Changing the direction of Nurse Education: The development and implementation of the first Non-commissioned BSc (Hons) Nursing (Adult) programme in England.

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Doctor of Philosophy: Professional Practice. (Retrospective)

Patricia Adele Houghton
Changing the direction of Nurse Education: The development and implementation of the first Non-commissioned BSc (Hons) Nursing (Adult) programme in England.

Patricia Adele Houghton

January 2017

“Portfolio of evidence submitted in partial fulfilment of the requirements of the University of Bolton for the Doctor of Philosophy Professional Practice”
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Declaration

“I declare that no part of this Thesis has been taken from existing published or unpublished material without due acknowledgement and that all secondary material used herein has been fully referenced.”

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<tr>
<td>AI</td>
<td>Appreciative Inquiry</td>
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<td>AR</td>
<td>Action Research</td>
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<td>BSc</td>
<td>Bachelor of Science</td>
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<td>CT</td>
<td>Clinical Tutor</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DHSS</td>
<td>Department of Health and Social Security</td>
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<td>ENB</td>
<td>English National Board</td>
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<td>FYE</td>
<td>First Year Experience</td>
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<td>HCC</td>
<td>Health Care Commission</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HEI</td>
<td>Higher Education Institute</td>
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<td>LTHTR</td>
<td>Lancashire Teaching Hospitals NHS Foundation Trust</td>
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<td>MAD</td>
<td>Making a Difference (curriculum)</td>
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<td>MSLAP</td>
<td>Multi-professional Support for Learning and Assessment in Practice</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHS Trust</td>
<td>A National Health Service Trust is an organisation within the English NHS generally serving either a geographical area or a specialised function (such as, an ambulance service). In any particular location there may be several trusts involved in the different aspects of healthcare for the local population.</td>
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<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>PaCT</td>
<td>Patient as Coach Team</td>
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<td>PEF</td>
<td>Practice Education Facilitator</td>
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<tr>
<td>PEST</td>
<td>Political, Economical, Socio-Cultural, Technological</td>
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<td>QUT</td>
<td>Queens University of Technology</td>
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RCN  Royal College of Nursing
SFE  Student Finance England
SLAiP  Standards to Support Learning and Assessment in Practice
UKCC  United Kingdom Central Council
UoB  University of Bolton
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The PhD Supervisors, Professor Jerome Carson and Dr Duncan Cross for their invaluable knowledge, guidance, continuing support, patience, along with recognising and adapting to the author’s individual learning and writing style.

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The participants, for volunteering to take part and giving their time and commitment, because without them there would have been no thesis.

Last but not least the author wishes to give special thanks to her husband David Houghton and 2 children, Daniel and Aimee who have shown extraordinary patience and given wonderful support and encouragement throughout the whole of the PhD.
Justification

The thesis is presented according to the criteria of the Regulations and Procedures Governing the Award of the Degree of Doctor of Philosophy by Professional Practice and is written for assessment to the criteria of The University of Bolton (hereafter referred to as the University). The University shall award work or professional or creative practice to registered candidates, provided that there is clear evidence to the satisfaction of the examiners that the candidate has carried out a critical investigation and evaluation of an appropriate topic(s) or theme(s) which has led to an independent and original contribution to knowledge and demonstrated an understanding of research methods appropriate to the chosen field (1.2 Principles)
Abstract

This critical commentary sets out the background to, and implementation of “The Bolton Model.” The model was developed by the researcher. The future health service will be constantly challenged, requiring a workforce built around the actual needs of the population (Willis, 2015). The ability of the NHS to deliver world class compassionate care is dependent on the quality of training and education of the healthcare workforce (DH, 2015a). ‘The Bolton Model’ of nurse education was designed, developed and implemented, so that NHS Partner Trusts could ensure the future supply of nurses to care for their service users. This innovative nursing degree programme is the first nurse education programme that is not funded by NHS commissioning bodies and has been approved by the Nursing and Midwifery Council, and the University of Bolton.

“The Bolton Model” features in Willis’s 2015 report ‘Raising the bar ’as good practice, and has led, influenced, trail-blazed the national debate on non-commissioned nursing programmes in England changing the face of nurse education. In addition, it has influenced other Higher Education Institutes to also develop similar programmes.

In this critical commentary the author sets out the policy and practice context for a new model of undergraduate nursing education, demonstrating that there have been decades of professional and government policies that have brought about the drive and change of nurse education which has led to ongoing challenges. A critical overview of the process used to design, develop and implement ‘The Bolton Model’ of nurse education is offered. The development of the programme utilised the principles of participatory action research, appreciative inquiry, Kotter’s (1996) 8 step change
management model and theories of collaboration. A key influence in the design of ‘The Bolton Model’ was based around a number of principles from the Transition Pedagogy Handbook (Nelson et al, 2014).

A personal critical reflection of the main aspects encountered throughout the journey of the innovation from initial ideas through to the current stage of the programme is presented. This includes the personal learning in relation to the project itself, reflections on the innovations of the curriculum at this point in United Kingdom nursing history, along with reflections on the responses from within the community of nurse educations providers and practitioners. The implementation of ‘The Bolton Model’ required confidence, enthusiasm, motivation, self-belief and willingness to take the risk of developing a completely new module of nurse education. In addition, it was necessary to research all aspects thoroughly, to challenge, defend and share the vision explicitly ensuring it was clearly communicated to all key stakeholders to enable the project to come to fruition and create the desired impact.

Finally it is recommended that HEIs and healthcare providers need to establish effective partnerships and work in true collaboration ensuring that they are more flexible and responsive to meet local workforce needs. In addition, HEIs and healthcare providers need to have a number of innovative provisions of nurse education programmes that will enable differing entry routes into nurse education.
Contribution to Knowledge

The innovative model / programme that I have developed is clearly known and recognised nationally as a contribution to knowledge.

- The programme and model has been recognised as good practice by Health Education England and features in the Willis (2015) report. Appendix 1.

- There has been huge media interest. The programme has featured in numerous articles in nursing and education journals including: the Nursing Standard and the Nursing Times, along with features in the local media. Appendix 2.

- I have received recognition and been nominated for a number of awards: Lancashire Teaching Hospital NHS Trusts - Quality Awards for Partnership Working and NHS Fab stuff. Appendix 3.

- Presented and published at a number of national and international conferences, for example, the RCN Education Forum National Conference and Exhibition, the NHS England and RCN Conference, and the NET 27th International Networking for Healthcare Education Conference. Appendix 4.

- The Department of Health requested my advice, knowledge and experience in preparation for the parliamentary debate that took place in January 2015. Appendix 5.

- National Health Service Trusts, Higher Education Institutes and Health Education England are engaging and consulting with me on a regular basis in an advisory capacity. Appendix 6.
Chapter 1

Introduction / Background
Introduction / Background

“Begin at the beginning” the king said, very gravely, “and go on until you come to the end; then stop” (Carroll, 1866, p. 182).

Introduction of Self

I have been employed by the University of Bolton (UoB) since 2005 as a Senior Lecturer. Over the years I have designed, developed and updated curricula as appropriate and I have implemented and delivered a number of programmes. I have worked in partnership with National Health Service (NHS) Trust colleagues in order to meet workforce needs.

I have 26 years of experience in relation to the Multi-professional Support for Learning and Assessment in Practice programme (MSLAP – previously known as mentorship). Throughout my clinical practice career I have supported junior staff and students in the clinical learning environment. Fifteen years ago I moved into an educational role where my main responsibilities were to ensure high quality learning experiences for pre-registration students and supporting mentors in practice. Through this experience I gained employment in a similar role for Post Registration students at the University of Bolton. Due to my experience in supporting mentors I was then appointed to lead the MSLAP programme and the development of mentors in the workplace (see Curriculum Vitae Appendix 7). My expertise lies within mentorship and supporting the learning and assessment of students in practice. All students on Nursing and Midwifery Council (NMC) pre-registration nurse education approved programmes are required to have a mentor and a ‘sign off’ mentor whilst in practice. In connection with this work
in developing and supporting mentors I have written a series of 11 articles for the 
Nursing Standard in relation to mentoring and supporting students in clinical practice. 
A list of the published series can be found in Appendix 8. Therefore, throughout my 
clinical and nursing academic career, I have been deeply involved in all aspects of 
pre-registration nurse education which thus led me to designing, writing, developing 
and implementing the innovative model of nurse education: BSc (Hons) Nursing 
(Adult) and referred to from here as the ‘The Bolton Model’. 

The thesis presented consists of my critical analysis, evaluation and justification of the 
professional practice that I established during the creation of ‘The Bolton Model’ an 
innovative nurse education programme. The chapters within the critical commentary 
will include:

1. Introduction and background to self and the Professional Practice undertaken.

2. The historical background to nurse education including the policy drivers, 
along with a critical analysis and review of nurse education.

3. A model of nurse education – ‘The Bolton Model’. An innovative model of 
nurse education which will include a critical commentary on the why and how, 
along with a critical analysis and justification of the methodologies, theories and 
tools used to design, develop and implement the programme.


Finally: recommendations for the future.
Introduction and background to the Professional Practice undertaken

The area of professional practice this thesis will present, is in relation to an innovative non-commissioned BSc (Hons) Nursing (Adult) Programme, ‘The Bolton Model’ in collaboration with local NHS Trusts. This is the first nurse education programme that is not funded by Health Education England (HEE) in the country and has been approved and validated by the NMC and the UoB. I commenced this project during 2013 and ‘The Bolton Model’ was approved in September / October 2014 following which I began implementation of the model from February 2015. Since then, in December 2015, the Government Spending Review took place and it was announced that the Bursary funding for nurse education was to be removed from August 2017. Thus, I had created, designed, developed and implemented this innovative model of nurse education more than a year ahead of the Government announcement.

It was recognised nationally that there was (and still is) a shortage of nurses (Department of Health, 1999a; Wanlass, 2002; DH, 2004a; DH, 2006a; Willis, 2012; Willis, 2015) and that there was a need to seek new ways in which NHS Partner Trusts could ensure the future supply of nurses to care for their service users. This is coupled with the demands and needs of the local population, whose needs continue to change, alongside NHS Trusts needing to ensure that they are able to care for service users by having a suitably qualified and trained workforce in place. I developed, led and worked collaboratively with Trusts to design, develop and implement the innovative model of nurse education to ensure the provision of additional student nurses in training to supplement those places already commissioned by Health Education England.
During the initial planning and implementation stages it was agreed that 50 to 60 students per year (via two intakes of 25 to 30 per intake) would be recruited with the first partner NHS Trust. Since the launch of the programme and the huge interest from other local NHS Trusts, the programme has been through a NMC major modification which entailed the approval of two additional partner NHS Trusts. One of these Trust partners agreed to a similar intake of 25 to 30 students twice a year and the other Trust partner agreed to 25 students annually, therefore, taking the overall numbers per year to 145 per year. However, in keeping with the ethos of the model in relation to small cohort sizes, each intake per partner Trust is taught in discrete groups, thus, the group size is never more than 30. Although numbers are small in comparison to other Higher Education Institutes (HEIs), any additional contribution to the nursing workforce to fill the gap is good.

The future health service will be constantly challenged, requiring a workforce built around the actual needs of the population (Willis, 2015). The ability of the NHS to deliver world class compassionate care is dependent on the quality of training and education of the healthcare workforce (DH, 2015a). As such nurse education is not static. The number of policy documents over the last two decades gives an indication that nurse education has received a significant amount of political attention (DH, 1999a; United Kingdom Central Council (UKCC), 1999; DH, 2001; NMC, 2004; EU Directive, 2005; NMC, 2006; DH, 2006a; NMC, 2008a; NMC, 2008b; DH, 2010a; NMC, 2010; Willis, 2012; Willis, 2015). However, the potential negative impact this can have on learners, clinicians and service users from the frequent and wide ranging changes should not be underestimated.
Many of the service improvements required of the NHS rely upon a well trained workforce with sufficient numbers to be able to deliver high quality care that is safe and effective. Hence, high quality nurse education curricula must reflect the needs and demands of healthcare delivery systems and service users (Ali and Watson, 2011). The main noticeable changes within nurse education over the past two decades have been the movement out of hospital based schools of nursing to university based education and an ‘All-Graduate’ profession.

This first major change in the last 30 years started with the Project 2000 curriculum (UKCC, 1987), followed by a further change of curriculum named the ‘Making a Difference’ (MAD) curriculum (NMC, 2004). The next change was in 2004 when the NMC published the NMC’s Standards of Proficiency for Pre-registration Nursing Education, and the most current nursing curriculum to date, is the ‘All-Graduate’ degree curriculum (NMC, 2010). However, despite attempts to restructure and refocus nurse education, criticisms remain (Glen, 2000; Willis, 2015). These will be critically discussed in more depth in Chapter 2.

Over the last few years there have been a number of critiques in relation to the provision of healthcare (Healthcare Commission (HCC), 2007; DH, 2012; Francis, 2013: Keogh, 2013; Berwick, 2013; Bubb 2014). The United Kingdom (UK) Health Ombudsman’s office produced a report detailing real life cases whereby a number of older people had received sub-standard hospital care (Ombudsman, 2011). This was published at a time when public confidence in the health care service, health care professions and nursing in particular, was at an all-time low. There had been earlier reports of poor patient care at Maidstone and Tunbridge Wells NHS Trust (HCC,
Moreover, some events have exposed some of the most vulnerable people in society to poor care. These have been demonstrated within the Winterbourne View Inquiry (DH, 2012) and the Francis Report (2013) following the Mid Staffordshire Foundation NHS Trust Inquiry. In addition to this, the NHS is faced with an ageing workforce, increased competition for nursing expertise along with financial difficulties. These have the potential to affect the commissioning of nurse education, due to the limited places and available funding from Health Education England. These issues will have an effect on the nursing workforce and in the future it may fall into difficulty (Longley et al, 2007). Longley et al (2007) go on to report that there is concern throughout the UK over the future recruitment and retention of nurses with applications for nursing courses increasing, but varying across the country and region.

