Did Project 2000 fulfil the intention set by nursing's leadership to create a profession of highly educated practitioners?

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This study has been undertaken during the COVID-19 pandemic.

I would like to dedicate this study to my colleagues in the National Health Service who have fought, and continue to fight, gallantly.

This thesis is also dedicated to the colleagues we have lost to the pandemic, and the friends we will forever miss working with.

To those I have worked alongside who were there for me, helped me, encouraged me, and put an arm around me when I needed it: thank you!

Kelly

Contents

Abbreviations

ACP/ANP	Advanced Clinical/Nurse Practitioner
A&E	Accident and Emergency
BMA	British Medical Association
CFP	Common Foundation Programme
COHSE	Confederation of Health Service Employees
DHA	District Health Authority(ies)
DHSS	Department for Health and Social Security
ECG	Electrocardiogram
ENB	English National Board
GMC	General Medical Council
GNC	General Nursing Council
GP	General Practitioner
IANE	The Institute of Advanced Nursing Education
ICN	International Council of Nurses
NHS	National Health Service
NMC	Nursing and Midwifery Council
NQN('s)	Newly-Qualified Nurses
P200/P2K	Project 2000
PREPP	Post-Registration Education and Practice Project
RCN	Royal College of Nursing
SRN/RGN	(State) Registered (General) Nurse

SEN	State Enrolled Nurse
SN	Staff Nurse
SR	Sister
UKCC	UK Central Council for Nursing, Midwifery and Health Visiting

Abstract

Project 2000 was implemented in 1989. It was a revolution for nursing; it reflected a growing need for nursing to modernise and for nurses to be trained for the future in light of growing health demands. For the first time in over a century, the profession was radically changing how it trained its practitioners. Project 2000 changed how nursing saw itself. It challenged the traditional view of nurses as handmaidens and changed how nurses practiced and how nursing care was delivered to patients. The driving factors behind Project 2000 were political, economic and professional. The British government needed highly educated nurses so practice boundaries could be broadened and for nurses to undertake more skilled responsibilities and advanced practices roles. Equally, the profession desired adequate training and a respected professional status. The key to it all: Project 2000.

Project 2000 had one primary intention: to create a profession of high educated nursing practitioners. As such, debate has arisen over whether Project 2000 fulfilled the intentions of nursing's leadership and the government. This study will address the changes introduced to develop highly educated nurses and the debates generally surrounding Project 2000, like whether it was fit for purpose.

While Project 2000 remains a contentious topic in nursing history, in-dept analysis of Project 2000, its successes in fulfilling its intentions and its shortfalls have not been updated since the early years of the twenty-first century. Therefore, this study presents a modern take on the reforms and considers a broader range of documents and government policy neglected in the investigations of the 1990s and awareness of contemporary nursing developments.

Research for this study re-examined the original Project 2000 proposal and RCN publications and secondary evidence from the 1990s scrutinising the reforms. Additionally, this study is amongst a scarce number of studies that have considered the more comprehensive NHS reforms of the 1980s and 1990s and the politicisation of NHS funding. However, uniquely, this study is the first to combine the broad context to the Project 2000 reforms and analyse how they affected implementation and the creation of a highly educated practitioner. Ultimately, this study finds that Project 2000 was by no means perfect; however, later documentation, primarily government policy and the testimonies of Project 2000 trained nurses, demonstrated that Project 2000 succeeded in fulfilling its intention of creating a profession of highly educated practitioners.

Introduction

Nursing is a profession that exists in a paradox: it relishes and reveres its traditions, but it is also remarkably adaptable to both internal and external forces. Nursing's development since the days of Nightingale has not occurred in a vacuum.[1] Rather, nursing has evolved against a backdrop of wider political, social and economic issues.[2] Project 2000 is such an example. Project 2000 was a revolutionary moment in nursing history.[3] It was a reaction to the wants and desires of both nursing's leadership and the government; it was forward-looking in its intentions and was triggered by a radical evaluation of nursing's future. Project 2000 is a contentious topic in the history of nursing, primarily because the planning and implementation of the scheme forced the profession to challenge its vocational, altruistic, and Nightingale-inspired image.[4] It was the overhaul of the apprentice system of training that had existed for over a century. It changed not just how nurses were prepared for practice but also how nursing care was delivered and drastically altered the profession's future. The proposals centred around a key intention – the creation of a profession of highly educated practitioners.[5] The proposals aimed to train and educate nurses who would have

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[1] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.14.; Royal College of Nursing. (2007). *Pre-registration Nurse Education. The NMC review and the issues*. London: Royal College of Nursing. p.5.

[2] Zhang, R. (2014). *Preparing an educated nurse: past and future trends within the UK and mainland China: a case study [PhD Thesis]*. p.1.

[3] Casey, G. (1996). The curriculum revolution and Project 2000: a critical examination. *Nurse Education Today*, 16(2), 115-120. p.115.

[4] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.22.

[5] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A New Preparation for Practice*. London: UKCC.

the capabilities to 'marshal information, to make an assessment of need, devise a plan of care and implement, monitor and evaluate it.'[6] An intention this study argues was fulfilled.

The role of the nurse

The debates over the specifics of the nurse's role are as old as the nursing profession itself. It is a debate worthy of its own thesis and one that this study will not assert has reached the ultimate conclusion. However, it has always been evident that from the late nineteenth century, through the twentieth century and the Project 2000 discussions, to the early twenty-first century, a nurse's primary duty has always been to their patients and caring and advocating for the sick and helpless.[7] While the nursing role has differed slightly at intervening periods since the mid-nineteenth century, this has remained a nurse's foremost obligation.

By the 1980s, the nurse's practical role still encompassed many of the traditional duties outlined by Florence Nightingale in her *Notes on Nursing*.[8] These tasks included: cleaning, distributing meals, feeding and generally caring for another person.[9] Moreover, nurses were still expected to be proficient in bedmaking, bed bathing, drug administration, wound dressings, and domestic ward management.[10] From the late nineteenth century to the dawn of Project 2000, nursing also placed great emphasis on a nurse's character, which over decades transformed how nursing was regarded and ensured that the first principle of the

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[6] Ibid, p.5.
[7] Bradshaw, A. (2001). *The Nurse Apprentice, 1860-1977*. Aldershot: Ashgate. p.99.
[8] Nightingale, F. (1859). *Notes on Nursing: What It Is, and What It Is Not*. London: Harrison & Sons.
[9] Anderson, E. R. &., Royal College of Nursing. (1973). *The Role of the Nurse: Views of the Patient, Nurse and Doctor in some General Hospitals in England*. London: Royal College of Nursing. p.11.
[10] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.3.

nursing system rested on moral character. Nightingale nursing, therefore, established that nurses should learn cleanliness and neatness alongside a potent composition of obedience, truthfulness, and orderliness.[11] Indeed, in Catherine Wood's *A Handbook of Nursing for the Home and Hospital*, the six essential qualities of a nurse were: presence of mind, gentleness of heart, gentleness of touch and accuracy, an excellent memory, sharp observational skills and forthrightness.[12]

Amendments to the nurse's role from Nightingale's period to the Project 2000 proposals were slight and rarely dictated by policy change as curriculum and practice reforms often came after nursing had already embraced the new elements of its role. As such, much of the nurse's role remained dedicated to complementing that of the doctors. It was made very clear under Nightingale that nurses were to care for their patients under the direct supervision of a doctor.[13] In *The Role of The Nurse*, Evelyn Anderson stressed that doctors expected nurses to care for patients, calm them and make them comfortable and record any changes to their condition, all ready for the doctor.[14] Ultimately, as Anderson argued, the primary expectation of a nurse was to listen to the doctor's instructions and be their assistant in every situation.[15] Here, the key distinction between nursing and medicine is drawn; it is the doctor's responsibility to cure, it is the nurses' responsibility to care.[16]

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[11] Ibid, p.4.
[12] Wood, C. J. (1888). *A Handbook of Nursing for Home and Hospital*. London: Cassell & Co.
[13] Smith, J. P. (1981). *Nursing Science in Nursing Practice*. London: Butterworths. p.10.
[14] Anderson, E. R. &., Royal College of Nursing. (1973). *The Role of the Nurse: Views of the Patient, Nurse and Doctor in some General Hospitals in England*. London: Royal College of Nursing. p.42.
[15] Ibid, p.42.
[16] Wall, A. &., Owen, B. (2002). *Health Policy* (2nd ed.). London: Routledge. p.63.

Conclusively defining the doctor's role is equally challenging. The medical role has developed over the last few centuries in response to socio-political changes, technological progression, the rise of chronic illnesses and the shift to multidisciplinary working in healthcare.[17] Medicine has shared a key core objective with nursing: to provide high-quality care to patients with a desire to encourage good health and treat them when they are sick.[18] However, doctors have been the clinicians who, alone amongst their healthcare colleagues, take the final decisions and responsibilities.[19] From the nineteenth century onwards, it became paramount that doctors had the ability to assimilate new knowledge and have a robust grasp of scientific principles and developments while managing the uncertainties, ambiguities, and complexities of patient care.[20] As such, healthcare was prescribed according to the doctor's instruction. Indeed, doctors, up until the introduction and advancement of nurse practitioners, were the sole healthcare professionals who could diagnose and treat mental and psychological illnesses, injuries and disorders.[21]

During the Project 2000 discussions in the 1980s, there was a realisation that many of the core professional values had not changed despite a century separating Nightingale and the era of modern nursing. Equally, nor had the principal duties of nurses regardless that two world wars, an overhaul of the British healthcare system and rapidly evolving scientific advancements had taken place. However, the world around nursing had changed. British

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[17] Godlee, F. (2008). Understanding the role of the doctor. *British Medical Journal*, 337(7684), 1425-1426. p.1425.
[18] Finch, R. (2008). The role of the doctor. *British Medical Journal*, 337. p.3.
[19] Godlee, F. (2008). Understanding the role of the doctor. *British Medical Journal*, 337(7684), 1425-1426. p.1425.
[20] Ibid, p.1426.; Godlee, F. (2007). The role of the doctor. *British Medical Journal*, 335(7628), 1. p.1.
[21] Ibid, p.1426.

society and its values had changed. Most importantly, the needs of society had changed, and the role of the nurse needed to change in accordance with the modern world.

Methodology

This study is a reinterpretation of how nursing historiography has understood Project 2000. It is also an attempt to update our current knowledge of the reforms. Much of the key literature on the subject was written within the first decade of the implementation in 1989. However, since the publication of many early studies, over two decades have elapsed, and an entire generation and thousands of nurses have qualified. Moreover, opinion within the profession itself has changed as many have had the chance to see the benefits of the contributions of highly educated nurses. Consequently, the reforms have become accepted and praised by many in mainstream opinion.[22] Simply, the initial paralysing anxieties of the profession towards overhauling reform have settled. Project 2000 has been found to have not hindered the quality of nursing care despite moving nurse training away from the wards.[23] It was found that after a decade, the intentions set out by nursing's leadership had materialised.[24] However, since the early years of the twenty-first century, nursing history has neglected to re-evaluate its stance on Project 2000. This is primarily because successive reforms have built onto Project 2000's foundations under the banner of new names; this

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[22] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.139.

[23] Roberts, J. &., Barriball, K. L. (1999). Education for Nursing: Preparation for Professional Practice . In I. Norman, & S. Cowley (Eds.), *The Changing Nature of Nursing: In a Managerial Age*. (pp. 123-149). Oxford: Blackwell Science. p.124.

[24] Fulbrook, P. &., Rolfe, G. &., Albarran, J. &., Boxall, F. (2000). Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today, 20*(1), 350-357. p.352.

includes *Making a Difference* and *Modernising Nursing Careers*.[25] A key idea that has been

largely ignored in nursing history, and something that this study will address, is the idea that

Project 2000 was both revolutionary and evolutionary, and that the successive policies

merely built on the educational foundations laid by Project 2000. Their presence should not

be seen as a nail in Project 2000's coffin but as an example of how Project 2000 placed

nursing on sound educational footing, thus, later allowing the profession the opportunity to

continue its evolution and expand the boundaries of practice.

This study has consulted a range of primary sources. Firstly, to understand Project 2000, its

objectives and plans to fulfil its intentions, this research scrutinised the Project 2000

proposals. These include the first version published by the United Kingdom Central Council

for Nursing, Midwifery and Health Visiting (UKCC), nursing's regulatory body, in 1986, and

the later project papers that detailed the compromises reached between the profession's

leadership and the British government.[26] Moreover, this study investigated many pieces of

academic health sciences research conducted during the 1990s. These publications

examined key issues that arose within the first few years: 'the teething problems.'[27] These

included the so-called 'theory-practice gap' - the perceived widening gulf between what was

taught in the lecture theatre and what was practiced on the wards - and the rise of

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[25] Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times*, 98(20), 38. p.38.; Department of Health. (2006). *Modernising nursing careers: setting the direction*. London: Department of Health.

[26] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A New Preparation for Practice*. London: UKCC.; United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project Paper 7, The Project and the Professions: Results of the UKCC Consultation on Project 2000*. London: UKCC.; United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1987). *Project 2000: The Final Proposals, Project Paper 9*. London: UKCC.

[27] Webster, C. (2002). *The National Health Service: A Political History*. Oxford: Oxford University Press.; Lowe, R. (2005). *The Welfare State in Britain Since 1945*. (3rd Eds). Basingstoke: Macmillan.; Slater, B. (1998). *The Politics of Change in the Health Service*. Basingstoke: Macmillan.

academic-related stress felt by students. Some of these publications attempted to grapple

with the issue of whether Project 2000 was fit for purpose. However, they were written too

early to sufficiently judge Project 2000 against its intentions. Many of these studies did not

juxtapose Project 2000 with the necessity of reform, nor did they detail the inadequacies of

the apprentice model. In the early publications, there is little mention of reports from the

previous decades, significantly, the Platt and Briggs Reports of 1964 and 1972, that detailed

the growing issues with the apprentice system in preparing nurses for practice in light of

NHS (National Health Service) reforms.[28] As a result, this study incorporates analysis of the

Platt and Briggs Reports alongside scrutiny of other significant policy documents that were

published in the later 1990s and early 2000s, which many studies on Project 2000 do not

make reference to, yet are highly relevant in determining whether Project 2000 fulfilled its

intentions. These include *Making a Difference*, *Fitness for Practice* and the *NHS Plan*, which

all demonstrate that by the late 1990s, nurses were educated to a high academic level and

regarded as knowledgeable practitioners.[29] They show that nursing's boundary of practice

was being expanded to include advanced practice, which required a Masters degree and

additional qualification in areas like prescribing, and for nurses to play a leading role in the

NHS going forward.[30]

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[28] Platt, H. &., Royal College of Nursing. (1964). *Platt Report: A Reform of Nursing Education. First Report of a Special Committee on Nurse Education*. London: Royal College of Nursing.; Briggs, A. (1972). *Report of the Committee on Nursing*. London: HMSO.

[29] Department of Health. (1999). *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: Department of Health.; United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999). *Fitness for Practice. The UKCC Commission for Nursing and Midwifery Education*. London: UKCC.; Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform*. London: HMSO.

[30] Castledine, G. (1991). The advanced nurse practitioner, part 2. *Nursing Standard*, 5(44), 33-35.; Thompson, D. R. &., Astin, F. (2019). Education for advanced nursing practice worldwide – is it fit for purpose? *Heart and Lung*, 48(3), 176-178. p.177.

Much of the work by nurse academics from the 1990s appears to examine the reforms as if they occurred in isolation. Nursing is affected by every other element of healthcare and the NHS, with any slight change altering the way the profession practices.[31] Project 2000 was planned and implemented during a period of administrative and operational change in the wider NHS. However, the majority of publications fail to reference such changes. As such, many studies from the 1990s are limited due to a lack of crucial contextualisation. Key omissions from the early publications include mention of the Griffiths Report of 1983.[32] This is possibly because it challenged nursing's hierarchical structure, the traditional role of the matron, and the power of senior nurses. Much of the work published by nurse academics reflect nursing's conservative and traditionalist instinct, which appears to have led to a bias in the information consulted and included.[33] Another crucial exclusion from the literature is mention of economics and NHS funding in relation to Project 2000. This study corrects such lapse by including reports written by the Centre for Health Economics at York University who analysed the effect of Thatcherism on the NHS; as well as Goodwin and Bosanquet, who detailed the predicted expenditure of the Project 2000 changes, and Bourn, who

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[31] Berg, M. (1997). Problems and promises of the protocol. *Social Science & Medicine*, 44(8), 1081-1088.; Power, M. (1997). *The Audit Society: Rituals of Verification*. Oxford: Oxford University Press.; Dent, M. (1999). Professional judgement and the role of clinical guidelines and evidence-based medicine: Netherlands, Britain and Sweden. *Journal of Interprofessional Care*, 13(2), 151-164.; Purkis, M. E. (2001). Managing home care: visibility, accountability and exclusion. *Nursing Inquiry*, 8(3), 141-50.; Purkis, M. E. &., Bjornsdottir, K. (2006). Intelligent nursing: accounting for knowledge as action in practice. *Nursing Philosophy*, 7(4), 247-256.; Crawford, P. &., Brown, B. (2008). Soft authority: ecologies of infection management in the working lives of modern matrons and infection control staff. *Sociology of Health & Illness*, 30(5), 756-771.; Traynor, M. (2009). Indeterminacy and technicality revisited: how medicine and nursing have responded to the evidence-based movement. *Sociology of Health & Illness*, 31(4), 494-507.; Allen, D. (2010). Care pathways: an ethnographic description of the field. *International Journal of Care Pathways*, 14(1), 47-51.; Bevan, H. (2010). How can we build skills to transform the healthcare system? *Journal of Research in Nursing*, 15(2), 139-148.; Morrow, E. &., Robert, G. &., Maben, J. &., Griffiths, P. (2012). Implementing large-scale quality improvement: lessons from The Productive Ward: Releasing Time to Care. *International Journal of Health Care Quality Assurance*, 25(4), 237-253.

[32] Griffiths, R. (1983). *NHS Management Inquiry*. London: Department of Health and Social Security.

[33] Girvin, J. (1996). Leadership and nursing: Part three: traditional attitudes and socialisation. *Nursing Management*, 3(3), 20-22. p.21.; Hempstead, N. (1992). Nurse management and leadership today. *Nursing Standard*, 6(33), 37-39.

exposed the realities of the government limiting funding to its bare minimum and accelerating the implementation of Project 2000 to the detriment of its objectives.[34]

Historiography

There is limited historiography on Project 2000. Much was what exists are breadth studies of the reforms. These include Ann Bradshaw's *The Project 2000 Nurse*, and Brian Dolan's *Project 2000: Reflection and Celebration*.[35] Bradshaw was quintessential in detailing the foundations of Project 2000 with her outline of the fundamental statutory and educational changes leading up to the proposals. Her analysis of competence added significantly to nursing history's understanding of the concept.[36] However, while Bradshaw touches on the issue of Project 2000 nurses being trained to be highly educated practitioners, her analysis lacks the depth to make her judgements conclusive. Her work is, after all, a general commentary on Project 2000 and not an exhaustive or comprehensive investigation of Project 2000's key intention. Moreover, while Dolan provides a valuable insight into the canvassing of the profession during the planning stages and presents the challenges of merging nursing with higher education, the strength of Dolan's work is limited. Firstly, it was published in 1993, and by that point, only one cohort had qualified; therefore, it should not be considered as a thorough examination of Project 2000. Moreover, it lacks extensive

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[34] Centre for Health Economics: Health Economics Consortium, University of York. (1993). *Expenditure on the NHS During and After the Thatcher Years: Its Growth and Utilisation, Discussion Paper 113*. York: University of York.; Goodwin, L. &., Bosanquet, N. (1986). *Nurses and Higher Education: The Costs of Change* (Discussion Paper). York: University of York: Centre for Health Economics.; Bourn, J. (1992). *Nursing Education: Implementation of Project 2000 in England.* London: National Audit Office.

[35] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers.; Dolan, B. (Ed.). (1993). *Project 2000: Reflection and Celebration*. London: Scutari Press.

[36] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. pp.18-45. pp.47-82.

analysis into the issue of Project 2000 attempting to create highly educated practitioners, and its tone is, at times, celebratory as opposed to methodical and analytical.[37]

Due to the lack of nursing historiography on Project 2000, this study has consulted wider reading on nursing history. This research has consulted Dingwall, Rafferty and Webster's *An Introduction to the Social History of Nursing,* along with Bradshaw's *The Nurse Apprentice, 1860-1977*, and Hart's *Nurses and Politics: The Impact of Power and Practice.*[38] These works were used to highlight the significant issues in nursing history and the profession's relationship with politics and the government. Similarly, this research has referred to broader reading on British history and the relationship between the NHS, healthcare and nursing and the government during the 1980s, 1990s and early 2000s to improve the contextualisation of Project 2000. Therefore, this research has examined works such as Charles Webster's *The National Health Service: A Political History*, alongside Rodney Lowe's *The Welfare State in Britain Since 1945* and Brian Slater's *The Politics of Change in the Health Service*.[39] Such publications lay the groundwork for the contextualisation of this study and highlight the complex relationship between the government and the NHS that played a major role in the necessity of reform, the planning of the changes and the implementation, something largely overlooked in the available literature.

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[37] Dolan, B. (Ed.). (1993). *Project 2000: Reflection and Celebration*. London: Scutari Press.; Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 3-16). London: Scutari Press. pp.8-9.; Charlwood, J. (1993). The Challenge of Higher Education. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 47-56). London: Scutari Press. pp.49-53.

[38] Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge.; Bradshaw, A. (2001). *The Nurse Apprentice, 1860-1977*. Aldershot: Ashgate.; Hart, C. (2004). *Nurse and Politics: The Impact of Power and Practice*. Basingstoke: Palgrave Macmillan.

[39] Webster, C. (1998). *The National Health Service: A Political History*. Oxford: Oxford University Press.; Lowe, R. (2005). *The Welfare State in Britain Since 1945*. (3rd Eds). Basingstoke: Macmillan.

Oral History

To evaluate whether Project 2000 fulfilled its primary intention, this study has conducted interviews with nurses who trained under the apprentice system and under Project 2000. The participants included seven females and three males. The fewer number of male participants available plausibly relates to nursing being a traditionally female-dominated profession and remained largely gender segregated during the late twentieth century. The number of male intakes has long been substantially less than that of females.[40] Men's journey to acceptance within the profession has not been smooth. Men were once banned from the General Register and assigned to jobs societal perceptions and assumptions deemed suitable, usually in mental asylums as men where were believed to be apt at subduing violent and physical patients.[41] As a result, the participants' demographics largely represents the female bias of the profession. Of the participants, four had been trained under the apprenticeship model and the remainder under Project 2000. All participants had served as registered nurses.

The value of oral history lies in it being a rich source for providing insight into the events of the past.[42] Oral history seeks to understand the experiences and outlooks of individuals towards events.[43] For this reason, oral history can add significantly to our understanding of the past. Historiography often presents the formal information on a subject, whereas oral history helps 'fill in the gaps' between UKCC policy, official Royal College of Nursing (RCN)

[40] Vere-Jones, E. (2008, March 3). Why are there so few men in nursing?. *Nursing Times.*

[41] RCN Belfast Branch. (2018, May 14). *That this meeting of RCN Congress asks Council to develop and promote a strategy to recruit more men into the nursing profession*. Paper presented at the Royal College of Nursing Annual Congress, Belfast.

[42] Fisher, H. E. S. (2006). Oral History, Childhood and Schooling: A Review Article. *Journal of Educational Administration and History, 15*(1), 56-57. p.56.

[43] Roberts, B. (2002). *Biographical Research*. Buckingham: Open University Press. p.1.

publications and Acts of Parliament.[44] Many of the nursing voices from the 1980s and 1990s

are of nurse leaders and those in senior positions. By their admission, those interviewed for

this study were at 'the bottom of the heap'.[45] Nevertheless, their thoughts and impressions

form a valuable contribution to our understanding of the necessity of reform and how

Project 2000 was perceived by the profession.

Oral history has faced questions over rigour and its reliability in studying the past.

Thompson and Ritchie both voiced concerns over bias being introduced by the researcher,

who often have research agendas, in questioning that could influence responses given by

the participants.[46] Moreover, as put forward by Portelli, there have been questions about

whether we can trust accounts provided in oral history. Portelli argued that as we get older,

we go through periods of 'life reviews' where we significantly re-evaluate our thoughts and

beliefs; therefore, responses provided by someone when they are older may not entirely

reflect how they felt at the time in question.[47] This is significant as the Project 2000 reforms

occurred over thirty years ago. Therefore, the participants may have altered their opinions

of their training and Project 2000 from how they thought in the 1990s. This presents an

issue for historians as the thoroughness of their methods and evidence impacts their degree

of certainty about the past.[48] For these reasons, the rigour of oral history is often compared

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[44] Ibid, p.56.
[45] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 7).
[46] Thompson, P. (1978). *The Voice of the Past: Oral History*. London: Oxford University Press. p.92.; Ritchie, D. A. (1995). *Doing Oral History, Twayne's Oral History Series No. 15*. New York: Twayne Publishers. p.96.
[47] Portelli, A. (1992). Conversations with the Panther: The Italian Student Movement of 1990. In R. J. Grele (Ed.), *International Annual of Oral History, 1990: Subjectivity and Multiculturalism in Oral History* (pp. 159-173). New York: Greenwood. p.164.
[48] Kirby, K. R. (2008). Phenomenology and the Problems of Oral History. *Oral History Review*, 35(1), 22-28. p.26.

to 'authentic texts' ranging from archival material to chronicles.[49] Nevertheless, this research sought to achieve Frisch's vision of oral history providing 'more history' whereby the spoken word reveals aspects about the past that are not available through conventional documents.[50] As a result, many of the issues relating to oral history in the past were acknowledged during this study. The following sections detail the provisions made to ensure the accounts provided were as accurate as possible.

Sampling

To gauge a comparison between the apprentice model and Project 2000, how the nurses felt about their courses and whether they felt prepared to enter clinical practice by the end of training, this study sought to interview both apprenticeship and Project 2000 nurses. Participation in this study was advertised on social media. Twenty-three qualified nurses offered their voluntary participation; however, due to the restrictions of the COVID-19 pandemic, only 13 interviews could take place. All interviews were conducted on a single occasion. Before the interview, participants were sent background questionnaires with questions about what year they started training, where they trained, and their career after qualification, including the hospitals and specialities where they worked.

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[49] Rosaldo, R. (1980). Doing Oral History. *Social Analysis: The International Journal of Anthropology*, 4, 88-89. p.88.
[50] Frisch, M. (1990). *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History*. Albany, New York: State University of New York Press. p.187

Interviewing

At the beginning of the interview, once the recorder had been turned on, the researcher stated the participants' name, the date and location of the interview, and a short pre-written statement summarising the consent form before asking the participant if they were willing to continue. Once they had agreed, the researcher began asking the interview questions. Each interview lasted approximately one hour and consisted of ten open-ended questions to reduce the possibility of the researcher introducing any preconceived ideas and influence the answers given, as is a well-established practice in phenomenology.[51] The interviews were pre-arranged and took place in private. The interview questions began by generally centring on their memories of training before addressing more specific experiences that had been common topics in historiography and studies conducted during the 1980s and 1990s. Moreover, the participants were asked for their opinion on Project 2000 as a concept and an education scheme and whether they thought Project 2000 fulfilled its intentions. The interview questions were designed to combine structure with flexibility to allow for spontaneity in answering to underpin a thematic approach as outlined by Ritchie and Lewis, Douglass and Moustakas and Olesen and Oakley.[52] The first couple of questions were intended to reveal the participants' 'surface level' thoughts and recollections. The later

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[51] Field, P. A. &., Morse, J. M. (1985). *Nursing Research: The Application of Qualitative Approaches*. London: Croom Helm.

[52] Ritchie, J. &., Lewis, J. (2003). Qualitative Research Practice. London: Sage Publications.; Douglass, B. G. &., Moustakas, C. (1985). Heuristic Inquiry: The Internal Search to Know. *Journal of Humanistic Psychology*, 25(3), 39-55.; Olesen, V. (2000). Feminisms and qualitative research at and into the millennium. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 215-256). Thousand Oaks: SAGE.; Oakley, A. (1981). Interviewing women: A contradiction in terms?. In H. Roberts (Eds.), *Doing Feminist Research* (pp. 30-61). London: Routledge and Kegan Paul.

questions, which were more specific, were asked to better understand their memories, opinions, and beliefs.[53]

Participants' permission was gained to record the interview on an MP3 device. All recordings were stored on an external hard drive and were encrypted and password-protected, with only the researcher knowing the password. On the original tape recordings, the participants' names were written in the file name. However, as part of the consent process, it was made clear that anonymity and confidentiality would be assured in any written analysis, and pseudonyms would be used. Moreover, beyond gaining the participants' consent at the beginning of the recording, their name was not repeated.[54]

Analysis of transcripts

The researcher transcribed all the interviews. Each transcript was intermittently re-read numerous times before any writing of the study began to ensure the reliability of each transcript as Miles, Huberman, and Brown et al. asserted was necessary for accurately reflecting the participants' thoughts.[55] Each participant was also offered the opportunity to review the transcript of their interview to ensure the true spirit and meaning of their words were captured. This was to ensure that transcripts would be of value to historians in the future who access the interviews.[56] This study used a comparative approach throughout.

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[53] Batty, E. (2009). Reflections on the use of oral history techniques in social research. *People, Place and Policy Online*, 3(2), 109-21.

[54] Ford, J. S. &., Reutter, L. I. (1990). Ethical dilemmas associated with small samples. *Journal of Advanced Nursing*, 15(2), 187-191.

[55] Miles, M. &., Huberman, A. (1994). *Qualitative Data Analysis*. London: SAGE.; Brown, S. &., McIntyre, D. (1993). *Making Sense of Teaching*. Buckingham: Oxford University Press.

[56] Charlton, T. L. &., Myers, L. E. &., Sharpless, R. (2007). Legal and Ethical Issues in Oral History. In L. Shopes (Ed.), *History of Oral History: Foundations and Methodology* (pp. 125-159). New York: Altamaira.

While analysing the transcripts, the data was simultaneously categorised into the primary issues the study would address to summarise the information efficiently.[57] The categories were as follows:

1. The support they received throughout training,

2. The responsibilities held by the participants as students,

3. Whether the participants felt adequately prepared for practice by the end of training,

4. Their thoughts on Project 2000 and whether it fulfilled its intentions of creating highly educated practitioners.

Ethics

This research was granted ethical clearance from the Ethics Committee of the School of Music, Humanities and Media at the University of Huddersfield. Per ethical guidelines, before the interview, all participants were provided with a consent form and an information sheet outlining the study's objectives with a contact email address attached so participants could ask questions to ensure they could give informed consent.[58] Additionally, the participants were provided the opportunity before and after the interview to consent to the recording being transferred to an archive. No permission was required from NHS trusts as there would be no contact with patients, and the participants volunteered to take part in the research. Consideration was also given to any potential harm. While it was expected for

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[57] Wainwright, S. P. (1994). Analysing data using grounded theory. *Nurse Researcher*, 1(3), 43-9.; Pollit, D. &., Hungler, B. P. (1991). *Nursing Research, Principles and Methods* (4th ed.). Philadelphia: J.B. Lippincot.

[58] Appendix 1.; Appendix 2.; Field, P. A. &., Morse, J. M. (1985). *Nursing Research: The Application of Qualitative Approaches*. London: Croom Helm.; Holloway, I. &., Wheeler, S. (1995). Ethical issues in qualitative nursing research. *Nursing Ethics*, 2(3), 223-232.; Rubin, H. J. &., Rubin, I. S. (1995). *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks: SAGE.

no or very minimal harm to come from the project, before the interview, participants were

made aware of local support services where they could seek help for any trauma sustained.

Moreover, safeguarding provisions were made for the possibility that some participants may

be elderly or considered vulnerable. These provisions included participants being

accompanied by someone else during the interview, with both being free to pause or stop

the interview at any point.

Determining how Project 2000 created a profession of highly educated practitioners

In assessing Project 2000 and how it fulfilled its intentions, it is essential to discuss the need

for reform, both within the profession and externally. This study will address such necessity

at length in Chapter 2. Within the profession, there arose a crucial question during the

1960s and 1970s: was nursing still fit for practice?[59] To the disappointment of the

profession's leadership – the UKCC and the Royal College of Nursing – it was rapidly

emerging that the profession was being significantly hindered by its apprentice training

model, which many nurses and educationalists were coming to regard as inadequate to

prepare nurses for their role.[60] The practice-driven apprenticeship system focused on

teaching student nurses psychomotor skills in a growing intellectually demanding healthcare

system where nurses were expected to assume more specialist and skilled duties than

before, irrespective of unsuitability or lack of competence.[61] Traditionally trained nurses

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[59] Royal College of Nursing. (2007). *Pre-registration Nurse Education. The NMC review and the issues*. London: Royal College of Nursing. p.3.

