

Discussion paper

Preparing for the future: nurse education and workforce development

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ABSTRACT

Nurse education needs to be responsive to changes not only within health policy but also those relating to workforce development. Viewed within this context this discussion paper highlights areas of consideration when planning for and responding to such demands.

Keywords: education, health policy, nursing, public health

How this fits in with quality in primary care

What do we know?

Nursing education needs to develop in line with the current and future scope of nursing in both acute and community practice.

What does this paper add?

This paper discusses how nursing has developed in response to health service policy and a model of nursing education that encompasses current practice and future developments in nursing.

Introduction

Nursing practice in the UK has changed dramatically over the last 20 years, and this pace of change shows no sign of slowing down.¹ Nurses in acute settings manage an increasingly complex range of healthcare interventions that incorporate advances in technology and disease management, while nurses in primary care

settings manage an increasing burden of chronic diseases and facilitate patient self-management of their health. The focus of health care has moved from hospital to community settings and has a far greater emphasis on health promotion for maintaining good health and wellbeing than has been seen previously.^{1,2}

A key turning point was seen with the publication of the Wanless reports in 2002 and 2004 which identified an over-reliance on acute hospital care and recommended more primary and community based care with public involvement in health improvement.^{3,4} This change in focus was echoed in the NHS Improvement Plan, which further signalled the need for major cultural change to address this move from sickness to health.⁵ The reports also recognised that the role of the nurse was changing and that they were undertaking work traditionally carried out by doctors.

There has for some time been a formal commitment to increasing the contribution nurses make to public health but it is only now that it is starting to gain momentum. Since the publication of the Acheson report into health inequalities in 1998, the need for a radical approach to improving the health of the population has been recognised.⁶ In 1998 an official statement of intent to examine the role of nurses within the public health arena was published by the European and UK Chief Nursing Officers. This was later further enforced in the Munich Declaration,⁷ when ministers pledged to ‘enhance the roles of nurses and midwives in public health, health promotion and community development’.

It was recognised, however, that this would not be possible without an accompanying shift in the focus of the workforce. *Choosing Health* made direct reference to the need to ‘develop training and support for all NHS staff to develop their understanding and skills in promoting health and to foster and expand a comprehensive range of community health improvement services’.⁸ This focus on prevention was further reiterated in a number of key policy documents including, *The Future Nurse: the RCN vision* (2004),² *The Future Nurse: the future for nurse education* (2007),¹ and *Modernising Nursing Careers: setting the direction* (2006).⁹

Shift in care from hospital to community

Since 1997, the number of nurses working in community and primary care has increased by 37%.¹⁰ A wider range of services is being provided outside hospital settings: new services are being developed by general practices, primary care trusts (PCTs) and other providers, who provide care for people with both acute and long-term conditions as well as preventative services. New opportunities are emerging for less-experienced nurses to work in general practice and the community, with some qualified staff never having worked within the hospital setting other than in their training.

Increasingly, specialist nurses are working outside hospital providing care to patients with long-term conditions in their homes and providing specialist advice to other community staff. District and school nurses, health visitors and others who have a long history of working in the community are adapting their roles to meet the changing needs of patients and clients. For many, nurses provide the first point of contact with the healthcare services through NHS Direct and NHS walk-in centres. Developments in healthcare delivery including an ailing healthcare system and large-scale public dissatisfaction, higher activity levels, expanding roles for clinicians with increased accountability, technological developments and international recommendations to re-orientate healthcare systems have expedited these changes.

This change in emphasis has implications not only for service delivery and development, but also for nurse education. It is important that the quality of nurse education is continuously improved upon and is in keeping not only with what is happening now but what is likely to happen in the future, incorporating advances in social, educational and health sciences and fostering the emergence of innovative approaches to care delivery. Curricula must be planned in relation to total health needs and resources of the target population and their social and cultural background.

Pre-registration nurse education and how this has changed

For many years, pre-registration nurse education was based on an apprenticeship model. Student nurses were employees of the health service and learnt their required skills ‘on the job’, with minimal time allocated to theoretical input. Schools of nursing were allocated to specific hospitals with the educational programmes adhering to the syllabus of training produced by the nursing governing body.