The NHS Five Year Forward View (HEE, 2014) emphasised the lack of resources for the future development for the NHS, along with the need to be efficient as well as effective and the only way to do this is through service reform. This however, will have workforce implications for nursing and most NHS providers are struggling with nursing vacancies (HEE, 2014; Willis, 2015). This is demonstrated through excessive use of agency nursing staff as well as the large numbers of nurses being recruited from overseas (Willis, 2015). Health Education England reviews the commissioned numbers annually which has resulted in increases to the nurse training commissioned places in the last few years. These increases will not impact on the system until 2017. However, this increase, along with other workforce strategies such as, ‘Return to Practice’ and international recruitment is unlikely to lead to a full solution to the supply and demand of workforce needs.
The discussion above has provided a brief initial overview of the current challenges within nursing, along with the major issues in relation to a shortage of the nursing workforce coupled with the lack of confidence in nurse education. The following chapter will provide a more in-depth critical analysis and evaluation of nurse education over the last three decades.
Chapter 2


“The most powerful influences on the future of nurse education will be what happens to nursing, and the most powerful influences on nursing will be what happens to healthcare” (Longley et al, 2007, p. 7).

Introduction

The following chapter provides a timeline of the key changes within Pre-registration nurse education over the past three decades that have been influenced by the most pertinent relevant political documents. The most significant of them will be critically discussed in this chapter. The health care agenda is rapidly transforming and thus nursing is changing almost as quickly as the context in which it is practised (DH, 2006a; DH, 2007; DH, 2008; DH, 2010b: DH, 2010c: HEE, 2014). Moreover, an improvement in health, together with an associated ageing population means nurse education within the United Kingdom (UK) has undergone numerous significant revisions.

Successive governments have consistently taken an interest in the education and training of the NHS workforce (Pollard et al, 2006). There have been a plethora of health and health education policy documents (UKCC, 1987; DH, 1999b; UKCC, 1999; DH, 2001; NMC, 2004; EU Directive, 2005; NMC, 2006; DH, 2006a; NMC, 2008b; DH, 2008; DH, 2010a; NMC, 2010; HEE, 2014). A brief summary of all the main policy documents can be found in Table 1 - Appendix 9. This demonstrates the significant number of changes and revisions to the structure and development of nurse education in the UK over the last 29 years.
The NMC (2004; 2010) identified in the Standards for Pre-registration / Standards of Proficiency for Pre-registration nursing that in order for students to enter the ‘NMC Register’ on successful completion of their courses they must be assessed as ‘competent autonomous practitioners’. In contrast, according to Darbyshire and Fleming (2008) they assert that over the past 29 years nurse education has suffered from an hierarchical and asymmetrical approach to learning which does not support or foster autonomous student learning.

Since 1989, according to Glen (2009), there has been a constant discourse that pre-registration nurses are emerging from nurse education programmes without essential skills (While et al, 1995; Luker et al, 1996; Runciman et al, 2002). Since the 1980s, four models of nurse education can be identified:

- The apprenticeship model or what is also known as the ‘traditional style of nurse training’,
- The supernumerary / the ‘Project 2000’ model (post 1989),
- The partnership model or the ‘Making a Difference’ model or the ‘Fitness to Practice’ model (post 2000) and finally,
- The current ‘All-Graduate’ model (post 2010).

The NMC’s decision to have a provision of an ‘All-Graduate’ preparation programme (NMC, 2010) from September 2013 had emerged from previous revisions to the pre-registration nursing curriculum.

**Brief History of Nursing Pre Apprentice Style.**

Caring, the main business of nursing, has been with us for millennia. Christianity made caring for the sick a work of charity (Bingham and McEwen, 2008). Often nursing
duties were undertaken by religious women and their services sometimes were extended into people's homes. At the time, no real training existed but clinical experience taught nurses valuable skills. The most significant figure in the history of professional nursing is Florence Nightingale. She helped to shape the nature of the profession following her illustrious career as a nurse during the Crimean War. There were no hospital training schools until 1846, when the first school opened in Germany. It was here where Florence Nightingale herself received training and she was then able to set up the 'Nightingale Training School at St Thomas' Hospital London, using donations provided by the general public. This formed the platform for professional nurse education in the UK and many other countries. Florence Nightingale was regarded as the founder of nurse education (Goodrick and Reay, 2010).

During the First World War many unmarried women devoted their time to nursing. This provided the final impetus to the establishment of nursing regulation, partly because of the specific contribution made by nurses to the war effort and also as a reflection of the increased contribution of women generally in society. In 1919 after six failed attempts, the Nurses Registration Act was passed, therefore, allowing formal nurse registration. The University of Edinburgh in 1950 was the first to run a course for nurse teachers in the UK. In 1972 the University of Wales started the first nursing degree and this was followed two years later by the University of Manchester, the University of Leeds and the University of Newcastle. The Nurses, Midwives and Health Visitors Act (1979) was launched and this represented the beginning of the modern nurse education system in Britain.
Apprentice style – (pre 1989)

Until 1989 registered nurse education was based on an apprenticeship model of training (Royal College of Nursing (RCN), 2007) and took place traditionally in hospitals which had Schools of Nursing. The requirements for nurse training at this time were overseen by the General Nursing Council. The apprentice model, or what is more commonly termed in the UK as, the ‘traditional style’ of nurse training was very much based around nurses learning their trade ‘on the job’ (Longley et al, 2007) and learning the craft of nursing under the guidance of a skilled supervisor (Macalister-Smith, 2013). The emphasis of teaching was based around the ‘medical model’¹, despite the 1977 syllabus stating, nursing should be viewed in terms of the nursing process (Ousey, 2011). The gaining of knowledge was important but secondary to the understanding of ‘why’ not being a necessity, as long as, they could ‘do’ (Macalister-Smith, 2013).

Most nursing students undertook Universal State Final Examinations for the part of the register² for which they were working towards. These exams were undertaken by all nurses at the end of their programme on the same day. This model of training relied upon experience gained in the practice setting as a means of acquiring knowledge and skills. Students learned quickly and became more confident from observing role models and practising skills on-site rather than in the classroom (Glen, 2009). According to Glen (2000) the traditional pattern of nurse education relied heavily on teaching factual information and did not foster independent learning, critical reasoning

¹ The traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western world. The physician focuses on the defect, or dysfunction, within the patient, using a problem-solving approach. The medical model is focused on the physical and biologic aspects of specific diseases and conditions.

² On completion of an NMC approved Pre-registration programme successful students can Register their relevant qualification with the NMC. The NMC keeps a ‘Live Register’ of current qualified nurses and midwives who are ‘fit for practice’. The key purpose of the register is to protect the public.
or problem solving skills. Furthermore, it relied heavily on the assumption that all practice areas are staffed by highly competent and motivated staff to pass on their skills to a student nurse. Additionally, there was little or no research activity conducted by nurses or nurse academics and equally important, no professional development (UKCC, 1987).

The Briggs Committee was established in 1970 due to pressure from the RCN to consider issues around the quality and nature of nurse training and the place of nursing within the NHS. The Briggs Report (DH, 1972) recommended the first major radical overhaul of nurse education with a movement from ‘training’ to ‘professional’ education, suggesting degree preparation should increase recruitment of people with innovative flair and leadership qualities, along with nursing becoming a research based profession. This report questioned and criticised the preparation of nurses (at that time) to enable them to meet the needs of a changing healthcare service (Glen, 2000).

The Briggs Report (DH, 1972) had identified that nurses in employment lacked the skills necessary to keep pace with the technical and medical advances within a continually evolving modern health care system. This report proposed major changes to nurse education and the nursing statutory bodies, resulting in the establishment of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). National Boards were set up in each country (for example, the English National Board) to monitor the quality of nursing and midwifery education courses and to maintain the training records of students on these courses.
Nevertheless, the apprenticeship model of training enabled the student to acquire considerable experience and thus be perceived as skilled and experienced. Accordingly, Mannix et al (2000) have raised the question as to whether this model was abandoned too hastily. Conversely, McKenna et al (2006) assert that many have conveniently forgotten that nurses at this time were regarded as handmaidens, subservient, dependent, and unthinkingly carrying out routine practices that had been passed down without questioning. Moreover, Lathlean (1987) and Gerrish (1990) felt that the curricula in this model failed to provide the necessary knowledge and understanding of clinical skills for their roles once qualified.

**Supernumerary Model / Project 2000 (Post 1990s) – Move to Higher Education Institutes (HEIs).**

The Project 2000 curriculum was implemented during the early 1990s and radically changed pre-registration nurse education in the UK (Farrand et al, 2006). It moved from the ‘apprenticeship style’ training of to an ‘education led’ approach proposing the development of a ‘knowledgeable doer’ (UKCC, 1987). It was named Project 2000 because by the year 2000 all nurses entering the register would have completed this type of preparation (Roxburgh et al, 2008). There was a rapid regrouping of hospital based ‘Schools of Nursing’ into ‘Colleges of Nursing’ and eventually into Higher Education Institutes (HEIs) (Watson et al, 2002). It was the first diploma for pre-registration nurse education and it located nurse education firmly in Higher Education.

The move of pre-registration nursing programmes into higher education was necessary to improve the quality of education and to enable the recognition of nursing as an academic discipline (Glen, 2009). It enabled the profile of the profession to be
raised along with its status (Gillespie and McFerridge, 2006). However, according to Willis (2012) the move to HEIs was not easy as the profession did not have a strong tradition of scholarship and research. In addition, Willis (2012) purports that some universities had doubts about hosting a practice discipline for fear it would dilute academic esteem.

The drive to give nursing ‘academic currency’ in order to push forwards towards professionalisation was seen politically as a positive move (Meerabeau, 2004). Likewise, Watson (2006) stated that by educating rather than training nurses, this would lead to them becoming accountable for their practice, which is the hallmark of a profession. The move to diploma level nurse education was believed to increase both the depth and breadth of the curriculum and also emphasised the need for nurse tutors to raise their own level of academic education (Kirk et al, 1997). This was also supported by Watson (2006) who asserted that nurse education should be taught by research active staff, who are at the leading edge of their subject. This curriculum brought about the four differing specialisms or branches of nursing (Adult, Child, Mental Health and Learning Disabilities\(^3\)).

Project 2000 was implemented to meet the needs of a changing society by preparing nurses to meet healthcare needs in the 1990s and beyond (UKCC, 1999). Its aim was to introduce a more critical approach to nursing, increased emphasis on health promotion, focusing on the ‘wellness model’ (Watkins, 2000) to produce

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\(^3\) In the UK students qualify in a specific field (Branch) of nursing practice and may apply to enter the NMC register as a nurse in one or more of four fields: adult, mental health, learning disabilities and children’s nursing. The pre-registration nursing standards (2010) includes the generic competencies that all nurses must achieve. The competency framework sets out the standards for competence and the related competencies that every nursing student must acquire before applying to be registered at first level on the nurses’ part of the register. There are separate sets of competency requirements for each of the four fields of adult nursing, mental health nursing, learning disabilities nursing or children’s nursing.
knowledgeable, reflective, critical research-based practitioners who are able to function in a rapidly changing environment (Farrand et al, 2006). It aimed to provide a more rounded view of patient care, which included community nursing being run in parallel (Hart, 2004). In addition, Project 2000 was to enable more collaborative links with HEIs and service providers.

The English National Board (ENB) proposed a common core initial training of eighteen months known as the ‘Common Foundation’ programme. It aimed to give all nurses a common introduction to the basic sciences as well as nursing care and skills. This was then followed by a further eighteen month branch programme which equipped them to undertake the specialist branch of study. The ‘Common Foundation’ part of the programme spent more time on theoretical subjects and was intended to be equally applicable to all branches of nursing. However, according to Parker and Carlisle (1996), it appeared to be more focussed towards the adult branch.

Project 2000 attracted motivated university students with good ‘A’ levels (McKenna et al, 2006). Conversely, Davies et al (2000) stated that Project 2000 did not attract more academically qualified nurses nor did it lead to more rapid career progression. Project 2000 was to be a mechanism by which standards of care could be raised and McKenna et al (2006) believed that without the Project 2000 reform, recruitment to nursing would be much more difficult than today and the standards of care would be lower overall.

The recommendations following the RCN’s commission on nurse education in 1985 and those of the ENB (RCN, 2007), nursing students were no longer part of the
workforce and were to be regarded as supernumerary within the clinical setting. The main reason behind this review of nurse education was due to concerns over the large numbers of students requiring supervision in placements and the attrition rate of 15 to 20%, with a further 30% failing to meet the qualification criteria. However, figures from the Project 2000, MAD curriculum and ‘All-Graduate’ curriculum have shown little difference in attrition rates (DH, 2006b). The importance of supernumerary status was to enable students to focus on learning at every opportunity. This meant that rather than being supplemental to care delivery as ‘working learners’, their time in clinical practice would be better spent as surplus to the requirements of service demand. Therefore, this led to better supervision and the students were able to undertake activities which were more directly related to course learning outcomes (Macleod Clarke et al, 1997).

At the same time the introduction of experiences in a wide variety of settings and shorter placements were embedded into courses. However, this meant there was less time spent in the hospital setting developing those essential fundamental nursing skills (Studdy et al, 1994). There was also a greater emphasis on self-directed learning for both attaining the knowledge and practical skills required in the hope it would lead to expert clinical practitioners with a deeper background understanding of clinical situations (Rolfe, 1993).

A consequence of the above changes was the perceived lack of skills and confidence of the newly qualified diploma nurse (Glen, 2003), from the newly qualified nurses themselves but also from employers and managers (O’Connor et al, 2001). Managers expected new staff to be competent in practice (Luker et al, 1996) but the impressions
of their clinical competence fell well below expectations which caused a great deal of anxiety (Carlisle et al, 1999). Conversely, studies showed that after a period of time, between three to six months post qualifying, the skills deficits disappeared (Kelly, 1996). However, many preceptorship programmes for newly qualified staff had begun and these helped to reduce these deficits.