[60] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.1.

[61] Roberts, J. &., Barriball, K. L. (1999). Education for Nursing: Preparation for Professional Practice. In I. Norman, & S. Cowley (Eds.), *The Changing Nature of Nursing: In a Managerial Age*. (pp. 123-149). Oxford:

were practically competent, but few knew the reasons behind their practices or had the educational foundation to practice pragmatically. This thesis also addresses an issue that has seldom been addressed in nursing historiography: the difference between education and training. Prominent nurse historians such as Rafferty and Bradshaw have tended to focus on discussing issues around nursing identity or professionalisation while more widely (and globally) by nursing historians such as Julie Fairman or Patricia D'Antonio have concentrated on American nursing renegotiating its boundaries of practice, breaking though gender barriers and nursing's involvement in wider socio-politics issues.[62] Interviews conducted for this study and others contended that probationers were trained merely to pass exams and actually received very little formal education as part of their course.[63] The calls for reform from many nurses in clinical practice were guided by their insecurities over their nursing knowledge, with many believing themselves to be unprepared for the growing complexities of nursing.[64] Therefore, this thesis will address the efforts of Project 2000 to both train and educate its practitioners with the intention to create a profession of highly educated practitioners. Simply, momentous change was needed to place nursing on sound educational footing, and that change was Project 2000.

Blackwell Science. p.126.; Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647. p.642.

[62] D'Antonio, P. (2010). *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*. Baltimore: Johns Hopkins University Press.; Fairman, J. (2009). *Making Room in the Clinic: Nurse Practitioners and the Evolution of Modern Health Care*. New Jersey: Rutgers University Press.

[63] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 5).

[64] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.1.; Brown, H. &., Edelmann, R. (2000). Project 2000: a study of expected and experienced stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing, 31*(4), 857-864. p.858.

External forces also weighed heavily on the need for Project 2000; therefore, this study has contextualised the backdrop in which Project 2000 was implemented in Chapter 1. By the 1980s, western healthcare services were approaching a major crisis in meeting increasing demand with limited funding, and the NHS was no different.[65] Therefore, this study will acknowledge the external forces that demanded a highly educated nurse to fulfil the NHS's chief purpose of providing care.

Financially, the government has had an uneasy relationship with the NHS since its inception in 1948. The fact that the NHS was paid for by direct taxation that has gone beyond National Insurance contributions has meant that the government has always felt obliged to continually review NHS funding and revise how much state revenue was devoted to healthcare. The ideological stance of the Thatcher government in the late twentieth century heightened tensions over this issue and directly impacted the introduction and implementation of Project 2000. These issues will be discussed further in Chapter 1.

Throughout history, it has been necessary to change how nurses are trained in order for healthcare to meet the needs of society.[66] Project 2000 was a reaction to the government facing an impending need to expand the boundaries of nursing practices in order for nurses to play a more active role in care delivery. Project 2000 was not immune to the limitability of government finances. This study will consult the funding proposals for Project 2000, as well as explore how the steep price of widespread educational reform was underestimated,

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[65] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.14.
[66] Ibid, p.11.

and present the evidence for the government wishing to rush the implementation of Project 2000 to limit the expenditure required.

Project 2000 marked a considerable change in how student nurses were prepared for professional practice and will be addressed in Chapter 3. This thesis will address the introduction of supernumerary status for probationers, which freed probationers from the shackles of employment to the hospitals during training, and gave them the freedom to shadow qualified nurses with minimised distraction from rostered service commitments and patient caseloads.[67] Moreover, Project 2000 introduced a system of mentorship and preceptorship to aid students and newly-qualified nurses (NQN) in efforts to bridge the expected gap between theory and practice, as detailed in Chapter 4. Mentors and preceptors were key in contextualising the theoretical and ideological image of nursing presented in the classroom. In this sense, Project 2000 was haphazard. Theory and practice had distinct differences; theoretical teachings of nursing were developing at an accelerating rate. However, clinical practice was still dictated largely by tradition and convention and was upheld by socialisation, as is discussed in Chapter 5. Mentors and preceptors were crucial for supporting students in implementing their evidence-based practices on the wards. This study will examine their effectiveness in providing support that enabled students to be both highly educated and clinically competent.

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[67] Drennan, J. (2002). An evaluation of the role of the Clinical Placement Coordinator in student nurse support in the clinical area. *Journal of Advanced Nursing*, 40(4), 475-483. pp.475-6.; Jones, M. L. &., Akehurst, R. (1999). The cost and value of pre-registration clinical placements for Project 2000 students. *Journal of Advanced Nursing, 30*(1), 169-178. p.175.; Parker, T. J. &., Carlisle, C. (1996). Project 2000: students' perceptions of their training. *Journal of Advanced Nursing, 24*(4), 771-778. p.772.

Project 2000 is an often divisive topic in nursing history. Parts of this study might make uncomfortable reading for the professions' leadership – the Nursing and Midwifery Council and the RCN, the profession's most prominent trade union – and the traditionalist elements of the profession. This study addresses the hostilities felt by some within the profession towards change and the conservative impulse of the profession's leadership. However, this study is an updated approach to Project 2000 and details how nursing developed into the twenty-first century with highly educated nurses having enabled nursing to expand its boundaries of practice whereby nurses have formed a central place in the evolution of the NHS. This study is a re-evaluation of nursing history's verdict on Project 2000, updated with acknowledgement and reference to the broader context and with a modern perspective, ultimately finding that Project 2000 succeeded in its intention to create a profession of highly educated practitioners.

Chapter 1:
Viva la révolution? Charting the changes to the NHS and healthcare in Thatcher's Britain

The latter two decades of the twentieth century witnessed a revolution in healthcare. The 1980s and 1990s saw the overthrow of the NHS's operating structure, a changing of the guard from senior clinicians running the hospitals to the introduction of general managers, and nursing faced the most radical changes since Nightingale. The myriad changes should not be confused as inclusive or part of a coordinated raft of intended reforms. The reforms' implementation was somewhat haphazard and arbitrary, too often based on the government's political whim, with the costs of the NHS being of prime importance.

Nursing's progression from Nightingale to registration to expanding the boundaries of practice did not take place in a vacuum; instead, the changes to the profession occurred against a backdrop of more comprehensive political, social and economic events.[68] Consequently, to effectively investigate whether Project 2000 fulfilled the intentions set out by nursing's leadership, we need to understand what was happening in the NHS more widely, and this chapter will present the broader context of the 1980s and 1990s. This chapter will also discuss a new and innovative way to interpret nursing's relationship with the state. Neglect by the government led to a less than adequate implementation of Project 2000. Through a thorough analysis of the politicisation of the health service, the Griffiths Report (1983) and the creation of an 'internal market' in the NHS, this study will demonstrate the effect of the socio-economic events had on Project 2000's implementation

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[68] Slevin, O. &., Buckenham, M. (1992). Preface. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak - Innovations in the Nursing Curriculum*. (pp. 7-9). Edinburgh: Campion Press. p.14.

and why it led to a flawed implementation where many believed Project 2000 did not meet nurse leaders' expectations.

When discussing this period's political, social and economic context, it is difficult not to recognise Margaret Thatcher as the orchestrator of change. Historians, including Butler, Day and Klein have described Thatcher's changes to the NHS as the most crucial and extensive since 1948.[69] The incoming of Thatcher as Prime Minister meant that during the 1980s, the NHS, and by default nursing, were subject to a continuous revolution due to constant policy reappraisals.[70] In their 1979 manifesto, Margaret Thatcher's Conservatives deemed Britain an economic and social failure.[71] Britain's post-war economic growth slowed in the 1960s and further in the 1970s during the global recession, yet despite this, as the Conservatives highlighted, the state's expenditure continued to rise.[72] Therefore, upon the election of Thatcher in 1979, for the first time since 1945, there was a drastic break with the post-war political consensus towards funding welfare.[73] Thatcher's government, led partly by her conviction driven politics, followed New Right ideas of monetarist economics that emphasised the necessity for reductions in public spending.[74] These ideas laid the

[69] Butler, J. (1992). *Patients, Polices and Politics: Before and after Working for Patients*. Milton Keynes: Open University Press.; Day, P. &., Klein, R. (1991). *Political Theory and Policy Practice: the case of general practice 1911-1919*. Paper presented at the Political Studies Association Conference, University of Lancaster.; Le Grand, J. &., Bartlett, W. L. (1994). *Quasi-markets and Social Policy*. London: Macmillan.; Allsop, J. (1995). *Health Policy and the NHS: Towards 2000*. London: Longman. p.172.

[70] Webster, C. (1998). *The National Health Service: A Political History*. Oxford: Oxford University Press. p.141.

[71] Allsop, J. (1995). *Health Policy and the NHS: Towards 2000*. London: Longman. p.155.

[72] Fazeli, R. (1996). *The Economic Impact of the Welfare State and Social Wage*: The British Experience. Aldershot: Avebury. p.2.

[73] Collette, C. F. &., Laybourn, K. (2003). *Modern Britain since 1979: A Reader*. London: I.B. Tauris. p.1.

[74] Allsop, J. (1995). *Health Policy and the NHS: Towards 2000*. London: Longman. p.155.

foundations for the erratic set of policies that sought the restructuring of the state's role in the economy regarded under the umbrella term 'Thatcherism'.[75]

The Griffiths Report

The Conservatives' 1979, 1983, and 1987 election manifestos reflected Thatcher's assertion that the state's relationship with the NHS needed to change, and to do so, the NHS needed restructuring. As part of Thatcher's efficiency drive, there emerged a suggestion to operate the NHS similar to a private business. The term 'efficiency' and the NHS had been synonymous since 1948, and as early as 1953, committees were being established to recommend ways to run the NHS more efficiently.[76] Thatcher's equivalent was the commissioning of the Griffiths Report, published in 1983.[77] Roy Griffiths, director of Sainsbury's, emerged as the appropriate candidate as he was a thriving private-sector businessman. As a result, he became a prominent figure in the politicisation and managerial revolution of the NHS as his report guided the policies of Thatcher's government towards NHS management.[78]

Martin Gorsky has written extensively on Griffiths and his report. Gorsky's *Searching for the People in Charge* article highlighted that the report produced 'far-reaching recommendations' after a swift period conducted without open consultation of healthcare

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[75] Jessop, B. &., Bonnett, K. &., Bromley, S. &., Ling, T. (1988). *Thatcherism: A Tale of Two Nations*. Cambridge: Polity Press. p.3.

[76] Kendall, I. &., Moon, G. (1990). Health Policy. In S.P. Savage., &. L. Robins. (Eds.) *Public Policy Under Thatcher*. (pp. 103-116). Basingstoke: Macmillan. p.103.

[77] Bosanquet, N. (1988). An ailing State of National Health. In R. Jowell., & S. Witherspoon, & L. Brook. (Eds.) *British Social Attitudes: The 5th Report*. (5th ed., pp. 93-105). Aldershot: SCPR. p.94.

[78] Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. p.37.

professionals or patients.[79] Griffiths' conduct ran counter to Norman Fowler's, Secretary of State for Health and Social Services between 1981 and 1987, promise to the House of Commons in 1983 that the government would 'consult the health authorities and professional(s) involved.'[80] Nevertheless, nurses were not consulted once during the consultation period, and their voices were not heard. The lack of discussions with nurses and other health professionals allowed Griffiths to diagnose the NHS with a bout of institutional stagnation. Griffiths' infamous remark: 'If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge' reflected his bemusement at how the NHS could operate with no general managers who assumed overall control of day-to-day operations.[81]

While Griffiths' name was on the report, it should be recognised that Griffiths appears to have been at the behest of Thatcher's wishes; therefore, it could be presumed that his report had to reflect her ideological thinking towards NHS management. It is, thus, little surprise that Griffiths did not reach out to nurses as nursing practices from the period demonstrated that the NHS was flexible. Nurses have always been burdened with the constant changes in healthcare, and each time they rose to the challenge, and each time, the NHS was adaptable enough to continue to provide healthcare free at the point of use. The evolution of thoughts and opinions towards Griffiths' reforms are mixed.[82] Many, including Lowe and Pollock, have labelled Griffiths as the father of the modern NHS

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[79] Gorsky, M. (2013). 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry. *Journals of Medical History*, 57(1), 87-107. p.88.
[80] Fowler, N. (1983, October 25). *National Health Service (Management Inquiry)* [Hansard]. (Vol. 47).
[81] Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. p.37.
[82] Gorsky, M. (2013). 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry. *Journals of Medical History*, 57(1), 87-107. p.89.

management structure and the individual who fired the starting gun for Thatcher's NHS revolution.[83] Timmins has argued that Griffiths' report, and the changes that subsequently occurred, were among the most important changes to the NHS since 1948.[84] Indeed, Griffiths should be credited with introducing a new management structure to the NHS, and the fact that his structure still exists in the twenty-first century should be recognised as an achievement. Under his reforms, chief executives, recruited externally, would take the place of senior hospital doctors who, under the consensus management operation, previously controlled the NHS.[85] By 1986, one thousand general managers, accountable for a wide array of administrative, financial, and legal responsibilities, were hired.[86] For Peet, the new management structure was a welcome step forward for the NHS and on which it could build for future success.[87]

Two narratives on the Griffiths Report have emerged: firstly, that it was a pivotal moment for the NHS as a clear management structure where doctors and nurses could step back from management and go back to chiefly caring for patients. Secondly, that it was a means for the government to implant government enforcers to control the state's public expenditure bill. The only group to support the report was the Institute of Health Service Administration, representing healthcare administrators.[88] Representative bodies of health professions urged that the executives and managers brought into the NHS had turned the

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[83] Lowe, R. (2005). *The Welfare State in Britain Since 1945*. (3rd Eds). Basingstoke: Macmillan. p.372.; Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. pp.36-38.

[84] Timmins, N. (1995). *The Five Giants: A Biography of the Welfare State*. London: Harper Collins. pp.409-410.

[85] Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. p.37.

[86] Ibid, p.37.

[87] Peet, J. (1991). Healthy Competitions. In R. Haas., &. J. Knox. (Eds.) *Policies of Thatcherism: Thoughts from a London Thinktank*. (pp. 389-416). London: University Press of America.

[88] Gorsky, M. (2013). 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry. *Journals of Medical History*, 57(1), 87-107. p.90.

inability to make decisions into an art form as they did not possess the medical or nursing knowledge to make all decisions.[89] Indeed, political scientist Harrison concluded that the consensus management structure had been harshly portrayed as a failure; in fact, it had mainly been a success and that Griffiths' management structure would make no difference to efficiency.[90] There is corroborating evidence for the consensus system's defence as the 1979 Royal Commission into NHS management deemed the consensus system an acceptable management model.[91] As Gorsky argues, contemporary analysis into the consensus management system has produced no definitive evidence that it was unsuccessful.[92] Therefore, it is clear, Thatcher's government ignored the report's conclusions.

Significantly for this study, Griffiths has also been criticised for turning the NHS into a money-orientated business. The NHS had always been directed, to a certain degree, by costs, but as David Morrel argued, it led the way in 'deploring the treatment of healthcare as a commodity'.[93] Geoffrey Rivett has also been very critical of Griffiths. He condemned his report as oblivious to the NHS as a multi-professional environment where private sector-influenced changes would have a deleterious impact, especially for nurses, in loss of clinical leadership and an inevitable decline in practice standards.[94] NHS historian Charles Webster has concluded that the Griffiths Report and proves Thatcher was reluctant to fund the NHS

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[89] Ibid. p.91.
[90] Harrison, S. (1994). *National Health Service Management in the 1960s: Policymaking on the Hoof?*. Aldershot: Avebury. p.80.
[91] Department of Health and Social Care. (1979). *Royal Commission of the National Health Service*. London: Department of Health.
[92] Gorsky, M. (2013). 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry. *Journals of Medical History*, 57(1), 87-107. p.93.
[93] Lowe, R. (2005). *The Welfare State in Britain Since 1945*. (3rd Eds). Basingstoke: Macmillan. p.372.
[94] Rivett, G. (1998). *From Cradle to Grave: Fifty Years of the NHS*. London: King Fund. pp.353-354.

adequately.[95] Thatcher's government was unwilling to accept the 1979 Royal Commission's conclusions, which was published just months after she entered office, and therefore ordered a new report that agreed with her New Right ideas and her plans for privatisation. Thatcher's plans to underfund the NHS were hidden behind the suggestions of cost improvements and meeting budgets.[96] The true costs of Thatcher's policies in the NHS were shown during the implementation of Project 2000. When Project 2000 came to be implemented, the resources provided were inadequate as the government was fixed on reducing the NHS bill. Simply, state neglect led to the implementation of Project 2000 being under-resourced, and this significantly affected the standards of training and the experiences of the students on clinical placements in the hospitals. The NHS is a labour-intensive service. Therefore, any change to expenditure has major implications for front-line staff, primarily nurses, which was largely ignored.[97]

The internal market

A central feature of NHS history has been the relationship between the need to contain costs and the 'reasonable boundaries' set around cost and efficiency targets.[98] In efforts to control costs and use the NHS to stimulate the wider private economy, the Thatcher government set sights on another major review of the NHS.[99] In 1987 the Conservative government published the *Working for Patients* white paper. Officially, the justification for

[95] Webster, C. (2002). *The National Health Service: A Political History*. Oxford: Oxford University Press.
[96] British Medical Journal. (1983). NHS management inquiry. *British Medical Journal*, 287, 1391-1393. p.1393.
[97] Centre for Health Economics: Health Economics Consortium, University of York. (1993). *Expenditure on the NHS During and After the Thatcher Years: Its Growth and Utilisation, Discussion Paper 113*. p.ii.
[98] Kendall, I. &., Moon, G. (1990). Health Policy. In S.P. Savage., &. L. Robins. (Eds.) *Public Policy Under Thatcher*. (pp. 103-116). Basingstoke: Macmillan. p.103.
[99] Bosanquet, N. (1988). An ailing State of National Health. In R. Jowell, S. Witherspoon, & L. Brook (Eds.) *British Social Attitudes: The 5th Report*. (5th ed., pp. 93-105). Aldershot: SCPR. p.50.

the white paper was for the government to raise the performance of hospitals and general practice to that of the best globally.[100] However, it is difficult not to see the Thatcher government's true intentions behind the white paper. The white paper led to the National Health Service and Community Care Act, 1990, and created an internal enterprise market within the health service.[101] Despite the Act being implemented under John Major, it was crafted by Thatcher's administration, and it is here where Thatcher's New Right allegiances become starkly apparent. New Right thinking leaves economic, labour and efficiency successes to the market and believes only the market can bring about competitiveness that would expand the British economy.[102] Brian Slater has argued that Thatcher adopted the idea that successful mechanisms in the wider economic market could be applied to the NHS.[103] Naturally, as the New Right advocated self-determination and regulation, they saw the NHS as wasteful and open to excess.[104] The New Right ideology led Thatcher to see the NHS as a potential market where monopolies could be disregarded, and services sold off to generate cost savings and limit the state's role in funding the NHS and reduce opportunities to increase the NHS budget.

The creation of the internal market opened the NHS up to external competitive forces. Profit was always the driving force; therefore, many of the NHS's ancillary services were the first services to be contracted out.[105] In many areas, such as domestic and catering services, it was cheaper for the District Health Authorities (DHA) to outsource services to companies

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[100] Department of Health. (1989). *Working for Patients*. London: HMSO.
[101] Allsop, J. (1995). *Health Policy and the NHS: Towards 2000*. London: Longman. p.155.
[102] Fazeli, R. (1996). *The Economic Impact of the Welfare State and Social Wage*: The British Experience. Aldershot: Avebury. p.36.
[103] Slater, B. (1998). The Politics of Change in the Health Service. Basingstoke: Macmillan. p.7.
[104] Ibid, p.7.
[105] Punnett, R. M. (1994). *British Government and Politics.* (6th Eds). Aldershot: Dartmouth. p.389.

who paid their staff approximately twenty per cent less than the NHS paid its staff for the same job.[106] As a result, 260,000 non-clinical staff from 1981 dwindled to 157,000 in 1990 and 120,000 in 1994.[107] Privatisation has always been part of the NHS. In 1948, Aneurin Bevan, then Minister for Health, allowed consultants to hold private practice sessions on behalf of the NHS; under Thatcher, it was estimated that 85% of NHS consultants engaged in private practice earning 10% of their overall NHS salary from the growth of private beds.[108] Nevertheless, the NHS became further fractured under Thatcher.[109]

The creation of the internal market did improve efficiency and helped keep the ballooning costs of the NHS down, allowing it to survive into the 1990s and twenty-first century. It is important to remember that the pot to fund the NHS is not unlimited. It is drawn from taxation paid by the British public. Therefore, limiting costs is key for the survival of the NHS. However, the NHS is a people business, and as the British Medical Association (BMA) argued, the focus on finance impeded treatment given to patients.[110] Outsourced poor-quality meals became a notorious part of NHS hospital stays, and in extreme cases, these meals made an estimated 10% of seriously ill patients malnourished as inpatients.[111] The rise of privatisation also exposed the gaping difference in healthcare quality provided by private and NHS hospitals. There arose a notion of the NHS failing to deliver in the late 1980s and 1990s. The government had ground the NHS down to the point where private healthcare was a preferable option as the public widely believed that the NHS was being

[106] Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. p.38.
[107] Ibid, p.38.
[108] Griffiths, H. &., Iliffe, S. &., Rayner, R. (1987). *Banking on sickness, commercial medicine in Britain and the USA*. London: Lawrence & Wishart.
[109] Allsop, J. (1995). *Health Policy and the NHS: Towards 2000*. London: Longman. p.167.
[110] Kendall, I. &., Moon, G. (1990). Health Policy. In S.P. Savage., &. L. Robins (Eds.) *Public Policy Under Thatcher*. (pp. 103-116). Basingstoke: Macmillan. pp.112-3.
[111] Pollock, A. M. (2004). *NHS plc: The Privatisation of Our Health Care*. London: Verso. p.38.

starved of funding.[112] This was a hidden motivation of the New Right inspired Thatcher

government as the NHS's demand always outweighs the supply.[113] Ultimately, the only way

for the government to cut costs for the NHS was to reduce the demand. Therefore, the

Thatcher period saw a substantial increase in private healthcare spending. In 1983, private

expenditure stood at £450 million per year, and by 1986, the figure was £733 million per

year.[114]

Any change to the NHS has always been burdened by those seen at the bottom of the

professional hierarchy – nurses - and the reforms under Thatcher were felt most by the

nurses. Thatcher's changes prioritised penny-pinching over patients, rationing over high-

quality care standards, and the Pound Sterling over people. By the implementation of

Project 2000, student nurses were on placements in a stripped-down NHS. Students were

learning from nurses who were shouldering more duties than ever before to compensate for

lower staffing levels. The rationing of resources also prevented Project 2000 from being

implemented with the best chance of achieving its aims. Thatcher's disembowelling of the

health service through the managerial reforms and the creation of the internal market

meant that Project 2000 was competing with the rationing system for survival. General

managers and DHA's undermined the importance of low staffing levels; low-quality staffing

levels and low morale in the nurse's training meant that Project 2000 was scuppered from

the beginning.

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[112] Meadowcroft, J. (2005). Health care markets, prices and coordination: The epistemic explanation of government failure and the UK National Health Service. *HEC Forum*, 17(3), 159-177. p.160.
[113] Slater, B. (1998). The Politics of Change in the Health Service. Basingstoke: Macmillan. p.23.
[114] Bosanquet, N. (1988). An ailing State of National Health. In R. Jowell, S. Witherspoon, & L. Brook (Eds.) *British Social Attitudes: The 5th Report*. (5th ed., pp. 93-105). Aldershot: SCPR. p.95.

Chapter 2:
The decades of discontent: An exploration of how the inadequacies of the apprenticeship system led to the planning of Project 2000

The apprenticeship system of training

In the decades before the implementation of Project 2000, nurses were still being taught under the shadow of Nightingale's vision of nursing. By the mid-twentieth century, the training system was outdated. Still, it is essential to remember when discussing the need for reform, amongst the emerging failings of the system, there were positives and successes of the apprenticeship model.[115] The apprenticeship system existed in a period characterised by nurses predominantly performing manual tasks that required little specialist skill or knowledge. It is a simplistic but appropriate statement that the early to mid-twentieth century were merely different times where society had different values and morals. Therefore, to judge the apprenticeship system by modern-day expectations of nurse training is unhelpful.

A prominent example of societal changes affecting healthcare was the evolution of science and the subsequent technological and pharmaceutical advancements of the post-war period.[116] In medicine, significant technological advances had been made in cardiology that contributed to a sizable reduction in the mortality from cardiac diseases. Examples include the emerging widespread use of electrocardiograms. Practitioners were coming to be

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[115] Bradshaw, A. (2001). *The Nurse Apprentice, 1860-1977*. Aldershot: Ashgate.p.143.
[116] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.214.

trained in coronary care, to detect abnormal heart rhythms on ECGs and adept at correcting arrhythmias with a defibrillator.[117] Moreover, there were radical improvements in highly intricate and previously unperformable surgical procedures.[118] Similarly, improvements in anaesthesia led to more successful operative procedures and at earlier stages of disablement.[119] Transplants had too become increasingly successful procedures, including liver transplants, first reported in 1963, which were exceptionally difficult procedures due to the liver being sensitive to any interruption of blood supply and the swift perfusion required for survival.[120] 'Spare-part' surgery was also on the rise in the 1950s and 1960s.[121] Surgeons could replace parts of the body with inert mechanical functions, such as joints, valves and arteries with metal, plastic, or dead tissues.[122] Such evolutions, however, demanded radical change.

Nurses have long proven to be the most flexible and adaptable element of British healthcare and were, therefore, present in both medical and surgical areas, both acute and nil acute. As a result, nursing was greatly affected by advances in medicine. As doctors acquired more duties due to technological advances, nurses found themselves expected to carry out technical and specialist duties traditionally belonging to doctors that exceeded the traditional skills of nurses.[123] In this respect, the apprenticeship model was a suitable

[117] White, N. M. &., Parker, W. S. &., Binning, R. A. &., Kimber, E. R. &., Ead, H. W. &., Chamberlain, D. A. (1973). Mobile coronary care provided by ambulance personnel. *British Medical Journal*, 3(5881), 618-22. p.618.
[118] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.214.
[119] London Health Planning Consortium. (1980). *Report of the study group on ophthalmology services*. London: Department for Health and Social Security.
[120] Calne, R. Y. &., Williams, R. (1968). Liver transplantation in man. *British Journal of Nursing*, 4(5630), 535-42. p.536.
[121] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.214.
[122] Browse, N. (1967). Spare-part surgery. *British Medical Journal*, 4(5527), 782-3. pp.782-3.
[123] Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge. p.112.; Bradshaw, A. (2001). *The Nurse Apprentice, 1860-1977*. Aldershot: Ashgate. p.114.

response. Nursing is, after all, a practical art, and the apprenticeship system should be praised for being an appropriate method of training by focusing on the skills needed for nurses to carry out the duties expected of them.[124] Ultimately, McManus, Richards, Winder, and Sproston concluded that for a practitioner to be confident and competent, they need to be provided clinical experiences, and the traditional method did this.[125]

Another positive aspect of the apprentice system was that it fostered a sense of community among students. The literature has been relatively quiet on this subject; however, the words of the nurses interviewed for this thesis testify that the communal atmosphere was one of the highlights of their training. When asked what she remembers most vividly about her training, Elizabeth replied, 'the relationships [that] you have with your peers.'[126] Elizabeth was part of the final cohorts of the apprenticeship system, beginning her training in 1987, and spent her three years in the nurses home. Elizabeth remembered how she formed bonds with her peers that have lasted over thirty years. These close relationships made Elizabeth feel 'like you belonged,' because the support they offered each other was 'amazing'.[127]

Similarly, Victoria praised the 'tight knit' groups encouraged by the apprenticeship system as a crucial part of her success in the course.[128] Victoria was in a group of ten students and

[124] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.41.

[125] McManus, I. C. &., Richards, P. &., Winder, B. C. &., Sproston, K. A. (1998). Clinical experience, performance in final examinations, and learning style in medical students: prospective study. *British Medical Journal*, 316(7128), 345-50. pp.348-9.

[126] Elizabeth. (2021, 11 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 3).

[127] Elizabeth. (2021, 11 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 3).

[128] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 4).

remarked that the small group helped create a 'safe learning environment, in that you knew everybody very well, you were learning together.'[129] Therefore, the close sense of community cultivated by the apprenticeship system appears to be one of its biggest successes and one of its most humanistic hallmarks.

By the mid to late-twentieth century, however, it had become evident that the apprenticeship system had reached its limit in preparing students for a career in nursing. By the latter decades of the twentieth century, technological advancements meant a different kind of nurse was being required, and the apprenticeship system was falling short of providing such practitioners. Nurses were being expected to know more than simply how to carry out procedures. They were expected to understand the reasons behind their practices and make timely judgements regarding patient care semi-autonomously.[130] Nurses needed to be *educated*, as opposed to just *trained*. George trained in the late 1980s and observed a clear distinction between education and training. During his time as a probationer, he was trained, not educated.[131] George points to the difference in the course's focus as the cause. 'From the hospital's perspective, [you] were sent out to work, in the numbers,' as a result, the focus was on being trained to do tasks, not to teach nurses why tasks were performed.[132] Frankly, he believes the apprenticeship system was not the appropriate route to guide nursing into the twenty-first century as it was designed to train. Instead, nursing needed a universal course to educate as well as train, and that was Project 2000.

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[129] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 4).

[130] Benner, P. (1984). *From Novice to Expert*. California: Addison Wesley Publishing Company.

[131] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 5).

[132] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 5).

Nevertheless, the apprenticeship system had lasted the test of time. It had trained the nurses who had earned British healthcare a positive reputation in the late nineteenth and early twentieth century, and it had produced the nurses who answered the call of duty to staff NHS hospitals after 1948. These apprentice-trained nurses had also borne the brunt of successive spending cuts and inadequate resources to perform their duties properly. Nonetheless, they persevered, and arguably the survival of the NHS and the public affection it commanded is to the credit of apprenticeship nurses.

The need for change

From the mid-twentieth century, it was recognised that a significant flaw of the apprenticeship model was the utilisation of students. The traditional image of the nurse was of them strictly being by the bedside of their patient, ignorant of any decision-making processes. This meant student nurses were almost always learning solely manual tasks. Equally, the Department for Health and Social Security (DHSS) found that students were being used as workers on the short-staffed wards, with 75% of all patient care being provided by students, all in the name of nurse training.[133] Many commentators, including Jill MacLeod Clark, have pointed to the irony of a Nightingale quote to expose the growing inadequacy of the apprenticeship system. In her *Education for the Future* article, Clarke cites Nightingale's 'if a nurse is learning she cannot be in place of another nurse' comment.[134] However, under the apprentice system, student nurses were staff, they counted in the ward staffing numbers, they had their own patient caseloads and they were expected to work

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[133] Department of Health and Social Security. (1972). *Report of the Committee on Nursing*. London: HMSO.
[134] Clark, J. M. (1998). Education for the future. *Nursing Management*, 5(2), 14-17. p.17.

full-time, all while supposedly training.[135] Probationers were expected to practice under

qualified supervision, however, the level of supervision varied enormously, and on short-

staffed wards with high acuity levels, supervision was sometimes inexistent.[136] Therefore,

under the apprentice system, a student was in the place of a nurse, and many remarked

that the lack of supernumerary status hindered their learning.

Nurses were also increasingly required to expand their knowledge and skill base during the

1960s to 1980s. However, the educational provision was not in place under the

apprenticeship system, with many recognising the apprentice model as anachronistic and

anti-educational.[137] Jacka and Lewin argued that as probationers fulfilled the duties of

qualified nurses, their teaching time was cut short as ward staff were expected to teach

when clinical opportunities arose.[138] Yet, the use of students hints that those chances rarely

occurred.[139] Because of this, Chapman argued that the joint student/employee status of

probationers prevented students from learning as much as was intended.[140] The RCN

acknowledged that nurse training must reflect the complex demands placed on nursing, and

the probationer is to meet the evolving needs of patients and services post-registration.[141]

Yet, the apprenticeship model was not meeting these demands.

