

# **Nurse Education: Graduate Versus Diplomate**

## **Does having a nursing degree make you a better nurse?**

A Dissertation submitted in fulfilment of the requirements for the EdD – Education Sustainability, Equality and Diversity

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To my mum and 'big' brother who both sadly passed away unexpectedly during the completion of this thesis....there are no words.

To my father an historic academic and philosopher, who fuelled my enthusiasm to undertake this programme some 8 years ago, at a time when Alzheimer's had not robbed us of the intelligent, witty and caring man that he was..... *'I can still hold my dad's hand, but I miss him every day'*. This is for you dad.

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To my three beautiful children who have forgone time with their mum, while I have locked myself away to complete my studies.

## **Abstract**

In 2013, nurse education in the United Kingdom (UK) moved to a graduate-only approach in the preparation of the future nursing workforce. This research study explores the key drivers for this historic change at a point of transition aiming to:

- ***Explore the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care from the perspectives of nurses in a particular setting.***

Currently the NHS is operating within a liminal space in which nurses with degrees and nurses with diplomas work side by side. Interrogating the reality of this situation from the perspective of nurses who are directly impacted by the changes, is a central aspect of this study. It examines issues of power and influence from the inception of the NHS, and considers their impact on the current position of the nursing profession. Factors, which influence the preparation of nurses and implications for the provision of future health care are explored and give rise to the question of whether a degree is needed to be 'a good nurse'. The thesis examines the various meanings attributed to the idea of 'being a good nurse'. Drawing on the works of Husserl (1931) and Heidegger (1962), Interpretive Phenomenology is utilised to interrogate the lived experience of the participants and gain further understanding from their perspectives, with the objective of:

- ***Exploring graduate and diplomate nurses own perceptions of the impact that a graduate only qualification may have on nursing care delivery.***
- ***Exploring nurses experiences of working with the graduate vs diplomate nurse, to ascertain ways in which they may perceive difference in ability***
- ***Identifying the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity***
- ***Identifying any overall perceived differences in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff.***
- ***Exploring participants perceptions of the 'good nurse'***

Data reveals a variety of understandings and experiences of both diplomate and graduate nurses. All participants discussed facing an increasingly challenging healthcare working environment, having to manage day-to-day care provision with diminished staffing levels and increasingly more complex patient requirements. These factors revealed tensions and left nurse participants questioning what sort of implications the introduction of the graduate only approach may have for the delivery of frontline care. The thesis concludes by recognising that there remain questions over the practical application of the graduate only approach to nurse education. Potential similarities and differences in expected performance and expectations of the new workforce were drawn from the research. Participants raised concerns in relation to possible changes to the qualitative nature of healthcare following the introduction of a graduate-only profession. Equity and access to nursing programmes was highlighted as an issue in relation to the supply of caring nurses and the possibility of missing out on potentially good nurses, who would be unable to undertake a graduate training programme for various reasons. Original contribution to knowledge is claimed in that the nurses themselves provided their own insights which were analysed in detail. The investigation was limited to a specific context, but the approach was sufficiently rigorous to allow for the study to be replicated elsewhere and potentially further contribute to knowledge beyond the original setting.

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## Abbreviations

AEI	Approved Education Institution
Band 8	A registered nurse who has had a number of years post registration experience and who has taken on a leadership role within nursing
Band 7	A registered nurse who has a number of years post registration experience in nursing, who has taken on a specialised role within nursing.
Band 6	A registered nurse who has some post registration experience within the field that they are working in and takes on leadership within the role in which they work
Band 5	This can be either a newly qualified nurse, or a junior nurse with limited post registration experience. However there are a number of Band 5 staff who have been working in the role for a number of years and have not wanted to progress.
BIS	Department for Business Innovation
BSc	Batchelor of Science
BBC	British Broadcasting Company
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CQC	Care Quality Comission
DH	Department of Health
DHSS	Department of Health and Social Security
EIA	Equality Impact Assessement
FTE	Full Time Equivalent
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HEE	Health Education England
HESA	Higher Education Statistics Agency
HEFCE	Higher Education Funding Council for England

MSc	Master of Science
NHS	National Health Service
NMC	Nursing & Midwifery Council
NRES	National Research Ethics Service
NVIVO	Qualitative Data Analysis Tool
OFFA	Office for Fair Access
PGCE	Post Graduate Certificate in Education
PGDip	Post Graduate Diploma
PhD	Doctor of Philosophy
R&D	Research and Development
RCN	Royal College of Nursing
RGN	Registered General Nurse
SEN	State Enrolled Nurse
SRN	State Registered Nurse
UCAS	Universities and Colleges Admissions Service
UKCC	United Kingdom County Council
UK	United Kingdom

We all joined our professions to make a difference; we must never underestimate our significance. As health and social care changes, what does not alter is the fundamental human need to be looked after with care, dignity and compassion (DH, 2012).