The deliberation on the theory-practice divide was re-ignited with further debates on nurses as ‘knowledgeable doers’ (Carlisle et al, 1999; McCallum, 2007). In support of this Hislop et al (1996) commented that many believed that this model had more theory and too little practice. Likewise, While et al (1995) examined the implementation of Project 2000 and identified that the increased emphasis upon the academic components of the curricula led to shortfalls concerning the clinical skills of the newly qualified nurse. Similarly, Gerrish (2000) also found that newly qualified nurses felt they were ‘fumbling alone’ and thus felt inadequately prepared for their role which was similar to her findings in an earlier study (Gerrish, 1990). Subsequently, it was also identified that the shortfalls in the development and practice of clinical skills led to anxieties amongst student nurses (While et al, 1995; Luker et al, 1996; Runciman et al, 2002) with many students reporting that there was too little emphasis on the acquisition of practical skills (Elkan and Robinson, 1993).

In addition, newly qualified nurses felt they lacked confidence and experience in order to make decisions and implement care effectively (Charnley, 1999; Last and Fulbrook, 2003). Furthermore, in 1999 the UKCC Commission for Nursing and Midwifery Education report ‘Fitness for Practice’ was published demonstrating that the legacy of Project 2000 was an acceptance generally that this particular nursing programme had
left newly qualified nurses deficient in their practical skills. Farley and Hendry (1997) suggested that there was little empirical evidence to support these claims. Nevertheless, the ‘Fitness to Practice’ report recommended that nurse education needed to integrate the teaching of theory and practice more effectively and to place greater emphasis on clinical skills.

**Fitness for Practice Report**

There is an expectation by health care employers, the public and the government that newly qualified nurses are able to demonstrate fitness for practice, fitness for purpose and fitness for their awards (Flannagan et al, 2000). This is coupled with the greater demands upon nurses and midwives for technical and scientific rationality and expectations that nurses and midwives will provide holistic care. Sir Leonard Peach was asked by the UKCC to Chair the Commission for Education in April 1998. From this review of nurse education the ‘Fitness for Practice’ Report was published in 1999, which confirmed concerns regarding student nurses graduating from the diploma programmes, who did not possess the necessary skills for practice expected by future employers or the public (UKCC, 1999).

In the main, prospective employers were primarily concerned about the fitness for purpose to function competently in clinical practice at the point of registration. However, no other healthcare profession is expected to ‘hit the ground running’ in the way that is expected of newly qualified nurses (Buchanan, 2013). Additionally, the speed of change in the context and content of health care makes it difficult to define fitness for purpose (UKCC, 1999). The report concluded that the original Project 2000 curriculum had been weakened by concurrent widespread changes. The main
recommendations included increasing flexibility, achieving fitness for practice and working in partnership. There was a perceived imbalance of the common foundation programme (which was eighteen months in length), a perceived imbalance of theory and practice, variable nature of practice placements and variable support for student learning in practice.

As a consequence of these findings the DH (1999a) proposed a new pre-registration curriculum as part of its nursing strategy known as ‘Making a Difference’. This strategy launched proposals for an innovative model of nurse education based upon ‘outcomes based’ competency principles, with a stronger role for the NHS in the management of pre-registration nurse education. The emphasis was on the output, on the achievement of learning outcomes, workplace application and the provision of evidence to validate competence (Wolff, 1996). However, doubts were raised as to whether competency standards were appropriate for professional nursing practice as they have the potential to be reductionist and focussed on outcome orientated technical procedures (Redfer et al, 2002). The strategy emphasised that the assessment of performance in a practice context was essential with students developing evidenced based portfolios, along with self-assessment, due to this being an important feature of outcomes based education (UKCC, 1999).

There was an ambition to develop a system of nurse education that is responsive to the needs of the NHS. In addition, it was also suggested that there needed to be an increase in the level of practical skills in the training programme. Placements needed to be of higher quality with enhanced learner support from lecturers to enable students to gain better practice skills. Moreover, widening access to nurse education
particularly for under-represented groups and to create more flexible carer pathways into and within nursing and midwifery was seen as essential.

A further key policy document that influenced a change in nurse education was the NHS Plan (DH, 2000a). This was published with the aim of modernising the NHS, ensuring high quality patient-centred care and thus modernising the workforce. Another influential document, ‘Placement in Focus: guidance for education in practice for health care professions’, was published in 2001 by the Department of Health. This document was an integral part of the Government’s modernisation agenda and NHS Plan (DH, 2000a) which provided practical and contemporary guidance for education in clinical practice placements in order to enhance the quality of practice placements. From these major documents the Partnership Model of pre-registration nurse education known as the ‘Making a Difference Curriculum (MAD) was published by the NMC in 2004. In 2002 the UKCC ceased to exist and its functions were taken over by the Nursing and Midwifery Council (NMC). At the same time the National Boards were abolished and this quality assurance role was taken over by the NMC (Eaton, 2012).

**Partnership Model (post 2000) – Making a Difference (MAD) Curriculum**

As demonstrated above, by the end of the 1990s and post 2000 there were numerous key government and professional body reforms, policies and reports that influenced the changes to nurse education. These government reforms were to enable the NHS to deliver a high quality and comprehensive service across health and social care (DH, 1999a; DH, 1999b; DH, 2000a; DH, 2000b; DH, 2001; DH, 2003a; DH, 2003b; DH, 2004a; DH, 2004b; DH, 2005; DH, 2006a). In 2004 the NMC published the ‘Standards of Proficiency for Pre-Registration Nursing Education’ – this was known
as the Partnership Model of nurse education and known nationally as the MAD curriculum (Farrand et al 2006). This model of education was delivered at diploma and degree level, with the number of students on the diploma programme being in the majority.

This outcome based curriculum was student-centred and valued both learning in the workplace and in the academic setting (Farrand et al, 2006). It included a reduced theory component following the ‘Fitness to Practice’ Report (UKCC, 1999), to ensure students gained greater clinical exposure and experience, along with the clinical experience occurring earlier in the programme. The common foundation programme was reduced from eighteen months to twelve months in length. The course contained 50% theory and 50% practice with accreditation for both components defined. With this introduction, Carr (2007) identified that many felt this 50% split between theory and practice was both useful and worked well. In addition, part of the debate for more clinical experience to be embedded was as a result of the focus on nurse education in the UK, adhering to the European Union Legislation of a minimum 2,300 hours of clinical placement. This represents at least half of the total course learning (EU, 2005) of which the current pre-registration standards must comply (NMC, 2010).

The curriculum placed more emphasis on the evaluation of performance in practice and evidenced based portfolios of learning (Scholes et al, 2004). There was greater involvement by clinical staff in the development of practical skills in order to improve confidence in clinical practice (Howard, 2001) along with a consolidation period of a minimum of three months intensive supervised practice at the end of the three year programme (DH, 1999a; UKCC, 1999). It was hoped that this increased focus upon
the development and practice of clinical skills would improve self-confidence of nursing students in this area. Consequently, a quantitative study by Farrand et al (2006) during the time when Project 2000 was being phased out and the MAD curriculum being introduced did initially demonstrate that those on the MAD curriculum rated themselves as more confident in their abilities. However, on the basis of this study alone it was too premature to conclude that those on the MAD curriculum were more self-confident to those on Project 2000. Similarly, this lack of confidence in their abilities according to Roberts (2009) is often misapprehended as lack of competence, which is not always the case. Later studies have also highlighted that confidence is an important aspect of learning to become a nurse (Calman, 2006; Spouse, 2003).

The establishment of the Essential Skills Clusters (NMC, 2007) was launched to complement the existing proficiencies for entry to the NMC register. Alongside this was the development of the ‘Standards to Support Learning and Assessment in Practice (SLAIP) (NMC, 2006; 2008a) followed by a revised version in 2008. The NMC (2008a) SLAIP stipulated that students on an NMC approved pre-registration nurse education programme, leading to registration on the nurses’ part of the register, must be supported and assessed by mentors. A ‘sign-off’ mentor, who has met additional criteria, must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved.

Unfortunately, during this period there were a number of articles and letters that expressed concerns regarding recently qualified nurse’s abilities. There were many concerning quotes such as, ‘Too posh to wash’ (Hall, 2004: Fletcher, 2009; Chapman and Martin, 2013) and ‘not fit for practice’ (UKCC, 1999) with policy makers and
managers feeling that the move of nurse education to HEIs was a mistake (McKenna et al, 2006). Similarly, Higgins et al (2010) expressed concerns that developments in nurse education have supported a broader and deeper knowledge base for practice. However, there are variations in practical skills attained at the point of qualification. A study by Greenwood (2000) indicated the main areas that employers felt nursing students lacked ability in included: numeracy, time management, clinical skills, critical thinking and the ability to liaise appropriately with colleagues. Similarly, Ryan (2008) suggested that the role of modern nurse education was for nursing students to attain critical, analytical, problem solving, decision making and reflective skills which are essential to the art and science of nursing. However, these types of skills are complex and prove difficult to demonstrate and articulate in clinical practice.

In contrast, studies by Lauder et al (2008) and Roxburgh et al (2008) evaluated the ‘Fitness to Practice’ curriculum in Scotland and the predominant opinion amongst HEIs, NHS academics, clinical practitioners, managers, students and carers / service users, perceived that newly qualified nurses were fit for practice at the point of registration. This is a fundamental shift from findings of earlier studies (Willis, 2012). Previous concerns focussed on the perceived lack of clinical skills at the point of registration, not on competence to practice in general, therefore, the MAD curriculum has made some difference in improving clinical skills.

Over this period of time and to date, there is an increasing recognition of the sharing of responsibilities for the students’ practice learning between HEIs and their NHS Partners. During 2000 to 2005 HEIs worked successfully with NHS partners in order to expand provision of education to meet the requirements published in the NHS Plan
(DH, 2000a). This involved increasing student numbers to meet workforce needs, expansion of practice placements and provision of opportunities for inter-professional learning that linked to patient-centred care. However, these partnerships were tested by the impact of sudden financial constraints within the NHS occurring at a time when there was restructuring of the NHS Strategic Health Authorities.

During this same period 2000-2005 there had been many debates and policy documents concerned with recruitment and retention strategies, nurse education and moving nursing to an ‘All-Graduate’ profession with the aim of providing diversity in the workforce (Longley et al, 2007). In 2006, the Government published the blueprint for registered nurses which was one of the most radical and important initiatives for nursing (Taylor et al, 2010) named ‘Modernising Nursing Careers’ (DH, 2006a).

The delivery of an effective healthcare workforce is dependent on a radical rethink of education (Westwood et al, 2008). The priorities and vision for nursing published within this document included: a competent and flexible workforce, updated career pathways, preparation for nurses to lead a changed healthcare system and modernising the image of nursing and midwifery careers. This advocated a more flexible approach to recruitment onto nursing programmes and to widen the entry gates.

According to Longley et al (2007) nurses need to possess the ability to critically evaluate the evidence base and thus asserted that nurse education needed to be comparable to other healthcare professionals at Bachelor Degree level at the point of registration. Subsequently, this led to tensions between policies to widen access to
nurse education and the possibility of introducing a degree level programme, which, therefore, may present difficulties for some applicants. In support of this, McKenna et al (2006) stressed that people require and deserve to be cared for by intelligent, caring and skilled nurses whom have been educated where the best knowledge, skills and understanding is produced, challenged, tested and applied. Thus, nurses need to be educated within the HEI and attain a University qualification. They go on to stress that there is no evidence that degree qualified nurses are less caring. Similarly, Watson et al (2002) also support this but most importantly they found that graduate nurses remain in nursing longer, as well as in clinical practice and have superior decision making skills.

‘All-Graduate’ Curriculum

Cummings and Bennett (2012) assert that the nursing profession is always evolving, treatments and techniques develop; therefore, nurses need to build on their knowledge and skills. They went on to express that the role of the nurse 20 years ago has changed as nurses now administer treatment that is far more complex and thus have a greater professional responsibility and autonomy. There has been a move away from following a procedure book, to nurses applying more independent thinking and therefore, it was essential that nurse education also needed to evolve in order to support this.

In June 2008 Lord Darzi’s Report, ‘High Quality Care for All’ (DH, 2008) was published. The report recommended that pre-registration nurse education should be set at degree level. Similarly, within a national review of the future for UK Nursing and Midwifery professionals, ‘The Front Line’ (DH, 2010a), the most significant
recommendation was for nursing to become an ‘All-Graduate’ profession’ by 2013. The Commission was established in March 2009 to explore how the nursing and midwifery professions could take a central role in the design and delivery of 21st century services in England. It built on Lord Darzi’s 2008 Report of the NHS ‘High Quality Care for All’, and considered all branches of nursing as well as midwifery, in all settings, services and sectors within and outside the NHS. The ‘Front-Line’ Review discovered that negative perceptions of nursing were still held, in regards to nurses being poorly educated, and seen as lower down the hierarchy of health care professions (Fletcher, 2013). They were seen as handmaidens to doctors who might be kind hearted and hardworking but had limited knowledge or skills to make decisions or influence outcomes (DH, 2010a). Thus, confirming even further the need to raise the profile and recommend an ‘All-Graduate’ profession and academic recognition.

Following these reviews and after extensive consultation the NMC in 2010 introduced the current standards for pre-registration of nurse education. All HEIs, whom provided pre-registration nursing programmes across the UK were required to design, develop, seek approval and implement these standards by 2013. The move to an ‘All-Graduate’ profession by 2015 brings it in line across the UK and many countries throughout the world. The aim of these standards is to create nurses who are able to meet the complex and challenging healthcare needs of the future. They emphasise that nurses should practice more independently, think more analytically, be able to justify their actions with evidence and be better able to lead others than diploma educated nurses (Callanan, 2011). The Project 2000 and ‘MAD’ curriculum also aimed to ensure nurses were ‘knowledgeable doers’ but the difference with the ‘All-Graduate’ curriculum
emphasised the need to develop those deeper analytical skills to use evidence to support their practice as well as more leadership abilities.