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[135] Melia, K. M. (1981). *Student nurses' accounts of their work and training: a qualitative analysis* [PhD Thesis, University of Edinburgh]. p.116.

[136] Ibid, pp.117-8.

[137] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.38.

[138] Jacka, K. &., Lewin, D. (1987). *The Clinical Learning of Student Nurses. Nursing Education Research Unit*. London: Kings College, University of London.

[139] Ibid, p.4.

[140] Chapman, C. (1980). The learner as worker. *Medical Teacher*, 2(5), 241-4.

[141] Royal College of Nursing. (1960). *RCN Annual Report, 1960*. London: RCN.

Nursing is renowned for having a robust public image, and a key part of that image has been nursing's long militaristic sense of loyalty. Loyalty to one's mentor, supervisor, colleagues, nurse-in-charge, patients, and, in significant relevance to this study, loyalty to one's system of training.[142] Indeed, many senior nurses who formed part of nursing's leadership retained allegiances to the traditional training method and, therefore, resisted reform.[143] Even so, many nurses lower down the nursing hierarchy were growing disgruntled with the shortfalls of the apprenticeship system, and its inadequacies complicated their loyalty. By the 1960s, nursing was introducing the concept of assertiveness into their professional moral values, and the growing consensus among lower-ranking nurses, often younger staff nurses and modern sisters, demonstrated nurses beginning to argue for themselves and the future of the profession.[144] Several studies reflected many nurses' thinking from the period.[145] In recordings, it was said that the apprenticeship system was failing to meet the demands of advancing healthcare, and consequently, the duties nurses were being expected to assume. Simply, nurses believed that the traditional system inadequately trained them, and upon qualification, many experienced a reality shock as they were not fully prepared for the pressing demands of nursing.[146]

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[142] Wurzbach, M. E. (1999). The moral metaphors of nursing. *Journal of Advanced Nursing*, 30(1), 94-9. p.94.
[143] Hickey, G. (1996). The challenge of change in nurse education: traditionally trained nurses' perceptions of Project 2000. *Nurse Education Today, 16*(6), 389-396. p.389.
[144] Wurzbach, M. E. (1999). The moral metaphors of nursing. *Journal of Advanced Nursing*, 30(1), 94-9. p.96.; Marris, P. (1984). *Loss and Change*. London: Routledge.; Robinson, J. (1991). Project 2000: the role of resistance in the process of professional growth. *Journal of Advanced Nursing, 16*(7), 820-4. pp.820-4.
[145] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall.; Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256.; Fulbrook, P. &., Rolfe, G. &., Albarran, J. &., Boxall, F. (2000). Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today, 20*(1), 350-357.
[146] Kramer, M. (1974). *Reality Shock: Why Nurses are Leaving Nursing*. St Louis: Mosby.

Nursing's period of discontent: the reports that spurred reform

Nursing's professional discontent deepened in post-war Britain and brewed the basic principles behind reform that would last decades.[147] During those decades, official government, RCN and UKCC reports spelt out the deficiencies in the apprenticeship model and alternatives were devised to correct the situation. Similarly, historians and social scientists conducted studies that highlighted the voices of students and qualified nurses trained under the apprenticeship system.[148]

Two major reports that paved the way for Project 2000 were the Platt Report (1964) and the Briggs Report (1972). The RCN commissioned the Platt Report in 1961 to explore the means to overhaul the apprenticeship model.[149] Sir Henry Platt chaired a commission of forty people drawn from nursing, medicine, education, sociology and administration. He presided over a report that exposed, for the first time, the deep wounds the apprenticeship model was inflicting on nursing and the urgency needed to implement reform.[150] The recommendations were clear: nursing education should be governed by the educational needs of students rather than NHS service needs.[151] Higher education, therefore, came to

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[147] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.1.

[148] Melia, K. M. (1981). *Student nurses' accounts of their work and training: a qualitative analysis* [PhD Thesis, University of Edinburgh].; Watson, L. D., & Kiger, A. M. (1994). Clinical staff and the new student nurse: anticipating change. *Nurse Education Today, 14*(6), 457-464..; Elkan, R. &., Robinson, J. (1991). Project 2000: a review of published research. *Journal of Advanced Nursing, 22*(2), 386-392.; Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing, 32*(2), 473-480.

[149] Platt, H. &., Royal College of Nursing. (1964). Platt Report: A Reform of Nursing Education. First Report of a Special Committee on Nurse Education. London: RCN.; John, A. J. (1964). A Reform of Nursing Education. First Report of a Special Committee on Nursing Education. (Royal College of Nursing and National Council of Nurses of the UK). *Mental Health*, 23(6), 249-250. p.249.

[150] McGann, S. &., Crowther, A. &., Dougall, R. (2009). *A History of the Royal College of Nursing 1916-1990: A Voice for Nurses*. Manchester: Manchester University Press. p.216.

[151] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.187.

be seen as the natural home for the future of nurse training with theory suggested as a major component of the curriculum. It was assumed that a university nursing degree would promote the research, and such research would shape the foundations of the knowledgeable nurses' practice and aid them in dealing with changes in healthcare. The practical training elements would be conducted under controlled clinical placements undertaken in a wider variety of large hospitals with at least 300 beds. Alongside hospital placements, students would undertake training in general medicine, surgery, gynaecology, paediatrics, theatre, ENT (Ear, Nose and Throat), and ophthalmology.[152]

It should be acknowledged that none of the core suggestions of the Platt Report were new. Many of the RCN's Annual Reports from the 1950s and 1960s advocated for nurse-training to move to universities, polytechnics and colleges.[153] Equally, the Nuffield Report (1953) had earlier detailed the need for a highly educated professional nursing class to lead nursing teams of the future.[154] The reiteration of proposed, and ultimately un-acted, policies to reform nursing education occurred aimlessly between successive reports in the second half of the twentieth century. The Briggs Report demonstrates this unfortunate fact.

Hockey and Schrock are among many who point out that the Briggs Report suggested the future of nursing was in higher education as nurses must be supported by a researched rationale and scientific base.[155] The Briggs Report also supported the separation of theory

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[152] Ibid, p.187.

[153] Royal College of Nursing. (1960). *RCN Annual Report, 1960*. London: RCN.

[154] Goddard, H. A. (1953). *The Work of Nurses in Hospital Wards: Report of a Job Analysis*. Nuffield: Nuffield Provincial Hospitals Trust.

[155] Schrock, R. A. (1981). Philosophical Issues. In L. Hockey (Ed.), *Current Issues in Nursing*. (pp. 3-17). Edinburgh: Churchill Livingstone. p.3.

and practice. The report recommended that students undertake a common 18-month

foundation period followed by an 18-month branch programme in either adult, child,

mental health or special needs nursing.[156] Significantly, and originally, the Briggs Report also

concerned itself with the structure of nursing and argued that for reform to be successful,

nursing would need a unified statutory body.[157] The United Kingdom Central Council for

Nursing, Midwifery and Health Visiting (UKCC) was subsequently established in 1979,

replacing the General Nursing Council (GNC). It marked the first significant step towards

tangible reform as it would be the UKCC who ushered in Project 2000 under its purview.

However, the recommendations of the Briggs Report were too shelved like the Platt

Report.[158]

The Platt and Briggs Reports provide a window into the acknowledgement of the RCN and

the state that nursing education needed to be urgently reformed. Yet, it seems the reports

were commissioned and then ignored. Both Platt and Briggs, just like Horder (1943), Wood

(1947) and Nuffield (1953), were shelved after publication.[159] There appeared to be a

pattern in nursing history; every couple of years, there is a report commissioned by the RCN

or by the government in efforts for each party to appear interested in nursing's problems

and to look as if, finally, action would be taken. In the words of Jowett et al., nursing had

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[156] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.6.
[157] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. pp.11-12.
[158] Girot, E. (1990). Nurse education: a political dimension. *Nursing Standard*, 4(35), 28-29. p.28.
[159] Horder, T. (1943). *Report of the Nursing Reconstruction Committee*. London: RCN.; Wood, R. &., Ministry of Health. (1947). *The Working Party on the Recruitment and Training of Nurses (Wood Report)*. London: HMSO.; Goddard, H. A. (1953). *The Work of Nurses in Hospital Wards: Report of a Job Analysis*. Nuffield: Nuffield Provincial Hospitals Trust.; Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256. p.247.

produced 'a veneer of change through documentation, whilst leaving underlying practices untouched.'[160] But it would not be until 1984 that, forty years after Horder, Project 2000 would begin to be planned. One interpretation of why so little was done until the 1980s was that students and nurses' voices were rarely heard. Nursing's leaders, the GNC, then UKCC, RCN and the government, were never really confronted with the disgruntled attitude of many nurses towards nurse training. They rarely had to face the gross inadequacies of the apprenticeship model on the wards, nor did they provide a forum in which nurses and students could speak out. Instead, it was the studies conducted by social scientists in the decades of discontent that shone the focus on the practical issues of the day-to-day for students and nurses, tutors and mentors. These studies went a long way in edging nursing closer to reform.

Morton-Williams and Berthoud's study published in 1971 concluded that the apprenticeship model was outdated as students and qualified nurses had recognised their weaknesses in their theoretical knowledge.[161] This built on earlier research by MacGuire from 1961 and 1966, who found that most nurses wanted more theoretical training.[162] One of the most comprehensive studies into the traditional training system's inadequacy was conducted by Vaughan in 1980.[163] Vaughan's conclusions reflect that nursing was becoming a self-aware

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[160] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.3.

[161] Morton-Williams, J. &., Berthoud, R. (1971). *Nurses Attitude Study: Report on Depth Interviews (Ref. 02.194)*. London: Social and Community Planning Research.; Morton-Williams, J. &., Berthoud, R. (1971). *Nurses Attitude Survey (Ref. 02.188)*. London: Social and Community Planning Research.

[162] MacGuire, J. (1961). *From Student to Nurse – The Induction Period: A Study of Student Nurses in the First Six Months of Training in Five Schools of Nursing (September)*. Oxford: Oxford Area Nurse Training Committee.; MacGuire, J. (1966). *From Student to Nurse – Training and Qualification: A Study of Student Nurses in Training at Five Schools of Nursing (May)*. Oxford: Oxford Area Nurse Training Committee.

[163] Vaughan, B. (1980). *The Newly Qualified Staff Nurse – Factors Affecting Transition.* [PhD Thesis]. Manchester: University of Manchester.

discipline as nurses recognised what needed to change. The majority of respondents in the

study shared the opinion that they were trained only to pass an exam, not how to cope with

the pressures of the job, how to engage with colleagues in a multidisciplinary environment

or how to run a ward. However, these responsibilities were becoming critical elements of

modern nursing. With the over-reliance on auxiliaries to provide direct patient care on the

wards, professional nursing was moving towards managerialism and teaching. Yet, modules

on the skills, principles and legalities of management were neglected from the

apprenticeship curriculum, as were opportunities to learn and practice teaching skills.[164]

Vaughan found that nursing was not evolving alongside healthcare developments and

Vaughan's findings reflect the interpretation that nursing was so deeply entrenched in its

traditional practices that conservatism was getting the better of the profession. The world

around nursing was changing rapidly with healthcare practices constantly developing, yet, in

many ways, nursing appeared to stand still.

Under the apprenticeship system, probationers continued to be taught glorified nursing

practice rituals portrayed as the best of the profession. The neatness of a made bed and the

speediness of a drugs round were, at times, prioritised over the patient's high-quality

holistic care. Roberts and Barribal argued that under the traditional system, the ritual

practices passed down by generations of nurses had turned into an industrial-focused

fixation on task performances. On the wards, this was what was being taught to students.[165]

Fretwell and French expanded on this argument further. They claimed that the

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[164] Lathlean, J. &., Corner, J. (1991). Introduction. In J. Lathlean, & J. Corner (Eds.), *Becoming a Staff Nurse: A Guide to the Role of the Newly Registered Nurse*. (pp. xi-xii). London: Prentice Hall. p.2.
[165] Roberts, J. &., Barriball, K. L. (1999). Education for Nursing: Preparation for Professional Practice . In I. Norman, &. S. Cowley (Eds.), *The Changing Nature of Nursing: In a Managerial Age*. (pp. 123-149). Oxford: Blackwell Science. p.125.

apprenticeship model was limited as a training system by emphasising that students were

primarily learning psychomotor skills in task-centred practices.[166] Chapman, Orton, Ogier,

and Greenwood built on this and stressed that the repetition of tasks performed on the

wards directly inhibited the individual or collective drive for acquiring more theoretical

knowledge.[167] Nursing had built an embedded desire for routine and conformity through the

apprenticeship system, which was resistant to change.[168] However, for Benner, until nurses

learnt the reasons behind their practices and relied on their knowledge, logic and

independent thought, nursing would be trapped in stagnation.[169] Simply, Benner's argument

shows that the apprenticeship system failed to provide the framework for nurses to practice

as autonomous practitioners; instead, they were merely servants to other professionals.[170]

Lathlean et al.'s 1986 study of the apprenticeship model's inadequacies dug deeper into the

issue and produced a broad but thorough report.[171] Significantly, Lathlean's research found

that the apprenticeship model was insufficient in guiding the probationers in articulating the

concepts of nursing practices and teaching students how to plan the long-term care of

patients. Upon consultation with the participants – student nurses, tutors and mentors -

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[166] Fretwell, J. E. (1980). An inquiry into the ward learning environment. *Nursing Times*, 76(16), 69-73.; French, P. (1989). *An assessment of the pre-registration preparation of nurses as an educational experience*. [Unpublished PhD thesis]. Durham: University of Durham.

[167] Chapman, C. (1980). The learner as worker. *Medical Teacher*, 2(5), 241-4.; Orton, H. D. (1981). *Ward Learning Climate: A Study of the Role of the Ward Sister in Relation to Student Nurse Learning on the Ward.* London: Royal College of Nursing.; Ogier, M. E. (1982). *An Ideal Ward Sister: A Study of the Leadership Style and Verbal Interactions of Ward Sisters and Nurse Learners in General Hospitals*. London: Royal College of Nursing.; Greenwood, J. (1993). *The apparent desensitisation of student nurses during their professional socialisation: a cognitive perspective.* Journal of Advanced Nursing, 18(9), 1471-9.

[168] Fretwell, J. E. (1985). *Freedom to Change – the Creation of a Ward Learning Environment*. London: Royal College of Nursing.

[169] Benner, P. (1984). *From Novice to Expert*. California: Addison Wesley Publishing Company.

[170] Benner was writing in the American context of the failings of the apprenticeship system, however, her arguments are applicable to the British apprenticeship system.

[171] Lathlean, J. &., Smith, G. &., Bradley, S. (1986). *Post-Registration Development Schemes Evaluation*. London: King's College, University of London.

Lathlean discovered that during their training, students' level of understanding and learning needs as individuals were never addressed. In one student's words, the apprenticeship system 'seems to knock out of you any individual thought or creativity;' the students were there simply to pass the exams. It, therefore, seems plausible, when the collective findings by Lathlean, Vaughan and others were examined, that one of the primary faults in the apprenticeship system was it neglected to appreciate student nurses as individuals with differing thoughts, values and ideas. Lathlean's study supports this theory as it found that probationers almost universally demonstrated a tendency to assimilate into the culture of 'accept and not question'. The humanistic need to fit in is a powerful instinct.[172] Psychologists and socio-biologists including, Bowlby, Barash, Buss and Baumeister and Leary, have linked the sense of belonging to our need for survival, or in nursing's case, the student's desire to succeed and, as a consequence, impress their nursing tutors, mentors and colleagues.[173] This meant that students were not inclined to question or raise issues; instead, they followed the precedent set by past nurses.

In a period where nursing was globally evolving, the longevity of the apprenticeship model reveals nursing's instinct to remain motionless and carry on as before despite the developments of the world around it. It was during nursing's period of discontent that nursing globally was evolving far beyond British practices. In the USA, nursing was already entrenched within higher education after the first degree was introduced in 1909 at the

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[172] Lambert, N. M. &., Stillman, T. F. &., Hicks, J. A. &., Kamble, S. &., Baumeister, R. F. &., Fincham, F. D. (2013). To belong is to matter: Sense of belonging enhances meaning in life. *Personality & Social Psychology Bulletin*, 39(11), 1418-1427.
[173] Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York, NY: Basic Books.; Barash, D. P. (1977). *Sociobiology and behaviour*. New York, NY: Elsevier.; Buss, D. M. (1990). The evolution of anxiety and social exclusion. *Journal of Social & Clinical Psychology*, 9, 196-210.; Baumeister, R. F. &., Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117, 497-529.

University of Minnesota.[174] Fitzpatrick et al. found that there had been a reluctance to accept the potential successes of a nursing degree.[175] However, as Carter discovered, higher education was soon acknowledged as the only way forward for nursing, not just in the USA but globally.[176] From their Bachelor of Science foundations, American nursing led the way in developing Masters degrees in nursing and encouraged specialisation.[177] Canadian nursing too had moved on from the apprenticeship system. Major changes occurred in the early 1960s, and by 1963, 16 baccalaureate schools of nursing had been established in Canada, with half being integrated into higher education. By 1972, all 22 baccalaureate schools were operated by universities.[178]

This study has made the case that British nursing did not exist and develop in a vacuum, rather it was shaped by prominent political, economic and social external forces and, albeit rare, influential internal reformers; however, this is not to dismiss the reality that nursing has certainly tried to insulate itself against the waves of change. By the latter decades of the twentieth century, Britain was one of the last developed countries still training nurses under an apprenticeship system.[179] In many ways, the period of discontent before Project 2000 firmly woke nursing to the realisation that it could not continue to retain its traditional

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[174] Roberts, J. &., Barriball, K. L. (1999). Education for Nursing: Preparation for Professional Practice . In I. Norman, & S. Cowley (Eds.), *The Changing Nature of Nursing: In a Managerial Age*. (pp. 123-149). Oxford: Blackwell Science. p.126.

[175] Fitzpatrick, J. &., While, A. &., Roberts, J. (1993). The relationship between nursing and higher education. *Journal of Advanced Nursing*, 18(9), 1488-97.

[176] Carter, G. B. (1956). *A Study of the Course for Nurse Tutors Organised by the Royal College of Nursing (Scottish Branch) Leading to the Certificate Awarded by the University of Edinburgh*. London: Royal College of Nursing.

[177] Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge. p.209.

[178] Willis, L. (1981). Issues in Nursing Education. In L. Hockey (Ed.), *Current Issues in Nursing*. (pp. 51-63). Edinburgh: Churchill Livingstone. pp.51-2.

[179] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.342.

practices without progression. Instead, it would have to evolve with every other element in healthcare, and Project 2000 was that evolution.

A great tragedy for nursing is that nursing's leadership preserved the status quo during the decades of discontent. Their primary interest was focused on maintaining the role and influence of matrons and other senior nursing figures as during this period, the position and authority of senior clinicians was being reduced.[180] The leadership's commitment to stalling reform in favour of maintaining the status quo meant that the inadequacies of the apprentice system had permeated into every element of practice, from providing patient care to nursing management.[181] They had presided over high standards of care – the pride of the profession – being progressively diluted.[182] When commenting on British nursing, American nursing historian Reinkemeyer argued that the professional leadership's 'do-nothing' policy had paralysed the profession.[183] By the mid-1980s, it was found that British nurses on the wards were failing to meet the professional standards set out in the UKCC's 1984 Code of Conduct.[184] Most significantly, many nurses were unable to meet the requirement to maintain up-to-date professional knowledge, chiefly due to nursing knowledge being decades behind the progress made by other health professions.[185] The Powell Report, published far earlier in 1966, exposed the sad state of nursing stagnation.[186]

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[180] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.43.

[181] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.1.

[182] Ibid, p.1.

[183] Reinkemeyer, M. H. (1966). *The Limited Impact of Basic University Education Programs in Nursing: A British Case Study*. [PhD Thesis]. California: Berkeley University. p.121.

[184] Hunt, G. &., Wainwright, P. (1994). *Expanding the Role of the Nurse: The Scope of Professional Practice*. Oxford: Blackwell Science. p.41.

[185] Ibid, p.42.

[186] Powell, M. (1966). *The Post Certificate Training and Education of Nurses*. London: HMSO.

Up to 66% of ward sisters and 76% of staff nurses believed that they could not improve their professional knowledge or competence as the means to do so were not in place.[187]

The 1960s to 1980s – the decades of discontent - also highlighted that it was of primary importance to establish a knowledge base. With each additional duty nurses were expected to take up, they were required to reflect on its educational foundations. However, this highlighted the reality that nursing did not have a distinct knowledge base; rather, nursing had to rely on medicine. With the apprenticeship model being task-orientated, it had deterred any urgent need to establish a knowledge base. Hunt argued that under the apprentice model, nursing had suffered more than most professions. Hunt argued that nursing had been under the 'stranglehold of complacent authoritarianism' originating from those in positions to push reform, namely the government and nursing's hierarchical leadership.[188]

Nurses at the frontline knew the means to improve nurse training. In a study conducted by Humphries in 1987, nurses suggested that nursing needed a more profound knowledge base, students needed to be taught interpersonal skills, and more personal support for probationers was required for them to thrive in training.[189] The suggestions made by many of the students and nurses in these studies were adopted under Project 2000. Unlike nursing's leadership of the early twentieth century, who fought the hard-won battle for

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[187] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.5.

[188] Hunt, G. (1992). Project 2000 - Ethics, ambivalence and ideology. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak: Innovations in the Nursing Curriculum*. (pp. 89-107). Edinburgh: Campion Press. p.90.

[189] Humphries, A. (1987). *The Transition from Student to Staff Nurse*. [Unpublished BSc Thesis]. Leicester: Leicester University.

registration, nursing in the 1960s to mid-1980s had an ineffective and conservative leadership.[190] Nursing was also lacking a central figure to rally behind. Ethel Bedford Fenwick was a key influencer in the campaign for registration and had moulded much of nursing's drive for professional development in the early twentieth century.[191] In many ways, figures like Fenwick kept nursing's leadership accountable for their treatment of nurses. Without their guiding presence, nursing fell back on its traditions and rituals, and Nightingale's vision for nursing, which even by 1919, was accepted by Fenwick to be old-fashioned. In Helen Scott's view, without figures to lead the profession, nursing lacks an identity and resorts to relying on its past.[192] Simply, by the mid-1980s when Project 2000 began to be planned, it had become apparent that the days of passive conservatism on the part of the state, UKCC and RCN were over; radical change to nurse training was needed.

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[190] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.3.
[191] Hallett, C. E. &., Cooke, H. (2012). *Historical Investigations into the Professional Self-Regulation of Nursing and Midwifery: 1860-2002*. London: Nursing and Midwifery Council. p.40.
[192] Scott, H. (2000). Prescribing must not be at the expense of nursing. *British Journal of Nursing*, 9(6), 320.

Chapter 3:
Crossing the Rubicon: the development of the Project 2000 proposals

Asking the profession

Project 2000 was a unique achievement in nursing's history.[193] After decades of indecision and infighting, the planning of Project 2000 marked a rare occasion where the profession's leadership united to drive reform. One of the great strengths of Project 2000 was that it was argued mainly along educational grounds with the English National Board (ENB) set to play a key role in the provision and administration of the course.[194] Another great strength of the proposals was that the planners listened to the profession. The UKCC went to great lengths to make Project 2000 inclusive and the canvasing of nurses allowed the UKCC to convincingly present Project 2000 as being created and led by nurses.

It was the UKCC, as nursing's regulatory body, that led the Project 2000 charge and was chiefly relied upon to make a case for the reforms and speaking on behalf of the profession's leadership. The UKCC was responsible for championing the reforms to primarily the nursing profession itself, including many nurses working at practice level who were otherwise none the wiser to the debates around amending nurse training. This chapter will further explore how nurses were consulted. The UKCC was also making the case to the British Government, who held the ultimate authority whether to pass and approve the

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[193] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.9.
[194] English National Board for Nursing, Midwifery and Health Visiting. (1985). *Annual report 1984-1985*. HE 3/2. The National Archives, London, UK.; English National Board for Nursing, Midwifery and Health Visiting. (1986). *Annual report 1985-1986*. HE 3/3. The National Archives, London, UK.

plans. While it was a UKCC intention to appeal to various other healthcare professions to gain support for the reforms, the UKCC appear to have stuck to the narrative that this was nursing directing its future, not, for instance, being directed by the work of another discipline such as medicine. Indeed, plenty of doctors, including Brian Gibberd, a Consultant Physician at Westminster Hospital, had their thoughts on Project 2000, but to assert that they significantly affected the Project 2000 proposals is an overstatement.[195] Many healthcare professionals went as far as applying pressure on the government to resist the Project 2000 reforms.[196] Instead, in the face of criticism from many healthcare disciplines, the UKCC appears to have stood firm on its vision that this was in the best interest of the nursing profession. For the UKCC, the cost of innovation would be balanced by the increased productivity of Project 2000 nurses through their advanced skills and greater opportunities to participate and contribute to patient care.[197] What is interesting and became starkly apparent during theo research of this thesis was that the UKCC made little effort to draw the interest of the wider British public. This is most likely due to the assumption that most Britons would have little knowledge of how nurses were trained, a complete understanding of the nurse's role, or the intricacies of modern healthcare demands.

The UKCC embarked on a series of consultations across the United Kingdom from the summer of 1984 to late 1986 seeking the views of nurses as well as many NHS chairmen and

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[195] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.41.; Gibberd argued that nursing's leaders needed to stop trying to make nursing compete with theory and academic professions and acknowledge that nursing is centred strictly on patient care.
[196] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.13.
[197] Ibid, p.22.

managers.[198] In the summer months of 1986 alone, the UKCC reported that between 30,000

to 50,000 members of the nursing profession attended meetings held by the UKCC.[199]

Throughout the consultation period, 1900 individual nurses responded to the Project 2000

plans, 600 nursing groups also took part and submitted 8000 opinions.[200] Project 2000

sparked invigoration among ordinary nurses. Davies argued that nurses wanted 'root and

branch reform of the nature and conditions' of nursing, and Project 2000 demonstrates that

the only way to achieve such reform was to give a degree of power to the nurses.[201]

Irrespective of whether nurses eventually supported the proposal, the planning stages

highlight the inclusion of lower ranking nurses. Many nurses who were not involved in the

profession's leadership or day-to-day professional politics were given the platform to join

the charge for reform and because of the lengths the UKCC went to, it is little surprise that

by the publication of Project 2000 in 1986, the *Nursing Times* had conducted a poll that

revealed only 22% of nurses surveyed were unaware of Project 2000.[202]

The UKCC also welcomed comments from other healthcare professions, such as medicine.

The medical profession's involvement should not be overstated as it was minimal.

Presumably, doctors were consulted in attempts to deter staunch opposition from them, as

in medicine, Project 2000 was not wholly supported.[203]

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[198] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.12.

[199] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project Paper 7, The Project and the Professions: Results of the UKCC Consultation on Project 2000*. London: UKCC.

[200] Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 3-16). London: Scutari Press. p.8.

[201] Davies, C. (1995). *Gender and Professional Predicament in Nursing*. Buckingham: Open University Press. p.3.

[202] Dickson, N. (1986). Winding up the roadshow. *Nursing Times*, 82(43), 47-8. pp.47-8.

[203] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.41.; Anonymous. (1987). Final proposals on "Project 2000". *British Medical Journal, 294*(6569), 458. doi: 10.1136/bmj.294.6569.458. p.458.;

Project 2000 represented the UKCC's view that the improvement of the education and training of nurses was key to professional development.[204] Therefore, the UKCC's Educational Policy Advisory Committee took a central role in devising Project 2000's education policy. The Committee represented a range of specialisms within nursing, representatives from all four home nations and educationalists.[205] It was primarily the educationalists who directed the Committee's recommendations. Many of the previous reports on nursing and the NHS had fixated on service needs and trying to mould the profession around them. However, Project 2000 would be written in tune with educational theory.[206] The Project Group of the Committee agreed with the ENB that the new curriculum should produce a registered practitioner who was competent at providing care in institutional and non-institutional settings. The ENB, like the Advisory Committee, realised that nursing was being envisaged to become more technical and sophisticated, and that nurses would play a much more significant role in healthcare in the future.[207] Budget cuts elsewhere in the NHS were forcing nurses to push the boundaries of practice, and by the 1980s, the UKCC acknowledged the need for a course to promote advanced level practice.[208] The Project 2000 proposal, therefore, demonstrated their belief that the move to higher education would foster the development of specialist nurse practitioner roles that would

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[204] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A New Preparation for Practice*. London: UKCC. p.1.

[205] Le Var, R. M. H. (1997). Project 2000: a new preparation for practice – has policy been realised? Part I. *Nurse Education Today*, 17(3), 171-177. p.175.

[206] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.342.

[207] English National Board. (1985). *Professional Education/Training Courses: Consultation Paper*. London: ENB.

[208] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.16.

enable distinct clinical careers different from traditional general nursing job opportunities.[209]

For the higher education diploma, the ENB proposed that the first year of the three-year course would follow a Common Foundation Programme (CFP) theory-based curriculum. Student nurses would then move onto their chosen Branch Programme during their second and third years.[210] The CFP would unite the students of the four areas of practice: adult, child, mental health and mental handicap nursing. The CFP would focus on students as individuals and stretch their thinking towards social and behavioural sciences.[211] Students would be introduced to the new health focus of preventative treatment instead of being taught primarily how to treat illness.[212] Students would also be exposed to a wider variety of clinical settings. Under the traditional method, students trained solely on the hospital wards, and as a result, nurses were unprepared for careers in the community.[213] Placements would remain a key component of the course alongside the theoretical elements of training.[214] Students would undertake placements in the community as well as hospitals, reflecting the government's primary care drive where community services would lead the NHS's response to growing health needs.[215] In this sense, Project 2000 was a hybrid

[209] Orr, J. (1990). Project 2000 and the specialist practitioner. *Nursing Standard*, 17(4), 35-37. p.35.; Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge. p.223.

[210] Ousey, K. (2011). The changing face of student nurse education and training programmes. *Clinical Practice Development*, 7(1), 70-76. p.72.

[211] Eaton, N. &., Williams, R. &., Green, B. (2000). Degree and diploma student nurse satisfaction levels. *Nursing Standard,* 14(39), 34-39. p.34.

[212] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.17.

[213] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.342.

[214] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1987). *Project 2000: The Final Proposals, Project Paper 9*. London: UKCC.; Farrand, P. &., McMullan, M. &., Jowett, R. &., Humphreys, A. (2006). Implementing competency recommendations into pre-registration nursing curricula: Effects upon levels of confidence in clinical skills. *Nurse Education Today*, 26(2), 97-103. p.97.

[215] Levitt, R. &., Wall, A. &., Appleby, J. (1999). *The Reorganised National Health Service*. Cheltenham: Stanley Thornes. p.103.; Brown, H. &., Edelmann, R. (2000). Project 2000: a study of expected and experienced

between the apprenticeship model and the new education-centred approach. The UKCC made it clear that it agreed with the calls for students to have hands-on experience, and that it was critical to the training of probationers as it was in clinical practice where students would learn practical skills.[216] Lathleen and Heslop pointed out that there were a multitude of methods for students to learn on the wards. These examples include probationers observing handover, a time where varying ideas would be shared on how best to care for patients, information would be shared on diagnoses, different medications and treatment options, and it provides an opportunity for nurses to problem solve on issues they are not clear on.[217] Similarly, Lathlean argued that medication rounds allowed students to ask about different medications, their doses, their side effects and their function in treating varying illnesses.[218] Simply, the incorporation of placements in Project 2000 reflects that fact that nursing is, after all, a practice-based profession. The UKCC were, therefore, determined for Project 2000 to maintain nursing's links to clinical practice while students would be educated primarily in higher education.

The Advisory Committee was clear: the move to higher education should mark nurses beginning to be educated to a high academic level.[219] Project 2000 would make the nursing qualification equal to all other higher education qualifications, including medicine and

stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing, 31*(4), 857-864. p.856.

[216] Andrews, G. J. &., Brodie, D. A. &., Andrews, J. P. &., Hillan, E. &., Thomas, B. G. &., Wong, J. &., Rixon, L. (2006). Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies*, 43(7), 861-874. p.866.; Lathlean, J. (1991). Teaching and Learning. In J. Lathlean, & J. Corner (Eds.), *Becoming a Staff Nurse: A Guide to the Role of the Newly Registered Nurse*. (pp. xi-xii). London: Prentice Hall. p.103.