## **Chapter 1 – Introduction**

The quality of nursing within the United Kingdom's (UK) National Health Service (NHS) has been identified as an issue of great national importance, especially over the last decade (NMC, 2010a: NMC, 2016). The NHS has been subject to much negative press over recent years (Francis, 2013: Berwick, 2013: Crick et al, 2014; BBC, 2018), with the quality of healthcare delivery under constant scrutiny. While the public generally have high regard for nurses, some high-profile examples of poor care have arguably given justifiable cause for concern (Francis, 2013: Berwick, 2013: Crick et al, 2014: (CQC), 2015). Berwick (2013) places the quality of patient care, especially patient safety, above all other aims of the NHS and also places great emphasis on the growth and development of all NHS staff. Understandably there is public interest in how nurses are educated and prepared for their roles and of course the development of future generations of nurses and the safeguarding of the health and wellbeing of the public, is a central aspect of the Nursing and Midwifery Council (NMC) (NMC, 2010a: NMC, 2016).

Modern health professional education is multi-faceted and must continually evolve to keep pace with the rapid change that we see in healthcare delivery today. It is important that nurses are able to respond to, lead and influence such change, practicing in line with up to date evidence-based approaches. This will enable nurses to make quality decisions and provide nursing care based upon clinical expertise, in combination with the most current and relevant research available on the topic (Willis, 2012: NMC, 2014: NMC, 2016). The NHS must attract the best recruits and promote their individual professional development, so they can provide the highest quality care and make an ongoing contribution to society (Willis, 2012). The 21<sup>st</sup> century nurse needs to be able to meet the challenges of a complex society and growing health challenges.

There is a focus on the preparation of future nurses, with nurses being the largest professional group in the NHS and at the forefront of health care. In 2013, nursing became an all-graduate profession and further changes have been proposed (NMC, 2016). Currently graduate and diplomate nurses work side by side and the NHS is operating within a liminal space during this transitional phase. This education doctorate seeks to explore ways in which historic structural changes to the teaching and learning of nurses

may have impacted the health workforce, within a specific context. Specifically this thesis aims to explore how the transition of nursing to a graduate only training pathway, has been experienced by those within the profession and thus identify some of the potential consequences of the change from the nurse participant's perspectives.

The aim of this chapter is to provide a background to the study. It begins with an outline of the recent history of changes in nurse education. The rationale, the focus of the study and the key research questions are then identified and subsequently addressed.

### **1.1 Historic perspective of nurse education**

Historically, nurses were arguably trained as opposed to educated in an apprentice-style training, whereby nurses were trained on the job. Trainee nurses therefore undertook the job of delivering health care, while being reimbursed with a wage. The training was focused on ensuring the acquisition of the relevant skills and experience in order to deliver the services required by hospitals (Bradshaw, 2000). Training consisted of a small amount of theoretical input with a majority element of practical experience on the wards. Theory was acquired primarily in the clinical setting, with a minimal amount of time spent in schools of nursing. Assessment of trainee nurses involved consideration of their moral character and how well they communicated with patients and colleagues. Practical tasks related to the roles undertaken, were also taught and nurses had to acquire competence and demonstrate certain personal qualities (Bradshaw, 2000). These were assessed in clinical practice on a pass or fail basis.