This changed in the UK in the late 1980s, driven by concerns about the ability of the educational system to produce nurses able to meet the challenges and demands of the modern healthcare system; a new form of education – Project 2000 – was launched. The intention was to create self-directed, autonomous practitioners,¹¹ and place all nurse education within higher education institutions (HEIs). One of the biggest outcomes of Project 2000 was that registered nurses in clinical practice took on the responsibility for student nurse practice learning supported by educational staff located elsewhere. This and the continued modernisation of health service provision have meant that there has been the need to develop effective collaborative approaches with not only service providers but also

service users. If student nurses are to develop the knowledge, skills and attitudes necessary to facilitate partnership working, service providers and users need to be involved at all levels of the learning process, including direct delivery and curriculum development. Nurse education should be based on knowledge linked to the healthcare needs of the population and the structure of the healthcare system. In order for education to be delivered in the most efficient way possible and translated into everyday practice, it is essential that a strong partnership arrangement exists between the student undertaking training, the nursing team responsible for the student nurse in practice, and the education centre providing the course.

The move to higher education also involved changes in how nurse education was commissioned and funded, resulting in further changes to nursing curricula as courses were redesigned to meet the requirements of such establishments. Subsequent changes to nurse education within the UK have centred on the British Government's health modernisation programme and the recognition that the role of the nurse was also changing.

Changes in the pre-registration programmes have been paralleled by the continuation of academic programmes for registered nurses and the instigation of a wide variety of post-registration degree programmes. Post-registration education has now come to the fore, both as a recommendation from government and professional bodies to make provision for career advancement in clinical practice and also as a result of role change, in part due to the changes in health care, but also as a result of changes in medical staffing in hospital as a requirement of the European Working Time Directive.

A consideration of the roles that nurses have taken on shows most to be fairly routine, repetitive tasks, which doctors themselves do not find as rewarding as other parts of their job. Paradoxically these new roles have brought nursing further under the control of medicine, as the medical profession defines the terms of nursing involvement, and circumscribes and supervises the work that the nurse takes over.¹²

Furthermore, the Nursing and Midwifery Council (NMC) is presently reviewing the need for having different points of entry to the nursing register. Over the summer months, the NMC was engaged in a pre-consultation exercise with stakeholders about the shape of pre-registration nursing education in line with the *Modernising Nursing Careers* agenda.⁹ A range of options are to be considered, including the introduction of a generic route into nursing. This would leave mental health, learning disability, and child nursing as a post-registration specialty, similar to the situation in a number of other countries, and put an end to the branches of nursing with which we are currently familiar.

The difficulty of recruiting and retaining nursing students and staff

Most alarming is the difficulty in recruiting nursing students and the shortage of qualified nurses. This is not a new problem but one that the government and professional bodies have struggled with for a number of years. The question is not how do we produce more nurses but how do we build in the rewards and the leadership opportunities that will attract and retain quality individuals in nursing? The International Nursing Council firmly believes that career development is a major contributing factor in the advancement of the nursing profession and health systems worldwide, and that it is directly linked to the maintenance of high-quality care delivery.¹³ It is essential that nurses' associations, governments and other bodies facilitate career development for nurses by means of articulated educational and career systems that provide opportunities for nurses to move from one category to another, or to other positions within or outside the healthcare system. To develop such systems it is necessary to identify the core knowledge, skills, attitudes and scientific principles for nursing practice. The question for education then becomes, how do we prepare our graduates so that they are better able to construct long-term careers in nursing? Central to the question is what is needed from the nurse of the future? Skills and knowledge are required that not only meet current demands but also equip the nurse with the means to adapt to an ever-changing care environment. The question for practice then becomes, how do we create a workplace that is intellectually challenging and emotionally satisfying for professional nurses?

The move to provide more services closer to home has significant implications for employers and nurses alike. While some nurses remain with their current acute trust providing outreach services, others may choose to work for community and general practice providers both within and outside the NHS. Nurses need to work in a range of settings, including homes, surgeries, clinics, school, care homes and community hospitals, some of which contain elements of both acute and community care.