[217] Heslop, A. &., Lathlean, J. (1991). Teaching and Learning. In J. Lathlean, & J. Corner (Eds.), *Becoming a Staff Nurse: A Guide to the Role of the Newly Registered Nurse* (pp. 98-128). London: Prentice Hall. p.116.

[218] Ibid, p.116.

[219] Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge. pp.223-4.

pharmacology.[220] This was monumental for nursing to be regarded as skilled. McKee and

Lessof discovered that doctors were presumed to be skilled and knowledgeable due to their

graduate-level training, yet nurses were assumed not to have the same level of skill or

knowledge.[221] Project 2000 also looked beyond qualifications. Project 2000 sought to create

a mentality where nurses would have the confidence to deal with all uncertainties, the

competence and critical thinking ability to work autonomously within a multidisciplinary

team, and awareness that nursing is continuously evolving. Thus, training did not stop upon

qualification. Project 2000 acknowledged that a nurse is never a finished product; therefore,

the course would reinforce the idea that continuous learning and training were central to

any nursing career. Michael Eraut argued that this was the key to maintaining long-term

competency within the profession and would enhance the status of nurse training.[222] As

Leigh et al. argue, the chief responsibility of all professions is to recruit competent

practitioners, and through Project 2000, nursing was preparing itself to meet this

requirement.[223]

The UKCC's final argument for Project 2000 rested on the issue that student nurses had

been used as labour to meet workload requirements for over a century.[224] Service

commitments often trumped educational needs under the apprenticeship system meaning

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[220] Delamothe, T. (1988). Nurses make the grade. *British Medical Journal, 296*, 1344. p.1344.

[221] McKee, M. &., Lessof, L. (1992). Nurse and Doctor: whose task is it anyway?. In J. Robinson, A. Gray, & R. Elkan (Eds.) *Policy Issues in Nursing*. Buckingham: Open University Press.

[222] Eraut M. (1994). *Developing Professional Knowledge and Competence*. London: Falmer Press.; Eraut, M. &., Alderton, J. &., Boylan, A. &., Wraight, A. (1995). *Learning to use Scientific Knowledge in Education and Practice Settings: an Evaluation of the Contribution of the Biological, Behavioural and Social Sciences to Pre-registration Nursing and Midwifery Programmes.* London: ENB.; Bradshaw, A. (1998). Defining 'competency' in nursing (part II): an analytical review. *Journal of Clinical Nursing*, 7(2), 103-111. p.106.

[223] Leigh, J. &., Douglas, C. &., Lee, K. &., Douglas, M. (2005). A case study of a preceptorship programme in an acute NHS Trust – using the European Foundation for Quality Management tool to support clinical practice development. *Journal of Nursing Management*, 13(6), 508-518.

[224] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.12.

students were stretched far beyond their already limited capabilities.[225] Sociologists and

educationalists argued that probationers should be afforded room to develop as

students.[226] Under Project 2000, students would be free of clinical responsibility and spend

their time on the wards and in the community observing trained nurses in every area of

practice. The UKCC proposed that students be supernumerary for 80% of their training, and

in lieu of students no longer being paid as students, they would receive a bursary from the

Treasury.[227] Therefore, student nurses would be based in higher education but would be

rostered to be supernumerary for a predetermined period.[228]

There were subtle differences between probationers being students as opposed to staff.

Dolan argues that the benefit of supernumerary status would be to the student, whereas

previously, students being treated as apprentices benefitted the service providers.[229] The

introduction of supernumerary status would also shift the purpose of training. The purpose

of the Project 2000 course was to educate the student. Yet, under the apprenticeship

system, the purpose of the training was simply 'getting the job done' as the syllabus was

task-orientated rather than theoretically-based.[230] The introduction of supernumerary

status under Project 2000 was fundamental in making the nursing curriculum student-

centred. Nurse training was now about raising questions, not expecting students to have

definitive answers. Most importantly, supernumerary status meant that training was now

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[225] Ibid, p.12.
[226] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.42.
[227] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. p.343.
[228] Ibid, p.446.
[229] Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration* (pp. 3-16): London: Scutari Press. p.4.
[230] Ibid, p.4.

focused on learning and the process of personal growth as Project 2000 would facilitate opportunities for students to think for themselves, not simply the completion of tasks.[231]

The economics of Project 2000

From the perspective of the British Government during the planning of Project 2000 in the mid to late-1980s, their focus was largely fixed on the costs of proposals. As discussed in Chapter 1, Project 2000 was proposed during a period of managerial and economic restructuring that placed significance on the balance sheets.[232] The Centre for Health Economics at York University's study is one of the key sources on Project 2000 economics.[233] Carried out over a two-month period on behalf of the RCN Commission on Education in 1986, Goodwin and Bosanquet presented the estimates of Project 2000's implementation. To arrive at the estimates, Goodwin and Bosanquet visited existing degree and diploma courses at Leeds Polytechnic, Manchester University, Chelsea College, Edinburgh University and Hull University, and based their costs on the 1982/3 academic year.[234] Goodwin and Bosanquet revealed that based on the 1982/3 student intake levels, the apprenticeship system cost an estimated £122.5 million per year, with each student costing an estimated £8,750 to train over three years.[235] However, Project 2000 was projected to cost around £154.5 per year, with each student costing £17,350 over their course.[236] Goodwin and Bosanquet also estimated that due to the greater focus on education, increased costs would be drawn from teaching salaries in higher education, teaching facilities, and teaching

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[231] Ibid, p.57.
[232] Salvage, J. (1995). What's happening to nursing. *British Medical Journal, 311*(7000), 274-5. p.274.
[233] Goodwin, L. &., Bosanquet, N. (1986). *Nurses and Higher Education: The Costs of Change* (Discussion Paper). Centre for Health Economics, University of York.
[234] Ibid, pp.8-9.
[235] Ibid, pp.1-2.
[236] Ibid, pp.1-2.

equipment. Significantly, the DHSS found that higher education tutors earned approximately 40%-50% more than nurse tutors, a divide that would need to be reduced.[237] Additionally, supernumerary status meant that students were no longer employees; this meant that the government would be forced to firstly replace students with staff, with an extra 21,000 ward staff expected to be needed. Secondly, the Project 2000 proposal included a bursary for students, which the government was expected to pay.[238]

There are issues with the credibility of Goodwin and Bosanquet's study. The report was written in 1986, therefore, there were no available sources for a nationwide universal nursing degree course. Moreover, other sources addressed included the Centre for Health Economics Discussion Paper on the Exchequer Costs of Registered and Enrolled Nurses Training.[239] This report was only circumstantially applicable to the transition to higher education as the data was drawn from the apprenticeship system costs. As a result, many of the statistics in the study are rounded figures to avoid the impression of complete accuracy. Nevertheless, the report provides a window into the costs the government was willing to accept under the Project 2000 reforms and is, therefore, a testament to the proposal's success as the government was trying to reduce NHS funding as much as possible.[240] It also reflected the prime position of nursing within the NHS. Project 2000 would have been a major investment by the government in nursing, but the government realised it was necessary. If the state was to meet its goal for primary care to lead the NHS's response to

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[237] Department of Health and Social Security. (1983). *Background Information for the Review Body for Nursing and Midwifery Staff and Professions allied to Medicine*. London: DHSS.
[238] Rivett, G. (1997). *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund. pp.445-6.
[239] Hartley, K. &., Goodwin, L. (1985). *The Exchequer Costs of Registered Nurse Training in England* (Discussion Paper). Centre for Health Economics, University of York.
[240] Crinson, I. (2009). *Health Policy: A Critical Perspective*. London: SAGE. p.31.

modern healthcare, the government needed to sanction training for advanced and specialist roles.[241] In the long-term, therefore, the state could boast a well-educated, highly-skilled, largely autonomous and competent nursing profession that could fulfil traditional nursing roles, and also roles previously undertaken by the medical profession, which too faced staff shortages.

The nurse of the future

Foresight was at the heart of Project 2000. The planners looked to the future needs of the nursing profession, healthcare and society to shape its proposals. At the heart of the plans was the key contentious question: what kind of nurse does the future need?[242] Under future NHS plans nurses would be required to play a more prominent role. Nurses were coming to be widely expected to have assessing, appraising, decision-making, and critical appraisal skills.[243] Nurses were also coming to be expected to play a more proactive role in maintaining and promoting good health in primary and secondary care.[244]

To do so, Project 2000 would build on the skills of nurses. Lathlean and Corner wrote a nursing textbook published in 1991 and stated that upon registration, nurses were expected to be: competent, clinically knowledgeable, able to manage the planning and implementation of care for patients, capable of taking charge of a ward, confident in practicing in a multidisciplinary environment and act as role models and mentors and

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[241] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.11.

[242] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.99.

[243] McSherry, R. &., Simmons, M. &., Pearce, P. (1998). An introduction of evidence-informed nursing. In R. McSherry, M. Simmons, & P. Abbott (Eds.), *Evidence-Informed Nursing: A Guide for Clinical Nurses* (pp. 1-13). London: Routledge. p.1.; Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.1.

[244] Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 3-16). London: Scutari Press. p.129.

teachers to students and colleagues.[245] Bradshaw argues that Project 2000 planned to

create competent practitioners by firstly educating student nurses and then exposing

students to clinical practice.[246] Nursing knowledge was a tool, and Project 2000 intended for

clinical placements to act as a platform for nurses to develop self-confidence and self-belief

through experience.[247] In return, Project 2000 nurses would be capable of being

autonomous practitioners and proficient in dealing with the uncertainties of nursing.[248]

Nurses would also be adept at self-monitoring their competency, thereby recognising their

weaknesses and where extra training and education was needed, a sense of self-awareness

not commonly promoted by the apprenticeship model.[249]

In the transition to higher education, students would be facilitated to learn more than

repetitive routines with the Project 2000 curriculum allowing students to think for

themselves and become capable of widening their intellectual horizons. Before Project

2000, it was said by many of the nurses interviewed for this study that probationers were

trained, not educated.[250] Nursing theory had not been regarded highly in the profession

with Miller contending that theory had come to be seen as an 'interrelated set of ideas' that

discussed nursing in an idealised manner.[251] Miller observed junior nurses early encounters

with theory in her 1985 study; many nurses commented that theory was 'waffle' and

[245] Lathlean, J. (1991). The Role of the Staff Nurse. In J. Lathlean, & J. Corner (Eds.), *Becoming a Staff Nurse: A Guide to the Role of the Newly Registered Nurse*. (pp. xi-xii). London: Prentice Hall. p.1.
[246] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. pp.48-9.
[247] Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 3-16). London: Scutari Press. p.1.
[248] McSherry, R. &., Simmons, M. &., Pearce, P. (1998). An introduction of evidence-informed nursing. In R. McSherry, M. Simmons, & P. Abbott (Eds.), *Evidence-Informed Nursing: A Guide for Clinical Nurses* (pp. 1-13). London: Routledge. p.1.
[249] Bem, D. J. (1972). Self-perception theory. *Advances in Experimental Social Psychology*, 6, 1-62.
[250] Anne. (2021, 26 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 6).
[251] Miller, A. (1985). The relationship between nursing theory and nursing practice. *Journal of Advanced Nursing*, 10(5), 417-424. p.419.

difficult to understand.[252] Wells and Hamilton-Smith suggested that many of the unsatisfactory practices upheld by the apprentice model pushed theory further away from practice.[253] Schröck came to similar conclusions in the early 1980s and insisted that the foundations of the apprentice course formed a gulf between theory and practice. As a result, many nurses developed unexamined and unproven assumptions about nursing practice and theory and integrated those into their daily practices and personal attitudes.[254] Project 2000 sought to change the relationship between theory and practice, and the first step was to make theory equal to practice.

Jean Watson observed that to educate nurses, nursing must follow medicine in promoting philosophical thinking in the moral context of providing care to people.[255] Ironically, providing care was the cornerstone of nursing, yet the nursing curriculum in the decades prior to Project 2000 had lacked a sense of human caring.[256] As noted, nursing had come to revolve around routine, rituals and tradition that were task-orientated with the patient often of secondary importance. Therefore, Allen argued Project 2000 was more humanistic. By being student-centred and appreciating the students as individuals and thinkers, patient care would be patient-centred, and each patient would be treated based on their individual

[252] Ibid, p.417.
[253] Wells, T. (1980). *Problems in Geriatric Nursing Care*. Edinburgh: Churchill Livingstone.; Hamilton-Smith, S. (1972). *Nil by mouth*. London: Royal College of Nursing.; Wright, L. (1974). *Bowel Function in Hospital Patients*. London: Royal College of Nursing.; Lelean, S. (1973). *Ready for Report Nurse*. London: Royal College of Nursing.
[254] Schrock, R. A. (1981). Philosophical Issues. In L. Hockey (Ed.), *Current Issues in Nursing*. (pp. 3-17). Edinburgh: Churchill Livingstone.
[255] Watson, J. (1988). A case study: curriculum in transition. In. National League for Nursing (Ed.), *Curriculum Revolution: Mandate for Change*. (pp. 1-11). New York: National League for Nursing. p.4.
[256] Kirby, C. &., Slevin, O. (1992). A new curriculum for care. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak: Innovations in the Nursing Curriculum*. (pp. 57-88). Edinburgh: Campion Press. p.57.

needs.[257] It was in ideas like this that the crux of the educationalist argument lay. Oakeshott

argued that education was more than 'acquiring a stock of ready-made ideas', instead,

education was 'learning to look, to listen, to think, to feel, to imagine, to believe, to

understand, to choose and to wish.'[258]

Social scientist June Clarke saw nursing as an intellectual activity where modern nursing

required practitioners who could make clinical judgements based on knowledge, reason and

logic.[259] As such, a nurse's ability to safely and competently perform assessing, planning,

evaluating and implementing skills would rest on the strength of their knowledge and

clinical judgement.[260] Clarke's assertions reflect the calls to educate nurses similar to

doctors as many of the growing demands placed on nursing were similar to those on

doctors. McManus et al.'s later study into the subject researched the teaching and learning

style of medical students.[261] They found that clinical problem solving was an essential

element of doctor training.[262] The intellectual basis for making clinical judgements was,

therefore, honed through theoretical learning. Many drew parallels and argued that nurses,

like doctors, needed to be taught the same sophisticated cognitive skills.[263] As Watson

argued, every patient, like every student, is an individual. Every patient presents a unique

case. Every patient has different needs and wishes. Therefore, they must be managed

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[257] Allen, C. (1993). Empowerment, taking chances, making changes. In B. Dolan (Ed.), *Project 2000: Reflection and Celebration* (pp. 57-74). London: Scutari Press. p.57.; Allen, C. (1990). P2000 problems. *Nursing Standard*, 5(6), 43-44. pp.43-4.

[258] Oakeshott, M. (1989). *The Voice of Liberal Learning*. London: Yale University Press. p.29.; p.32.

[259] Clarke, J. (1991). Nursing: an intellectual activity. *British Medical Journal, 303*, 376-7. p.376.

[260] Ibid, p.376.

[261] McManus, I. C. &., Richards, P. &., Winder, B. C. &., Sproston, K. A. (1998). Clinical experience, performance in final examinations, and learning style in medical students: prospective study. *British Medical Journal, 316*(7128), 345-350.

[262] Ibid, pp.348-9.

[263] Clarke, J. (1991). Nursing: an intellectual activity. *British Medical Journal, 303*, 376-7. p.377.

individually, making the nurse's work complex with infinite possibilities for assessing, planning, evaluating, and implementing.[264]

The 'Manchester Scheme' and early experimental degree courses

The planners, primarily educationalists, were able to draw on precedent for basing nurse preparation on educational grounds from pre-existing experimental programmes that arose decades earlier in the mid-twentieth century. The University of Manchester established the first British diploma course in community nursing, commonly known as the 'Manchester Scheme', in 1959.[265] The pre-registration diploma at Manchester was followed by courses at the Universities of Hull, Cardiff and Ulster.[266] These followed wider attempts to implement post-certificate diploma courses in nursing at Leeds University in 1921 and London University in 1926.[267] Lewis and Owen also found that other pioneering nursing diploma courses were being developed at the Universities of Edinburgh, Southampton and Surrey.[268] The University of Edinburgh first welcomed nursing students as undergraduates in the 1960s.[269]

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[264] Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing, 32*(2), 473-480. p.474.

[265] Hallett, C. (2005). The 'Manchester scheme': a study of the Diploma in Community Nursing, the first pre-registration nursing programme in a British university. *Nursing Inquiry*, 12(4), 287-294. p.287.

[266] Clarke, M. (1981). Innovation in nursing education: The Hull experience. *Nurse Education Today*, 1(6), 11-15.; Kemp, J. (1988). A longitudinal study of nursing graduates. *Nursing Times*, 84, 53.; Kemp, J. (1988). Graduates in nursing: A report of a longitudinal study at the University of Hull. *Journal of Advanced Nursing*, 13(2), 359-70.; Bircumshaw, D. &., Chapman, C.M. (1988). A follow-up of the graduates of the Cardiff Bachelor of Nursing Degree Course. *Journal of Advanced Nursing*, 13(2), 273-9.; Reid, N. G. &., Nellis, P. &., Boore, J. (1987). Graduate nurses in Northern Ireland: Their career paths, aspirations and problems. *International Journal of Nursing Studies*, 24(3), 215-25.

[267] Brooks, J. (2005). *'Visiting rights only': The early experience of nurses in higher education, 1918-1960.* [Unpublished PhD thesis]. London: London School of Hygiene and Tropical Medicine, University of London.

[268] Lewis, S. (1967, January 11). Nursing be Degree. *The Guardian.;* Owen, G. (1988). For better, for worse: Nursing in higher education. *Journal of Advanced Nursing*, 13(1), 3-13.

[269] Brooks, J. &., Rafferty, A-M. (2009). Degrees of ambivalence: Attitudes towards pre-registration university education for nurses in Britain, 1930-1960. *Nurse Education Today*, 30(6), 579-583. p.579.

Nevertheless, the Manchester Scheme was the first to link nurse training with higher education and recognise nursing as an academic subject in its own right. The Manchester Scheme was developed by Colin Fraser Brockington, a former Professor of Social and Preventative Medicine at Manchester, from 1952 to 1965. Christine Hallett has deemed Brockington's contribution to public health and the advancement of nursing as an academic subject as 'remarkable' as Brockington highlighted the 'enormous, largely untapped potential of nurses.'[270] With the hindsight of Project 2000, it is clear that Brockington's work formed the blueprint that nursing would follow to transform nurse training in Britain. It could be argued that Brockington's programme of nurse-education overcame the cultural barriers that had traditionally existed between nursing and higher education.[271] Among the higher ranks of the nursing profession were anti-intellectuals who feared that academically-educated nurses would not be hands-on practical nurses. Indeed, MacNaughton had urged the profession years before 'not to lose our practical skill for the sake of theory.'[272] Equally, within higher education, some held prejudices towards a practical education and were generally unwelcoming to nurses in universities.[273] Reinkemeyer, Marsh and Owen explained that there were universities who were reluctant to open their doors to nursing students as they saw nursing as an inferior subject in quality and status.[274] The Manchester

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[270] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.89.

[271] Miers, M. (2002). Nurse education in higher education: understanding cultural barriers to progress. *Nurse Education Today*, 22(3), 212-219. p.212.

[272] MacNaughton, N. (1947). A University Degree in Nursing – Section 5 of a Royal College of Nursing Conference on 'The Nation's Nurses'. *The Nursing Times*, 12 April, pp. 245–246. pp.245-6.

[273] Brooks, J. &., Rafferty, A-M. (2009). Degrees of ambivalence: Attitudes towards pre-registration university education for nurses in Britain, 1930-1960. *Nurse Education Today*, 30(6), 579-583. p.580.

[274] Reinkemeyer, M. H. (1966). *The limited impact of basic university programs in nursing: A British case study*. [PhD thesis]. Berkeley: University of California.; Marsh, N. (1977). Summary report of the school educational attainment, General Nursing Council test scores and performance in university examinations of Manchester

Scheme, followed by the establishment of other courses in British universities, helped dismantle the obstacles between nursing and higher education that resulted in the passing of Project 2000, where the nursing profession finally accepted that higher education had key contributions to make to nurse training.[275]

The Manchester Scheme was a four-year course which based students at the university. During the first year, students split their time between the theoretical components of the course and placements.[276] In second year students spend increasing time on the wards, with more clinical elements being integrated into the syllabus. In the final two years, students' time was split evenly between the clinical environment and the university.[277] The curriculum incorporated biological and social sciences alongside probationers being taught the fundamentals of nursing care and being introduced to nursing research.[278] Key objectives were set for the diploma course. Firstly, the Manchester Scheme was tasked with providing a university education for nurses, a simple but transformative objective.[279] The course would change the focus of practice from disease-orientated to preventative and curative, aspects of care already adopted by the medical profession. Manchester nurses were also taught how to advocate the principle of self-care for their patients.

university's undergraduate nursing students. *Journal of Advanced Nursing*, 2(2), 209-12.; Owen, G. (1988). For better, for worse: Nursing in higher education. *Journal of Advanced Nursing*, 13(1), 3-13.

[275] Owen, G. (1988). For better, for worse: nursing in higher education. *Journal of Advanced Nursing*, 13(1), 3-13. p.3.

[276] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.92.

[277] Ibid, p.92.

[278] Hallett, C. (2005). The 'Manchester scheme': a study of the Diploma in Community Nursing, the first pre-registration nursing programme in a British university. *Nursing Inquiry*, 12(4), 287-294. p.290.

[279] Ibid, p.290.

The Manchester Scheme was intended to provide a broader education than conventionally given on the apprenticeship course. The theoretical topics included human development and function, the process of disease, social institutions, their development and operation and the individual in relation to the environment.[280] The course was adapted after 1966 to include a dissertation where nurses could engage independently with nursing research and apply their learning in an examination context, another thing that had been proven to work in the medical degree.[281] Those teaching the course were labelled 'trailblazers', and the adoption of the scheme by Manchester University was intended to contribute to their reputation as innovators.[282] The course showed that the university-educated nurses were more mature in their attitude towards patients and their problems than apprentice-trained nurses.[283] Equally, the qualifying Manchester nurses were regarded by commentators as academically intelligent and committed to their practical duties as nurses.[284] This challenged the notion perpetuated by nursing's leadership that nursing would lose its high standards of patient care if nurse training were transferred to higher education.

As the course evolved during its five-year experimental phase, it was revisited to achieve its objectives better. Under the amendments, Marsh and Morton found that probationers would now be placed on the same wards as fourth-year students during the first year so

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[280] Hallett, C. (2005). The 'Manchester scheme': a study of the Diploma in Community Nursing, the first pre-registration nursing programme in a British university. *Nursing Inquiry*, 12(4), 287-294. p.291.
[281] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.92.; McManus, I. C. &., Richards, P. &., Winder, B. C. &., Sproston, K. A. (1998). Clinical experience, performance in final examinations, and learning style in medical students: prospective study. *British Medical Journal, 316*(7128), 345-350. p.349.
[282] Ibid, p.287.
[283] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.92.
[284] Ibid, p.92.

they could guide and support them through their first placements.[285] Here, the Manchester

Scheme's humanistic elements are highlighted. A first placement is a student's first exposure

to nursing. For many, it would be their first time looking after someone, their first time in a

caring role, and possibly their first time being involved in direct patient care.[286] Therefore, to

place first-year students with those approaching qualification provides them with someone

to ask the questions they would not ask their nurse mentors, and someone to convey time-

relevant advice.

This was the template that Project 2000 students would follow.[287] Like the planners of

Project 2000, Brockington addressed the need to tap into the previously unleashed potential

of nurses, and its success was undoubtedly considerable in the forming of Project 2000.

Prior to Brockington's Manchester Scheme, GNC were anxious about any amendment to

nurse training that would reduce the time students spent on the wards as they were

effectively staff, and the GNC did not want to exacerbate the already damaging staff

shortages.[288] Brockington also faced opposition from prominent nursing figures, including

the chair Lady Stopford of the Education Committee of Manchester Royal Infirmary.

Stopford vetoed the possibility of Manchester University using any Infirmary beds

exclusively for teaching purposes under the Manchester Scheme.[289] Brockington's prototype

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285 Marsh, N. &., Morton, P. (1970). Towards a university degree in nursing. 1. The course programme: Organisation and assessment. *Nursing Times*, 1-3.; Marsh, N. &., Morton, P. (1970). Towards a university degree in nursing. 2. Opinions on the course and follow-up of students. *Nursing Times*, 5-6.; Marsh, N. (1978). Development of the undergraduate nursing course in the University of Manchester. *Journal of Advanced Nursing*, 3, 297-313.
286 Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.55.
287 Ibid, p.292.
288 Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.91.
289 Brockington, F. (1989). *A life in social medicine. In and out of harness. In local government* (27–51) *and at the University* (51–64). Unpublished memoirs. p.219.

course was achieved in the face of the adversity fronted by nursing's leadership. It was

Brockington's extraordinary tenacity and ability to navigate the labyrinth of vested interests

held by the profession's leadership that led to the implementation of the Manchester

Scheme.[290]

However, from 1957, Brockington reported a weakening in opposition, and his course

represents the beginning of the profession's leadership changing its opinion.[291]

Brockington's aims for the establishment of a nursing university course appealed to the

motives of the GNC. By the mid-1960s, it became apparent that the Manchester Scheme

had met Brockington's plans to permit nurses to use their intelligence and enhance the

status of the university-educated nurses and, thus, the profession.[292] Upon entering nursing,

Brockington felt nurses were compelled to sacrifice their intellect and creativity to

assimilate.[293] They were cautious of fitting in while also promoting their university

education.[294] It is evident that it was felt the Manchester nurses were trained and educated

to a high standard by the hostility they faced from apprenticeship-trained nurses. Luker

points out that the Manchester nurses felt the burden of being different.[295] In many ways,

they experienced great stress in the face of hostility and resentment. They were seen as a

potential threat from nurse managers. A number of studies by nurse-academics indicated

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[290] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.93.
[291] Ibid, p.221.
[292] Hallett, C. (2005). The 'Manchester scheme': a study of the Diploma in Community Nursing, the first pre-registration nursing programme in a British university. *Nursing Inquiry*, 12(4), 287-294. p.289.
[293] Brockington, F. (1964). *A university course in nursing. A report on the first four years of the University of Manchester experimental course in nurse education*. Manchester: North Manchester Hospital Management Committee. p.4.
[294] Thomas, M. C. (1979). Achievement and conflict in undergraduate nurses. *Nursing Times*, 75(35), 93-5.
[295] Luker, K. A. (1984). Reading nursing: The burden of being different. *International Journal of Nursing Studies*, 21(1), 1-17.

Manchester nurses were expected to enter management positions as well as research and education due to their academic-based education.[296] Altschul, Andrew, Sinclair, Marsh and Scott-Wright among many others discovered that Manchester nurses were also expected to have long careers in clinical practice where many felt they threatened the future of nursing by guiding the profession away from the apprenticeship model, which claimed immense loyalty from many nurses.[297]

The Project 2000 planners faced many of the same problems as Brockington, despite the Manchester Scheme overcoming the obstacles. The scheme's success paved the way for the University of Edinburgh to introduce the first Bachelor of Science degree in nursing in 1964.[298] The Manchester Scheme sparked a period of innovation for academics in nursing departments throughout the United Kingdom. These academics saw themselves as the avant guard for developing nursing into an academic discipline. By 1973, Manchester University's Nursing Department had separated itself from the Medical Faculty, allowing nursing independence at the University.[299] The following year, the University established a

[296] MacGuire, J. &., Sparks, J. (1970). The nurse/graduate in the United Kingdom: Patterns of qualification. *International Nursing Review*, 17(4), 350-72.; MacGuire, J. (1971). The nurse/graduate in the United Kingdom: Career paths. *International Nursing Review*, 18, 367-80.; Auld, M. (1987). The need for nurse graduates in Scotland: A view from the Scottish Home and Health Department. *Nurse Education Today*, 7, 30-3.; Sinclair, H. (1987). Graduate nurses in the UK: Myth and reality. *Nurse Education Today*, 7(1), 56-9.

[297] Scott-Wright, M. &., Gilmore, M. &., Tierney, A. (1979). The nurse/graduate in nursing: Preliminary findings of a follow-up study of former students of the University of Edinburgh degree nursing programme. International *Journal of Nursing Studies*, 16(2), 205-14.; Altschul, A. T. (1983). Nursing and higher education. *International Journal of Nursing Studies*, 20, 123-30.; Andrew, S. H. (1984). Focus on developments in British nursing. *Journal of Advanced Nursing*, 9, 89-101.; Sinclair, H. (1984). The careers of nurse graduates. *Nursing Times*, 80(9), 205-14.; Marsh, N. (1976). Summary report of a study on the career patterns of diplomates/graduates of the undergraduate nursing course in the University of Manchester, England. *Journal of Advanced Nursing*, 1(6), 539-42.; Fraser, M. &., Titherington, B. (1989). Career paths of experienced graduates. *Nursing Standard*, 3, 29.; Fraser, M. &., Titherington, B. (1991). Where are they now? The career paths of graduates from post-registration degrees in nursing in England. *International Journal of Nursing Studies*, 28(3), 257-65.; Kemp, J. (1988). A longitudinal study of nursing graduates. *Nursing Times*, 84, 53.

[298] Hallett, C. E. (2008). Colin Fraser Brockington (1903-2004) and the evolution in nurse-education. *Journal of Medical Biography*, 16(2), 89-95. p.89.

[299] Ibid, p.92.

Diploma in Advanced Nursing Studies, which in 1975 became the first element of the two-year Master of Science degree in nursing.[300] Project 2000 followed the path set by Brockington. Project 2000 was a mark of faith in the nursing profession that nurses were capable of being highly educated clinicians.[301] Project 2000 was the full-scale reorientation of the changes to nurse training introduced by Brockington. The primary difference between earlier schemes and Project 2000 was that Project 2000 was supported by the profession's leadership, whereas individual pioneers drove earlier innovations in nurse education.[302]

Nursing's professional status

During the planning stages of Project 2000 in the 1980s, there are dissenting arguments for the proposals receiving the support of the leadership that should be acknowledged. By the planning of Project 2000 in 1986, professional status had become a sore point for nursing. There were stark differences between nursing and medicine, differences the profession wanted to bridge. Medicine was accepted as a profession, and as a result, the voice of the BMA has carried enormous weight in healthcare politics.[303] It was the BMA who, to an extent, held the introduction of the NHS hostage until Aneurin Bevan agreed to concessions for general practitioners to hold private clinics, and for NHS doctors to be able to

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[300] Ibid, p.92.

[301] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.15.

[302] Macleod Clark, J. &., Maben, J. (1998). Health promotion: perceptions of Project 2000 educated nurses. *Health Education Research*, 13(2), 185-196. p.185.

[303] Marmor, T. R. &., Thomas, D. (1972). Doctors, Politics and Pay Disputes: 'Pressure Group Politics' Revisited. *British Journal of Political Science*, 2(4), 421-442. p.422.

supplement their salary via private means.[304] This was in stark contrast to the voice of nursing's representatives – the RCN and UKCC.

Dingwall, Rafferty and Webster testify that the professionalisers within nursing wanted it to be recognised as a profession and make nursing a competitive career.[305] One method the RCN identified to improve nursing's professional status was to have a minimum of 70% of nursing staff be RNs.[306] However, as Dingwall et al. understand, in efforts to make nursing competitive, nurse managers had been willing to dilute nursing. Nurse managers had identified nursing duties that could be performed by less skilled assistants and auxiliaries while pushing the boundaries of practice by adopting more skilled duties for registered nurses.[307] Kath Melia reported in her PhD thesis that the assistants often had great responsibilities for the care of patients and often engaged with more aspects of patient care than their registered counterparts.[308] Melia also found that student nurses would often turn to the assistants for advice and guidance on technical nursing tasks as assistants and auxiliaries were occasionally in charge of the direct management of students.[309] J.F Wyatt's 1978 study into student nurses also revealed that it was the auxiliaries who often introduced students to the basics of nursing, including bed making and personal care.[310]

[304] Webster, C. (1998). The BMA and the NHS. *British Medical Journal*, 317(7150), 45-47. p.45.; Gorsky, M. (2008). The British National Health Service 1948-2008: A Review of the Historiography. *Social History of Medicine*, 21(3), 437-460. p.443.

[305] Dingwall, R. &., Rafferty, A. M. &., Webster, C. (1988). *An Introduction to the Social History of Nursing*. London: Routledge. p.225.

[306] Ibid, p.226.

[307] Ibid, p.225.