With the introduction of Project 2000 (P2K), came changes to nurse preparation. From the inception of P2K, nurses were to be educated to become the 'knowledgeable doer'. P2K occurred in the 1990s when nurse education moved from schools of nursing attached to NHS hospitals, into higher education institutions (HEIs). The English National Board (ENB) drove this change with the aim to produce nurses who were more autonomous, knowledgeable and politically and socially aware (Bradshaw, 2002: ENB, 1985). The framework for nursing knowledge was amended to incorporate two distinct forms of knowledge, theoretical and practical. These two elements formed the basis of assessments and each was given equal status. Students were required to spend half of

their time in an academic setting and half in the clinical setting. The theoretical element of the programme was delivered in HEI's, and the practical element continued to be based in NHS hospitals. Instead of learners being employees of the NHS and part of the workforce, they were afforded supernumerary status during their education and training (UKCC, 1986: Watkins, 2000). This approach to nurse education has remained with universities providing the taught elements of the programme and clinical placements in healthcare providing practical experience. Nurse education programmes up to 2013 in England, were provided at both diploma and degree level.

## **1.2 Why move to a graduate profession?**

The rationale advanced by the NMC (2013) for such a change was that nurses educated to graduate level would be better able to provide improved care, to practice more independently and to make autonomous decisions. These attributes were seen as a necessity for the future, aiming to increase skills and train a nursing workforce capable of operating in a more analytical and independent manner (NMC, 2016: Willis, 2016). Further, it was proposed that graduate nurses would think more analytically and use higher levels of professional judgment and decision making as a result of degree level education, which would provide new nurses with the decision-making skills they need to make high-level judgements in a transformed NHS (DH, 2016: NMC, 2016). NMC standards published in 2010 stated that they aimed to enable new graduate nurses to give high quality care, in a culture where patients would have much more choice and control (NMC, 2010a: NMC, 2016). The NMC also believed that all-graduate programmes would mean nurses would be better prepared earlier on in their careers to be more assertive, more questioning and take on more responsibility (NMC, 2016).

This move has been preceded by the pre-registration nursing approach in Wales being implemented in 2004. The approach taken in Wales at that time however, gave students the opportunity to leave the degree programme to complete a diploma. At the time of writing this was not an option within English graduate nursing programmes. Northern Ireland moved to degree only in 2011 and Scotland has offered degree only entry programmes in the University of Sterling since 2011.

### 1.3 Rationale for this study

At the point of commencement of this study in 2013, little was known of the impact that a degree only approach to nursing would have on the profession as a whole, or the service that nurses would provide because of its implementation. There was little evidence available to support the proposed impact of the move and no direct nursing voice in relation to its application in practice. At the point of commencement of this study, the researcher did not envisage the length of time it would take to complete the thesis and the life challenges that would ensue during the studies completion. More timely completion of the thesis would have pre-empted considerations subsequently posed by Merrifield (2017b) and HSC (2018) in relation to workforce preparation and nursing shortages. Concerns raised by the change in educational stance in 2013, have been subsumed by other NHS challenges affecting workforce demand and the implementation of parallel roles, including the introduction of the nursing associate role. These were not in existence at the point of study commencement and the researcher could not have envisaged that these would be introduced or have influenced the research findings outcomes and recommendations to the extent that they have.

A key driver for this study was fuelled by a personal and professional interest to explore current nurse education provision, following the introduction of an all-graduate nurse programme in 2013. Being a registered nurse and an advocate for the provision of quality care, my interest was driven by the promise of the new, better educated, more questioning nurse, who would make real impact on the challenges of nursing in the ever demanding NHS. Hopes of professional equality within the multi-disciplinary healthcare team and the development of nursing voice within this arena, further powered my enthusiasm to explore the potential impact that this move could make. Knowledge of past, present and future nursing education approaches, served to provide a conduit for me to undertake the research. In exploring this new concept my aim was to gain insight into the formation of the profession.

My interest was further fuelled by a desire to use the evidence base generated to contribute to improving nursing care provision, via improvements to nursing educational approaches. I hoped that the study undertaken would further inform and explore the

outcomes of the graduate-only route approach and its concentration on the 'graduateness' and employability post registration, of the 'new nurse'. I was interested in understanding what drives the nursing education agenda and why there was a perceived need for change. The gap in knowledge and research I identified was the impact of the introduction to a graduate-only nursing profession, with voice specifically from the perspective of nurses themselves. While there has been research into the outcomes of curricula changes, the views of nurses on the move to an all-graduate profession and its implications for the delivery of care have been conspicuously quiet.