Additionally, Taylor et al (2010) asserted that to educate nurses to degree level is not an end in itself, rather it is a preparation for a career in which active learning will always be essential. However, findings from the NMC (2008b) Alpha Research Report demonstrated that Key Stakeholder organisations expressed the view that safe and effective clinical competence is more important than academic achievement and that nurses do not need to be academic to be a good nurse and to be able to understand complex needs. In addition, they felt that the diploma is valuable as it can be more vocational and place more emphasis on practice skills (NMC, 2008b). Moreover, the diploma course would retain emphasis on ‘caring’ rather than on academic skills.

Furthermore, unions in England, along with patients, did raise concerns regarding the closing of diploma courses. They felt potentially it could exclude willing recruits from varied backgrounds and may worsen existing nursing shortages (Spooner, 2010). In contrast, applications for nursing degree programmes in 2012 were up by 25% whilst the applications for the diploma programmes decreased (Willis, 2012). That said the NMC have clearly stated nurse education programmes must still remain accessible to those who may not have the traditional academic qualifications or who come to nursing later in their working lives (NMC, 2010).

Another concern regarding the move to an ‘All-Graduate’ model related to the availability of funding for nursing degree students in England. Degree nursing
students have less access to financial aid as it is means-tested, where as those on diploma programmes were eligible for annual grants of £7000 (Spooner, 2010).

It is worth noting that England was the last country in the UK to fully embrace the concept of an ‘All-Graduate’ profession. The other three countries had already moved to ‘All-Graduate’ profession before the launch of the current 2010 Pre-registration Standards. Wales began the transition in 2004 with an option to step-off at diploma level. Scotland at the same time had already made a commitment to move to an ‘All-Graduate’ profession and Northern Ireland moved to a degree only programme in 2012.

**Willis Commission (2012)**

Unfortunately during the last few years as the ‘All-Graduate’ curriculum was developed and implemented, numerous incidents had been reported by the press raising concerns over the care given to patients. However, omitted by the press are the good news stories of nursing staff delivering excellent care in often difficult situations, for example, through staff shortages, financial constraints and the need to meet Government targets (Eaton, 2012). Nevertheless, the most serious situation was the shocking systematic failures of hospital care in Mid-Staffordshire that left patients routinely neglected, humiliated and in pain (Francis, 2013). This had created a damning public perception for the healthcare service, more so for the nursing workforce. The Francis Inquiry found 400 – 1,200 more people died at the Mid-Staffordshire Hospital NHS Foundation Trust than at any other hospital trust between 2005 to 2008 (Francis, 2013). Reports of poor nursing care had implied that the
quality of initial nurse education was at fault (Willis, 2012). Thus, the RCN called for an independent inquiry which was led by Lord Willis of Knaresborough.

The commission was launched in 2012 and published later that year. Since then a further review was undertaken named the ‘Shape of Caring’ Review (Willis, 2015) which was published in March 2015. However, at the time of the start of the initial review, it is important to note that the current NMC standards for pre-registration nurse education had only just been introduced in 2010 and started to roll out in 2011, with some universities yet to implement this by 2013. Nevertheless, according to Glasper (2012), the reason why the RCN decided to launch the commission was due to events being published at the time when registrants had been criticised for poor care delivery. Conversely, during his review Willis (2012) found that many nurses felt the move to an ‘All-Graduate’ profession was a cause for celebration and none of the evidence revealed any major shortcomings in nurse education that could be held directly responsible for the poor practice or perceived decline in standards of care. In addition, the commission saw no evidence to support that graduate nurses are less caring or competent than non-graduates (Willis, 2012). Willis alluded that many of the shortcomings of current education programmes stem from underfunding and over-rapid expansion of student numbers in the last decade, leading to placement capacity problems and shortage of suitable placements.

Since the publication of the ‘Shape of Caring’ Review (Willis, 2015) HEE carried out a national consultation via stakeholder events from September 2015 until December 2015 to ascertain views, ideas and the sharing of best practice, to feedback to the NMC. To date the NMC are reviewing the current Standards for Pre-registration
Nursing Education (NMC, 2010) and it is envisaged that the consultation of the new standards will take place in March 2017, followed by publication in 2018 and all HEIs implementing the new standards by 2019.

Many of the criticisms regarding the perceived deficits in nursing care appear to stem from the introduction of a more academic educational programme with the commencement of the diploma level Project 2000 policy in 1986 and the move of nurse education from ‘Schools of Nursing’ into Higher Education (Watson and Thompson, 2000; Meerabeau, 2004). However, it has been emphasised that although there were many criticisms of the Project 2000 curriculum this model undeniably increased the academic status of nursing.

Nursing has become ‘intensified’ with healthcare assistants carrying out procedures that were once the remit of a qualified nurse and nurses now undertaking roles that once belonged to the medical profession. In addition, modern healthcare is much more complex than it was two decades ago. Service users in many of the hospital settings are at the acute stage of their illness and as soon as they are stable they are discharged to community care. Therefore, nursing is no longer the common sense carrying out of uncomplicated tasks under the direction of others. According to McKenna et al (2006), it is a profession requiring highly qualified, knowledgeable nurses who often have to make decisions without a complete set of data and resources. Hence, an ‘All-Graduate’ profession is essential as otherwise the nurse of the 21st Century would be unprepared and overwhelmed if faced with the complexities of today’s healthcare setting. Thus, new reforms and policies will continue to drive the ever changing model of nurse education.
Summary

There have been almost three decades of professional and government policies that have brought about the drive and change of nurse education and with it associated problems. Many of the service improvements required of the NHS rely upon a well trained workforce with sufficient numbers to be able to deliver high quality care that is safe and effective. Thus, high quality nurse education curricula must reflect the needs and demands of the healthcare delivery system and services users (Ali and Watson, 2011). These constant changes have led to ongoing challenges for nurse education. There are concerns with the theory practice gap, continual pressures on practice placements and difficulties in ensuring appropriate learning environments for large numbers of students (Glen, 2000). In response to these consistent challenges, pre-registration training has evolved from an apprentice style model to a supernumerary model, then to a partnership model and more recently to an ‘All-Graduate’ model of education. However, despite attempts to restructure and refocus nurse education, criticisms remain (Glen, 2000).

There remains a tension for the public and nursing profession of how best to prepare and educate ‘knowledgeable doers’ that reflect the need for nurses to maintain a wide knowledge base, technical ability and skills range to provide nursing care. This is coupled with the shortage of nurses and the need for new ways to train nurses so that they are ‘practice ready’. Therefore, I developed the innovative model of the first non-commissioned nurse education programme in England. The following chapter will provide a critical discussion and justification of the professional practice undertaken to develop and implement this innovative model of nurse education.
Chapter 3

An innovative model of nurse education – ‘The Bolton Model’
An innovative model of nurse education – ‘The Bolton Model’.

“All things are created twice; first mentally; then physically. The key to creativity is to begin with the end in mind, with a vision and a blue print of the desired result” (Covey, 1992, p. 99).

Introduction

Shortages of nurses within the nursing workforce are a UK wide issue and cannot be solved with a single solution. This shortage is coupled with health care needs which are constantly shifting due to changes in demography, disease patterns and lifestyles. In order to keep up with these changes and challenges, the health care system requires intelligent, well educated, highly motivated caring and compassionate nurses (McKenna et al, 2006). Whilst working in partnership with a NHS provider, the Lancashire Teaching Hospital NHS Trust (LTHTR), to ensure the constant development and supply of mentors, the Head of Student Learning and Support approached me to discuss possible solutions to increasing the numbers of the nursing workforce. She asked for a programme of study that would ensure that students are ‘Practice Ready’ at the point of registration.

The partner had previously consulted with HEE to increase the number of commissioned places, and although they had requested a slight increase in the numbers, this still was not enough to meet workforce needs. Therefore, additionality of trainee nurses was required along with the current commissioned nurse training places, in order to lessen the gap of the nursing workforce shortfall. My solution in
order to further contribute to increasing the supply of the nursing workforce was to develop the first self-funded (Non-Commissioned) Adult nursing programme; initially with the aforementioned local NHS partner with a view to working with more local NHS Trusts to also meet their workforce needs. This innovative model of nurse education (‘The Bolton Model’) was approved and has been in place since late 2014. The first cohort of students started in February 2015 and they will graduate in 2018. The following chapter will provide a critical analysis and critical justification of the journey taken from initial ideas, design, and development to implementation.

A Research Methodological Approach to Design ‘The Bolton Model’.
Following the growth in social constructivist and postmodern approaches to organisational change models (Dawson and Andriopoulos, 2014), a range of alternative approaches have emerged that still hold on to the organisational development label, but ones that adopt a more social constructionist methodology (Dawson and Andriopoulos, 2014). The project aim was to design and develop an alternative approach from the current commissioning of nurse education and thus through the principles of Action Research and in the main Participatory Action Research, the innovative model was designed.

Action Research (AR) is described as cyclic and reflective (Swepson, 2003) which focuses on intervention rather than observation (Midgely, 2003). AR is an approach that focuses on actions and research simultaneously and in a participative manner (Coghlan and Brannick, 2004). However, according to Gray (2014) within this approach there are varied methodologies, each with their own priorities and modes of enquiry. Nevertheless, all approaches have at least three common features: research
participants are either researchers themselves or involved in democratic partnership with the research; the researcher is seen as agent of change; the data is generalised from the experiences of the research participants (Gray, 2014). Gray claims that participatory action research takes this latter feature seriously.

Participatory Action Research is a form of action research that involves empowering participants to have control over what they want to change and how this would happen (Parahoo, 2014). According to Kumar (2014), Participatory Action Research assumes inclusion will increase the possibility of accepting the findings and the willingness and involvement in solving the problems. Therefore, involving all key stakeholders was essential. It is about people working together to achieve a collective analysis and alliances being formed between people and others to make changes following research (Gerrish and Lacey, 2010).

In addition, AR involves an aspect of Appreciative Inquiry (AI) in order to engage people in the sharing and construction of meanings (Barrett and Fry, 2010; Cooperrider and Whitney, 2001). Many differing ways of doing AI have proliferated and according to Bushe (2011) it is inaccurate to say AI is done in any one way. The general outline of AI is the 4D method: 1) Discovery, 2) Dream, 3) Design, 4) Delivery, (Bushe, 2011).

I utilised the above approaches within their smallest sense to ascertain the partners’ issues, needs, desires and eventual design of BSc (Hons) Nursing (Adult) programme: ‘The Bolton Model’ of nurse education. Kumar (2014) insists that the emphasis is on people’s engagement, collaboration and participation in the process. Conversely,
getting all those involved to be motivated enough to see the project through to its successful completion can be tricky (Parahoo, 2014). Nonetheless, throughout the development and creation of this innovative model of nurse education that I designed, I adopted the use of participatory action research and AI to help me fact find, explore, interpret, construct and deconstruct in order to design and develop the model of nurse education required to meet the partner needs. I, as lead developer and programme leader, examined the interactions, along with the relationships in the social setting and sought opportunities for improvement. As the designer and also as a key stakeholder, I worked to propose a new course of action in the design, development and delivery of the programme.

In order to develop and implement this innovative model of nurse education, I also utilised Kotter’s (1996) eight step model (see figure 1 below), which is one of the models that can be used within organisational change management. Although many, rely on Lewin’s (1947) classic framework for change management, which posits three phases of change: unfreezing, moving, and freezing (Osland, et al, 2007). Despite the popularity of Lewin’s (1947) model it has been criticised for being vague regarding specific actions that are needed to produce change (Calegari et al, 2015). Kotter’s (1996) eight step model of organisational change addresses many of these criticisms. According to Calegari et al (2015) an advantage of this model is that it incorporates more specific procedural recommendations. However, no studies have examined the full scope of this model, but substantial literature supports the processes prescribed in the various stages (Appelbaum, et al, 2012). The efficacy of Kotter’s process has been broadly supported in the literature (Cegielski et al, 2006; Ansari and Bell, 2009). However, despite its popularity the criticisms are that it describes what has to be done
but does not show how this should be achieved (Pfeifer et al, 2005). Nevertheless, no single model of change management can provide a one-size fits all solution to organisational change (Sidorko, 2008). Furthermore, this process has enabled me to design, develop and implement the innovative nurse education programme.

Kotter’s (1996) 8 step model

Figure 1 Kotter’s (1996) 8 step model

Kotter's (1996) step 1 stage – Create a sense of urgency and AI 4D method 1 - Initial scoping (discovery)

Establishing a sense of urgency is crucial in order to gain the needed co-operation (Pollack and Pollack, 2014) of all parties for change to happen. The first step of Kotter’s (1996) model centres on articulating a compelling rationale for the change and recognising the importance of speed in implementing the change (Calagari et al, 2015). As previously mentioned the need for more qualified nurses to meet the nursing
workforce demand has been discussed. However, to reiterate the sense of urgency, in 2015 it had been reported that there was (and still is) a shortage of nurses. Nationally the vacancy rate was at 10% and at 7% within the North West (NHS Employers, 2015).

Nursing courses are normally three years in length and already at the same time as the initial ideas for the project, 93% of the Trusts who had participated in the NHS Employers (2015) survey reported registered nursing shortages. Moreover, 63% of these stated that they had recruited from outside of the United Kingdom. Thus, many NHS Trusts across the United Kingdom were and still are using agency and internationally recruited nurses to alleviate some of this demand. This is also compounded by an ageing population along with the predicted ageing workforce and potential loss of nurses in the next few years. This demonstrated that there was a need for additional trainee nurses to be in the system as soon as possible. Even though this sense of urgency was apparent to me and the Trust’s lead contact, it clearly needed to be disseminated to a much wider audience both within the Trusts and also within the HEI.