[308] Melia, K. M. (1981). *Student nurses' accounts of their work and training: a qualitative analysis* [PhD Thesis]. Edinburgh: University of Edinburgh. p.116.

[309] Melia, K. (1984). Student nurses' construction of occupational socialism. *Sociology of Health and Illness*, 6(2), 132-51.

[310] Wyatt, J. F (1978). Sociological Perspectives on Socialisation into a Profession: A Study of Student Nurses and Their Definition of Learning. *British Journal of Educational Studies*, 26(3), 263-276. p.269.

SENs and auxiliaries played key roles in the education and training of student nurses, they played a vital role in the NHS, and without SENs, many senior nurses felt they would not be able to staff their wards fully.

For a long time, the profession's leadership resisted reform to nurse training. The RCN had been one of the loudest voices to demonstrate what Peter Marris dubbed the 'conservative impulse.'[311] Marris adopts a sympathetic tone by arguing that conservatism is as necessary a key to survival as the ability to adapt. The physical environment in which nursing was practiced had become predictable. By being predictable, those within it had full knowledge of how it operated, where they stood in the hierarchy and the role of those around them. Jill Robinson pointed out that an example of this is the maintenance of the sister role which reflects nursing's ties to its religious origins.[312] Under Marris's theory, nursing's traditional leadership feared that any reforms would damage the validity of the integrity of the profession and the system of nursing, and the broader understanding by both nurses and the public about the meaning and function of nursing.[313] However, Robinson also argued that by acting on their conservative impulse, the leadership was knowingly stunting professional growth by resisting reform.[314] In the perspective of many, including the government, the RCN had flouted its duty to the profession; thus, the RCN was not a credible source to demand educational reform. Moreover, some senior nurses feared that a more highly educated counterpart would be better equipped for management positions and

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[311] Marris, P. (1984). *Loss and Change*. London: Routledge.
[312] Robinson, J. (1991). Project 2000: the role of resistance in the process of professional growth. *Journal of Advanced Nursing, 16*(7), 820-4. p.821.
[313] Marris, P. (1984). *Loss and Change*. London: Routledge.
[314] Robinson, J. (1991). Project 2000: the role of resistance in the process of professional growth. *Journal of Advanced Nursing, 16*(7), 820-4. p.820.

rival themselves for senior posts. It had become widely accepted during the planning stages that Project 2000 nurses would have a more comprehensive knowledge base and the skills to expand their professional knowledge further.[315] Bedeian found that the instinct for self-preservation was one of the pinnacle reasons why Owen, Huczynski and Buchanan argued that nursing's leadership feared and resisted the Project 2000 reforms.[316]

It appears ironic that nursing's leadership resisted Project 2000, yet, it was soon accepted that Project 2000 was nursing's route to achieving a greater professional status.[317] British nursing came under the powerful influence of American nursing where the profession is regarded highly.[318] For this reason, Murphy argued that Project 2000 would provide students with a professional education formed from an identifiable knowledge base.[319] Similarly, Betty Kershaw stated that Project 2000 aimed to mould an assertive practitioner who had the expertise to take on complex responsibilities and work effectively in a multidisciplinary environment.[320] For these reasons, Project 2000 was seen as the penultimate achievement in nursing achieving professional status.[321]

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[315] Orr, J. (1990). Project 2000 and the specialist practitioner. *Nursing Standard*, 17(4), 35-37. p.35.

[316] Bedeian, A. G. (1980). *Organisations: Theory and Analysis*. Illinois: Dryden Press.; Owen, G. M. (1983). The stress of change. *Nursing times, 79*(4), 44-46.; Huczynski, A. &., Buchanan, D. (1991). *Organisational Behaviour: An Introductory Text* (2nd ed.). Hertfordshire: Prentice Hall.

[317] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.xiii.

[318] Bradshaw, A. (1995). Has nursing lost its way? Nursing and medicine: cooperation or conflict?. *British Medical Journal, 311*(7000), 304-305. p.304.

[319] Murphy, N. J. (1993). An upstream approach to health care: the education of nurses for policy change. *Journal of Advanced Nursing*, 32(6), 285-287. p.286.

[320] Kershaw, B. (1993). Foreword. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. ix-x). London: Scutari Press. p.i.

[321] Ramprogus, V. (1995). *The Deconstruction of Nursing*. Aldershot: Avebury. p.xiii.

Chapter 4:
Nursing's new dawn: How the implementation of Project 2000 led to the creation of the knowledgeable practitioner

Project 2000 was rapidly rolled out in England and Wales in the summer of 1989.[322] To implement Project 2000, thirteen demonstration districts were established throughout England and Wales.[323] The thirteen demonstration sites included higher education institutions in various regions and major cities including, Manchester, Sheffield, Crewe and Macclesfield and Newcastle.[324] The UKCC and Department of Health intended for the demonstration sites to lead the way in pioneering Project 2000 with the course and nurse teachers acting as agents of change.[325] Equally, the demonstration districts were envisioned to highlight the expected teething problems that would emerge in the early stages and acknowledge the potential scope for reform.[326] The first student intake graduated in 1992, and Project 2000 was later implemented in Northern Ireland between October 1990 and May 1991 and in Scotland from 1992.[327] Each year, additional demonstration districts were approved by the Department of Health and added to England's original thirteen until Project 2000 was fully implemented throughout the United Kingdom. This chapter will analyse how

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[322] Dolan, B. (1993). Reflection and Celebration. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 3-16). London: Scutari Press. p.8.

[323] Jasper, M. (1996). The first year as a staff nurse: the experiences of a first cohort of Project 2000 nurses in a demonstration district. *Journal of Advanced Nursing, 24*(4), 779-790. p.779.

[324] Bourn, J. (1992). *Nursing Education: Implementation of Project 2000 in England.* London: National Audit Office. p.36. p.13.

[325] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.12.; Gerrish, K. (1992). The nurse teacher's role in the practice setting. *Nurse Education Today*, 12(3), 227-232. p.230.

[326] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.12.

[327] Slevin, O. &., Buckenham, M. (1992). Preface. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak - Innovations in the Nursing Curriculum*. (pp. 7-9). Edinburgh: Campion Press. p.8.

the implementation of Project 2000 led to the creation of nurses as knowledgeable

practitioners.

Establishing a knowledge base for nursing

The primary contributor to Project 2000 students developing into knowledgeable

practitioners was due to Project 2000 establishing a knowledge base for nursing. For

decades before the implementation, theoretical education for nurses was limited, but what

did exist often revolved around medical conceptualisations of illness and treatment.[328] A

debate sparked prior to the implementation of Project 2000 as to the place biological

science, directed more towards medical studies than nursing, should hold in nursing.[329]

Justus Akinsanya contributed to the debate by arguing that there is a difference in how

nursing and medicine uses biological sciences, therefore, nurses before Project 2000 were

learning content suitable more for a medical role.[330] Akinsanya pointed out that doctors

make decisions at a micro-level.[331] In contrast, nurses make decisions on a macro-level,

meaning nursing needed to develop its own knowledge base to teach biological sciences

suitable for nursing.[332] Leonard, Jowett and Courtenay agreed with this chain of thought and

further stated that as well as biological sciences, nursing had also relied on medically

influenced teachings of anatomy and physiology.[333] For these reasons, Clarke observed that

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[328] Smith, P. &., Masterson, A. &., Lloyd Smith, S. (1999). Health promotion versus disease and care failure to establish 'blissful clarity' in British nurse education and practice. *Social Science & Medicine*, 48(2), 227-239. p.229.

[329] Chapple, M. &., Allcock, N. &., Wharrad, H.J. (1993). Bachelor of nursing students' experiences of learning biological sciences alongside medical students. *Nurse Education Today*, 13(6), 426-434. p.427.

[330] Akinsanya, J. A. (1984). Development of a nursing knowledge base in the life sciences: problems and prospects. *International Journal of Nursing Studies*, 21(3), 221-227. pp.221-2.

[331] Ibid, pp.221-2.

[332] Ibid, pp.221-2.

[333] Courtenay, M. (1991). A study of the teaching and learning of the biological sciences in nurse education. *Journal of Advanced Nursing*, 16(9), 1110-1161.; Leonard, A. &., Jowett, S. (1990). Charting the course: a study

nurses were fostering a poor record for articulating the complexity of the clinical decisions they were called to make.[334] Clarke acknowledged that many nurses in the past had not had the chance to nurture their mental decision-making abilities as elements of their limited theoretical learning were inappropriate for the nursing role.[335]

In contrast, Melanie Jasper found that Project 2000 nurses displayed advanced analytical decision-making skills and were confident in applying theory into practice.[336] In her study, Jasper consulted eight staff nurses who formed part of the first Project 2000 cohort from 1989 to 1992.[337] Many of the early studies of Project 2000, which commenced immediately upon implementation, had focused entirely on the problems and successes of the scheme. For this reason, their legitimacy, irrespective of their conclusions, is limited as some were written before the first cohort had qualified. Additionally, there was a lack of sources that proved consistent or universal conclusions in the immediate years after the implementation. Therefore, many of these studies were laden with caveats and circumstantial evidence.

On the other hand, Jasper's study was written after these milestones in 1996 in an attempt to add validity to her results.[338] Jasper interviewed eight staff nurses and also set up focus groups of students and nurse tutors, using the bracketing method within her research to mitigate the effects of her admitted unconscious bias.[339] Jasper's conclusion centred around

of six ENB pilot schemes in pre-registration nurse education. Research Paper No. 1. *National Evaluation of Demonstration Schemes in Pre-Registration Nurse Education, 1990*. London: National Foundation for Educational Research in England and Wales.

[334] Clarke, J. (1991). Nursing: an intellectual activity. *British Medical Journal, 303*, 376-7. p.377.

[335] Ibid, p.377.

[336] Jasper, M. (1996). The first year as a staff nurse: the experiences of a first cohort of Project 2000 nurses in a demonstration district. *Journal of Advanced Nursing, 24*(4), 779-790. p.779.

[337] Ibid, p.780.

[338] Ibid, p.780.

[339] Ibid, p.780.

her finding that the course had been successful in producing a nurse capable of providing care to a high standard and supervising care through delegation and mentoring future students.[340] Admittedly, the qualified Project 2000 nurses felt that they were 'thrown in at the deep end.'[341] However, once settled into their clinical environments, their academic knowledge was soon called upon. They reported that it enabled them to progress in their professional development and quickly settle into the clinical atmosphere.[342] All nurses testified that they felt they functioned well in the staff nurse role. Furthermore, they felt prepared to confidently think analytically and challenge decisions made by other healthcare professionals and suggest alternatives, in stark contrast to previous studies into apprenticeship nurses.[343]

Jasper's study formed the benchmark for research into the effectiveness of Project 2000 in practice, as naturally, the changes made to nursing education sparked a wide variety of research projects. Subsequent research projects, conducted by nurse-historians and social scientists, including Parker and Carlisle's, Brown and Edelmann's, and Clark, Maben and Jones's, created a consensus opinion, both academically and professionally. They agreed that one of the biggest successes of Project 2000 was in meeting its intention of educating students to a high academic level.[344] It was only under Project 2000 that nursing began to create and define their knowledge base. As a result, nursing started to be seen as an

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[340] Ibid, p.787.
[341] Ibid, p.783.
[342] Ibid, p.783.; p.875.
[343] Ibid, pp.783-4.
[344] Ibid.; Brown, H. &., Edelmann, R. (2000). Project 2000: a study of expected and experienced stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing, 31*(4), 857-864.; Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256.

intellectual activity, and nurses began to be regarded as intelligent professionals.[345]

Ultimately, the key intention of Project 2000 was to create a knowledgeable nurse who was critical and analytical in thinking, able to apply research to practice and be flexible and responsive to patient's needs, an intention that had largely been met.[346]

Changing the focus of practice

One of the key changes in nurse education prompted by Project 2000 was to make nurses proficient in health promotion. In many ways, the inclusion of health promotion in the nursing curriculum re-focused the nurse's role. When the Department of Health announced that they accepted the broad thrust of Project 2000 proposals in May 1988, part of their acceptance rested on the re-orientation of practice towards health promotion.[347] Traditionally, the nurse's role was remedial as it was centred around sickness models of care delivery.[348] Pre-Project 2000, nursing's philosophy towards healthcare was characterised by disease and care.[349] However, Project 2000 also provides a glimpse into intentions and expectations set on the NHS going into the twenty-first century. It becomes clear that the NHS was exploring more preventative care delivery methods, and nurses would play a central role.[350] Nursing would, therefore, play a dual role in curing and promoting good

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[345] Clarke, J. (1991). Nursing: an intellectual activity. *British Medical Journal, 303*, 376-7.

[346] Taylor, J. &., Irvine, F. &., Bradbury-Jones, C. &., McKenna, H. (2010). On the precipice of great things: the current state of UK nurse education. *Nurse Education Today*, 30(3), 239-244. p.243.

[347] Bourn, J. (1992). *Nursing Education: Implementation of Project 2000 in England.* London: National Audit Office. p.10.

[348] Hamill, C. (1995). The phenomenon of stress as perceived by Project 2000 student nurses: a case study. *Journal of Advanced Nursing*, 21(3), 528-536. p.528.

[349] Smith, P. &., Masterson, A. &., Lloyd Smith, S. (1999). Health promotion versus disease and care failure to establish 'blissful clarity' in British nurse education and practice. *Social Science & Medicine*, 48(2), 227-239. p.227.

[350] Gray, M. A. &., Smith, L. N. (2000). The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. *Journal of Advanced Nursing*, 32(6), 1542-1549. p.1543.

health and positive lifestyle choices.[351] To achieve this intention, students needed to be educated in health promotion.

Health promotion has long been a widely contested concept as it means different things to different health professions.[352] Gott and O'Brien conducted a study examining nurses' views on health education.[353] They interviewed students and nurses from hospitals, the community, schools, and occupational health settings; they found distinctions between traditional nursing and nurses' emerging role as health promotors.[354] Additionally, the nurses appeared to have had a clear collective sense across the different clinical settings of health promotion and the nurse's role within it. They acknowledged that health promotion was centred on lifestyle and needed to be individualistic.[355] Maben and Clark conducted a later study on health promotion and the perceptions of the concept. Maben and Clark found that teaching of health promotion under the Project 2000 curriculum included studies of health as a broad socio-political and economic issue.[356] Similarly, within the curriculum, health promotion was encompassed in values that focused on providing information, teaching life skills, encouraging self-empowerment, promoting healthy choices, and assisting in those choices becoming attainable for patients.[357]

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[351] Crabbe, G. (1989). Staying the course. *Nursing Times, 85*(37), 33-36. p.35.
[352] Galli, N. (1978). *Foundations and Principles of Health Education*. Chichester: Wiley. pp.2-3.
[353] Gott, M. &., O'Brien, M. (1990). *The Role of the Nurse in Health Promotion: Polices Perspectives and Practice*. London: Department of Health.
[354] Ibid, p.14.
[355] Ibid, p.14.
[356] Macleod Clark, J. &., Maben, J. (1998). Health promotion: perceptions of Project 2000 educated nurses. *Health Education Research*, 13(2), 185-196. p.186.
[357] Ibid, p.186.

Clark and Maben's study from 1998, just shy of a decade after the implementation of the

proposals, included 498 Project 2000 students, each asked to complete three

questionnaires.[358] Clark and Maben's study affirmed that health promotion was one of the

key concepts underpinning the Project 2000 curriculum. Their study found that 70% of

respondents conveyed that the course's theoretical elements reinforced the re-orientation

of practice towards health promotion.[359] Clark and Maben's conclusion that Project 2000

students qualified feeling prepared to educate patients after developing a broad and

analytical understanding of health promotion is very similar to the following studies.[360]

McDonald's study of nine newly-qualified Project 2000 nurses also found that those nurses

felt prepared and equipped for their role as health educators.[361] Mitchinson's 1995 review

of health promotion sent questionnaires to 100 student nurses, 50 still learning under the

traditional method and the other 50 being Project 2000 nurses.[362] Mitchinson sought to

identify any similarities or differences between traditional and Project 2000 students in their

understanding and application of health promotion and education, and examine who felt

well prepared to be health promoters and educators.[363] Mitchinson deduced that Project

2000 students appeared better prepared for the health promotion role than traditionally

trained nurses.[364] Importantly, Mitchinson conveyed students' thoughts that while the

Project 2000 curriculum set good foundations for nurses to be effective health promoters

and educators, there was still a greater need for a clearer understanding of the concept and

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[358] Ibid, p.187.
[359] Ibid, p.191.
[360] Ibid, p.191.
[361] McDonald, E. (1998). The role of Project 2000 educated nurses in health promotion within the hospital setting. *Nurse Education Today*, 18(3), 213-220.
[362] Mitchinson, S. (1995). A review of the health promotion and health beliefs of traditional and Project 2000 student nurses. *Journal of Advanced Nursing*, 21(2), 356-363. p.357.
[363] Ibid, p.358.
[364] Ibid, pp.358-360.

nurses role and responsibilities as health educators.[365] Spence Laschinger questioned 114

undergraduate baccalaureate nursing students in 1996 and found that health promotion

was taught throughout the degree. Over the three years, the efficiency of students

promoting good health increased throughout their course.[366] Therefore, upon qualification,

students were well prepared to be efficient and effective health promoters and educators.

Similarly, Warne and McAndrew assert that another significant contribution to Project 2000

nurses' preparedness was the emphasis on emotional intelligence and its deployment in the

curriculum.[367] Their 2009 paper explored the idea of preparedness using the

psychoanalytical concept of mirroring.[368] They found that beyond the rhetoric of the Project

2000 proposals, it was acknowledged that educators needed to ensure the student

experience was personalised to the individual to validate the 'emotional context of the

students' personal experience as a foundation for their learning.'[369] In many ways, this was a

major change in how nurse training had treated its probationers. In an interviews conducted

for this thesis, Victoria stated how it was made clear from the beginning of her training that

she was 'at the bottom of the heap,' and, therefore, of little importance with non-existent

influence or voice to inspire any form of positive action.[370] Furthermore, Victoria spoke of

how she entered nursing with a familiar idealised image of nursing as welcoming, 'thinking it

would be full of kindness and angelic, and kind of lovely'. However, she instead discovered

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[365] Ibid, pp.360-361.
[366] Spence Laschinger, H. K. (1996). Undergraduate nursing students' health promotion counselling self-efficacy. *Nurse Education Today*, 24(1), 36-41.
[367] Warne, T. &., McAndrew, S. (2009). Mirror, Mirror: Reflections on Developing the Emotionally Intelligent Practitioner. *Journal of Mental Health and Learning Disabilities Research and Practice*, 6(2), 157-167.
[368] Ibid, p.158.
[369] Ibid, p.158.
[370] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 7).

that teachers and mentors could be punitive, sometimes even harsh, with training being 'contrary to what I believed nursing might be like.'[371] George, another student of the apprenticeship system interviewed for this study, echoed many of Victoria's claims. George was a student of the 1982 mental health nursing curriculum and clarified that compared to his adult nursing counterparts, his course was 'sort of a holiday really for three years' because his tutors 'couldn't be arsed to do anything with us.'[372] Similar to Victoria, George maintained that there were a plethora of bad practices performed by teachers and mentors and spoke of his trauma recounting that 'the things that happened to us as students are actually pretty dangerous,' yet, little consideration was given to the effect this had on the students.[373]

Emotional intelligence was not a new concept. By the mid-1980s, it had long been accepted that little of our lives is governed by logic alone.[374] As Goleman argues, humans have two minds – the rational mind and the emotional mind – with both influencing our decisions, actions and responses.[375] In relevance to healthcare, in 1973, Perls wrote that every breath is important, and something as simple as a patient sighing could communicate pain, suffering and a lifetime of emotions.[376] Therefore, coupled with emerging and improved awareness of emotional and mental health, it became inconceivable for Project 2000 not to include the means for students to develop into emotionally intelligent practitioners.

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[371] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 7).
[372] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 8).
[373] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 9).
[374] Ibid, p.91.
[375] Goleman, D. (1995). *Emotional Intelligence*. Bantam: New York.
[376] Perls, F. S. (1973). *The Gestalt approach and eyewitnesses in therapy*. Science and Behaviour Books: California.

In Warne and McAndrew's *Reflections on Developing the Emotionally Intelligent Practitioner*, they found that effective emotional practitioners would possess the qualities of nurturance, compassion, respect, and humanity and a strong sense of self-awareness and mindfulness.[377] The nurturing of these values, as Bellack argues, were the key to nurses being emotionally competent practitioners.[378] However, as Warne and McAndrew also identified, for students to be successful in developing emotional intelligence, they need to have had experienced the benefits of it themselves in their training.[379] Therefore, training must be individualistic and include reflective learning experiences, supportive supervision, and opportunities for working creatively with the arts and humanities.[380] Fishwater and Stickley detailed examples of experimental approaches to teaching emotional intelligence, including students being urged to read poetry, view art, attend plays, and be involved in planning elements of the course.[381]

Edward, also interviewed as part of this thesis, stated how as part of his diploma course at the University of Leeds from 1990-1993, one of these classes involved going to a local art gallery and being free to explore the art collection.[382] Edward also exposes early shortfalls in the teaching of emotional intelligence by stating he 'didn't know what was going on' during

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[377] Warne, T. &., McAndrew, S. (2009). Mirror, Mirror: Reflections on Developing the Emotionally Intelligent Practitioner. *Journal of Mental Health and Learning Disabilities Research and Practice*, 6(2), 157-167. p.158.
[378] Bellack, J. (1990). Emotional intelligence: A missing ingredient? *Journal of Nursing Education*, 38(1), 3-4.
[379] Warne, T. &., McAndrew, S. (2009). Mirror, Mirror: Reflections on Developing the Emotionally Intelligent Practitioner. *Journal of Mental Health and Learning Disabilities Research and Practice*, 6(2), 157-167. p.158.
[380] Freshwater, D. &., Stickley, T. (2004). The Heart of the Art: Emotional Intelligence in Nurse Education. *Nursing Inquiry*, 11(2), 91-98. p.96.
[381] Ibid, p.96.
[382] Edward. (2021, 2 March). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 10).

that class and saw it as a 'waste of time'.[383] It was almost inevitable that there would be

early failures in the teaching of emotional intelligence, primarily as the tutors charged with

teaching it had not been taught it before, nor possessed much knowledge regarding it.

Therefore, all too often, poor advice was provided to students.[384] Nevertheless, research

conducted in the later years of the 1990s revealed many successes. Cadman and Brewer

pointed out that evidence suggested there was a direct relationship between the qualities

of emotionally intelligent practitioners and the outcomes of their patients.[385] Moreover,

Freshwater and Stickley also hint that the teaching of emotional intelligence had worked to

re-moralise patients who had been demoralised by previous encounters with healthcare

where their emotional needs had not been met.[386] This had primarily been achieved by the

emotional intelligence content providing students with transferable knowledge, values and

ethics that enhanced their learning and practices in the clinical environment, thus, reducing

the theory-practice gap.[387]

Supporting students through clinical practice

Project 2000 was designed to adequately prepare students for a career in clinical practice in

all care settings.[388] Project 2000 recognised that it was on clinical placements where

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[383] Edward. (2021, 2 March). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 10).

[384] Freshwater, D. &., Stickley, T. (2004). The Heart of the Art: Emotional Intelligence in Nurse Education. *Nursing Inquiry*, 11(2), 91-98. p.95.

[385] Cadman, C. &., Brewer, J. (2001). Emotional intelligence: A vital prerequisite for recruitment in nursing. *Journal of Nursing Management*, 9(6), 321-324.

[386] Freshwater, D. &., Stickley, T. (2004). The Heart of the Art: Emotional Intelligence in Nurse Education. *Nursing Inquiry*, 11(2), 91-98. p.96.

[387] Ibid, p.98.

[388] Brown, H. &., Edelmann, R. (2000). Project 2000: a study of expected and experienced stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing, 31*(4), 857-864. p.858.

students would transform into clinically competent clinicians.[389] The clinical environment was also pivotal to the development of professional attitudes.[390] Project 2000 would, therefore, intend to improve upon the foundations laid by the traditional method for clinical placements. One essential improvement was the greater incorporation of mentors, tutors, and preceptors in placements. It was not a new or revolutionary idea as in American nursing courses, preceptorship programmes had existed for decades.[391] However, British nursing had had a relatively poor relationship with firstly understanding the terms and secondly implementing them. Gray and Smith found that the term 'mentor' and concept of 'mentorship' only slipped into British educational language from American texts in the 1980s with the discussions and plans around Project 2000.[392] When wider research is conducted into the term and its definition before its adoption under Project 2000, it is American sources, such as nurse-educator L.A. Darling's *What Do Nurses Want in a Mentor?* study that appear.[393] Given that mentorship was actively practiced in American university-level education, it was also predominantly American educationalists calling for more research into mentorship to clearly define the term to apply it better in education.[394]

The lack of clarity around mentorship and preceptorship appears to have been overlooked in the planning of Project 2000. Moreover, even after the implementation in 1991, Fox

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[389] Andrews, G. J. &., Brodie, D. A. &., Andrews, J. P. &., Hillan, E. &., Thomas, B. G. &., Wong, J. &., Rixon, L. (2006). Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies*, 43(7), 861-874. p.861.

[390] Ibid, p.861.

[391] Allanach, B. C. &., Mowinski Jennings, B. (1990). Evaluating the effects of a nurse preceptor programme. *Journal of Advanced Nursing*, 15(1), 22-8.

[392] Gray, M. A. &., Smith, L. N. (2000). The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. *Journal of Advanced Nursing*, 32(6), 1542-1549. p.1543.

[393] Darling, L. A. W. (1984). What Do Nurses Want in a Mentor? *Journal of Nursing Administration*, 14, 42-44.

[394] Merriam, S. (1983). Mentors and proteges a critical review of the literature. *Adult Education Quarterly*, 33, 161-173.

argued that while mentorship was central to the reforms in clinical placements, the guidelines supplied by the UKCC on the mentor role were inconsistent, reflecting the UKCC's limited knowledge regarding the concept. This ultimately fed into widespread confusion among those tasked to be mentors.[395] The aspiration was that mentorship and preceptorship would provide a safe and supportive professional atmosphere and lead to solid links between students and their tutors and mentors, both in clinical practice and in higher education, to ensure the improvements in research and academic knowledge were utilised in practice.[396]

Under Project 2000, mentors would be involved during the initial three-year training course, and preceptors would work with NQNs in the early stages of their careers. Amongst the confusion over definitions, there were several similar, albeit vague, expectations of mentors and preceptors. Mentors would be both based in higher education and clinically, whereas preceptors would be purely ward-based, usually a staff nurse. However, both roles were trusted to teach, counsel, and inspire their learners.[397] The following sections will discuss the impact of mentors and preceptors and analyse their effectiveness in creating knowledgeable practitioners.

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[395] Fox, J. (1991). Mentorship and the charge nurse. *Nursing Standard, 5*(23), 34-6.
[396] Andrews, G. J. &., Brodie, D. A. &., Andrews, J. P. &., Hillan, E. &., Thomas, B. G. &., Wong, J. &., Rixon, L. (2006). Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies*, 43(7), 861-874. p.872.
[397] Marrow, K. L. (1984). *Preceptorship in Nursing Staff Development*. Maryland: Aspen.

Mentors

An interview conducted with Mary provided a glimpse into why a mentorship system was deemed necessary under Project 2000. Mary was among the final years of adult nursing apprenticeship students; Mary recounted how, when on clinical placements, she felt long bouts of professional isolation.[398] Mary said that it was a frequent occurrence on her placements to be shown procedures a minimal number of times by the nurse she was working with and then be deemed competent to practice these procedures despite not feeling confident nor proficient.[399] Additionally, as apprentice students were not supernumerary and counted in the staffing numbers, Mary said there was an unconscious expectation that she 'needed to get on with the job' and not keep asking for more assistance or guidance.[400] Therefore, a mentorship system was essential for the development of student nurses.

In 1994, Jowett, Walton, and Payne conducted a study funded by the Department of Health to explore the challenges and changes that came with reforms to nurse education, with key chapters relating to changes to the clinical environment.[401] For their research, they interviewed 77 Project 2000 students from 1990 to 1991. Students described the course as 'a taxing three years, not to be undertaken lightly'.[402] Many students remarked on how they approached their training with apprehension. Nevertheless, the support they received

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[398] Mary. (2021, 12 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 11).
[399] Ibid
[400] Mary. (2021, 12 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 11).
[401] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales.
[402] Ibid, p.84

during training, including support by mentors, meant 86% of students in the study entered

nursing with a substantial degree of confidence.[403] Students recognised that with the proper

support, the Project 2000 course was 'thoroughly enjoyable,' 'brilliant' and made them 'a

better human being.'[404] Jowett, Walton and Payne, therefore, presented the case that

mentorship was an early success of the reforms.

Brown and Edelmann's 2000 study agreed with the fundamentals of Jowett's concluding

verdict on mentorship. Brown and Edelmann sought to identify the perceived stressors and

coping resources used by students and newly qualified nurses by sending questionnaires to

nurses who made up the first Project 2000 cohort.[405] These studies provided scope for not

only the success of the implementation of mentorship but also its evolution and how Project

2000 adapted to criticism during the 1990s. Similar to Jowett, Brown and Edelmann learnt

that students experienced anxiety over starting their clinical training. However, the majority

found that there were fewer stressors and more resources available to them than

expected.[406] It should be recognised that apprehension was not a new feeling for

prospective nursing students as it had existed long before Project 2000. Regardless of the

period, nurses have always strived to achieve the highest standards of care, and the feeling

of trepidation is a natural signifier that they care and want to be the best nurse they could

be. However, in this thesis, it is a key point to mention that one of the principal ways Project

2000 can be determined to have been a success or failure is through comparisons with the

apprenticeship model.

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[403] Ibid, p.99.
[404] Ibid, p.83.
[405] Brown, H. &., Edelmann, R. (2000). Project 2000: a study of expected and experienced stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing, 31*(4), 857-864. p.857.
[406] Ibid, p.857.

Brown and Edelmann reported that 84% of the students who were starting their course struggled with confidence over whether they could achieve the expected level of competency.[407] Yet, by the start of their Branch Programme, that figure reduces to 55%, and by qualification, it reduces further to 19%.[408] Likewise, upon commencing the Branch Programme, 60% of students experienced stress over feeling incompetent in clinical practice, but the figure lowered to approximately 20% by qualification.[409] Brown and Edelmann believed these figures showed the value of having a mentor. At the beginning of their training, students tremendously underestimated the value of a mentor to their learning with a mere 1% of students seeing mentors as a potential benefit.[410] However, 24-months into their training, once students had experienced clinical placements, a considerable 72% of probationers stated their mentor was an essential coping mechanism.[411] In fact, except for students' partners, mentors were the people they said they relied on the most for support, above the ward sister, personal tutors and academic staff.[412] Remarkably, the data submitted also shows they developed self-confidence. At the beginning of training, only 3% relied on themselves as a coping mechanism, but 66% viewed themselves as a resource to deal with stress by the end of the course.[413] Further literature written by Lindop, Boxall, Brunt, West and Rushton and Adey argued that up to 95% of students experienced considerable amounts of stress over minor elements of clinical

[407] Ibid, p.859.
[408] Ibid, p.859.
[409] Ibid, p.860.
[410] Ibid, p.860.
[411] Ibid, p.860.
[412] Ibid, p.861.
[413] Ibid, p.862.

nursing practices, such as the disposal of sputum samples, yet mentorship was of great help to probationers.[414]

Later research that was conducted in the late 1990s and into the twenty-first century into the effectiveness of mentorship shows that the parameters of the concept were becoming more clearly defined. Gray and Smith's study into the qualities of an effective mentor from student nurses' perspectives highlights how Project 2000 largely failed to define mentorship.[415] Instead, it was determined on an individual basis, with mentors often responding to the students' needs. While only a small study including ten students from a large Scottish College of Nursing, Gray and Smith produced a publication mostly representative of the nationwide picture on mentorship.[416] The key elements of learning both in clinical practice and higher education were teaching, supporting and assessing.[417] For many, having a mentor meant that teaching was likely to be more planned and meaningful, whereas students who had days without their mentors commented they felt as if they were 'hanging about' or 'tagging along' with no purpose to their learning.'[418] Over the three-year course, students did twelve placements, with mentors making them 'feel a lot better actually' with someone there 'to guide me.'[419]

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[414] Lindop, E. (1999). A comparative study of pre-and post-Project 2000 students. *Journal of Advanced Nursing,29*(4), 967-973. p.968.; Boxall, J. (1982). Some thoughts on stress to staff in neonatal units. *Nursing Times*, 78(27), 1137-1138.; Brunt, C. (1984). A very stressful place. *Nursing Times*, 80(7), 28-32.; West, M. &., Rushton, R. (1986). The drop-out factor. *Nursing Times*, 82(52), 29-31.; Adey, C. (1987). Stress: Who Cares. *Nursing Times*, 83(4), 52-3.

