuum curriculum model focuses on maternal, child health, experience with adolescents, and on acute care in middle age, assessment is by essay, a short answer test paper, a holistic nursing assignment and a research review. The third year focuses on psychiatric nursing in middle age, and independent and dependent elderly nursing care; a small scale nursing project and a holistic nursing assignment are the assessment methods proposed. The passmark required in each assessed component will be 40% - with a
5.27

variety of assessment methods designed to facilitate problem-solving skills, and skills of active, independent learning.

(Submission p.67)

Continuous assessment is referred to under the heading Evaluation in the Submission on page 83.

Practically the students will be evaluated against pre-determined criterion-keyed performance indicators. Such indicators will themselves be evolved by tutorial and clinical staff and their achievement will be determined via continuous assessment.

(Submission p.83)

Theoretically the student will need to demonstrate a research and problem-solving approach and show evidence of academic progression. The external examiners will obviously be actively involved in monitoring of these standards.

(Submission p.83)

Reference in the Submission is made to the examiners, but no detailed information is given of the Examination Board and its functions.

5.4.(vi) The Submission Part I and II from North Lincoln sets out the main content, the concepts and behavioural objectives for Unit I of the course (the first six months) on page 3, and the assessment of learning objectives on pages 11-13. The assignments in this unit are - student journal, seminar paper, essay and community study, each with equal weighting. One referral only in the essay and the community study is allowed, and a minimum of 50% is required in each assignment. In Unit 2 - the introduction to the application of care skills - the assessment will test the competencies listed on page 41a of the Submission Part I as 2b-2h. This Unit's aim is

to provide the students with the opportunities to observe and participate in caring Skills, and in a variety of community and hospital settings.

(Submission p.41a)
At the end of Unit 2 (the end of the first year)

The student will demonstrate an ability to give total care to a patient under supervision.  

(Submission p.1 of Unit 2)

The format of this submission sets out the activities, the learning principles, the strategies for learning and teaching, the resources required, and the proposed assessment at different taxonomic levels - exposure, participation, identification, internalization and dissemination.

No details were given of the proposals for examination, or of the Examination Board, or membership.

The researcher, therefore, was left to explore these issues later.

The Submission Part B from North Lincoln in August 1987 addresses these issues - pages 174-176, which are now summarised. The process of assessment is both formative and summative - in keeping with the underlying philosophy of the curriculum - an ascending gradient of professional competence in the individual's ability to assess, plan and evaluate total nursing care.

All practical experiences will be utilised in formative assessments, and successful completion of each unit is required, before moving on to the next unit. The four formal practical assessments in units 2, 3 4 and 6 are

    discrete and complement the learning and professional development objectives ...
For each of these assessments the student will be afforded two attempts. In the event of a referral at the first attempt, both the mentor and the ward sister/charge nurse must assess the student on the second attempt.

(Part B Submission August 1987 p.175)

Formative and summative strategies (theory) are also detailed with criterion - referenced marking, and a pass mark of 50% in each assignment.

The determinate examination will constitute the summative strategy for the RGN (pilot scheme) Course

(Part B Submission August 1987 p.175)

The composition of the Moderating Committee/Examinations and Assessment Board includes two external moderators; the four remaining members are drawn from teaching and service staff with the Assistant Director of Nurse Education (Curricula Studies and Educational Research) as Chairman-designate.

The Board is currently reviewing its parameters of responsibility in order to encapsulate the assessment of both the theory and practice of nursing.

(Part B Submission August 1987 p.176)

5.5. Evaluation proposals, course review, research, teaching/learning strategies

Content analysis of this category is discussed in two parts; evaluation proposals and course review in paragraph 5.5. (1) (a) to 5.5. (1) (f), and research and teaching/learning strategies in paragraphs 5.5 (ii) (a) and 5.5 (ii) (b).
5.5. (i) Evaluation proposals and course review

All the submissions address the need for evaluation, course monitoring and review. The formal mechanisms are those in use in the School of Nursing in the health authority, and those in the polytechnic in linked schemes.

Examples of course evaluation models in North Lincoln and in Central Birmingham are in diagrammatic form, and are illustrated in Appendix V. Each of the six submissions proposes to collect information from students, teaching staff, clinical staff and supervisors, about the progress of the course. Questionnaires for students regarding teaching content, and methods, learning opportunities and the learning environment, and questionnaires for mentors and trained nurses regarding both the clinical environment and the study programme are referred to, with some examples in the submissions.

5.5. (i) (a) The questionnaires in North Lincoln elicit student's views to be completed for each placement, for the preparation, learning objectives and outcomes, as well as the development of knowledge and application to skills and the supervision, and the student's attitudes and feelings about the experience. A similar student evaluation of study blocks, content, presentation and assessment is in use, and student suggestions for change are welcomed for each allocation. The Ward Sister's evaluation form, as the person who is responsible for the student during this time, is also in the form of a questionnaire with
open ended questions regarding the ward learning objectives, the preparation in the study block, the ward environment with learning, attitudes/relationships between ward and teaching staff, and assessment methods.

5.5(i) (b) Central Birmingham established a Course Evaluation Model in 1983 and the submission indicates that evaluation is both formative and summative in nature; the process adopted is to improve standards of patient care via effective nurse education:

- determining which stated intentions, expectations and standards were achieved in reality,
- collecting information to be used as a basis for future decision making and action,
- encouraging self evaluation by teacher, student and trained staff.

(Submission p.59)

The use of a questionnaire for staff development/school audit, (an audit by teaching, clinical and managerial staff of the clinical areas for learner allocation), appears in Appendix 12 of the submission. Newly qualified staff nurses are asked to write an evaluation of the course and to repeat this evaluation after one year.

5.5 (i) (c) Yeovil encourages formative evaluation also by questionnaire for each unit of the course - by learners, clinical staff, tutor/councillors, and curriculum planning team. These are to be collated and discussed by the team, and early changes are to be recommended if required. (Submission p.43-46). Questionnaires for
clinical staff include questions on course administration, support services, tutor contact, student participation, preparation for experience, assignments and assessment. The questionnaire for students includes similar topics and questions regarding access to library, media resources and to their tutors during the allocation. The questionnaire for tutor/counsellors includes questions regarding workshop, classroom and colleague support as well as items regarding knowledge testing, staff appraisal and outcomes achieved during the unit.

5.5 (i) (d) West Dorset evaluation procedures are set out in the Submission on pages 34-35 as indicated earlier in this chapter regarding the role of the course tutor, and the functions of the Course Committee which is to report to, and advise, the DME on evaluative procedures, as outlined in the Course Evaluation Package of the Joint Board of Clinical Studies 1979.

This includes student evaluations of the course, and of teacher's performance; teachers' evaluations of their own teaching, and summary evaluation by the Course Committee.

A working group of the Course Committee will review the suitability of micro-learning environments and report on

the range of skills in use in a particular setting, learning opportunities that arise consistently, state of staff development activity performance of placement supervisors, suitability of all placement settings used for the course.

(Submission p.35)
5.5 (i) (e) South Birmingham Submission states that evaluation is essential not only because this is a pilot scheme and therefore by nature experimental, but also because regular auditing contributes positively to the content and progress of any course. (Submission p. 47 para 8.5)

Existing systems within the polytechnic and the health authority will be incorporated into the procedure, with all course members participating in course evaluation.

but specific criteria and monitoring tests will be developed so that evaluation can be carried out systematically. (Submission p.47 para 8.5)

The Course Board of Studies will monitor progress and initiate changes, provide a vehicle for evaluation by teaching staff and students, and evaluate

the academic content, teaching methods and suitability of placements. (Submission p.47 para 8.5.0)

5.5. (i) (f) The Sunderland submission emphasises that the concept of systematic evaluation is a major concern of the pilot scheme. Amongst the strategies for evaluation outlined are - firstly student evaluation

Active and on-going monitoring of student performance theoretically and practically will provide a major thrust to the evaluation programme (Submission p.38)

The student would be required to demonstrate a research and problem solving approach, and show academic progression; and the

external examiners will obviously be actively involved in monitoring of these standards (Submission p.83)
5.34

The submission draws attention to the need for communication between these areas.

Communication between the school of nursing, polytechnic and practice areas is essential in communicating the aims, objectives and educational philosophy.

(Submission p.83)

The submission states that the Course Leader and the course committee would be required to undertake this, and to identify problems, initiating appropriate action. Review committee are proposed to monitor the educational programme and to provide constructive criticisms for the course leader and course committee.

(Submission p.84)

5.5. (ii) Research and teaching/learning strategies

5.5 (ii) (a) Research

The theme of research is approached in various ways in the submissions. West Dorset submission states that research in the teaching learning process should underpin the curriculum and be applied in nursing practice. It should be the basis upon which changes in patterns of nursing are made, and should ultimately be part of the overall function of the school of nursing.

(Submission p.6)
Yeovil's curriculum model, focusing on the eight roles of the nurse, identifies the nurse as researcher as one of these eight roles. In addition, the learner, as enquirer from the outset of the course, carries the research theme throughout the ten units. Central Birmingham and Sunderland emphasise the development of critical thinking and a problem-solving approach from the beginning of, and running throughout, the course. North Lincoln, within the framework of the course, stresses assessing, planning and evaluating care, and in the final unit, as staff nurse preparation includes clinical management, teaching and research. South Birmingham includes research as a unit in the first two semesters of the first year to develop student's interest in, and understanding of, research and to appreciate its application to nursing practice. The theme of research runs through all the remaining units of the course.

In addition three submissions refer to the research projects to be undertaken in each school. The Sunderland submission, page 84, refers to the difficulty of evaluating the impact on standards of patient care, made by the introduction of this new curriculum.

Research related to care provision and staff attitudes will be undertaken before embarking upon the scheme in specific care settings. This research will be on-going and help determine the impact of the new curriculum.

South Birmingham's submission p.48 refers to the in-depth case study to be undertaken by the research associate in nursing studies at the polytechnic. A list of overall objectives indicates the descriptive nature of the study which is to include: examining the process of
curriculum development; identifying problems experienced during the course; its perceived strengths and weaknesses; the development of student profiles and proposed career patterns.

Central Birmingham's submission p.60 proposes to appoint a research assistant to collect data - both quantitative and qualitative, and to work closely with the senior tutor - curriculum development. Data for statistical analysis include: correlation between practical and academic achievement; preferred learning style and the relationship with wastage/success; wastage/success; sickness absence rates compared with other staff. In addition, the research assistant is to devise methods to observe and record:

1. attitudes of teachers, learners, clinical staff and patients towards selected aspects of the pilot scheme
2. classroom interaction/teaching style
3. factors which enhance or inhibit learner independence from the teacher
4. ward based learning opportunities
5. changes in the ward learning climate
6. organisation changes which occur during the pilot scheme

(Submission p.60)

5.5. (ii) (b) Teaching/Learning strategies

All submissions stress the importance of student centred courses, encouraging self-direction and independent learning. The role of the
teacher, as a facilitator in the education of adults is addressed in each submission - West Dorset submission refers to Knowles (1973) and Central Birmingham to Mezirow (1983). The changes in the learner/teacher relationship - as equal partners in Central Birmingham, as counsellors/friend in Yeovil, to set the caring model for the nurse/patient relationship, - are issues to be explored later at interviews during this research.

Experiential learning is a feature of the proposed pilot scheme in South Birmingham, it is also emphasised in Yeovil, and in North Lincoln the experiential taxonomy on which the course is based involves changes in teaching/learning strategies and in assessment and evaluation.

5.6 Planning for change, communications, staff preparation and staff development

5.6 (i) Staff development

Programmes of staff development, as distinct from the preparation of staff for the proposed changes in the pilot schemes, are referred to in four of the submissions.

5.6 (i) (a) West Dorset's submission in Appendix VII p.95 gives detailed information about the department of Continuing Education for the Professional Development of Nursing staff, established in February 1985. The Senior Tutor (Continuing Education) is accountable to DNE, and the
department functions under the overall direction of the Assistant District General Manager (Professional and Managerial Development). The enhancement of nursing practice is the aim by

- facilitating the development of knowledge, skills and attitudes leading to critical awareness, so that professionals may be abreast of all developments.

- the department also believes that professional practice generates new knowledge and that the experience of practitioners is an essential component of the Professional Development and Continuing Education process.

(Submission Appendix VII (p.1) on p.95)

The full range of courses and opportunities for study are included in the eight appendices to Appendix VII in Volume Two of the West Dorset submission. These cover in-house courses - the nursing process; progress in implementation; ENB, 998 Course teaching and assessing in clinical practice; units of learning and workshops for staff nurses and enrolled nurses; clinical courses for ENB certificates including care of the elderly (ENB 941) and developments in nursing care (ENB 923); an in-house professional development course for Senior Nurses (Management and Education posts). The appendix also covers the opportunities for study in the East Dorset Health Authority, in Wessex, and in the Polytechnic of the South Bank, and Open University.

5.6. (i) (b) Central Birmingham submission addresses staff development and continuing education on page 61. This also includes the opportunities available for clinical staff to visit the school of nursing for two to three weeks when individual development programmes are devised, and the appointment of two teachers to hold joint Nursing
Officer/Nurse Tutor posts - one responsible for ward sister development, and one for clinical practice/research. A system of staff development/educational audit combined with staff appraisal for teaching staff:

enables strengths and weaknesses to be highlighted, not only of the person being appraised but also of the management structure and personnel within it, as well as the educational and organisational climate of the School of Nursing.

(Submission p.51)

Appendix 15 in this submission gives an example of the form used for the individual to prepare for this staff development discussion - twelve pages with questions addressing all aspects of the teacher's role and the environment for learning, with space for individual comments - views and suggestions for the modification of the curriculum, or for future professional experience to develop the individual's career. A development programme for newly qualified tutors is offered and the submission refers to evening sessions on statistics and research methods, and gives a summary for seven half-day study sessions for teaching staff during 1985 on subjects including self-awareness, counselling, experiential learning, value judgements, nursing models and theories, teaching communication skills and awareness of nursing research by student nurses. (Enclosure 6 Submission)

5.6. (i) (c) Sunderland's submission p.76 addresses the staff development policy of the health authority and the polytechnic, both considering this a high priority.
Close links have been forged between both parties to facilitate nursing research and to relate nursing theory and nursing practice more closely.

The polytechnic has actively encouraged nursing lecturers to establish links with health authorities to promote the effective communication of ideas and to exchange a range of views on professional nursing issues.

The health authority has an active in-service education programme - courses on the nursing process following a collaborative research project, management courses, examining and refresher courses and care of the elderly - and supports staff for studies at diploma and degree level in education, nursing and midwifery, for the ENB research appreciation course, and for certificates in health visiting and district nursing.

5.6. (i) (d) The South Birmingham submission addresses the opportunities for staff development in the health authority on pages 2 and 3.

Close relationships exist between educational and service staff to create a climate in which the student can learn and develop professionally. Many staff are themselves involved as students in continuing education

(Submission p.2)

A range of ENB clinical courses are listed on page 3 in the Post Basic School. The opportunities for staff development offered by the Department of Health Sciences at the polytechnic are indicated on pages 4-5 of the submission, including the CNAA Diploma in Professional Studies in Nursing, CNAA B.Sc. Nursing Studies, short courses in nursing and the supervision of M.Phil/PhD students in research and health-related areas.
The submission para 2.2 page 6 headed Staff development will be considered in this research project as staff preparation for the proposed changes.

5.6. (2) Staff preparation for the changes

The method of staff preparation in North Lincoln was not identified in Part I and 2 of the submission, but in August 1987 the following explanation is given on page 174.

The school has a thriving department of Continuing Education which provides a broad range of part-basic courses ... the school provides opportunity to pursue the ENB 998 Part-basic Nursing Course.

Before implementation of the RGN (pilot schemes) all staff were involved and/or invited to workshops ... In addition a number of articles were published on a regular basis in order to widely circulate the course in relation to its aims and the roles of all involved

(Part B Submission August 1987 p.174)

Yeovil submission, page 40, discusses the work of preparing for change - including all the trained staff studying the Open University Course P553 - A systematic approach to care, - and becoming involved in discussions regarding continuing assessment, the roles of the nurse and experiential learning. The In-Service Education Officer and Senior Tutors assist staff to move from the objectives model, and to appreciate the mentor role, and the preparation for the role; and to understand the curriculum model - the process of fulfilling the eight roles of the nurse.
West Dorset submission (page 20) addresses the theoretical context for teaching and learning strategies and the pre-requisites for the successful application of the theoretical proposition that learning occurs only under suitable conditions.

The submission also addresses the need to provide environments conducive to learning, and Appendix V in Volume Two of the submission offers a five page summary of the issues to be considered in a Profile of a Clinical Area. The role of clinical supervisors is discussed - their preparation is to include a course in the teaching and assessing of clinical practice, and attendance at preparatory workshops in readiness for their role.

They are not expected to be expert teachers or theoreticians. Their primary task will be to work in conjunction with the tutors to enrich students' learning experiences.

(Submission p.21)

Their preparation will include consideration of role-conflicts, for example, their perception of the role may be influenced by their own experiences as a student, and there may be professional/academic conflict.

The values of the teaching team may seem lofty and abstract whereas the supervisor's clinical world is seen to address concrete problems of human need.

(Submission p.22)

Lastly, there may be professional/bureaucratic conflict if there is conflict between the hierarchial setting in which nursing is carried out, and the learning activities seeking to produce autonomous practitioners.

(Submission p.22)
Central Birmingham submission page 61, refers to informal and formal peer group support networks to help teachers adapt to their changing role, and to the liaison between the Senior Tutor Continuing Education and the Senior Tutor Curriculum Development about the continuing education needs of the clinical staff.

The purpose of educational placements is to provide learners with opportunities to master the art and science of nursing care in a progressive manner and in line with statutory requirements and course objectives... these placements are of fundamental importance in developing the learner's perceptions of patient care and in providing this care.

(Submission p.73)

The criteria for determining these placements, including the periodic audit of individual patient care, the range of clinical experience offered, and the commitment of trained nurses to teach, supervise and assess the students, are listed, and all clinical staff who will become involved in the course will have further in-service preparation.

Current clinical nursing issues will form part of the new curriculum, and the involvement of clinical staff is therefore essential.

South Birmingham submission states

It is essential to the success of this scheme that, in order to integrate theory and practice, the student is presented with clinically expert role models. Therefore, teachers must be seen to be practising nurses, and practising nurses must be seen to be teachers.

(Submission p.11 para 3.13)
The role of the tutor, and of the clinical supervisors in linking theory and practice

are particular areas of concern as they are seen to be central to the success of the course.

(Submission para 2.2)

The proposals for developing staff and preparing for the pilot scheme include seminars for staff from both authorities to discuss issues relating to the pilot scheme and to nurse education; seminars for ward sisters to prepare for the clinical supervisor role, small working groups of tutors from the school of nursing and the polytechnic to discuss the integration of theory and practice with respect to the supporting disciplines; polytechnic tutors attending classes in existing courses in the school of nursing, and

a new course proposal in line with ENB Short Course 998... specifically to provide a means of training staff in preparation for the pilot scheme.

(Submission p.7)

It is argued that the following inferences may be drawn from the content analysis of the Submission. Firstly, the Board's selection of Sunderland, West Dorset and South Birmingham may reflect the intention to encourage collaboration between schools of nursing and other educational institutions. These three pilot schemes propose to alter the context of the curriculum, and to offer the student supernumerary status for the first year, or first two years of the course. In addition West Dorset reflects this student status in the style of remuneration for the student.
South Birmingham and Sunderland offer a polytechnic diploma in nursing studies and in nursing science respectively, whilst preparing the student for registration.

These three submissions stress the importance of joint planning teams, collaboration and communication, and joint staff preparation. Each refers to the close association required between all involved in giving clinical, community and educational support to students.

Collaboration between the school of nursing and Bishop Grosseteste College of Education is also a feature of North Lincoln's pilot scheme, which offers six months' supernumerary status and 'life experiences' followed by a period of six months' protected environments in unit 2 (with no unsocial hours - Monday to Friday 8.30 a.m. - 4.30 p.m.). At the end of the three years course there is a further period of six months' preparation for the staff nurse role - thus increasing the length of the course to three and a half-years.

Secondly, the Board's choice of Yeovil and Central Birmingham schemes based in schools of nursing, may be seen to reflect the discussion at the Board meeting, which preceded the invitation to experiment, as discussed in Chapter 2.

There are similarities and differences between these two schemes. Both submissions point to the need to consider the policy of the regional and/or district health authority/ies when planning a nursing
curriculum. Yeovil quotes these policies and their emphasis on care in the community as the basis for the proposal in the submission that the first six months of the course should offer the student supernumerary status and experience with related learning opportunities in community hospitals, clinics, with community nursing staff and with doctors in general practice to observe individual and family care. In this respect, therefore, it may be argued that Yeovil also altered the context as well as the design of the curriculum, during the initial six months' phase of the course. The submission also proposes a needs-based student-centred curriculum model.

Central Birmingham's proposed curriculum changes relate mainly to strategies for learning and teaching, and to the development of the educational process in the curriculum model. These two schemes adopt a process model, but differ in many respects - the size of intakes and the student numbers, the clinical and community experience available, and in geographical location - a rural area for Yeovil and a teaching health district in a conurbation for Central Birmingham. The latter draws expertise from lecturers in psychology and sociology from the extra mural department of a university, whereas Yeovil proposes to call in a wide range of experts from different disciplines, and from the locality as the need arises.

The categorisation and the outcomes of the content analysis of the submission raise further issues to be clarified on the first, and subsequent visits to each of the six schools. This chapter provides the framework for discovering more about the process of innovation, and of changing the nursing curriculum in the pilot schemes.
**SUBMISSIONS CONTENT ANALYSIS**

**CURRICULUM DESIGN FOR YEAR ONE**

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CHAPTER SIX

THE FIRST VISIT TO THE SIX SCHOOLS

The first visit by the researcher to each school was arranged during the early part of the pilot course to establish the aims of the research project, and the independent status of the researcher. It provided the opportunity to clarify statements, or address any omissions in the submission documents and to correct any misunderstandings or assumptions by the researcher.

Three areas of particular importance to the researcher at this stage were - the context, design and content of the new curriculum in comparison with the previous conventional course; the reason for the proposed change and the stimulus, or significant factors inducing change; the preparations made to introduce changes and to support those involved in changing the curriculum as the innovation progressed.

The outcomes of these first visits are now discussed.

6.1 West Dorset

This visit, on November 7th 1986, took place when students in the first intake group were in the tenth month of the course in the latter part of Stage I the supernumerary period.
6.1 (i) Context

It was arranged in the main building of the Dorset School of Nursing in Poole in the East Dorset Health Authority, and the researcher met the D.N.E., the A.D.N.E. responsible for the academic nature of the course and the course tutor based in West Dorset.

This enabled the researcher to appreciate the difficulties and opportunities presented by an area school of nursing, covering two health districts, with a radius of 40 miles. Staff and students travelling between the main centres have difficulties during the tourist season on the south coast, and in West Dorset particular difficulties are experienced in severe winters in the rural areas. Both the journey time and the travel costs have to be considered, and therefore, a system of allocating students to one of three circuits, or parts of the area, for their clinical experiences following an introductory course at the main school, has been devised. One circuit was based in West Dorset, where a pupil nurse training course was also based and would be discontinued as participants completed the course in 1987. The pilot scheme would be based within the West Dorset District.

The Dorset School of Nursing, with approximately 360 students preparing for general registration, has additional students in registration courses in mental, mental handicap nursing, a pupil nurse course, post-enrolment and post-registration courses and seven ENB
post-basic courses, and a well-established and active programme of staff development (Submission).

This educational programme has been adopted by both health districts, and a course in preparation for a diploma in professional studies in nursing is provided by the Dorset Institute of Higher Education in conjunction with the East and West Dorset Health Authorities.

A written statement of the policy of the school and the health districts' to maintain and improve the quality of nursing and of student's clinical experience based on sound knowledge is given to each student and member of the nursing staff.

The school building in West Dorset is self-contained, in a house in the grounds of Dorset County Hospital in Dorchester. There are classrooms and offices for teaching staff and secretaries. Additional teaching accommodation and offices are provided at Weymouth and District Hospital, where students are allocated for some clinical experience. There is a multi-disciplinary library for health district staff, with a full time librarian, on the Dorset County Hospital site, which is affiliated to the Wessex Regional Library services. Facilities for literature searches, photocopying and audio-visual material are available.

A team of nurse teachers (who also teach in East Dorset) assist the course leader, and the ADNE is based at Poole.
6.1 (ii) Design

There are three stages in the curriculum - reflecting the three years of the course. Stage I - the first year - consists of three terms of ten weeks, each week with three days theory and two days related observation, experience, or practice under supervision, in hospital, or in the community. The design and content of the curriculum is discussed by Bradshaw (1985). The first year is a supernumerary period, as shown in Chapter 5 - table 5.3, Stage II has a planned programme of clinical experience with contract learning, five study days and an unseen written paper at the end of the year. There are three study weeks in Stage III, and study days are arranged in the allocations for maternity, children's and elderly care. Continuous assessment in practice, and in theoretical achievement is a feature of the course.

The pilot scheme was planned with the help of lecturers from Weymouth College. Initially, students went to the college for sessions but this proved time-consuming, and the lecturers preferred to come to the school because this enabled them to participate in other activities, to meet clinical staff, and to learn more about the student's needs in different settings in practice. Community visits in social settings, in psychiatric hospitals and with community psychiatric nurses were included in Stage I.
The contrast between the curriculum for the pilot scheme and the conventional course, which had formative and summative assessment, continuous practical assessment and a modified modular pattern of clinical allocation with mentors to support students, was mainly in the design and content of Stage I and in altering the teaching/learning strategies from a more medically orientated model of nursing.

6.1 (iii) Content

The course tutor and the ADNE identified differences in the curriculum content which was presented during Stage I from the content of the conventional programme - the emphasis on health in its widest interpretation, then on the prevention of ill health, and health education; the development of helping skills, communications and inter-relationships and support mechanisms from the outset of the course; experiential learning - from actual situations and by sharing experiences, utilising experience available within the district in both community and hospital, and introducing the general principles of pathology by illustration within the clinical setting.

This issue of proximity of school, clinical and field experience will be given further attention as the research project and the pilot schemes progress.
Stage I provides the foundation course - biological and social sciences, concepts of health and disease, interactive skills and models of nursing, with nursing techniques. The taught sequences during the three terms, previously discussed in 6.1 (ii), include the human individual - an integrated approach to physiology and developmental psychology; the social context of health - an integrated approach to sociology, social psychology and medical sociology; paraclinical studies - anatomy, microbiology and an integrated approach to pathology and pharmacology. The development of inter-personal skills and communication, professional studies in nursing and the social policy of health, and the practice of nursing, models of health and illness, and the nursing process complete the studies in Stage I. Ten assessments are proposed for Stage I - two of which as unseen papers.

Stage II presents the major clinical content in acute nursing settings in a planned programme of allocation, with five study days during the rostered service. It is anticipated at this point that that students will negotiate learning contracts with their personal tutors and clinical supervisors. At this first visit students were being prepared for this activity. Students will negotiate learning contracts with their personal tutors and clinical supervisors. Stage III offers clinically related studies in maternity, children's nursing and care of the elderly with experience in hospital and in community, further experience in acute general nursing, including a period of night duty, and three weeks study. An unseen written paper is planned for the end of Stage II and a research essay, or project, related to clinical studies at the end of Stage III.
6.1 (iv) Factors inducing Change

Curriculum review and course monitoring in the Dorset School of Nursing is the responsibility of ADNE, and one of the issues highlighted during this process, was the need to prepare more registered nurses to care for the elderly. This was particularly pressing in a seaside resort, with a rising population of retired and elderly people. In view of those local needs, the demographic trends and the fact that the UKCC rules allowed for a registration course combining general nursing and a special age group - nursing of children - it was argued that a course for general nursing and an ENB course in the care of the elderly should be developed. On presentation of the plans to the ENB officers at the Board it was discovered, to great disappointment, that such a course would not be approved, within existing rules. The officers, on behalf of the Board, suggested that the proposals be reviewed and submitted as a pilot course. Accordingly this was done and submitted within three weeks receiving the Board's approval. Bradshaw (1985) describes the planning team's approach to providing a broad professional education as well as a rigorous vocational training to develop the entrant with 'O' levels to the diploma level in the study of nursing.

In answer to the researcher's question regarding the reason for the decision to base the pilot scheme in one of the two health districts, the DNE explained that it was hoped to extend the new curriculum to the other district in time. The present scheme was based in a
setting where management support for nursing service and education was marked, there was a stable teaching team who worked closely together and with their service colleagues. West Dorset Health Authority had given financial support for replacement staff, and for the college contribution to the course. This was 'pump-priming', because the savings of the full cost of students' training allowances by the payment pro rata during the first year of each course, would cover the replacement costs over a three to four year period. The nursing service manager and general manager, and other members of the district management team gave active support to the proposals for change which were endorsed by the health authority. Preparation for introducing the new curriculum, and for putting the plans into effect included workshops and discussion groups within the district with visual aids, in order to encourage challenge and debate by those involved in the changes.

The course committee set up a working group to review placement areas and the range of skills, learning opportunities and staff development activities within each setting, to bring forward suggestions and to share information regarding curriculum content and resources.

6.2 South Birmingham

The researcher's first visit to the pilot scheme in South Birmingham was on November 11th 1986, when the first intake group of students were in the seventh month of the first year and were supernumerary.
6.2 (i) Context

It was arranged that the visit should take place in Selly Oak School of Nursing, where the DNE met the researcher and explained that there were approximately 215 students preparing for general registration, and other students in courses for mental and mental handicap nursing registration, a pupil nurse course, post-enrolment and post-registration courses, five ENB post-basic clinical courses, and a wide variety of continuing courses listed in the National Clearing House Handbook. The courses for CNAA B.Sc. Nursing Studies and the CNAA Diploma in Professional studies in Nursing, and courses for health visiting, district nursing and community psychiatric nursing certificates at the City of Birmingham Polytechnic are also listed and the close working relationships between the two institutions is also indicated in the handbook.

South Birmingham Health District has a large general hospital, an accident hospital, an orthopaedic hospital and mental and mental handicap hospitals, in addition to two hospitals for the care of the elderly and a maternity hospital. Ten health centres offering community services are sited in different parts of the district, some of which are in areas of deprivation according to the Department of the Environment 'Z' scores (South Birmingham Health Authority Annual Report 1988).
The school of nursing is based at Selly Oak Hospital which is approximately nine miles from the polytechnic. The bus and train services are adequate, but involve changing, and the journey by public transport or by car may take up to one hour in urban traffic, particularly when it is heavy, in the morning and evening.

6.2 (ii) Design

The course lasts for three years - or 146 weeks excluding annual leave in common with ENB conventional courses. The researcher asked the DNE to explain the nature of the change in the pilot scheme from the conventional course.

The aim of the pilot scheme was to offer a student nurse an increased amount of time for learning to become a safe and competent practitioner by applying knowledge to care in a variety of settings and to develop a deeper theoretical understanding within an entirely different framework.

(DNE)

6.2 (iii) Content

The researcher then met the course tutor, the senior tutor responsible for the conventional course, and the principal lecturer in nursing studies from the polytechnic in the nursing school to discuss the course design and content, and the preparation of staff for the changes to be introduced in the curriculum. There are two intakes each year in April and September and the students are supernumerary for two years. There are no college terms - but over the three year
course students have two semesters each year which are divided into units of study based on 120 hours as required by the academic board of the polytechnic. These units vary in length in each course module and in each year.

At the time of this first visit, there were four weeks full time college-based studies in the first year; for sixteen weeks students spent four days each week in college and one day in community placements; for two periods of four weeks students spent five days (Monday to Friday) in full time placements in community or hospital settings, and for the remaining sixteen weeks of the first year students spent four days in college and one day in placement each week. At the time of the visit the second intake group were following a similar pattern in the first year of their course. The teachers pointed out that continuing evaluation might lead to some modification in the arrangement of the placement experience, but there would be no reduction in the number of weeks in studies or in observation and placements.

The plans for the second year of the course follow a similar pattern, with six weeks in college full time, two twelve week periods consisting of three days in the school of nursing or college and two days in placements, and three six week periods in full time (Monday to Friday) placements in wards and departments for the mentally ill, the elderly and children.
Plans for the third year include ten weeks full time studies in college or the school of nursing, and full time rostered service for experience in medical and surgical nursing in wards and departments for forty one weeks, divided on a modular pattern.

In answer to the researcher's question why it was decided to have two intakes each year with the consequent overlap in cohorts for teaching and placements, the group agreed that one intake annually would be ideal, but the course tutor explained that two intakes were required to provide for those qualifying for registration at different times each year to apply for appointments as staff nurses, to replace those leaving the service.

I still have a dream that this will be achieved.

(Course Tutor)

In response to the researcher's question regarding replacement staff required for the two years when these students were supernumerary, it was explained that there had been a planned reduction in the number of students from 60 to 40 annually, and this was to allow virement from the student budget to the staff budget.

The course content in the first year is concerned with people in society including health studies, physiology including genetics, psychology, sociology, communication, research and nursing studies. In the second year the factors affecting states of health - hazards at
work, community services, trends in illness, the spread and control of infection, the recognition of mental and physical illness, - and the consequences of illness for the individual and the provision of care for the individual, the family and society, are studied in relation to their placements, in seminars and workshops. Teacher-centred lectures are for imparting essential information, guidance in critical analysis and discussion of issues arising from student's questions, or formative assessments. Interdisciplinary sessions, role play and simulation and the use of closed circuit television for developing communicational skills and problem-solving are in use.

Formative continuous assessment in nursing practice is planned, the four ENB assessments will be included, there is an examination at the end of the first year, and students will be required to sit the final ENB devolved examination in the third year.

6.2 (iv) Factors inducing change

The DNE explained that a meeting to explore the possibilities of changing the nursing curriculum by a pilot scheme was called by the polytechnic to which DNEs and DNOs from the surrounding health districts were invited. The South Birmingham Health Authority agreed that collaboration with the polytechnic for an outline submission should proceed, and the joint planning began. A cross transfer of monies from the health authority on an annual basis provided for all the joint activities between the two institutions, and the EAG agreed
to fund a secretarial salary to support the course.

There was a real desire for change; in the school of nursing the two senior tutors had graduate status, one with a higher degree in educational psychology, one studying for a higher degree in life sciences. The close association with nursing lecturers at the polytechnic and the support of the principal lecturer in nursing studies, currently undertaking research, had enabled planning for a core curriculum to enable adaptation for courses for registration in mental handicap and mental nursing at a later stage.

The need to move from the study block system for the conventional course was recognised, planning to revise this to a more modular style was underway, in preparation for a visit from the ENB education officer, when the ENB letter arrived.

When questioned about the support for changing the curriculum in the school of nursing and the health authority the reply from both senior tutors indicated that both the district nursing officer, and the directors of nursing service were interested and in favour of the pilot scheme, and that the DNE was supportive, and delegated authority, whilst being available for consultation. A question about reactions from the clinical staff to the fact that the Allocation Officer and the Course Director were both allocating students to the wards for clinical experience received the reply that there were no adverse reactions because each placement was personally chosen and
pre-placement discussion took place with the clinical staff and staff in community and other settings. Pre-placement briefing for students, and post-placement discussions and evaluation took place with students, supervisors and teaching staff. The submission (p.11) refers to the clinically expert role models and relies on staff development programmes:

- teachers must be seen to be practising nurses and practising nurses must be seen to be teachers

(Submission para 3.13)

Asked to comment on this, and how this was achieved, it was explained by the group that continuing education for nursing staff was not yet under the control of the DNE in the customary way.

When asked to comment on the two differing institutions and the two sites for students and staff, the group pointed out that the course director had a base on both sites, and staff from the school of nursing and the polytechnic took part in activities on both sites. The main difficulty raised by the three staff members present was on the distance - 9 miles - and the time for travelling which at peak times took up to one hour by public transport, and half to one hour by car, depending upon urban traffic.

6.3 Sunderland

This was the first ENB pilot scheme to begin in September 1985, and an article by O'Brien and Craddock (1986) in Nurse Education Today
describes the scheme, and the plans for curriculum innovation.

In the first instance, one intake of 24 students were to form the pilot group - no other intakes were foreseen. In January 1987 with further financial support, a second group of 24 students began. Subsequently with support from the regional health authority, the district health authority had agreed to an intake of one group annually to continue until January 1989.

The researcher's first visit to Sunderland was postponed until April 1987, when students in the first intake group were in their second year. There were cogent reasons for this. During the first year of the pilot scheme's introduction the chief nursing officer was killed in a road traffic accident. The appointment of his successor was not long delayed, but then a proposed date for a visit by the researcher had to be postponed. ENB education officers visited in December 1986, and again in February 1987, followed by a two week visit by ENB officers in early March 1987. In view, therefore, of this delay the researcher arranged a two-day visit for discussion and interviews on April 8th and 9th 1987 - to meet both school of nursing and health authority staff on one day, and the polytechnic staff on the next. At that time there were two groups of pilot students, one group in rostered service for clinical experience and one group at the end of their first term at the polytechnic.
The researcher had interviews with the course leader and a senior tutor not working in the pilot scheme who was responsible for the conventional course. A discussion with the CNO and the DNE at lunch followed, and interviews with the DNE and the Allocation Officer. On the following day the researcher met staff at the polytechnic, who were jointly concerned with the establishment of the course, and met students and clinical staff informally in the polytechnic and the hospital.

6.3 (i) Context

Sunderland Health District serves a population of 299,400 (at mid-year estimate 1983) - it is an old county borough with two outlying townships and a new town (population 56,790 in 1984) and a population movement from inner urban to outlying parts. It is an industrial district designated as a special development area. Clinical sub-specialities are provided - eye, ear, nose and throat, oral and orthodontic surgery, skins and urology, but regional specialities are provided elsewhere by the teaching health district in the region. There are eight hospitals, providing 2,306 beds in the health district, and twenty three health centres/clinics are dispersed throughout the district.

Three general hospitals, a psychiatric hospital, an ophthalmic and an orthopaedic hospital provide clinical experience for general nursing students.
Sunderland school of nursing had approximately 360 students preparing for general nursing registration at the time of the visit. Courses in preparation for mental nursing registration, and pupil nurse courses for enrolment in general and mental nursing, and ophthalmic and orthopaedic courses for registered and enrolled nurses are provided.

This is also a midwifery school in Sunderland, and there is an active in-service programme of education for nursing and midwifery staff. Staff from Newcastle Polytechnic have collaborated with staff in the health authority in arranging courses, study days and conferences for nurses midwives and health visitors on a range of professional issues.

Newcastle upon Tyne Polytechnic is a major centre for health care professionals offering certificate, diploma and degree courses in the faculty of community and social studies. These include health visiting and district nursing courses, the diploma in professional studies in nursing, the advanced diploma in midwifery, the B.Sc.(Hons) degree in health studies (Behavioural Science) and courses in occupational therapy and physiotherapy.