It was crucial that the key stakeholders were fully informed of the nursing shortfall crisis, along with the length of time it takes to train a nurse. The need to design, develop and implement an alternative model of nurse education to enable additionality to the workforce as soon as possible was critical. ‘Buy in’ from all the relevant stakeholders within both organisations was essential and I needed to emphasise the urgency with those key important stakeholders. Therefore, to ensure all required parties were fully supportive and committed to this development this sense of urgency
was communicated both at the Trusts and the HEI, at all levels including executive, directorate, manager and ward manager.

From this, an analysis of the current issues and areas that would support or may have been potential barriers to the creation of this innovative model was undertaken using the PEST analysis tool (Morrison, 2014). This includes appraising the Political factors, Economic factors, Socio – Cultural factors and Technological factors (PEST) (see appendix 10). The PEST analysis is a framework for examining a situation and can be used to revise a strategy or position, or idea. It is used to assess any external factors in relation to the situation. In this case it helped to analyse the situation and to review a strategy, the position and direction of the partnership / collaborative project. Following this I completed a thorough critical evaluation of the literature to ascertain the current issues within nurse education which assisted in formulating and designing of the innovative programme.

The first stage of the project required an analysis and scope for funding. Since the move to a diploma / degree nursing programme in 1990s and currently to date in England, all nursing degree courses are funded by HEE via commissioned places. Thus, I needed to explore alternative ways for students to fund the tuition fees. A scoping exercise took place to explore possible tuition fee funding either via the Trust itself or potential funding from a third party such as, the NMC or the possibility of a NHS research grant. Neither of these was feasible given the financial constraints on the NHS. However, in the meantime it was through my experience of being the programme leader and admission tutors for a Top up programme that I was able to discuss, explore and debate with applicants via one to one interviews the issue of
alternative funding. These applicants had previously or just completed a self-funded Foundation Degree in Health and Social Care.

Following the interviews I used a thematic analysis. This was an appropriate method of data analysis so that an exploration and description of key issues or concerns of the participants were revealed. This approach involves familiarisation with the data, developing a coding frame, categorising and coding the recurrent or common themes (Saks and Allsop, 2013; Green and Thorogood, 2007). It aims to report the key elements of the participants’ accounts. I explored with them the feasibility and willingness for students to be fee paying. These applicants had already self-funded two years of their studies and were committing themselves to a further year of fees in order to attain a full honours degree. It also became apparent that they were using the paid Foundation Degree and ‘Top Up’ programme as a way to increase their chances of gaining a place onto a commissioned nursing course the following year or later in their career. I then explored and investigated if this concept of fee paying students was possible. I contacted the Student Finance team, Student Finance England, the NMC and HEE (North West) to ascertain the feasibility of this. Therefore, through one to one interviews I proposed the concept of fee paying students and thus the first non-commissioned nursing course in England.

**Kotter’s (1996) step 2 & step 3 stage – Building a guiding team; / – Getting the vision right; & the AI 4D method 2 & 3 - (dreams / design)**

A visual overview of ‘The Bolton Model’ which highlights the unique differences and key features of the innovative nurse education programme can be seen in figure 2 (page 570. (For a larger view see Appendix 11). The key features are:
• Small cohorts of no more than 30 students per cohort
• Intense tuition and support both in practice and theory
• Employment of a clinical tutor
• Clinical advisors linked to each module
• Clinical skills weeks
• Equal split of On campus and Off campus delivery of the theory sessions
• Recruitment to the Trust of choice on application
• Patient as Coach Team (PaCT).

The following will provide a critical overview of how I came to design ‘The Bolton Model’

Step 2 stage of Kotter’s (1996) model; the forming of a powerful coalition through the backing and ongoing support of powerful influential organisational decision makers is key (Kanter, 2003). Within the Trust and University I identified and requested key staff from both organisations to self-select into small steering / development groups (which included, from the Trust, the Head of Student Support and Learning, the Director of Workforce and Education, the Trust Chief Executive, the Director of Nursing and the Associate Director of Nursing. From the University: the Assistant Vice Chancellor, the Director of Admissions and the Dean of School). Therefore, I had recruited powerful influential organisational decision makers to the project and thus built a guiding team.
The Bolton Model
Curriculum Design and Programme Plan

| Recruitment & Selection: Partnership with HEI, NHS Trust and Service User – Apply for chosen Trust for practice placements – LTHTR or Bolton FT or CMFT |
| Year 1 Practice (50%) | Year 2 Practice (50%) | Year 3 Practice (50%) |
| At the chosen NHS trust with 3 weeks clinical skills delivered by Clinical Tutor | At the chosen NHS trust with 2 weeks clinical skills delivered by Clinical Tutor | At the chosen NHS trust with 1 week clinical skills delivered by Clinical Tutor |
| Year 1 Theory (50%) | Year 2 Theory (50%) | Year 3 Theory (50%) |
| Sessions at the UoB | Sessions at the chosen NHS trust | Term 1 Sessions– At the chosen NHS Trust Term 2&3 Sessions- At the UoB |

Intensive Tuition and Support in Theory and Practice

PRACTICE 25 - 30 Students per cohort

THEORY 25 - 30 students per cohort

Programme Lead
Clinical Advisor
Pathway Lead
Module Lead
Cohort Lead

Clinical Tutor
Practice mentor
Sign off mentor
Patient Coach
Clinical advisors

R. Garbutt & T. Houghton 2016
Through the use of participatory action research I facilitated and led a number of focus groups. The focus groups consisted of the aforementioned small steering / development groups in order to develop concrete proposals to assist in designing ‘The Bolton Model’ (see appendix 12 for example minutes and agendas). A focus group interview is a ‘conversation with a purpose’ (Holloway, 1997 p. 94). Its aim is to elicit, explore, gain access to the participants views of their perceptions, attitudes, opinions, experiences, understandings, feelings and social worlds (Silverman, 2000; Fossey et al, 2002; Kumar, 2014). Moreover, it enables the understanding of how people experience certain phenomena and the best way to do this according to Holloway et al (1998) is to ask people about their experiences. I was the catalyst for achieving the change by stimulating people to review practices, experiences and offer possible solutions along with the consequences.

During the focus groups I adopted a form of AI. AI not only focuses on the best of what is, but engages all stakeholders in a process of reimagining what could be and taking ownership for what will be. (Bushe, 2011). I was able to identify, outline, compare, execute, construct and deconstruct the organisations’ needs and issues with the current demand, supply and skills required for the nursing workforce to then design and develop the innovative programme.

I elicited a number of key concerns / requirements. Firstly, the commissioned numbers were not growing quickly enough to meet workforce needs. Secondly, the Trust staff felt that newly recruited graduate nurses were not sufficiently close to being ‘Practice Ready’. Thirdly, the Trust wanted the nursing students to have a sense of belonging to the organisation and for themselves to have a sense of belonging and part
ownership of the students’ nurse education programme.

Step 3 involves creating a vision that clearly and concisely communicates the purpose of the change (Calegari et al, 2015). In addition, it involves developing a strategy for achieving that vision (Dawson and Andrioppoulos, 2014). Most importantly Kotter (1996) notes that it must appeal to both the “head and the heart”. In this case, it is about ensuring we are all working to the same vision, which is, to ensure we have the required sustainable workforce that meets the service user’s needs.

A key influence in the design of ‘The Bolton Model’ was based around a number of principles from the Transition Pedagogy Handbook (Nelson et al, 2014). The guide is specially designed for managing first year students and the curriculum. A good first year experience is critical for student engagement and retention (Nelson et al, 2014). This guide contains the Queens University of Technology (QUT) First Year Experience (FYE) Framework and the QUT’s FYE programme which consists of four dedicated areas in its approach to designing the first year experience. (see figure 2) These are: 1. curriculum design and enactment so that students are engaged in learning, 2. the provision of timely access to support, 3. developing a sense of belonging for all students, 4. the development of academic and professional partnerships (Nelson et al, 2014). However, even though this framework revolves around the first year student experience, within ‘The Bolton Model’ these areas are embedded throughout the whole of the 3 year programme.
One of the main themes from the focus groups with key stakeholders highlighted that managers felt that newly qualified nurses were not ‘Practice ready’. They explained that many newly qualified nurses required a 12-18 month preceptorship period. The term ‘practice ready’ relates to nurses, although competent against the NMC (2010) pre-registration standards, they do not necessarily have the competencies and essential skills at the practical level required for the organisation. In the main, some of the specific clinical skills the trust felt newly qualified nurses were lacking included; venepuncture and cannulation and particularly in line with the organisational policies and procedures. The literature review also revealed that it has been argued previously (Fitzpatrick et al, 1993: Girot, 1993: Bradshaw, 2000) and has been reported more recently that nursing students lack sound clinical skills, are passing courses without
these required skills and therefore are not ‘practice ready’ (Wolfe et al, 2010: Teoh et al, 2013). Within organisations and institutions to date there are variable competency assessment procedures for specific clinical skills and thus many HEIs who work with numerous NHS partners are not able to prepare the student nurse to the specific level of skills that meet every organisational partner requirements. Consequently, this can be difficult for the student nurse to become ‘Practice Ready’ due to the continuously moving and ever changing face of healthcare (Kessier et al, 2014).

Still today there remains a tension for the public and nursing profession in relation to how best to prepare and educate ‘knowledgeable doers’ that reflects the need for nurses to maintain a wide knowledge base, technical ability and skills range to provide nursing care. During this stage I also asked the members of the focus groups to reflect and discuss the greatest aspects of the past and current nurse training programmes, i.e. the ‘positive core’ to bring out the signature strengths (Cooperrider and Whitney, 2011). I also asked them to discuss their own pre-eminent experiences from their own training, which is a key innovation of AI (Bushe, 2011).

To address the issues of ‘Practice Ready’, a curriculum that engages students learning, timely access to support and fosters a sense of belonging for all (the first 3 key strategies of the QUT’s FYE programme) was required. One aspect of ‘The Bolton Model’ is the inclusion of several clinical skills weeks that are embedded at pertinent points throughout the three years of the programme. This aspect is one of many that emphasises that the curriculum engages students in learning. The clinical skills are delivered within the Partner Trusts’ simulation suites and facilitated by the Trust clinical staff thus ensuring that the Trusts’ policies / guidelines are used and reiterated.
Another aspect of ‘The Bolton Model’ is the identification and allocation of ‘clinical advisors’ to each module. The clinical advisors are nominated Trust personnel who have the expertise, both clinical and theoretical, for the module that they are linked too. The clinical advisor is a specialist clinical practitioner who can either take a ‘light touch’ approach when they critically review the indicative content, learning outcomes, module handbooks and provide constructive advice to the module leader. Or depending on the type of module, the clinical advisor can be more involved and contribute more to the delivery of the module which is supported and overseen by an academic tutor. An effective accredited curriculum will succeed if there is input from employers to ensure the curriculum is relevant, up to date and matches the need of those employing successful graduates of the programme (Westwood et al, 2007).

The second key strategy within the Transition Pedagogy Framework is proactive timely access to learning and support. Edwards et al (2015) emphasizes the importance of organisational guiding and support for nursing students with effective supportive programmes. This includes mentoring, but ensuring that mentors are adequately prepared for and supported in this role is key to the success of the student. In addition, much of the literature highlights that self - confidence amongst newly qualified staff is very much lacking (Whitehead et al, 2013). Coupled with the early issue of being ‘Practice Ready’ an excellent feature within ‘The Bolton Model’ is the employment of the Clinical Tutor (CT). A CT is employed by the Trust to support a cohort of 25-30 students. They are the lynch pin between practice and the HEI. This role is very much based on the Practice Education Facilitator (PEF) role. The PEF role was introduced
in 2008, in the main due to the issues as a result of Duffy's (2003) report regarding ‘Failure to Fail’. Duffy (2003) found that mentors were assessing students’ competencies and passing the student as competent when they were not competent. PEFs support the quality of the clinical learning environment for all pre-registration healthcare students within the healthcare organisation they are employed in (Wells et al, 2014). However, the difference between the PEF and the CT in ‘The Bolton Model’ is that the CT supports a maximum of 30 students as opposed to 200 to 300. This small number is necessary to ensure each student feels secure, has direction (Westwood et al, 2007) and has timely access to support. The CTs work with mentors and students in practice to develop the student’s clinical skills and in particular they work with those whom appear to be struggling to attain the required skills for the stage of their programme. This role is not to replace the practice placement mentor, but is an additional support role for both the student and mentor. Through working closely with the student it is also envisaged that the CT will enable the Bolton students to increase their confidence throughout the course and thus be confident on qualifying.

The clinical tutors are based within the exiting PEF team employed by the trust. The PEFs have supported pre-registration nursing students for many years therefore, are ideally placed to support the CTs. In preparation for the implementation of ‘The Bolton Model ‘for each new partner Trust and newly appointed CT it was agreed that they would spend time and shadow the PEFs and the academic team during their induction and during opportunistic times when the PEF and academic were dealing with student issues. The CTs were provided with all the curriculum documentation such as, programme handbook, programme and module specifications, practice assessment handbooks, student placement and mentor handbooks, along with the students PDP
and clinical skills booklet. The University has been approved by the NMC to offer a Postgraduate Certificate in Teaching and Learning for Higher and Professional Education. This programme is an essential criterion for all nursing academic tutors who teach on NMC approved programmes. Through the partnership working and agreement with the executive teams the CT have the opportunity to undertake this programme if they wish to develop in their career.

In order to ensure consistency and equity for all students the UoB team and CT teams from each partner Trust meet on a regular basis at various fora or meetings. These include, monthly programme team meetings, placement support meetings and assessment board three times a year. Furthermore, twice a year I plan, facilitate and deliver a programme development day for all academic tutors and CTs. The purpose of these development days is to share best practice, ensure consistency of module delivery, clinical skills delivery and discuss and debate any issues or concerns in order to improve the programme. The CTs have also arranged regular peer support meetings between themselves and invite an academic tutor to attend so that any issues or concerns in relation the academic aspect of the course can be discussed and clarified. In addition, I have arranged for the CTs to have an external account to access the UoB moodle site so they can populate a clinical skills moodle site to share resources and ensure consistency.