The UK Quality Assurance Agency (QAA) benchmark statement for languages and related studies, identified that a graduate will be expected to be an 'effective and self-aware independent learner'. There is, however, no consensus on the definition of 'graduateness' in nursing and debate persists around the meaning of the term (QAA, 2002). Some recent studies have focussed on the impact of 'graduateness', but there is still limited knowledge in clinical practice on the impact of 'graduateness' and its meaning in nursing (Aubeeluck et al, 2016; Oritz, 2016).

#### **1.4 Focus of this study**

Having searched for relevant research, I identified limitations in current knowledge. Given my realisation of the gap in research literature regarding the impact of the change from diplomate to graduate only nursing on direct patient care, I concluded that there is enormous scope for research. This thesis sought to contribute to knowledge by laying firmer foundations in this field. The approach I chose to adopt was to first explore how this change was experienced by a group of nurses at the front line of care delivery. I next interrogated their perspectives on the perceived repercussions of graduate only nursing, with a view to gaining a rich understanding of the day-to-day working experiences of nurses. My aim was to give voice to the reality of the nurse participants of my study, in order to build a firmer footing for understanding the practical impact of the graduate nurse. During this process, I planned to isolate important areas and further research questions for future study. While I do not claim that my findings are generalisable beyond the context in which the study took place, my approach is replicable and could be utilised in different

settings. I anticipated that this study would lead me to a greater understanding about the introduction of the all-graduate programme and its potential role in the quality of nursing care within my context. Despite my study being limited to one context, the clarity with which I have approached this undertaking means that ultimately the contribution to knowledge could be broader if the study were to be replicated elsewhere. Nurses' voices have not been captured in this way before and this fact further enhanced my claim to making an original contribution to knowledge.

### **1.5 Aim**

- To explore the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care from the perspectives of nurses in a particular setting.

### **1.6 Summary**

Having identified a gap in current knowledge, chapter one has outlined the importance of this study and the drive for its completion. In order to inform the need for the research, the historic perspective of nurse education has been acknowledged. This will be explored further and the changes that have progressed the pre-registration nursing agenda will be considered. A clear rationale for the research has been developed and the aims for the study identified. This literature search conducted for the study identifies central constructs for further exploration, leading to key research questions and specific study objectives.

## **Chapter 2: Literature Review**

This chapter begins by setting out how the literature review was undertaken and goes on to explore the purpose of literature reviews within qualitative research. Nursing in England became a graduate-only profession in 2013, with the expectation that a graduate nurse would be more analytical, reflective and forward thinking (NMC, 2010a). For the purpose of this research therefore the concept of 'graduateness' will be explored generally in the context of the NMC vision, together with the evidence of the impact of 'graduateness'. The decision to become a graduate profession has raised questions as to whether a more academic nurse is synonymous with 'a good nurse' and this will be unpacked. This exploration will include consideration of what the idea of 'a good nurse' means from various perspectives, as this is not necessarily a term which will mean the same thing to different people. Arguably, there are questions as to whether the push towards 'graduateness' is about improving the status of the profession in the current healthcare environment. There are potential risks in the NMC taking this route and an aspect of this research proposes to identify and discuss what these may be from various pertinent standpoints.

The following aims and objectives are further discussed in the methodology section. They have been introduced at this point as a focus for the literature review, which is constructed precisely to address the research questions:

### **Aim**

- To explore the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care from the perspectives of nurses in a particular setting.

### **Objectives:**

- To explore graduate and diplomate nurses own perceptions of the impact that a graduate only qualification may have on nursing care delivery.
- To explore nurses experiences of working with the graduate vs diplomate nurse, to ascertain ways in which they may perceive difference in ability

- To identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity
- To identify any overall perceived differences in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff.
- To explore participants perceptions of the 'good nurse'