As the shift to out-of-hospital care gains momentum, in addition to nurses delivering hands-on clinical care, more senior nurses will also be needed to lead and co-ordinate multidisciplinary teams and work across organisations in planning patient treatment and care pathways. These roles in leadership and co-ordination, alongside expertise in supporting self-care and healthy living and working in integrated teams across health and social care, will be critical to achieving the successful shift from acute to community

settings and bring new opportunities for career development and specialisation for nurses.

While the skills and competences for acute and community care are broadly similar, and the constants of nursing care are the same whatever the setting, working in the community brings its own demands. It requires professional and interpersonal skills which acknowledge that patients at home are more in control of their decisions, and that patients and their families are often responsible for the majority of care.

As well as working in an environment that is less professionally led than that of hospitals, nurses working in the community may also need to make decisions in less than ideal circumstances, and at a distance from colleagues. Preparing a student to work within this environment is a challenge and one that requires an educational response that is both flexible and adaptive.

The University of Lincoln pre-nursing programme: a possible way forward

The University of Lincoln has developed a graduate pre-registration programme, the first in the UK, which enables nurses to work in the community, hospital and voluntary sector on qualifying. Commissioned and supported by the Trent Multiprofessional Education and Workforce Deanery, the course has a uniquely public health focus and this relates to both the theoretical teaching and practice placement: the students gain two-thirds of their clinical experience from a community setting.

The programme aims to provide an academically rigorous education, fostering a critical attitude, a lifelong commitment to learning, an ability to appraise, undertake and implement research, and a creative approach to nursing practice based upon public health principles. The curriculum is cyclical in that it builds upon nursing ideology and public health principles of promoting health and wellbeing, as well as managing disease and illness that are further explored over the course of the educational programme, both in theory and in clinical practice. Public health principles are incorporated into each and every theoretical taught module and throughout practice placements. For example, in teaching ethical and legal principles in health care, emphasis is given to not only the ethical principles and legal parameters associated with topics such as termination of pregnancy, but also to infectious diseases, immunisation programmes, fluoridation, preventative health, and rationing of healthcare resources. There is an emphasis in classroom teaching on the students' experience, with academics moving from traditional lectures to the integration of active

learning including use of web-based learning and the incorporation of an online learning community that can facilitate communication and support while students are on placement, from the academics and amongst their cohort peers and the whole nursing student body. Modular teaching is provided in a multidisciplinary format that promotes shared learning and reflects the context within which health and social care is currently delivered.

Multidisciplinary and multiagency working is consistently presented as key to delivering optimum and appropriate care.¹⁴ Health workers already work together to deliver patient and community care, and the activities of one professional or occupational group are informed by another. Shared multidisciplinary learning is seen as a means of further breaking down professional boundaries.

Although nurses and social workers have liaised and practised in similar areas of need for many years, it is a matter for debate how much effective collaborative working has taken place. For example, in the field of vulnerable children and young people, stereotypes and a mutual lack of understanding about professional roles' responsibilities and expertise have hindered optimum practice.^{15,16} A vision of integrated health and social care teams has recently been envisaged to pool resources and more positively address the needs of communities.¹⁷

Bruner has argued that collaboration and learning are natural bedfellows, and that the idea of learning 'alone' is a myth.¹⁸ Conversely, to attempt to educate purely within one's own professional culture is to produce a perspective of the world which is limited in scope and disabled in its potential for informing practice. It seems that where values and goals are shared but interpreted and approached differently, there is fertile ground for cross-cultural learning. Individuals from diverse personal and professional backgrounds bring diverse strengths to any learning forum. Through dialogue which is both structured and discursive, a mutual wide-angled view of need and corresponding interprofessional expertise is achieved.

The respective changes in nursing, social worker and medical undergraduate and postgraduate education are generating change in the boundaries between the professions. Although there is a welcome 'push' to develop interprofessional education, there remain historical interprofessional political tensions and hierarchical manoeuvring in which one profession seeks dominance over the other. This is demonstrated in the evidence on interprofessional learning. Early findings from a longitudinal study of 852 nursing and social work students in the UK suggest that while students valued interdisciplinary learning, they harboured overwhelmingly negative views towards active collaborative working.¹⁹ That the inclusion of a joint practice component is most crucial to successful outcomes

which are not left behind in the classroom but translate to real life can be deduced from this evidence, and this is reflected within the Lincoln programme in which nursing and social work students share a number of modules.