The fourth strategy within the framework is sustainable academic professional partnerships. The main aspect of this partnership strategy was embedded during the next stage of the implementation and delivery of the project and will be discussed later. However, this was embedded initially to ensure a collaborative partnership approach
was used to design and develop the curriculum. As previously mentioned I arranged and led a number of focus groups with other key partners including: newly qualified nurses, potential applicants and service users in order to present the initial curriculum design and seek their views and ideas / suggestions to strengthen the curriculum, model and design. (See Appendix 13 for copies of the presentation used at each focus group).

Solvoll and Heggen (2010) highlight the continuous debate regarding the academic nature of nurse education, which illustrates the tension between the expectation that nurses will have both clinical skills, a good underpinning of technical and theoretical knowledge base, whilst maintaining a strong compassionate caring focus to their work. To assist in developing students with strong compassion and caring focus a notable key element embedded within ‘The Bolton Model’ is The Patient as Coach Team (PaCT) and one that has now been recognised as notable practice by the NMC (see appendix 14).

The PaCT are essential partners within the development of the student nurse. The NMC strongly advocate that HEIs must embed and evidence that service users are involved in all aspects of an education programme. Active patient participation is a very effective method of delivering information (Westwood et al, 2007). I wanted to ensure that the programme utilised the service user in a more collaborative and innovative way from the normal traditions of service user engagement, such as, during recruitment, assessment and partaking in Objective Structured Clinical Examinations. Therefore, I ensured that a more collaborative element was built into the curriculum throughout the three years of the programme whereby service users and carers
contribution to the student experience of placements through 'coaching' sessions. These sessions are held within two weeks after the student has completed each placement and consist of small action learning sets which are facilitated by the service user. The service user is a trained 'coach' and facilitates reflection and helps the students to focus upon themes related to the ‘6C’s; (Caring, Compassion, Communication, Commitment, Competence and Courage’ (Cummings and Bennett, 2012). Students evaluate this very well and the service users recognise that the students appear to be relaxed and willing to disclose within a safe learning group and thus the students seem to appreciate the neutrality of a facilitator. The service users are selected and fully briefed and debriefed for this undertaking. Students have six opportunities within the three-year programme to participate.

All service users that are involved with any NMC approved programme are required to be fully prepared and trained for the role that they have undertaken (NMC, 2010). ‘The Bolton Model’ and the School identified a named service user champion whose role is to recruit, train, support and be an advocate for the service users that are involved in any of the healthcare programmes within the school. The recruitment of the service users for the varying roles embedded in ‘The Bolton Model’ consisted of the team contacting the Trusts own service user groups, many local support and self-help groups, along with advertising via poster displays in the Trusts own outpatient departments and local health centre waiting rooms. Volunteers were asked to contact the UoB service user champion who then arranged to meet with each volunteer. It was crucial that the service user champion ascertained from the service user the real motive as to why they had come forward to be a part of the programme and also to ensure they were recruited for the most suitable role within the programme. Essentially
I wanted to ensure that the service users were as keen as the team to assist in developing the future nursing workforce and not just taking part with their own agenda.

At the same time the School implemented a service user strategy and whilst this was being established the team also developed and designed a full training package for the service users. This training package includes sessions on equality and diversity, recruitment and selection, (delivered by the UoB Human Resources team), safeguarding and coaching skills which are essential for those service users that are taking on the PaCT role. There are a number of other training sessions for service users including, feedback and communication skills, Objected Structured Clinical Examinations (OSCEs) and these are delivered as and when required.

For those service users who had been recruited as a Patient Coach, prior to being allocated a group of students they were provided with the necessary training. The lead PaCT facilitator (service user champion) organised a development day which consisted of the PaCT role expectations, roles and responsibilities, coaching, along with facilitation techniques. The service users were provided with a PaCT pack, which includes the proformas and guidance sheets that are given to the students in preparation for the PaCT sessions. The same training continues to be provided for any newly recruited service users. In addition, the PaCT attended regular support groups which are facilitated by the service user champion to enable the PaCT to access peer support and network with each other.

The above has provided a very brief overview of how I designed and developed a few of the main innovative aspects of ‘The Bolton Model’. For the full curriculum design
see appendix 15 named ‘Curriculum Documents for the joint approval with Nursing & Midwifery Council & University of Bolton for BSc (Hons) Adult Nursing Degree.

**Kotter’s (1996) step 4 & 5 stage – Communicate for buy-in; / - Empower action & the AI 4D method 4 - Implementation (delivery)**

The innovation has been designed, developed and implemented using the existing theories of collaboration (Dillenbourg et al, 1994) and partnerships. According to Carnwell and Carson (2008) partnership and collaboration are often used interchangeably. A partnership is a relationship in which two or more people, organisations, or countries work together as partners (Collins Dictionary, 2016). Stern and Green (2005) define a partnership as a programme that has a high level of commitment, mutual trust, equal ownership and the achievement of a common goal. Collaboration is the “mutual engagement of participants in a coordinated effort to solve a problem together” (Stern and Green, 2005). Collaborative interactions are characterised by shared goals, symmetry of structure, and a high degree of negotiation, interactivity, and interdependence (Lai, 2011). This includes a consideration on the different notions of collaboration, the division of labour, the collaborative state and the purpose of collaboration, effective support for collaboration, and partnership working models.

In stage 4 of AI, there is a need for widespread agreement with key participants who made self-chosen personal commitments to take action and help bring the design of the model to fruition. Therefore, in order to commence agreement and implementation I and the NHS partner had the same shared vision / goal, commitment and ownership of the project. After establishing an inclusive vision it is important to communicate the vision and ensure ‘buy in’ from all involved. I engaged the right people to communicate
and assist with the implementation of the programme. This included the executive
team at both the Trust and the University. Having ‘buy in’ from the executive team is
the key to success (Calegari et al, 2015). The defining attributes of partnerships and
collaboration according to Carnwell and Carson (2008) and Baars and Menzies (2016)
include:

- Trust and confidence.
- Respect for specialist expertise with knowledge and expertise being more
  important than the title of their role.
- Members sharing the same vested interests and common goal.
- Joint venture with a willingness to work together towards an agreed purpose.
- Participation in planning and decision making.
- Effective communication and cross pollination of ideas.

Moreover, Sharp et al (2006) summarise the key elements of effective partnerships
as:

- Common understanding of mutual benefit.
- Establishing a shared vision and mutual trust.
- Sharing of resources, benefits, responsibilities and risks with a reasonable
  balance of power.
- Commitment to joint working with each partner bringing different complimentary
  types of expertise.
- Joint planning with sufficient flexibility.
- Consistent and effective communication.

This was certainly the case within the project with all key stakeholders respecting what
each other could bring to the relationship (Labonte, 1994). There was the readiness
from each partner to engage, clear understanding and acceptance of roles and
expertise. Along with this was the confidence in ability and recognition of disciplinary boundaries, effective communication, visions and outcomes and trust in the collaborators.

Through the support of the executive team at the Trust and the University I presented the vision of the programme along with the design and model of the programme at numerous stakeholder events to Trust managers, placement staff, service users, newly qualified staff, potential future students and the HEI team. During this time I sought feedback via focus groups to strengthen certain aspects of the model as well as gaining the Trust and the HEI staffs’ commitment to the vision and taking ownership of the innovative model of nurse education (Dawson and Andriopoulos, 2014). During the presentations I clearly emphasised that the programme had senior executive agreement and support (Pollack and Pollack, 2014).

**Kotter’s (1996) step 6 stage – Create short term wins & post approval - response and interest**

Once the programme was approved and started to recruit students the numbers of applications for the small amount of places was pleasing to see. With a short turnaround of six weeks to recruit 25 students to the February 2015 intake, over 60 applications were received. As soon the February 2015 intake were recruited the recruitment cycle to the September 2015 intake commenced, with a staggering 650 applications received for just 30 places (UoB, 2015). These short term wins gave confidence in the project and ‘The Bolton Model’ of nurse education and helped to demonstrate the viability of change (Calegari et al, 2005) and to build momentum within the team and partners (Pollack and Pollack, 2014).
In addition, during the recruitment to the September 2015 intake, I took the opportunity during the numerous recruitment and selection stages to ask applicants to complete a recruitment and marketing questionnaire. This was in order to gain further insight, analyse and evaluate why they were choosing ‘The Bolton Model’ nursing course, as opposed to the many other commissioned nursing programmes available (See appendix 16). This survey demonstrated that many chose to apply to the Bolton Programme because of the key features of the programme. This included: the small cohorts sizes, intense personal tuition and the reputation of the programme / the University. Interestingly, 37 of the respondents had applied for nursing courses previously but obviously without success and 66 out of 76 said, “they would choose ‘The Bolton Model’ over the commissioned course any day”.

**Kotter’s (1996) step 7 & step 8 stages – Consolidating; / - Institutionalising new approaches**

As the programme was implemented and students commenced practice placements, I visited placement areas to meet with the student mentors, to explain the origins of the model and the requirements from them to support the students. Continuing this consolidation and institutionalising the concept of ‘The Bolton Model’ clearly constitutes steps 7 and 8 of Kotter’s (1996) model. The clinical tutors and the HEI staff continually visited practice placements to meet with mentors and staff involved in supporting the students on ‘The Bolton Model’.

Since the programme was approved and implemented in October / November 2014 there has been huge interest in this innovative approach (see appendix 2, 4, 5 & 6). I
have been asked to present ‘The Bolton Model’ to many other NHS key stakeholders, including the Directors of Nursing, and also the Heads of Education and Workforce leads at Continuing Professional Development Network meetings (see appendix 17). Thus, I am still maintaining the sense of urgency and re-emphasising the critical need for the change in the way to increase the nursing workforce; a key part of step 7, consolidating the change (Calegari et al, 2015). Through this, the provision has expanded and I am now working in partnership with two further local NHS trusts to also meet their workforce needs.

In addition, I was contacted by the Department of Health so that they could prepare for the parliamentary ministerial debate that took place in January 2016. This parliamentary debate was a result of the post spending review earlier that year regarding the removal of the bursary system for nurse training (See appendix 5). They were keen to gather information of my knowledge and experience so far. They were very interested in the number of applications received, the demand for the course, attrition rates and applicants’ perception of paying the tuition fees.

Furthermore, I was also contacted by, Lord Willis of Knarlesborough during his independent review of current nurse education and ‘The Bolton Model’ features positively in the ‘Raising the bar’ publication (Appendix 1). This publication sets out the recommendations following an independent review on behalf of HEE, which focused on care staff and registered nurses to determine if current education and training is fit for purpose. Lord Willis visited many healthcare organisations and HEIs during the review to ascertain what works well. ‘The Bolton Model’ was seen as innovative and an excellent collaborative partnership to support the education of the
future workforce and determine together how practitioners will be developed and encouraged to meet the future needs of the local patient population. Lord Willis states “this example confirms that there must be more encouragement of local-based innovations, rather than the imposition of top-down workforce solutions” (Willis, 2015, p. 59).

Many staff within the HEIs and the Trusts from around the UK have been in contact with me asking if I would be willing to share my experiences and disseminate the key elements to the success of the design and the key features of implementing this model. The main aspects that they were keen to learn about included: the views, support and commitment from the NMC, demand for places, recruitment numbers, implications in practice with students sharing the same placement circuit as other commissioned students, students views regarding fee paying and attrition numbers. However, in the main they were keen to learn how I led, implemented and managed the project along with any of the key lessons learned and essential tips I could offer them if they were to pursue the same model (See Appendix 6 and Appendix 18 for each Testimony).

I have presented the project now at a number of fora. I have had numerous visits from other HEIs seeking my experience so they too can develop something similar. Moreover, I was nominated for an award by The Academy of Fabulous Stuff, Roy Lilley (appendix 3). The Academy is a web based social media site for the NHS to share ideas in order to create a mass movement of NHS staff demonstrating the difference they can make by one simple act, showing that large-scale improvement is possible. Although I did not win the final award it was a privilege to be nominated in the first place. Additionally I was the winner of a Quality Award organised by Lancashire
Teaching Hospital Trust in regards to Collaborative working – Working in partnership (Appendix 3). Moreover, I have presented at the RCN Education and International Forum (Appendix 4), along with being invited and took part in a professional debate titled ‘Cutting student nurse bursaries will encourage far more students into training’ at The Changing Strategic Context: leading the nursing contribution supported by NHS England and the RCN (Appendix 4). I submitted an abstract and the paper was presented at the NET 2016 27th International Networking for Healthcare Education Conference (Appendix 4). Finally, I have been “head hunted” and acted as an external panel member, along with providing guidance and support to other HEIs who are or have developed their own non-commissioned nursing programme (see appendix 19).