## 2.1 Literature Review Protocol

An extensive search of literature relevant to the study was conducted using health-related databases CINAHL, MEDLINE, Proquest, Pubmed and Ovid. A variety of other pertinent nurse education databases, relevant government and nursing policy green and white papers were also accessed. In order to maintain focus on the research question the literature review concentrated mostly on knowledge and evidence from the UK. Approaches to student nurse education and facilitation vary greatly from country to country, making international literature not specifically relevant to this particular study. However, illuminating and arguably potentially generalisable insights from other countries were included where appropriate. The areas that informed the search strategy were pre-registration nursing graduate/diploma and nurse education, degree versus diploma, and nurse education quality and assurance. Approximately 1,000 primary articles were found via various search engines during the process of this study. These were filtered by origin, age and relevance to the study. Literature concerning both qualified and unqualified nurses was considered where the source was deemed credible by virtue of its author, publication outlet and applicability. Literature was excluded if credibility could not be assured due to author or data confidence. Credibility examines how congruent the research findings are with reality; Lincoln and Guba (1991) argue that ensuring credibility is one of most important factors in establishing trustworthiness and honesty in participants' data. According to Patton (1990), the credibility of the researcher is especially important in qualitative research as it is the person who is the major instrument of data collection suggests that credibility is dependant on the credibility of the researcher and that the researcher need make explicit what they bring to the research in terms of experience, qualifications and perspective. The criteria for considering papers was made in relation to

the credibility of the author, and the applicability of the discussions to the research underway, also considering the impact of the discussion on the research findings.

The majority of the literature came from online articles from refereed journals. The search engine, Google Scholar, was also accessed using various search terms that were a sound match with the purpose of the study. There was no date parameter set for literature, as the researcher wanted to explore relevant information about the historical context of nurse education, as well as the current drivers for change. As the thesis took 7 years to complete, literature was revisited repeatedly.

<b>Electronic Literature Search</b>			
<b>Sources searched:</b>	<b>Date of search</b>	<b>Search strategy</b>	<b>Comments</b>
Myathens, Ovid, Pubmed, Proquest, Medline, Google Scholar	Throughout EdD completion period 2011 – 2018	Nurse Education, Graduate Nursing, Diploma Nursing  Filter: UK-based	Broad range of literature searched and considered, including government Green and White papers, nursing body documents, journal articles and book extractions

## **2.2 Purpose of Literature Reviews**

A detailed comprehensive current and critical literature review is essential in order to underpin the research study and provide a sound basis for understanding the perceived problem. The rigorous process for conducting the literature reviewed within this study has been explained. Desktop research identified a gap in current knowledge which the thesis has addressed and formed a basis for the conceptual framework (Figure 1), used to plan qualitative interviews and data analysis. The literature search was informed by the research questions to ensure relevance. It focused on current awareness of nurse training within universities and the NHS, and included relevant research to underpin the discussion more broadly. Consideration for example of the notion of ‘a good nurse’ from a philosophical perspective emerged as an important concern. Analysing the impact of the

graduate-only approach and factors affecting the development and introduction of the new approaches, would further inform the debate.

### **2.3 Why move to a graduate profession?**

This study explored the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care. In 2008 the NMC announced that the minimum academic level for nurse qualification would from 2013, would be a bachelor's degree (NMC, 2008). It stipulated that nursing had to become a graduate profession, as it needed to meet the needs of complex care delivery in an increasingly fast-paced healthcare system. The argument was that systemic changes in healthcare demanded flexible, responsive and highly skilled practitioners (NMC, 2008). The move to graduate nursing reflected the gradual transformation of nursing practice through better evidence, stronger professionalism, developments in technology, scientific advances and responsiveness to individual and population healthcare needs (NMC, 2008). The UK government further endorsed the decision (DH, 2006), stating that degree-level education would provide newly qualified graduate nurses with the decision-making skills that they needed to make high-level judgments.

#### **2.3.1 'Graduateness'**

The concept of the graduate nurse began to take shape in policy documents via reports in the late 1990s published by the NMC (in its prior inception as the UKCC – the UK Central Council for Nursing, Midwifery and Health Visiting). Here, the graduate, as opposed to diplomate nurse was explicitly equated with “an enhanced level of analysis, synthesis and decision-making” (UKCC, 1999: Clinton et al, 2005). Despite the introduction of the graduate pathways in nursing, Burke & Harris (2000) suggested that the concept of 'graduateness' still lacked definition.

The first published standards for graduate nursing were by the QAA in 2001. Their benchmark statement set standards for both diplomate and graduate nurses and directly compares standards between the two training pathways (QAA, 2001). In this document, while many of the standards are similar, those aspiring to the honours degree must show

the capacity for “critical analysis” of for example, their own skills, the evidence for nursing practice and roles within the healthcare team. It is this capacity for critical thought that appears to form the basis of the concept of the graduate nurse in these early policy documents.