Lessons for the future

A lot of lessons can be learned from the 'First Contact Care' programme which was piloted in several areas of England and hosted by the fated NHS University. The programme was developed to help meet the target by which patients would see a primary care professional within 24 hours and a general practitioner (GP) within 48 hours. The programme led to either a postgraduate diploma or a masters (MSc) degree, depending on the number of modules undertaken. The course covered how to access and diagnose a patient and how to plan subsequent treatment. This included referral to another professional, advising on self-care or discharging the patient. What it really promoted was independent working and status within a framework of interprofessional collaboration and understanding. Core skills included working within limitations and boundaries, consultation skills and demonstrating competence in a variety of clinical settings.

Promoting healthier communities and tackling health inequalities are challenges that can only be met by working in partnership. Contemporary nurse practice must be thought about in a healthcare environment, one in which user responsibility and a broad context of clinician accountability are increasingly apparent.²⁰ Current practice requires greater sensitivity to the social environment and the advocacy needs of users and their families. It also mandates thoughtful consideration of complex legal and ethical dilemmas, arising from a delivery system that is focused on the efficiencies of managed care.

Modern community based services are increasingly geographically dispersed – a necessary corollary of being closer to patients' homes. Many users receive care in several different contexts – day hospital, community visits, outpatients etc. In general, the more chronically disabled the patient, the more different elements will be involved. Frequently these are all based in different places.

Specific nursing skills required to work within the community include the ability to monitor the health of the wider community and to proactively target services where most needed; working with others to address wider causes of ill-health such as housing, social isolation and low income; managing any risks associated with patients and their carers making their own decisions; understanding and influencing primary care trusts (PCTs) and practice-based commissioning, and taking responsibility for the effective use of

resources and delivery of contracts; and above all demonstrating the nursing contribution to integrated health and social care services.

As health care becomes knowledge intensive, nurses are challenged to effectively manage clinical information and keep abreast of professional knowledge. Rapid proliferation of knowledge, expanding professional expectations and dynamic and uncertain practice environments require that nurses become lifelong learners capable of constantly reflecting on and modifying their practice. As a practice profession, much learning occurs in the clinical areas in both undergraduate and postgraduate programmes. Nursing practice placements facilitate students to develop domains of competence enabling them to become safe, caring and competent practitioners utilising evidence-based practice. It is recommended that students undertake clinical placements early in the programme and that curricula should facilitate reflective time. The importance and development of critical thinking and reflective practice is stressed here in bridging the theory–practice gap and preparing students for the workplace. Increasingly, practice is centred on decision support processes that stress the need for clinical practice standardisation as a means of providing baseline information to evaluate practice processes and patient outcomes. While this goal is commendable, the prescriptive approach to decision making through the use of standardised practice protocols restricts nurses' ability to creatively explore alternative approaches to clinical practice problems. These systems can only advise nurses on the knowledge that they contain. Nurses who come to rely exclusively on the advice of such systems may not be able to discriminate when advice is not applicable and they should seek other knowledge resources. Clinical practice standardisation also underscores an assumption that clinical practice variation represents resistance to change, when it may actually reflect legitimate variation based on the nurse's use of professional artistry in new and uncertain clinical practice situations. This serves to illustrate the need for nurses to be able to articulate what it is they do and provide underpinning evidence in support of their practice. Nurse education is charged with instilling these skills in their students and enabling them to contribute to the overall quality of health care, practice and policy at the point of qualification and beyond.

Conclusion

The need for change and for the improvement of services to patients will always be with us. Given this, and the huge sums of public money involved in

preparing nurse students for practice, it is important that the quality of healthcare education is continuously improved and in keeping not only with what is happening now but what is likely to happen in the future. If in the future nurses are to develop the critical awareness and analytical skill that will prepare them for practice then they need to form a central part of any training and be developed within the clinical environment in partnership with practice staff of various disciplines and supportive of the local community and healthcare needs. The University of Lincoln provides a course that not only meets these requirements but also acts as an example for others to replicate.

CONFLICTS OF INTEREST

None.

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