6.3 (ii) Design

The course design is based on a new approach to the first year, with two terms at the polytechnic and a twelve week bridging module. These are followed by nine modules based on an age continuum, with specified clinical placements and related studies. The students have
supernumerary status in the first year of the course; in the second year they have rostered service, with study days or weeks, and continuous assessment in practice with an unseen paper examination at the end of the first year and holistic nursing assignments in each year. The course leader has a base/office in both the polytechnic and the school of nursing, and timetabling is arranged to reduce the amount of travel between the two sites in the first two terms. There is a journey of approximately half to three quarters of an hour, depending on urban traffic, and availability of public transport between the two sites. Community placements are arranged within the Sunderland Health District – preferably near the student's home as the majority of students are non-resident, and many have family commitments.

6.3 (iii) Content

There are two themes for the two terms at the polytechnic during each of which students have community placements. The themes - in term one - models of man, and in term two - health deviations and nursing - encourage students to develop learning strategies, to carry out a literature search, and a health care project, and to demonstrate communication skills. An opportunity is also given to undertake an introduction to computing as a course specially designed, using examples of the nursing process, is in use in the Northern Regional Health Authority. The aims of these terms at the polytechnic were confirmed during discussions; illustrating that the course content
supports the intention in the submission

- to introduce students to the problematic nature of health and its measurement; the relationship between conceptions of health and of nursing in contemporary society

(Submission p.10)

and

- to consider critically what is meant by deviations from health, using physiological, psychological and sociological perspectives.
- to show the relationship of these concepts to contemporary nursing practice.

(Submission p.14)

Community placements in the first term emphasise the healthy individual, health education and the role of the health visitor, and clinical placements in this term stress the value of observation and communication skills in assessing the health of individuals. The second term offers opportunities for clinical placements to study deviations from health, and to gain practical skills in planning, implementing and evaluating nursing care to meet actual or potential health care deviations.

The bridging module, two six-week experiences, enables the student to become familiar with essential nursing skills in two acute care settings, and nine modules on an age continuum follow, with maternal and infant care as the first and dependent elderly as the last module.

Evaluation of suitable clinical placements for the pilot scheme included the staffing levels, the qualified nurses' commitment to supervision and teaching of learner and the level of commitment to advanced nursing education and professional performance. After this
tool had been used, further intensive preparation was offered to staff in the designated areas. This consisted of polytechnic staff offering sessions on contemporary nursing research and developments, 5 day courses for developing teaching skills for clinical staff at a technical college, open meetings for familiarising staff with the programme attended by the CNO DNE and Course Leader, and letters to all those involved including the staff organisations.

Open meetings and discussions between all grades of staff at the polytechnic and in the health authority were well attended. The strategy for developing the pilot scheme - and establishing this partnership is illustrated in O'Brien and Cruddace (1986) and the importance of communication networks and the development of the infrastructure is emphasised. At the researcher's visit, the staff participation in these networks become clear, including the amount of time and energy expended on the preparatory stages of the joint venture.

It is very tempting to present curriculum development as a smooth series of steps .... from educational philosophy to course commencement ... In reality, such smooth progression is not feasible, and several inter-related activities are developed simultaneously.

O'Brien and Cruddace (1986 p.110)

During the visit, the researcher was able to establish that the initial proposals for the curriculum design and content in the pilot scheme were being implemented, although there were some areas of concern. The sharing of knowledge and expertise between teaching
staff in both the polytechnic and the nursing school was proceeding well, as the course leader explained at interview. There was also, he explained, a 'spin off' from the pilot course to the new conventional curriculum, and this, combined with the impact of the pilot scheme, caused concern for traditional course students, who were continuing their course. An agreement had to be reached by negotiation between these students and the teaching staff for a 'teaching package' which would be maintained until existing students on the traditional course had completed their training. There had been some logistical problems during the early part of the scheme with 'bottlenecks' which occurred in clinical placements, when the needs of traditional students prior to completion for statutory recognition, and the fixed pattern required by the pilot scheme students, had to take precedence over the conventional course programme. These were being overcome at the time of the visit. Clinical links for teachers in the pilot scheme had been established, with approximately 25% of the nurse teacher's time being spent in clinical areas. The conventional students appreciated this - pointing out their needs also, and joining in discussion and evaluation sessions. A mentor-ship scheme was in the initial stages of preparation.

Monitoring the environment for learning, by ward audit and assessing criteria for placements - by a team approach between nurse managers, clinical staff and teachers - was proceeding. Evidence was being collected, checked and discussed to 'prevent lip-service without implementation' in the words of the course leader.
Continuing assessment was an essential component of the pilot scheme during rostered service, and was being carried out, but it was not yet sanctioned for the conventional course because the ratio of registered nurses to students for heading all shifts was not yet high enough in all areas. It was hoped to rectify this shortly. The assessment schedule for the pilot scheme was proceeding as outlined in the submission pp 66-71.

O'Brien and Cruddace (1986) present a case study, and trace the theoretical and practical issues encountered when planning a major educational innovation between a health authority and a polytechnic - and in developing an ENB pilot scheme.

The initial strategy was to develop a 'blue print' from which logical developments could proceed. It is argued that, whilst the formal educational curriculum provides the central thrust for development, it is doomed to failure unless concurrent clinical development occurs.

O'Brien and Cruddace (1986 p. 109)

6.3 (iv) Factors inducing change

The driving force for curriculum innovation was acknowledged to be the late C.N.O., by the establishment of active and close links between the school, the health authority and the polytechnic. The steps taken to prepare for change, and to implement the pilot scheme were also discussed in the article by O'Brien and Cruddace (1986).
A senior tutor interviewed by the researcher indicated that frequent changes in the numbers of intakes, and the design of the traditional students' course had led to an intake of 60 students twice each year. This was an unwieldy number which had to be divided into three groups for allocation to clinical areas to ensure a smooth flow for service, and this involved triplication of teaching sessions, tests and examinations. A different approach to the curriculum was considered to be essential.

The C.N.O. and the DNE confirmed that support for the pilot scheme's introduction was given by the chairman and general manager of the health authority, who were keen to try to find ways and means of pursuing the plans. The regional health authority and the E.A.G. were supportive (but no extra staffing was agreed) and the regional nursing officer was a member of the board of the polytechnic.

Both the DNE and the CNO emphasised that support from the trained staff in the wards and in the community and the close links already established with the polytechnic, with the development of a part-time diploma in nursing science, were major factors in deciding to put forward a submission for a pilot-scheme. In spite of a difficult financial situation, rationalisation of beds in the hospitals and possible amalgamation of schools of nursing in the region, the support for the pilot scheme came from both management and the clinical and community staff.
The C.N.O. was anxious to develop the midwifery education, and the DNE agreed that, with some modifications, the pilot scheme would offer a core curriculum for registration in mental nursing at some future date. Asked later during an interview, to identify other factors which influenced the curriculum innovation, the DNE replied that the presence on the staff of a senior tutor able and keen to develop the philosophy and content of the course, and to link with the polytechnic, was one factor. Others, - including an opportunity to review the structure in the school because of the retirement of two senior tutors, the increasing interest in curriculum theories, and a humanistic approach to nursing theory and practice amongst the nursing staff - assisted in both the decision to make a submission, and in the preparation and introduction of the new plans. In response to the researcher's question about the preparations for introducing the changes the DNE reiterated the importance of planning a strategy to develop the infrastructures. The DNE and CNO and/or the Course Leader went round to all the units in the health authority, - the hospitals and primary health care teams, - to explain the possibilities, the proposals that were being developed, to seek challenge and debate. The desire for a better deal for students, and a wish to put Sunderland on the map, were the responses from nursing staff which repeatedly occurred at these sessions.

Two further points made by the DNE and the Course Leader illustrated this process of consultation and discussion. Some of the ward sisters expressed real concern on some issues. For example, a
question raised from time to time, was whether this scheme would be fair to students? Any such concern, or fears expressed were respected and discussed openly; open dialogue was encouraged because grumbling below the surface was not a feature of the local ethos, it was said. The second point was that, in retrospect, the DNE believed that the agreement of ward sisters and other nursing staff to support the innovation was based on trust and was probably an affective decision, as there was no real knowledge of the possible future outcomes and effects at the time the decisions were taken, and agreement was freely given.

The researcher had an interview with the allocation officer, a very experienced nurse manager, very interested in the students, and in their education and training programmes, who had developed a system of allocation and recording by computer programmes.

At one time there were 680 learners in the district, but as the hospitals became grouped, the numbers were being reduced. There had been many changes previously in the course design and the timing of intakes. At the time of the visit there were students in three different courses for general nursing - the pilot scheme students entering in September 1985 and January 1987, and plans for intakes in January 1988 and 1989; the students in four groups annually since 1987 entering the new conventional course based on the pilot scheme but without the polytechnic link, and five similar groups entering in 1986; and the third were the students entering the traditional course
in 1985 who were due to complete the course in 1988. The complexity of these placements, coupled with the needs of students in the other statutory courses outlined in 6.3 (i) presented a challenge and a determination to overcome the constraints, she volunteered. Monthly meetings were held with the nursing officers at management level in each unit and attended by the DNE and CNO if possible. Full discussion of any issues arising took place at these meetings. She confirmed that the fixed pattern for the pilot students in the age-continuum modules was adhered to, but the pattern for the conventional course students had to be adjusted in the interest of those on the traditional course. Student progress report forms were used for students in all the courses - using the King's Fund style Report Form. Assessment in practice for pilot course students was made by ward or department nursing staff, but additional assignments were discussed between the clinical staff and the course leader. A ward library of reference books and ward procedure books is available in all training areas. Individualised care for patients, using the nursing process, is advocated, and conferences and sessions on planning and evaluating patient care are held regularly. The clinical experience available is sufficient to allow designated areas to be used for all student allocation.

On the second day of this visit, the researcher met staff at the polytechnic to discuss the pilot scheme - the senior lecturer, diploma in professional studies in nursing, senior lecturers in medical social science, and the head of the school of behavioural
science, and others concerned with the course. The support for the course from all those involved at Newcastle upon Tyne Polytechnic, the school of nursing and the health authority staff in hospital and community, was clearly evident.

6.4 North Lincoln

The researcher's first visit to the pilot scheme was made on November 10th 1986; the first intake group of students, who entered in January 1986 were then in Unit II of the course, in their tenth month. Articles written by the participants and published in Senior Nurse during the early part of the year - from January to October 1986 - had augmented the submission documents - Part I and II. At this first visit the researcher met the DNE and the senior tutor who was acting ADNE and also acting as course tutor. The ADNE who had been closely involved had left for promotion, and the appointment of a successor was pending.

6.4 (i) Context

The health authority provides health care services for approximately a quarter of a million population, and decentralisation is necessary due to geographical extent. There are two general hospitals and a psychiatric hospital, one within the city, and two in towns within the district, providing clinical experience for pilot scheme students. Capital developments at the hospital in the city are due for commissioning and a second phase of re-development will then begin on
site, including a multidisciplinary educational centre. Services for the mentally ill and handicapped are being revised, as a community-orientated service develops.

The school of nursing has courses for registration in general, mental handicap and mental nursing, and a number of ENB post-basic clinical courses. There are four distinct departments - general nursing, mental health nursing, mental handicap nursing and continuing education and training - each department is responsible to the DNE for curriculum design, implementation and evaluation.

Bishop Grosseteste College of Education is close to the city hospital and the residential accommodation for nursing staff.

6.4 (ii) Design

The DNE and the acting ADNE explained to the researcher that, initially, it was hoped that the whole of the first year would provide the student with supernumerary status. In the end, the first six months, Unit I, is supernumerary and students in Unit II - the remainder of the first year - have a protected environment, working from Monday to Friday with no unsocial hours; and a weekly study day.

The basis for the innovation was this foundation year - with the gradual introduction to nursing practice, and a philosophy based on the concept of health running throughout the course, increasing the
emphasis on health education, promotion and maintenance as the course progressed. Teaching and learning strategies were aimed at learner self-discovery and problem-solving, initially teacher-directed, but becoming student-driven. The first half-year devoted to health and life studies is totally school and college based - with a wide range of placements in community settings, industrial and commercial environments, schools and health centres.

The design team adopted the curriculum model of an experiential taxonomy - a new approach to teaching and learning discussed by Steinaker and Bell (1979) using this model in teacher-training. The ADNE had discovered this work during day release study for a higher degree, and the article by Nicklin (1986) in Senior Nurse discusses this fully. A three day workshop by the design team resulted in the course submission at the end of a twelve week period of activity. Five members of the curriculum design team were invited to the Board to discuss their proposals on March 26 1985, after shortlisting of the submission, which was accepted as one of the six schemes, and began in January 1986.

6.4 (iii) Content

The experiential taxonomy provides the framework for understanding, planning and evaluating the meaning of total experiences, and for each experience describes learning objectives, learning principles, learning strategies, teaching strategies, assessment techniques.

Kenworthy and Nicklin (1986 p.12)
It is more than a teaching/learning strategy, and the curriculum planned on this basis uses a whole range of experiences to develop understanding and disseminate skills as a competent practitioner and an effective role model. The learning opportunities to move from participant observer to autonomous practitioner include a professional development module lasting 16 weeks at the end of the three year course.

At the researcher's first visit Units I and II were detailed, and methods of assessment, and of evaluation of the course, were identified for these two units. The planning team were currently working on the remaining units, which were detailed in the August 1987 submission.

Internal evaluation by planned educational audit was proceeding, and an external research project on the pilot scheme was being undertaken, and funded by the health authority. A research assistant, with supervision from the City of London Polytechnic, was conducting a limited study for six months to identify whether pilot scheme students presented significant differences regarding concepts of health care, and about their attitudes, and expectations for future nursing practice, by comparing the views of the second group of pilot scheme students with the views of a group of traditional students. The research assistant lived in the Nurses' Home and conducted the research by questionnaire and participant observation. The report was awaited.
as the project was underway.

6.4 (iv) Factors inducing change

There was active support from the health authority managers, the district nursing officer and directors of nursing service. Financial support from the EAG (utilising part of the salary allotted for a clinical teacher to one of the hospitals) for two fifths of the salary of a senior lecturer at the college of education was agreed.

It is the policy of the health authority to encourage in-house and in-service education. The continuing education and training department provides courses in assessing and teaching, attendance at City and Guilds' Course 730 at a local college is encouraged, and ENB 998 professional development course and advanced psychiatric and mental handicap nursing courses are mounted and supported by teachers from each speciality. There had been no opposition to the proposals from the medical staff. It was the policy of the EAG in the region to reduce finance for payment of fees to medical lecturers prior to the introduction. Some medical staff continued to teach without fees.

The researcher was told that although continuous assessment is a feature of this process-type curriculum, approval had not yet been given by the ENB, and therefore the four practical assessments were built into the pilot scheme curriculum similar to those required for the conventional courses.
The researcher learned also that

summative examination is currently the subject of discussion

(Acting ADNE)

The DNE explained that there was dissatisfaction with the previous curriculum - a modified modular scheme based on a medical model and with ward learning objectives. The stimulus for change was a manpower review from which it was apparent that too many students were being trained, and not all trainees were offered jobs on completion. There was a young and keen group of teachers, qualified with a certificate of education from different colleges, including Nottingham and Huddersfield, who were interested in curriculum development. The acceptance by the GNC of their plans for an RMN course for registration as a mental nurse (RMN) utilising the 1982 syllabus had provided a stimulus also - because this was the first school to gain approval for this new RMN course, after the withdrawal of approval for their previous RMN course in 1981. Kenworthy (1986) maintains that a number of new ventures in the health authority - the style of management in the re-structured N.H.S., and the establishment of continuing education, for example - contributed to the desire for change.

Two weeks after the ENB invitation was received the decision was taken to submit a curriculum proposal, and a design team was established. In addition to the DNE, the ADNE and two senior tutors, the team
consisted of the assistant director of community nursing services, two ward sisters and two senior lecturers from the local College of Education. The creation of a senior post for health studies was agreed in the health authority's annual operational plan for 1985/86 and an appointment was made. This enabled the planning and the co-ordination of the health and life studies unit, and health themes throughout the pilot course, as described by Goodchild (1986).

6.5. Yeovil

The first visit of the researcher to the pilot scheme in Yeovil took place on November 17th 1986. The first intake group of twelve students began in April 1986. The researcher was met by the course tutor, and later met the senior tutor, and a tutor in the Yeovil school who were both teaching in the conventional course, but were not yet involved in the pilot scheme. The senior tutor who had been primarily concerned with the proposals and planning for change, had been moved from Yeovil to Taunton, where proposals were being considered to mount a new curriculum based on the pilot scheme. The DNE and other members of the teaching team were met informally at lunch.

6.5 (i) Context

The school of nursing has courses for sick children's, mental and general nursing registration, and courses for the ENB certificate in
6.35

geriatric nursing.

The health district covers the county of Somerset, with a number of small community hospitals and clinics spread throughout the rural areas of the district, with a general hospital in each major town - Taunton and Yeovil, and a psychiatric hospital. The policy of the health authority is to accord a high priority to developing the community services, with the highest priority given to health promotion and the prevention of ill health. This policy is also in accordance with the policy of the South West Regional Health Authority (as quoted in the submission) that priority must be given to improving the existing provision of health visiting and home nursing services, and the need to move the emphasis of care from institutions.

6.5 (ii) Design and 6.5 (iii) Content

The curriculum follows a process model designed to identify the student's needs to fulfil the eight roles of the nurse, (submission p.42) as indicated in Chapter 5. The course tutor explained the pattern of experience to follow the foundation course of twelve weeks, and the twelve weeks community experience.

The six months period of supernumerary status offers two major opportunities. Firstly, the establishment of the learning strategies with the student as enquirer, and the teacher as companion, counsellor
or facilitator. This requires any formal teaching sessions to be based on students' needs and requests, and moving from a subject-based timetable to student-led seminars, group activities and student participation in discussion and timetabling. The second opportunity is to introduce the health model, and nursing care in the community, and the introduction to different aspects of life in community settings and hazards to health. Support with enthusiasm, is given by managers in local factories, industrial employers, the National Farmers Union, as well as by local general practitioner clinics.

For eighteen months prior to the introduction of the pilot scheme the staff in the small community hospitals had been introducing the nursing process, and the course tutor and other senior nurses had been preparing the community health authority staff for the changes being planned.

The researcher discussed the scheme with teachers not yet participating, and was told that, whilst they were not involved in the initial proposals, they were aware of the plans - because in a small setting it was easy to know what was happening. When asked whether staff in the acute wards were aware of the changes, and the different approaches to the assessment on the eight roles of the nurse, and the mentor system, it became clear that there was a need for further explanation and discussion with clinical staff of the effects of moving to this new curriculum. The previous conventional course was based on an 8 week introductory course, and the remaining 20 weeks of
study were divided between clinical experiences in three or two week study blocks, based on a medical model. The allocation plan for the conventional course was based on a 'fixed flow' system of student nurses to the wards and departments.

6.5 (iv) Factors inducing change

The DNE confirmed that the decision to prepare a submission had been strongly influenced by the wish to prepare a scheme for a rural area, with no easily identifiable link with an institute of higher education within easy travelling distance. Parkin (1986) stated that it was decided

that a marker should be laid down for a scheme which could work in rural communities.

Parkin (1986 p 22)

The tutor who was the course tutor when the pilot scheme began had formerly been a district nursing sister, and had been exploring ways of broadening the conventional course for some time prior to the proposals. Staff in the small community hospitals were keen to participate and provide support, although these units had not previously been included in the training courses. It was recognised that there was a need for further preparation of the teaching and clinical staff - particularly for the establishment of the tutor/counsellor role, and the learner/enquirer role throughout the course - including in the ward settings. Continuing practical assessment was in effect before the pilot scheme began.
An assessment/assignment in each unit with the role profiles of the nurse forming the basis for continuing assessment was now planned. Formative assessment by a combination of methods was proposed - essays based on health needs, a project with some degree of option with the student negotiating the topic with the tutor/counsellor.

6.6. Central Birmingham

The first visit by the researcher was on November 26th 1986, first meeting the acting DNE, who was previously the senior tutor, curriculum development, and later meeting tutors informally at lunch, and in the staff room. The first intake to the pilot scheme was in March 1986; there are three groups of fifty entrants in March, July and November, a similar pattern to the previous training courses. There is no designated course leader for the pilot scheme - the acting DNE is also continuing as the senior tutor - curriculum development, until a new structure is established following the appointment of a DNE. There are twenty five members of the teaching staff, including a research assistant and two joint appointees - a tutor/nursing officer role. A tutor/counsellor post is planned.

6.6 (i) Context

The Central Birmingham Health Authority is responsible for the teaching health district in the centre and south part of the conurbation and serves a population of approximately 185,000. There are nine
hospitals and two clinics listed in the submission (p.3) some of which are for regional specialities, and there is highly specialised work in non-regional specialist areas of medicine at the Queen Elizabeth Medical Centre. There are six hospitals where students in the general nursing course gain experience, two general hospitals, a children's hospital, a maternity hospital, a psychiatric hospital and a hospital for the care of the elderly. The acute wards in both general hospitals and in the children's hospital call for highly skilled nursing care in view of the technical nature of the work.

There is a small area of community surrounding the hospitals, with areas of deprivation and a high level of immigrant population, according to the submission.

The school of nursing has approximately 630 students in courses for general and sick children's registration, and post-registration specialised courses for ENB certificates in intensive care and sexually transmitted diseases are mounted. The health district has schools for medical, radiography, physiotherapy, midwifery and nursing education, and the health visitor and district nursing courses at the polytechnic are supported. Vousden (1985) maintains that this pilot scheme is different —

the belief that radical changes can be made without moving away from the hospital is what sets it slightly apart from the other pilot schemes

Vousden (1985 p.25)
The acting DNE explained to the researcher that the pilot scheme had been put forward as an alternative model for discussion. The rationale was to see what could be done in a situation where restraints or conditions were made - that there was to be no lessening of the learners' contribution to the nursing service, and where no extra funding was available.

There was, therefore, to be no change in the context for the pilot scheme, and there was little room for manoeuvre in the curriculum design. At the outset, however, two extra weeks for community experience had been possible, and it was hoped that further modification would be achieved whilst maintaining the regular flow of learners for service needs.

Modifications to the traditional curriculum were required as a result of the GNC officers' visit in 1977, when it was made clear that the time was ripe for a critical review of the situation. The curriculum was, therefore, revised and this began in 1979 with the development of a mentor scheme for the conventional course, by preparing ward staff for change, and by introducing monitoring, and individualised care for patients.

The acting DNE believed - and this was later confirmed by the teachers of nursing - that the 1985 pilot scheme was achieved mainly because this preparation, and the modifications to the conventional course, had been taking place over the preceding three to four years.
The design of the conventional course was based on an eight week introductory course, and three week study blocks between allocations for clinical experience. It was established in 1981, and began the move from the traditional product model of the curriculum to a process model.

6.6.(ii) Design

At this time there was little variation in the design except that a ten week foundation course was established, followed by one week annual leave, one week study preparing for an eighteen week placement. The purpose of this long placement in one ward setting with rostered service is to enable the student to become familiar with one team, with a mentor, and to reduce the anxiety produced by moving to another setting every eight to twelve weeks. At the end of this first experience in the clinical setting a two week study period to consolidate the learning experiences, is followed by three weeks annual leave. The second placement - based on a similar period of study weeks - one for preparation and two for consolidation - also lasts for eighteen weeks in another clinical setting. These placements are identified as acute and chronic clinical experiences - and are not labelled as surgical or medical nursing experience. Clinical teaching hours are also identified during these study weeks as the aim is to integrate theory and practice in the specialised nursing setting.
This modular pattern follows throughout the remainder of the course, beginning with care of the elderly including community visits, and placing maternity and children's experience and the care of the mentally ill in the latter part of the course. The acting DNE explained that the paediatric module had been moved from the first to the third year in the conventional course, because of the increasingly demanding and highly technical nature of the work at the Children's Hospital which called for highly specialised nursing care. The high accident rate, and severe burns in young children had also given rise to stress amongst young students. Community experience in the pilot course was increased from two to four weeks, and occurred in both the paediatric and mental illness module. Additionally a patient-education experience of eight weeks included both clinical and community experience.

6.6 (iii) Content

The researcher asked whether the key sessions by lecturers from the extra mural department of the university, - listed in the submission pp 44-48 - are lectures, since they are listed as hours. For example - four hours are allocated for key sessions in the psychology of communication and six hours for applied sessions relating written and verbal communication and the nurse, and listening, questioning and non-verbal cues (Submission p.45). The acting DNE explained that the specialist teams of teachers who had opted for the applied sessions, discussed the content and format with the lecturer to determine the
method of presentation.

The change in curriculum content is most marked in the health studies base - the health studies group of teachers and community nursing staff are responsible for this, and the thread runs through the studies in each module. This was confirmed by teaching staff during the informal visit - and the teaching staff includes tutors with district nursing, health visiting and psychiatric nursing qualifications and experience.

The acting DNE confirmed the researcher's inference, following content analysis of the submission, that the main differences between the conventional course and the pilot scheme, in this context, were in the curriculum content, teaching/learning strategies and in assessment and evaluation systems. She explained that the pilot scheme encourages self-directed learning and relies on the learners' understanding of their preferred learning style, and willingness to accept responsibility for professional development, and on the teachers' adoption of a facilitating role, progressively decreasing the learner's dependency on the teacher. The researcher asked how the large group of entrants were allocated to clinical areas, or divided for small group teaching. It was explained that a pre-test was offered in the foundation course before psychology, sociology and physiology sessions began. Following these results the set is divided into three groups.
those appearing to need more than the average amount of help
- those whose knowledge appears average (usually about 54% in the sets)
- those who appear to have above average knowledge

(Acting DNE)

The researcher questioned whether these were tests of ability to recall, and whether they were linked to previous studies, and learned that some entrants with 'A' levels, or 'O' level human biology were unable to reach a level to satisfy exemption from some sessions when negotiated study plans were being formulated.

Practical skills in nursing continue to be taught in the classroom setting prior to practice under supervision in the wards - each teacher having five students to supervise. Practice is on two sites - in two general hospitals differing in size and in medical and surgical specialities.

The conventional scheme had four practical assessments, formative tests and examinations and the summative ENB examination - devolved to all schools.

The pilot scheme has continuous assessment in theoretical and practical knowledge. This occurs in each module, and is both formative and summative - in keeping with the process model of the curriculum the summative assessment is interpreted as the summation of these assessments.

Concern was expressed, during this visit, that the devolved examination system, as proposed by the ENB, would not 'fit' the
concepts in the pilot scheme. The views of teachers also indicated that devolution of the final examination to the schools was considered to be too precipitate and without adequate preparation.

The evaluation of the course - by internal audit - is in progress - by recording data, questionnaires, and discussions with students clinical and community staff and teachers. A post is funded by the special trustees for three years, for a research assistant to assess the progress of the scheme.

The acting DNE commented that staff nurses, and students nearing completion of the conventional course, are in favour of the changing course - and say that they believe their evaluation of previous courses helped to evolve the pilot scheme. In answer to the researcher's question regarding the cost of the key sessions - it was confirmed that this was met from E.A.G. funds.

6.6. (iv) Factors inducing change

The commitment of staff in wards, senior nurses and teachers was considered to be a major factor in changing the curriculum. Nurse managers had co-operated to fund a nursing officer post in each of five units to work with the Senior Tutor - Continuing Education, to set up in-service study programmes for clinical staff, and to prepare for continuous assessment. Study days for ward sisters were well attended. Study sessions for teachers of nursing previously teaching
in teams, were also arranged, and they enjoyed the opportunity to apply their specialist nursing knowledge in the new approach to team teaching in the applied sessions, and several teachers had studied, or were studying, at higher degree level.

6.7. **Discussion**

The first visit to each of the six schools enabled the researcher to gain more understanding of the factors which had influenced the choice of curriculum model, its design and content, the reasons why a pilot scheme was submitted, the nature or extent of the proposed changes, and the context in which curriculum innovation was taking place.

Torres and Stanton (1982) discussing curriculum process comment -

> Curriculum development does not take place in a vacuum. It takes place in the context of the parent institution which influences, gives direction to and sets limits for the development of any curriculum within the academic unit. It takes place within the context of the larger community or society ... reflects to some extent what was considered important by society at the time ... it should also give some idea of what was expected to be important at some future time. Torres and Stanton (1982 p.11)

The location of the parent institution in each of the six schemes shows considerable variation. Two of the nursing schools are sited in a conurbation, one in a northern town and associated with a nearby city, one in a city within a rural setting, one in a south coast town in a retirement area, and one in a town in a south west rural area. These differences in location, in geographical and social context, it
is argued, offer diverse opportunities and limitations for curriculum developers. Access to higher educational institutions is easier in the cities, or to tertiary colleges in the towns - but different approaches to linkage with these institutions are taken by Yeovil and Central Birmingham from those in the remaining pilot schemes. The needs of the local community to care for the elderly led to the creative innovation proposed by West Dorset, which was unacceptable to the ENB because of the interpretation of the current UKCC rules; but, in the event, this enabled the curriculum planners to modify their proposals and to submit this pilot scheme. This pilot scheme also reflects the current pressure for student status for nursing students in the curriculum design and content, and demonstrates that a different form of remuneration in the future pattern of nursing education in the light of UKCC Project 2000, is realistic in the views expressed by students in this course.

There are considerable variations in the size of the six nursing schools, in the numbers of students and annual intakes to the pilot schemes. In three schemes - North Lincoln, Central Birmingham and South Birmingham - the conventional course was replaced by the pilot scheme; in West Dorset and Yeovil the pilot scheme replaced the conventional course in one circuit of the school, and in Sunderland the pilot scheme replaced one of the five annual intakes to the conventional course in 1985, and subsequently in 1987, 1988 and 1989.

The six nursing schools also differ in the number of registration courses they provide and the consequent number of teachers of nursing
with specialist qualifications and expertise on the staff. This factor may also be affected by the number of ENB post-registration courses mounted, and the extent of the provision for teaching staff for continuing and in-service education.

The curriculum model adopted by Sunderland and South Birmingham in linking schools of nursing and polytechnics, and the design of the curriculum in each one are different in many respects, and the assessment procedures in the two schemes differ.

The process model of the curriculum adopted by North Lincoln, Central Birmingham and Yeovil differs according to the constraints or opportunities in the local setting. The Yeovil curriculum contrasts with the former traditional course, as the North Lincoln pilot scheme does - both emphasising the health promotion, health education and self development aspects of the course preparing students to disseminate their knowledge and skills, and to adapt to future needs in society.

All the six schemes, whether linked with an educational institute of higher education, or a tertiary college, or with a course based in the school of nursing in a health authority, designed the curriculum to reduce the anxiety, or stress for students in the first year of the course. The periods of supernumerary status with observation and supervised practice vary in the five schemes - but the aim and intentions of this period are clearly stated.
In Central Birmingham, the only scheme without a supernumerary period, the foundation course is lengthened to ten weeks, and the two placements of eighteen weeks, each in a setting chosen for its educational opportunities, with mentor and personal tutor support, offer a different initiation to a highly demanding clinical setting for student nurses in the early part of the course. On the future visits and at interviews the researcher seeks to discover the views of those involved about the outcomes of this curriculum innovation.

The following chapter will identify the views and opinions of the participants which were shared with the researcher during interviews and discussions, and any modifications that occur as the pilot schemes progress.
The main part of this chapter focuses on how the participants involved in the curriculum innovation in these six schemes viewed the changes, and about the modifications which occurred as the plans were implemented. This information was collected in interviews with individuals, discussions with individuals and groups, and in conversation in social or professional settings. A total of 111 interviews with individuals were conducted of which 36 were tape-recorded. Examples of some transcribed interviews are included in Appendix VI. The issues raised by the participants are discussed in Chapter 8, but, in order to present the range of views and opinions, and to try to convey the depth of feelings expressed by those involved, this chapter will include a number of statements, and quotations from those interviewed.

Educational changes, according to Fullan (1982) are acts of faith, and he raises the question of personal costs, the energy and skill costs required to bear ultimate fruit without necessarily giving an immediate return. Nursing as a practice discipline relies on the experience offered to students in the actual care of patients and clients in wards, departments and in community settings. Hitchen and Fannon (1988) discussing the South Birmingham pilot scheme and the collaboration between a polytechnic and a school of nursing in a health authority stress the importance of practising nurses as supervisors and assessors of clinical experience.
The views and opinions of nursing staff who are practitioners in hospital or community settings, and who were interviewed in this research project, are therefore considered first in this chapter. Many views were also given during discussions at meetings, or in social settings and contributed to the researcher's data, and understanding of the issues raised.

7.1 The views of clinical and community nursing staff and mentors

All those interviewed indicated that they were convinced of the need for change in the initial preparation for nursing, and that, to a greater or lesser extent, they were aware of the type of changes being introduced, but different views emerged about how these plans were made, and about how they were being implemented. These interviews were conducted with clinical nursing staff when students were not supernumerary and were in rostered service in the teams, and they were asked to comment on the pilot scheme and the effects of implementing the changes - on the individual and on the organisation. Any aspect of the innovation, including their assessment of its strength and weaknesses, which affected them was being sought. The interviews were open, and the ward sisters and staff nurses had volunteered to be interviewed as indicated in Chapter 4. Views on the need for changes in initial preparation for nursing included:

Nursing is in need of a change, students ought to be supernumerary - I agree with Project 2000.

Ward Sister - Mentor
I think it's good - we couldn't go on as we were - it has to come, it's good for students - they need to have a career.

Ward Sister

Well, I wouldn't want us to go back to my type of training.

Ward Sister

It's a good thing to have this review of nurse training, before I went into nursing I went to a tertiary college (agricultural student)* and academic learning is so much easier if you are a student - studying in your day's work - its difficult - the stress on these students I think is less.

Nurse

*Researcher's note

7.1 (i) Views regarding the awareness of plans to introduce the changes and to prepare supervisors and mentors for their part in the innovation included:

I did ENB998 Course and I had preparation for the supervisory role in a one week in-house course which I enjoyed.

Ward Sister

I learned about it because I was a second sister and my predecessor as ward sister was on the planning team. I like the pilot - it's good. There may be too much children's experience and not enough medical and surgical nursing experience - but students are good at identifying their needs.

Ward Sister

I'm on the course committee - I am a mentor and my two staff nurses are - of course we had a mentor scheme before the course started.

Ward Sister - Mentor
I went to a workshop when the pilot scheme began, there were circulars from the school, and meetings to voice misgivings - then we had sessions in the school about the student's evaluations - I couldn't go, but the other ward staff went and fed back the information - they felt it quite valuable.

Staff Nurse - Mentor

I have been a staff nurse for more than a year, I went to a two day course, it was very interesting - I learned a lot - but it's very difficult when I'm acting up for sister - which is quite a lot of my time.

Staff Nurse - Mentor

Well - I learned about it during my three year course - it seemed a good idea.

Staff Nurse - Mentor

It's difficult when I'm in charge for Sister to be with a student for a whole shift, but Sister plans the off duty rota to give me two shifts a week with my student.

Staff Nurse - Mentor

It's very difficult to be a mentor and run the ward, some Sisters are not mentors because of that, but it's easier with a five-day ward because I'm there every day, and I can plan the duty rota so that mentors are with their students four days out of five.

Ward Sister - Mentor

I think the pilot scheme would work if there were enough staff on the ward to cope with teaching students. The plan is good, but I do not think students can learn in the wards because we do not have enough time to teach them.

Staff Nurse - Mentor

When asked whether she was keen to become a mentor, and what Preparation she had received, the response was:

Well, when I began on the ward the tutor came up and went through the paper with me - and I thought - yes, I could have a go.

Staff Nurse - Mentor

It's very difficult when students are not supernumerary and they are part of the team. My nursing officer is very good and supportive - she works in the ward if necessary - but it's difficult to be a mentor when students are part of the ward team.

Ward Sister - Mentor
This Ward Sister was then reminded by the researcher that she had said earlier that she enjoyed being a mentor, and she replied:

Well, I do, given the time and the opportunity, I am happy in the ward and in the hospital - there is a good rapport between doctors and nurses.

Ward Sister - Mentor

7.1 (ii) In response to a question about the effects of the pilot scheme on the individual and on the organisation, the views expressed tended to focus on available resources, (or lack of resources), on the students, and on the need for more support for students from the teaching staff in the practical setting. None of those interviewed commented on the views of medical staff except the Ward Sister quoted above. The researcher asked others about medical staff reactions to the new curriculum and the responses from Ward Sisters and Staff Nurses were very similar to these:

There are three consultant physicians in my ward. We have a good rapport; if we are happy with the changes - they are.

Ward Sister

Quite honestly I do not think they notice - or comment anyway. They see the care plans and the goal setting - but there are no difficulties.

Ward Sister

I would not really think they would know the difference between the pilot scheme students and the one's we get which are not - they do not teach a great deal, some consultants are very good and they point out, and explain things which is better for the third years. (Students)*.

Staff Nurse - Mentor

* Researcher's note

Some junior medical staff are very helpful - some very difficult - the housemen change over and they rely on the nursing staff for
what they do not know - therefore they rely on the Staff Nurse rather than the students. I think some registrars are quite good at teaching.

Staff Nurse - Mentor

In reply to the enquiry about the effects of the mentorship system on the ward work and organisation the answers from all the sisters and the staff nurses who were interviewed were similar in all six schemes. It was a role they enjoyed when there was time to fulfil it, it was of benefit to the student and to the patients when it could be arranged.

Yes - I enjoy it - but it always comes back to the time factor - when I have time.

Staff Nurse - Mentor

7.1 (iii) Views of the effects on the students in the pilot scheme.

When asked for their views about the effect of the new curriculum on the students, the sisters and staff nurses tended to combine comments about the pilot students with the comments about the resources available or desirable, for carrying out individualised care of patients.

I'm on a group looking at standards of care - for the necessary things like staffing levels and adequate resources - things we are sometimes short of - so that we can say - we cannot meet these standards because we are short of x resources.

Staff Nurse - Mentor

Well - I find the students are very good - they talk to patients - sit down and chat without being told to do so. They are practical - but hesitant sometimes - they ask when in doubt but, you know, they really do not have enough practical experience. They ought to have that before coming to the wards - they say they do need more, I think they do, because its not helpful to them.

Ward Sister
Students seem more confident (after one year with supernumerary status)* - so on the whole it's difficult for us to adjust to them - not knowing a lot practically - we have to keep reminding ourselves.

* Researcher's note

This knowledge is good - but different - they need protection in the first allocation in the team - they are good at asking, and not afraid to acknowledge need - but it takes time to relate knowledge to practice - for example their knowledge of the 'A & P' of the gallbladder is good - but it takes a long time to relate that and apply it to care for a patient, in pain, with a drainage regime after cholecystectomy - and feel competent.