Summary
Attention to this model is important in light of the government plans to move away from commissioned health professional education in September 2017. This chapter has provided a critical overview of the process used to design, develop and implement ‘The Bolton Model’ of nurse education. The use of participatory action research, and appreciative inquiry, along with Kotter’s (1996) 8 step Model of change management and how ‘The Bolton Model’ has been designed around the Transition Pedagogy guidelines. The following chapter will provide a critical personal reflection and evaluation of the journey I encountered throughout this project.
Chapter 4

A Critical Personal Reflection
A Critical Personal Reflection

“It is not sufficient to have an experience in order to learn. Without reflecting upon this experience it may quickly be forgotten or its learning potential lost. It is from the feelings and thoughts emerging from the reflection that generalisations or concepts can be generated. And it is generalisations that allow situations to be tackled effectively” (Gibbs, 1988, p. 14)

Introduction

Reflection is a process that is an important human activity which enables people to recapture their experience, think about it and evaluate it (Boud et al, 1985). Moreover, with any type of practice that has taken place critical reflection is an important capability to develop as it contributes to greater depth of understanding and learning (Moon, 2006) and is widely recognised as a key component in the learning process of individuals in areas of professional practice (Brookfield, 2009; Leijen et al, 2011). Reflection ‘In and On action’ (Schon, 1983) took place throughout the whole of the project and continues to do so. Reflecting on the impact of all aspects of the process from initial ideas, design, development and implementation of the model was crucial. Reflection was especially important during focus / steering groups and one to one interviews (Smith, 1999). In contrast, Steale (1999) notes the limits of reflexivity in that it is difficult to be aware of all the subconscious ways in which assumptions shape approaches to research and learning. An important aspect whilst critically reflecting is to use an integral and transparent approach in order to increase sensitivity towards decisions and their consequences (Dearnley, 2005). Moreover, reflecting and evaluating on the collaborative process of the project was essential for me in order to strengthen the effectiveness of the partnership model that had been developed (Bronstein, 2003). Therefore, the following chapter will provide a critical reflection of
the main aspects that I encountered and deliberated throughout my journey on this project.

The collaborative project discussed within this thesis, although it is in the early stages with the first cohort not due to graduate until 2018, it has already had a major impact nationally. In the two years since the approval of the programme, ‘The Bolton Model’ is recognised widely in the UK (see evidence in appendix 1, 2, 4, 5, 6, 17) and it is a major topic of debate within many HEIs and at many nurse education conferences across England. It has also influenced government policy and has led to a change of the current funding model of nurse education.

The project has been successful partly because it was the ‘right idea’ at the ‘right time’. It was developed and implemented when the NHS was faced (and still is) with a shortage of nurses, and shortage of funding. The need to look at an alternative approach was essential. However, this was a big risk because historically any change in nurse education has always been via a top down approach from the Government and NMC. This risk was one that I was willing to take because an alternative route to increase the workforce was clearly needed. From the work that I have undertaken I have now pioneered a new funding model of nurse education and provided the government with a model which can save them several millions pounds on funding for nurse education. Initially while it began as a small project, it is one that has created a significant impact. This have been through my contribution and advising the DH by sharing my experience in preparation for the Parliamentary debate that took place in January 2016. The impact within the HEI has increased and will continue to increase the student body significantly. Through continuous critical reflection numerous aspects
arose of which have been grouped into 3 main themes and are critically discussed below. The 3 main themes are:

- Reflection on personal learning in relation to the study topic and in the context of the following two other reflection themes.
- Reflection on the innovation of the curriculum at this point in UK nursing history
- Reflection on the responses from within the community of nurse education providers and practitioners

1. **Reflection on personal learning in relation to the study topic and in the context of the following two other reflection themes**

At the start of the project, following initial discussions with the NHS Trust, I was excited by the challenge and keen to develop an alternative way to ensure additionality to the nursing workforce. More so, because of previous experience in my early career when I was very much part of developing the future nursing workforce in the Bolton district. However, my initial critical reflection challenged my own ethical and moral perspectives, for example, whether I should propose and therefore, condone student funded education rather than the existing HEE funded arrangement. Initially this did not sit comfortably with me. I questioned firstly was it ethically right. I contemplated how potential students would feel regarding the large debt they would incur at the end of the programme before their career had even commenced. Even more so, for those mature students who have children. Students are required to pay the tuition fee and maintenance loans once the income salary is over the current repayment threshold. This is dependent on where the student lives; if living in England or Wales the threshold is £21,000. The threshold is slightly lower (£17,495) for those students who live in Scotland or Northern Ireland or EU students funded via Scotland or Northern Ireland (Student Finance England, 2016a). A newly qualified nurses’ salary is normally
£21,909 (Health Careers, 2016), therefore, all newly qualified nurses would need to commence repayment of this debt once in full-time employment.

Students on any undergraduate full-time course struggle financially during their studies, with many undertaking a part-time job at the same time (The Telegraph, 2016). This is especially difficult for student nurses who are required to fulfil the NMC (2010) criteria of 4,600 hours of theory and practice. The opportunity for student nurses to be able to work part-time alongside their studies would prove difficult, especially when they are in practice. Therefore, the quandary I was faced with was that fee paying student nurses may have more financial worries (due to the large debit accrued by the end of the programme) than commissioned students and whether this would adversely impact on their learning. Through discussions with lay people and family members I questioned this initial dilemma. If the course was not Healthcare related, such as, a History degree, I would not be having the same deliberations. However, it was my desire to be a part of developing the future workforce that I had been involved in during my previous role that was influencing my decision. I concluded that in the context of high demand of applicants wanting to enter nurse education programmes, along with the national shortage of nurses, additional provision should be created via the fee paying route.

Conversely, if the main focus for this programme were to promote nursing and increase access to being a professional, then it might be argued as favouring those with the means to pay. Nevertheless, potential applicants were not dissuaded to apply for a self-funded education programme and were grateful of another opportunity that would be available to them to apply for nurse training (see recruitment and marketing
research survey results appendix 16). In addition, feedback conversations with candidates had indicated that money was not the main driver for these applicants, rather they highlighted the intrinsic benefits of a nursing career. In support of this, one of the themes within the longitudinal study commissioned by HEE (see appendix 20, Executive Summary) has shown that it is the financial issues during their studies that needed to be managed, rather than the worry of the tuition fees on completion. This reflects a broader student perspective on education regardless of the programme of choice.

I had used one to one interviews in a previous research study, but I still felt very much a novice (Benner, 1984) and uncomfortable in asking the participants if they were willing to pay the tuition fees. I felt anxious about the response I might have received, and did not want to hear if they were disapproving of the idea. I obviously wanted a positive reaction / response. As a novice at both interviews and focus groups it was difficult to decide whether some of the aspects discussed by the participants were important to pursue or not, or if they were informing me of what they thought I wanted to know especially during the applicants’ one to one discussions. This could have potentially affected the validity and reliability (Saks and Allsop, 2013) of the analysis of the results. However, triangulation via the recruitment and marketing research survey and the data available on the number of applications received for the programme contributed to the reliability of the analysis from the interviews. In addition, it was necessary for me to maintain an objective balance, due to my preconceived ideas and experiences, and thus carefully consider the questions and wording I used during the interviews, so that my own analysis from the critical review of the literature and development in my field did not have a potential impact on the participants.
Furthermore, during the interviews I felt that my role as programme leader and admissions tutor might have influenced some of the participants’ responses regarding their willingness to pay the fees. Therefore, the setting of ground rules was critical here, along with informing the participants at the outset that that there was no specific right response required to enable them to be as open and honest as possible. However, some of the feedback might not have always been honest. It is generally known that during the interviews participants have been known to inform the interviewer what they think the interviewer wants to hear (Low, 2007). Nevertheless, all those who took part in the one to one interviews stated they were willing to fund their fees and in all cases, they had already funded two years of a degree programme to enable their career progression. It is presumed that for some, if given the choice of fee paying as opposed to a commissioned place, they would choose a commissioned place, but interestingly that was not always the case and many would choose the programme that meets their needs best (see question 9 of the recruitment and marketing research survey results – appendix 16). In future, it would be beneficial to use an alternative data collection method than the one to one interviews. This could include: anonymous surveys and focus groups (to triangulate findings), along with recruiting an experienced independent interviewer who has no connection with the project or development of the model thus, would have greater freedom to ask questions (Dearnley, 2005).

Another pertinent lesson learned was linked to my lack of understanding of students’ eligibility for funding. Especially for those who hold an equivalent or higher level of qualification to the one they intend to study. Those students who have studied at HE4
level and above are not eligible for additional funding (Student Finance England, 2016b). Consequently, a number of students from the first two cohorts had to either withdraw from the programme or were fortunate enough to find other financial support from their parents to help fund the fees for the first year. I should have sought further information from Student Finance England, so I would have been able to advise applicants correctly. I have since researched this aspect and have a better understanding to be able to inform potential applicants. As a result, this is now a key feature in the recruitment campaign for future cohorts and I do stress during open days / events and through the whole of the recruitment cycle that applicants need to contact Student Finance directly to ascertain their eligibility for funding. However, from September 2017 this may not be too much of an issue because nursing students will be eligible for a second loan.

2. Reflection on the innovation of the curriculum at this point in UK nursing history

Attrition and retention in the nursing profession are national concerns with recent reports highlighting that NHS Trusts are looking overseas for nursing staff and that vacancies are at nine percent (Marangozov, 2016; BBC, 2016). The need to recruit and train those who are passionate and committed to a nursing career is essential. Furthermore, from a Utilitarian as opposed to a Deontological view, which considers the greatest good for the greatest number of people (Beauchamp and Childress, 2001), coupled with the retention issues, commissioning nursing places could be construed as a “waste” of NHS monies. This is due to the cost of training these nurses, who then choose to leave at no cost to them but to that of the NHS. Moreover, I believed that the provision of students paying their own fees would recruit a more
ambitious and committed student who will register with the NMC on qualifying. From the initial marketing survey this theme was clearly evident. Furthermore, it is envisaged that the longitudinal evaluation and completion rates will either prove or refute this idea. In contrast, at the time and still today there is a need to increase the nursing workforce, therefore, we need to offer this opportunity. Thus, the main aim for this innovative model was to ensure the NHS Trust workforce needs were being met by providing additionality to the workforce. Therefore, if the aim is to increase the nursing workforce then many routes are a solution. Conversely, the need for a more long term strategic workforce plan would be critical to prevent the ‘boom and bust’ cycle, without this it might put healthcare in crisis (The Times, 2016).

‘The Bolton Model’ has now changed the way in which nurse education will be funded from September 2017 with the announcement following the spending review (DH, 2015b) that more places can now be made available to assist in reducing workforce shortages. Historically, many HEIs had taken for granted the continuation of the existing funding model and so an alternative would pose a threat to the current commissioned business model. However, a new model of funding would create competitiveness and raise concerns by recruiting from the same pool of applicants. This potentially could lead to destabilizing nursing faculties / schools within the HEIs. Little did I know the impact this would have on the future of nurse education in the UK at the time.

The purpose of pre-registration nurse education is to provide appropriately skilled staff to deliver care that is required by the service users (Westwood et al, 2008). Nurse education over the past three decades has transformed radically to meet the demands of the ever changing healthcare needs. High quality nurse education curricula must
reflect the needs and demands of the healthcare delivery system and service users (Ali and Watson, 2011). At the start of the project during the initial meetings it became clear that the Trusts’ vision, expectations of the programme and anticipated model were very ambiguous. Their vision was for the development of a ‘School of Nursing’ on the Trust premises with Trust staff delivering most of the teaching, and the University providing only a quality assurance role for the provision of the programme.

This was a step back to the nurse education model of a previous era before education relocated to HEIs and to the traditional route of the nurse training in the 1980s. Many members of the group had undertaken their own nurse training within a ‘School of Nursing’. Therefore, I felt that some of the members wanted to revert back to this model, along with having complete ownership of the programme and just wanted the University to act as an awarding body. I was concerned, because as potential partners, it signalled an unequal power relationship that needed addressing. Consequently, this model that had been previously criticised as not producing students as ‘fit for practice’, was wrestling control of professional identity back from the HEIs. I was worried that the sharing of resources and responsibilities (Sharp et al, 2006), a key element of effective partnerships was threatened. I too, wanted to ensure that I and the nursing academic team contributed fully in developing the future workforce and not just to pay ‘lip service’ to the provision.

In addition, the respect for specialist expertise, another key attribute to partnership working (Carnwell and Carson, 2008), also appeared in jeopardy as the Trust staff perhaps were unaware of the purpose of Higher Education as opposed to just ‘training’. From the outset, the NMC had been very clear that they had no appetite to
return to ‘Schools of Nursing’ and that nurse education clearly belonged in Higher Education, therefore, making the Trust plans unrealistic.

Trying to agree a workable model and curriculum was challenging at times. Utilising stage 3 of Kotter’s Model (1996) which asserts the preparatory stages of change leadership and ‘getting the vision right’, I applied my negotiating skills and appreciative inquiry within the relevant focus groups. I was conscious that I needed to negotiate strongly on some aspects of the model and that these could potentially fracture the relationships and affect the collaborative partnership that was evolving. According to Parahoo (2014), by listening and understanding people’s needs, motives and circumstances, it is possible to develop interventions or programmes that suit both parties best. Moreover, within Action Research (AR) the role of the researcher is to help in its implementation by analysing any weaknesses and helping to locate other ways and / or resources (Gray, 2014). Furthermore, Stringer (2014) asserts that the aim of AR is not to finalise answers to problems but to discover the truths and realities held by different groups.

I felt that to ensure the model was realistic I had to draw upon my previous experience of curriculum programme design, especially in the development of NMC approved programmes. Therefore, demonstrating within the partnership, the distinct and different skills necessary for a successful outcome. Thus, I feel it was through having mutual goals, being open, transparent and honest with what is workable and realistic for each partner, that has led to a clear vision for the partnership to flourish and the model being approved.
Through my critical personal reflection I feel that my anxieties may have been unfounded. Initially I was subconsciously concerned that if both parties did not agree on a realistic model the consequences would lead to the project collapsing. On reflection, the main driver for the Trust was to ensure they recruited staff locally and to ensure the students had a sense of belonging to the organisation, so that on completion they would seek employment with them. Therefore, the Trust’s initial ambitious model could potentially have been out of enthusiasm and the need for students to feel a sense of belonging to the Trust, to be a part of developing the local population and ensuring workforce needs were met.

Conversely, they may have seen this as an alternative way to raise their profile in developing the future nursing workforce as the idea of having a ‘School of Nursing’ and becoming a NHS University had previously failed. Therefore the Trust pursued the next best option to work in partnership as the ambitious plan would not have succeeded without a HEI. However, it transpired that they were just as keen to have as much involvement and part of the development and delivery of the programme as the University staff and team.