[415] Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647.

[416] Ibid, p.1542.

[417] Ibid, p.1542.

[418] Ibid, pp.1543-4.

[419] Ibid, p.1545.

Furthermore, when the individual responses in Gray and Smith's study are collated, it emerged that there were widely agreed upon qualities of a good mentor, including encouraging practical involvement as opposed to students just standing and observing, an accusation that has frequently been thrown at Project 2000.[420] Mentors should also take time early on to determine the student's abilities, weaknesses and targeted outcomes.[421] On top of that, another key feature of the mentor role was that they would operate between higher education and clinical practice. Therefore, a mentor would bridge the gap between both sides and plan opportunities for students to meet their learning outcomes.[422] Finally, many students and nurses agreed that mentors should allow students to develop their independence and self-motivation, with student dependency statistics declining in the third year as students become more confident making autonomous decisions.[423]

Naomi Watson's research came to similar conclusions. In her 1999 study, Watson interviewed 35 students and 15 mentors to investigate the experiences of pre-registration nursing student's perceptions of mentorship.[424] Watson aimed to scrutinise how and when students were introduced to the concept, staff's views on mentoring – something that broader literature has largely neglected – and what changes students think should be made to improve the then-present system.[425] Both groups were asked what they understood by

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[420] Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647. p.1547.
[421] Ibid, p.1547.
[422] Ibid, p.1547.
[423] Ibid, p.1547.
[424] Watson, N. A. (1999). Mentoring today – the students' views. An investigative case study of pre-registration nursing students' experiences and perceptions of mentoring in one theory/practice module of the Common Foundation Programme on a Project 2000 course. *Journal of Advanced Nursing*, 29(1), 254-262.
[425] Ibid, p.256.

the term 'mentor'. The responses suggest that students and mentors had similar

understandings, agreeing that mentors should be assessors, facilitators, role models, and

active in clinical practice.[426] When more studies are consulted, it emerges that these skills

were a critical part of the mentor role.

In Watson's study, the clinical careers of the mentors ranged from six months to just over a

year.[427] Watson does not discuss the short length of the mentors' careers, presumably

because the UKCC or ENB did not ever definitively state the length of clinical career suitable

for a mentor. However, it is essential to recognise that upon implementation, and in the

early years, it was apprentice-trained nurses and tutors teaching, supervising, and

implementing the course. While still being qualified registered nurses operating in clinical

practice, apprenticeship nurses were trained under a different ethos, a different focus in

terms of education and practice, and held, at times, negative opinions of the Project 2000

changes. As explained in the calls for reform, many apprentice nurses felt they were

inadequately trained for their roles as it was, never mind now being called upon to

materialise the reforms that expanded nursing's boundaries of practice further. Therefore, a

responsibility they were almost certainly not prepared for. This is not a criticism of the

apprentice nurses. After all, a nurse is only as good as what and how she is taught. Rather, it

is a critique of the, at times, poor planning on the part of the UKCC in implementing Project

2000.

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[426] Ibid, p.259.
[427] Ibid, p.259.

However, in fairness, when the issues around the implementation are scrutinised further, reform was becoming a pressing issue that had been stalled and impeded for decades. Thus, by the mid-1980s, change was urgently needed, and it becomes difficult to hypnotise methods for reform that would not have taken years, if not decades, to implement sufficiently. This is yet another example of nursing operating in impossible circumstances. The possible explanation for the mentors in Watson's study having short careers could, therefore, be because they were more likely to be Project 2000-trained nurses. Watson published in 1999, ten years after the first stages of implementation, and it could be presumed that the Project 2000-trained mentors embodied the nature of the reforms closer than apprenticeship nurses. Kate Gerrish exposes this issue. Gerrish looked at nurse teaching roles and ENB expectations, stating that they wanted mentors to retain clinical competence, therefore, still actively practice. Thus, apprentice nurses were the logical solution to mentoring Project 2000 students as they met the UKCC Rule 18 regulations of clinical competence, defined as being able to function as a nurse and possess the skills required and practice clinically.[428] However, the ENB also expressed interest in mentors having in-depth advanced nursing knowledge and having detailed nursing knowledge at both macro and micro levels, including nursing politics.[429] Additionally, Gerrish acknowledged that the aims of Project 2000 mentors were for them to adopt creativity, foster a critical question approach, and encourage students to inquire about any area of practice and facilitate research findings.[430]

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[428] Gerrish, K. (1992). The nurse teacher's role in the practice setting. *Nurse Education Today*, 12(3), 227-232. p.227.
[429] Ibid, p.228.
[430] Ibid, p.230.

Many studies into mentorship hint at recommendations for improvements by way of criticism, as done by Watson. However, one of the few that clearly outlines recommendations is Wilson-Barnett et al.'s 1995 publication. One of the key recommendations was for more consideration to be paid into the type of educational preparation that could assist staff in their capacity as a mentor.[431] This was alongside suggestions that a more precise conceptualisation of diploma level practice was desirable, likely as by 1995, Project 2000 was rolled out by apprentice-trained nurses, thus, there were understandably discrepancies in the understanding of diploma-level education.

Furthermore, staffing levels on the wards needed to be addressed to create a better learning environment.[432] Wilson-Barnett confronts several logistical issues with the mentorship system, whereas many studies centre on how mentorship was received by students who were otherwise unaware of practical problems. Therefore, Wilson-Barnett et al. shed light on many of the issues widely known in clinical practice but are sometimes neglected in the literature. The assertion that the influence of team spirit should be further explored hinted that low morale was an issue, either on the part of the mentor, the student, or the clinical practice staff, showing there were improvements to be made around logistical issues proves that point. [433] Admittedly, Gerrish was writing in 1992, and the points she incorporated in her research were forward-looking. Still, it emerges that, despite the best and dedicated efforts of apprentice-trained nurse mentors, there could have been early

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[431] Wilson-Barnett, T. &., Butterworth, T. &., White, E. &., Twinn, S. &., Davies, S. &., Riley, L. (1995). Clinical support and the Project 2000 nursing student: factors influencing this process. *Journal of Advanced Nursing, 21*(1), 1152-1158. p.1157.
[432] Ibid, p.1157.
[433] Ibid, p.1157.

Project 2000 students who did not receive the standard of clinical educated that the reforms campaigned.

Nevertheless, Watson joins many in hailing mentorship a success.[434] Her conclusions resemble many others, including Wilson-Barnett et al., who pointed out that despite the loose definition of 'mentor', there was a common expectation for mentors to support the 'educative process of developing skills'.[435] Equally, many studies mentioned that a chief responsibility of mentors was to provide the student with a picture of what nursing should be like.[436] It was often an idealised image, set in the context of nursing being fully staffed. Nonetheless, mentors were expected to demonstrate what a practitioner should be.

As Project 2000 progressed and evolved during the 1990s, the concept of individualism became central to mentorship as it allowed adaptivity and flexibility with mentors shaping their support to their students.[437] This should not be used as an explanation or justification as to why the UKCC did not definitively define mentorship. Remarkable since under Project 2000, nurse mentors, tutors and preceptors were meant to be 'agents of change,' and it appears the UKCC failed in defining the more minor elements of change, concentrating on

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[434] Watson, N. A. (1999). Mentoring today – the students' views. An investigative case study of pre-registration nursing students' experiences and perceptions of mentoring in one theory/practice module of the Common Foundation Programme on a Project 2000 course. *Journal of Advanced Nursing*, 29(1), 254-262.

[435] Wilson-Barnett, T. &., Butterworth, T. &., White, E. &., Twinn, S. &., Davies, S. &., Riley, L. (1995). Clinical support and the Project 2000 nursing student: factors influencing this process. *Journal of Advanced Nursing, 21*(1), 1152-1158. p.1153.

[436] Ibid, p.1153.; Darling, L. A. W. (1984). What do nurses want in a mentor?. *Journal of Nursing Administration, 14*(10), 42-44.

[437] Morle, K. M. F. (1990). Mentorship – is it a case of the emperor's new clothes or a rose by any other name? *Nurse Education Today*, 10(1), 66-69.; Anforth, P. (1992). Mentors not assessors. *Nurse Education Today*, 12, 299-302.; Fowler, J. (1996). The organisation of clinical supervision in the nursing profession: a review of the literature. *Journal of Advanced Nursing*, 23, 471-478.; Oliver, R. &., Enderby, C. (1994). *Teaching and Assessing Nurses. A Guide for Preceptors*. London: Balliere Tindall.

the larger, more attention-grabbing proposals.[438] Simply, it was not defined because the

UKCC did not know how to define it. Instead, the achievements of mentorship were an

indirect success and a success that should be claimed entirely by the mentors themselves.

Mentors had had their mentoring duties added to existing ones and, like nurse tutors and

preceptors, were burdened with increasing responsibilities throughout the 1990s as more

came to be expected from them all without a set framework for practice.[439] Wright

evaluated the experiences of final year apprenticeship students and concluded that if any

future mentorship system were to be successful, mentors needed to be appropriately

prepared.[440] Project 2000 largely failed to do this. While all the mentors in Spouse's study

had attended the ENB mentor course and a brief induction, this was not

universal.[441] Ultimately, however, mentorship was an important and irreplaceable aspect of

the student's education, an argument that is almost entirely held universally. There were

faults with mentorship, but there is no element of nurse training that has ever been perfect.

Charlotte, interviewed for this study, remarked that the presence of mentors meant herself,

and many of her peers, felt 'really well supported; we felt like their presence encouraged us

to think freely and seek things out for ourselves, not to just do as we were told with no

explanation…'[442] Charlotte's thoughts, alongside the evidence presented in other student's

testimonies demonstrates that mentorship enhanced clinical learning and was pivotal in

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[438] Gerrish, K. (1992). The nurse teacher's role in the practice setting. *Nurse Education Today*, 12(3), 227-232. p.230.
[439] Atkins, S. &., Williams, A. (1995). Registered nurses' experiences of mentoring undergraduate nursing students. *Journal of Advanced Nursing*, 21, 1006-1015.
[440] Wright, C. M. (1990). An innovation in a diploma programme: the future potential of mentorship. *Nurse Education Today*, 10, 355-359.
[441] Spouse, J. (1996). The effective mentor: a role model for student-centre learning. *Nursing Times*, 92(3), 32-35.
[442] Charlotte. (2021, 2 February). *Oral History Interview. Interviewed by K. Swaby*. [Leeds]. (See Appendix 12).

joining theory and practice, with one of the biggest fears of Project 2000 was that it would

widen the gap more, but it is clear there were conscientious efforts to tackle that issue.

Preceptorship

Preceptorship was arguably another success of Project 2000. Preceptorship was introduced

as a concept after Kramer's 1974 study that tested whether it could help nurses transition

better from education to the clinical environment.[443] Preceptorship was a system of post-

qualification support provided by experienced nurses that had been adopted in the USA,

Canada and Sweden, but it was only introduced widely in the UK under Project 2000.[444]

Preceptors supervised newly qualified nurses who were entering clinical practice for the first

time for around six to twelve months during their period of adjustment.[445] When Maben

and Clark interviewed NQNs between December 1994 and January 1995, few studies

looking at preceptorship had been done.[446] Since then, studies by Billay and Yonge, Allen

and Ohrling and Hallberg have built on Maben and Clark's foundations by investigating the

perceptions of preceptees and preceptors.[447] Maben and Clark's study highlighted that the

'reality shock' of qualifying and entering clinical practice remained from the apprenticeship

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[443] Kramer, M. (1974). *The Reality Shock: Why Nurses Leave Nursing*. St Louis: C.V. Mosby.
[444] Bukhari, E. A. (2011). *Nature of Preceptorship and its Impact on Clinical Nursing Care from the Perspectives of Relevant Nursing Staff* [PhD Thesis]. Manchester: University of Manchester. pp.46-7.
[445] Bond, M. &., Holland, S. (1998). *Skills of Clinical Supervision for Nurses: A practical guide for supervisees clinical supervisors and managers*. Buckingham: Open University Press. p.18.
[446] Maben, J. &., Clark, J. M. (1998). Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing, 7*(2), 145-153. p.147.
[447] Billay, D. &., Yonge, O. (2004). Contributing to the theory development of preceptorship. *Nurse Education Today*, 24(7), 566-574.; Allen, C. (2002). Peers and partners: a stakeholder evaluation of preceptorship in mental health nursing. *Nurse Researcher*, 9(3), 68-84.; Ohrling, K. &., Hallberg, I. (2000). Student nurses' lived experience of preceptorship. Part 2 – the preceptor-preceptee relationship. *International Journal of Nursing Studies*, 37(1), 25-36.; Ohrling, K. &., Hallberg, I. (2001). The meaning of preceptorship: nurses' lived experience of being a preceptor. *Journal of Advanced Nursing*, 33(4), 530-540.

model.[448] When considered, it would be surprising if there was no sense of shock during the transition from student to RN. In discussions on the concept, the sense of shock reflected anxiety, which equally reflected the responsibilities of the nurse. Indeed, Maben and Clark make a crucial point – nursing is one of the few professions that expects its practitioners to be a finished product by the end of training.[449] This mentality is characteristic of nursing, but it is an impossible task. In fact, it is debatable if a nurse is ever a finished product, regardless of how long they have practiced.

In their study, Maben and Clark found students thought the transition was 'terrifying,' 'distressing,' 'stressful', and 'absolute hell.'[450] Many Project 2000 graduates were anxious over the quality of their practical skills, with many criticisms of Project 2000 at the time, especially from practicing nurses and nurses in management positions on the wards, being the perceived lack of skills learnt by Project 2000 students compared to apprentice-trained nurses.[451] Also, many NQNs had to face the hostile views towards Project 2000 held by some nursing colleagues on the wards.[452] There were great expectations placed on Project 2000 NQNs; they were expected to be knowledgeable, analytical thinkers, demonstrate assertiveness in challenging colleagues from the beginning, and faced criticisms if they did not.[453]

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[448] Maben, J. &., Clark, J. M. (1998). Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing, 7*(2), 145-153. p.146.
[449] Ibid, p.150.
[450] Ibid, p.148.
[451] Ibid, p.150.
[452] Ibid, p.149.
[453] Ibid, p.149.

Maben and Clark provide an excellent foundation as to why preceptorship was needed. Bukhari's 1998 PhD thesis concluded that 'preceptorship is important for integrating newly hired nurses into their new roles.'[454] Bukhari had worked as a qualified nurse for nine years on a paediatric surgical unit and witnessed first-hand how NQNs had had problems integrating into the clinical area without support and guidance. Bukhari's sentiments have been echoed by many others, including Kaviani and Stillwell and Guhde, who argued that preceptorship had proven effective in socialising NQNs into their new clinical environments.[455] Through preceptorship, many NQNs were found to have fostered greater professional development, and preceptorship had enhanced their confidence in applying knowledge and skills taught during their training.[456] The goal was for preceptorship to mould the NQNs from well-educated students to autonomous practitioners competent in using their nursing knowledge to practice.[457] Project 2000 was attuned to the fact that students and NQNs needed more support than before. Thus, a system of support was required to navigate students through experiences not traditionally associated with nurse training. The evidence presented in this chapter suggests that overall, mentorship and preceptorship were successes of Project 2000.

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[454] Bukhari, E. A. (2011). *Nature of Preceptorship and its Impact on Clinical Nursing Care from the Perspectives of Relevant Nursing Staff* [PhD Thesis]. Manchester: University of Manchester. p.11.

[455] Kaviani, N. &., Stillwell, Y. (2000). An evaluative study of clinical preceptorship. *Nurse Education Today*, 20(3), 218-226.; Guhde, J. (2005). When Orientation Ends…Supporting the New Nurse Who is Struggling to Succeed. *Journal for Nurses in Staff Development*, 21(4), 145-149.

[456] Bourbonnais, F. &., Kerr, E. (2007). Preceptoring a student in the final clinical placement: reflections from nurses in a Canadian Hospital. *Journal of Clinical Nursing*, 16(8), 1543-1549.

[457] Bukhari, E. A. (2011). *Nature of Preceptorship and its Impact on Clinical Nursing Care from the Perspectives of Relevant Nursing Staff* [PhD Thesis]. Manchester: University of Manchester. p.42.

Chapter 5:
How the drive for perfection cursed Project 2000

Project 2000 was not perfect. In fact, in some areas, the reforms were far from ideal and fell

short of the promises and intentions of the 1986 proposals. Historically, any major changes

in nursing have always been hard-won victories, fought in the face of stereotypical images

of nursing, both within and outside the profession.[458] Nursing is a traditionalistic profession

that does not relish change, some nurses on the wards were naturally hostile towards

Project 2000.[459] This is not to discredit their negative feelings. For much of the late 1980s,

Project 2000 was being promoted by nursing's leadership and nursing print outlets as the

solution to all the problems endured under the apprenticeship system. For many, this was

not just an affront to their training and their mentors but also themselves. Equally, Project

2000 was being presented as changing the fundamentals of nursing, which for many, was

the reason they entered nursing.[460] For these reasons, ill-feeling can be justified.

Parts of these ill-feelings and hostilities arguably emerged even before the implementation

and led to a pre-determined judgement within professional circles that Project 2000 would

fail. As such, it is highly plausible to claim that the scheme was not given a fair chance to

make the mistakes commentators at the time dubbed as inevitable with any

change.[461] Project 2000 had the monumental task of linking two very distinct worlds

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[458] Robinson, J. E. (1993). All Change - Project 2000's Greatest Challenge?. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 31-46). London: Scutari Press. p.31.
[459] Orr, J. (1990). Traditional v Project 2000 – something old, something new. *Nurse Education Today*, 10(1), 58-62.
[460] Robinson, J. (1991). Project 2000: the role of resistance in the process of professional growth. *Journal of Advanced Nursing, 16*(7), 820-824.
[461] Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256. p.250.

together - the clinical environment and higher education - not previously done on a universal scale in nursing.[462] While it is clear that the UKCC did not fully understand the complexities of the transition into H.E, there was no obvious blueprint for the profession to follow.[463]

This chapter will explore the perceived failings of Project 2000. It will examine the role of the hostilities towards Project 2000 and its effects on things like socialisation, which were key for students to integrate into the profession. Similarly, this study will investigate how well nurse training merged with H.E, and the problems that arose and the difficulties faced by nurse tutors that Project 2000 was wholly unprepared for. This chapter will also present a verdict on the theory-practice gap, and the effect Project 2000 had on it.

The theory-practice gap

There has emerged a misconception that Project 2000 created the theory-practice gap. However, it had been a prominent feature of nurse education for years as the profession had struggled to merge theory and practice.[464] Nevertheless, while Project 2000 cannot be held responsible for creating the theory-practice gap, it should be critiqued for not eradicating it, and at times, widening the gap as it created a physical separation between

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[462] Charlwood, J. (1993). The Challenge of Higher Education. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 47-56). London: Scutari Press. p.53.
[463] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.23.
[464] Elkan, R. &., Robinson, J. (1995). Project 2000: a review of published research. *Journal of Advanced Nursing*, 22(2), 386-392. p.389.

theory and practice.[465] Project 2000 entrusted the theoretical side of training to higher

education and practical learning to the clinical environment. As a result, there was a distinct

separation between those who taught the course with academics operating solely in H.E.

and mentors and preceptors spending much of their time in clinical practice.[466]

Allmark and Rafferty have both made convincing arguments for the planners and

implementors not understanding the variability and complexity of the clinical environment,

which had further widened the theory-practice gap.[467] For Roxburgh, while Project 2000

was a heavily research proposal, its one major failing was in not thoroughly preparing nurses

for the wards.[468] While the gap is inevitable, with Karen Ousey stating that 'total elimination

of the gap may be an unrealistic goal', Project 2000 should have included more provisions to

intertwine both concepts better.[469] In response to the growing awareness that theory and

practice needed to be linked better, Barnum asserted that the curriculum should emphasise

that theory formed the basis of evidence-based practice.[470] In general terms, the theory-

practice gap exposed the discrepancies between what probationers were taught in the

classroom and what they experienced on clinical placement.[471] Maben, Latter and Clark's

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[465] Ousey, K. (2000). Bridging the theory-practice gap? The role of the lecturer/practitioner in supporting pre-registration students gaining clinical experience in an orthopaedic unit. *Journal of Orthopaedic Nursing*, 4(3), 115-120. p.115.

[466] Jarvis, P. &., Gibson, S. (1985). *The Teacher Practitioner in Nursing, Midwifery and Health Visiting*. London: Croom Helm.

[467] Allmark, P. (1995). A classical view of the theory practice gap in nursing. *Journal of Advanced Nursing*, 22(1), 18-23.; Rafferty, A. M. &., Allcock, N. &., Lathlean, J. (1996). The theory/practice gap: taking issue with the issue. *Journal of Advanced Nursing*, 23(4), 685-691.

[468] Roxburgh, M. &., Watson, R. &., Holland, K. &., Johnson, M. &., Lauder, W. &., Topping, K. (2008). A review of curriculum evaluation in United Kingdom nursing education. *Nurse Education Today*, 28(7), 881-889. p.887.

[469] Ousey, K. (2000). Bridging the theory-practice gap? The role of the lecturer/practitioner in supporting pre-registration students gaining clinical experience in an orthopaedic unit. *Journal of Orthopaedic Nursing*, 4(3), 115-120. p.116.

[470] Barnum, B. S. (1998). *Nursing theory: analysis, application, evaluation*. Philadelphia: Lippincott. p.45.

[471] Corlett, J. (2000). The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education. *Nurse Education Today*, 20(6), 499-505. p.499.

work found that while Project 2000 students emerged from their H.E courses 'with a strong set of nursing values', they were sabotaged by clinical practice continuing to operate under the traditional covert nursing rules.[472] These included hurrying physical care to move onto the next task as not to be seen as shirking their duties, often feeding into the myth that a quick nurse is a good nurse and that handing over duties to the next shift was a sign of inefficiency.[473]

Earlier works, such as Bendall's and Melia's, drew attention to the fact that what nurses were taught in the classrooms did not always correlate to how they could practice on the wards, an issue Project 2000 did not resolve.[474] Indeed, by the early 2000s, Maben et al. found that nurses were still struggling with the compromise of practicing effectively, as had been shaped by the theoretical input of the classroom, and practicing efficiently, as the busy ward demanded.[475] In Davina Allen's words, the theory-practice gap suggests that Project 2000 failed at minimising the mismatched culture and ideas between theory and practice that acted as a primary contributor to chronic practitioner dissatisfaction.[476]

Project 2000 emphasised the importance of theoretical learning as it was the key to the UKCC fulfilling their intention of creating knowledgeable practitioners. However, in Jowett, Walton, and Payne's study, several students reported their thought that the theoretical

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[472] Maben, J. &., Latter, S. &., Clark, J. (2006). The theory-practice gap: impact of professional-bureaucratic. *Journal of Advanced Nursing, 55*(4), 465-477.

[473] Ibid, pp.470-1.

[474] Bendall, E. (1976). Learning for Reality. *Journal of Advanced Nursing, 1*(1), 3-9.; Melia, K. M. (1987). *Learning and Working: The Occupational Socialisation of Nurses*. London: Tavistock.

[475] Maben, J. &., Later, S. &., Clark, J. (2006). The theory-practice gap: impact of professional-bureaucratic. *Journal of Advanced Nursing, 55*(4), 465-477. p.466.

[476] Allen, D. (2004). Re-reading nursing and re-writing practice: towards an empirically based reformulation of the nursing mandate. *Nursing Inquiry*, 11(4), 271-283. p.283.

components had 'swung too far' in terms of content, and they felt the course was so broad that it only offered superficial insights into topics.[477] On the other hand, many topics regarded as irrelevant or not as important as others were covered too much, including the psychology, sociology, and legal and ethical studies, mainly due to perceived poor teaching.[478]

Moreover, in studies conducted in the 1990s, it was revealed that many students struggled with the academic components of the Project 2000 curriculum. Stress has always been a prominent feature of nurse training. However, in Lindop's 1999 study comparing the stress of pre-and post-Project 2000 students, it was revealed that the educational environment contributed to more significant amounts of immense stress.[479] As well as the always present demands of clinical placements, students were burdened with the stress and pressure of the amount and intensity of workloads, exams and the level of academic attainment required for qualification.[480] Simply, Lindop asserts that the Project 2000 theory elements made students exhausted.[481] As it is doubtful this was intentional on the part of the planners, it indicates that not enough time or thought had been put into planning the realities of the two very distinct elements of the course, with probationers experiencing stress from both sides.

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[477] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. pp.45-6.

[478] Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256. p.250.

[479] Lindop, E. (1999). A comparative study of pre-and post-Project 2000 students. *Journal of Advanced Nursing,29*(4), 967-973. p.970.

[480] Ibid, p.970.

[481] Ibid, p.970; p.971.

Lindop's recommendation that educationalists needed to reflect better on the demands of the Project 2000 curriculum in relation to students feeling overworked rings true in other studies.[482] For instance, Braithwaite found that many probations belonging to the traditional demographic nursing attracted dropped out of the Project 2000 course because of the theoretical content of the course.[483] This led to non-traditionalist recruits coming into nursing as many conventional recruits felt the reforms put them at a disadvantage. Kevern, Ricketts and Webb found that mature students struggled greatly under Project 2000 as they usually lacked many of the educational qualifications held by younger recruits.[484] Moreover, younger students were too likely to drop out due to the academic difficulty of the course, as many did not anticipate the educational emphasis of theory.[485] Frankly, the theory-practice gap added to the staffing crisis. Nursing's leaders and the Department of Health had hoped that the focus on theory would attract a higher calibre of nursing recruit.[486] This hypothesis was partly disproven by Davies who confirmed in her 2000 study that the reforms did not attract more academic recruits, significant as Project 2000 was intended to have reformed nurse training by the turning of the millennium.[487]

Similarly, a 1989 study conducted by Crabbe found that many of the positive reactions to Project 2000 were related to producing a more intelligent nurse, encouraging research in nursing, and shifting the focus of practice away from curing to preventative care.[488] The

[482] Ibid, p.973.

[483] Braithwaite, D. N. &., Elzubier, M. &., Stark, S. (1994). Project 2000 student wastage: a case study. *Nurse Education Today*, 14(1), 15-21. p.15.

[484] Kevern, J. &., Ricketts, C. &., Webb, C. (1999). Pre-registration diploma students: a quantitative study of entry characteristics and course outcomes. *Journal of Advanced Nursing, 30*(4), 785-795. p.787.

[485] Ibid, p.785.

[486] Davies, C. &., Stilwell, J. &., Wilson, R. &., Carlisle, C. &., Luker, K. (2000). Did Project 2000 nurse training change recruitment patterns or career expectations?. *Nurse Education Today, 20*(5), 408-417. p.408.

[487] Ibid, p.408.

[488] Crabbe, G. (1989). Staying the course. *Nursing Times, 85*(37), 33-36.

professions leadership hypothesised that Project 2000 would put nursing on a better career

path and improve nursing's professional standing, in spite of the interjections that a more

intelligent nurse does not make a better one.[489] Indeed, Parker and Carlisle argued that

under Project 2000, many of the vocational elements of nursing were lost.[490] Moreover, for

many, they entered nursing to practice as a nurse, not to study in higher education. Project

2000, therefore, missed the mark and did not reflect this. Project 2000 tried to change too

much too soon. While albeit necessary, in one gust, the reforms transformed nurse training

from being training and service orientated to being an educational model.[491] Equally, Project

2000 failed to consider the attraction of nursing and thought, rather deludedly, that recruits

would choose nursing regardless of such changes. As a result, it meant that the reforms

failed at improving the previously poor retention rates.[492]

The misconception of Project 2000 creating the theory-practice gap has overshadowed the

real issue. While it existed under the previous system, the practical skills held by apprentice

nurses had always been a hallmark and praiseworthy element of the scheme. However,

under Project 2000, the expansion of theory with the link to H.E was to the detriment of

clinical skills learnt on placement.[493] As stated by students, Project 2000 tried to squeeze as

much into the curriculum as possible. Still, there was an assumption that Project 2000

nurses were more theoretical thinkers and considered more intelligent. This is a positive

[489] Davies, C. &., Stilwell, J. &., Wilson, R. &., Carlisle, C. &., Luker, K. (2000). Did Project 2000 nurse training change recruitment patterns or career expectations?. *Nurse Education Today, 20*(5), 408-417. p.408.
[490] Parker, T. J. &., Carlisle, C. (1996). Project 2000: students' perceptions of their training. *Journal of Advanced Nursing, 24*(4), 771-778. p.772.
[491] Lathlean, J. &., Vaughan, B. (1994). *Unifying nursing practice and theory*. Oxford: Butterworth Heinemann.
[492] Parker, T. J. &., Carlisle, C. (1996). Project 2000: students' perceptions of their training. *Journal of Advanced Nursing, 24*(4), 771-778. p.772.
[493] Hickey, G. (1996). The challenge of change in nurse education: traditionally trained nurses' perceptions of Project 2000. *Nurse Education Today, 16*(6), 389-396. p.391.

that has often been sacrificed in favour of literature focusing on the negatives, in this case, reducing ward time and practical skills. This is further proof that nursing operates in impossible circumstances as there is likely no perfect medium in nurse training. Project 2000 recognised that modern nurses needed strong educational foundations for their practices; thus, theoretical learning was expanded. Yet, more theory meant less practice and any reversal would too be criticised. It appears that the narrative in nursing is naturally pessimistic.[494] This is hardly surprising when nurses are often overlooked, overworked and underpaid. Yet, the focus on the theory-practice gap has deterred from recognising that Project 2000 did succeed in its intention of creating more knowledgeable nurses by expanding theory in the nursing curriculum.

Socialisation

Professional socialisation is the process by which individuals, in this case, students and newly qualified nurses, learn the culture of the profession and the values and attitudes that make nursing distinct.[495] Socialisation has always been crucial to nurses assimilating into the profession and the clinical environment they belong to. Socialisation provides a reality-based image of nursing often not provided by theory. However, while it has been the most effective way of introducing students and NQNs to the realities of a career in nursing, it has not always been a benefit. Many students were encouraged by H.E tutors to be agents of change and to inspire change in clinical practice; however, socialisation often acted in direct opposition to that.

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[494] Ibid, p.392.
[495] Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647. p.640.

Several papers have looked at the impact of occupational socialisation of nurses on Project 2000 and are united in their conclusion that socialisation hindered the implementation and success of Project 2000. Gray and Smith investigated professional socialisation in relation to the H.E diploma nursing course.[496] Their results were drawn from a three-year longitudinal study that adopted grounded theory.[497] Seventeen students were involved, ten being interviewed on five separate occasions and kept a diary on their mentorship experiences.[498] Another seven wrote a diary strictly on their experiences of supernumerary status.[499] Gray and Smith chose their students from the third Project 2000 cohort to diminish comments regarding the initial teething problems that had characterised studies of the first cohort undertaken by Bradbury and Soothill, and May et al.[500] Responses to the survey reflected initial naivety that they would be the primary concern of the mentor and staff on the ward. However, one student commented that those thoughts were soon forgotten as 'you certainly soon realise…that you are one of the many pressing priorities' of ward staff.[501] As such, students were expected to act like the nurses on the ward and rush duties and often neglect the psychological elements of care that their course reinforced was an essential aspect of care. Students were expected to practice under the influence of their mentor's preference and conform with the ward order.[502] In response, they were rewarded with

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[496] Ibid, p.639.
[497] Ibid, p.640.
[498] Ibid, p.639.
[499] Ibid, p.639.
[500] Ibid, p.639.; Bradbury, M. &., Soothill, K. (1993). From common foundation programme to branch: recognising a status transition. *Nurse Education Today*, 13(5), 362-368.; May, N. &., Veitch, L. &., McIntosh, J. B. &., Alexander, M. F. (1997). *Preparation for Practice Evaluation of Nurse and Midwife Education in Scotland*. Glasgow: Department of Nursing and Community Health, Glasgow Caledonian University.
[501] Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647. p.641.
[502] Ibid, p.642.

being treated as part of the team, treated like a real nurse, and, if they conformed, they

were more likely to have a good placement as conformity reduced stigma of the

supernumerary status and hostilities towards the reforms generally.[503]

Socialisation introduced students and NQNs to the traditional practices of nursing.[504] As

mentioned, the realities of the ward conflicted with the hypothesised image of nursing

presented in classrooms, and during socialisation, students were caught between wanting

to practice under the idealised images of the profession and how they were expected to

practice on the wards by busy staff.[505] Philpin found that socialisation was harsher in acute

settings, including acute wards, operating theatres, high dependency units and surgical

wards. Moreover, while positive reinforcement was used widely in most training settings,

the acute wards in Philpin's study dispatched negative sanctions to ensure compliance with

the traditional elements of nursing.[506] Ultimately, as Philpin reports, the hospital is an

institution entirely separate from higher education. Therefore, the hospital was largely

isolated from new teachings in nursing as within it, students and NQNs, like those before

them, were expected to learn the various formal and informal rules and regulations of the

institution.[507] Any encouragement of change was believed by many to be rocking the boat,

and in the hospital setting, conformity was valued above going against the grain.[508]

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[503] Ibid, p.642.