In their third year they are very good at leading a team - with supervision. But they are very apprehensive about becoming a staff nurse because they think they haven't enough pharmacological knowledge - and I agree - they need six months' experience after qualifying to become familiar with drugs.

Given a named student makes you feel more responsible to them - you relate more to them - those particular students - you make sure they have seen and done something. I feel the students are a little bit disappointed with the system because it has to be a compromise - because of covering the ward and having a suitable skill mix on duty - patients' needs take priority over students - you feel you are not doing justice to the students - but patients' needs do come first.

These students are different - their teaching is different with psychology, and sociology - it seemed threatening at first - but I find students are more open, they find the time to talk with patients' and find out information about patient's needs - its excellent.

Well - they are very willing to learn - some staff think they are challenging - you know, cocky - but I think they are assertive - they know what they want to learn. Some say they are slow - but that's only in their first allocation to the team - after that they are very understanding, can talk to patients and they get to know a lot. Students need to be part of the team.

* Staff Nurse - Mentor
* Ward Sister - Mentor
* Staff Nurse - Mentor
* Ward Sister
7.1 (iv) Views of the effects on the community experience

Community nursing staff, after initial misgivings in some instances, were very much in favour of the pilot scheme, and in the broadening of the students' experience by visits to voluntary agencies, social support groups and occupational health departments in industry and commerce.

The students were supernumerary during their experience in the community in all the pilot schemes, and in maternity experience and in psychiatric wards the placements were arranged to provide support from appropriately qualified staff. In contrast, in elderly care and children's wards students were working in rostered teams. The timing of these special experiences varied in the six pilots, and was often earlier in the course than the conventional course student's placement had been previously.

A midwife commented about having students early in the second year, after the one year supernumerary period:

I was not keen on the idea at first - but they are the most innovative group we've ever had.

Midwife Teacher

I resented the idea of odd days at first, but later I saw how the student's knowledge developed over these days during the year.

Health Visitor

Experience for students in the community was jointly planned by health visitors, district nurses and teaching staff.
In South Birmingham the researcher interviewed an experienced tutor acting as a placement review officer who was responsible for coordinating plans, and conducting reviews to evaluate both students' views, and the views of the staff. In Yeovil the community experience during the first six months included nursing experience in small community hospitals, visiting patients with district nurses, attending clinics with health visitors and a period of observation in a general practitioners' surgery which was rated highly by the students and the medical staff. This experience was augmented by visits with midwives and health visitors during the maternal and child care allocation, and with community psychiatric nurses at the appropriate allocation. Goodchild (1986) describes the North Lincoln community experience, which offers students an opportunity to follow child development by a study of one child and the family, with the cooperation of health visitors, and one elderly person at home all have by arrangement with the general practitioner, for one year, and following up two patients through the hospital, and on their discharge. She comments on the enthusiastic support of the medical staff in their innovation. The students' enjoyment of this health model approach is confirmed by their evaluation and by the teaching staff who see their application of this in their ward experience, as well as in written work.

7.1 (v) Views on liaison between teaching and clinical staff

I think the students are - well, overprotected in the first year, there isn't enough contact with tutors later - if the tutors had more time they could visit the wards more often.

Staff Nurse
When asked by the researcher whether tutors were involved in ward discussions on contract learning during the student's second year - the response was:

Yes, they are - but the students' study days are not in the ward - it still seems separate instead of working together - the main drawback could be overcome if - well - by tutors being in the ward more often - the ratios are not right.

Staff Nurse

Well - it’s difficult in a children's ward - students go out visiting with the health visitor, and to special schools and so on. Its difficult for students to relate because children are different - the older mature students are very good and it shows up the others - some male students are very good - but some cannot come to terms with children - they have no mothering instinct.

When asked whether the tutors help with ward teaching the response was:

Yes - Mrs x comes every Thursday and does a teaching session - but we never have time to go. You know - I thought I knew what nursing would be like at 18 - I'd been a voluntary worker in hospital but - it's different with ward pressures.

Staff Nurse - Mentor

The views of teaching and clinical staff about the issues of time and work pressures, and the wish - strongly expressed to see students actively learning about caring from patients with support from mentors and teaching staff - were similar in all the six schemes - whether students were supernumerary for six months, one or two years, or were not supernumerary as in Central Birmingham. One other issue was raised which would merit further study - the need for continuity. A ward sister raised this by saying:
The course is changing all the time it's difficult to keep track of all the changes.

Ward Sister

A staff nurse - mentor, asked by the researcher about her views on the future, and the proposals in Project 2000 replied:

I don't know - this pilot is working towards a new system, if it carries on to Project 2000 as it is at the moment it will be all right. It's gone through little changes already, and students find it quite, sort of - well not exactly disturbing, but its quite hard when two sets behind them have variations.

Staff Nurse - Mentor

However, these views contrast with the views expressed by a senior tutor not involved with the planning or introduction of the pilot scheme.

To some extent the ENB's five year approval is an inhibition to change. In my philosophical view the pilot should have been allowed to change as things emerged within it which required change.

In response to the researcher's comment that some modification did appear to have been made, the response was:

Well, yes, we have moved into areas that were required; guidelines for assignments, and study days for teaching staff and developing mentors.

Senior Tutor

Ward sisters and staff nurses said that they felt the need for more continuing support from teachers for the students in the clinical setting. This factor needs further exploration because there may be confusion between needs and demands, or between perceived needs, wishes or demands, and the actual realities.
7.1 (vi) Views of clinical staff on assessment and evaluation

Similar opinions were offered about assessment of students' progress, the evaluation of the learning opportunities in the environment, on performance review or ward audit, even when the systems in use differed in the six schemes. In common with many nursing schools in England, when the pilot schemes started, student progress report forms were based on the 'King's Fund style report'. These were replaced in the pilot schemes when continuous assessment in practice, or continuous assessment in theory and practice, was introduced and a new system of recording evolved.

Student profiling is very good - we complete it after discussion with other staff - the students seem to find it helpful too.

The researcher asked: Do you mean you fill it in, and complete it?

The response was:

No - I meant I sign it - but any supervisor fills it in where appropriate. I am responsible for the assessment. Ward Sister

The documentation for continuous assessment is very difficult. It takes a good hour to do the assessment - you have got to get right away from ward work. The mentors do the assessment - they get to know the student's work much better than sister - sister has to agree and countersign it. Ward Sister - Mentor

Yes - we sign the progress reports - we call together all the staff nurses, they are not countersigned. Its a lot of words - with the old system the ward sister filled it in - on nursing care it was quite straight forward. Miss X (tutor)* went through the form with me - but its still difficult and hard work. Staff Nurse - Mentor

* Researcher's note
They are very verbose, you have to sit down and think - what does this mean? They use ten words when one would do. Surgical experience is mainly basic nursing skill - the objectives are geared to professional development, they are not specific.

Staff Nurse - Mentor

I enjoy carrying out assessments, I think most of the students - they say so - are pleased to have had this experience - care of the (elderly)* - some know they want to specialise in it - I really have a medical ward for the older age group - the patient turnover is high.

Ward Sister

* Researcher's note

The ward sister and staff nurses and the community nursing staff who were interviewed were all committed to the concept of changing the nursing curriculum. Their views were offered mainly in the light of the students' needs in the clinical setting. Any criticisms offered were about any possible disadvantage to the students and their concerns about the mentorship role which varied between the schemes. The seven mentors who were interviewed were convinced of the advantages of a mentorship system whilst being keenly aware of the limitations imposed by the pressure to time, ward management, and in some instances, shortage of resources to make the system work.

Issues left for future study which were raised in interviews with clinical nursing staff include the relationship between continuity and change during a period of experimentation, and the exploration of the need for students to practise within a team to learn from the clinical setting in order to enhance their knowledge of nursing. There were no adverse comments on the students' lack of knowledge - only about how that knowledge becomes understanding in the practice of nursing.
7.2 The teachers' views of implementing the plan

In this section the term 'teachers' includes all those involved in the pilot schemes whose roles and appointments are primarily educational. It includes registered nurses who are qualified as clinical teachers, nurse, midwife or health visitor teachers (i.e. teachers of nursing in the broad sense) registered nurses who are nursing lecturers, senior lecturers or principal lecturers in nursing, and lecturers in other disciplines engaged in nursing courses. The views of nurses who, whilst primarily engaged in caring from patients or clients, have a teaching and supervisory role in nursing were considered in 7.1.

Open interviews during the first year, and towards the middle of the second and third year of the pilot scheme were conducted, and those interviewed were encouraged to give their views freely about their experience in introducing change. The framework for these interviews was provided by the categories that emerged by content analysis of the submission - Chapter 5 - and the first visit to the six schools by the researcher - Chapter 6 - which increased the researcher's level of understanding of each social milieu in which curriculum innovation was occurring.

The aim was to try to discover what teachers putting the plans into effect thought and said about the proposals, the plans, the effects on the student's and the teacher's role, and the effect on the organisation or the two organisations collaborating in the scheme.
The comments to the researcher, which were given in confidence, are identified by the type of post held by the respondent, and, if appropriate, the point in the project when it was made, and not by the name of the pilot scheme. An attempt is being made in this phase of the research project to search for common ground, or divergent views, within the six schemes - for theory grounded in reality.

7.2 (i) All the teachers began their comments by explaining how they viewed the proposals, their involvement or otherwise, in the curriculum planning, and their preparation for the proposed changes. Some of their comments are quoted:

I am not the initiator of the scheme - x has left - I am managing it for the first year.

Nurse Teacher

In the same scheme where this response was made, the DNE commented:

We had a group of young, keen tutors and they were keen to plan this - we had to do something.

DNE

In another scheme, in the first year of the course, when asked about how the plans were formulated, and participation in planning a nurse teacher commented

Well - the tutorial side was not really involved until the submission was accepted - but we knew x and the ADNE and the DNE and we trusted x, the course tutor, - and we carried on from there.

Nurse Teacher

In the second year of the course the same respondent said:
Well - it was very hard work, but worth it. I would not go backwards, these pilots are for the future. Nurse Teacher

A respondent in a different pilot scheme in the second year of the course said:

We were not involved in planning - it was done by z but of course we knew it was happening. Nurse Teacher

These comments appear to indicate that, in the three schemes quoted, one individual was seen as the prime mover, or innovator, in curriculum planning. Fullan (1982) argues that innovative skills are different from the skills required to implement the innovation. The comments that follow indicate the different views about preparation for implementation:

I was on the initial planning group - and given a brief to design a method of continuous practical assessment - with a 'group' of experienced ward sister, nurse manager and myself. Nurse Teacher

Well - I'm responsible for teaching the conventional course until the students qualify. We - my colleague and I were not involved in planning the pilot scheme - it was done by z but, of course we knew what was happening. In a small set up we listen to each other and discuss things. Nurse Teacher

I belong to the curriculum development group - it's been very useful to come to terms with the pilot scheme to see where its going ..... I think preparation of teachers and clinical staff is very important to make sure everyone is aware of the implications for change - and aware of the staffing implications - for the wards, and the teachers. I think you should have an outline plan - know where you are aiming with main lines drawn - bound make modifications as you go along. Nurse Teacher

If I were designing a pilot scheme - I would prepare staff in the school of nursing more than they were prepared - Nurse Teacher
I think it's very important if you are going to make such drastic changes to take more time to prepare - the speed at which the ENB put it through - I told the ENB officer I thought it was far too quick - there is so much to do - planning content, getting other people in as specialist lecturers - ward auditing.

In answer to the researcher's question - But the ward audit and student evaluation had been underway for some time? The respondent answered -

Yes - but even so planning in specialist areas - and with the lecturers - it's very time-consuming.

Nurse Teacher

Well - things have got to change. I've seen changes over the years from four intakes to the school, three times a year and then twice a year. Many young tutors are studying for diplomas and degrees in their own time and it's hard for them. I would have participated in the pilot scheme if I were ten years younger, but I am taking early retirement - I considered it was right to make way for someone younger.

Senior Nurse Teacher

Planning the curriculum was a joint effort between representatives of two educational institutions - there was great goodwill - academic staff were keen to participate in course planning, teamwork and the application of theory to practice.

Nursing Lecturer

Staff needed more preparation for change - possibly we could have done
more - but the time factor was a problem.

Nursing Lecturer

I was previously familiar with the NHS and hospitals as a psychiatric social worker - but I did a stint as a nursing auxiliary in a general ward to discover the current situation.

Lecturer

Bennett (1986) who also prepared himself in a similar way for the joint venture between a school of nursing and a College of Education comments on:

The open exchange of ideas ..... This collaborative approach has encouraged the staff from both institutions to acquire new concepts, skills, methods and expectations of students.

Bennett (1986 pp 24-25)

He also draws attention to his experiences in the nurses' world of work:

These experiences helped me to appreciate the complex nature of the role of the nurse and the wide range of sub-roles he or she is expected to perform.

Bennett (1986) p 25

These and other comments from lecturers in the disciplines fundamental to nursing illustrate a willingness to collaborate with understanding in their efforts to share in the preparations for, and the implementation of, the curriculum.
There is great good will and commitment. I moved to this post because of it - it really is a collaborative exercise.

There are ... 'obstacles' because the structures of the two organisations are so different ... I feel, at the beginning for people to realise the difference - well, it was problematic - understanding the differing ethos in both environments. The organisational structure in the school of nursing has evolved to meet the course needs. Time was a problem when the course was up and running whilst still evolving - laughter - it made it difficult for us to get together but that was an advantage - it encouraged ideas - to get on with trying something - then reflecting and discussing and altering if necessary.

Nursing Lecturer

In answer to the researcher's question about the extent of the educational linkage in another pilot scheme the comment was:

We could do more - I'd like to see this, the logistics problem with two intakes of student nurses makes shared learning a problem.

Nurse Teacher

In Chapter 2 reference was made to Benne (1976) and the differences between the two worlds of academic and practice settings. He also instances the difference in time and decision-making - an issue raised in some of the comments quoted earlier. For the academic a longer time perspective allows judgements to be made on the basis of an accumulation of evidence - and choices of action to be debated without the pressure of time. For the practitioner, those involved in social action, time presses for a decision on how to act.

They must depend on their own hunches and insights in attributing meaning to incomplete or contradictory evidence. Their knowledge is impregnated with their own - values. It is more personal, more dependent on their ability to read a situation.

Benne (1976 pp 170-171)
He argues that by joint seminars between students, practitioners and academics these different approaches may be discussed to allow students to use knowledge gained in the field to confront academic knowledge and to understand the strengths and limitations of both.

Benne (1976 p 169)

7.2 (ii) The teachers' view of the effects on the student's role

Lecturers in disciplines other than nursing made very similar comments to these:

I enjoy the applied knowledge the students bring to discussions - we very rarely give lectures - the sessions are student-centred or person-centred, with the emphasis on learning. I find the students highly motivated and committed to study and practice.

Lecturer (in the first year of one course)

The quality of their work - in discussion and in project work and writing is of a high level - very comparable to degree students. They are active - challenging assumptions - seeking evidence in group work.

Lecturer (in the second year of another course)

Examples from the six schemes of nurse teachers' comments included:

Students are very different - they have communication skills from the early days they are used to listening, speaking and identifying need. They use the knowledge they have gained - about how people live and work.

In answer to the researcher's question whether they presented a challenge to ward staff the reply was:

Some do - they are assertive, they ask but they are good at interpersonal skills - they can utilise knowledge to reduce the challenge.

Nurse Teacher
We try to treat these students as adults - to encourage thought, to be active in their learning. In the first six months they learn a lot from each other, a lot of development goes on - of interpersonal skills - there's a big difference.

Asked by the researcher - How do you identify this difference? She replied:

They have learned to speak up - some are very quiet at first - their parents have commented to me they are different individuals - have wider perspectives.

Nurse Teacher

The students are looking at people - why, and where they work, where they live, and how what they do has an effect on their health. With the conventional students, because of the teaching methods and the medical model there was no opportunity to do this.

Nurse Teacher

When asked by the researcher about the amount of practical experience for students in the clinical setting the same respondent replied:

In the first year, there is a registered nurse teacher always there to supervise practice. In the second year, during the ward placement weeks full time, I would say they contribute to the service in exchange for supervision by clinical staff. They have mentors, and there is a placement supervisor.

Nurse Teacher

They are different; they have a different theory backing and knowledge, they can care for patients with their tutor's supervision - but it seems to take them longer to put it into practice in this concept within the ward team.

Nurse Teacher

A senior tutor not in the pilot scheme commented:

The pilot scheme has stimulated the conventional students to do some more reading, particularly of research reports - they are doing some very good projects. The flexibility is good - I can really treat them as students (conventional course)*. The students' comments indicate that the pilot scheme students are now asking for more tuition in practical skills before their ward experience - they evaluate their ward experience, and in ward
discussion groups pilot students say they have suffered from cultural shock - they will see they get what they need, I'm sure.

Senior Nurse Tutor (not in Pilot Scheme)

* Researcher's note

A nurse teacher who had recently joined the pilot scheme commented:

The students are very keen, committed, they work hard, the clinical staff thought they were slower on arrival in their first team, but on the other hand, the sisters have commented on their knowledge, and ability to talk to patients in their first year.

Nurse Teacher - recently joined pilot

7.2 (iii) The teachers' views of the effects on the teacher's role

We have a better relationship with students - we are more companion, people come to us with their problems, we are not distanced - nearer to students and nearer to service side than we were before, because we had to go out on to the wards to get our credibility with ward staff - so that qualified staff and students could see we knew what we were talking about.

Nurse Teacher

The teaching workload was not too bad - it was the marking of the new assignments, planning the criteria for marking was difficult - there is more moderating which adds to the workload. As a school we are all finding it takes extra time because we were making different interpretations ... and the feedback is slower.

Nurse Teacher

There have been some very stressful times - constant changes in the school of nursing - changes in philosophy, in management. I mean, I was naive - I thought thats how the tutor's role was, ... I realised it was just a philosophy, and to actually put it into practice was another thing and I think as we became more research-based in our teaching, students are questioning the gap between theory and practice which becomes more evident to them.

Asked by the researcher how students react to this discrepancy, the respondent answered:

Some very mature approaches - discuss with me, or with trained staff in the wards; some became very angry - and quite rightly - are angry with us. It's difficult when they express their anger to us - we are taking responsibility for educating them but don't have power over what goes on in the wards.

Nurse Teacher
The teachers' views on preparation for clinical practice

A nurse teacher who was strongly committed to the pilot scheme was asked about the disadvantages encountered, after some thought the following response was made:

The one disadvantage was that we would have liked to have stopped one intake of conventional students, so that we could have a bit more time to prepare ourselves - a bit more of a breathing space because the on-going block system is continuing for these conventional students.

Nurse Teacher

Another nurse teacher commented on the students' transition from supernumerary status to team membership:

I thought 'they will get used to it' - but I think now that it's much more of a problem than I think we think it is.

Nurse Teacher

It has been a constant battle by the team to initiate and maintain a supportive environment in the second and third years. The supervisory nurses acknowledge this need - and that nursing cannot be learned unless support is given.

Nursing Lecturer

In response to the researcher's question about why there was a difficulty with such support the answer was:

current demands on the use of hospital facilities make this difficult and sometimes impossible.

Nursing Lecturer

The researcher then asked if the respondent was suggesting that supernumerary students need sufficient role models to supervise them - apart from those supervising patient care, and after reflection the respondent answered:
The strength of this battle for support is that the use of experiential learning techniques in both ward and community experience means that this is brought to the surface as it occurs.

Nursing Lecturer

I was on the course planning team and staff preparation was going on before the pilot began, but clinical staff find it difficult to understand that a student in the second year is not the same animal as a second year conventional student. The student has the same basic skills - but cannot put them into practice yet - they need time.

Nurse Teacher

7.2 (v) The teachers' views about the mentor's role and preparation

The teachers were asked for views about mentors and their preparation for the role or support mechanisms; the following quotations are supported by other comments by teachers to the researcher:

With in-house courses - well, cannot do it all on a course - the teaching staff's relationships with the ward team are essential to augment this. Some miss out on the courses - but then we catch up with some on assessors' courses.

Nurse Teacher

There was a lack of understanding at first - and apprehension about mentors, and clinical supervision, but no real opposition.

Nurse Teacher

In answer to the researcher's question whether it was the policy of the health authority to release staff for study days the same respondent commented:

It's the policy - yes, but nursing service managers vary, some are only too willing, some are anxious and slower to release staff.

Nurse Teacher
In another school a nurse teacher commented:

I try to organise a weekly teaching session by one of the ward staff in the unit, I discuss the mentor's role with staff nurses individually in the wards, and monitor their progress. The district policy is to have staff nurses study days in the first six months after their appointment. They are usually well attended.

I would like to develop a mentor-support group for staff nurses to share and develop their ideas. It's a stressful role being a mentor.

Nurse Teacher

In answer to the researcher's request to explain why this was stated, the interviewee explained further:

Well - the students are grabbed by the health concept in unit one - but they do not overlap with their mentors in the team in unit two. It's stressful for clinical staff when students have study days - but it's improving. The mentors have to lead the team, when in charge - and cannot supervise their student, and it's stressful for the teaching staff - acting as an educational advisor.

The researcher asked why the respondent had asked to join the pilot scheme from elsewhere, and the response was:

I liked the idea - an open system, all equal in teams, with freedom to discuss. It works - but the pilot could be better -

After the researcher's query:

with student status to give students time to learn - not to expect them to work and study. Before I became a nurse I was a BEd, I did a certificate in education and know how much these students miss out.

Nurse Teacher
Another teacher raised the question of preparation of both clinical staff and teachers of nursing:

I think preparation of teacher and the clinical staff is important to make sure everyone is aware of the staffing implications for change.

Nurse Teacher

Initially there were workshops but the response was not that good, then assessors - sisters meetings and mentors some areas good attendance, some areas not, and we found these were the problem areas - nobody knew.

Nurse Teacher

Well, I was involved with the first group and under the impression that no final examination would be needed - they were a fair way on in training when they were told they would have to - there was a lot of stress and anger, and I felt - and I think, they are very heavily assessed.

Nurse Teacher

7.2 (iv) The teachers' preparation for curriculum innovation

Greaves (1982) states that in designing a nursing curriculum the present realities of the world of nursing, and major problems and issues need to be addressed. The teachers' views of the effects of implementing the curriculum plans as the course progressed were considered by the researcher to be very important.

The present realities within each of the six courses may be viewed from different perspectives by individuals according to their own personal values and the strength of their commitment to or degree of involvement with the course. The different perspectives from which
the respondents viewed the innovation, it is argued, may be influenced by their preparation as a teacher. The researcher therefore questioned the respondents, and other teachers during the visits about curriculum studies during the course of their preparation for teaching. One nurse tutor, recently qualified, said that this formed an important part of the one year course she attended. Two nurse tutors had a teaching qualification before entry to nursing - but had not studied curriculum in relation to nursing education. The remainder, who had studied for a tutor qualification in a variety of courses - two years for a diploma, a one year course for the certificate of education, or a part-time course, - had not studied the curriculum - its planning or process of development and evaluation - during their teaching course - but relied on their own reading, and the experience of their senior tutor colleagues who had studied this at an advanced level. DNEs, Senior tutors and course leaders who were interviewed spoke warmly of the efforts made to take part-time studies by teachers of nursing, and of their regret that similar opportunities for clinical staff were restricted because of the difficulty of funding the replacement staff.

7.2 (vii) Support and sharing

Clark and Gifford (1987) discussing the experience of managing change in the nursing curriculum in Central Birmingham at the April 1987 Conference, stressed the importance of developing the individual, both the student and the teacher, and of the threat to personal values
posed by change - and by the speed of change. Gifford stressed the importance of support - the need for specialist groups or friendship groups when, as she phrased it, the forms of an old culture are dying. Fullan (1982) quotes Schön who describes the zones of uncertainty in which the crux of change is how individuals come to grips with it.

The nursing lecturers, lecturers in other disciplines and teachers of nursing in the schemes in Lincoln, West Dorset, Sunderland and South Birmingham stressed the importance of sharing knowledge expertise and maintaining communication during collaborative schemes. Staff in the participating institutions had much to learn from each other - and to offer to disparate settings. In all six schemes the importance of continual - and continuing - dialogue between nursing staff in clinical and community settings, and teaching staff in the nursing school, wherever it was sited, was considered to be very important.

7.3 The course leaders' views, and modifications to the plans

The view was expressed frequently during interviews and discussions with participants and others during the research project that the course leader plays a crucial role in all aspects of the pilot schemes. This was borne out by the content analysis of the submissions, and in the researcher's visits to the six schemes over the three years of the research project. Interviews and telephone discussions with the course leaders were conducted at the beginning, the mid-point and at the end of the research project, and there were discussions at the Board in October 1986, January 1988 and February 1989 between the course leaders and representatives of the six schemes, the researcher and the Boards' offices.
7.3 (i) There were changes in course leadership during the three year research project, in Central Birmingham the staffing structure of the school changed; in Yeovil, there were changes in staff as the scheme progressed, and in North Lincoln the course leader was appointed in April 1987, when the pilot scheme had been operational for fifteen months, therefore the views of the ADNE, who acted as course leader for the first and early part of the second year are included. Both these respondents were committed to the pilot scheme, and in the opinion of the researcher were analytical in their review of the process of curriculum innovation.

In the Yeovil pilot scheme, the tutor to the course and the senior tutor mainly responsible for planning the innovation were interviewed during the three years, at different points, either in the school or at conferences and meetings in London and elsewhere. The senior tutor/management was interviewed during the third year, after he had taken up his appointment to the Somerset School of Nursing - i.e. Taunton and Yeovil.

In Central Birmingham, one person had three different roles during the pilot scheme - curriculum developer, acting DNE and then as DNE. The views of the senior nurse educational managers who contributed to the development of the curriculum, and whose roles changed as the new management structure became operative have been included in this section.
Course leaders in South Birmingham and Sunderland remained fully committed to the pilot scheme throughout the interviews in the three years, and the course leader in West Dorset, also fully committed to the scheme, who left to marry in October 1988, gave her views to the researcher in writing at that time -

I am still convinced we were on the right track - but would certainly like to see students supernumerary for the whole three years - but not necessarily away from the clinical experience. I believe we - the nursing profession - should strive towards improving the theory/practice relationship - we in our pilot were getting there.

Course Leader

7.3 (ii) Communication

The need to keep all those involved in changing the curriculum constantly up to date with information presents a major difficulty for course leaders. This is less difficult in West Dorset and Yeovil, where curriculum innovation in the pilot scheme is based in the school of nursing although in Yeovil the diversity of students' needs - even with a relatively small group (12 x 2 p.a.) - involves contact with many different people.

The researcher as facilitator can be imprisoned by the course at times - good rapport with students leads to - well - all forms of counselling are called for. There are difficulties in anticipating calls on experts - and arranging visits on an ad-hoc basis.

Nurse Teacher

In West Dorset involvement of college lecturers in activities in the school of nursing, the proximity of school and clinical experience in wards and departments, and the relatively small size of the student
body (10 entrants x 2 p.a.) made communication between all involved very easy.

In South Birmingham, with a slightly larger student body (18 entrants x 2 p.a.) there were difficulties in communication between all those involved in teaching on the two sites in the school of nursing in the health district and in the polytechnic. The course leader comments

- working together is very satisfying, its like two horses pulling together in a team.

Course leader - first year

and also

In spite of all our efforts there were delays and confusion, and the mis-information system prevailed. The course team meets every 3-4 weeks. The information is disseminated - in a paper with a logo to attract attention - and it goes to all concerned with the course - teaching staff, everyone who has students for placement.

Course leader - second year

In Sunderland, with intakes to the pilot scheme once in September 1985 and then once annually from January 1987, there were fewer pilot students, and the course design provided more continuity in the first year - either at the polytechnic or the school of nursing - than the more intricate pattern in the first intakes to South Birmingham, although this was modified later.

Course leaders in the six schemes acknowledged that the innovation was planned and introduced within a very tight time-scale, and that more time in preparing teaching and clinical staff would have been helpful. It was stated that this would have improved communications at a later stage.
In Sunderland the course leader said that at the beginning of the scheme there were difficulties in communication between the clinical and teaching staff in the three hospitals within the health district - some remained unaware of the implications of an inter-collegiate body

Course leader

Although Central Birmingham had been preparing for curriculum change for four years, by joint appointments between teaching and nursing management in the clinical setting, and a mentorship system was in operation, two factors made communications difficult. One was the size of the student body (46-50 x 3 p.a.) and the other the speed at which major changes in the curriculum process were introduced in a health district providing a high technology setting. All those interviewed indicated this needed constant efforts to maintain constant communication between nursing staff and teachers to share their expertise.

Planning the course has justified itself by increasing the interest and participation of nursing staff in clinical areas.

Acting DNE first year of course

In our view the implementation of Continuous Assessment of theory and practice has been one of our major achievements in view of the quality of student work.

DNE third year of course

7.3 (iii) The effects of changing the curriculum on the individual and the organisation were explored during each of the three visits to the 6 pilot schemes for discussion with course leaders. All the responses indicate the benefits of supernumerary status for students.
- it's a breathing space for learning - to develop understanding
  West Dorset, Course leader

- student enjoyment of the course is witnessed by their
  commitment - they are articulate, able to initiate activity
  South Birmingham, Course leader

- students are different, good at questioning, communication and
  self-appraisal, able to deal with stress - their own and in
  their environment
  Sunderland, Course leader

The original proposals for supernumerary status in the first year in
North Lincoln both for Units I and II had to be altered after the
first intake group as there were insufficient financial resources for
replacement staff. The modification to provide a protected
environment for Unit II in subsequent courses caused some difficulties
at first, because the rota for mentors and the students hours did not
coincide. After the establishment of the service contribution of 25%
in the first year by learners, and with manpower planning to provide a
better skill-mix, the problem has been overcome (Annual Report
1988/89). The benefits of the six months' supernumerary status for
students in North Lincoln and in Yeovil are commented on in relation
to the changing curriculum, and in the reactions of clinical and
community nursing staff to students with a different preparation, or
else in the changing relationships between teachers of nursing and
practitioners and their preparation for change. In Yeovil comments
include-

The students are more enquiring, they read and absorb current
articles in nursing journals, periodicals and newspapers - there
is evidence in the assignments of applied knowledge, using
references, which is not evident in the work of other students.
Nurse teacher - Yeovil first year
A senior tutor comments that:

The feedback from qualified staff includes - 'I have never read so much myself to update my knowledge'.

and 'I am now questioning why certain practices and procedures are performed' - it is difficult yet to evaluate the effect in clinical settings.

Senior Tutor - second year

In North Lincoln comments regarding the effects of the innovation on students included:

Our intuition and feelings in the first year indicate there is a difference - they are challenging, assertive

North Lincoln - first year

The involvement of clinical staff and community nursing staff in the curriculum development remains impressive with ideas, interest and above all, support.

North Lincoln - second year

7.3 (iv) There were references in the annual reports from North Lincoln to the ENB, and from interviews, that there were some difficulties in clinical settings where staff were unwilling, or felt unable, to act as assessors. In the first year, and second year the mentorship system was being developed

The success of the mentorship system appears directly proportional to the amount of time given to preparing staff. In clinical areas where students were allocated at a later stage of the course excellent support has been given by mentors

ADNE - second year North Lincoln

The 1988/89 report indicates that this problem of support for clinical nursing staff in a new situation was addressed by developing the educational advisory role for nurse teachers in the clinical setting, once full teaching staff levels were achieved.

The educational advisory role in the clinical setting, and criteria for selection of placements for students are now
established, and the ratio of trained staff to students is rising - but there is still a need to emphasise that the biological basis of behaviour is there in the curriculum - it runs through the course. Students - and ward staff would like it labelled 'Anatomy and physiology'.

Course leader - third year North Lincoln

In South Birmingham it was anticipated from the outset that the student's manual dexterity and level of practical skills would be different from conventional students because there was less repetition, but that, whilst slow initially in this respect, they would catch up quickly. An experienced nurse teacher in a pilot scheme put forward a different view of the amount of practical experience offered - not solely for dexterity - or for familiarity leading to confidence, but because

it takes a long time to learn how to do assignments, how to answer nursing questions, how to apply knowledge from other disciplines.

Nurse Teacher

This latter statement echoed the concern of a ward sister quoted in 7.1 (iii) that the pilot scheme students have a different knowledge base and that it takes a long time to relate knowledge to practice in nursing.

During the second year of the course in Sunderland the researcher asked about reactions to the pilot scheme students, and the course leader commented that there was no personal antagonism, or overt criticism, but

there was anxiety about whether the pilot students would be able to cope - as nurses - some staff nurses wondered if they would get the best jobs - and some role models were not appreciative of
the need for change in the first pilot course ... everyone's training is the best! - but there was gradual change.

Course leader

In the third year - the researcher asked the same question, and the reply was -

They are committed to the new conventional course - but not necessarily to the pilot scheme. The disquiet expressed by traditional staff earlier about whether the pilot students would be capable - sadly, three years later those who were traditionally prepared feel they have missed out that their training was not as good as the pilot, or the new conventional course.

Course leader

7.3 (v) Changing Role of Teacher - Workload

Changing demands on teachers of nursing, and the changing role of the nurse teacher, and the increasing workload for staff in schools of nursing, were of considerable concern to course leaders. Snowley (1986) refers to the action-packed year, or three, ahead of the teachers in the pilot course. The rising workload Course leaders indicate is caused not only by the overlap with conventional or traditional courses, but also by the arrangements for introducing the changes in a complex setting, and devising methods of monitoring and evaluating the course, of assessing student progress, and selecting and monitoring placements in hospital and community. Additionally, the need to participate in, or arrange, 'Back to Nursing Courses' to recruit replacement staff; teaching and supervising courses for assessors; mentorship systems, and in some of the schemes by arranging open days, or making recruitment visits outside the United Kingdom, adds to the work of the teaching and nursing management staff.
It is also suggested that the teachers' workload escalated because of the nature of the courses, and the expectations of the students. O'Brien and Smith (1987) presenting an integrated model of the nursing curriculum in Sunderland at the April 1987 conference drew attention to the humanistic philosophy on which it is based, which emphasises the need for holistic care for students - if they are to learn to practise holistic care for patients. Yeovil nurse teachers aim to develop the caring role of the individual, and to identify individual needs. Individual learning styles, and the development of the student's ability with negotiated contract grading in the Central Birmingham scheme, and the introduction of a new management structure added to the teachers' workload.

The comments of a nurse teacher in South Birmingham were endorsed by the course leader.

We went into overdrive here - we worked overtime, used holiday time on the submission

Nurse teacher

In Yeovil, where one nurse teacher was introducing the pilot scheme students twice a year - and therefore the commitment to conventional scheme students was reduced - this did not reduce the workload - it altered it

Being a resource person rather than 'an authority' allows one to develop a good rapport with students - but there are difficulties - students expect me, and everyone, to be available for consultation. It's time consuming to explain and plan appointments for them with experts - to negotiate their
individual learning needs. The students have a healthy anxiety about plotting their own course - requiring counselling, support and encouragement.

Nurse teacher

In response to the enquiry whether the increased workload caused strained relationships, as Nisbet (1975) suggests, the course leaders referred to strain, or stresses, for individuals, but not to strained relationships between staff where the levels of commitment to the pilot scheme were rated highly. An example of the responses from a course leader is given:

The workload of all the teaching staff increased when the pilot was being run in, and there were large numbers of conventional students still in training. The tension levels rose - but there was no strain on relationships.

West Dorset, Course leader

This view was confirmed by two nurse teachers in the same course, independently at a later date.

The Course leader from Sunderland raised another point - in a school with three general nursing courses running simultaneously.

- tutors quickly saw there was not a discrete body of knowledge e.g. students knew more than the staff on some aspects of health care. The ratchet-effect of this was good - but also dangerous. It was difficult to hold back ... there was a rising expectation by the staff, both tutors and qualified nurses - for study, and self-education, which if carried to extremes might divert attention from the students' needs

Sunderland, Course leader

The increase in workload during the overlap of conventional and pilot courses also affected the time available for ward teaching and discussion, in all the schemes. In West Dorset the changing role of tutor facilitator for contract learning for students in the second and
third year, although a valuable opportunity for student support, was proving time consuming and reducing the nurse teachers' availability for other ward contacts.

7.3 (vi) Changes in the management structure occurred in five schools during the early part of the pilot scheme. In Central Birmingham the system of teams of tutors - senior tutor and two or three tutors responsible for one group of students for the three years of their course - was replaced by a new structure of senior educational managers with a specific role and function and special advisory groups of teachers and lecturers for specific aspects of the course. This change from a hierarchical managerial style in the teams, to an approach emphasising individual expertise and a colleague-relationship offering choice and responsibility, was not easily achieved, the chance to revise the structure coincided with retirements of staff, and with a wish for partnership in learning and teaching Central Birmingham DNE.

In South Birmingham at the outset the course leader had a dual accountability - to the DNE in the school of nursing, and to the head of the department in the polytechnic. In an interview in the first year of the pilot scheme, when asked by the researcher if this dual accountability posed a problem, no difficulty was acknowledged. The same question repeated in the third year elicited a full reply -

At the beginning - yes - not because they interfered, or were difficult, or unapproachable, but - I had to get them to give me answers so that I could make decisions - so I used to write formally to each one for an answer.
Its easier now, with the course structure established and really working.

South Biurmingham, Course leader

The course leaders were asked what advice they would give to others planning major curriculum innovation in collaboration with an educational institution, and teachers of nursing in both schools of nursing and higher education establishments were asked to identify the strengths and weaknesses of the pilot scheme in which they were teaching.

Table 7 - modifications to the original proposals reported 1986 - 1989 on page 7.51.

7.4 The views of the pilot scheme students about their course

The researcher was very aware of the fact that in all six pilot schemes, students were completing evaluation forms - of self evaluation, about their course, their teachers and teaching methods, about visits and community and clinical placements, their experience in diverse settings - and that the course leaders were charged with recording and monitoring all aspects of students' progress. In addition, some research projects were being conducted for internal or external evaluation, regarding the curriculum process and the product.

The focus of the present research project is on the process of curriculum innovation from the view points of those planning and preparing for change and participating in the process of changing the nursing curriculum. Although, therefore, the views of students
participating in the schemes are crucial to those concerned with planning and conducting the innovation, they are unlikely to assist the current research regarding the previous curriculum, the preparations for change, and the initial planning and introduction of change.

The researcher, therefore chose to meet students informally in small groups, to discuss their views of their participation in the pilot scheme - at the end of the first year, or at the end of the third year - and one interview was conducted and tape-recorded with a mature student who had completed the pilot course, and volunteered to be interviewed. (see Appendix VI)

7.4 (i) Groups of students at the end of the first year expressed their views about their supernumerary status, and about their involvement in evaluation of their learning experiences, which they enjoyed. Some voiced their hesitancy at first about self-direction, learning from experience and group work. One group, ten students, of whom only one was under twenty one, expressed their pleasure that their experience of life seemed to be valued by their teachers.