3. Reflection on the responses from within the community of nurse education providers and practitioners

Action Research is a methodology for examining the impact of a local intervention (Midgely, 2003). The change associated with an intervention has several dimensions including political. Therefore, another anxiety that I reflected upon was linked to the change to the traditional funding provision for pre-registration nurse education. I was very apprehensive of the reaction that this would have with other HEIs, the nursing
profession, the media, the Unions, the policy makers and the placement providers.

Initially, I wondered what consequences or impact this would have. However, I thrive on a challenge. I was prepared to take a risk, as I am passionate about nurse education and even more so in ensuring that the needs of the service users are met. The feedback to the proposal was varied from Nurse Educators.

Over the years a number of NHS Trusts had tried to look at alternative ways to develop the workforce outside of the traditional commissioned places, however all unsuccessfully. Many organisations (HEIs and NHS Trusts) in the background were sceptical and thought the programme would never be approved by the NMC. Therefore, the fear of failure was at the forefront of my mind. However, this made me more determined to be successful and develop the first non-commissioned programme in England. It was exciting, but I was also very concerned as I did not want the partnership to fail and that in itself was a latent issue in the background. This created an added pressure but at the same time motivated me during the challenging times.

Local HEIs and peers were very reticent about the innovative model and at times made me feel very uncomfortable in meetings. I was also exasperated when I was excluded from a pertinent steering group meeting of which all local HEIs attended to discuss pre-registration nursing programmes, practice and associated issues. It was clear to me that a close collaborative relationship would be beneficial as there were many issues and concerns to be aware of across the whole of the placement circuit. Therefore, some might construe this as a lack of professionalism on their part especially as nursing professionals who are bound by the NMC ‘The Code for nurses
and midwives’ (2015). In particular this relates to the ‘Working Collaboratively’ (point 8.1\textsuperscript{4}, 8.2\textsuperscript{5} and 8.5\textsuperscript{6}) and the ‘Promote Professionalism and Trust’ (point 20.8\textsuperscript{7}) sections of The NMC Code (2015).

Peers were concerned about the impact on practice placements and felt the quality of these would be affected. Also, there were some concerns that using the same placement circuit would reduce other HEIs placement capacity, with such comments as, “The Bolton Model is pinching our placements” being mooted. On reflection, this revealed the politics of competing HEIs which I needed to consider. At first I felt irritated with this, as the whole model and planning of the theory / practice weeks and agreed number of student intakes, were based on ensuring the quality of the learning environment so that placement capacity was not put at risk. During the approval of the programme it was the NMC’s role to ensure that student learning, both in theory and practice, was of good quality and that assurance and evidence was available which demonstrated that additional student numbers could be accommodated. I was frustrated when the competitors questioned the NMC programme approval and yet the NMC had raised no concerns during and since the approval event. The lack of information regarding how ‘The Bolton Model’ was developed and how it would fit with their existing nursing programmes may have contributed to their hostility. Conversely, it was reported anecdotally they were displeased with the extra students on the placement circuit and that these extra student numbers might potentially have some impact on their placement quality feedback. On the other hand, it is more likely about the fear of possible change to the current funding model of nurse education and the

\textsuperscript{4} 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate.
\textsuperscript{5} 8.2 maintain effective communication with colleagues.
\textsuperscript{6} 8.5 work with colleagues to preserve the safety of those receiving care.
\textsuperscript{7} 20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to.
potential impact personally. This may have been in relation to their current employment and / or jealousy of not being the one to develop this innovative model. Furthermore, local HEIs may have been opposed to the change either due to, not being agile enough, or have not been willing to be in the vanguard of this change. Another possible reason for this might have been that it was a pilot / project, therefore it would not change the landscape. Moreover, envy that the University of Bolton, who previously never had a history of, nor had a current approved pre-registration nursing programme, could claim prestige of this development for themselves and has now pioneered and changed the future of nurse education.

On the contrary, many more HEIs from across England, other NHS Trusts, HEE, amongst others have been very supportive, and keen to meet with me to discuss the model and approach I have developed. I have met a number of Programme Leads and Deans of School, along with the Directors of Nursing from NHS Trusts, who were all inquisitive and eager to know the origins, the key successes and lessons learned. Reflecting on their eagerness demonstrates that they see the direction of travel and need the intelligence to pave the way for replicating the provision in their own areas.

Initially I was and remain ecstatic, to have generated so much interest from other HEIs and other organisations. I was excited but also apprehensive when meeting with them. I could not be certain, despite their expression of interest, that they too had the same opinions and support for the model. Nevertheless, the feedback from these peers was very positive. They acknowledged that the model was innovative and on many occasions identified the model as a ‘Trailblazer’ as it was the first of its kind, and one that has looked at an alternative funding model and true partnership working. I felt
delighted with their response, proud of what I had accomplished, along with being thrilled but at the same fearful of the responses received from the media interest and the number of publications that had been published in the nursing journals. However, it is clear that I was able to give other HEIs the ideas, the confidence and potential opportunity to develop their own model of nurse education programmes.

Interestingly, I was contacted to contribute to a Professional debate following the recent Government Spending Review announcement regarding the removal of the nursing bursaries and to voice my support to this announcement. The assumptions from the organisers were that I agreed with the removal. However, I was bemused by their belief, as I had reiterated throughout the project, the model was mainly to provide additionality to the student nurse population alongside the current system of commissioned places. Nevertheless, I can see from their initial perspective, hearing from others and the media and not knowing the full origins behind the model, they would assume that this was my belief. The model has a financial driver in line with the government approach to reducing costs and the introduction of ownership of paying for education that was claimed to enhance future earnings.

Finally, it was when the Department of Health contacted me in January 2016 that reality hit home and I could comprehend the impact of what my work had contributed to the future of nurse education. To be asked for my personal knowledge and to share my experience in order to assist in the preparation for a forthcoming Parliamentary debate regarding the removal of the bursaries was unbelievable. I was shocked, but also felt privileged at the same time. Yet, I was conscious that I needed to ensure I
articulated and answered the questions to safeguard the philosophy and origins of the programme.

I was fearful that the ethos behind the model of a non-commissioned programme would be misconstrued. Therefore, controlling the agenda here was at stake. I was conscious that I had to continually reiterate that ‘The Bolton Model’ was to enable additionality to the student nurse population. However, there is a broader agenda required in reshaping the service provision in the face of the forecasted changes in the UK population (an extra 10 million people by 2030) and the pressures that this places on health and social care. Consequently, following the spending review the Department of Health have seen the benefit of fee paying provision with the announcement that from September 2017 all students entering pre-registration programmes will be fee paying and that the number of potential students could increase to ten thousand. That said, if this is the case, an urgent appraisal of placement capacity and mentorship provision is required.

Following that announcement I had to stand back and ask myself “What have I done?” I really have made a contribution and influenced the future of nurse education. To some nursing academics they saw this as a positive contribution but others raised some negative connotations. Nonetheless, on reflection the announcement hopefully will have a positive outcome for ‘The Bolton Model’. I feel that I have made a contribution to the future of nurse education and have assisted in reviewing the eligibility of funding for future students following the feedback that I provided to the RCN and the DH. The Government has since announced that from September 2017 nursing students will now be eligible for a second loan (DH, 2016).
From my overall reflections on the impact of ‘The Bolton Model’ it was clear that I had a communication strategy from the initial start of the project which was successful within the Partner Trusts and within my own HEI. However, I had underestimated the amount of communication needed to develop a consistent understanding (Kotter, 1996). This was clearly needed with other local organisations that the project could be seen to have an impact upon. I needed to share the vision more explicitly and clearer with the other HEIs locally, regionally and nationally to dilute their concerns. This would have helped to avert the ‘Chinese Whispers’, thus preventing the wrong information being discussed and disseminated. The reason why I did not communicate to a wider audience was from the fear of potential failure. In addition, if the programme was not approved then the need for others to know about the programme was irrelevant. Nevertheless, a clear component of change management is communication (Kotter, 1996). Therefore, in future I will communicate to all current and potential stakeholders that the project could have a potential impact on.

**Summary**

This chapter has provided a brief critical reflection of my journey throughout the initial ideas of the project through to the current stage of the programme. I have included my reflections on the most controversial areas that arose from the project and ones that had a strong influence on myself and others. I have reflected either ‘in or ‘on’ action which has enabled me to develop the project to fruition. Continuous reflection and evaluation is needed in order to enable the programme to develop, improve and continue to have an impact in practice. Most importantly to ensure we strive to meet workforce needs in order to ensure a high quality health care service is provided.
Moreover, continuing to develop this model and other models of nurse education is essential for all HEIs in partnership with local NHS Trust and other healthcare providers to meet local workforce needs. I am in the process of proposing a number of research projects and evaluations of ‘The Bolton Model’ especially the PaCT element. In addition, I am planning a research and evaluation project that will involve the journey of one or two student cohorts from year one to 12 months post-registration.

Following my journey and critical reflection I have become more self- confident in my own ideas, beliefs, abilities and in future will not be too anxious and concerned regarding the risk and fear of failure with other projects. I now feel I have the confidence to communicate any initial thoughts and ideas to all major stakeholders and to make explicit the vision in order to prevent unnecessary misconceptions. For any future projects that maybe similar in terms of major change to the traditional historical ways and ones which peers may challenge or criticise, this project has given be the self-assurance to challenge and defend any new beliefs, concepts and designs of future nurse education.
Recommendations for the Future
Recommendations for the Future

From the work undertaken during the development, design, implementation of the innovative model of nurse education and following critical reflection of the lessons learned the following recommendations have been proposed:

- HEIs need to establish true effective partnerships and work in true collaboration with their local NHS Trusts and healthcare providers by being open, honest and transparent in order to meet workforce and service user needs.

- HEIs need to be more flexible and responsive to meet local workforce nurse education requirements.

- HEIs, NHS Trusts and Healthcare providers need to be innovative, work together to have a clear workable vision and models in creating nurse education programmes to meet local workforce needs.

- HEIs, NHS Trusts and Healthcare providers need to have a number of innovative provisions of nurse education programmes that will enable differing entry routes into nurse education.

- It is essential that there are clear and explicit strategies for communication to local, region and national stakeholders at the start and throughout any innovative project.

- It is critical that the sharing of best practice and lessons learned following any innovative projects are disseminated.

- Continual research and evaluation of ‘The Bolton Model’ of nurse education is required in order to enhance the model and share best practice.
Statement of Collaboration
Statement of Collaboration

I, Trish Houghton can confirm that the conference paper (Houghton, T. and Howarth, J., 2016), The development of a Non-Commissioned BSc (Hons) Nursing (Adult) programme the first in England in order to meet the workforce needs: Initial reflections, presented at the RCN Education Forum National Conference and Exhibition on the 16th March 2016 was written in collaboration with Jane Howarth. I Trish Houghton took the lead in submitting the abstract, designing the conference paper and the presentation. The presentation was led by myself at the conference with Jane Howarth in attendance and available to answer questions following the presentation.

I, Trish Houghton can confirm that the Professional debate ‘Will removal of bursaries increase the student recruitment?’ held at the conference, The changing strategic context: Leading the nursing contribution, hosted by HEE in April 2016 was designed and written in collaboration with Jane Howarth. Both parties attended the debate and the final version was presented by Jane Howarth. Both parties were available for question and answer session at the end of the debate.

I, Trish Houghton can confirm that the conference paper (Houghton, T. and Howarth, J., 2016) An innovative model of nurse education: Non-commissioned adult nursing programme through collaborative / partnership working, presented at the 27th International Networking for Healthcare Education Conference on the 8th September 2016 was written and designed by myself and presented at the conference by Jane Howarth.

I Trish Houghton can confirm that the presentation to the Directors of Nursing at Central Manchester University Hospitals NHS Foundation Trust in January 2015 was designed, written and presented by myself with Jane Howarth in attendance to provide support and both parties being available to answer any questions.

Signature:  
Date: 11/11/16

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Statement of Collaboration

I, Jane Howarth can confirm that the conference paper (Houghton, T. and Howarth, J., 2016, The development of a Non-Commissioned BSc (Hons) Nursing (Adult) programme the first in England in order to meet the workforce needs: Initial reflections, presented at the RCN Education Forum National Conference and Exhibition on the 16th March 2016 was written in collaboration with Trish Houghton. Trish Houghton took the lead in submitting the abstract, designing the conference paper and the presentation. I attended the conference with Trish Houghton and was available to answer questions following the presentation.

I, Jane Howarth can confirm that the Professional debate ‘Will removal of bursaries increase the student recruitment?’ held at the conference, The changing strategic context: Leading the nursing contribution, hosted by HEE in April 2016 was designed and written in collaboration with Trish Houghton. Both parties attended the debate and the final version was presented by myself. Both parties were available for question and answer session at the end of the debate.

I, Jane Howarth can confirm that the conference paper (Houghton, T. and Howarth, J., 2016) An innovative model of nurse education: Non-commissioned adult nursing programme through collaborative / partnership working, presented at the 27th International Networking for Healthcare Education Conference on the 8th September 2016 was written and designed by Trish Houghton and presented by myself at the conference.

I, Jane Howarth can confirm that the presentation to the Directors of Nursing at Central Manchester University Hospitals NHS Foundation Trust in January 2015 was designed, written and presented by Trish Houghton and I were in attendance at the meeting to provide support to Trish Houghton and both parties were available to answer any questions.

Signature: [Signature]

Date: 03/11/16

Jane Howarth

Head of School – Health and Human Sciences - University of Bolton
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Sage Publications.


Appendices
University of Bolton

Research and Postgraduate School

Changing the direction of Nurse Education: The development and implementation of the first Non-commissioned BSc (Hons) Nursing (Adult) Programme in England.

January 2017

Doctor of Philosophy: Professional Practice. (Retrospective)

Appendices

Evidence to support the critical commentary

P. A. Houghton
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