[504] Philpin, S. M. (1999). The impact of 'Project 2000' educational reforms on the occupational socialisation of nurses: an exploratory study. *Journal of Advanced Nursing*, 29(6), 1326-1331. p.1326.

[505] Ibid, p.1327.

[506] Ibid, p.1326.

[507] Ibid, p.1327.

[508] Maben, J. &., Latter, S. &., Clark, J. (2006). The theory-practice gap: impact of professional-bureaucratic. *Journal of Advanced Nursing, 55*(4), 465-477. p.471.

The way people are socialised into a profession is crucial to the development of the profession.[509] It is important to remember that socialisation has the power to advocate reform and the abolition of outdated practices and values.[510] For instance, Fitzpatrick et al., and Beech and Brickbank and Stevens and Crouch all argued that socialisation could profoundly influence the future of nursing practices.[511] However, compliance has become a requirement for nurses and an irremovable constraint on the profession.[512] The expectation that nurses think and act the same could be driven by the reality that nursing is not a homogenous profession.

Nevertheless, it has persevered, and under Project 2000, there was widespread disapproval of things like supernumerary status in some settings. In her interview, Alexandra stated that some of the qualified nurses on the wards 'made nasty comments about Project 2000 and things like our supernumerary status.'[513] She said that she, alongside many others, 'were told we were expected not to rise to it...so basically, it was accepted that that was not professional behaviour, but we had to just put up with it,' and admitted that by her third year, ' I was sick of it, it was cruel sometimes and got to me.' Nevertheless, while there were many socialisation-related negatives attached to it, Alexandra admitted, 'we did see the

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[509] Tooth, B. (1996). Group continuing: the impact of professional training. In KaleKein-Fishman, P. & Walker, B.M. (Ed), *The Construction of Group Realities: Culture, Society and Personal Construct Theory*. Florida: Kriegar Publishing Company.

[510] Mackintosh, C. (2000). Is there a place for 'care' within nursing?. *International Journal of Nursing Studies*, 37(1), 321-327.

[511] Fitzpatrick, J. M. &., While, A. E. &., Roberts, D. (1996). Key influences on the professional socialisation and practice of students undertaking different pre-registration nurse education programmes in the United Kingdom. *International Journal of Nursing Studies*, 33(5), 506-518.; Beech, N. &., Brockbank, A. (1999). Power/knowledge and psychosocial dynamics in mentoring. *Management Learning*, 30(1), 7-25.; Stevens, J. &., Crouch, M. (1995). Who cares about care in nursing education?. *International Journal of Nursing Studies*, 32(2), 233-242.

[512] Kenny, G. &., Pontin, D. &., Moore, L. (2004). Negotiating socialisation: the journey of novice nurse academics into higher education. *Nurse Education Today*, 24(8), 629-637. p.632.

[513] Alexandra. (2021, 30 January). *Oral History Interview. Interviewed by K. Swaby*. [Leeds]. (See Appendix 13).

advantages of it [supernumerary status] later on' as it had allowed her time to observe

qualified professions and watched them perform technical and skilled tasks. Catherine

echoed much of Alexandra's exacerbated feelings towards the hostility Project 2000

students faced on the wards. Catherine felt that socialisation grew out of fear for change

and many of the traditionally trained nurses saw 'us [Project 2000 students] as a threat...in

their eyes, we were 'wannabe docs [doctors]' and not real nurses like they thought they

were.' As a consequence, she states that 'very few nurses were interested in us because we

were supernumerary and many believed we weren't contributing and just took up their

time, but all we were doing was trying to learn and be the best nurses we could be.'[514] The

majority of staff on the wards had been rostered students, and for that reason, there were

misconceptions perpetuated by socialisation that students were not learning, that they

were not doing anything and were a hindrance.[515] Marrow and Tatum researched student

supervision on the wards.[516] They disclosed that staffing numbers largely directed the

quality of supervision and the relationship between student and supervisor.[517] When

staffing was low, and demand was high, tasks were shown to students haphazardly, with

little explanation and rarely broken down.[518] In fact, Marrow and Tatum's conclusion

reflects many others that placements and supervision are not effective or efficient when

staffing is low.

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[514] Catherine. (2021, 23 January). *Oral History Interview. Interviewed by K. Swaby*. [Sheffield]. (See Appendix 14).

[515] Clark, J. M. &., Maben, J. &., Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Preparation for practice. *Journal of Advanced Nursing, 26*(2), 246-256. p.249.

[516] Marrow, C. E. &., Tatum, S. (1994). Student supervision: myth or reality? *Journal of Advanced Nursing*, 19(6), 1247-1255.

[517] Ibid, p.1252.

[518] Ibid, p.1253.

Out of this thinking emerged the opinion that Project 2000 nurses were not skilled practitioners, or at least not as skilled as apprentice nurses.[519] While there is an element of truth to that claim, it was used more widely under socialisation to present Project 2000 as a failure. Indeed, many students at the time were often dismayed by the quick write-off of Project 2000 by many, with one respondent to Gray and Smith's study saying, 'it annoys me intensely when I hear it being said…I think it's a handy peg to hang their hang-ups about the course on.'[520]

The economics of Project 2000

The implementation of Project 2000 went on to impact its success, and the primary element of the implementation was the funding. Simply, the funding would make or break Project 2000.[521] It is remarkable that despite Project 2000 being taught along educational lines and recognised as necessary, financial corners were cut by the Department of Health at every possible opportunity as the educational need came second to the finances available.[522]

As Chapter 1 explains, the Project 2000 reforms were being introduced during a period of cost-cutting and privatisation.[523] John Bourn's 1992 report commissioned by the House of

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[519] White, E. &., Davies, S. &., Twinn, S. &., Riley, E. (1993). *A Detailed Study of the Relationships Between Teaching, Support, Supervision and Role Modelling for Students in Clinical Areas, Within the Context of Project 2000 Courses*. London: English National Board for Nursing, Midwifery and Health Visiting.

[520] Gray, M. &., Smith, L. N. (1999). The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3), 639-647. p.644.

[521] Cheung, P. (1992). Delivering the goods: resource management for Project 2000. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak: Innovations in the Nursing Curriculum*. (pp. 156-165). Edinburgh: Campion Press. p.157.

[522] Ibid, p.157.

[523] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.125.

Commons on the implementation of Project 2000 explores the reality that NHS funding was competitive.[524] Bourn mentions how the NHS employed approximately 400,000 nurses at the cost of £5 billion per year, and as of 1992, there were around 50,000 student nurses training at the expense of £600 million per year.[525] To implement Project 2000 fully, the Department of Health estimated it would cost £580 million over fourteen years.[526] These were daunting figures, but in Bourn's report, it becomes clear the government was desperate to lower the costs. Bourn states that the reforms would be implemented 'depending on the availability of funds.'[527]

Moreover, Bourn asserts that the 'constraints of public expenditure' in the planning of Project 2000 'made it difficult for the Department of Health to establish a firm implementation timetable.'[528] This mirrors the vague approach undertaken by the UKCC, but in the government's case, it was used to not commit the state to provide a promised level of funding. An example of this occurred in 1993 when the Health Department went into the financial year without knowing precisely how much funding they would provide to health authorities to implement Project 2000.[529] This was after the Department of Health allocated a massive £207 million to support the implementation in 64 colleges following the graduation of the first cohort in 1992.[530]

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[524] Bourn, J. (1992). *Nursing Education: Implementation of Project 2000 in England.* London: National Audit Office.
[525] Ibid, p.1.
[526] Ibid, p.1.
[527] Ibid, p.1.
[528] Ibid, p.2.
[529] Ibid, p.2.
[530] Ibid, p.2.

As Project 2000 was a radical and costly change, it is natural there would have been enquiries into efficiency and value for money.[531] This is how Bourn present's his government-commissioned report, but his words point to a different intention – the government beginning to withhold funds, plausibly as they had finally woken up to the cost of change. Jowett's report exposes how the lack of adequate funding hindered the implementation.[532] Jowett et al. exposed how Project 2000 was being hastily implemented to the detriment of the ideas that drove change.[533] Jowett argues that it was the rush to implement Project 2000 to likely save funds that resulted in issues with mentorship, preceptorship, low staffing levels and a poor skill mix on the wards.[534] Funding was available for new support staff to replace supernumerary students, but no financial provisions were available for the training of new nursing assistants, and little was made available for the training of mentors, preceptors and supervisors.[535]

As early as 1992, plans to make savings were already being made.[536] This was right at the moment when Project 2000 was emerging from its first cohort and in a position to improve and correct the teething problems that had emerged. However, Project 2000 was moving into the phase where the availability of funds would determine any change.[537] For many, including Diane Marks-Maran, a senior tutor at St Bartholomew's Hospital, believed that the

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[531] Ibid, p.5.

[532] Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales.

[533] Ibid, p.13.

[534] Ibid, p.16.

[535] Ibid, p.16.

[536] James, J. &., Jones, D. (1992). Education for the future: meeting changing needs. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak – Innovations in the Nursing Curriculum*. (pp.11-25). Edinburgh: Campion Press. p.22.

[537] Cheung, P. (1992). Delivering the goods: resource management for Project 2000. In O. Slevin, & M. Buckenham (Eds.), *Project 2000: The Teachers Speak: Innovations in the Nursing Curriculum*. (pp. 156-165). Edinburgh: Campion Press. p.157.

government was trying to scupper the Project 2000 plans because they were extensive.[538]

Marks-Maran pointed to a letter issued by the Department of Health as the basis for her fears. The letter stated that the government had misunderstood the full scale of the costs around implementation.[539] Fears over the government retreating from their commitments was widespread by many in nursing's leadership who had grown fond of Project 2000 and its intentions. Betty Kershaw, Director of Nurse Education at Stepping Hill and Margret Green, RCN Director of Education, were both worried that the government saw Project 2000 purely through a finance perspective.[540]

The lack of funding fed into many other issues Project 2000 encountered. Had the funds and provisions been available, staffing on the wards could have been sufficient to allow supervisors time to demonstrate tasks. Equally, mentors and preceptors could have been given the training required to meet students' needs. Proper funding would not have solved everything. There would always have been animosity in the transition from ward to higher education, there would always have been a resistance to change, and there would always have been socialisation. But it is clear that adequate funding could have eased pressure during the implementation.

Conclusion

Much of the criticism of Project 2000 has been drawn from the myth that the era before Project 2000 was the golden age of nursing. Ian Norman presented the idea that nursing's

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[538] Naish, J. (1990). Retreat from commitment. *Nursing Standard*, 4(35), 18-19. pp.18-19.
[539] Ibid, pp.18-19.
[540] Ibid, pp.18-19.

view of the pre-Project 2000 period is viewed through a jaundiced perspective.[541] Criticism of Project 2000 has centred around the assertion that Project 2000 nurses lacked skills and were overly educated. The off-the-cuff remark of Project 2000 nurses being 'too posh to wash' has come to characterise Project 2000 within the profession.[542] Many traditional and senior nurses struggling with staffing problems often embellished this view by harping back to the past. They reflected on the past through their rose-tinted glasses and glorified nurses as obedient, unquestioning, and conformist.[543] They were conveniently forgoing the parts where nurses were thought of as handmaidens, subservient and unthinking, while patients were subject to ritualist practices that had hardly changed since Nightingale's day.[544] Under Project 2000, students were transformed into knowledgeable practitioners who were competent at practicing in an ever-changing healthcare environment. As much as it is desirable for probationers to spend as much time on the wards as feasible, for nurses to be highly educated, they need to be based at a university.[545] It is the drive for perfection that has cursed nursing's attitude to education and reform, and because Project 2000 was not perfect, it was regarded as a failure. There has been an expectation that a nurse must have a complete skill set upon qualification, often forgetting that nurses never stop learning. It is in nurses' hostilities that it becomes clear that nursing's approach to Project 2000 was deeply embedded in the traditional values that were at the heart of nursing.

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[541] Norman, I. (2006). The good old days of nurse training: rose-tinted or jaundiced view? *International Journal of Nursing Studies*, 43(2), 135-137. p.135.

[542] Ibid, p.135.

[543] Ibid, p.135.

[544] Ibid, p.135.

[545] Patterson, C. (2012, April 11). Reforms in the 1990s were supposed to make nursing care better. Instead, there's a widely shared sense that this was how today's compassion deficit began. How did we come to this?. *The Independent.*

Much of the work investigating Project 2000 is from the 1990s, predominantly because it has been superseded by further educational reform proposals, including *Making a Difference* in 1999.[546] However, while Project 2000 was the name given to the proposal, it should also be recognised as a platform on which nursing would build. Project 2000 was as much about evolution as it was revolution. For this reason, many of the later proposals reflect the same policies as Project 2000. Maggie Lord's article discussing *Making a Difference* explains that it saw a reformed curriculum that strengthened nursing's ties to higher education.[547] The Peach Report, published the same year, had recommended curriculum reforms include shortening the CFP from 18-months to 12-months.[548] Making a Difference would also look to provide nurses with the skills so many were qualifying without.[549] One way of viewing these reports and programmes was to see it as fine-tuning Project 2000. While, Project 2000 had its flaws, Project 2000 was an initiative that was successful in forming a platform for future reform.

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[546] Department of Health. (1999). *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: Department of Health.
[547] Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times*, 98(20), 38. p.38.
[548] Roxburgh, M. &., Watson, R. &., Holland, K. &., Johnson, M. &., Lauder, W. &., Topping, K. (2008). A review of curriculum evaluation in United Kingdom nursing education. *Nurse Education Today*, 28(7), 881-889. p.882.
[549] Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times*, 98(20), 38. p.38.

Conclusion:
Project 2000 and the creation of the highly educated practitioner

The implementation of Project 2000 can be argued to have been one of the most important moments in nursing history. Project 2000 was a period of significant change for nursing. It changed how practitioners were trained, it changed the fundamentals of practice, and it changed how nursing care was delivered.[550] Project 2000 was the professions' 'high-wire act,' if, as John Naish says, the wire was tangled by squabbles, disagreements and broken promises from the government.[551] Nursing history is marred with stories of compromise. It is a history of struggle over triumph and often one of defeat. Still, it is largely dominated by accounts of individuals and leaders in the field, such as Nightingale, and defining moments like the Registration Act.[552] The profession has also been depicted as a collective of people driven by the ideals of vocation and altruism. Project 2000 challenged nursing's image of itself, and it challenged how many within the profession saw the future of nursing. The key intention for Project 2000 set by nursing's leadership and the government was to create a highly educated practitioner, a nurse who could carry out their traditional duties as well as have the knowledge base to specialise and adopt technological and diagnostic responsibilities.[553]

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[550] Kershaw, B. (1993). Foreword. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. ix-x). London: Scutari Press. p.i.

[551] Naish, J. (1990). Retreat from commitment. *Nursing Standard*, 4(35), 18-19. p.18.

[552] Kitson, A. (1996). Does nursing have a future?. *British Medical Journal, 313*(7072), 1647. p.1647.; Maggs, C. (Ed.) (1987). *Nursing History: The State of the Art*. London: Croom Helm. p.2.

[553] Thomas, J. &., Dolan, B. (1993). The Changing Face of Nursing - 2000 and Beyond. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 121-130). London: Scutari Press. p.123.

It was during the planning stages of Project 2000 that the phrase 'knowledgeable doer'

emerged in nursing discourse, but it aptly summarises what Project 2000 was trying to

achieve.[554] The UKCC stated that introducing the diploma would create 'a knowledge doer,

able to marshal information, make an assessment of need, devise a plan of care and

implement, monitor and evaluate it.'[555] Out of the increasing need for nurses in non-

traditional nursing roles grew a need for evidence-based practice, which would form the

bedrock of nursing.[556] The UKCC also intended for nurses to be fit for practice within a

multidisciplinary team. To do so, they required an intimate knowledge of nursing research

and evidence-based practice, and a rudimentary understanding of the role and

responsibilities of their colleagues. In this respect, nursing was taking inspiration from the

medical profession.[557] To be effective in this role, nurses needed to be firstly knowledgeable

and confident in their understanding of nursing but also flexible and adaptable.[558] These

intentions were largely met. Project 2000 produced more confident, analytical and assertive

nurses who defied the handmaiden image, but most importantly, studies conducted within

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[554] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A New Preparation for Practice*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting. p.40.; Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.3.

[555] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A New Preparation for Practice*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting. p.5.

[556] Davidoff, F. &., Haynes, B. &., Sackett, D. &., Smith, R. (1995). Evidence based medicine. *British Medical Journal*, 6987(310), 1085-6.; Deighan, M. &., Hitch, S. (1995). *Clinical Effectiveness: From Guidelines to Cost-Effective Practice*. Brentwood: Earlybrave Publications.; Batstone, G. &., Edwards, M. (1996). Professional roles in promoting evidence-based practice. *Management Review*, 2(3), 144-7.

[557] Heslop, A. &., Lathlean, J. (1991). Teaching and Learning. In J. Lathlean, & J. Corner (Eds.), *Becoming a Staff Nurse: A Guide to the Role of the Newly Registered Nurse* (pp. 98-128). London: Prentice Hall. p.117.

[558] Farrand, P. &., McMullan, M. &., Jowett, R. &., Humphreys, A. (2006). Implementing competency recommendations into pre-registration nursing curricula: Effects upon levels of confidence in clinical skills. *Nurse Education Today*, 26(2), 97-103. p.98.; Clark, J. M. (1998). Education for the future. *Nursing Management*, 5(2), 14-17. p.14.; Parker, T. J. &., Carlisle, C. (1996). Project 2000: students' perceptions of their training. *Journal of Advanced Nursing, 24*(4), 771-778. p.771.

the first two decades of the diploma's implementation indicated that Project 2000 nurses

were the highly educated, knowledgeable practitioners the planners intended.[559]

The Project 2000 proposal

Project 2000 was less successful when it came to the fine details. The proposals featured the

hopes and aims of Project 2000, but very little substance; hence there were issues with, for

instance, the training and preparing mentors and preceptors to equip them for their role.[560]

To a certain degree, healthcare is, and always has been, ever-changing; therefore, it is

impossible to plan every detail of reform minutely. However, Project 2000 was sold to

nurses, probationers and the public as the reform that would solve nursing's longstanding

educational deficiencies. It was sold as the plan that would put nursing on a solid

educational and professional footing. Simply, too much was riding on Project 2000 to be an

unequivocal success. The future of the nursing profession, nursing's leadership and the

government could not afford - educationally or financially - for Project 2000 not to fulfil its

intention to create a profession of highly educated, skilled and knowledgeable practitioners.

The profession needed to increase its academic standing significantly. From the 1950s to the

1980s, medical innovation was inseparably accompanied by doctors' lesser technical duties

being handed down to nurses.[561] Kraft argued that with rapid technological changes and

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[559] Kendrick, K. &., Simpson, A. (1992). The Nurses' Reformation: Philosophy and Pragmatics. In K. Soothill, C. Henry, & K. Kendrick (Eds.) *Themes and Perspectives in Nursing*. (pp. 91-101). London: Chapman & Hall. p.352.; Bartlett, H. P. &., Simonite, V. &., Westcott, E. &., Taylor, H. R. (2000). A comparison of the nursing competence of graduates and diplomates from UK nursing programmes. *Journal of Clinical Nursing*, 9(3), 369-381. p.371.
[560] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.36.
[561] Ibid, p.112.

advancements, patient acuity levels rose.[562] As such, nursing required a clinician who could

confidently differentiate and understand the multitude of modern ailments and be creative

in their approach to treatment.[563] Professionally, nursing was expanding beyond its

traditional practice boundaries. Medical advancements meant healthcare was becoming

knowledge-intensive, as such, nursing was becoming a more intellectually demanding

occupation.[564] Nursing was no longer a job simply directed by common sense and based

around un-complicated tasks under the orders of someone more senior.[565] Instead, nursing

was a profession that now required highly knowledgeable individuals who were increasingly

expected to make sophisticated decisions.[566] However, the issue was that such decisions

were being made with inadequate knowledge as the apprentice system appeared to be void

of a sound knowledge base from which probationers could be educated.[567] Therefore, the

training was being taught from an ideology based on largely unsubstantiated myths that

developed over generations.[568] Nursing practices taught to apprentice students may have

been relevant in the late nineteenth century but, by the mid to late twentieth century, when

nurses were expected to perform specialist duties, the apprentice model was inadequate for

preparing nurses for modern healthcare.[569] Consequently, many, including Bowman, have

argued that the apprentice model left longstanding educational shortcomings.[570]

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[562] Krafft, S. (1998). Faculty practice: why and how. *Nurse Educator*, 23(4), 45-48.

[563] Ibid, pp.45-48.

[564] Allen, D. (2015). *The Invisible Work of Nurses: Hospitals, organisation and healthcare*. London: Routledge. p.30.

[565] Norman, I. (2006). The good old days of nurse training: rose-tinted or jaundiced view? *International Journal of Nursing Studies*, 43(2), 135-137. p.136.

[566] Ibid, p.136.

[567] Ibid, p.136.

[568] Schrock, R. A. (1981). Philosophical Issues. In L. Hockey (Ed.), *Current Issues in Nursing*. (pp. 3-17). Edinburgh: Churchill Livingstone. p.14.

[569] Wells, T. (1980). *Problems in Geriatric Nursing Care*. Edinburgh: Churchill Livingstone.; Hamilton-Smith, S. (1972). *Nil by mouth*. London: Royal College of Nursing.; Wright, L. (1974). *Bowel Function in Hospital Patients*. London: Royal College of Nursing.; Lelean, S. (1973). *Ready for Report Nurse*. London: Royal College of Nursing.

[570] Bowman, M. (1995). *The Professional Nurse: Coping with Change, Now and the Future*. London: Chapman & Hall. p.139.

These educational shortcomings had permeated into every area of nursing practice. Many

nurses working on the wards struggled under the burden of increased duties that required a

higher level of skills than they were taught, nor did the educational provisions in place at the

time allow them to expand their knowledge. Moreover, many nurses suffered from a lack of

confidence in decision-making and ability to think critically with most accepting outdated

practices un-questioningly, a serious issue for senior nurses in positions of authority and

responsibility, such as nurse managers.[571] The 1984 Code of Professional Conduct stipulated

that all registered nurses should maintain and improve their professional knowledge.[572]

However, the lack of a nursing-specific knowledge base, the absence of a higher education

presence and the limitations of advanced nursing courses meant nurses accessed ad hoc

training, and nursing knowledge was grossly unequal.[573] Ultimately, the profession was

trapped in its own traditions.

The apprentice model was well equipped to teach the practical aspects of nursing, but the

traditional method fell short of educating probationers. Project 2000 exemplified the

significant difference between education and training; training relates to the acquisition of

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[571] Maben, J. &., Clark, J. M. (1998). Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing, 7*(2), 145-153. p.146.
[572] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1984). *Code of Professional Conduct for the Nurse, Midwife and Health Visitor*. London: UKCC.; Hunt, G. &., Wainwright, P. (1994). *Expanding the Role of the Nurse: The Scope of Professional Practice*. Oxford: Blackwell Science. pp.41-2.
[573] Myco, F. (1980). Nursing research information: are nurse educators and practitioners seeking it out? *Journal of Advanced Nursing*, 5(6), 637-46.; Barnett, D.E. (1981). Do nurses read. *Nursing Times*, 77(50), 2131-4.; O'Brien, D. &., Heyman, B. (1989). Changes in nurse education and the facilitation of nursing research: an exploratory study. *Nurse Education Today*, 9(6), 392-6.; Chiarella, M. (1990). Developing the credibility of continuing education. *Nurse Education Today*, 10(1), 70-73.; Studdy, S. &., Hunt, C. (1980). A computerised survey of learning needs. *Nursing Times*, 76(25), 1084-7.; Lathlean, J. &., Farnish, S. (1984). *Ward Sister Training Project. London*: Chelsea College, Nursing Education Research Unit.; Rogers, J. (1987). Limited opportunities. *Nursing Times*, 83(36), 31-2.; Clarke, J. &., Rees, C. (1989). The midwife and continuing education. *Midwives Chronicle*, 102, 288-90.; Mackereth, P. (1989). Investigation of the developmental influences on nurses' motivation for their continuing education. *Journal of Advanced Nursing*, 14(9), 776-87.

psychomotor skills, and education teaches the theory and desired outcomes of practice.[574]

The key to educating nurses lay in the transition to higher education. The move to higher education marked an emphasis on the acquisition of skills and knowledge.[575] The apprentice model was blinkered by its duty to prepare nurses practically for the clinical environment. The overbearing focus on practical training was believed to inhibit the individual's capacity to acquire knowledge and undermined the need for further learning.[576] However, higher education provided scope for interest, explanation and exploration.[577] Higher education also offered respect for probationers students who were still learning, something interview accounts of the apprentice system reveal had been deficient in the old-style training. The RCN came to recognise the value of the presence of higher education in training nurses. The RCN realised that the complexity of nursing required a level of knowledge and cognitive skills that corresponded to the objectives of degree-level education.[578] Ultimately, the move to higher education would put nursing on sound educational footing and produce of profession of highly educated practitioners. This, of all the issues confronting the profession, was the most important to tackle to provide the greatest long-term importance.[579]

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[574] Norman, I. &., Cowley, S. (1999). Preface. In I. Norman, & S. Cowley (Eds.), *The Changing Nature of Nursing in a Managerial Age*. (pp. iv-v). Oxford: Blackwell Science. p.126.; Fretwell, J. E. (1980). An inquiry into the ward learning environment. *Nursing Times*, 76(16), 69-73.; French, P. (1989). *An assessment of the pre-registration preparation of nurses as an educational experience*. [Unpublished PhD thesis]. Durham: University of Durham.

[575] Elliot, M. &., Wall, N. (2008). Should nurse academics engage in clinical practice. *Nurse Education Today*, 28(5), 580-587. p.581.

[576] Fish, D. &., Twinn, S. &., Purr, B. (1991). *Promoting reflection: improving the supervision of practice in health visiting and initial teacher training: how to enable students to learn through professional practice. Report No.2.* London: West London Institute of Higher Education.; Ogier, M. E. (1982). *An Ideal Ward Sister: A Study of the Leadership Style and Verbal Interactions of Ward Sisters and Nurse Learners in General Hospitals*. London: Royal College of Nursing.; Greenwood, J. (1993). *The apparent desensitisation of student nurses during their professional socialisation: a cognitive perspective.* Journal of Advanced Nursing, 18(9), 1471-9.

[577] Ramsden, P. (2003). *Learning to Teach in Higher Education*. London: Routledge.

[578] Taylor, J. &., Irvine, F. &., Bradbury-Jones, C. &., McKenna, H. (2010). On the precipice of great things: the current state of UK nurse education. *Nurse Education Today*, 30(3), 239-244. p.240.

[579] Hunt, G. &., Wainwright, P. (1994). *Expanding the Role of the Nurse: The Scope of Professional Practice*. Oxford: Blackwell Science. p.50.

The government too needed highly educated nurses. The government had recognised the value of the specialisation of nursing. The expansion of practice boundaries in the post-war period demonstrated that nurses could fulfil more specialist roles. The government needed a flexible nursing profession where its practitioners could match the changing needs of society.[580] As such, the government foreshadowed that nursing was intended to play an integral role in the future of the NHS. As part of the re-organisation of the NHS in the 1980s, the government sought new ways to deliver care.[581] With advancements in healthcare came more complex health conditions. Healthcare was seeing an increase in the levels of preventable mortality,[582] increasing levels of chronic illness,[583] and a population that was living significantly longer than before.[584] Treatments in acute medical settings were expensive, even short episodic stays in hospitals, and the state wanted cheaper ways to provide care.[585] The solution was to place increased importance on primary care and put nurse-led services and general practice, where nurses' contributions were becoming increasingly significant, at the heart of the NHS.[586] The passing of the NHS and Community Care Act in 1990 demonstrated the effort to place primary care at the forefront of healthcare provision meant the government needed a nurse who could act autonomously,

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[580] Taylor, J. &., Irvine, F. &., Bradbury-Jones, C. &., McKenna, H. (2010). On the precipice of great things: the current state of UK nurse education. *Nurse Education Today*, 30(3), 239-244. p.243.; Norman, I. &., Cowley, S. (1999). Preface. In I. Norman, & S. Cowley (Eds.), *The Changing Nature of Nursing in a Managerial Age*. (pp. iv-v). Oxford: Blackwell Science. p.141.

[581] Le Var, R. M. H. (1997). Project 2000: a new preparation for practice – has policy been realised? Part I. *Nurse Education Today*, 17(3), 171-177. p.173.

[582] Smith, A. &., Jacobsen, B. (1988). *The Nation's Health: A Strategy for the 1990s*. London: King's fund.

[583] Office of Population, Censuses and Surveys. (1987). *Population Projections No. 16*. London: HMSO.

[584] Office of Population, Censuses and Surveys. (1989). *Social Trends, No.19*. London: HMSO.

[585] Audit Commission. (1986). *Making a Reality of Community Care: A Report*. London: HMSO.

[586] Roland, M. &., Wilkin, D. (1996). Rationale for moving towards a primary care-led NHS. In R. Boyd (Ed.), *What is the Future for a Primary Care-Led NHS?* (pp. 6-14). Oxford: National Primary Care Research and Development Centre. p.7.; Miller, P. &., Craig, N. &., Scott, A. &., Walker, A. &., Hanlon, P. (1999). Measuring progress towards a primary care-led NHS. *British Journal of General Practice*, 49(444), 541-5.

independently, and competently. At the centre of that was a highly educated and knowledgeable nurse; simply, apprentice nurses did not have the educational training to provide such a service.

Project 2000's perception problem

Within the history of nursing, it appears Project 2000 has suffered a perception problem. Due to the exceedingly high expectations placed on Project 2000, any and all shortcomings were labelled failures. Many of the verdicts on Project 2000 were written within a decade of the implementation, some even within the first five years. This is despite several commentators, including Aggleton, Chalmers and Casey, declaring that even a decade after the implementation was still too early to evaluate Project 2000's impact on nursing practice fully.[587] Therefore, many issues that remained in nurse training or emerged under Project 2000, like the maintenance of the theory-practice gap and the rise of academic-related stress felt by student nurses, were deemed failures. However, much of the early criticism, which has dominated nursing history's presentation of Project 2000, is harsh and overly critical.

It appears many nurse-academics were looking for an excuse to dilute the credibility of Project 2000 as a necessary reform. The presentation of Project 2000 during the 1990s and early 2000s reflects Maggs' idea of different generations of nurses interpreting the past with varying objectives in mind.[588] We must remember when scrutinising the work of nurse

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[587] Aggleton, P. &., Chalmers, H. (2000). *Nursing Models and Nursing Practice*. (2nd Eds.) Basingstoke: Macmillan Press. p.7.; Casey, G. (1996). The curriculum revolution and Project 2000: a critical evaluation. *Nurse Education Today*, 16(2), 115-120.
[588] Maggs, C. (Ed.) (1987). *Nursing History: The State of the Art*. London: Croom Helm. p.4.

historians on Project 2000 that they were not dispassionate. They are all trained nurses, irrespective of whether they were still actively practicing, therefore, it is plausible that they felt a sense of protectiveness and ownership over the profession and demonstrated a natural degree of caution over the path nursing was going down. Moreover, many of the nurse-historians writing about Project 2000 were also influencing the on-going reforms. For instance, Celia Davies is referenced in this thesis, and during the roll out of the reforms she was Project 2000's project officer.[589] Therefore, their work should not be seen as separate to the Project 2000 reforms, but as part of the moulding. As such, those primary sources shed light on the mindset of many nurse commentators at the time.