7.4 (ii) At another discussion, an older student commented that it seemed that the sociology lecturer did not realise how much older students already knew. An older student in West Dorset commented that
I found it easy to study after all those years - I really enjoyed the periods of leave between the terms.

Student

whilst another mature student in the same course said -

I had CSE's - but really didn't try hard at school - then I went to the technical college and did a City and Guilds' in horticulture. Then I married and had a family, and looked after mentally handicapped children. When my children had grown up - I came into nursing. I worried so much about study - it was nerve racking at my first exam. I didn't believe my tutor when he told me I could do it! I love nursing - but it's hard work - it is hard physical work - and stressful - there's a lot of pressure.

Student

7.4 (iii) At another group discussion with a group of third year students nearing the end of a polytechnic-linked course a view was expressed about repetition of material in their lectures and discussions

It's been difficult with replication of material - you know - poly lecturers repeating what we have had before - and the journey to the poly - it takes ages standing about waiting for buses.

Student

7.4 (iv) This travelling problem recurred with others in the group, although one student contended that it was not such a problem with later groups because time-tabling seemed to be arranged so that some polytechnic lecturers now come to the school of nursing.

7.4 (v) When asked if there were any modifications they would suggest in their course, a group of students who were not the first set in the pilot scheme, but were in the third year, considered that the balance of theory and practice was either
- about right

    First Student - prior to completion

or - we need more medical and surgical experience

    Second Student - prior to completion

Asking how that might be achieved in the three year course in their view the researcher asked -

To give that experience, what would you like left out or reduced - children's, or elderly experience, or what?

and the response from four students in chorus was -

    Oh! no! you couldn't take anything out!

A general comment from these students indicated agreement that we are not going to find it easy to be staff nurses after our course.

This latter remark was volunteered by a student in a polytechnic/school of nursing course, and the view echoed the view expressed by a ward sister from a course based in a school of nursing noted earlier in this chapter.

Students enjoyed taking part in the curriculum review groups or committees; and played a full part in discussions of one such committee attended by the researcher.
7.5 The views of managers of nursing service and of nursing education

The chief nursing officers/advisers and the directors of nurse education were committed to the courses linking the nursing schools and polytechnics or colleges. The replacement staff had been recruited without difficulty in the areas concerned - although financial constraints had been a factor, and in 1986 there was some delay because the nursing service managers had to work out the skill-mix required to replace first year, and second year, students and this took time to achieve in practice. The co-operation of general managers, and members of health authorities and the chairmen, were warmly acknowledged.

7.5 (i) In the later stages of the research project, the grouping of schools, forecast by regional plans for rationalisation, gave rise to some concern, regarding the continuation of the pilot scheme, which all those interviewed would wish to support.

7.5 (ii) The DNEs indicated the developments already happening or foreseen as a result of the pilot scheme, in Yeovil the Taunton circuit of general nursing has evolved a scheme, based on the Yeovil experience, and linking with a technical college; in Central Birmingham the planning and development of a degree course within the medical faculty of the university is under way; in Poole, a part-time course for mature students within the Dorset Institute of Higher Education is in operation, based on the West Dorset pilot scheme.
Students in this part-time course receive credit towards a CNAA certificate. In Newcastle Polytechnic, a 3 year B.Sc(Hons) degree course in nursing studies is being established and in South Birmingham the extension of the pilot scheme for registration in mental handicap nursing is established.

In Birmingham Polytechnic the establishment of a degree course in nursing studies has been announced.

In North Lincoln the pilot scheme course has been validated by the University of Hull (of which Bishop Grosseteste College of Education is now a part) for the award of a Certificate in Health Studies, granting one year exemption for the B.Sc.(Nursing Studies) course to begin in 1990.

7.6 The views of ENB officers about the pilot schemes

The views of the education officers of the Board were sought by the researcher at the beginning and at the end of the project, to provide an external source of information about the ENB proposals, and about the curriculum innovation in the pilot scheme in the schools in their regions.

Organisations, like individuals, are not 'islands unto themselves'. They are surrounded by and in interaction with other organisations, individuals and the general social concerns of which they are a part.

Hall (1972 p.49)
Four education officers are responsible for advising the six schools with pilot schemes, as two pilot schemes are within the area for two education officers. When the research project began two officers had left, and replacement appointments were being made. Two of the officers had less knowledge therefore than their two colleagues about the ENB proposals, the pilot schemes, nursing schools and health authorities concerned. These officers became more actively involved in visiting the schools to clarify the proposals, and to advise on modifications - for example, the proposed assessment procedures.

7.6 (i) The researcher met the then CEO in December 1986 after the first visits to five the schemes, to discuss the process that led to the selection of the six pilot schemes. Eighteen schools had shown interest in preparing a submission, and these were considered by the Chairman and two Board members with the CEO. Six were given provisional approval to prepare a detailed submission by March 1985. The aim was to look for creativity and flexibility with an educational linkage and local support. Representatives were then called to a meeting with Board officers to discuss their proposals and if necessary, to revise certain aspects or seek further development. A final meeting with members representing the Board, at which the education officers were invited to be present, took place during the Autumn 1985 and the decisions taken were ratified by the Board in December 1985.
Amongst the issues raised by the Board's officers in interviews with the researcher was real concern whether local pressures or constraints would affect the proposals - despite their appreciation of the intentions and strong wishes of the managers and influential members of district and regional health authorities, or educational institutions, to support the innovation.

Another concern was whether there were sufficient resources - of time, money and individuals, - for continuing education, staff development and the additional preparation required for clinical and community nursing staff, and staff in schools of nursing and in the colleges, who were to collaborate in this venture.

The short time scale between the invitation, the deadline for the initial submission, and between the final approval and the actual starting date of the scheme was also of concern. This was particularly pertinent to those education officers where schools were already having difficulties in meeting the requirements for a planned allocation programme, and in raising the ratio of registered nurses to students in clinical areas to permit the introduction of continuous practical assessment.

Three of the pilot schemes gave rise to concern, in the early stages, about the proposed educational linkage and the amount of involvement with educational institutions, or individuals. One officer commented whilst wholehearted support could be given to the proposals for a
pilot in one circuit of one of the schools, there were reservations regarding the extension to the other circuit - if that were to be suggested at that time, since there was much groundwork to be covered before such approval would be recommended.

7.6 (iii) In the later interviews as the course progressed, or was nearing completion, the comments from education officers included expressions of concern such as:

- there were impressive efforts by teaching staff and managers to develop the appropriate conditions for innovation - e.g. the skill-mix.
  ENB education officer

- there was a very heavy workload for those involved in preparing for - and continuing to support the proposals - it was not only time-consuming, but never-ending in these schemes
  ENB education officer

- monitoring of later parts of the course during rostered service is still a problem
  ENB education officer

- there is continuing concern regarding the skill-mix for continuous assessment and a lack of understanding or support in some wards
  Two education officers' comments

There were also comments of commendation - such as:

The DNE's support, after real delegation was evident
  ENB education officer

- the students are showing self awareness and developing confidence as the scheme progresses
  ENB education officer

- the lecturers in higher education were either familiar with nursing courses - or took steps to find out about nursing and the NHS
  ENB education officer

- continuous assessment was a 'reality shock' for clinical staff
- but many overcame this by their commitment to the scheme
  ENB education officer
- there is a very high standard in theoretical assessments - the written work is very impressive

ENB education officer

The extent to which education officers felt they were consulted about the Board's intention to call for pilot schemes, and the extent to which their advice was sought by the Board on the selection or short-listing process of the submissions was variable.

It was suggested to the researcher in visits to the six schools by course leaders and nurse teachers that there might have been some advantages in having one education officer in contact with the six pilot schemes during the experimentation. This might possibly, it was argued, have disseminated information for consideration between the six schools, - for example on the methods of recording internal evaluation in use in each, - and might have prevented fragmentation of advice regarding the limits set by the statutory bodies for the creativity and flexibility which was called for in the ENB invitation.

It is contended that these views may indicate a factor to be explored further in the role of education officers and their advisory role in relationship not only to the schools in their area, but to their colleagues on the Board's staff, to the members of the Board, and to the Board as a statutory body.

This chapter has indicated some of the main views of participants implementing the proposed curriculum innovation. Additional information is offered in transcripts of interviews in Appendix VI and in the modifications to the schemes listed in Table 7 on page 7.51.
The relevance of the research findings for future curriculum development in nursing education in England is discussed in Chapter 8.
Table 7

Modifications to the original proposals reported 1986 - 1989

Key
A = West Dorset : B = South Birmingham : C = Sunderland
D = North Lincoln : E = Yeovil : F = Central Birmingham

1. Course design
A. Second placement in surgical setting amended to include experience in theatre, trauma ward, and accident and emergency to provide enhanced learning opportunities. Some modification of maternity/paediatric experience to meet service demands.
B. Single days for clinical placement to learn and practice basic skills associated with daily living now grouped in the second experience in year one. Adjustment to maternity care experience - previously 2 weeks plus 2 weeks in first and second year, - to 4 weeks in year 2 only, after considerable discussion with ENB Advisor for Midwifery. Experience and placements in occupational health and district nursing moved from Year 1 and Year 2.
C. No change
D No change
E Final 26 weeks of course planned leadership learning contract and self evaluation in preparation for staff nurse posts after registration.
F No change

continued
2 Changes in Curriculum Content

A Human individual and Paraclinical Studies sequences brought closer together; a greater degree of integration by contributing teachers, and more sharing on a generic basis - as opposed to early experimentation with specialisation. Lecturers, in Social Context of Health and Psychology sequences, from tertiary college, continue to evolve the sequences and this affects integration also increased input to Professional studies, and nursing sequence includes models.

B Team teaching-subject based - continues. Topics introduced include sexuality, aids, transcultural care and alternative therapies. One day workshop on coping with aggression and violence in first long placement.

C No change

D Sociology contribution from Senior Lecturer continues in Unit 1 - and continues in late stages of the course; mental handicap experience re-designed.

E No change (except as in 1 above.)

F No change - but student evaluation by researchers - in house - suggests the students' preferences for the teachers applied session, rather than the lecturers key sessions which are more theoretically based.

continued
3 Assessment.

A After discussion with external examiners the anatomy, physiology and pathology assessments have been amalgamated into one unseen paper in Stage 1 and student profiles - clinical profile assessment introduced for continuous assessment. An unseen written paper in Stage 3, and two learning contracts in Stage 2 and formative assessments in context related essays in the social context of health and psychology, and professional studies in nursing, and a research-related assignment complete the assessment process.

B No change in proposals, but the four observed assessments in practice are placing a heavy demand on existing assessors. Examination paper and assignments are marked by two internal markers. External examiners report indicates that the second year integrative assignment results are impressive. A greater demand should be placed on students in the examination - referencing, analysis of issues and background reading it is suggested.

C Continuing assessment in practice continues. First years assessment unchanged; second year essays in maternity care, care of children, and care of mentally ill; third year holistic nursing assignment in care of the elderly and small scale nursing project. Examination - unseen paper at end of year 1; short answer test paper in year 2.

continued
It is not proposed to change the assessment scheme at all unless there is a long delay in implementing Project 2000. Theoretical and practical assessment continues, and incorporates the four practice based assessments and a final devolved examination. Despite the ENB decision in 1988 to allow pilot schemes to proceed as approved it was decided it would be detrimental to students now anticipating a final examination. Students are presenting very high quality work in assignments.

No change continuous assessment. High standard of competency based work, and assignments.

Continuous assessment of theory and practice has been a major achievement in view of the quality of student work. The patient centred assignments with contract grading have been very successful - many are working comfortably at Diploma level.

DNE
Advice From Course Leaders on Curriculum Innovation in Collaboration with Educational Institutions

WEST DORSET
Prepare the ground before beginning to plan
 gain co-operation from nursing service management develop in-service training for nursing auxiliaries study days for trained staff assessors courses ward audit and learning opportunities evaluated by nurse manager and teachers

Plan curriculum jointly with the educational institution representatives teaching staff, clinical nurses and community staff. Assessment and evaluation systems.

Take time to plan how to introduce plan to all concerned - assess resources of time, space, materials, manpower. Assess replacement staff needed.
Recruit to start when necessary.

When the new curriculum begins - keep communication system active involve participants in this - and in support networks.

SOUTH BIRMINGHAM
Take time to prepare Nursing school - needs to ask polytechnic for what is wanted - needs to explain what the school has to offer
Polytechnic needs time to understand the realities of nursing.
Staff preparation in both institutions essential.
Creative thinking needed to achieve a network of community placements in the first year of a health based course.
Evaluation built in at the outset and carried through the course.
Assessment criteria clear at the outset and jointly agreed by Polytechnic, school and statutory body.

SUNDERLAND
Collaboration between a nursing school and polytechnic - establish this where the polytechnic already offers advanced nursing courses at diploma degree level
Prepare role models in community and clinical areas.
Utilise change theory.
Expect scepticism by trained nurses about practical skills and manual dexterity. Discuss and determine with clinical staff what learning opportunities are offered in practice; identify the essential skills needed before students are in rostered team placement, e.g. baseline observations in theory and practice, safety factors, learning to plan and assess needs (but not evaluate).
Joint validation and assessment criteria agreed before course starts.

NORTH LINCOLNSHIRE
Collaboration with higher education take time to prepare both institutions - to consider how sharing expertise may be achieved.
Resources for qualified staff to take advanced nursing course.
Time to prepare all staff involved for change - and changing -
Planning - determine a 'cut off' date for decision asking
Introduce change - with support networks for all involved for communication.
Joint validation by educational institution and statutory body.
Evaluation 'built in' from the start of the planning -
Continuous theoretical and practical assessment - Summative.
CHAPTER EIGHT

DISCUSSION OF THE FINDINGS

This chapter discusses the findings from the research project on the planning and implementation of the proposals for curriculum innovation in the six pilot schemes, and the issues arising for further consideration. These findings are based on the discussion following content analysis of the submissions in Chapter 5, and the comparison between the conventional course and the new curriculum in the six schemes discussed in Chapter 6 after the first visit by the researcher. The interpretation by the researcher of views and opinions, freely given and expressed by participants over the three year period of the study, forms a major part of the project, and extracts from these interviews were discussed in Chapter 7. Further views are given in examples from transcripts of interviews in Appendix VI.

Lawton (1978) suggests that an illuminative approach to curriculum innovation aims to discover the courses most significant features that relate to what happens as the course proceeds and as adaptation occurs in the light of what happens in practice:

> a more free discussion with all concerned of what is happening at all stages of the course rather than considering precise measures of what has been achieved and what has not.

Lawton (1978 p.157)

In visits to the schools a clearer picture emerged of the significant features of each course, and the factors influencing the process of changing the curriculum.
8.1 The process of implementing the plans

All the schemes based the curriculum on a nursing philosophy concerned with the individual – the person as a patient, a client, a nurse, a student – an approach that demonstrates the nursing values of caring, and of practising care that is humanistic or holistic. To support this value, or belief, studies in the first year of each course are broadened to include the concept of health, health education, disease prevention, skills in communication and inter-relationships, and in enquiry and problem-solving skills. These themes are further developed in the curriculum content and the teaching/learning strategies in each course.

Student-centred approaches in educational design are features in North Lincoln where the aim of the first year to reduce stress for students by a gradual introduction to reality in the ward environment is based on research by Birch (1975, 1978). A concern for the individuality of the student is also demonstrated in Yeovil where the curriculum is based on a student-needs approach. In Central Birmingham the design of the first year by lengthening the first ward experience, and the emphasis on learning styles and contract grading for patient-centred assignments also indicates the student-centred approach.

8.1 (i) During interviews with teachers, mentors and students it became clear that there were difficulties, in some instances, for students in relating their experience gained by six months supernumerary status in community settings in the early part of the course to their first
experience in the ward team, although this was not so in the third year of the course:

- the health concept grabs them - but in the first year it is not understood in clinical areas - it is sometimes said in the second year they cannot do anything - but some staff say the third years are better than before.
  
  Nurse Tutor

- in their first allocation - it's a surgical ward, they are slow on arrival - but they are able to talk to patients - they seem to find out things, but I think they should know more practical skills. They are better later.
  
  Staff Nurse Mentor

The relationship between community and ward experience appeared to present less difficulty in South Birmingham where these experiences were integrated throughout the first two years of the course and in Sunderland where community and ward visits and observation featured in the first two terms at the polytechnic during the first year of the course.

8.1 (ii) The transition from supernumerary status to rostered service in teams, wherever and whenever it occurred, presented a difficult adjustment for students, who described it as a 'culture shock'. This was supported in interviews with ward sisters, staff nurses and mentors irrespective of the length of the supernumerary period. The discrepancy between the ideal and reality, or between expectations and actual practice, was also raised in interviews with staff nurses, mentors and teachers of nursing in the pilot scheme in Central Birmingham where the ten-week foundation course was followed by allocation in nursing teams. Clarke (1981) draws attention to the conflicts between the ideal and the expedient which all nursing students experience, and to which
undergraduate students in particular are subject:

in a sense the course itself heightens this conflict. For example, the emphasis on the nursing process, on communication with patients, the importance of implementing research findings are the very areas which are neglected in the pressure to get the work done in the ward.

*Clarke (1981 p.15)*

A mature student, a married woman with a grown-up family, referred to the culture shock, after one year with supernumerary status, in the following terms:

It still comes as a bit of a shock when you actually start shifts - it’s a culture shock when you go on to the wards in a team - I do not think anything will remove it from that first allocation - you will never get away from it, but you can go some way to helping it - if you actually work shifts - in a team for some days (in the first year)*researcher’s note.

*Student*

a nurse teacher comments:

These students are very much more demanding - I think the philosophy has raised their expectations of us - they are more questioning - and as we are becoming more research-based - I think the gap between theory and practice becomes more evident ... some become very angry with us and express this anger, quite rightly - it’s difficult for us, the teachers, we are taking the responsibility to educate them but do not have power over what goes on in the ward areas.

*Nurse teacher*

This illustrates the questions posed by Warwick and Kelman (1976) and raised in Chapter 2 about the ethical issues in social intervention - the choices, of means of implementing changes, assessing consequences, and the conflicts of values that occur.
8.5

What values are we prepared to sacrifice for a valued change?
Warwick and Kelman (cited in Bennis et al 1976 p. 472)

It also raises the problem of the context of learning to nurse - the relationship between theory, knowledge and practice - the issues addressed by Benne as discussed in Chapter 2, and the need for consensus between practitioners and educators in the preparation of all those involved in changing the curriculum.

8.2 Joint Collaboration

A collegiate approach between schools of nursing and educational institutions with joint planning for collaboration in curriculum innovation and in implementing the changes, was adopted by four of the schools - West Dorset, North Lincoln, Sunderland and South Birmingham. In Central Birmingham collaboration with lecturers from the extra-mural department of the University of Birmingham in planning the curriculum developments and in key lectures during the course also occurred, as discussed in Chapters 6 and 7.

8.2 (i) The extent to which lecturers from higher and further educational institutions became involved in the changes varied.

The interviews confirm that lecturers in disciplines fundamental to nursing showed a willingness, and in some cases an eagerness, to collaborate with understanding in their efforts to share in curriculum innovation in nursing. To some extent, Benne's (1976) suggestion that seminars between students, academic and non-academic participants are
valuable in overcoming blocks to communication, was illustrated in South Birmingham, Sunderland, North Lincoln and West Dorset. It is suggested that it is a pointer for future planning of curriculum innovation in Project 2000.

8.2 (ii) Hitchen and Fannon (1988) discuss the contribution of lecturers from disciplines fundamental to nursing to the curriculum content in South Birmingham in communication, sociology, physiology, anatomy and research.

In the discussions and interviews with teachers in South Birmingham it became clear that they also contribute to debate and discussion regarding modification, assessment and evaluation of the course. This was also evidenced in Sunderland, where the research-based problem solving approach to curriculum content and process was an essential feature of the course design and was reflected in the context of the course. In North Lincoln and West Dorset, lecturers, from the college of education and tertiary college respectively, participated similarly, and also actively participated in seminars, and in classroom activities and ward discussions. Students, mentors and teachers of nursing in both these schools commented that this factor was considered valuable, and they were aware that the lecturers had prepared themselves for their contribution by observation and participation in the wards, prior to the introduction of the new curriculum.
I was previously familiar with the NHS and hospitals as a psychiatric social worker - but I did a stint as a nursing auxiliary in a general ward to discover the current situation

Bennett (1986) also comments on his experience in North Lincoln of working as a nursing auxiliary to appreciate the complex nature of the role of the nurse and draws attention to the similarities of the philosophy of the college of education, and the philosophy of the pilot scheme, and the needs of student teachers and student nurses for a sound foundation in the skills of observation, organisation, presentation and evaluation.

The lecturers in North Lincoln rated students' achievements in written work highly, and this led to the award of a certificate in health studies by the University of Hull, and in Sunderland the award of distinction in the polytechnic diploma was achieved by 10 students in the first pilot course.

8.2 (iii) All lecturers interviewed during the research project emphasised how much they had learned (and how much others in the educational institution had had to learn) about nursing, about nursing schools and about nurses. Lecturers whose disciplines supported nursing theory advocated team teaching - or applied studies with nurse teacher colleagues - and the use of small group methods for teaching nursing students. Lecturers in both the polytechnic-linked nursing schemes and in West Dorset and North Lincoln highly rated the participation of nursing students in group work, their ability to bring forward questions arising from practical or field experience, and their response to
experiential learning.

8.2 (iv) Students' comments, and responses during interviews from both mentors and teachers of nursing indicate that closer involvement between lecturers and nurse teachers to prevent replication of content, and more understanding by sociology lecturers of the issues arising in the students' practical experience are considered to be needed. This was raised in four of the pilot schemes. A mature student commented that it appeared that one lecturer did not seem to understand how much older students already knew, and a comment from a nurse teacher about a group of older students' views included:

very vocal that there is too much sociology - they would like one lecturer instead of two - I think they realise they are older - with more experience of life, and they are probably older than the lecturer - they would like more time in subjects that are new to them - for example, to study biological sciences. Nurse teacher

This raises the problem of planning the curriculum, and the timetable, to meet the needs of disparate groups of students, and the needs of the lifelong learner as defined by Jarvis (1987).

It also suggests that in joint planning and collaboration between nursing schools and educational institutions in the future, lecturers in disciplines other than nursing in colleges and polytechnics may need to learn new educational techniques and new bases for their educational practice.
8.3 Learning and Teaching

8.3 (i) In all the six schemes methods of teaching were adapted to reflect the emphasis on the changing roles of student and teacher. The nurse teacher's role as facilitator, or friend and counsellor, and the student's role as an enquirer, an independent learner, or a self-directed learner, was re-iterated in all the interviews with teachers and mentors, and with clinical community staff.

8.3 (ii) Students in the Yeovil scheme had difficulty at first in assuming the enquirer role, and in identifying their own needs; one student commented that her colleagues found it a new way of learning because

   at school they were spoonfed.

   Student

Speakers at the conference in April 1987 indicated that the student's expectations of note-taking at lectures presented challenges to be overcome in the first months of each intake set. A problem, it is suggested, not confined to students in pilot schemes. Extracts from interviews with ward sisters and mentors quoted in Chapter 7 suggest that this problem was addressed, and that pilot scheme students were questioning and had learned to be assertive. Teachers of nursing at interviews also indicated the ability of students to recognise stress in themselves and others in the environment - a view expressed by teachers who were not, at their own decision, involved in the pilot scheme. A
factor, it is suggested, that may discount the 'halo' effect of a new scheme.

These students have a shock when they get to the ward - they are not prepared for tasks - the repetition ... but they ask for what they want - they know what they want to know.

Nurse teacher - not in pilot scheme

- these students have a different form of socialisation

Course Leader

- our intuition and feelings in the first year indicate there is a difference - they are challenging - assertive.

Course Leader

- these students are different - their teaching is different with psychology and sociology - it seemed threatening at first - but I find students are more open, they find the time to talk with patients -

Ward Sister

Well - they are very willing to learn - some staff think they are challenging - you know, cocky, but I think they are assertive - they know what they want to learn.

Staff nurse - mentor

Students are very different, they have communication skills, from the early days they are used to listening, speaking and identifying need.

Nurse teacher

8.3 (iii) The students in the pilot schemes, who were interviewed, when asked if they considered they were different, responded that, since they considered their course was different they believed that their contribution should be, and should be expected to be, different in the wards and other settings. Some students expressed concern that in some instances this was not so in reality - they were expected to be the same as conventional students. A point which raises the concerns discussed in 8.1 (ii).
8.3 (iv) This question of difference in the students was pursued further by the researcher to discover whether these students presented different entry qualifications as candidates, and whether there were different methods of selection for the pilot schemes from those for the conventional course. The candidates came in through The Nurses' Central Clearing House System and if accepted for entry to one of the six of schemes, had to meet the UKCC requirements. The general educational attainments of those entering the six pilot schemes were similar to those entering conventional schemes. In each of the pilot schemes there is a wide range from degrees, diplomas, A and O levels and CSE grade I to the D.C. test. There is also a wide range in the ages of entrants to all the schemes - a study by Hutt (1988) indicates 84% of the pilot scheme students at the time of the study - the Spring 1988 - were under 25 years of age, compared with 88% - 89% of conventional scheme entrants.

8.3 (v) The selection criteria and methods of selection were not substantially different from those used for conventional students in each school, except in the four schemes adopting a collegiate approach. In these schemes, joint interviewing by lecturers from the polytechnic or college with nursing colleagues, and a tour of both sites for candidates before interviews, are arranged. In South Birmingham and Sunderland candidates have to fulfil the polytechnic entry requirements, i.e. A level or A level equivalent in Newcastle; A level or alternative criteria in Birmingham (Submission 62).
The motivation and commitment of all those nurses and teachers involved in the schemes was evident from the first visit of the researcher. Their desire to improve the course to base it on educational theories, was equally stressed by nurses in the management of the service and of education.

8.4 Staff Preparation and Communication

8.4 (i) In all the schemes it was acknowledged that more time for the preparation of staff involved in implementing the changes - and particularly those in the clinical setting - would have been helpful. The resources - of time and money - for this activity to continue after the initial stages of the scheme are raised frequently at interview.

8.4 (ii) Chapter 7 illustrates the difficulties of maintaining communication systems in a changing situation which many respondents raised and which was confirmed by an interview with a clinical teacher, who emphasised the need for personal contact between teaching staff and their colleagues in the wards, community and voluntary agencies:

there is a need for continuing the communications by continual contact - you cannot do it all on a course.

Clinical teacher

In Chapter 2 reference was made to Nisbet (1975) who points out three fundamental needs when organisations are required to innovate - the need for support, involvement and evaluation. In this research the need for
support was closely linked by respondents at interview with the need for increased communication. Mentors in particular indicated this, and many teachers and clinical staff supported their views.

8.5 The Mentor’s Role

8.5 (i) The mentor role was appreciated by students, teachers and clinical staff as a means of helping both patients and students, but in all the pilot schemes it was identified during interviews as a difficult role to fulfil. Foy and Waltho (1989) report that in a study of mentorship for student nurses in a conventional course out of a small sample of 48 respondents (33 student nurses and 15 pupil nurses) 91.7% considered that having a mentor was beneficial to learning.

8.5 (ii) ENB (89) 17 January 1989 discusses the preparation of teachers, practitioner teachers, mentors and supervisors in the context of Project 2000 recommending the IT-INSET scheme, sponsored by the DES in 1978/79, for the initial and continuing preparation of teachers of nursing, and the role of mentors in support of student teachers. It recommends that:

mentors should be facilitated in their role by a role-based development (INSET), within a supportive environment of continuing education.

ENB (89) 17 p.10 para 12

It suggests that staff nurses should be mentors for student nurses, and indicates that a named mentor should be provided in the initial phase, whilst the students may select a supplementary mentor as their needs change and awareness develops.
8.5 (iii) Burnard (1988) discusses some of the potential problems arising in the mentor role and raises questions regarding the possibility of conflict between the student's perception of needs and the mentor's perception of needs in a negotiated - learning situation. He suggests that the mentor's preparation should include skills in identifying learning opportunities, counselling, and in developing self-awareness, and self evaluation for both student and mentor.

8.5 (iv) Northcott (1989) discusses the role of mentors and their preparation in Somerset where mentors act as assessors for students in the clinical settings with the transfer of authority for the assessment of practice and the support in the clinical areas to mentors Northcott (1989 pp 26-28)

The findings in this research project indicate that this was not so in other schemes where mentors were not the sole assessors of clinical practice.

8.5 (v) The difficulties identified by mentors in the interviews include the pressure of service demands when the staff nurse was in charge of the ward - in most instances a staff nurse who was a mentor alternated with the ward sister on the duty rota. In wards where there is more than one staff nurse on duty at any one time the specialised nature of the work in some wards is seen to increase the difficulty of supervising the patients' treatment and acting as a mentor for a student. The respondents who are mentors with experience of supervising
and helping students whether or not they are supernumerary, indicate that the difficulty arises not from the status of the student, but from the status and responsibilities of the mentor:

I think the mentor system would work if there were enough staff on the wards to cope with training students. The plan is good but I do not think students can learn in the wards because we do not have enough time to teach them.

Staff Nurse Mentor

A ward sister who was a mentor in another pilot scheme commented:

It's very difficult to be a mentor and run the ward - some sisters are not mentors because of that - it's easier with a five day ward because I am there every day, and I can plan the duty rota so that mentors are with their students four days out of five.

Ward Sister Mentor

These comments were supported by all the interviews with mentors and clinical staff.

A student, asked if she found the mentorship system worked, responded:

I personally have, but others say not ... they do not always actually work with us but I think most of the time they try to work with us two shifts per week - it seems to have worked out for me - but if the mentor is acting up for sister it causes a few problems.

Student

These comments suggest that mentors play a limited role in the clinical setting when they are responsible for ward management. It is suggested that this is an important issue, and that further research is required on the function of a mentorship system in educational programmes, such as those proposed in Project 2000.
8.6  **Management style in education**

8.6 (i) Changes in management structures, to reflect changing function, were happening in five of the schools of nursing in the initial stages of the pilot schemes. Such changes were not peculiar to these schools; Parker (1987) discusses the process of changing structures in one college of nursing to bring about changes in reality.

8.6 (ii) In five pilot schemes the DNE was very experienced in the management of complex schools of nursing with differing initial courses for registration on different parts of the register and a variety of post registration clinical courses. Four of the DNEs were also responsible for in service training and continuing education within the district(s). In the sixth pilot scheme the Acting DNE, previously the senior tutor for curriculum development, had been planning for changes during the four years prior to the adoption of the pilot scheme, and was promoted to DNE during the first year of the course. The 1985 management structure in this latter scheme indicated a long and complex chain between the teachers of nursing and the DNE and district health authority, which was simplified to offer a less hierarchical structure in 1987.

8.6 (iii) In four of the other five schemes the course leader has delegated authority from the DNE, reporting directly to the DNE and thence to the health authority, or the course leader reports to a course committee, with representatives of the health authority and the college,
and thus to the participating institutions. The issue of the course leader in the initial stages of the South Birmingham scheme reporting to two heads - one in each of the collaborating institutions, was discussed earlier in Chapter 7 and is contrasted with the Sunderland scheme where from the outset the course leader reported directly to the course committee set up jointly by the collaborating institutions.

8.6 (iv) Fullan (1982) points out that implementing change calls for support for staff in schools, and that principals and peer groups play a crucial role in this, although he also argues that principals need not be involved in the changes if leadership roles are taken at other levels. These two issues were raised during visits and interviews in this research. In four of the schemes the course leader enjoyed the delegated authority and indicated that the DNE, or the ADNE was available and would give support if required, although day to day decisions were made without reference. In one scheme, when the pilot scheme was operative, there was no designated course leader - each senior educational manager taking responsibility for the course, with similar access to peer groups for support, or to the DNE or ADNE for advice. In the remaining scheme, where the DNE delegated authority for introducing and implementing change, the course tutor felt isolated and unsupported in the early stages of implementation, and sought peer group support from service colleagues, who fulfilled this need.

8.6 (v) Two questions are therefore raised in the research. What constitutes support in the cognitive and affective domains? How are
communication links established in the social milieu to clarify whether perceptions of delegated authority and of support mechanisms are mutually understood? The perception of needs by those delegating authority, and those at the interface, it is suggested, need to be illuminated by negotiation to prevent misunderstandings and problems arising.

8.7 Strategies for changing

Strategies adopted for introducing and implementing the new curriculum were similar in the six schemes; teachers and members of the curriculum planning team - nursing colleagues and lecturers in four of the schemes - were involved in a series of meetings to encourage questions and challenge as described in Chapters 5, 6 and 7.

8.7 (i) In the polytechnic-linked, and college-linked schemes lecturers in disciplines fundamental to nursing, and lecturers in the polytechnics who were nurses, contributed to joint staff preparation workshops for their colleagues in the college and the nursing school and for nursing staff from community and hospital settings. These sessions formed what might be termed preparatory courses for adopting plans, discussing the curriculum and proposals for change, and the introduction of the new course.

8.7 (ii) The present research suggests that accepting and implementing plans - changing - requires continuing dialogue and discussion
throughout the process of changing the curriculum. Those interviewed found this necessary because, even when the proposals for change and for introducing changes in the curriculum were understood at the outset, modifications were made as the process of making the plan work - making sense of it as it was put into operation - brought either problems or more effective solutions to light.

8.7 (iii) The need for active participation in sharing accurate information is demonstrated in the interviews. Some staff reported that they relied on others to tell them what was proposed, and found they were mis-informed, and although members of other staff in the health authority participated in curriculum planning teams, there were no well-established channels of communication to disseminate the proposed plans - or the agreed modifications. For example, in North Lincoln although a medical representative is a member of the course advisory group, his colleagues had at first felt uninformed, and the course leader had to arrange for alternative ways of providing information which encouraged participation by medical staff later in the course.

In Yeovil, where the curriculum innovation began with the students spending six months in community settings, staff in the small community hospitals had been prepared over two years before the course started. After six months the new curriculum, based on the eight roles of the nurse called for the active involvement of clinical staff in the acute wards with continuing assessment in practice as described by Parkin (1986 and 1988). A rapid re-appraisal of the needs for staff in these
acute areas had to be made to prepare them for their new commitments. South Birmingham devised a newsletter with a distinctive logo to describe modifications, or to raise matters of concern; the process of implementing any scheme inevitably leads to adaptation if the original plans do not work out in practice, and dynamic situations call for different strategies.

8.7 (iv) The evidence from this research points to the need for a network of support groups for all those involved in curriculum innovation. Strategies for changing were discussed in Chapter 2 with reference to Schön's argument that significant learning - involving change in underlying values and knowledge - disrupts the stability and predictability of the organisation. It is contended that, in these six schools such support mechanisms were the intention, although there were differences in interpretation by those for whom they were intended.

Skelton (1987) discussing student profiling in West Dorset refers to a questionnaire to clinical supervisors and mentors in which respondents indicated the need for teachers to spend more time in clinical areas, and suggests that this indicates a dichotomy in perceived reality and reality itself as this scheme is designed so that teachers spend two days each week in the clinical setting.

8.7 (v) External factors brought to bear on the implementation of the plans include restraints on resources which delayed the approval of continuous assessment of practice in clinical settings; or limited the length of the supernumerary period; or reduced the funding from the
education advisory groups of the ENB; and the delay in the interpretation of the summative assessment procedures required by statute.

8.7 (vi) The complexity of changing.

Fullan (1982) points out that all change is a learning experience for the adults involved.

Implementation consists of the process of putting into practice, an idea, a programme or a set of activities new to the people attempting it.

Fullan (1982 pp 54-55)

He suggests also that major barriers to change include failure to provide a clearly defined picture of the discrepancy between current practice and the new proposals (the need to change) and insufficient attention to the complexity of the change in terms of its extent and difficulty (the process of changing).

8.8. Evaluation

Teaching staff - lecturers and nurse teachers - and qualified nurses are involved in the formative and summative assessments of students, and they and the students contribute to the course evaluation by questionnaires and discussion. Course leaders were responsible for devising methods of recording information, in conjunction with senior educational managers from the outset of the scheme to contribute to the
course review in each pilot scheme and to the annual reports which lead to in-house evaluation of the pilot scheme. The methods vary between the six schemes, but reflect the descriptive approach of Stenhouse (1975) to curriculum development.

8.8 (i) Kelly (1977) points out that curriculum evaluation:

must vary according to the area of the curriculum we are dealing with, the curriculum model we have chosen, and the purposes we have in mind when we set up our evaluation procedures.

Kelly (1977 p.105)

8.8 (ii) Kelly also draws a distinction between two discrete kinds of questions - those searching for relevant data - empirical questions which explore relative merits of products, for example, and questions concerning the value of the activity, the goals of the curriculum and not merely the effectiveness of its procedures. He suggests that assessment of the attainment of pre-specified or prescribed objectives is concerned only with the success or failure of the programme and not with an understanding of it. The holistic view sees evaluation as part of a continuous programme of research and development and recognises that the curriculum is a dynamic and continuously evolving entity.

Kelly (1977 p.116)

8.8 (iii) Annual reports to the ENB from the schools about the process of implementing the pilot schemes, collated by the researcher, provide further evidence of course monitoring and evaluation.
8.8 (iv) North Lincoln developed a peer review system, and educational audit, between the staff in the school of nursing and the York School of Nursing - establishing a curriculum evaluation scheme, based on similar models in polytechnics and universities, described by Nicklin and Kenworthy (July 1987) - both of whom were involved in the plans for the pilot scheme in North Lincoln.

8.8 (v) The external examiners to each pilot course also contribute to the course review and evaluation procedures, in addition to advising on the proposals for assessment of students.

8.9. Research

There are research projects associated with five of the pilot schemes.

8.9 (i) In Lincoln a study by the City of London Polytechnic, of the pilot students' conceptions of health, health care and the nurse's role in Unit I identified that they had a different learning orientation from traditional students, but cross comparisons with a 'non-pilot' control group could not be made as intakes to the traditional scheme had ceased.

Funding for a longer study was not available.

8.9 (ii) A longitudinal study, which will continue until January 1990, is being conducted by Bradshaw into student nurses' occupational socialisation experiences in the Dorset School of Nursing for two groups of students, one a pilot and one a non-pilot group.
8.9 (iii) In Sunderland the pilot course is one of a range of courses involved in the C.N.A.A. project - Course evaluation: using students' experiences, - co-ordinated by the Educational Development Services of Newcastle-upon-Tyne, Polytechnic.

8.9 (iv) In South Birmingham a nurse researcher, based at the Polytechnic and funded by the RHA, is conducting a comparative study of the views of students in the first intake of the pilot scheme with a group of students on the conventional course.

8.9 (v) The special trustees in the Queen's Medical Centre funded a post for a nurse researcher for a three year period to assist the DNE with statistical data regarding the recruitment and characteristics of entrants to the pilot scheme, their achievements and attrition, and to study their evaluation of the course, their attitudes to continuous theoretical and practical assessments, learning styles and teaching methods and curriculum content.

8.10  Methods of assessment of students

The six pilot schemes, in common with all nursing schools, are required to carry out the function of examining students to fulfil the role of a safe and competent practitioner in order that successful students may make an application for their names to be entered on the Register of the UKCC, in accordance with the statutory rules. The relevant part of the Rules appears in Table 8.1
Table 8.1 The Nurses, Midwives and Health Visitors Rules, 1983 No. 873

(19 (i)) to qualify to be registered a student shall

(c) have passed an examination held, or arranged by a Board in accordance with Section 6 (i) (c) of the Act, which may be in parts and which shall be designed so as to assess the students theoretical knowledge, practical skills and attitudes and demonstrate her ability to undertake the relevant competencies specified in rule 18 of these rules.

8.10 (i) ENB Circular 1985 (19) ERDB, April 1985 is illustrated in Table 8.2, and states the procedures to be adopted for interpreting the rules. Detailed instructions for conducting a written final examination to be taken during the final six months of the course follows in this circular.

Table 8.2 ENB Circular 1985 (19) ERDB April 1985

Since the early 1970s, schools of nursing have been responsible for examining practical skills and attitudes. The ENB has now agreed that assessment of theoretical knowledge shall also be devolved to schools of nursing under examination procedures arranged by the Board.

continued overleaf
2. In the long term the Board sees the assessment of knowledge, skills and attitudes and the measurement of competency as a continuing process.

2.1 A small number of schools are currently approved to undertake continuous assessment as an alternative to the four ward-based practical tests. The schools may submit a programme of assessment of knowledge, skills, and attitudes. Once the submission is approved, a final determinant written paper will no longer be required.

2.2. Some schools are in the process of developing a programme of continuous assessment as above (2.1). Guidelines will be issued by the Board as soon as possible setting out optional strategies to enable these schools to work towards integrating the assessment of knowledge, skills, attitudes and competency for a submission to the Board.

6.10 (ii) In June 1985 Circular 1985 (38) APS - an addendum to the previous circular - gave guidelines for external examiners, and for Chairmen of Examination Boards, and a list of approved examiners in England. Page 2 of the guidelines to external examiners, paragraph 1.9.

1.9 The ENB recognises that to ensure that continuous assessment is carried out effectively may present difficulties for external examiners. Particular consideration should be given where a major discrepancy occurs between a candidate's progress during training and his/her attainment in the final written examination.
Paragraph 1.13 refers to the collective responsibility of all examiners, internal and external, and expects that agreement will be reached in respect of each candidate through free and open discussion. If there are conflicting views or adverse reports on particular candidates consultations should be held with the relevant teachers and clinical service staff who may be invited to attend a meeting of the examination board.

These were the ENB regulations applicable for students entering initial training on or after July 1st 1983 and operative when the pilot schemes were given approval in March 1985. This information, it is contended, supports the views of the participants in the six pilot schemes that their submissions had been approved for continuous assessment in practice, or for continuous assessment of theory and practice. South Birmingham, in the submission had opted for the conventional form of assessment by four observed practical assessments and a final written examination. West Dorset, Yeovil and Sunderland had specified continuous assessment, and holistic assignments, and Central Birmingham had put forward continuous assessment in theory and practice in the submission. North Lincoln's Unit 1 and 2 in the original submission, includes the experiential learning taxonomy incorporating the learning principles and strategies, the teaching strategies and resources, and the method of assessment at the five taxonomic levels - exposure, participation, identification, internalization and dissemination. This process type curriculum illustrates an ascending gradient of professional competence, with formative and summative assessment in each Unit of the course. The four ward-based practical assessments were included in the proposals - but it was not anticipated by teachers or their students that a final determinate examination would be required. It was also understood in West Dorset by teachers and students, that in
the final analysis of their performance, their assignments - both formative and summative would be taken into account. In another scheme at interview a student commented that there appeared to be:

a conflict of values in the debate.

Student

8.10 (iii) At the meeting of representatives on January 1988 at the ENB with members and officers of the Board and in the presence of observers from the DOH and the researcher, it became clear that there was uncertainty about the extent to which the approval given to the pilot schemes was being interpreted centrally and locally in the light of the statement that

central regulations/control will be kept to a minimum to allow maximum local creativity and flexibility.

ENB September 84 para 1.3

It was pointed out that the lack of clarification or misunderstanding, for whatever reason, was of concern to students some of whom were entering the third year of the course. The CEO agreed to refer this to the Chairman and members of the Board and a letter to each school followed later confirming that assessment in the pilot schemes should proceed as approved, in line with the submissions. Appendix VII sets out UKCC interpretive principles - from Appendix 1; ENB Circular November 1988/57/APS.
The 1988/89 report from North Lincoln - June 1989 indicates that as students had been prepared for the final examination, in view of the previous uncertainty, this examination would remain:

another change would be detrimental to our students who were now anticipating a final examination

North Lincoln Report 89 p.6

The point is made also in the report that if there is delay in implementing Project 2000, the position will be reviewed and an application for continuous assessment of theory and practice will be carried out as a matter of urgency.

Nurse teachers who attended the ENB regional discussions on the subject of the devolved final determinate examination for all schools expressed concern lest the prescribed criteria set by the Board would restrict logical progressions towards examining according to developments in the nursing curriculum.

8.11 The curriculum context

The ENB invitation in September 1984 offered an opportunity for pilot schemes to change the context, design and content of the nursing curriculum. This research project makes a contribution to the debate regarding the process of changing the curriculum in the context of the six schools. Docking (1987) argues that major curriculum change and curriculum development in nursing education are different. This raises
the question - were the six pilot schemes planning a new curriculum or developing the existing course?

8.11 (i) Were the proposals practicable in the context?

The six schemes proposed different curriculum innovation in very different contexts. In their reports for the third year of the scheme they indicate that the schemes have achieved the implementation of the proposals, although, as discussed in Chapter 7, these were modified in some instances.

8.11 (ii) The five pilot schemes with supernumerary status for students, were able to introduce concepts of health and community care at an early stage, by changing the context, the design and content of the course. The observations that communication and inter-relationship skills were increased would merit further research study.

8.11 (iii) In Central Birmingham local constraints precluded a change in context, and the proposals for a pilot scheme, at the outset, did not include supernumerary status for students. Curriculum development in this pilot scheme includes changes in teaching/learning strategies, and in continuous assessment of theory and practice. The DNE in a letter - June 1989 reports that:

36 weeks theory plus 24 weeks supernumerary status is the present position. The patient centred assignments with contract grading have been very successful. We have been delighted with the quality of the work produced by our students; many are working comfortably at diploma level.
In our view the implementation of Continuous Assessment of Theory and Practice has been one of our major achievements in view of the quality of student work

DNE Central Birmingham

The use of the term 'supernumerary' in this letter differs from the definition of 'supernumerary status' in the other 5 schemes, where it means that the student is removed from rostered service in the hospital setting for six months, one year or longer, i.e. there is a change in the curriculum context.

In Central Birmingham the research shows that the 24 weeks includes 9 weeks in the patient education module in both hospital and community; 9 weeks in psychiatric nursing experience; 4 weeks in maternity nursing experience and 2 weeks observation in operating theatres. That use of the term, in manpower planning to describe periods when the student is unavailable for service in rostered teams in general, children's or elderly care wards, should not be confused with the status of the student in an educational course.

8.11 (iv) The rationalisation of schools in England was referred to in Chapter 7. It is clear that the context of nursing education in these six schools is likely to be the subject of major change in the future. Increasing the geographical area of schools and colleges and its effects on learning, teaching, and the resources for staff preparation are factors to be addressed.
8.11 Joint collaboration

The pilot schemes in Sunderland and South Birmingham, in addition to changing the context of nursing education demonstrate differences in curriculum design. Modifications to the design in South Birmingham were addressed in Chapter 7. Both these schemes illustrate the personal costs in time and energy required to prepare the way for change, to introduce change, and to prepare and support all those involved in the changes during the process of changing the curriculum. Collaboration between higher educational institutions and schools of nursing requires goodwill, commitment and time to understand the differing environments, the ethos, and the advantages each may offer to the other. Lecturers in both the polytechnic-linked schemes and in West Dorset and North Lincoln emphasise the importance of sharing the strengths and weaknesses of the respective settings.

8.12 Summary

Five pilot schemes demonstrate the advantages of supernumerary status for students, and this is supported by evidence from nurses in clinical, managerial and teaching posts in schools and colleges, in hospital and community.

The advantages include a broader knowledge base, developing enquiry and communication skills, self-awareness and a wider range of opportunities to develop relationships and to understand the effects of stress in
others. The time to think, discover and learn from practice, the ability of students' to converse with patients, to discuss problems was given as evidence from mentors, students and qualified nurses in different settings. Curriculum innovation, makes demands on individuals and resources. The workload of developing plans, preparing for change, adopting plans and then preparing staff who are likely to be involved at all stages in implementing the plans - should not be underestimated.

Maintaining support throughout the process of implementing change is crucial. The research reveals that developing channels of communication for a collegiate approach, and determining the resources of money, manpower and materials, are a pre-requisite for these activities.

Educational staff in higher and further education, staff in health districts at management level, the staff in the units within the health district, and members of other professions affected by changing the nursing curriculum, need time to understand the teaching/learning strategies, and the complexity, of nursing education. The research reveals the difficulties experienced when the annual intake to a nursing school occurs more than once in the year, in collaborative programmes with educational institutions where there is one annual intake.

The parameters, and the statutory requirements, in which curriculum innovation is to occur, need to be established - and clearly understood by all parties - before the course starts. The timescale for introducing curriculum innovation, the time needed to prepare for
evaluation of the plans, and their modification as the course is reviewed, was an important issue raised in visits and interviews.

These and other issues raised in the research are relevant to current developments and preparations for introducing the changes recommended by UKCC Project 2000.

Table 8.3
First Cohort : Attrition and Final Results 1986 – 1989

<table>
<thead>
<tr>
<th>Pilot</th>
<th>1st Cohort</th>
<th>Attrition</th>
<th>Completing Course</th>
<th>R.G.N.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A West Dorset</td>
<td>12</td>
<td>1 left early disliked nursing</td>
<td>11</td>
<td>11 passed at first attempt</td>
</tr>
<tr>
<td>B South Birmingham</td>
<td>18</td>
<td>1 left health reasons</td>
<td>17</td>
<td>2 referred at first attempt - passed .. 17 passed</td>
</tr>
<tr>
<td>C Sunderland</td>
<td>24</td>
<td>4 left</td>
<td>20</td>
<td>All passed 10 distinctions</td>
</tr>
<tr>
<td>D North Lincoln</td>
<td>31</td>
<td>3 left early</td>
<td>28</td>
<td>Passed</td>
</tr>
<tr>
<td>E Yeovil</td>
<td>12</td>
<td>1 left early wrong choice of career</td>
<td>11</td>
<td>Passed</td>
</tr>
<tr>
<td>F Central Birmingham</td>
<td>24</td>
<td>1 left early - 2nd year</td>
<td>1 deferred - long sick leave</td>
<td>19 passed at first attempt. (1 passed at 2nd and 1 passed at 3rd attempt .. 21 passed)</td>
</tr>
</tbody>
</table>
CHAPTER 9

CONCLUSION

This research project makes a contribution to the literature by describing what actually happens in the views of participants during the process of changing the nursing curriculum. It reveals six different approaches dependent upon the context in which curriculum innovation and development occurs, the organisation(s) concerned, and the individuals involved in formulating, reviewing and modifying plans as they are implemented.

Generalisation from a qualitative research project such as this is impossible. It may be argued however, that generalisations are inappropriate in dynamic situations, such as educational institutions and schools of nursing in health districts, where the context, the social milieu, influences, or sets limits to, the planning and introduction of change, and thereby affects the process of changing the nursing curriculum - see Torres and Stanton (1982).

The research project began in July 1986, ten months after the first pilot scheme started. An earlier start, if this had been possible, might have yielded further information regarding the discussions and the rationale for the Board's decision to call for pilot schemes, the criteria for their selection, and the support offered during the experimental period.
It might also have enabled a clearer picture to emerge of the differences between the conventional and the innovative curriculum in each school; the reasons for dissatisfaction with the previous course; any earlier developments in teaching and learning strategies in each school and the extent to which all the staff involved in the pilot scheme were prepared for the changes. This exploration of the context before the curriculum innovation began might also have revealed the contribution of individuals to the innovation e.g. the effect of one individual pressing for change, or planning in isolation, or the extent to which groups were involved in the discussions at the outset to contribute to planning by challenge and debate.

The speed of change - the escalation of changes and proposals for change since 1985 when the first pilot scheme began - affected the six schools, e.g. the publication of UKCC Project 2000 and acceptance of the proposals; NHS management changes and the debate about the White Paper; the Judge report, and the regional plans for the rationalisation of nursing schools in England.

Some aspects addressed in the research are also issues of concern to the ENB, as the following examples illustrate. A study of the interface between the ENB and approved training institutions, by Deloitte, Haskins and Sells, Management Consultancy Division, November 1988 was circulated by the ENB for discussion by schools and colleges, and a number of other papers from the Board in 1989 as course development guidelines, following UKCC Project 2000. A 'new preparation for practice', included;
links with higher education; joint validation procedures, and the preparation and role of mentors.

Each of the six pilot schemes merited a study in depth of their plans for innovation, the preparations for introducing planned changes, and their implementation of the plans. Such research, whilst offering both qualitative and quantitative data, would have called for more resources in personnel and funding than those available for this project. In choosing the broad approach as a record of EMB experimentation the researcher discarded alternative choices. A comparative study of the six schemes might have offered a detailed account of the curriculum content in each, and the degree of integration achieved (or not achieved) when subject specialists from other disciplines participate in innovation in the nursing curriculum. A more detailed study, such as that, might have revealed differences in the six pilot schemes between the four fundamentally different perspectives from which Beattie (1987) argues curriculum-building may be viewed, and the extent to which each of the six schemes achieved a balance between four essential components - curriculum as a map of key subjects, as a schedule of basic skills, as a portfolio of meaningful experiences and as an agenda of cultural issues.

On reflection, however, whilst the findings in this research may be viewed with a degree of circumspection, there are issues raised in this study calling for further consideration. Some of these were indicated in Chapter 8 - the time required to prepare for change; the students'
difficulties in the transition to full team membership, and the conflict in the mentor's role when supervising the ward and the student. Lawton (1983) suggests that the educationist attempting to analyse his own society tends to take for granted aspects which ought to be questioned, assuming the value of certain practices which ought to be examined. One of the issues this project brings into focus is the question of curriculum in context. Each nursing school, whatever its locus, is an organisation differing from other nursing schools. The setting in which it operates and the curriculum process in each school varies - but they have one purpose in common - to prepare the 'products' to meet the statutory standards of competence required for registration as a general nurse. Such standards are currently judged within parameters prescribed nationally. This research demonstrates that continuous assessment of theory and practice is possible within statutory rules. Nursing students in three of the schemes gain further recognition - a certificate granting exemption from one year of an undergraduate course and a diploma from the polytechnic gaining similar exemption. In the Sunderland scheme ten of the first cohort of twenty four were awarded distinction in the diploma in nursing science from Newcastle upon Tyne Polytechnic. It is suggested that this is a factor to be explored further in line with the ENB Course Development Guidelines Paper H 1989.

Linkage between schools of nursing and higher educational institutions is another area where further studies are indicated, it is argued. These six schemes illustrate different interpretations of linkage - but all emphasise the importance of linkage in context. There is, it is
suggested, a triangular relationship which nursing students have to negotiate between the practice of nursing i.e. the individual giving care to another individual; the study of nursing theory, and the role of the nurse in teams. The proximity of practice settings and educational centres encourages discussion of issues that arise in either, or both, areas, and allows research to inform both theory and practice. The advantages of proximity were instanced in West Dorset, and also in North Lincoln, where both schemes were sited within the nursing school but with strong educational links. In North Lincoln the teamwork between a nurse teacher and an educationist in developing the pilot scheme for nursing students in parallel with student teachers provides another area for research.

The two pilot schemes linked with polytechnics demonstrate different approaches in curriculum design - but caution those planning future courses to seek the best of both worlds, and to be aware of the personal and financial costs of travel between two sites.

This is an important point which merits further study. The Judge Report (para 2.12 page 9) commends polytechnics with experience of dispersed sites. Little evidence appears in the literature about the issues of time and travel costs in polytechnic courses, and the effects on course planning, time-tabling, and the use, or mis-use, of the opportunities for learning and teaching. Students and staff in the ENB pilot schemes were critical of the amount of time, e.g. between one and two hours, spent travelling, even when this factor was taken into account in time-tabling.
The formation of large schools or colleges of nursing and midwifery in England, following rationalisation of schools in the regions, by increasing their geographical extent may present similar concerns, which need to be taken into account in the planning stages.

The two remaining pilot schemes offer the greatest contrast in the context of the curriculum; both schemes demonstrate the argument of Torres and Stanton (1982) that curriculum development, whilst it may be limited by circumstances, takes place in the context of the larger community or society and reflects what is considered important at the time - and what is considered likely to become important in the future.

Central Birmingham, calling on lecturers from the extra mural department of the University of Birmingham to assist in the pilot scheme, and now planning on undergraduate nursing course, demonstrates that future educational development is not limited by current constraints. The Yeovil scheme devising a curriculum to meet local needs in a rural community, relies on local support and proximity for different experiences in practice, on the professional and educational experience of nurses and nurse teachers and does not make links with an establishment of higher/further education. The curriculum content, design, process and assessment are based on the students' needs and the roles the nurse is called upon to play, both in hospital and the community, reflecting the views of Hockey (1978) that the body of knowledge which a professional nurse applies:
represents a composite science which is unique in the qualitative and quantitative mix of the underlying disciplines of which it is composed.

The aim of this research project, as stated in the Introduction is to record the contribution to the development of nursing education by the six schools, and to raise issues for further consideration by those planning courses following Project 2000 recommendations.

Fullan (1982) maintains that a lengthy period between the adoption of plans and their implementation is necessary to prepare all those who will be involved in the process of curriculum innovation and change. It is an observation that the participants in the pilot schemes, and the researcher, endorse and recommend to those concerned with future planning in nursing education.

In an important sense this world of ours is a new world, in which the unity of knowledge, the nature of human communities, the order of society, the order of ideas, the very notions of society and culture have changed and will not return to what they have been in the past. What is new is new, not because it has never been there before, but because it has changed in quality. One thing that is new is ... the changing scale and scope of change itself, so that the world changes as we walk in it.

Oppenheimer cited in Bennis et al (1985, p.1)
APPENDIX I

Terms of reference for committees on nursing education and training
1937 – 1989
Terms of reference for committees on nursing education and training

1937 The Interdepartmental Committee on Nursing Services set up by the Minister of Health and the President of the Board of Education, under the chairmanship of the Earl of Athlone,
- to inquire into the arrangements at present in operation with regard to the recruitment, training and registration, and terms and conditions of service of persons engaged in nursing the sick and
- to report whether any changes in the arrangements or any other measures are expedient for the purpose of maintaining an adequate service both for institutional and domiciliary nursing.

1939 The interim report of the Committee (1939) was concerned with salaries and conditions of service. No final report was made and the Committee was postponed owing to the outbreak of war.

1941 The Nurses Reconstruction Committee set up by the Royal College of Nursing under the chairmanship of Lord Horder.
- to consider ways and means of implementing the recommendations of the Interim report of the Interdepartmental Committee on Nursing Services
- to recommend such further adjustments to the nursing
services and as the present situation and post-war reconstruction may demand.

A series of reports was published between 1942 - 1949, the first, Section I, on the Assistant Nurse; the second, Section II, on Education and Training. The remit for the second report was:

- to consider how best to model nursing education so as to ensure the observation of the highest professional standards,
- to consider present defects and
- to suggest remedies, with special reference to the educational functions of the General Nursing Council and the adequacy or otherwise of the system of state registration now in force and
- to make recommendations promoting further post-certificate education.

1946 A Working Party on the Recruitment and Training of Nurses set up by the Minister of Health, Secretary of State for Scotland and the Minister of Labour under the chairmanship of Sir Robert Wood,

- to review the position of the nursing profession - the impending establishment of a National health Service ...
rendered a comprehensive review of the whole nursing service and its problems of the highest importance.
- to survey the whole field of the recruitment and training of nurses of all types, including an examination of such
questions as: -

(a) What is the proper task of a nurse?
(b) What training is required to equip her for that task?
(c) What annual intake is needed and how can it be obtained?
(d) From what groups of the population recruitment should be made?
(e) How can wastage during training be minimised?

1947 the Report of the Working Party (1947) made forty recommendations including student grants, a common foundation programme with specialisation later, regional nurse training boards, and composite training units under a Director or Principal and an Education Committee.

1961 A Special Committee on Nurse Education set up by the Royal College of Nursing under the Chairmanship of Sir Harry Platt,

- to consider the whole field of nurse education and training in the light of developments since the Nursing Reconstruction Committee completed its work and in reference to the part which the nurse is called upon to play in the various spheres of nursing service; and to make recommendations.

1964 The first report, A Reform of Nursing Education (1964) recommended that regional councils for nursing education should be established, that schools of nursing should have an identity
separate from the hospital, principals of schools of nursing should be appointed, responsible to school councils, and that the ward sister should be given time and adequate supporting staff to fulfil her teaching role.

1968 A Working Party, set up by the Ministry of Health, the General Nursing Council for England and Wales, and the Royal College of Nursing, under the Chairmanship of Dame Kathleen Raven, Chief Nursing Officer DHSS

- to identify the current and foreseeable educational and training needs of student and pupil nurses and the role of teaching staff in meeting these needs and to examine the resultant staffing pattern.

1970 The Report of the Nurse Tutor Working Party (April 1970) addressed short term measures to increase the number of nurses qualified to teach, and drew attention to the need to recognise the changing role of the nurse in hospital and community. It recommended a planned educational programme, in a learning environment with concurrent teaching and practice under supervision, in a modular course with preparatory, and consolidation, study weeks between each experience. A choice of courses for the register to suit students with different needs - and with opportunities for a university degree or diploma - were advocated.
1970 The Committee on Nursing was set up in March 1970 by the Secretary of State for Social Services under the chairmanship of Professor Asa Briggs.

- to review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.

1972 The Report of the Committee on Nursing (October 1972) was presented to Parliament by the Secretary of State for Social Services, the Secretary of State for Scotland, and the Secretary of State of Wales, by command of Her Majesty.

The recommendations were widely reported and discussed throughout the United Kingdom. Reference to this report appears in Chapter I.

1979 The Nurses, Midwives and Health Visitors Act led to the setting up of a new statutory structure for the United Kingdom - the U.K. Central Council for Nursing Midwifery and Health Visiting, and National Boards, for the four countries in the U.K.

1981 The U.K.C.C. (The Shadow Council to prepare for the handover of functions from the statutory bodies to the newly elected Boards and Council in 1983) set up a Working Party Group 3
- to prepare a consultation paper on the philosophy which might govern nurse training and education.

1982 The report of the Working Party, Consultation Paper I, on Education and Training - The Development of Nurse Education, released in January 1982 appears in Appendix II. The general philosophy outlined in the document was endorsed by the ENB.

The ENB, in February 1982 released a consultation paper on The Organisation of Nursing, Midwifery and Health Visiting Education in England.

This proposed the setting up of Colleges of Nursing and midwifery at single or multi district level to be controlled by governing bodies, and the creation of Institutes of Nursing, Midwifery and Health Visiting at Regional or sub-regional level. The debate was shelved in the light of comments from the Royal Colleges (both of Nursing and of Midwives) that decision should be left to the elected Board.

1984 The newly formed U.K.C.C. set up a project group of members of its Educational Policy Advisory Committee - under the chairmanship of Miss Margaret Green - to determine the education and training required in preparation for the professional practice of nursing, midwifery and health care needs in the 1990s and beyond and to make recommendations.


1987 In February 1977 the U.K.C.C. agreed its policy on education and training reform, presented the report to the Ministers of the four Health Departments of the UK, endorsed by the four National Boards. Project Paper 9 sets out the new education framework and the context of the reforms.

1988 In April 1988 - provisional approval given by the Secretary of State for Social Services to the proposals; and a letter to the Chairman of the U.K.C.C. appears in this Appendix.

1989 In April 1989 the Secretary of State for Health announced thirteen demonstration districts, where school of nursing would implement the Project 2000 proposals - subject to two conditions:

First, the need for discussion and negotiations with my officials over the manpower and cost aspects of their proposals, and second, the need for educational approval from the English National Board.

Secretary of State for Health
APPENDIX II

UKCC Working Group 3 -
Education and Training

The Development of Nurse Education
January 1982
UNITED KINGDOM CENTRAL COUNCIL
FOR NURSING, MIDWIFERY AND HEALTH VISITING

WORKING GROUP 3 - EDUCATION AND TRAINING

CONSULTATION PAPER

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UNITED KINGDOM CENTRAL COUNCIL
FOR NURSING, MIDWIFERY AND HEALTH VISITING

WORKING GROUP 3

CONSULTATION PAPER 1

EMBARGOED UNTIL
25.1.82

EDUCATION AND TRAINING

THE DEVELOPMENT OF NURSE EDUCATION

January 1982
The standard of nursing care provided in any health care delivery system depends on the commitment, skill and expertise of the individual nurse. As the statutory body responsible for professional nursing standards in the United Kingdom it is the duty of the UKCC for Nursing, Midwifery and Health-Visiting to formulate proposals for professional preparation and training which will ensure that the individual nurse is properly equipped to provide a nursing service of a type that every citizen has a right to expect.

The Group believes that the education of the nurse* should be accorded similar importance to that of any other practitioner in the health and welfare services. It is also believed that, in view of changes both in society and in the health care professions, the present and previous patterns of nursing training cannot be continued indefinitely. Changes in the programmes for Registration are essential in order that the nurse may be able to promote health in the home, at school and at work; to prevent illness and also to give supportive nursing care at home as well as in hospitals and other institutions.

'Prevention and Health: Everybody's Business'** was the apt title of the Health Departments' booklet which appeared in 1976. In it were outlined some of the successes of the past; the conquest of cholera, diphtheria, measles, whooping cough, tuberculosis and poliomyelitis. Reference was made to some of today's problems: the behavioural diseases brought about by prevalent social practice. Coronary heart disease, dental decay, road traffic accidents and alcoholism are examples. Mental handicap, psychiatric illness and depression also take their toll in today's society.

NB: 'She' is used for brevity instead of the greater accuracy of he/she.

* 'Nurse' in this paper is intended to include midwife and health visitor.

** 'Prevention and Health: Everybody's Business' HMSO 1976.
present appear on the different parts of the Registers. The preparation will incorporate a common core derived from elements of existing programmes. Colleges of nursing and midwifery with governing bodies, independent of health authorities should be established and nursing students, preparing for Registration, should have the status of 'protected employees'.

Continuing education is a sine qua non of any professional person today. Every opportunity must be offered to all professional nurses for the updating of clinical knowledge. Refreshment of learning is especially important in an occupation where women predominate and whose career patterns may be interrupted by marriage and child-bearing. Opportunities need to be provided for the development of courses in further and higher educational establishments in collaboration with colleges of nursing and midwifery.

Basic nursing preparation, leading to Registration, is the subject of this paper. Its overriding objective is to equip the individual to provide the highest possible standard of nursing care to the individual patient/client in her care. This preparation demands the acquisition of the skills, knowledge and attitudes necessary to carry out the care of the sick person. It also requires a sympathetic understanding of the client and the support services available to him in his social setting.

Elaboration of plans for further and continuing nursing education will appear in future consultation papers that the Working Group will prepare.

SECTION 2 - BACKGROUND

A number of factors point to the need for change in the preparation of nurses for Registration. The piecemeal nature of nursing legislation in England and Wales, Scotland and Northern Ireland since the Nurses' Act, 1919, has led to much duplication and overlap in various nursing programmes. This has produced confusion both to the public and in the minds of many nurses. The current and past inadequacy of the impoverished 'apprenticeship' system on which much nursing training in the past was based has been increasingly highlighted by the rising expectations of a public which, with the nursing profession itself, has come to seek for individual responsibility for nursing care.

Numerous reports over the years - the Lancet Commission (1932), the Athlone Report (1938), the Horder Committee (1942, 1943 and 1948), the Wood Report (1947) and its Minority Report, the Nuffield Report (1953) and the Platt Report (1964) - all bear testimony to the fact that all was not well with the nursing profession. All of these reports made recommendations; few were acted upon.

By the late nineteen sixties change was in the air. Local Government, the subject of many reports, was reformed. The National Health Service was examined in two Green Papers (1968 and 1970) and a White Paper (1972) which culminated in the reorganisation of the National Health Service in 1974.
The then Secretary of State, Mr. Richard Crossman, set up a Committee on Nursing in 1970, in anticipation of a reorganisation of the N.H.S. The Committee made its recommendations accordingly in 1972. The status of the Committee, the significance of the Governmental and Departmental support and the obvious enthusiasm of the nursing profession led to vigorous discussion and an expectation for change. There was a very real awareness of an increasingly well informed public, fuelling the expectations of a service which nurses, together with other health care professions, were not always able to meet. Pharmaceutical advances and a changing medical technology altered the work of nurses. Many, welcoming the proposals outlined in the Briggs Report, saw the potential contribution that nurses could make to the nation's health in an integrated service. They were well aware of the constraints that fettered them - not only of a financial nature - and prevented their filling a newly perceived role. Individual responsibility for individual patients was generally accepted as an overall aim. This perception was arrived at by the widespread adoption of the need for nursing care to be based on observation and interpretation, and assessment of need, an executive plan with goals to be drawn up and a final evaluation of outcome. It is to this concept of patient care that the term Nursing Process has been given. It is unfortunate if the term is allowed to suggest yet another technical procedure whereas it is, in fact, a problem solving approach to the patient/client's needs.

The traditional organisation of care in hospitals has been built up on the task-centred approach. This led to a routinisation of 'getting the work done' where the actual giving of care was not supervised personally by the trained nurse.

The nursing student has never been a true apprentice under supervision of trained nurses. The imbalance in numbers of supervisors to learners and the misuse of untrained nursing auxiliaries and assistants has constantly bedevilled any attempt at a true apprenticeship for nursing students. Thus the promise of the thoughtful, sensitive care that all patients would hope to receive, at home as well as in hospital, and which most students would hope to give, has become impossible. Insufficient numbers of trained staff for personal supervision, the organisational pattern of care and an undue reliance on untrained staff have all led to a very unsatisfactory situation in many places.

The reorganised structure of an integrated N.H.S. should be matched by a training programme to reflect the continuity of care provided and planned for each individual patient or client. He sees his treatment as a continuum, irrespective of where it takes place. Such has been the institutionalising effect of some training schemes in the past that some nursing students, proceeding to courses for community care, have had to unlearn attitudes inculcated in wards and departments. For others, their initial commitment and aspirations have not been met and this has led to a discontinuation of training.

There are a number of excellent programmes, organised by imaginative tutors and supported by sympathetic and compassionate managers, that have been mounted with the help and support of nurses, physicians and paramedical staff. Such schemes have surmounted some of the problems inherent in the past. But it is suspected that they may have been achieved only at high personal
cost to individuals. With reducing hours of duty it is becoming increasingly difficult and soon it may well be an impossibility.

The aim of the Group's proposals is to make possible for all a system whereby the nursing student's preparation enables her to give personal care to the individual patient. Such a system has to be achieved within the existing and future framework of the EEC Directives. In this respect it must be borne in mind that 'length' is no indication of quality and that 'improving' and 'shortening' are different objectives.

Glossary and Usage

'Education', 'Training', 'Student Status' and 'Professional Nursing' are terms which can divert the mind readily from the overall purpose of the service. Accordingly the Group ascribed the following meanings to these terms:

'Training and Education'

The first function of the Council, as defined in the Act is 'to establish and improve standards of training and professional conduct for nurses, midwives and health visitors.' Accordingly 'training' has been used generally throughout. It is used in the sense that 'training' seeks to develop knowledge, skills and attitudes necessary to enable the nurse adequately to fulfil her role in respect of his/her patient/client and, as such, as part of professional preparation.

'Student Status'

The Group decided to drop this emotive phrase which means different things to different people. In referring to a 'nursing student' the Group refers to one who, in preparation for a statutory qualification is in a controlled learning situation and who, while never being in a position of professional accountability, nevertheless is required to assume increasing responsibility for the care of his/her patient/client. This preparation, set within the professional code of practice, will need the acquisition of all those skills, knowledge and attitudes essential to meet the legitimate aspirations of those in his/her nursing care.

'Professional Nurse'

Members of a profession are characterised by an attitude of service to clients. Action is based on the best available knowledge and skill and thus, the professional accepts accountability for his/her actions. For this reason the Group is suggesting Registration as the entry point to the profession.
SECTION 3 - PREPARATION FOR THE ROLE OF THE PROFESSIONAL NURSE

The Group recommends that the new framework should aim to prepare for a single standard of qualification as a Registered nurse.

The first post as a professional nurse will require her to work in a team with her peers and with social, medical and paramedical staff. The preparation does not equip her to lead a team of equals. Further preparation would be required. A first post allows consolidation of learning of the skills and knowledge acquired and the attitudes inculcated throughout studentship. The care and management of individual patients and clients should be well within her competency. At times she will be required to deputise for short periods for her immediate superior.

The present position where there are two types of nurse, each with a statutory qualification, has led to confusion both in the minds of practitioners and of the general public. But the Group is anxious to emphasise that its recommendations are quite without prejudice to existing enrolled nurses, many of whom have been unfairly placed in positions for which they have had inadequate preparation. The proposals for a Single Professional Register ensure that existing nurses holding statutory qualifications would be enabled to continue to practise.

The new proposals depart from the concept of a certificate in nursing as advocated by the Committee on Nursing. It is believed that each National Board should make provision for special conversion courses to be made available for an enrolled nurse who wishes to proceed to Registration. Not every enrolled nurse who wishes to register might be able to qualify but none should be denied the opportunity to test her entry to further training. The Group believes that many enrolled nurses currently enjoy their work, give excellent service and would not wish to alter their status. But these proposals would enable those who have the innate ability to pursue the path to Registration and the upward professional mobility which is at present denied them.

SECTION 4 - PREPARATION OF SUPPORT STAFF

The Group considers that there is an essential difference between the preparation needed for the professional, Registered nurse and those who will support her in her work. However, the Group is convinced of the necessity of some preparation for all who will be in direct personal contact with patients and clients. It sees merit in removing the word 'nursing' from any title and suggests the term 'Care Assistant'.

The means of preparation for care assistants, which should be of short duration, should be determined at local level. Such periods of instruction, needed for the acquisition of basic skills and of an appreciation of membership of caring teams, have already been instituted in many parts of the country. The Group is convinced that such instructional periods should not be under statutory control. Strategies for the employment of care assistants will need to be determined at local level. Assistance with instructional courses may well be offered by training establishments and no doubt guidance will be offered by the four National Boards in this respect.
Although any care assistant who demonstrates the commitment, ability and capacity to embark on a professional training should be encouraged to do so, the Group is mindful of the lessons of the past and of the difficulties encountered by enrolled nurses.

SECTION 5 - FUNCTION OF NURSING TRAINING

Nursing training has one single, overriding objective; to equip the individual to provide the highest possible standard of nursing care to the individual patient/client in her charge. Although this preparation demands the acquisition of skills, knowledge and attitudes needed to carry out the care of the sick person, it also requires a sympathetic understanding of him in his social setting. A broad background and understanding is both desirable and necessary in a complex society such as is Britain today. Tensions in society can readily be generated by a failure to understand ethnic and socially deprived minorities. Nurses, like medical, paramedical and social workers will always meet patients and clients who are both apprehensive and vulnerable. As committed health care workers, nurses are in a position to reduce some of the conflict which can arise from mutual misunderstandings.

The nurse should be able to observe and recognise the significance of her observations, to plan nursing care - taking into account the doctor's prescription, and the patient's requests as well as her own assessment of the needs of her patient. She should be able to document, analyse, and evaluate the outcome of her planned prescription of nursing care.

SECTION 6 - ROUTES TO REGISTRATION

The Group affirms that entry to the profession is at the point of Registration. There may be differing routes to achieve this entry point. All forms of training for Registration in the UK need to take account of the EEC legislation and this will determine the framework set by the UKCC for the Boards to interpret. The pace at which nursing students achieve the goal of Registration may vary. A variety of courses should meet the needs of different groups of students.

The Group believes that all courses for Registration should encourage the promotion of health - in the home, at school and at work - the prevention of illness, as well as giving supportive nursing care in the home and in the hospital. This common core (which is NOT a common portal of entry) is not an amalgam of the present syllabuses. It is a focus on the development of the human being, on the nature of care, and of the support services available to help those in need. There must be an appreciation of the difference between self-care, nursing in the home, in the school and in the work place as well as of the patient in his hospital bed. Past achievements by the existing statutory bodies should not be lost, but the development of a variety of courses for special needs and for changing patterns of care is vital if the purpose of the Act is to be achieved. Moreover, in view of the changing needs in society continuing change is essential in the courses of preparation for all, especially for those qualifying for professional service in the health, social and welfare fields.
It will be for each National Board, calling upon advice from expert groups where necessary, to plan detailed programmes to meet the requirements of the individual countries. All such programmes will eventually lead to Registration for entry to the profession. The intention of the Group is to give recognition of all who register by different routes, and to depart from the previous pattern of enrolled nurse and also from the 'Certificated Nurse' envisaged in the Briggs' proposals. While some might ask for credit for those who have demonstrated the ability to cover a part of the course, the award of a 'certificate' would perpetuate some of the ambiguities and disadvantages seen by the misuse of some present enrolled nurses.

The number of qualified nurses needed to run the Service is the subject of current review. An estimate will need to be made of the numbers of enrolled nurses requiring 'conversion courses' for Registration and for the numbers of Registered nurses needed to run the Service within an overall manpower plan.

It will be for the colleges of nursing and midwifery and for the colleges of further and higher education providing courses for nurses, midwives and health visitors, together with managers in the health authorities, to determine the numbers to be trained bearing in mind the amount of clinical placements available. Such an exercise needs to be done without further delay.

SECTION 7 - THE NURSING STUDENT

The status of the 'learner' has been the subject of greater concern than almost any other when the preparation of the professional nurse has been under discussion. The Group decided to drop the emotive term 'student status' which means different things to different people. The Group envisages the nursing student as one who, undertaking a statutory training for Registration is in a controlled learning situation. In such a supervised position the student, while never being put in a position of professional accountability for patient care, nevertheless is required to assume increasing responsibility.