It is apparent that Project 2000 was limited from the beginning, something that has been largely ignored by nursing historiography. This study has, therefore, re-evaluated much of the primary evidence that exists on Project 2000, including the original policy proposal, many of the studies conducted immediately afterwards, several government reports on the finances of Project 2000, and has added to the data by conducting interviews with nurses who trained under both the apprentice model and Project 2000 to gage a comparative insight.

The primary evidence has been amalgamated with the limited range of secondary evidence. Project 2000 was a contentious topic in the late 1980s and throughout the 1990s. However, with the re-branding of nursing education reform following the *Making a Difference* proposal, literature on Project 2000 is scarce, limited to a few publications providing an

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[589] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.35.

overview of the planning and implementation of Project 2000, such as Bradshaw's *The Project 2000 Nurse* and Dolan's *Project 2000 – Reflection and Celebration*.[590] Much discussion on Project 2000 since the early years of the millennium has centred on Project 2000 being earmarked in debates around the theory-practice gap and nursing's continued place in higher education as Project 2000. The Project 2000 changes were both revolutionary and evolutionary, and Project 2000 laid the foundations for evolutionary changes to perpetuate growth, development and movement within the profession and its professional boundaries.[591] Project 2000 created scope for nursing to be considered an all-graduate profession, which it became in 2009.[592] Moreover, since the turn of the century, nurses have entrenched themselves in primary care and nurse-led clinics. These nurses have come to be expected to hold advanced degrees, largely possible because Project 2000 based nurse education in universities where students and qualified nurses could continue their studies.[593]

Articles from the early years of Project 2000 reflect a hostile stance towards Project 2000, and due to the re-branding of nursing reform and the direct citing of later reforms, the profession's opinion of Project 2000 has remained hostile. Discussing how Project 2000 was viewed by the profession has been pivotal in nurse-academics writing their judgements on whether Project 2000 created a profession of highly educated practitioners. Significant

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[590] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers.; Dolan, B. (1993). *Project 2000: Reflection and Celebration*. London: Scutari Press.

[591] Kershaw, B. (1993). Foreword. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. ix-x). London: Scutari Press. p.1.

[592] Bernhauser, S. (2010). Degrees will equip nurses to meet future challenges in healthcare. *Nursing Times*, 106(21), 8. p.8.; Timmons, J. (2010). The debate for an all-graduate nursing profession. *Wounds UK*, 6(2), 140-143. p.140.; Department of Health. (2006). *Modernising nursing careers setting the direction*. London: Department of Health.

[593] Thompson, D. R. &., Astin, F. (2019). Education for advanced nursing practice worldwide – is it fit for purpose? *Heart and Lung*, 48(3), 176-178. p.177.

change can evoke excitement, but in nursing, change can conjure anxiety, stress, and fear.[594] For this reason, Project 2000, representing overhauling change, has continuing to be remembered negatively, spurring a propensity to focus on the negatives of the reforms. How Project 2000 has been recognised and written about is in stark contrast to *Making a Difference* and the reforms that have succeeded it, which have appeared digestible to the profession as they were small and logical changes. By *Making a Difference*, Project 2000 had already been in place for a decade, and the changes in *Making a Difference* appeared small in comparison.

Interviewing a select few of those who studied under Project 2000 and some who studied under the apprenticeship model provided a greater sense of clarity regarding the need for reform and the success and failures of the changes to nurse training under Project 2000. The interviews with the nurses who trained under the apprenticeship model offered a valuable insight into the content of the pre-Project 2000 nursing curriculum, the ethos of training, the aims and objectives of students and their mentors and the conditions of training. All of the apprenticeship trained nurses interviewed were still practicing when Project 2000 was introduced. Moreover, Victoria, Elizabeth, George, and Anne became practice educators. The final question of their interviews was: do you think Project 2000 improved nurse training? This question was open-ended as to allow the participants to be as open and free to declare a stance as they wished, and given the longevity of their careers (they are all still practicing today) in practice and clinical education, it provided this study with insight into a long-term perception of the reforms. Victoria reflected that she thought 'nursing is always

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[594] Kershaw, B. (1993). Foreword. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. ix-x). London: Scutari Press. p.i.

vulnerable to the latest big idea' and despite initially thinking that Project 2000 was a

'dismal failure… speaking 30 years later as a lecturer, and put in the context of a long

professional history it, despite all its failures, and despite some things about it not working, I

think it maybe did push the agenda forward for nurses and allow recognition for their

ability, it pushed the academic entry up…you know it started to allow people to

conceptualising nursing as a profession and as an educated profession.'[595] George shared a

similar stance. George remarked how the initial failings of Project 2000 appeared 'glaring'

and 'many really took them to define the entire programme of reform, and sometimes

nurses are their own worst enemy; some of the most vocal critics about Project 2000 had

been nurses.' However, '[Project 2000 was] definitely was for the better… I think that

nursing practice is a lot safer as a result of Project 2000 compared to what it was like before

when I trained and the practices I witnessed. And tutoring students now under the

programme we have gives me hope.'[596] Simply, the interviews with the apprentice-trained

nurses demonstrated what nurse training was like before the reforms, and the testimonies

of those who carried on their careers into nurse education provided a rarely heard

perspective on the history of nurse training.

The interviews with those who trained under Project 2000 provided some much-needed

accounts of the student experience. The limited history of Project 2000 is littered with

sociological studies that have tended to argue the successes and failures of Project 2000

based on statistics as opposed to the voices of those who trained under Project 2000. In

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[595] Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 15).

[596] George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield]. (See Appendix 16).

some ways, this has left a void in the history of Project 2000 and was one of the reasons why this study embarked on interviewing Project 2000 trained nurses. Like the interviews with the apprenticeship nurses, the discussions with the Project 2000 nurses added clarity to this study's understanding of the reforms. There was a mixture of responses from the group regarding whether it was explained to them that they were training under a ground-breaking curriculum change for nursing. Edward and Charlotte, who both began their training in 1990, attested to the idea that they felt 'part of this amazing new experimental progressive way of training nurses' while also facing hostilities from ward staff.[597] Their testimonies spoke to and informed the idea that many held high hopes for the potential of Project 2000, but that not all shared that aspirational hope in the profession and socialisation was a stumbling block to the early successes of Project 2000.

On the whole, many of the statements from the Project 2000 participants complimented and affirmed suggestions made by nurse-historians who have written on Project 2000. But, there were also very pleasant glimpses into the participants' mannerisms, attitudes, and personalities. For instance, William colloquially remembered the theoretical side of training as suffering 'death by PowerPoint' as they felt too much importance was placed on theory.[598] Ultimately, due to the assurances that anonymity would be guaranteed, and possibly because a fellow healthcare worker was interviewing them, their admissions were frank and provided a valuable insight into the Project 2000 reforms. Moreover, their testimonies offered useful perspectives in the debate of whether Project 2000 fulfilled the intention to create a profession of highly educated practitioners.

[597] Charlotte. (2021, 2 February). *Oral History Interview. Interviewed by K. Swaby*. [Leeds]. (See Appendix 17).
[598] William. (2021, 9 February). *Oral History Interview. Interviewed by K. Swaby*. [Manchester]. (See Appendix 18).

One stark issue that arose in the research for this study was the realisation that Project 2000 was handicapped from the very beginning by a lack of government funding – an issue sometimes overlooked in favour of exaggerating other problems with the reforms. Even before the implementation roll-out, the government were startled by the price tag associated with the widespread and overhauling reform of nurse training.[599] By 1992, as the first Project 2000 cohort was graduating, the British government sought to 'revise the financing and organisation of nursing education,' resulting in the speeding up of the implementation and reducing funding as much as possible.[600] The graduation of the first cohort marked a pivotal opportunity for the profession's leadership and government to correct the shortcomings of Project 2000. Still, just as the planners and the leadership would be in a prime position to improve the scheme, the government aimed to have Project 2000 fully implemented by the mid-1990s instead of the original 2000 deadline they initially anticipated it would take.[601] Project 2000, therefore, operated on a haste timetable with a skeleton budget. Project 2000 was not the immediate success nursing's leadership had hoped for, and the primary reason was its financial backing.[602] Simply, in the eyes of the British government, the importance of Project 2000 was overtaken by reforms elsewhere in the NHS, and nurse training remained focused on preparing nurses for practice as cheaply as

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[599] Bourn, J. (1992). *Nursing Education: Implementation of Project 2000 in England.* London: National Audit Office. p.5.
[600] Ibid, p.7.
[601] Ibid, p.13.
[602] Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times*, 98(20), 38. p.38.; Jolley, M. &., Brykczynska, G. (1993). *Nursing: its hidden agenda*. London: Edward Arnold. p.116.

possible.[603] It could be argued that nurse training was being left, similar to NHS organisations, to sink or swim.[604]

Project 2000 also ran up against the traditionalist hostilities of the profession as many apprentice-trained nurses swiftly rejected the relevance and possible benefits of nursing being taught in higher education.[605] While healthcare rapidly evolved throughout the mid-to late-twentieth-century, however, McGann, Crowther, Dougall, Davies and Maggs have argued that nursing appears to have remained stagnant and has an instinct for wanting to operate in isolation.[606] While it cannot be said nursing remained wholly oblivious to medical and scientific innovation and advancements as nursing was the most adaptable element of the NHS during its formative years, with nurses beginning to catheterise and administer intravenous infusions, previous a doctors responsibility.[607] However, the profession's leadership did not do enough to ensure nursing knowledge remained current and relevant to practice. Consequently, by the 1960s, it was glaringly apparent that nursing was falling behind other healthcare disciplines, and even more so concerning nursing elsewhere, such as the USA.[608]

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[603] McGann, S. &., Crowther, A. &., Dougall, R. (2009). *A History of the Royal College of Nursing 1916-1990: A Voice for Nurses*. Manchester; New York: Manchester University Press. p.305.; Hart, C. (2004). *Nurses and Politics: The Impact of Power and Practice*. Basingstoke: Palgrave Macmillan. p.241.

[604] Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform*. London: Stationary Office. p.29.

[605] Andrews, G. J. &., Brodie, D. A. &., Andrews, J. P. &., Hillan, E. &., Thomas, B. G. &., Wong, J. &., Rixon, L. (2006). Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies*, 43(7), 861-874. p.863.

[606] McGann, S. &., Crowther, A. &., Dougall, R. (2009). *A History of the Royal College of Nursing 1916-1990: A Voice for Nurses*. Manchester; New York: Manchester University Press. p.304.; Davies, C. (Ed.). (1980). *Rewriting Nursing History*. London: Croom Helm. p.122.; Maggs, C. (Ed.) (1987). *Nursing History: The State of the Art*. London: Croom Helm. p.4.

[607] Hughes, E. &., Hughes, H. &., Deutscher, I. (1958). *Twenty Thousand Nurses Tell Their Story*. Philadelphia: J.B. Lippincott.

[608] Elliot, M. &., Wall, N. (2008). Should nurse academics engage in clinical practice. *Nurse Education Today*, 28(5), 580-587. p.581.

Did Project 2000 fulfil the intention set out by nursing's leadership to create a profession of highly educated practitioners?

Project 2000 fulfilled the intention set by nursing's leadership. By the turn of the twenty-first century, having given the reforms a decade to settle, to improve on teething problems and show the benefits of a university-educated nursing profession, it was coming to be agreed, for some reluctantly, that the implementation of Project 2000 had been the right decision for the future of the profession.[609] Project 2000 nurses were in possession of a significant number of the qualities desired by the leadership and the government – effective diagnostic and communication skills, research awareness, and a high level of analytical and cognitive thinking ability – all things many apprentice-trained nurses lacked.[610]

There was a significant amount of trepidation associated with Project 2000. Many within the profession feared a reduction in the practical skills of the new generation of nurses. There is certainly credibility in the concern that the profession valued academic achievements over the development of skills.[611] However, some, including Fulbrook et al. appreciated that for a profession to evolve, it should be theory that leads the charge, not practices based on traditions and baseless perceptions of care delivery.[612] Project 2000 ensured that nurse

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[609] Fulbrook, P. &., Rolfe, G., &., Albarran, J. &., Boxall, F. (2000). Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today, 20*(1), 350-357. p.350.

[610] Ibid, p.350.; United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: A new preparation for practice*. London: UKCC.; Bartlett, H. P. &., Simonite, V. &., Westcott, E. &., Taylor, H. R. (2000). A comparison of the nursing competence of graduates and diplomates from UK nursing programmes. *Journal of Clinical Nursing*, 9(3), 369-381 .371.

[611] Gilmartin, J. (2000). Psychodynamic Sources of Resistance Among Student Nurses: Some Observations in a Human Relations Context. *Journal of Advanced Nursing*, 32(6), 1533-1541.; Freshwater, D. &., Stickley, T. (2004). The Heart of the Art: Emotional Intelligence in Nurse Education. *Nursing Inquiry*, 11(2), 91-98.

[612] Fulbrook, P. &., Rolfe, G. &., Albarran, J. &., Boxall, F. (2000). Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today, 20*(1), 350-357. p.356.

education maintained a close relationship with training and practice.[613] There was also an assertion perpetuated by many that Project 2000 created clinical practitioners who lacked confidence.[614] However, as noted, the history of Project 2000 is filled with opinions towards the scheme, as opposed to evaluations of the suitability of the course in fulfilling its intentions.[615] The *NHS Plan* recognised the many successes nurse education had made in the previous decade to meet the principal intention of the reforms.[616] By the early twenty-first century, the NHS was able to increase its capacity numbers due to nurses expanding their boundaries of practice on the basis of an improved educational foundation.[617] As a result of a better education, nurses could develop specialist skills and manage their own caseloads.[618] These nurses could order their own tests and investigations, run their own clinics, prescribe medication, send referrals, and work in various clinical settings, bringing both knowledge and practical skill.[619] In fact, by 2000, the nurse-consultant role had been created, and by 2004, there were 631 nurse-consultants in England.[620] By the *Modernising Nursing Careers* report, the Department of Health, the government had acknowledged that nurses were capable of leading a changed healthcare system.[621]

Project 2000 was not perfect. There were issues with Project 2000 students transitioning into qualified nursing. For periods of training, there were extended periods where students

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[613] Lord, M. (2002). Making a Difference: the implications for nurse education. *Nursing Times*, 98(20), 38. p.38.

[614] Ibid, p.38.

[615] Bradshaw, A. (2001). *The Project 2000 Nurse*. London: Whurr Publishers. p.58.

[616] Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform*. London: Stationary Office.

[617] Talbot-Smith, A. &., Pollock, A. M. &., Leys, C. &., McNally, N. (2006). *The New NHS: A Guide*. London: Routledge. p.152.

[618] Ibid, p.152.

[619] Ibid, p.152.

[620] Ibid, p.152.

[621] Department of Health. (2006). *Modernising nursing careers setting the direction*. London: Department of Health.

would go without patient contact.[622] Moreover, several studies expressed experiencing

stress and fear during their time in clinical practice.[623] But, one thing that has not been

appreciated enough is that no training method could fully prepare students for qualifying, as

many of the students in Gerrish's study, or those interviewed for this study, testified.[624] It is

a given that qualification will evoke anxiety as nurses adjust to their new responsibilities,

including the responsibility to save lives. However, several reports, including *Fitness for*

Practice, found that any skill deficit disappeared after three to six months.[625]

Project 2000 changed nursing indefinitely, but ultimately, the creation of a highly educated

nursing workforce changed the profession for the better. The reforms were poorly

understood by many both in and out of nursing.[626] The reforms were poorly sold to nurses,

many of whom feared their apprentice education would be valueless and felt neglected and

undervalued.[627] There was a lot of anger, and that anger translated into hostility towards

the programme and to some students with their new supernumerary status. This anger

infiltrated into writings of Project 2000 that has influenced the writing of nurse-academics

towards the reforms. However, the accepted impression of the scheme is, in part, nothing

more than a façade for nursing's insecurity over the diminishing of its century-old traditions

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[622] Fulbrook, P. &., Rolfe, G. &., Albarran, J. &., Boxall, F. (2000). Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today, 20*(1), 350-357. p.351.

[623] Maben, J. &., Clark, J. M. (1998). Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing, 7*(2), 145-153. p.148.; Jowett, S. &., Walton, I. &., Payne, S. (1994). *Challenges and Change in Nurse Education – A Study of the Implementation of Project 2000*. Slough: National Foundation for Education Research in England and Wales. p.93.

[624] Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing, 32*(2), 473-480. p.477.

[625] United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999). *Fitness for Practice. The UKCC Commission for Nursing and Midwifery Education*. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

[626] Dolan, B. (1993). Introduction. In B. Dolan (Ed.) *Project 2000: Reflection and Celebration: Reflection and Celebration*. (pp. 1-2.). London: Scutari Press. p.1.

[627] Naish, J. (1990). P2000 anger. *Nursing Standard*, 21(4), 24. p.24.

that were simply not fit for practice. Reform was urgently needed by the 1980s, and while Project 2000 was not perfect, it fulfilled its primary intention to create a highly educated profession. The progress nursing has made since the turn of the millennium has shown that nurses' capabilities are limitless because they have a sound, researched and evidence-based educational foundation to build on. Nursing has evolved into a profession that can provide the traditional care of Nightingale nurses as well as possess degree-level knowledge and a specialist skillset, all made possible because Project 2000 laid the foundations for nurses to develop into highly educated practitioners.

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Appendix

Oral history paperwork

Appendix 1: Introduction, page 20

<div align="center">

University of Huddersfield

School of Music Humanities and Media

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<div align="center">

<u>Participant Consent Form (E4)</u>

</div>

Title of Research Study:

Name of Researcher: Kelly Swaby (u1753030@hud.ac.uk)

Participant Identifier Number:

☐ I confirm that I have read and understood the participant Information sheet related to this research, and have had the opportunity to ask questions.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐ I understand that all my responses will be anonymised.

☐ I give permission for members of the research team to have access to my anonymised responses.

☐ I agree to take part in the above study

Name of Participant:

Signature of Participant:

Date:

Name of Researcher:

Signature of Researcher:

Date:

Appendix 2: Introduction, page 20

<p style="text-align:center; color:#4472C4;">University of Huddersfield</p>

<p style="text-align:center; color:#4472C4;">School of Music Humanities and Media</p>

<u>Participant Information Sheet</u>

Research Project Title: Did Project 2000 fulfil the intention set out by nursing's leadership to create a profession of highly educated practitioners
Name of Researcher: Kelly Swaby

Contact Details of Researcher: U1753030@hud.ac.uk

You are being invited to take part in a research project that will form an integral element of my postgraduate degree. Before you decide whether to take part it is important for you to understand why this research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Feel free to ask myself about anything that is not clear, or if you would like more information. May I take this opportunity to thank you for taking time to read this.

1. A brief outline of the research:
This study is investigating whether Project 2000 succeeded in its intention to create knowledgeable, skilled and competent nurses. Project 2000 marked a radical, and to an extent, revolutionary, change within nursing. Nurses would now be educated in universities, and clinical placements would be controlled and regulated as to make student nurses supernumerary. Project 2000 was met with resistance and scepticism from many within nursing, and this project seeks to examine whether the successes of Project 2000 were overshadowed by its poor implementation, lack of the economic resources behind it, the political backdrop of the period, and socialisation within the profession.

2. Why have I been chosen?

The ultimate judgement of whether Project 2000 was a success, through meeting the intentions set out to create a new generation of more knowledgeable, skilled and competent nurses than ever before is decided on opinion. This study will aim to demonstrate that the voices of the past are integral to informing the opinions of the present, therefore this research would like to consult your memories of Project 2000 and your training experiences more widely.

This research will use your voice as a facet to explore Project 2000, and your memories will inform this study as to how Project 2000 was implemented, how it compared to traditional nurse training, and whether you believe Project 2000 helped create a profession of highly educated clinicians.

3. Do I have to take part?

Participation on this study is entirely voluntary, so please do not feel obliged to take part. Refusal will involve no penalty whatsoever and you may withdraw from the study at any stage without giving an explanation.

4. What do I have to do?

You will be invited to take part in interview and/or questionnaire. This should take no more than 45 minutes of your time.

5. Are there any disadvantages to taking part?

There should be no foreseeable disadvantages to your participation. If you are unhappy or have further questions at any stage in the process, please address your concerns initially to myself (u1753030@hud.ac.uk) if this is appropriate. Alternatively, please contact Professor M. Adkins (m.adkins@hud.ac.uk) at the School of Music, Humanities and Media, University of Huddersfield.

6. Will all my details be kept confidential?

All information which is collected will be strictly confidential and anonymised before the data is presented in any work, in compliance with the Data Protection Act and ethical research guidelines and principles.

7. What will happen to the results of the research study?

The research used in this study forms the dissertation for my postgraduate degree. Therefore, the results of this research will be written up in a 25,000-word essay. If you would like a copy of the final edited piece, please feel free to ask.

8. What happens to the data collected?

The interviews will be digitally recorded. The file will be saved and stored on an external hard drive. All previous copies will be removed off said devices. Similarly, any and all transcripts of the interviews will be stored on the external hard drive. I will be the only person able to access the recordings.

For the questionnaires, it is much the same. The questions will be scanned and converted into PDF files and then stored on the external hard drive. The original paper copies will be shredded and recycled.

9. Will I be paid for participating in the research?

No payment will be made for participation in this study.

10. Where will the research be conducted?

The location of the interviews will be agreed to on a person-to-person basis owing to the COVID-19 restrictions. To the best of my ability, accommodations will be made to suit each individual.

11. Criminal Records check

I have active annual DBS checks done as part of my job within the NHS.

12. Who has reviewed and approved the study, and who can be contacted for further information?
The supervisor for this research is Professor Christine Hallett (c.hallett@hud.ac.uk).

Oral history interviews

Appendix 3: Chapter 2, page 38

Elizabeth. (2021, 11 January). *Oral History Interview. Interviewed by K. Swaby***.**

[Huddersfield].

Years of service: 1987 – present

KS: What are your most vivid memories from your training?

E: '…probably the relationships [that] you have with your peers. You know, I lived in the Nurses Home at the time, you know, the balance of supporting each other was absolutely amazing…you were really part of that workforce and that organisation. You really felt like you belonged…If there's one thing that stands out, it's that. You know the friendships; you know your friends for life and still in touch with people now you know twenty odd years on [2021]. Very inclusive, absolutely, you know the comradery, the support for each other. You know, if somebody had a bad day you supported each other. You did see quite a lot and were exposed to a lot as a student…and you supported each other through it.'

Appendix 4: Chapter 2, page 38 & 39

Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby***.**

[Huddersfield].

Years of service: 1980 – present

KS: Are there any particular happy memories regarding your training?

V: '...Yes, small groups, very small groups of tight nit, kind of, and closed. So, I was, both times I was in a group of 10 the first time and 9 the second time, because they used to take frequent, the groups were more frequent and much smaller, and I think because I trained in a very rural – the countryside – a little country general hospital in Scotland, halfway between Aberdeen and Inverness...so it was a very small hospital. So, you were in a small community...They would take, I think, if I remember rightly 10 about 4 times a year...You were in a kind of safe learning environment, in that you knew everybody very well, you were learning together, you were kind of stuck together, all the way through...I think that has been lost a little bit, and I thought that was really helpful...It was the same when I came to England. It was a group of 9, and we went all the way through together. So, I think there was something quite close nit about that in supporting.'

Appendix 5: Introduction, page 22; Chapter 2, page 39

George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*. **[Huddersfield].**

Years of service: 1987 – present

KS: What do you remember most vividly about your training?

G: '...What of the actual training? And I do say training rather than education, as we got very, very little education, and that was for a number reasons. One was that, I think at the time, what was more important, from the hospital's perspectives, were that you were sent out to work, in the numbers... so there was theory, obviously there was theory, but the theory wasn't seen as particularly important. Our cohort sort of had this mass panic like a few months before hand that we actually haven't done anything relevant to this examination, and that we need to start doing some revision and background work to get us

prepared for that, so, it's almost like the old apprenticeship training…that the emphasis was so much on clinical practice, and not on the having anything to back it up, because you just did you were told, you know your practises were based on what people been doing for years, and there was not much critical thought about what went on.'

Appendix 6: Chapter 3, page 65

Anne. (2021, 26 January). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield].

Years of service: 1982 – present

<u>A:</u> '…you see, there was a big difference between the apprenticeship system and Project 2000. The apprenticeship system wanted to simply train its students, but under Project 2000, students would be taught like other university students, they'd be educated. Apprenticeship nurses were *trained*, Project 2000 nurses were *educated*…'

Appendix 7: Introduction, page 16; Chapter 4, page 86 & 87

Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*. [Huddersfield].

Years of service: 1980 – present

<u>KS:</u> What do you remember most vividly about your training?

<u>V:</u> '…I found that quite…I found the way that people treated you actually, in that training, quite…contrary to what I believed nursing might be like. It felt like it was a bit punitive and maybe harsh…I had had gone into nursing thinking it would be full of kindness and angelic, and kind of lovely. I was only 17...(laughter)…I think it burst a few bubbles for me as well in terms of what my ideological kind of sense of healthcare was, so those are my biggest memories of being shocked by things…having my idealistic notions of thinks kind of

corrected towards the negative rather than anything more positive, and so I decided I'd

rather be a mental health nurse…

[on training in psychiatric hospitals in the late 1980s]…but there was beginning to be a

challenge then to this idea that: a) you were the bottom of the heap, I think were

treated…first to be treated a little bit more like the new 'pins'…we need to challenge things,

we need to move things forward…maybe what we have always done is not that good…'

Appendix 8: Chapter 4, page 87

George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*.

[Huddersfield].

Years of service: 1987 – present

KS: What do you remember most vividly about your training?

G: '…we had tutors who really weren't that engaged with us, and every time we were in

class, or in 'block' as it was called, we were just sent on another couple of weeks holiday

because they couldn't be arsed to do anything with us. I mean, we did some bits, [but they]

were completely disconnected [*from us*]…'

Appendix 9: Chapter 4, page 87

George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*.

[Huddersfield].

Years of service: 1987 – present

KS: When you were training, did you ever feel like you were given too much responsibility as

a student? Or do you ever feel like you weren't given enough?

G: '…The things that happened to us as students are actually pretty dangerous. So, like on night duty, being told as a third-year student that you can be in charge of the ward now, and so we would just be left. I mean, these are some of these are some of the major criticisms of the old apprenticeship model. Students are exploited, and they're still exploited. It would still get exploited now. It doesn't matter. One thing you've notice about clinical practise is that, when things get tight, very poor decision's get made…'

Appendix 10: Chapter 4, page 88 & 89

Edward. (2021, 2 March). *Oral History Interview. Interviewed by K. Swaby*. **[Huddersfield].**

Years of service: 1990 – present

KS: Did you engaged in independent learning outside of the clinical environment?

E: '…I guessed that there was a meaning to some of the stuff they were doing with us, but to be honest, not all of it came through to us. Like, they took us to this art gallery near the uni, and, well, it was interesting but I didn't know what was going on, not a clue…we were free to explore; they told us to go and look 'round and some of the work was beautiful, but, yeah, not in the foggiest, not a clue what we were meant to take from it…if you ask me, it was a bit of a waste of time…'

Appendix 11: Chapter 4, page 92

Mary. (2021, 12 January). *Oral History Interview. Interviewed by K. Swaby*. **[Huddersfield].**

Years of service: 1992 – present

KS: When you were training, did you ever feel like you were given too much responsibility as a student? Or do you ever feel like you weren't given enough?

M: '…I think as well, what was really interesting was [that] we were in the numbers, we weren't supernumerary, so we were part of the ward team, so you were thrown in there and got stuck in and you did it. If you needed to do something and you didn't know how to do it, somebody would come with you, but then after that, as long as you were deemed confident you were off and expected to do that yourself with no support even if you yourself didn't feel competent, which a lot of us didn't…you were simply expected and needed to get on with the job and not keep asking for help all the time…yeah, you definitely felt isolated from time to time…depending on what ward and what speciality were could be left alone a lot of the time, but we were only students you know, we weren't qualified nurses…'

Appendix 12: Chapter 4, page 101

Charlotte. (2021, 2 February). *Oral History Interview. Interviewed by K. Swaby*. **[Leeds].**

Years of service: 1990 – present

KS: What was the student/mentor dynamic like?

C: '…It was actually pretty good, yeah. With them, I felt really well supported; we felt like their presence encouraged us to think freely and seek things out for ourselves, not to just do as we were told with no explanation like some of the older, more traditional nurses approached their training. Like, they helped us settle on our placements. They were a real source of support for me, someone I could ask those silly questions and get advice from when I needed it. I'm definitely thankful for them, absolutely…'

Appendix 13: Chapter 5, page 115

Alexandra. (2021, 30 January). *Oral History Interview. Interviewed by K. Swaby*. **[Leeds].**

Years of service: 1995 – present

KS: What were your unhappiest memories from your training?

A: '…supernumerary definitely took a lot of time to get used to. There were a lot of nurses on the wards who made nasty comments about Project 2000 and things like our supernumerary status. In fact, before some of our first placements, were told we were expected not to rise to it by some of our mentors and academic staff who had been fed back by other students what it was like… So basically, it was accepted that this was not professional behaviour, but we had to just put up with it, like just grin and bare it. But don't get me wrong, by my final year I was sick of it, it was cruel sometimes and got to me. I'll admit, I cried quite a few times over that [supernumerary status]…Looking back, yeah, I can see the benefits. Yeah, there were the negatives, but there were some good points; we did see the advantages of it [supernumerary status] later on. It gave me a chance to watch and learn from the qualified nurses. I saw so much, some really impressive stuff and I really value that!...'

Appendix 14: Chapter 5, page 116

Catherine. (2021, 23 January). *Oral History Interview. Interviewed by K. Swaby*. **[Sheffield].**

Years of service: 1993 – present

KS: What do you remember about Project 2000 being introduced?

C: '…P2K [Project 2000] was a major change. I think it scared a lot of the old timers. I wholeheartedly think they saw us [Project 2000 students] as a threat...in their eyes, we were 'wannabe docs [doctors]' and not real nurses like they thought they were… [they

thought] we were training more like docs and not like nurses, like some of the stuff we were

learning wasn't anything to do with nursing… Many of them ignored us; very few nurses

were interested in us because we were supernumerary and many believed we weren't

contributing and just took up their time, but all we were doing was trying to learn and be

the best nurses we could be…We didn't choose this, we wanted to be nurses and that was

the nursing course available at that time, it's not like we were in some management office

planning all this out…'

Appendix 15: Conclusion, page 134

Victoria. (2020, 11 December). *Oral History Interview. Interviewed by K. Swaby*.

[Huddersfield].

Years of service: 1980 – present

KS: Do you think Project 2000 was for better or for worse?

V: '…I think they were very ambitious, and nursing is always vulnerable to the latest big idea.

At the time I remember thinking it's a dismal failure, but when I think about it now, speaking

30 years later as a lecturer, and put in the context of a long professional history it, despite

all its failures, and despite some things about it not working, I think it maybe did push the

agenda forward for nurses and allow recognition for their ability, it pushed the academic

entry up…you know it started to allow people to conceptualising nursing as a profession and

as an educated profession…'

Appendix 16: Conclusion, page 134

George. (2020, 15 December). *Oral History Interview. Interviewed by K. Swaby*.

[Huddersfield].

Years of service: 1987 – present

<u>KS:</u> Do you think Project 2000 was for better or for worse?

<u>G:</u> '…it looked like a bit of a failure. Some of the issues were glaring, so obvious. And 'many really took them to define the entire programme of reform, and sometimes nurses are their own worst enemy; some of the most vocal critics about Project 2000 had been nurses. But, I do think, [Project 2000 was] definitely was for the better… I think that nursing practice is a lot safer as a result of Project 2000 compared to what it was like before when I trained and the practices I witnessed. And tutoring student's now under the programme we have gives me hope…'

Appendix 17: Conclusion, page 135

Charlotte. (2021, 2 February). *Oral History Interview. Interviewed by K. Swaby*. **[Leeds].**

Years of service: 1990 – present

<u>KS:</u> What do you remember most vividly about your training?

<u>C:</u> '…But there was also a sense that we were part of this amazing new experimental progressive way of training nurses…'

Appendix 18: Conclusion, page 135

William. (2021, 9 February). *Oral History Interview. Interviewed by K. Swaby*.

[Manchester].

Years of service: 1992 – present

KS: Can you think of any specific teaching methods that helped or hindered your training?

W: 'Oh gosh, death by PowerPoint comes to mind very quickly! In our classes, there were a lot of group discussions too, so so many discussions which for me was a hindrance because I'm a kinaesthetic learner and the training lacked hands on both theoretically and clinically...'