The central purpose of nursing training and education is the improvement of patient care, the encouragement of positive attitudes to health and the prevention of disease. The aim of the programme is to prepare the nurse for a professional qualification; to seek to develop the individual student's awareness of her own needs, as well as an awareness of the needs of others; to encourage a sensitivity and the acquisition of knowledge and skills that will enable her to observe accurately and to recognise the significances of her observations; to develop an ability to become self-critical, analytical and to initiate change where and when change is necessary. The motivation and commitment of the student needs to be matched by the motivation and commitment of the profession to provide an environment where such learning can grow and flourish.
The complex and sophisticated workings of the welfare state - often underused because of non-comprehension by the elderly, the mentally ill and the handicapped - need to be understood by the nursing student if she is to provide the support that the client has a right to expect of those who will so often be closest to him in periods of stress, sickness and deprivation.

The Group is convinced that the art and science of nursing is best learned in the clinical setting, whether it be in the hospital, the health centre or the home. Theoretical learning can be achieved in the lecture room, the group discussion, the audio-visual aid centre and the library but the newly acquired knowledge needs to be shown to be of value in the settings where patients and clients are to be found. The Group is certain of the need for the students to be, in some measure, involved in the care being provided. The purpose of Registration is to provide a professional nurse able to function safely in a first position. The nurse will then require to extend her specialist clinical ability and develop her competency. She may also need to acquire the necessary skills to manage a group.

It would be idle to suggest that there will never be any degree of conflict between the training needs of students and the demands of the service in the clinical setting. The Group asks for a recognition of the primacy of learning for nursing students and administrative arrangements to reflect this. The performance of the Registered nurse of the future will depend largely upon foundations laid throughout preparation for her professional role. Soundly based foundations can do much to enhance comprehension of post-basic programmes and may even shorten them. In an occupation where there is a preponderance of women many practitioners will experience career breaks. Refresher courses are needed for non-practising Registered nurses. At present many are reluctant to return, fearing their own inadequacy. A soundly based foundation will ease their return to employment after a break in service.

The Group sees the nursing student as one whose time is spent in preparation for her future role as a Registered nurse. This pursuit will take her into wards and departments of hospitals, into health centres and into people's homes, as she acquires skills, knowledge and experience her role will change from one of a participating observer to that of an observant participant. Her contribution to service will grow as she becomes increasingly able to shoulder responsibility for patients' care.

SECTION 8 - THE LEARNING ENVIRONMENT

It has already been stated that, as it is the conviction of the Group that the art and science of nursing can only be learned where there are patients and clients, service and training must be linked.

Nevertheless it is also held that the educational structure must be separated and identified in order that learning and teaching is not neglected in the interests of short term service needs. This requires the establishment and recognition of the role of the nursing student within a controlled learning situation.
With such a recognition must also come an awareness by professional nurses of their own contribution to the learning experience. Their supervision and example will be a major factor in the students' progress. In order to achieve this difficult aim all practising professional nurses will need support. The Group suggests the need for specifically designated clinical areas to which students should be allocated. Examples of the criteria which might be adopted to achieve this are:

(i) Areas where all Registered nurses would be required to have undergone some preparation in supervision and teaching.

(ii) Areas where staffing ratios would be recommended by National Boards, in a manner similar to the procedure presently undertaken by the Central Midwives Board (England and Wales).

(iii) Areas where the staffing levels and the organisation of the work is such that the trained staff supervising the students are able to work alongside them in giving direct patient care.

Once the initial learning has occurred the student will need to become more adept in accepting service pressures as part of her preparation for reality. As this occurs so will her service contribution increase. But at no time should she be professionally accountable. This must remain with her supervisors.

Although it is envisaged that training areas will be identified, it is hoped that the presence of students within the districts will create an atmosphere of inquiry, learning and research. Such an ambience can provide a stimulus to all for learning and the pursuit of excellence. Such an atmosphere underlines the need for continuing professional education.

The Group is well aware that putting nursing students into a variety of situations cannot, of itself, ensure the quality of learning. This can only derive from the nature of the programme, the curriculum and the guidance and supervision of those responsible. Learning should progress from the structured to the facilitated and finally to the self-directed. The strategies needed for this progression must be devised by nursing educationists who, in turn, must be prepared to provide help and support for their colleagues in the service areas who may be without formal teaching preparation.

The framework described is believed to be necessary to safeguard the learning experience of the nursing student in preparation for her professional role. But in no way can it be regarded as a substitute for the quality of teaching and guidance.
SECTION 9 - EMPLOYMENT LEGISLATION

With an acknowledgement that the art, craft and science of nursing can only be learned where there are patients, the preparation period of the nursing student must be inextricably linked with the service structure.

Recent employment legislation has caused difficulties in some areas where the student's role as an employee has predominated over her role as a learner. However, there are numerous examples of good practice where no difficulties have arisen.

In the short and medium term the Group envisages the nursing student as having the legal status of a protected employee. With adequate forethought and planning the Group sees little need for conflict between educational counselling and the implementation of the employment legislation.

The employment status of the nursing student is not seen as an urgent priority for alteration. The Group, however, would want to see this aspect kept under review.

SECTION 10 - COLLEGES OF NURSING AND MIDWIFERY

The educational structure requires colleges of nursing and midwifery. Common sense dictates the need for bricks and mortar but separate and isolated premises are not needed. There is a virtue in the nursing students being able to see and inhabit an institution dedicated to their learning and where Registered nurses pursue further studies.

Each college is seen as having a separate identity, guided and regulated by an independent governing body, responsible to a National Board. The Group views the governing body as central to the concept of an educational structure.

It will be the responsibility of the governors to ensure that the college is run on sound educational principles at the same time as having due regard to the needs of the health service. Members of the governing body should be drawn from general and professional education, from health authorities and the community in order that the college provides preparation which transcends short term employment considerations. The quality of the preparation provided for the students will be determined by the ethos of the college and it is this, more than any other factor which will give meaning to the role of the nursing student.

It will be the responsibility of National Boards to ensure that the preparation of students is of a standard necessary to comply with the requirements of professional qualification in accordance with the rules of the Central Council. The National Boards will determine the numbers of colleges and will be responsible for the budget allocation to these colleges. The number of teachers and trained nurses needed to support the students will be assessed by collaboration between the director and the nursing service managers. The director of the college should be directly responsible to the governing body for the quality of teaching, for the staff and for the nursing students. Local situations will differ, but it will be essential for the director and staff to work closely with nursing
service managers to plan and provide programmes in different clinical settings. The purpose of each attachment should be agreed and defined.

The advantages of a college providing post-basic and further training for professional staff should be stressed. This should stimulate a greater awareness of the need for continued professional education.

SECTION 11 - THE EDUCATION BUDGET

The Group considers it essential that the total funding of the education of the nurse at basic level, and for the continuing education of nurses, midwives and health visitors should be identified and provided separately from the nursing service budget of the health authorities. This funding should include the salaries for teaching and support staff in colleges of nursing and midwifery and, in due course, the training allowances for nursing students.

It has often been argued that nursing students should be supported in the same way as students in further and higher education. Opinions are divided as to whether or not a system of grants composed of parental and local authority moneys would be appropriate for the nursing student.

However, the Group is agreed that such a system is not a precondition for identifying and funding an educational structure, in which the nursing students' training allowances are a component of the college's budget and identified separately from the Service budget.

The amount of such training allowances will need to be determined by reference to various criteria such as the support trainees receive in similar professions, the salaries of newly registered nurses in first level positions and other student grants. The Group is convinced that the nature of the nursing student's training and preparation should be recognised by a system of allowances which reflects the fact that the purpose of a student's allocation to a clinical area is different from that of an ordinary employee. The 'protected employee' status of the nursing student will ensure fewer hours committed to the work in the clinical setting during the first year, but with increasing hours of work and responsibility during later years of training.

SECTION 12 - SERVICE IMPLICATIONS

The Group's proposals are put forward in the belief that they will lead to an improved standard of care. But it is accepted that change will not occur overnight and that the process is slow and often accompanied by difficulties. It is also accepted that there will be national differences between the four Boards. A comprehension of the underlying philosophy, however, is more important than any blueprint that can be provided at this stage.

For more than a hundred years the greatest constraint that has been placed on nursing training has been the pressure of service demands in various clinical settings. These demands have given rise to the piecemeal developments in courses of training in response to crises rather than by the planned development of innovation.
The historical aspect, with separate bodies responsible for different parts of professional preparation, has given rise to fragmentation, to some extent duplication and overlap and, more important, to some gaps in the training courses.

It is clearly unsatisfactory that those undergoing advanced courses should sometimes be found so lacking in basic knowledge that time has had to be spent in making good deficiencies in initial preparation. It is moreover, indefensible that first year nursing students have had laid upon them responsibilities far beyond their level of preparation. The Group's proposals are made in the interests of patients and potential clients as well as in the interest of those preparing to serve them. These proposals should provide for closer links between the three professions of nursing, midwifery and health visiting, and higher and further education. The greater flexibility and interchangeability in having one grade of nurse, and the provision of updating and refreshment courses for those thinking of returning to work should help to offset the effect on the nursing service. The provision of conversion courses for enrolled nurses will further strengthen the professional work force. There will inevitably be some loss to the service of the contribution which first year nursing students have made in the past. However, as all training plans have had to be adapted for the shorter working week and compliance with the EEC directives, the present contribution of students to service is already noticeably less than it was previously.

It is impossible to quantify precisely, on a nationwide basis, the staffing levels that will enable nursing students to contribute to the work of the ward in a manner which would maximise the learning nature of the experience. But it seems likely that an increase in the number of Registered nurses in the designated clinical areas will be necessary to make the best use of resources. Similarly there will be the need for more teachers to plan and provide the educational element.

The implementation of the Group's proposals will require a substantial and continued commitment by all in the health service.

SECTION 13 - THE TRANSITION PERIOD

The planning and provision of nursing care, in accordance with every individual's need, requires knowledge and skill that can only be expected of Registered nurses. Staffing levels should reflect this principle. In the long term the Group hopes that all responsible for nursing care will have received the professional preparation outlined above. This should provide the standard of care that every citizen has a right to expect. But the move to such a situation requires a transition period which will vary in length according to the local conditions.
The future timescale might be regarded as follows:

1. Short Term. Shortly after the appointed day.

   Priorities.
   - To continue the development of post-basic training opportunities.
   - To establish colleges of nursing and midwifery with governing bodies.
   - To review staffing establishments in designated teaching areas.
   - To plan and initiate preparation for Registered nurses in designated areas.
   - To review the position of enrolled nurses in post and to plan conversion courses for those wishing to proceed to Registration.

2. Medium Term.

   Priorities.
   - To develop 'common core' courses for the preparation of teachers of nursing, midwifery and health visiting.
   - To encourage governing bodies of colleges to introduce initiation courses for care assistants.
   - To transfer the 'employment' of nursing students from health authorities to governing bodies of colleges.
   - To transfer the nursing students' budget from nursing service moneys to governing bodies.
   - To encourage local and national evaluation of, and research into, programmes.
   - To stimulate National Boards to work together to provide cross fertilisation and co-ordination of programmes in association with UKCC.
   - To set up groups to work towards a cohesive programme for professional training.
   - To establish mandatory training programmes for supervision and teaching.

3. Long Term.

   - To review progress of the previous decade.
   - To continue to develop plans for future change.
SECTION 14 - THE ROLE OF THE NATIONAL BOARDS

It is for the UKCC to determine overall policies and standards and to draft statutory rules. Within these each National Board will be responsible for the execution of all education/training functions in its own country. Many of these functions have been mentioned in this paper.

The Boards will plan and oversee the setting up of colleges of nursing and midwifery and the establishment of independent governing bodies to whom the staff of these colleges will be responsible. The Boards will approve these institutions which meet the stated criteria and will disburse funds allocated for training.

The Boards will provide, or arrange for others to provide, courses for learning for Registration to the standards laid down. These will include not only courses to prepare nursing students but also those needed to cater for enrolled nurses who wish, and are able, to register.

The four countries do not, presently, have identical programmes and practices or structures. While each Board must work within UK policy, towards agreed goals, the speed of change, the structures involved and the transitional stepping stones may well not be the same. There will almost certainly be national differences in the links between the Boards and those directly responsible for the provision of training courses. It will be for each Board to consult the profession in its own country on these points.

SECTION 15 - SUMMARY

The aim of this paper is to stimulate debate. It seeks to promote discussion of an integrated approach to care based on sound educational principles and a challenge for practitioners to keep abreast with sociological and technological changes.

The Working Group has recognised that for many years many published reports have presented recommendations for change to nursing education - with little action being taken; there is, however, with the establishment of the 1979 Act a final opportunity to grasp essential issues and make the required change.

This first paper has tackled several issues:

Section 3 - The preparation for the role of the professional nurse.
Section 4 - The preparation of support staff.
Section 5 - The function of nursing training.
Section 6 - Routes to Registration.
Section 7 - The nursing student.
Section 8 - The learning environment.
Section 9 - Employment legislation.
Section 10 - Colleges of nursing and midwifery.
Section 11 - The education budget.
Section 12 - Service implications.
Section 13 - The transition period.
Section 14 - The role of National Boards.
The timescale for future development and change is a matter for detailed discussion by the profession and the National Boards to whom this document is being distributed, with the earnest endeavour that a model of care to meet the present and future needs of the community, to integrate professional interests at all levels of education and service can be evolved.

The Working Group look forward to active debate on this paper highlighting the major issues; philosophy; timescale; priorities linked to this; and the administrative structure within which nursing education will be established.

January 1982
THE PROVISIONS OF THE 1979 ACT RELATING TO EDUCATION AND TRAINING

The parts of the Nurses, Midwives and Health Visitors Act, 1979 which relate to the subject of this paper are set out below for ease of reference. They are:-

1. Section 2 (1) Functions of Council

   (1) The principle functions of the Central Council shall be to establish and improve standards of training for nurses, midwives and health visitors.

   (2) The Council shall ensure that the standards of training they establish are such as to meet any Community obligation of the United Kingdom.

   (3) The Council shall by means of rules determine the conditions of a person's being admitted to training, and the kind and standard of training to be undertaken with a view to Registration.

   (4) The rules may also make provision with respect to the kind and standard of further training available to persons who are already registered.

2. Section 6 (1) Functions of Boards

   The National Boards shall in England, Wales, Scotland and Northern Ireland respectively -

   (a) provide, or arrange for others to provide, at institutions approved by the Board -

      (i) courses for training with a view to enabling persons to qualify for Registration as nurses, midwives or health visitors or for the recording of additional qualifications in the Register; and

      (ii) courses of further training for those already registered;

   (b) ensure that such courses meet the requirements of the Central Council as to their content and standard;

   (c) hold, or arrange for others to hold, such examinations as are necessary to enable persons to satisfy requirements for Registration or to obtain additional qualifications;

   (d) collaborate with the Council in the promotion of improved training methods.
3. **Section 9 (1) Local training committees**

The Secretary of State may by order provide for the constitution of training committees of the Boards for such areas of England, Wales, Scotland and Northern Ireland as the order may prescribe.

(2) The committees shall be charged with assisting the Boards in the exercise of their training functions.

(3) The committees shall discharge the training functions of the Boards to such extent and in such cases as may be prescribed or (subject to orders under this section) the Boards may direct.

(4) The committees shall carry out their functions in accordance with directions given to them by the Boards.

(5) Orders under this section may make provision for persons who are not members of a Board to be appointed as members of any of its training committees.

(6) Before making an order under this section, and before varying or revoking such an order, the Secretary of State shall consult the Central Council, and have regard to any proposals made by the Council after it has consulted the Boards for the parts of the United Kingdom affected.

4. **Section 19 (3) Finances of Council and Boards**

The Secretary of State may make grants to the Council and the Boards towards expenses incurred, or to be incurred, by them with the approval of the Secretary of State in connection with -

(b) the promotion by the Council and Boards of improvements in the education and training of nurses, midwives and health visitors.

5. **Section 23 (1) Interpretation of Terms**

In this Act -

"training" includes education.
MEMBERSHIP OF WORKING GROUP 3

Miss C.M. Fraser O.B.E. (Chairman)  Head of Department of Health and Nursing, Queen Margaret College, Edinburgh.

Miss C.M. Chapman  Director of Nursing Studies, Welsh National School of Medicine.

Miss S.M. Collins O.B.E.  Associate Lecturer, Polytechnic of the South Bank, formerly Director of Nursing Education, Tower Hamlets Health District (Teaching).

Mrs. M. Damant  Senior Tutor, Community Department, Charles Frears School of Nursing, Leicester.

Miss P. Grosvenor  District Nursing Officer, West Cumbria Health District.

Professor D.E. James  Director of Adult Education, University of Surrey.

Miss M. Mackay  Senior Tutor, School of Midwifery, Aberdeen Maternity Hospital.

Mr. C. McCullagh  Principal Administrative Education Officer, Southern Group School of Nursing, Co. Armagh.

The Chief Executive Officers of the five new statutory bodies also participated in the Working Group's discussions:

Miss M. Storey  Chief Executive Officer, UK Central Council.

Dr. E. Bendall  Chief Executive Officer, English National Board.

Mr. W. Preece  Chief Executive Officer, Welsh National Board.

Miss E.M. Welsh  Chief Executive Officer, Northern Ireland National Board.

Miss M.W. Thomson  Chief Executive Officer, Scottish National Board.

Mr. T. Snee  DHSS

Miss W.W. Thomson  SHHD

Health Departments' Representatives (Observer)
I am writing on behalf of the four Health Departments to give the more definitive statement on Project 2000 which was foreshadowed in John Moore’s letter of 20 May 1988. I should like to echo his appreciation of the progress made by the statutory bodies which has continued since he wrote. The challenges for health care in the future have in no way diminished in the meantime. We now have the added dimension of the White Paper “Working for Patients”, to which I return briefly at the end of this letter.

2. Turning first to the overall framework for pre-registration education and training, I confirm our agreement that there should be an 18 month common foundation programme, followed by 18 month branch programmes. However, I am not convinced that we yet have a sufficiently explicit understanding on the determination of the student service contribution. I appreciate the desire of the Council and Boards not to be over-prescriptive on curriculum planning, and the need to ensure flexibility of approach locally. Nonetheless, NHS management needs clarity in this area if planning for the implementation of Project 2000 is to have a firm basis. I suggest, therefore, that the ground rules should be that students of nursing of the future would normally be expected to contribute not less than 1,000 hours of rostered service contribution during the course of their 3 year training programme. I understand that normally this would be delivered in the third year. Any lesser figure than this would have to be agreed explicitly with health authorities and funded by them. If the Council and Boards can agree this formulation, we can regard this issue as settled.

3. On bursaries, we shall be making an announcement shortly about the levels to be paid to the first Project 2000 students. We should be pleased to discuss any detailed questions you may have at that time.
4. Your proposals argued for the creation of an all-degree teaching workforce. As our May response said, the Government does support an expansion in degree opportunities for nurses, midwives and health visitors and will expect this to be reflected in the number of graduate teachers. Since then, the University Grants Committee has agreed a 50% expansion of undergraduate nursing degree places and the Polytechnics and Colleges Funding Council has taken on the question of nursing degrees as a priority. In addition, the NHS Management Executive and the Council for National Academic Awards are collaborating on a feasibility study to examine the scope for extending post-registration degree opportunities. A parallel study has been mounted in Scotland.

5. I accept that it is a pre-requisite for future developments that education, and the qualifications which derive from it, should command confidence and respect. Future teachers must be able to demonstrate at an advanced level a knowledge of the theory and practice of nursing and midwifery education. They must be qualified or clinically credible in the area of practice they teach and hold a recognised teaching qualification. An increasing proportion of the profession and its teaching staff will hold degrees, and the developments outlined in the previous paragraph will assist in this. But it would be impractical and wrong to require an all-graduate teaching force at this time to the exclusion of other teachers of the required standard.

6. Your proposals left the future of midwifery education and training largely unresolved. We have not yet received any formal proposals from you. It may be helpful, therefore, if I set out the general Government view on this subject. We should welcome an expansion of direct entry midwifery education and training. We accept that this should be along broadly similar lines to the Project 2000 proposals for nurse education, insofar as supernumerary status and rostered service contribution are concerned. We should welcome the development of shared learning with future nursing students, both to facilitate subsequent collaborative professional working and to share scarce educational resources. I hope that the Council and Boards will do what they can to stimulate moves in this direction.

7. John Moore's response also looked for more detail on the Council's thinking on the role and function of specialist practitioners and of the scope for shared learning in post-registration education and training. I understand that Council is about to consider post-registration education and practice, and we wait with interest to hear the results of your work.

8. I turn next to the inter-linked issues of access to nursing education and training, the future of enrolled nurse training and the role and training of support workers. I recognise the progress which the Council has made in widening the entry gate to education and training since last May. This includes amending legislation to provide that Council-approved vocational qualifications may be
accepted as well as academic ones; acceptance of successful completion of access courses for entry to higher education as satisfying the entry criteria for nursing education; and the work the Council has commissioned to develop its education tests. This is, of course, an area in which one would expect continual evolution and change. There are, however, some specific aspects which the Government would urge the Council to consider:

a. we should like to see rapid progress in converting the acceptance in principle of vocational qualifications into reality. I note the Council's helpful position paper on the potential for the support worker vocational qualification as an entry route to professional training. But it will be some time before a training framework and qualification structure for support workers will be in place. Meanwhile, I should welcome the Council's views on the potential for existing care-related vocational qualifications in satisfying the Council's entry criteria to nursing education;

b. on access courses, I also note the Council's acceptance of successful completion of access courses for entry to higher education as satisfying the entry criteria for nurse education and training. There are two ways in which this approach could be broadened. First, we should like to see access courses designed specifically for entry to nursing, in addition to courses designed for entry into higher education. This need in no way prejudice the development of closer links between nursing education and training and higher education. Second, there are access arrangements which do not depend on a formal course. I was pleased to learn that your officials are exploring these issues with the Learning from Experience Trust, and I hope there can be rapid progress in this direction;

c. the Health Departments - and, no doubt, the Council itself - still get a number of complaints about what appear to be unduly rigid interpretations of entry requirements by schools and colleges of nursing. I realise that this is not directly the Council's responsibility and that schools and colleges of nursing may add to the statutory minimum entry requirements at local level. Nonetheless, anything the Council and Boards can do to encourage greater local flexibility would be helpful.

9. I referred earlier to the Council's position paper on the role and training of support workers. In particular, I endorse the statement that "development of the support worker role ... yields the potential for increasing recruitment to professional preparation from both young and mature persons who have made progress to an appropriate NCVQ level and obtained the vocational qualification to permit eligibility for entry to nursing programmes". Much further work remains to be done on developing appropriate roles for support workers in a variety of different organisational and care settings and in establishing a training framework. I welcome the positive contribution which the statutory bodies are making to this process.
10. In this connection, I think that the time has come to get away from the inelegant, and less than descriptive, title of "support worker". While I would not wish to be prescriptive about titles to be used locally, I think we would all agree on the need for an official title which is attractive and at the same time comprehends the full range of duties which support workers will undertake - including those of ward clerks, ward orderlies, receptionists and so on - and avoids any confusion between the roles of qualified nurses and support workers. I know that we are agreed on the importance of this second point. One suggestion that has been made for the title is "health care assistant" but I should be grateful for the Council's views.

11. John Moore's letter of 20 May said that "the Government accepts the proposal that there should be a move to one level of professionally qualified nurse, but this must be subject to the further work on widening the entry gate, to the successful development of vocational training ... and further consideration of the implications of these developments for the future pattern of the nursing workforce". What is needed is the establishment of a formal vocational qualification for support workers at an appropriate level within the National Vocational Qualification and the Scottish Vocational Education Council frameworks, the achievement of which would qualify them (subject to normal selection procedures) to progress to professional education and training, in line with general Government policy to encourage links and ladders between different vocational qualification levels. I hope we can reach that position with all speed as it is vital that there should be complete clarity about this, including clarity about the respective roles of qualified nurses and support workers.

12. Although there is important unfinished business here - and I acknowledge that that business is not wholly for the Council - we are prepared to move forward on the basis that we should plan for the discontinuation of Enrolled Nurse training within the next five years. Both this timetable and discontinuation itself must be dependent on satisfactory resolution of the issues set out in paragraph 8 in particular. We should like to review the position with you in say, 9 months time and at intervals thereafter. Where Project 2000 itself is implemented locally, we expect to see EN training discontinued as part of the implementation process.

13. I reiterate my predecessor's assurances that current Enrolled Nurses have a crucial and continuing role to play in the nursing workforce as a whole. The Council's decisions to allow more flexible modes of conversion to the first level will go a long way to providing opportunities for Enrolled Nurses to pursue their careers as far as their abilities take them. Moreover, the more sensitive recognition of individual skills and responsibilities through the new clinical grading structure should help to reduce the incidence of Enrolled Nurses being used in ways for which neither their training nor experience fits them. I confirm that we regard Enrolled Nurse conversion and plans for safeguarding the continued contribution of those who do not convert as an integral part of the implementation of Project 2000. I am glad to see that the number of conversion courses is fast increasing, though I am sure we should all agree that it is nowhere near sufficient yet.
14. As you will know, plans for the initial implementation of Project 2000 are well advanced throughout the UK. Inevitably, this letter has not resolved all the outstanding issues; but the process of moving to a Project 2000-style preparation for all nurses is, as you recognise, not going to be accomplished overnight. There will undoubtedly need to be modifications in the light of experience. When Tony Newton met the Council last May, he stressed the importance that the Government placed on having well educated nurses, midwives and health visitors who will be able to meet the challenges of the next century. I assure you that the commitment given by Tony Newton remains. I look forward to working closely with your Council in order to achieve a better Health Service for our nation.

15. I said at the start of this letter that I would return to the NHS Review White Paper. As you know, we are considering the future organisation and funding of NHS education and training in the light of the Review changes. I give you three assurances. First, whatever arrangements are put in place will safeguard the position of nursing, midwifery and health visiting education and training. We take very seriously our duty to ensure that the Service of the future has the skilled staff to meet its needs. Second, in undertaking this work, we will have particular regard to the need to ensure that the momentum on implementing Project 2000 is maintained. Third, the statutory bodies will be involved in the work. There have already been informal discussions and we will be seeking the bodies' formal views before reaching any conclusions.

I am sending copies of this letter to the chairmen of the four National Boards.

KENNETH CLARKE
APPENDIX III(a)

English National Board for Nursing, Midwifery and Health Visiting

The Future Pattern of Basic General Student Nurse Training/Education

Invitation to submit programmes for consideration as pilot studies

September 1984
TO: District (Chief) Nursing Officers
    Directors of Nurse Education
    Official Correspondents at Institutions
    of Further/Higher Education approved
    by the English National Board

FOR INFORMATION TO: Regional Nursing Officers
    Education Advisory Group Chairmen
    National Association of Health Authorities

THE FUTURE PATTERN OF BASIC GENERAL STUDENT NURSE TRAINING/EDUCATION

Invitation to submit programmes for consideration as pilot studies
1 Background
2 Regulations
3 Funding
4 Submissions

Appendices:
A Debate at the Board's seminar
B Nurse Training Rules 18(1), 19(1)(c)
C Nurse Training Rules 14(1)(a), 16(1)(a),(b)and(c), 17(1)(a)
D EC Directives in respect of nurses responsible for general care
E Outline submission form
F Other data available

E R D Bendall PhD MA SRN RSCN RNT
Chief Executive Officer

September 1984

COPIES ALSO TO: United Kingdom Central Council for
    Nursing, Midwifery and Health Visiting
    National Board for Nursing, Midwifery and
    Health Visiting for Scotland
    National Board for Nursing, Midwifery and
    Health Visiting for Northern Ireland
    Welsh National Board for Nursing, Midwifery
    and Health Visiting
    Department of Health and Social Security
    (Chief Nursing Officer)
    Organisations with professional membership on
    the Staff Side of the Nurses and Midwives
    Whitley Council
INVITATION TO SUBMIT PROGRAMMES
FOR CONSIDERATION AS PILOT STUDIES

The English National Board for Nursing, Midwifery and Health Visiting is aware that, in the future, patterns of health care will vary widely, both as to the location where care is given and as to the form care will take. Qualified nurses who organise and give this care will require expertise in many skills; they will need to think critically, to be adaptable, to be accountable, to use judgement and to make decisions in formulating, co-ordinating and giving the most effective care for their patients. In addition, whilst requiring an initial knowledge base in the physical and social sciences, they will need to develop the inner motivation constantly to acquire, apply and test new knowledge.

In the Board's view, present patterns of training/education do not always inculcate such skills. New methods must be devised, tested and evaluated so that final choices can be made as to patterns for the future. Pilot studies are required to provide information which can enable debate and decision.

1 BACKGROUND

1.1 At its residential seminar in January 1984, the Board debated the role and preparation of the nurse; the relevant section of the 1983/84 Annual Report, which describes this debate is appended (A).

Following this debate, several working groups were set up. One is still discussing the concept of a 'foundation' course for the future and will report to the Board early in 1985. A second group looked at the need for pilot studies to elicit information which could enable widespread debate about the future pattern of basic general nurse training.

1.2 The United Kingdom is one of a decreasing number of countries in which the basic training of nurses still takes place within the health care sector; the control of education is in the hands of the employers, whether one speaks of Health Authorities or of the DHSS, by whom the English National Board is largely funded.

Nurse training is one of the very few vocational courses in the United Kingdom still in this position; course places are (or have been until now) offered primarily to meet the immediate manpower needs of the Health District and only secondarily to meet the projected requirements for qualified staff.
Many of those who work in, or have been educated through, the further/higher education system, believe that the provision of a sound knowledge base, the development of critical thinking, the need to be in contact with a variety of attitudes and approaches and the motivation to 'find out', are more likely to be acquired in an intrinsically educational establishment than in a monotechnic institution accountable to and funded by those responsible for service.

Whilst not rejecting this, the Board believes that mastery of the craft of nursing is achieved essentially through caring for patients, providing that the nursing student can work closely with, and learn from, qualified staff who are effective, well motivated role models.

1.3 In an attempt to achieve a synthesis of these elements, the Board will approve a number of institutions to provide pilot schemes for basic general student nurse training/education on an experimental basis.

(i) Central regulations/control will be kept to a minimum to allow maximum local creativity and flexibility.

(ii) Provided all those who are involved at local level agree and provided the regulations set out subsequently in paragraph 2 are met, planners are free to submit whatever arrangements they wish.

(iii) The Board hopes to see proposals for experimentation in such areas as:

(a) the status and method of remuneration of the student;
(b) the balance and content of theory and practice;
(c) the pattern/length of clinical experience
(d) the creation of effective clinical learning environments;
(e) methods of examination/assessment;
(f) joint practice/teaching appointments.

2 REGULATIONS

2.1 The course must provide the student with the opportunities set out in Rule 18(1) of the UKCC Nurse Training Rules and must include "an examination", as described in Rule 19(1)(c). (Appended, 8)
2.2 The course must fulfil the Rules stated below and appended, (C):

Rule 14(1)(a) Length of course
Rule 16(1)(a),(b)and(c) Educational standard of entry
Rule 17(1)(a) Interruption of training

2.3 The course must fulfil the overall precepts laid down in the EC Directives in respect of nurses responsible for general care. (Appended, D)

2.4 It is not intended that the pilot scheme should be for a selected group, but that the whole of the normal intake of general student nurses should be included. If, however, it is felt that, for the purpose of evaluation, a proportion of students could be included in the pilot scheme and a proportion could continue under the present training system, details should be included in the submission.

2.5 Concurrent and final evaluation of the pilot scheme should be an integral part of the programme. At the end of three to four years, the Board will require information as to:

(i) the effect on the Health Authority in terms of cost and staffing;
(ii) attitude change in key groups during the period of the pilot scheme;
(iii) performance levels at agreed points and upon completion.
(iv) sickness, absenteeism and wastage.
(v) the effect on the educational institution, where applicable, including costs.

3 FUNDING

No extra funding will be available from the Board. The Board does, however, hope to fund a comparative evaluation. When this is complete, information will be published and wide consultation will take place prior to any final decision for change on a national basis.

4 SUBMISSIONS

4.1 The Board seeks initial competitive submissions to undertake pilot schemes for basic, general student nurse training on an experimental basis from:
(i) 'Pairs' of District Health Authorities and local institutions of further/higher education. The latter must, currently, be approved to run either an ENB course or some other professional course such as the Diploma in Nursing.

(ii) District Health Authorities alone.

At least six pilot schemes will be chosen, some from each group.

4.2 An outline submission form is appended, (E). Variants on this form are acceptable, provided similar information is included.

4.3 Outline submissions for schemes intended to start in September/October 1985 should be received by 31 January 1985. Schemes will be 'short-listed' and interviews held in February/March 1985.

Decisions will be announced by 1 April 1985.

Selected schemes should start in September/October 1985.

It is hoped that this time scale will enable a number of schemes to begin towards the end of 1985. However, consideration will be given to those who state an intent to submit by January 1985, but who do not wish to begin a scheme until 1986.
At the seminar, it was agreed first to consider the fundamental issue of the role of the nurse and preparation for that role, then to tackle specific pragmatic problems and, finally, to set a pattern for future work.

The role and preparation of the nurse, midwife or health visitor

Members and senior officers divided into six groups; each group contained individuals with differing expertise. Groups were asked to discuss first:

- What is a nurse?
- What does a nurse do?
- What should be 'basic' and what should be the 'continuance'?

Each group wrote up its conclusions and reported to the whole gathering. Secondly, the groups built on their earlier work and discussed:

- How is a nurse prepared?

Again, each group wrote up its conclusions and reported back.

Given the breadth of the remit for discussion, it was of interest to note the similarity of core concepts which emerged from the six groups. While fields of view differed, the overall panorama was shared, with the 'primary' nurse seen as a professional who is able to

(i) work independently, be accountable and be responsible for initiating his/her own actions;

(ii) work in co-operation with other colleagues, other disciplines, patients/clients and relatives;

(iii) exercise inter-personal and communication skills of teaching, advising/guiding, directing action and counselling;

(iv) exercise judgement in relation to
- (a) the allocation of resources according to the priorities needed for care;
- (b) the management of the environment in which care is given.
As to what a nurse does, there was general agreement with the concepts

(i) a nurse makes a contribution to the quality of life of his/her patient/client and offers assistance in the performance of the activities of daily living to those who do not have the necessary knowledge, strength, ability or will;

(ii) a nurse enters a contract with the patient/client and establishes a relationship. This at times, may be controlling or custodial or a guardianship; the contract varies to meet the needs of individuals, but often involves an unusual degree of intimacy, both physical and mental.

As to the 'basic' and the 'continuance', this, almost inevitably, became meshed with "how is a nurse prepared?".

It was generally agreed that, for the future, the present pattern of building one training on another so that it could, for example, take in excess of seven years to become a health visitor, should not continue. For the 'basic' element, some form of foundation course must be developed encompassing the concept of health, the common aspects of prevention of disease and the universal needs of patients/clients. On this foundation the differing elements of preparation for specific health care sectors could be built. It was stressed that a 'generic' nurse was not envisaged; simply the wish to develop a shared educational foundation on which the present different primary (basic) registration courses could build, leading to the possibility of shorter, post-registration (continuance), courses.

There was total agreement that the core of (basic) professional education is learning through caring for patients/clients. There are three stages:

(i) The competencies set out in the new rules must be acquired during a period under close, direct, supervision, with concurrent assessment and with well prepared trained nursing staff as role models/supervisors.

(ii) There should then be a period of consolidation, still under supervision.

(iii) Finally, there should be an 'intern' period, leading to independence, self-determination and registration.

Three of the six groups felt that the Board should explore the use of institutions of further/higher education to provide the theoretical base for primary nurse education. Many stressed that there is a need to explore the effects of changing the present status of the nurse learner.
With regard to the 'continuance', a useful series of definitions was provided by one group:

"The continuance enables the practitioner to develop an advanced form of contract (with the patient/client/relative), to become expert, to pass on skills to others and to contribute to the formulation of professional knowledge. There are three areas of 'continuance':

Post-basic - education into a new specialism
Further - the development of skills and knowledge in the existing specialism
Refresher - reactive/proactive responses to influences extraneous to nursing"
18(1) Courses leading to a qualification the successful completion of which shall enable an application to be made for admission to Part 1 of the register shall provide opportunities to enable the student to accept responsibility for her personal professional development and to acquire the competencies required to:

(a) advise on the promotion of health and the prevention of illness;

(b) recognise situations that may be detrimental to the health and well-being of the individual;

(c) carry out those activities involved when conducting the comprehensive assessment of a person's nursing requirements;

(d) recognise the significance of the observations made and use these to develop an initial nursing assessment;

(e) devise a plan of nursing care based on the assessment with the co-operation of the patient, to the extent that this is possible, taking into account the medical prescription;

(f) implement the planned programme of nursing care and where appropriate teach and co-ordinate other members of the caring team who may be responsible for implementing specific aspects of the nursing care;

(g) review the effectiveness of the nursing care provided, and where appropriate, initiate any action that may be required;

(h) work in a team with other nurses, and with medical and para-medical staff and social workers;

(i) undertake the management of the care of a group of patients over a period of time and organise the appropriate support services;

related to the care of the particular type of patient with whom she is likely to come in contact when registered in that Part of the register for which the student intends to qualify.

EXAMINATIONS

19(1) To qualify as a person who can apply to be registered in Part 1 of the register - the student shall

(c) have passed an examination, held or arranged by a Board which may be in parts, and which shall be designed so as to assess the student's theoretical knowledge, practical skills and attitudes and demonstrate her ability to undertake the relevant competencies specified in rule 18 of these rules.
UNITED KINGDOM CENTRAL COUNCIL TRAINING RULES
(Nurses, Midwives and Health Visitors Rules
Approval Order 1983 No 873)

14(1) The length of training for courses the successful completion of which shall enable an application to be made for admission to Part 1, of the register shall be:

(a) if taken as a first qualification, not less than three years

EDUCATIONAL REQUIREMENTS

16(1) The minimum educational conditions for entry to training leading to qualification for admission to Part 1, of the register subject to paragraph (2) of this rule shall be either:

(a) a minimum of five subjects at ordinary level A, B or C grade in the General Certificate of Education of England and Wales or Grade 1 in the Certificate of Secondary Education; or

(b) a minimum of five subjects at O Grades (Bands A, B or C) in the Scottish Certificate of Education; or

(c) the Northern Ireland Grammar School Senior Certificate of Education of five passes in the examination for that Certificate, or five subjects at A, B or C grade in the Northern Ireland General Certificate of Education at ordinary level

INTERRUPTION OF TRAINING

17(1) A student having an interruption in training of:

(a) less than twelve weeks, shall complete the outstanding period of training as specified in the appropriate section of this part of the rules
Appropriate details of -

COUNCIL DIRECTIVE

of 27 June 1977

concerning the co-ordination of provisions laid down by law, regulation or administrative action in respect of the activities of nurses responsible for general care.

(77/453/EEC)

THE COUNCIL OF THE EUROPEAN COMMUNITIES HAS ADOPTED THIS DIRECTIVE:

Whereas, with a view to achieving the mutual recognition of diplomas, certificates and other evidence of formal qualifications of nurses responsible for general care laid down in Council Directive 77/452/EEC, the comparable nature of training courses in the Member States enables co-ordination in this field to be confined to the requirement that minimum standards be observed, which then leaves the Member States freedom of organization as regards teaching.

ARTICLE 1

1. Member States shall make the award of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care as specified in Article 3 of Directive 77/452/EEC subject to passing an examination which guarantees that during his training period the person concerned has acquired:

(a) adequate knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;

(b) sufficient knowledge of the nature and ethics of the profession and of the general principles of health and nursing;

(c) adequate clinical experience; such experience, which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patients;

-(1)-
(d) the ability to participate in the practical training of health personnel and experience of working with such personnel;

(e) experience of working with members of other professions in the health sector.

2 The training referred to in paragraph 1 shall include at least:

(a) a general school education of 10 years' duration attested by a diploma, certificate or other formal qualification awarded by the competent authorities or bodies in a Member State, or a certificate resulting from a qualifying examination of an equivalent standard for entrance to a nurses' training school;

(b) full-time training, of a specifically vocational nature, which must cover the subjects of the training programme set out in the Annex to this Directive and comprise a three-year course or 4600 hours of theoretical and practical instruction.

3 Member States shall ensure that the institution training nurses is responsible for the co-ordination of theory and practice throughout the programme.

The theoretical and technical training mentioned in part A of the Annex shall be balanced and co-ordinated with the clinical training of nurses mentioned in part B of the same Annex in such a way that the knowledge and experience listed in paragraph 1 may be acquired in an adequate manner.

Clinical instruction in nursing shall take the form of supervised in-service training in hospital departments or other health services, including home nursing services, approved by the competent authorities or bodies. During this training student nurses shall participate in the activities of the departments concerned in so far as those activities contribute to their training. They shall be informed of the responsibilities of nursing care.

4 Five years at the latest after notification of this Directive and in the light of a review of the situation, the Council, acting on a proposal from the Commission, shall decide whether the provisions of paragraph 3 on the balance between theoretical and technical training on the one hand and clinical training of nurses on the other should be retained or amended.

5 Member States may grant partial exemption to persons who have undergone part of the training referred to in paragraph 2 (b) in the form of other training which is of at least equivalent standard.
ARTICLE 2

Notwithstanding the provisions of Article 1, Member States may permit part-time training under conditions approved by the competent national authorities.

The total period of part-time training may not be shorter than that of full-time training. The standard of the training may not be impaired by its part-time nature.

ARTICLE 3

This Directive shall also apply to nationals of Member States who, in accordance with Council Regulation (EEC) No 1612/58 of 15 October 1968 on freedom of movement for workers within the Community, are pursuing or will pursue, as employed persons, one of the activities referred to in Article 1 of Directive 77/452/EEC.

ARTICLE 4

1. Member States shall bring into force the measures necessary to comply with this Directive within two years of its notification and shall forthwith inform the Commission thereof.

2. Member States shall communicate to the Commission the texts of the main provisions of national law which they adopt in the field covered by this Directive.

ARTICLE 5

Where a Member State encounters major difficulties in certain fields when applying this Directive, the Commission shall examine these difficulties in conjunction with that State and shall request the opinion of the Committee of Senior Officials on Public Health set up by Decision 75/365/EEC, as amended by Decision 77/455/EEC.

Where necessary, the Commission shall submit appropriate proposals to the Council.

ARTICLE 6

This Directive is addressed to the Member States.

Done at Luxembourg, 27 June 1977

For the Council
The President
J SILKIN

-(iii)-
ANNEX

TRAINING PROGRAMME FOR NURSES RESPONSIBLE FOR
GENERAL CARE

The training leading to the award of a diploma, certificate or other formal qualification of nurses responsible for general care shall consist of the following two parts:

A Theoretical and technical instruction:

(a) Nursing:

- nature and ethics of the profession,
- general principles of health and nursing
- nursing principles in relation to:
  - general and specialist medicine,
  - general and specialist surgery,
  - child care and paediatrics,
  - maternity care,
  - mental health and psychiatry,
  - care of the old and geriatrics;

(b) Basic sciences:

- anatomy and physiology,
- pathology,
- bacteriology, virology and parasitology,
- biophysics, biochemistry and radiology,
- dietetics,
- hygiene:
  - preventive medicine,
  - health education,
- pharmacology;

-(iv)
(c) social sciences:
sociology,
psychology,
principles of administration,
principles of teaching,
social and health legislation,
legal aspects of nursing.

B Clinical instruction:
Nursing in relation to:
- general and specialist medicine,
- general and specialist surgery,
- child care and paediatrics,
- maternity care,
- mental health and psychiatry,
- care of the old and geriatrics,
- home nursing.
General Nursing Council for England and Wales

Educational Policy, June 1983
(83/13 + 83/13A)

A Statement of Educational Policy
July 1977
(77/19A + 77/19 and 77/19B)
This circular supersedes Circulars 77/19 and EX/74/9/15, and should be read in conjunction with Circulars 77/19 B - D + enclosure 83/13/A

14th June, 1983

EDUCATIONAL POLICY, June 1983

The attached Circular brings up to date the document on Educational Policy 1977 and the previously circulated Specification of Nursing Competence. The syllabuses for general and sick children's nursing remain unchanged and this document should be read therefore in conjunction with these syllabuses, and serve as a guide to discussion on curriculum development within the training school.

To:-

District Nursing Officers, Chief Administrative Nursing Officers and Directors of Nurse Education, or Senior Tutors in Charge of all training schools for the Register and Roll of Nurses

Tutors to the Courses for Teachers of Nurses

Regional Nursing Officers

Secretaries of Regional Nurse-Training Committees

(83/13)
THE GENERAL NURSING COUNCIL
FOR ENGLAND AND WALES

A STATEMENT OF POLICY RELATING TO BASIC NURSING EDUCATION
IN GENERAL AND SICK CHILDREN'S NURSING

1. PREAMBLE

1.1 The aim of this paper is to bring up to date the document on Education Policy 1977 and the previously circulated Specification of Nursing Competence. The syllabuses for general and sick children's nurse training remains unchanged; this document should be used in conjunction with these and serve as a guide to discussion on curriculum development within the training school.

1.2 Nursing education is a process concerned inter alia with providing the foundation for nursing practice. In this context the caring role, which is central to nursing practice, may be seen as working towards the physical, psychological, social and spiritual wellbeing of the patient. It encompasses all age groups of differing cultures whether well or sick and includes teaching and educating towards health.

The initial aim of nursing education is to provide for the learner an appropriate balance between theory and practice so that newly qualified nurses have the knowledge, skills and attitudes necessary to enable them to provide systematic individual patient/client-centred care. While training is concerned with the mastery of nursing skills (practised under supervision), the practice of which can be modified according to circumstances, it forms only part of the broader educational issues with which the nursing profession is concerned.

2. Nursing Education

2.1 Nursing education should enable the individual to:-

a) follow a planned educational course leading to qualification as a registered nurse;

b) acquire the knowledge, skills and values upon which sound nursing practice is based;

c) develop a disciplined pattern of learning together with an enquiring mind;

d) make an effective contribution as a member of a health care team;

e) develop and grow as a person who makes reasoned decisions about his/her life style;

f) help others make informed decisions about their life styles;

g) work as an autonomous practitioner able to assess, plan and carry out care for one patient/client or group, and modify the care as appropriate;

h) accept responsibility for her own professional and personal development.
3. **THE CURRICULUM**

'A curriculum is an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice'

(Stenhouse, L. 1975. An Introduction to Curriculum Research and Development. Heinemann)

It is important that all involved in the learning process are aware of the overall aims of the nursing course. The content of basic nursing education and training is contained in the syllabuses compiled by the statutory body. The teaching staff, the learners, and the staff of the selected areas within the hospital and community where the learner gains experience must all be involved in translating the syllabus for the course into a realistic curriculum which will form the basis of teaching, learning and assessment within each area. The curriculum therefore will state the overall aims of the course and will include, in the course plan, the objectives of the teaching and learning activities as well as the content. The content should state the knowledge to be gained, the values to be fostered and the nursing skills to be developed. The curriculum should be subject to ongoing scrutiny and change as the result of evaluation; it should reflect the changing context in which nursing is practised.

4. Changes in the structure of society, which contains an increasing number of different cultural groups, have resulted in changes in patterns of health and illness and in the needs and expectations for health care. The nurse's role as a potential innovator in meeting these needs and expectations should be recognised.

4.1 The multi-cultural nature of society means that:-

a) the need for patients and families to have adequate information, health education and their cultural and personal identity preserved, must be recognised and their differing values accepted as part of their individuality which must not be ignored or destroyed;

b) the employment of members from different ethnic groups in health care services necessitates adequate preparation of the nurse to recognise and be sensitive to the values of groups other than her own within the health care team in order to achieve effective working relationships.

These factors make it essential that learners are enabled to develop improved interpersonal skills and perceptions.

4.2 Demographic trends suggest:-

a) a continuing increase in the number of people in the older age groups resulting in a similarity of nursing experience in the 'acute' medical wards of district general hospitals and the assessment wards of geriatric hospitals, and producing a heavy workload of continuing and community care;
b) that care must be valued for its own sake and learners enabled to develop skills in maintaining prolonged relationships with patients and their relatives. New approaches to care are required in a variety of settings in co-operation with the family or other professional groups and voluntary organisations.

4.3 Social trends show:

   a) a changing balance between work and non-work, for example, leisure may alter demands on health care;

   b) an increasing emphasis on the individual's responsibility for his/her health;

   c) an increasing demand for choice in the provision of care in the community and the full integration of the health care services;

   d) an increase in violence to the self and others;

   e) an increase in the number and range of groups who will challenge systems of care;

   f) socio-economic factors which place constraints on the provision of health care and its delivery.

The nurse must be able to adapt her role, use resources effectively and accept the legal implications of her nursing practice.

4.4 Changes in nursing and medical practice require the nurse actively to be involved in:

   a) the decision making process;

   b) the resolution of ethical dilemmas based on reasoned evidence;

   c) treatment and care which may be beneficial and/or produce detrimental effects;

   d) an increased use of medical technology which may affect the nurse/patient relationship;

   e) an increasing amount of medical and nursing research.

These changes require the nurse actively to participate in the assessment, planning, implementation and evaluation of individual patient-care based on nursing research, and require the development of problem-solving and negotiating skills based on the communication and inter-personal skills developed during her basic education and training. Nursing care is but one facet of total patient-care and must be carried out in co-operation with other members of the health care team.
5. The characteristics of a satisfactory setting for learning

5.1 There must be commitment on the part of the authorities to:—

a) the provision of good health care, apparent in the confidence and interdependence of the staff and in the satisfactory provision of facilities;

b) meeting the requirements for clinical experience;

c) providing adequate teaching and supervision by appropriately qualified staff;

d) agreeing and adhering to the number of student and pupil nurses accepted for training;

e) providing opportunities for continuing professional education;

f) making adequate financial provision for the maintenance of these standards.

5.2 There is a successful partnership between education and service.

5.3 The wards and departments chosen for training must offer a good climate for learning in which:—

a) learning opportunities are identified and used by all staff concerned;

b) ward sisters and charge nurses are examiners and assessors;

c) nursing research findings are used in nursing care;

d) nurses demonstrate enthusiasm in exploring nursing knowledge and skills.

5.4 There should be a nursing education centre equipped to enable students and teachers to learn and work together.

5.5 The number of teaching staff provides an acceptable teacher/learner ratio.

6. The characteristics of a framework for the development of curricula in basic nursing education

6.1 The framework for the course shall provide fixed points for the planning of practical experiences, their related full-time study periods and holidays. Practical experience periods may need to vary in length for educational and 'logistic' reasons and there is virtue in the longer period whenever this is practicable.

6.2 Numbers in entry groups will be calculated and agreed between service and education, and according to the availability of experience and teachers.
6.3 The master design of the sequence of experience units and the placement of learners should ensure an even flow of learners in all clinical areas used for training.

6.4 The plan should be agreed by those responsible for nursing service and there should be a commitment to implement, maintain, monitor and evaluate it.

6.5 The efficient functioning of the allocation and records office is vital to the organisation of nursing education.

7. Design of curricula

The syllabus is designed to produce a safe practitioner of nursing; there are however many models of curriculum design which should reflect the opportunities and needs of the local setting.

It is recommended that schools of nursing define the aims for each course and that the concept of systematic patient/client-centred care provides a unifying thread for the study of patient care and a helpful framework for nursing practice.
SPECIFICATION OF NURSING COMPETENCE

1. OBSERVATION

Observation may be defined as an interested awareness of the total situation despite competition and distraction, combined with the ability to control and direct attention towards correctly selected specific stimuli. This always requires knowledge and training and sometimes also requires skill in using special tests or specific equipment.

Specification

a) with knowledge of specifics and training in techniques, the nurse is able to recognise that the patient is functioning and behaving within normal limits for his/her age, temperament, mood, social or cultural status, and physical and intellectual capacity.

b) with knowledge of classification, categories, trends and sequences, and with training, the nurse is able to recognise that the patient is functioning and behaving as he/she would be expected to in view of his/her present pathological or altered state.

c) with knowledge of criteria to enable discrimination and training in techniques, the nurse is aware of any change in the patient's functioning or behaviour, expected or unexpected for that patient with that pathological or altered state, thus observing signs that the patient:

- is in immediate danger/or a danger has passed
- is in potential danger/is no longer in potential danger
- is likely to come to harm/appears safe
- is likely to have discomfort/is comfortable
- is experiencing pain/free from pain
- has or is likely to have cause for apprehension/is confident
- shows ignorance/insight
- is emotionally unstable/emotionally stable
- has changed intellectual performance/usual level of intellectual performance
- is socially isolated/socially integrated
- is lacking awareness of environment/aware of environment, including self
- is dependent/independent
- has loss of self-respect/has self-respect

2. INTERPRETATION

With a knowledge of principles and generalisations, a nurse is able to put together and interrelate her observations—the interpretation of the resultant "whole" will be more valuable in assessing the patient's needs than just the sum of the discrete observations.
A knowledge of terminology and conventions enables the interpretation of a doctor's or therapist's instructions, and also enables the nurse to communicate her own interpretation of the situation.

For the nurse, interpretation may be defined as reasoned foresight or anticipation of the needs, not only of the patient, but the requirements of the total situation.

**SPECIFICATION**

A nurse is able to assess a patient's needs by interpreting:

- a) the patient's requests (spoken or unspoken)
- b) the nurse's observations (or other nurse's observations)
- c) the doctor's or therapist's instructions
- d) the potential or constraints of the environment

### 3. PLANNING

Planning may be defined as deciding upon the sequence of the programme of nursing care, both immediate and long term, and requires the ability to judge priorities, make decisions and co-ordinate and define the nursing care objectives. Observation and interpretation both precede the planning and continue after it. Any plan must have sufficient flexibility to allow for adaptation should the situation change.

**SPECIFICATION**

The nurse needs:

- a) knowledge of priorities - i.e. when medical care or nursing action is required urgently
- b) knowledge about treatment of disordered structure, function and behaviour and any assistance the nurse might give in this respect
- c) knowledge of the appropriate nursing care that will enable the nurse to assist the patient to behave within normal limits within his/her pathological or altered state
- d) knowledge of the resources required and available for the above care
- e) knowledge of the staff required and available to give this care
- f) flexibility - so that the plan can be adapted should concurrent observation and interpretation indicate the necessity for a change of plan
- g) the ability to make decisions
- h) the ability to use managerial skills
4. ACTION

Action may be defined as the putting into use of such affective, interpersonal, communication, personal care or managerial skills which will provide the appropriate patient care in a suitable therapeutic climate, in so far as other existing factors allow.

The taking of appropriate action may, in some instances, be inaction or cessation of action.

SPECIFICATION

a) the ability to use interpersonal skills to establish the necessary relationships with patient/patients, and/or their relatives, and other members of the caring team requires:—
   i) knowledge of individual differences in human behaviour and behaviour in groups
   ii) willingness to initiate and sustain relationships
   iii) willingness to be receptive to the efforts of others to initiate and sustain relationships
   iv) ability to participate effectively as a team member (including assessment of self and others)
   v) ability to exercise a controlling influence within a group (e.g. ability to re-direct non-therapeutic situations)

b) the ability to use communication skills: communication being defined as the exchange of information to enable further action. This requires:—
   i) knowledge of the language, spoken and written
   ii) awareness of national and local culture
   iii) knowledge of lay and professional language/terms
   iv) ability to utilise knowledge of environment
   v) acquisition of skill in conveying signals from patients and others in appropriate forms
   vi) ability to convert professional directions into appropriate terms

c) the ability to select, apply, use, adapt or combine the necessary skills to give the appropriate care with dexterity, accuracy, correct speed and complete safety requires:—
   i) cognitive knowledge of normal/abnormal bodily function, the possible causes of malfunction and suitable methods of preventing it
   ii) acquisition of psychomotor skills basic to the physical handling of patients and the performance of nursing procedures
   iii) a working knowledge of principles of treatment to restore or maintain an optimum level of function
   iv) knowledge of and training in the skilful use of nursing aids, apparatus or equipment, and the administration of pharmaceutical preparations
   v) knowledge of possible hazards and the ability to continue concurrent observation and interpretation, with verbal and written reporting as appropriate
   vi) knowledge of how to prevent inconvenience to others - patients, relatives, other staff and personnel of other departments
vii) knowledge of the legal, professional and ethical aspects/restrictions/responsibilities of certain actions, and how these apply to learners, trained nurses and ancillary staff

d) the ability to use organisational skills to provide the required therapeutic climate. requires:-

i) appreciation and knowledge of environment and resources

ii) acquisition of skill in making the best use of the environment and resources

5. EVALUATION

Observation and interpretation made initially to assess the patient's needs and plan the appropriate care are also to be used concurrently and finally to assess the results obtained. These should be critically analysed against the aims of nursing care. Action should only be allowed to continue or be repeated if there is full awareness of any risks involved and it is proving to be of optimum benefit to the patient. This continuing observation and interpretation requires the same knowledge, training and skills as those used in the first instance.
A Working Party to advise on future educational policy was set up in December, 1975, in the continuing absence of major decisions stemming from the Committee on Nursing's Report and the nursing directives of the European Economic Community. It was agreed that no changes could be introduced which would run counter to these major changes and neither could Council pre-empt them within its present legislative framework. It was, however, possible to suggest modifications in the syllabus documents already in use and continue to develop improvements in the practice of nursing education within present constraints. These constraints were seen to be:

a) The increasing conflict arising from the condition of the learners as employees.
b) The poor morale within the Health Service following the upheaval of reorganisation and the economic crisis.
c) The continuing inadequacy of sufficient trained staff able to give supervision during clinical experience, and the deteriorating numbers of nurse teachers.

The substance of the discussions was, therefore, divided between consideration of the setting in which nursing education is practised and the content of the syllabus for the courses preparing for registration and enrolment.

Council has now agreed that this statement of policy should be circulated to training schools for immediate guidance, until more precise details are known about the implications of the nursing directives.

1. The changing needs of society

Changes in the patterns of health and illness, and in the expectation for health care in society, must of necessity affect the preparation of the nurse. Important trends were identified:

1.1 Matters concerned with the decreasing birth-rate and changes in the patterns of care and the standard of child health necessitate review of the way in which both obstetric and 'paediatric' experiences are provided.

1.2 The rapid turnover in acute-illness hospitals, both for physical and mental illness, necessitates careful preparation for participating in an intensive therapy team; time for personal interaction with patients and their relatives becomes minimal.

1.3 The concentration of trained nurses in these areas of intensive therapy often leaves other areas seriously depleted.
1.4 The increasing number of patients in the older age groups and the similarity of experience in acute medical wards of the district general hospital and the assessment wards of geriatric hospitals produces a heavy workload of continuing care. This necessitates acceptance of the value of care for its own sake and skill in maintaining a prolonged relationship with patients and their relatives.

1.5 An increasing awareness of patients and their families, of their need for adequate information and health education necessitates the development of improved skills in responding to this need by medical and nursing staff.

1.6 The trend towards increasing provision of care in the community and the full integration of the health care services poses serious logistic problems for nurse educators. There are at present only 9% of nurses in the National Health Service employed in the community services and the provision of a long period of experience in community nursing for all learners is seen to be very difficult. This aspect of nursing education needs to be re-examined.

2. The characteristics of a satisfactory learning/training setting

The institution in which training takes place has an incalculable effect: learning which takes place in the day-to-day experience of living constitutes the 'hidden curriculum', and in this context the criteria on which training schools are approved are re-stated:

2.1 The commitment of the health authority to the provision of good care, apparent in the confidence and interdependence of the staff and in the satisfactory provision of facilities.

2.2 That the requirements for clinical experience can be met.

2.3 That the number of student and pupil nurses to be accepted for training is agreed and adhered to.

2.4 That the number of trained staff is sufficient to provide adequate supervision in the different care areas.

2.5 That the wards and departments chosen for training offer a good climate for learning: i.e. demonstrate a professional enthusiasm to share nursing expertise and to extend the boundaries of nursing knowledge and skills, e.g.:-

a) Opportunities are given for continuing professional education.

b) Ward sisters are keen to become G.N.C. examiners and assessors.

c) Learning objectives and opportunities are identified and written worksheets are available for student and pupil nurses.
2.6. There is full provision for the courses to be organised from a school of nursing building(s) equipped to enable learners and teachers to work effectively.

2.7. That the number of teaching staff provides an acceptable teacher/learner ratio - 1:25 is present policy, aiming towards a ratio of 1:15.

In the absence of national guidelines it has not been possible to offer definitive figures other than the crude one third of trained staff, one third of learners and one third of nursing auxiliary support for the balance within nursing service numbers. Knowledge and expertise in manpower planning is developing and Council's inspectors should expect to have this type of information when visiting training schools. It has now been agreed that information about the learner 'establishment' should be sought in the bi-annual review of teaching staff establishments in education divisions. It is also suggested that, as statistics from the developing personnel departments become available, indicators of morale, such as attrition, sickness and absence rates should be made available for groups of learners and also for the different hospitals within a school of nursing.

3. The characteristics of a framework for the development of curricula in basic nursing education

There are practices and behaviours within a Health District or Area which are indicators of attitudes to care and to standards of work and these may affect the learners profoundly. It is also evident that the presentation of a satisfactory programme for the curriculum, which is explicit in its sequence of learning units and which enables full integration of theory and practice, signifies the trainee role and provides the framework for the course content.

3.1. It should provide the fixed points for the planning of practical experiences, their related full-time study periods and holidays. Practical experience periods may need to vary in length for educational and 'logistic' reasons and there may be virtue in the longer period whenever this is practicable, the usual length being from 8-12 weeks duration.

3.2. Numbers in entry groups will be calculated according to the agreed 'establishment' and the availability of experience. The intake groups should be equal in number during the year and may occur:

- Twice
- Three times a year
- Four times
- or even more often

A reasonably economic number should be taken in at a time.

3.3. The master design of the sequence of experience units and the placement of learners should be carefully tested for its effectiveness in ensuring an even flow of learners in all clinical areas used for training over the whole course - dovetailing with the previous group and the succeeding group of learners. The plan should be fully studied by those responsible for nursing service and for nursing education and there should be a high degree of commitment to implement, maintain and monitor it and later undertake its evaluation.
3.4 The efficient functioning of the allocation/placement and records office is crucial to the organisation of curricula for nursing education and training.

4. Design of curricula

It is recommended that schools of nursing define the overall aims for each course and it is suggested that the concept of the nursing process provides a unifying thread for the study of patient care and a helpful framework of nursing practice. The aims should be defined in behavioural terms and be clearly understood by all involved in the teaching/learning process. Previous statements published by the Council might provide useful guides, e.g. the profile of professional responsibility drawn up in connection with the nursing directives for the E.S.C. (general nursing). This was described as having nine component abilities:

To be able to:
- observe the patient in his environment;
- assess and state his needs;
- instigate action if required;
- seek assistance if required;
- interpret and carry out prescriptions and report on the results;
- communicate with patients’ relatives and colleagues;
- organise and teach other nurses in the health team;
- assess critically and evaluate her own work and that of her colleagues.

Until there is much more clarity concerning the respective roles of registered and enrolled nurses there is a continuing reluctance to define specific training outcomes for the two levels of training.

Improvements in the design of the total curriculum for the courses and especially for sound plans for practical experience placements are crucial for the achievement of integrating the learning process. Suggestions are made to illustrate the need to draw up statements of learning objectives for each experience - which should then become the basis of measuring progress and achievement.

Despite the acceleration of the programme for preparing nurse teachers, numbers are likely to be in short supply for some time yet. Opportunities should be built into curriculum plans for nurse teachers to develop their style and expertise in teaching, especially in enabling the learning process by a variety of methods; most nurse teachers should have a close involvement with some part of the practice setting.
THE GENERAL NURSING COUNCIL FOR ENGLAND AND WALES

SYLLABUS AND PRACTICAL EXPERIENCES REQUIRED FOR ADMISSION TO THE GENERAL PART OF THE REGISTER

Syllabus

There is an extension of the study of social, cultural and economic factors which influence the promotion of health, the incidence of disease and health care provision in society.

The section Preparation for Management is now entitled Preparation for Professional Responsibility and has been widened to emphasise the need for nurses to develop skills in the effective instruction and education of patients and their families in self-care as well as in the skills of communication and organisation needed for the nursing management of a group of patients. An introduction to the study of personnel procedures in the light of recent industrial legislation is also added. Attention is drawn to the nurse’s responsibility for the advancement of nursing practice by an introduction to the appreciation of nursing research.

Practical experience

There are changes recommended in order to meet the expected requirements of the nursing directives for the E.E.C.

Records of experience

The syllabus documents will be printed without the pages for the record of practical experience. Training schools will be required to draw up written statements of learning objectives and opportunities for each clinical experience area. It is considered that these are more effective tools for learning and for assessing achievement than the format of the present records.

Teaching time

There is no change in present requirements until the details of the nursing directives are known.
I. Principles and practice of nursing, including First Aid

Introduction

Outline of the history of nursing as a background to the present day.
Outline of the Health Service.
The Health Area/district: its hospital and community services and relationship with social services.
Personal qualities, beliefs and attitudes of the nurse.
Code of professional practice.
Relationship between the nurse, patients and relatives.
The place of the nurse in the hospital team, relationship with medical staff and other health workers.

General care of the ward unit

Plan of patients' day.
Organisation of ward routine.
Ventilation, heating and lighting.
Reduction of noise.
Cleanliness of the ward as it affects the safety and comfort of patients.
Prevention of spread of infection.
Care of linen; disposal of soiled and infected linen.
Storage and custody of drugs.
Storage and preparation of lotions and poisonous substances.
Care and use of equipment.
Care and storage of food.
Fire precautions.

General care of patients and nursing procedures

Reception, identification and admission of patients.
Reception of relatives.
Transfer and discharge of patients.
Recording of necessary particulars.
Care of patients' clothing and property.
Observing and reporting on the general condition and behaviour of patients.
Responsibility for the general cleanliness and hygiene of patients.
Bed and cot making with modification of method for special conditions.
Methods of warming the bed.
Moving and lifting patients, helping patients to get in and out of bed.
Relief of pressure and prevention of skin abrasions.
Care of patients confined to bed.
Bathing and feeding of infants.
Care of ambulant patients.
Serving meals and feeding patients.
Measuring and recording fluid intake and output.
Taking and charting the temperature, pulse, respiration and blood pressure.
Recording weight and height.
Giving and receiving reports.
Observing and reporting on sputum, vomit, urine and faeces.
Disposal and/or disinfection of sputum, vomit, urine and faeces.
Care of infested patients.
Care of patients requiring isolation.
Care of incontinent patients and prevention of incontinence.
Care of patients in plaster or on traction.
Care of unconscious patients.
Care of paralysed patients.
Care of the dying and of the bereaved.
Last offices.
Care of patients before and after anaesthesia.
General pre- and post-operative nursing care.
Principles of asepsis, sterilisation and disinfection.
Aseptic technique.
Conduct of surgical dressings and other sterile procedures.
Methods of securing dressings.
Methods of disposal of soiled dressings.
Administration of oxygen and other inhalations.
Nursing of patients requiring assisted respiration.
Intravenous, subcutaneous and other parenteral infusions.
Artificial feeding.
Peritoneal dialysis.
Gastric aspiration and washout.
Preparation and administration of enemas and suppositories; passing of a flatus tube; rectal washout.
Vaginal irrigation; perineal care; insertion of pessaries.
Catheterization, irrigation and drainage of urinary bladder.
Treatment of eye; bathing; irrigation; instillation of drops; application of ointments and dressings.
Treatment of the ear; swabbing; instillation of drops; insufflation; syringing; application of ointments and dressings.
Treatment of the mouth, nose and antra.
Uses and application of heat, cold, medicated preparations.
Care of patients with pyrexia and hypothermia.
Principles and methods of treatment by baths and sponging.

**Human behaviour in relation to illness**

Preparation of patients for coming to hospital as in-patients or out-patients.
Effects on patients and their relatives of coming to hospital.
The nurse-patient relationship.
The nurse-relative relationship.
Visiting of patients in hospital.
Family participation in care.
Relationship between emotional states and physical conditions.
Death and bereavement.

**Administration and storage of drugs**

Requirements under current legislation.
Weights and measures.
Rules for the storage of drugs.
Rules for and methods of administration of drugs.
Tests and investigations

Collection of specimens of sputum, vomit, urine, faeces and discharges.

Urine Testing.
Preparation and care of patients and preparation of apparatus for:-

a) examination of ear, eye, nose, mouth, throat; of respiratory, alimentary, urinary and genital tracts; neurological examination; x-ray examinations.

b) procedures including the examination of body fluids, gastric analysis, renal and liver efficiency tests, investigation of endocrine activity; biopsies, venepuncture; lumbar puncture; cisternal puncture; bone marrow puncture; aspiration of the pleural cavity and drainage of the peritoneal cavity.

Nursing care in the operating theatre

Observation and care of patients during anaesthesia and immediate after care.
Safe care of the patient in the operating theatre.

First aid and treatment in emergencies

Aims and principles of first aid treatment.
Improvisation of equipment.
Methods of moving and carrying injured persons.
Resuscitation.
Haemorrhage.
Shock.
Asphyxia.
Fractures.
Bites and stings.
Burns and scalds.
Poisoning.
Fits.

Emergencies, e.g. fire and accidents in the ward.

Preparation for professional responsibility

Skills of communication, organisation of care and the elementary principles and skills of learning and teaching.
An introduction to personnel policies and employment legislation.
Appreciation of nursing research.

II. Study of man and his environment

Normal growth and development of the human individual, physical and mental.
General structure of the body in relation to function; how the body works.
The skeleton and its functions. How joints and muscles function.
Exercise, fatigue, relaxation and recreation.
Need for oxygen and supply to the tissues.
Basic dietary requirements; the use of food and fluid.
The circulation of the blood; the functions of lymph and tissue fluid.
Heat regulation; clothing.
Elimination of waste products.
Reproduction.
Control of activity by the nervous system and hormones; rest and sleep.
The appreciation of environment; the senses of sight, hearing, smell, taste and touch.
Development of mind and personality.
The basis of health.
Family relationships and security. Social and cultural influences on the development of the individual during infancy and pre-school years. The importance of play and leisure activities.
Social development at school, during puberty and adolescence, at work, in courtship, marriage and parenthood. How communities are formed.
Differences in urban and rural life. Personal and interpersonal behaviour in groups. Influences of group membership in social and institutional life.
Maturity. Re-adjustments needed in middle age and old age.
Effect of the environment on health.
Provision of a safe environment.
Personal responsibilities for health.

III. The nature and causes of ill-health, principles of prevention; nursing care and treatment of sick people

The nature and causes of ill-health

The following headings set out in the broadest terms an approach to the study of the nature and causes of ill-health and can be applied to the study of all types of conditions general and specialised, affecting all age groups.

Congenital abnormalities, inherited and acquired, physical and mental.
Nutritional disorders; deficiencies or excesses in diet; failure in absorption.
Metabolic and endocrine dysfunction.
The inflammatory response; local and general effects.
Infections: types of organisms; pathways of spread; specific infections.
Immunology.
Allergy: auto-immune phenomena.
Trauma: types of injury including non-accidental and self-inflicted; processes of healing.
Poisoning and self-poisoning.
Degenerative conditions.
Conditions of undetermined cause.
The promotion and maintenance of health

Factors contributing to the maintenance of health, including health education.

Personnel contributing to the maintenance of health and co-ordination of the health care and other services.

Factors contributing to the breakdown in health.

The influence of the patient's cultural, home and economic background in the prevention of ill-health and as an associated cause of disease.

Nursing care and treatment of sick people

The nursing care of patients should be studied and practised in the sequence of the nursing process:

Observation of the patient in his total environment.

Assessment of need.

Making a plan of care.

Giving care.

Evaluating the effectiveness/suitability of care.

Ability to interpret the observations made, to understand the significance of disturbed function and to know the pattern of defined diseases and the patient's response to treatment will be part of the equipment needed to carry out the nursing process intelligently. The following headings may be useful in this context, applied to any condition from which the patient may be suffering:

Relevant knowledge of normal function and structure.

Causes of the disease.

Symptoms and well-known signs.

Reasons for and methods of investigation.

Normal course of illness; possible complications.

Medical treatment.

Social aspects; convalescence and rehabilitation.
Definition of overall aims and learning objectives for the course

When defining the overall aims and the learning objectives for the course it will be important to identify the common core of the curriculum and the expected outcomes of the whole course: the synthesis of nursing knowledge, nursing skills and the body of beliefs and values which support a code of professional practice. The stages of the nursing process, as described by Professor Jean McFarlane, and others, is helpful in offering a theoretical framework for practice.

The use of this method commits all concerned in the various caring/learning situations to a shared approach and a common purpose.

Practical experiences

The majority of experiences will be gained in hospital, and steps should be taken to include some aspects of community care by arranging experience in community/home nursing preferably by incorporating suitable placements to enable the students to study home and hospital care in one or more of the other periods of experience, e.g. during the study of the care of children or the care of the elderly. The aim should be to provide a minimum of 60 hours excluding any specific teaching sessions but including 'on-the-job' teaching.

In selecting the areas for inclusion and building those up into a curriculum it should be possible to ensure that student nurses have the opportunity to learn the following aspects of care:-

Initial care in illness: planned and emergency admission to hospital.

High and medium dependency care.

Preparation for self-care, following discharge from hospital.

Continuing care for patients with long term disability or recurrent illness necessitating re-admission to hospital.

Care of the dying and the bereaved.

The course should include experience of nursing people of all age groups and, although participation in a primary care team may be difficult to arrange, promotion of health and preventative care should be emphasised wherever relevant in all areas of practice.

Specific units of experience should be arranged as follows:-

Care of acute and long-term physically ill patients in 'medical' and 'surgical' wards, including accident/emergency nursing and operating theatre experience.

Care of mentally ill or mentally handicapped people.

Maternity care and care of the newborn (by means of an obstetric nursing course, jointly approved with the Central Midwives Board).

Child welfare and care of sick children.

Welfare of elderly people and care of the elderly sick.
These experiences are already included in the present requirements but with geriatric or mental/mental subnormality nursing and obstetric or community nursing as alternatives. It is expected that the nursing directives for countries within the European Economic Community will require the nurse qualified in general nursing to have had learning experiences in all four of these areas during her basic training.

Although there will be a period of two years following signature of agreement to the directives before member countries must conform, it is advisable that training schools begin to work towards the provision of these experiences — especially if new curricula are now being designed.

**Night duty**

The Council believes that experience of care at night is an integral part of training but since the total time for practical experience has been reduced by increased holiday allowances, the time spent on night duty should be:

- **Minimum** - 8 weeks (320 hours)
- **Maximum** - 24 weeks (960 hours) in three year training

**Specific aims and objectives for each experience**

Specific statements of general aims and learning objectives will need to be defined for each period of experience. The following two examples are given to illustrate the possibility of including care at home and in hospital in one experience:

1. **Welfare of children and care of sick children**

   **General aims**

   To introduce the learner to an overall concept of child care.

   **At the end of the experience** the students should be competent to:

   1. Demonstrate recognition of the special needs of children in relation to their physical, social, mental and emotional development.
   2. Recognise and respect the part played by parents/substitutes in the care of a child.
   3. Participate in providing an environment in which the child is safe, is enabled to play and make social contacts.
   4. Demonstrate the ability to assess and satisfy the needs of children for:
      - food
      - hydration
      - excretion
      - rest
      - cleanliness
      - suitable clothing
      - confort
      - play

   Make and record accurately observations of the child and, where necessary, take appropriate action.

   Devise and carry out a programme of management for a child:
   1. admitted in an emergency.
   2. whose admission is planned.
Recognise and accept her own emotions concerning such matters as death of a child, congenital malformations.

Demonstrate competence to provide comfort for the distressed child and parents.

This is achieved by:

a) some 'formal' teaching prior to and during the practical experience which should include discussion of developmental milestones and what needs to be observed in children (well and sick);

b) A period of experience which might consist of:

   - Eight weeks in a ward.
   - Four weeks in a ward and four weeks in any other centre where children are cared for in groups, e.g. nurseries, where the local situation allows.
   - Six weeks in a ward and a two-week programme of visits, e.g. health visitor clinics, assessment centres, nurseries; up to one week might be arranged in two places or a varied programme.

It is important for the sake of the children, as well as the learners and other members of staff, that there is not too much fragmentation of the period.

Although experience in the care of a wide age range might be desirable, the provision of this should not assume excessive importance.

More detailed objectives should be worked out at practical work level and methods devised to assess the achievement of these.

2. Welfare of elderly people and care of the elderly sick

At the end of the experience the students should be competent to:

Demonstrate an awareness of the normal manifestations of ageing and to recognise deviations from health in the elderly.

Promote the maximum degree of dignity for elderly people by recognising the value of their experience in life and by encouraging them to maintain independence in as familiar a social environment as possible.

Recognise, support and complement the part played by relatives in the care of the elderly.

Practise the nursing care of elderly patients during acute phases of illness, programmes of rehabilitation and long-term care.
This experience should be gained in a ward or a unit designed for elderly patients who are in the care of a physician specialising in this area of work. Alternatively, depending on local policies for the care of geriatric patients, wards where a high proportion of the patients are elderly might be used. It may be possible to plan a unit of experience which includes observation or participation in a day hospital/day centre and in the community nursing and social services for the elderly to give an overall view of the different aspects of care, e.g.:

a) Admission to hospital and assessment of the elderly person's physical, mental and social needs.
b) Medical and nursing care during acute illness.
c) Rehabilitative care.
d) Long-term and terminal care.

3. Accident and emergency nursing

There are difficulties in some training schools arising from the requirement for an experience in accident/emergency nursing. The general aims of the experience are that, at the end of the experience, the student should be competent to:

Assess and manage the care of patients in an accident/emergency situation.

Participate effectively in life-saving measures.

Demonstrate competence in clinical nursing and administrative procedures concerned with the admission and treatment of an acutely ill patient.

Be perceptive of changes in the condition of patients awaiting and receiving treatment, and be able to respond to such need.

Carry out nursing procedures and treatments for patients after less serious accidents.

Know the procedures for the discharge of patients able to return to their own homes after treatment in the department, to ensure that care is continued where necessary by the patient's relatives or by health care and/or other personnel, and to liaise, if needed, with other public services, e.g. the police.

If sufficient training places are not available in the accident/emergency department, a unit of experience should be planned in one or both of the following:

A ward designated for the care of patients following accidents.

A high dependency unit, such as an intensive care or coronary care unit.

Detailed learning objectives will be different depending upon the clinical area concerned, but the general aims for the experience should be met.
Experience/observation in the operating theatre and care of the post-anaesthetic patient

It is the policy in many hospitals now for the patients to be supervised during the post-anaesthetic recovery phase following surgery in a recovery unit, often part of the operating theatre suite. Where this is so, students should have a programme of participative experience as well as the period of experience/observation in the operating theatre.

The general aims of these experiences are that, at the end of them, the student should be able to:

- Have had opportunity to observe the continuity of care in the anaesthetic room, operating theatre and recovery room.
- Demonstrate an awareness of the procedures ensuring safety for the patients undergoing surgery:
  - the nurse's role in the maintenance of vital processes for the unconscious patient;
  - the discipline of aseptic techniques;
  - positioning patients to prevent damage to skin and underlying structures;
  - checking of all drugs, including gases and infusion fluids.
- Have observed the significance of team work in achieving high standards of safe and efficient practice.
- Further her knowledge about the post-operative needs of patients by observing surgical procedures.
- Be stimulated to acquire the further knowledge and skills needed to become an operating theatre nurse at post-registration level.

The minimum length of this combined programme should be:

- Two weeks' observation period in the anaesthetic room and operating theatre.
- One week's experience in the recovery room.

5. Mental Nursing

General aims for a period of experience in mental nursing (re-printed from G.N.C. Circular 74/8/18).

General aims

To enable the general nurse to take responsibility for maintaining a good relationship with all patients, by deepening her knowledge of common psychological needs and individual differences.
To teach the general nurse some of the skills needed to deal with emergency situations arising from mental disorder.

To promote a greater understanding of the patient admitted to a general hospital for physical treatment of a condition associated with a mental disorder, e.g. attempted suicide, psychosomatic illness, thus enabling the general nurse to modify her behaviour and attitudes to these patients.

To enable the general nurse to know when to seek expert guidance, by teaching her to recognise signs of mental disorder in patients admitted for treatment with physical conditions not necessarily associated with an abnormal mental state.

An increasing number of psychiatric units in general hospitals have been approved for training and the Education and Mental Nurses Committees have reviewed the position whereby some schemes are based on mental hospitals or units which can provide both short and long stay experience and some are based on acute psychiatric units with long stay experience gained in a day hospital or by secondment to a mental hospital for six weeks.

It is now agreed that the period of mental nursing experience can be more flexible. Providing the course is planned to meet the above aims, the period can vary between 8-12 weeks and could be spent in one clinical area. Night duty should not be included. As a general principle only when the period remains at 12 weeks should it be divided between two different types of ward.
Content Analysis : Categorisation
## Content Analysis: Categorisation

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Adapted after discussion following peer review

Category 1. Philosophy of nursing to precede models and theories in the title.

Category 6. Staff development included in title in addition to staff preparation.
APPENDIX V

Course Evaluation Model
Pilot F

Schematic representation of the Total Curriculum and Monitoring Team
Pilot D
Course Evaluation Model

Course Rationale, Philosophy and Aims

Teachers/students backgrounds experiences, expectations

Practical Curriculum
- intentions
- expectations
- standards
- Outcomes
- Observations
- Experiences

Theoretical Curriculum
- intentions
- expectations
- standards
- Outcomes
- Observations
- Experiences

Hidden Curriculum
- intentions
- expectations
- standards
- Outcomes:
  - Values
  - Attitudes
  - Opinions

Judgements/Decisions re. Curriculum

APPENDIX VI

Transcripts of Interviews, examples from interviews.
Transcript of Interview with a Ward Sister - Mentor - in the Second Year of the Scheme

Q. Would you tell me about the pilot scheme, and your experience of it?

A. Well, I am a ward sister with a five-day ward - I was used to the mentor scheme and the evaluation of trainees before the pilot scheme began. I felt defensive - it - the pilot - was totally new, and it was nerve-racking before that when I had to fill in the student's form. I was a new sister - and from elsewhere - I needed to know how to do it. And then we had ward audit - I worked out my evaluation of the ward during the student's stay. Then I met the Nursing Officer and the Tutor and we talked about it.

Q. What do students enjoy in your ward?

A. Well - its different - we have swapped to a five-day ward - previously it was a very busy women's surgical ward - the students enjoyed that although it was stressful with a very heavy workload. Now we have a five-day ward, with a longer allocation so the students can get to know the ward and the routine, and the team. But the disadvantage is that it's similar surgery, repetitive, with less variety. During that time, though, the student becomes a very valuable team member - good at basic surgical nursing. The morning is very busy, then we have a more relaxed afternoon and students find it very helpful - we can teach and supervise. There
are a lot of special investigations - we have all the surgeons with different schools of thought.

Q. What is your view of the pilot scheme after eighteen months?

A. It’s changing all the time - as students evaluate it, and feed it back. I am the surgical representative on the curriculum management team and it’s difficult for me to keep track of change. Ward sisters find it very difficult - the psychology and sociology - they find it threatening. The students are more open, happy to chat with patients, they find the time, and they get information out of patients that I could never do - it’s excellent. Some of the first warders we have had - they have gained so much information about patients' needs.

Q. Do they take a nursing history? Do the paperwork?

A. Yes - in a five-day ward we have 16 or 17 admissions on Monday morning - everybody takes histories!

Q. Do you observe changes in the student during the allocation?

A. Oh yes. they are all uncertain at first - but they learn - and they learn to assert themselves.

Q. Do you, or the staff nurses assess their progress?

A. The documentation for continuous assessment analysis takes a good hour.
We have to go right away from the ward work. The mentors get to know the students very well — much better by the staff nurses than sister! The only difficulty on my ward is there are only three trained staff, and either five or six students. So I "mentor" two students. We cannot really do with more than six students at one time.

The mentors assess — and when we have "second warders" the students do three weeks night duty, and there are regular part-time night staff nurses always there to supervise and teach.

Q. How does the course committee work?

A. I only go to meetings when surgical nursing is concerned — the Committee meets every other month.

Q. Who is on it?

A. Mostly tutors and clinical teachers and representatives from surgical or medical words in both the hospitals.

Q. Does the committee take action?

A. Reviewing the students' evaluations of the school teaching and its relevance to the wards. Documentation and the staff views of booklets — I learn a lot about what is going on. The tutor visits the ward — we have good liaison.

Q. There were two schemes running — students, I mean, how do they
react?

A. At first the old students felt threatened by the new students - and they seemed to have more supervision. After about a year - it's O.K.

Q. And the medical staff - do they comment on what is happening?

A. Quite honestly I do not think they notice - or comment anyway. They see the care plans and the goal setting - but there are no difficulties.

Q. Do you have staff development programmes?

A. There is a course for newly qualified staff nurses - in teaching and assessing and the O.U. nursing process pack. My two (staff nurses) are not on the course - they have been qualified for some time. We have a very stable team - one is eighteen months since qualifying, one has been with me a year. And I have a part-time staff nurse for four hours on four days each week. She did a Back to Nursing Course - a mature woman, after a break of sixteen years. She took time to settle - and there was no yardstick to assess her progress - the students found she was learning with them at first - and I think she found them a bit of a threat, but after twelve months they use her as a mother figure.

Q. Are the students stressed?
A. They seem better prepared to cope - they are taught to question and to call for help - if not happy with something they will come and tell you. It's very difficult to be a mentor and run the ward, some sisters are not mentors because of that, but it's easier with a five-day ward because I'm there every day - except for holidays - and I can plan the duty rota so that mentors are with their students four days out of five.

Q. Does your Nursing Office comment on the scheme?

A. She is very happy with it - scrutinises the off-duty - she works in the wards too - makes it a priority in her work.

Q. Are there any disadvantages?

A. Well - yes - the long allocation - sometimes seems too long. Some students find the work very repetitive - it's a long time if the "match" with the mentor is not - easy like. The workload can be disheartening.

Q. What is your view of P.2000?

A. Nursing is in need of a change - students ought to be supernumerary
Transcript of Interview with a Mentor in the Second Year of the Scheme

Mentor The students are in the second year - they do one week internal rotation night duty - they are keen to learn, we do expect more than they are capable of - but we are getting used to it now.

Q. How did you become a mentor?

A. All staff on the unit are expected to do it as part of our staff nurse responsibilities. As the Senior Staff Nurse I get less students because I have to act up for sister more often. I tend to have a third year (student) so that she can see what I am doing - she is then learning managerial skills and may act as team leader for a group of patients with a state-enrolled nurse or a junior student. I work less with the second year students who need to learn and to be shown basic or technical skills - like taking a drain out - as I am constantly being called away or interrupted, because on all my shifts I act up for sister.

Q. You obviously enjoy being a staff nurse - how long have you been one?

A. Three years. On the whole I enjoy it - I don't think anyone can say they enjoy any job every minute of the day!

Q. Do you enjoy being a mentor?
A. Yes - given a named student makes you feel more responsible to
them. You related more to them - those particular students,
you make sure they have seen and done something. I feel the
students are a little bit disappointed with the system because
it has to be a compromise - because of covering the ward and
having a suitable skill-mix on duty - patients' needs take
priority over students. You feel you are not doing justice to
the students - but patients' needs do come first.

Q. What preparation did you have to become a mentor?

A. I went to a workshop when the pilot scheme began. There were
circulars from the school and meetings to voice misgivings -
then we had sessions in the school about the students'
evaluations - I couldn't go but the other ward staff went and
fed back the information - they felt it quite valuable.

Q. What does your ward sister think about the pilot scheme?

A. Um - pause - well, I think she had certain misgivings
initially, wondering what the situation was going to bring but
I feel from what she has said that she feels the students have
the same problems as with most ....

Q. And what about the orthopaedic surgeons?

A. I would not really think they would know the difference
between the pilot scheme students and the ones we get which
are not. They do not teach a great deal. If students can join the ward round some consultants are very good and they point out some things and explain things, which is better for the third year. Some junior medical staff are very helpful - some very difficult - the housemen change over and they rely on the nursing staff for what they do not know. Therefore, they rely on the staff nurse rather than the students - I think some registrars are quite good at teaching.

Q. Do you have ward tutorials or teaching sessions?

A. As regards formal ward teaching sessions if we are slack - but the majority is done one to one, by example. From the school, they come over and do a teaching session - I'm not quite sure if its every week, or every other, but on a regular basis.

Q. Did you have an increase in staff for the pilot scheme?

A. Well - we did have an increase in staff nurses, but it's difficult to point the cause as the ward has moved from one hospital to another and expanded - with another consultant. We are a major accident centre, for all except head injuries, we do nurse spinal injuries and cervical fractures unless there is neurological involvement.

Q. Have you any other views about the pilot scheme?
A. On the whole - it's a good thing to have a review of nurse training. I trained elsewhere, and I've had experience also (in a teaching hospital) but there are a lot of attitudes that take a long time to die... Having been to a purely "academic" college as a student (H.N.D.) I think you are "bred up" on a lot of tradition and prejudices. When I've spoken to students I have said, I appreciate it's very difficult to strike the balance between being assertive and just plain "bolshie" and where the difference lies I'm not always sure myself ...(laughter). Today we were discussing a lot of the feedback from students and there was very much the attitude - they are too relaxed and too informal in the school. But I found it so rigid when I trained that I cannot feel that way. There is a certain element, too, from mentors that 'students expect to be spoon fed' but I have not found it that way myself.

Q. You have a higher national diploma - is that the way nursing education might go, in your opinion?

A. I've often thought so - it was a very practical course on an academic level - there should be a way around - a system of one year college, one year experience, one year college. I certainly do not agree that any practical experience in nursing by going into observe during academic hours is enough - you have to work on the job in a team. Nursing is a very stressful occupation - the team gives support. I mean - I have been three years as a staff nurse, therefore I am confident - but its tiring, both physically and emotionally.
Transcript of Interview with a Mentor in the Third Year of the Scheme

Mentor It's difficult to be a mentor when you are in charge of the ward - you cannot be with the student for a shift. We try to plan the rota for me to have two shifts a week with a student - but I alternate with sister - so we are always opposite. I can get clinical advice from the sister in the opposite ward or the person in charge of the acute unit - but I cannot really keep an eye on a student.

Q. How were you chosen to be a mentor?

A. Well - I wanted to - and I'm doing the 998 course now - it's one day, then three separate weeks and then one day summarising it all. I am enjoying it - the gaps between allow for inter-block work.

Q. Are the pilot scheme students any different from conventional students - or are they the same?

A. They seem to be far more confident than they ever were - on the whole - it's difficult for us to adjust to them - coming on to the wards after being in training for a year - but not knowing a lot practically - we have to keep reminding ourselves.

Q. What sort of things do they find difficult?
A. It's the little things - I mean, first of all, handling a patient - odd things like working until 9.30pm - it's daunting for them!

Q. Do they have experience of a late shift before the allocation?

A. Yes - a couple of days just before - a couple of days - an 'early' and a 'late' (shift).

Q. Do you think it's a bit like it was at the end of the 8 weeks Introductory Course?

A. Yes - only more so - they are more knowledgeable in sociology and psychology than we were...

Q. Do you think that helps them?

A. Yes, I think it does - they are quite good at talking to patients - they usually manage to get a good rapport from (sic) them ....

Q. How many students do you have as "fledglings" and how do you cope with their inexperience?

A. I have one or two in their first ward. I try to work with them and think how I felt in the first ward - then I have students in their last ward - in the middle they do night duty.
Q. Do you have the same students in their first and third year?

A. I may do — in women’s surgical — some go to men’s surgical. I find that older students are no problem — the patients almost prefer them — because they’ve had experience — the care plans I need to go over it until they feel confident — they do not do them in the first ward. We have a handover around lunchtime between the early and late shift — students are encouraged to participate — but the office is very small — it’s a squash!

Q. How do you think P.2000 will affect the pilot?

A. I don’t know — this pilot is working towards a new system — if it carries on to P.2000 as it is at the moment it will be all right — it’s gone through little changes already and students find that — quite — sort of well not exactly disturbing, but it’s quite hard when two sets behind them have variations. I think the students are — well — over protected in the first year, and there isn’t enough contact with tutors later — if the tutors had more time they could visit the ward more often.

Q. The student’s contract learning in the second year, are the tutors involved with that in the ward?

A. Yes, they are — but the student’s study days are not in the ward, it still seems separate instead of working together — the main drawback could be overcome if — well — by tutors
being in the ward more often - the ratios are not right.

Q. Are the pilot students ready for staff nurse experience in your opinion? For the change in role and status?

A. It's quite frightening at first anyway - a belt - a uniform - a label. It's the ward management they find most frightening. They are confident and capable with patients - carrying out nursing care - but it's the discharge arrangements, having to arrange district nursing, for example.

Q. But they have community experience - as you had ???

A. Well - one week with a district nurse and one week with a health visitor, which we had - and their visits - "going out" makes one more appreciative of needs - like dressings and little things important to patients - but it does not make one any more knowledgeable about how to arrange things - how to do it - to make the arrangements.
Transcript of Interview with a Nursing Lecturer in a Polytechnic in the Second Year

Q. Would you explain what you do in the pilot scheme?

A. I'm a lecturer in the diploma and degree courses in nursing, and I have been involved in the pilot scheme for the past eighteen months. I am involved in interviewing candidates, and teaching in the pilot scheme.

Q. The submission discusses the joint collaboration - is that your view, and what are the assisters and obstacles - as Allen (1987) suggests?

A. There is great goodwill and commitment, I moved to this post because of it, many feel similarly. There is a willingness to learn and share with each other. It really is a collaborative exercise - although at first (as a member of the validation committee I was external to the course) - there were obstacles because the structures of the two organisations are so different - so very different, and the more obvious since I got here - I feel at the beginning for people to begin to gain insight, to realise the difference - well it was problematic - the organisation in the school of nursing did not facilitate this early on- the ethos was so different between the two - it has evolved to meet the course needs. The major obstacle was understanding the different ethos in both environments. Time was a problem when the course was up-and running whilst still evolving (laughter) - it made it
difficult for us to get together, but that was an advantage, too -
to give it a trial, it encouraged ideas, to get on with trying
something - then reflecting, discussing and altering if necessary.

Q. If you were advising another course, where would you put your
priorities?

A. The people factor first. Launching such a collaborative venture
calls for understanding and commitment from staff - it makes so
many demands on them. You need time and effort, and a willingness
to change and modify. Investing in people first means looking at
the structure. Will it meet new needs? You can only plan as far
as you can, but you need to look ahead - you cannot anticipate all
needs and clearly this has not been possible because it was beyond
the experience of most of us.

Q. There must be flexibility for local creativity?

A. You cannot take it off the peg and use it! But the planning of
the change process could give some 'anticipatory information' to
others.

Q. How were mentors prepared for their role?

A. Well - there were a couple of days - on a neutral site - when we
had a joint discussion to take stock, to develop further and
decide how to proceed. We all got together to share, with an
outside facilitator. This reflective sharing was helpful - and
it's a useful approach for anyone, for anything. Then there were small groups in the placement areas to talk about the pilot scheme, and the possibilities, long before the students were to be placed there, e.g. operating theatres. We had more formal sessions to publicise the scheme - with career officers in the area and at conventions. A newsletter with information was circulated - possibly it might have been more widely distributed. We need to have liaison within the polytechnic as well as the school - the health authority and the local community! It's a slow process to inform everyone properly.

Q. How many nursing lecturers and nurse teachers are involved?

A. There are five at the polytechnic - the lecturers do take personal students. For each unit of study in the programme the teaching material is discussed between the subject specialist, a nurse teacher and tutors with a coordinating role for each year of the course. Each intake group of students has a team, including lecturers, looking after them!

Q. Were there staffing difficulties in the wards when students became supernumerary?

A. It was a difficult time - the authority made monies available - this helped - but there is a danger of any shortage being seen as due to the pilot scheme. In my experience, any change causes a hiccup in the system.
Transcript of Interview with a Senior Tutor not teaching in the Pilot Scheme in the Second Year

Examples of the previous curriculum were discussed - and the difficulties were explored.

Senior Tutor Well - as you can see - the curriculum is based on a traditional medical model - the content has not changed much over the years but the design of the course has changed - particularly in the size and number of intakes over the year. Well, things have got to change. I've seen changes over the years from four intakes to the school, three times a year, and then twice a year. Many young tutors are studying for diplomas and degrees in their own time and it's hard for them. I would have participated in the pilot scheme if I were ten years younger, but I am taking early retirement - I considered it was right to make way for someone younger.

The work load for the sixty students entering twice a year triplicated - because the large group were split into three forward experience and allocation - so there were three separate groups twice a year for teaching, marking and so on. And we were short of tutors, because we had seven clinical teachers, and when the officers of the statutory body visited they were urged to become nurse teachers and do a course -
because many were qualified by virtue of experience or a City & Guilds Certificate.

Then the ENB devolved the final examination. This greatly increased the workload by paper-setting, marking, moderating and so on. and the Central clearing house system increased the interviewing - we interviewed candidates, who then went elsewhere!

Q. Is recruitment steady? - where do you draw recruits from?

A. Mainly from the North East of England - not entirely. We do have problems with transfers. We have had more mature entrants, but if their husbands are unemployed and get a job elsewhere, they have to move, and transfer their training elsewhere. That's another thing - I have been doing a survey of the applicants over the years. The number of entrants with 4 or 5 'O' level passes has risen - (we used to have two or three 'O' level entrants) and we use the DC test for mature students, which I don't like, I doubt it myself. In the mixed ability groups we teach some with no 'O' levels come out on top - but how many of those we had to turn down, because of the DC test failure, might have done well too? We don't know enough about motivation and commitment, and the persistence some people have to become a nurse.

Q. And after the past years, of the pilot scheme, what is your view about it?
A. The pilot scheme has stimulated the conventional students to do some more reading, particularly of research reports - they are doing some very good projects. The flexibility is good - I can really treat them as students (conventional course). The students' comments indicate that the pilot scheme students are now asking for more tuition in practical skills before their ward experience - they evaluate their ward experience, and in ward discussion groups pilot students say they have suffered from cultural shock - they will get what they need, I am sure.
Transcript of Interview with a Nurse Teacher in a Pilot Scheme in the Second Year

Nurse Teacher: I came after the pilot scheme had started—I liked the philosophy of the course. I realise I was very idealistic, I still believe in the philosophy but I've experienced the problems of it.

Q. Reality versus idealism? What, in your view, are the problems?

A. First of all—this concept of andrology—yes, it is adult education, but most of these people who are on our course.... have not been developed at school enough to be able to cope with it. Therefore, they come from a very teacher-directed environment into one which we hope is student-directed. A lot of them cannot cope with that—they love structure—they find a lot of what we do just not structured enough. Because in the study time each week they would like us to tell them what to do in the study time—to give them lists of what to do. They find self-direction very difficult.

Q. When they come here from school they have these difficulties—do they change at all—over two years? Have you seen any change?

A. Yes—quite definitely there are changes—but it's quite difficult for them—we certainly need to pay much more attention to how we help them to become more self-directed.
Q. Yet in the philosophy of the course there is contract grading - how does it work?

A. Well - they are given the criteria for assignments - it states quite clearly A, B or C grades - the resources available, and they are given freedom to negotiate how much they want to put into it - but it never ceases to amaze me how many of them do actually wish to aim for an A - because the basic need is to achieve well - however much we try to help them to become self-aware. One student contracted for an 'A' when marrying and occupied with everything - got a 'D' - then discussed a contract for a lower grade - so possibly wiser.

Q. How do these students compare, say with students you taught elsewhere as a clinical teacher?

A. These students are very much more demanding. I think the philosophy raised their expectations of us....

Q. They are challenging?

A. Yes

Q. After two years, do you see the process as an enjoyable experience for yourself?

A. (Five seconds hesitation) There have been some very enjoyable times - I can look back and say I have learned an enormous amount
- but there have been some very stressful times as well...

Q. Did that happen also after your clinical teaching course?

A. No - there were different problems then (laughter).

Q. Are problems you encountered here those of changing your own role?

A. A certain amount I'm sure - yes - but also a certain amount of it is due to constant changes in the school of nursing.

Q. You had a lot of changes - in a short time?

A. Yes - changes in philosophy, changes in management. I mean, I was naive when I first came for an informal visit and heard about the philosophy, and how the tutor's role would be - in my naivety I thought that that's how the tutor's role was, and... I realised that was just a philosophy, and to actually put it into practice was another thing... And I think as we become more research-based in our teaching, students are questioning the gap between theory and practice, which becomes more evident to them. It's always been evident, but I feel it becomes more evident, looking at research, you know, makes it difficult - they are more aware of it now.

Q. How do students cope with the discrepancy in their expectations of ward experience?
A. Some very mature approaches - discuss with me, or with trained staff in the wards; some become very angry, and quite rightly are angry with us. It's difficult when they express their anger to us, we are taking responsibility for educating them - but don't have power over what goes on in the wards.

Q. How much ward contact do you have?

A. One day each week. I follow my personal students closely - with three wards - the discrepancies do not arise there. There are good relationships between nursing management, and nursing and medical staff.

Q. Is the health model in the curriculum being applied?

A. Yes. It's an area of frustration, though. We can talk about using a health model - we can teach them about health education, but at the end of the day they go to hospital to nurse sick people. Yes - they apply the health model to these people - but it's a problem for them. The students are more enlightened about the health model than the trained staff.

Q. Is experiential learning proceeding?

A. I use role play - in my course (teaching) at college we used it - some colleagues are more reticent. I belong to the group using it in the first month - with a very good lecturer - some of them (lecturers) do not come up to (that) standard, though.
Q. What are the advantages and disadvantages of the pilot scheme—in your view?

A. The advantages are obvious—students are more questioning, more assertive, disrupting at times (laughter); more aware of health needs and the needs of the NHS; they have a broader view—an education for a profession. The disadvantages are that students complain— not only about the dichotomy—but about constant change. There is some insecurity—will the pilot scheme last? What is it worth?

Q. What are your views about P.2000?

A. Two years ago I would have said it was wonderful. Now, I agree the main principles, students need more education before they go into practice. We need to put students’ needs first—but on the other hand, there are always people who want to nurse—to get into the practice straightaway. A supernumerary status, based with the educational establishment, but with ward contact and practice very closely regulated so that they were not part of the work force would be ideal—with clinical learning facilitated by a tutor.

Q. Does the pilot scheme affect the teacher’s role?

A. I do not know if it causes more work—but there are grey areas of responsibility—role conflict that did not seem apparent before—there are so many different demands.
Q. Would you advise someone to teach in a pilot scheme?

A. Yes – I would, I think. The problem for me was that I had to settle into a role that required experience and, really, I did not feel sufficiently supported.

Q. What advice would you give to others starting a new scheme?

A. (Sigh). You can never have too much communication when changes are being proposed – and when changes are being made. Communication and consultation are so important. I feel quite strongly that if you are told to be autonomous, you should be allowed to be. If you start off with self-assessment and the senior manager is communicating with you, monitoring performance should present no problem.
Transcript of Interview with a Nurse Teacher during Second Year of the Course

Nurse: I was given a brief to introduce continuous assessment. I was on the initial planning group.

Teacher: The Group - an experienced ward sister, a nurse manager and myself - decided to look at student profiles - comparable with other forms of assessment. Self-education was essential first; my husband is a teacher and put me in touch with head teachers locally who were designing student profiles in general education. (P.E.U. profiles book was very helpful). We decided that the large numbers of staff using the profiles, and the mobility of the trained staff were important factors - it must be a simple system, easily read and easily understood. We chose a graded statement, adapted from City and Guilds, with four levels of achievement so that we could identify the competencies we wanted. There are four areas of ability and skill; social ability; communications; practical skills and decision-making abilities. Each is subdivided into categories, making a total of thirteen sections. The four levels of ability extend from the basic functioning level to the R.G.N. level of the nine competencies.

Q: So does this replace any other form of continuous assessment?

A: It replaces two things - the four practical assessments and the student nurse's progress report form as in the
traditional course. It was a 'winner' when marketing it to
the wards as this simple document replaced two onerous and
time consuming events. There are no grades - or marks - they
are shaded as competent. They take a brand new sheet to each
placement, and have to work through all the levels again -
which is an advantage - it maintains standards over a period.
The student is responsible for taking it to the wards; it's
kept available, not locked away; with the learning objectives
for the ward it can be continually used. It hangs up near
the off-duty sheet, and it's filled in as the mentor and
student complete a 'rota'.

Q. Do students have an interview with the ward sister?
Initially?

A. Yes, but we also operate a mentor scheme. The named mentor
is allocated to the student and, although it is not only the
mentor who fills it in - (I have to try to hack down this
tree - its taken root!) - the mentor is responsible for
consulting other members of the team with whom the student
works, e.g. when the mentor is off sick, or on holiday, or
has to change a duty rota, and so on. But the ward sister
must sign it because she must take ultimate responsibility
for continuous assessment. That's another difficulty -
getting people to see it as an assessment form and not a
report form. We have two systems in use, while we are
phasing out one system - so it's difficult for them, and
difficult to get the concept over. We are getting there -
they like it very much.

Q. You have an 'active' continuing education policy here - do all trained staff have 'preparation' for assessing?

A. I try to see all staff nurses when they arrive - but it does not always work - but I do see all ward sisters to explain profiles, and the system.

Q. Do most staff nurses come from the students who qualify?

A. It's mixed - the majority. We have quite a big "Bank" but a regular "bank", so I find they are often in the same wards - a lot are married with husbands working in the area.

Q. What do students say about these profiles?

A. They find there is regular discussion, consultation and counselling by the use of the profile documents - when its done properly! - more so than with the traditional document - they realise they have to maintain the level as they make progress.

Q. In the submission it seemed that staff preparation was going on before the pilot scheme started - was it readily accepted?

A. They were interested and delighted the scheme was accepted - in a small area like this. They are doubtful about the
outcome - it's difficult to understand the pilot scheme second year student is not the same animal as a conventional scheme student!
I hold regular meetings - Progress on the Profiles - with ward staff and the nurse manager and such comments as "they do not seem to see things as we did - things that have to be done", or "we saw there was dirty linen to be bagged up - we got on with the job when we were thrown in at the deep end".

Q. Your ward sisters will not yet be able to assess the pilot scheme students' ability in the third year?

A. No - and I think its the fact that they are different (emphasised) that they have a different theory backing for their knowledge - and they have a lot of skills - they can care for patients with their tutor's supervision but it seems to take them longer to put it into practice in this concept within the ward team - I think its that they are not seeing themselves as team members.

Q. Are they being prepared for team membership at the end of the supernumerary period?

A. Can I answer that obliquely - yes, but! - I'm finding this is one of the biggest areas of transition - I thought - "they will get used to it", but I think now that it's much more of a problem than I think we think it is.
Q. The post-introductory course syndrome in the conventional course?

A. Yes but much, much more so, because they have been 'in the school' longer...

It's wonderful - it's the first time in 26 years in nursing when I can take one or two students into the ward and when you do something that is allocated to you.

Q. The submission explained the introduction of the nursing process - how is it going?

A. Variable. It's there - but some wards practice it more than others - but it's there.

Q. Is it there - implicitly in all but recorded in some?

A. Yes - a fair summary. Care plans are a 'bit of a bother' whilst old style reporting and note pads are still there.

Q. How do you feel about linkage with a college - has it affected your work?

A. Not at all - or only to the good. It's excellent. The first year is more relaxed, we can have more discussion and get to know the students as people - the guided study encourages self-direction.
Q. Do you have to exercise control over negotiated topics - i.e. students' choice of research project?

A. Yes - especially as a facilitator - a student told me she wanted to find out whether pre-operative care really did prevent post-operative complications. We had a discussion on a more focused view and it turned out there were two patients in the ward with deep vein thrombosis.

Q. There are tensions and stress in any change - what are the disadvantages of being a nurse teacher in this pilot scheme?

A. Very few - I would never wish to go back to conventional course teaching again - my husband is looking for a change of job - and I said - "In this area, please, I could not teach in another school of nursing". We have to solve the problem of the gap - from supernumerary to team member status.
Transcript of interview with a student in the first cohort at the end of the course

Q. Why did you choose to come here to the pilot scheme?

A. I live in the area, I am married - so it was that or nothing!

Q. When you came, did you have any idea what it would be like?

A. No - not really - but I've loved it - I have thoroughly enjoyed it - the first year in school, which was something I had not done for a long time, and I've enjoyed the wards.

Q. You were in the first set - what was it like being a pioneer?

A. Sometimes when you went on to the wards it got a bit tedious explaining it - "Oh! I don't agree with it" and all that - sometimes I wished I was doing something else (laughter) but most of the time it was alright, and I think now that people are beginning to understand it - they don't get that so much.

Q. Do you think the pilot scheme has changed?

A. Yes - I think it had to really - there were a few things that were wrong - they do different wards now and I think that's good - the Accident and Emergency department which we didn't. I don't think the first year has changed very much - but I think it is necessary, it probably still needs to change some more.
Q. What would you like to see changed?

A. I think, in the first year when we get two days on the ward, I'd like to see us actually doing shifts, rather than going on at 9 a.m. and coming off for lunch and then back. I think the days are a bit unrealistic - perhaps we needed two days a week of realism - it still comes as a bit of a shock when you actually start shifts for these two days - its still a culture shock, when you go on to the ward - in teams on shifts ...

Q. Do you think anything will make that better - or remove it?

A. I don't think you'll get away from it on that first allocation, but I think you can go towards helping it - actually by working in the team and getting a handover and everything you get much more idea of what its like to be on a ward than you do by going on when most of the work is done and then finishing not long after.

Q. You have a mentor - have you found the mentor system works?

A. I personally have - but other people say not - they do not always work with us - but most of the time they try to actually work with us for two shifts each week - it seems to have worked for me.

Q. What happens when the mentor is acting up for sister?
A. That causes a few problems - but I think it's a good system, though. You've always got someone you could go to, and they do tend to look after you. They are definitely helpful in those first weeks on the rota - it worked for me - a lot of people I've heard haven't ....

Q. You have a student profile assessment ??

A. That's caused a lot of problems - it didn't happen for the first year, but it's still causing problems - people don't understand it - the blocks of four with 20 items - they still get a bit stuck - we have to - I suppose - tell them ... what they are supposed to be doing.

Q. You mean the trained staff are a bit hesitant? Who fills them in?

A. Yes - they are rather overkeen, or not really sure! Its getting better ... its usually the mentor who fills them in - it has to be a trained member of staff - that causes confusion - as people do not realise that in each allocation you need to get them all filled in - I think it will work - we've had the problems as the first group.

Q. What other assessments or hurdles do you have?

A. Well - a lot in the first year - A & P; sociology and psychology, project - and we've just taken finals - quite a few, really I
found them difficult - but a lot of that was because it was a long time since I left school. We had an unseen paper with two sections and a choice - covering three years! It was hard.

Q. But - are all these assessments part of the whole assessment?

A. (Sigh). Well - there seems to be some confusion about that - thats what we were under the impression when we started - but we had to pass this final exam three months ago - so thats different from what we were told initially ... if we failed we were told they would look back over our work for 2½ years and grade accordingly - some of us felt it ... well, I did as well ... I think it was the ENB - but we weren't told until quite late - before the exam - I think it was a bit hard.

Q. Being a pioneer? - your successors will be more informed?

A. Yes - but I think it - well, we thought the philosophy changed - it changed from continuous assessment to continual assessment - it's quite hard being continually assessed - and having a well quite a crucial exam now.

Q. What about your set - did any leave ?

A. Only one - she left after the first ward because she didn't like it in the wards - that's another problem, I think, that they are not sure if they like it until after the time in school - two of the set are re-sitting this last exam - I hope they pass.
Q. What advice would you give to entrants to nursing?

A. Think hard - you need to be very fit and have a lot of commitment - some of the younger ones in the set found it quite a struggle - it's hard physical work and there is a lot of pressure - it's stressful.

Q. You were a mature student with school leavers - what was it like?

A. (Laughter) The first week was hard - but I forgot about it - I don't think of it now. I worked with mentally handicapped children before I started - that was hard work - but not as hard as nursing. I worried about study, I worked so hard at it - the first exam was nerve wracking. I didn't believe my tutor who encouraged me - I would like to work in orthopaedic nursing, or be a staff nurse in a surgical ward.
Student's Views in a Discussion Group towards the end of the course

Q. Would you share with me your views about the pilot scheme? Why you chose it, and whether you would advise a friend to take the course?

Answers during the discussion included:

St.1 Well - we take the final exam in 4 weeks so it's rather colouring my views at present. No, I had no idea really about it at the beginning.

St.3 I just wanted to be a nurse.

St.2 That's true for me and for all of us - we learned about the scheme as we went along.

St.3 I wouldn't advise a friend to do it - I'd say do the 3-year course somewhere, I've not really enjoyed having so much theory. - I've done it, but I want to be a nurse ...

St.2 I would advise her to think carefully what she wants - if you want a career you need to do this course - but not if you just want to enjoy being a nurse ... we don't have enough practical experience.

St.5 I've enjoyed the course - I would encourage someone to do it - in a way we have benefitted from being the second group - we
were not the guinea pigs. (Laughter).

St.1 We stood out like sore thumbs - we needed more practical experience and to get the "know-how" about things...

St.4 I think I would advise someone taking up nursing to be older - put it off until you are more mature so that you can do the things you want to do whilst you are young.

Three students together - I certainly agree with that.

Three students - People treat you better if you are older ...

St.1 I certainly would like people to treat us as adults...

Q. Do you mean in school, or college or wards?

St.1 It has been difficult with replication - you know - poly lectures repeating what we have had before - and its a journey to go to the poly - it takes ages standing about waiting for buses.

Q. Has replication been everyone's experience?

St.3 Repetition - yes, they needed to get together more ...

St.7 I think its been better for us - some lecturers have come over here.
Q. Have you any ideas about how you would want to modify the course?

St.2 More medical and surgical nursing practice - we haven't had enough.

St.1 Yes, I agree we need more before becoming a staff nurse.

St.2 I think the course should be longer to give more time for practical experience.

Chorus - No - not any longer.

Q. Well - if it is a 3 year course, what would you give up to put more medical/surgical nursing in? Children's? Elderly Care?

Chorus - Oh No! You cannot take anything out! (Laughter)

Q. So the balance is about right??

(A period of quiet thought by all)

St.4 Well - we are not going to find it easy to be staff nurses. We need six months or a year post registration experience - like doctors do.

Q. Before RGN?

All Oh No!
APPENDIX VII

UKCC's Interpretive Principles -
(from Appendix I ENB Circular Nov. 199/57/APS)
UNITED KINGDOM CENTRAL COUNCIL'S

Interpretive Principles

1. Endorsement of the role of the qualifying examination at National Board level.

2. The need for examination procedures which ensure that the requirements of the EC Directives are met.

3. The total qualifying examination to be conceived of as having identifiable 'PARTS' which could be progressive or continuing or summative examination, thereby representing an aggregate of achievement, a clear pass being required in each 'PART'.

4. The total examination to which each of the 'PARTS' relate being effectively a measurement of theoretical knowledge, observed practical skills and attitudes, and demonstrated abilities to achieve the relevant competencies, as embodied in the curriculum, reflecting and being integral to the curriculum design.

5. Continuation of a formal written examination to test the depth of theoretical knowledge and concepts, applied to practice, but rejection of the notion of a written examination as the only final determinant.

6. The allocation of proportions of 'PARTS' to the whole examination shall be clearly defined including the 'PART/PARTS' which will be subjected to independent external monitoring.

7. Examination patterns should give recognition to the fact that nursing is a practice based profession.

In addition the Council has agreed that:

(i) a summation of components of a continuing assessment at the end of a number of modules or a period of time may constitute a 'PART' of the total examination;

(ii) there should be a move towards an examination of the application of knowledge and the delivery of skilled care at one and the same time, but not at the expense of demonstration of conceptual theory.
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