‘Graduateness’ has been termed a broad academic cultivation enriching students with the skills and knowledge of higher education systems and learning, whilst others perceive ‘graduateness’ to be more of a tailored professional training with a strong emphasis on employability (Steur et al, 2012). It could be argued that there are distinct demarcations between ‘graduateness’ and employability, particularly when considering such approaches in nursing education. In nursing, ‘graduateness’ pertains to the more academic components of nurse education, rather the practical component of pre-registration training.

Glyndŵr University (2014) defines graduates and ‘graduateness’ as being those who are experts with a well-structured and detailed knowledge of their subject and associated skills and attitudes. People who are enterprising with the ability to identify or create opportunities and take advantage of them within the clinical setting. Professionals with professional attitudes and behaviours in working environments, who are independent thinkers with the self-confidence in their personal abilities, based on self-knowledge, being able to develop, hold and communicate an independent view and be able to apply and demonstrate this in practice (Glyndwr, 2014). Interestingly the university does not articulate how these skills and behaviours differ from that of the skills and attitudes of the diploma or non-graduate nurse, who has historically provided a quality and evidence based service to patients. It is not clear whether these are new, different or additional skills.

Keele University (2009) identified similar graduate attributes, stating that graduates should demonstrate; an open and questioning approach to ideas, curiosity and independence of thought. ‘Graduateness’, according to Keele, gives one the ability to locate, evaluate and synthesise large amounts of frequently conflicting information, ideas and data. This would indicate that the diplomate may have been lacking in these skills and that there was a need for the nurse to manage this demand. To date here has been little exploration of

nursing voice in validating these claims and this study sought to explore this concept further. Keele (2009) believed that 'graduateness' gives the ability to communicate clearly and effectively in written and verbal forms for different purposes and to a variety of audiences, further 'in-time' evaluation through the proposed study would prove invaluable to either supporting or discounting these claims.

In a study by Glover, Law and Youngman (2002) some final year students were shown to focus on what they could gain from completing a university taught programme, equipping them with a set of capabilities that improve their employment prospects, with less emphasis being placed on the attributes of the course itself. This study concluded that there is no one fixed identity for 'graduateness' or 'graduate employability'. Certain themes emerged that called into question the traditional model of graduate employability comprising skills, competencies and attributes (Glover, Law and Youngman, 2002). The authors developed a four-stranded concept of identity comprising value, intellect, social engagement and performance. Their model begins to demonstrate the complexity of nursing education. The four elements of identity are by no means independent of each other. Rather, they are expected to interpenetrate producing a composite identity, with different employers emphasising different facets of this identity (Hinchcliff and Jolly, 2011). This study aimed to go further in exploring key drivers for the impact that 'graduateness' and employability could have on an all graduate nursing programme. A particular consideration was whether the promise of a degree, indeed influences aspiring nursing students.

Rigorous literature searching revealed that there is scant research which casts a critical eye over the theory/practice correlation and the diploma/graduate approach in nursing. Whilst there is a focus on 'graduateness' and a more autonomous and forward thinking practitioner, the impact on direct hands on care is sparse. This study including nursing voice could potentially further validate or discredit these claims.

## **2.4 The impact of 'Graduateness' within nursing**

The introduction of the graduate-only profession has received criticism that focuses on the need for nurses to care for patients. Nursing demands, empathy, compassion and clinical expertise to meet the needs of the patients. Such intangible competencies are arguably

as important as the ability to think critically. Some studies have argued that if graduate nurses were less willing to undertake important nursing tasks that they may perceive as more menial, this could harm patient care (Martin, 2009; Patients Association, 2009). Their arguments are founded on the assumption that all-degree nursing fosters academic elitism (Wales on line, 2013). Arguably these studies are flawed as there is a lack of compelling evidence that the move to degree-level registration of all nurses in the UK would impact on nurse's ability, or desire, to care with compassion (Willis Commission, 2012).

The medical profession aside, every other healthcare professional completes three years in university culminating in a degree (Wales on line, 2013). While groups including The Patients Association (IPA) (2009) welcomed the graduate-only approach, they too expressed concern that nurses may lose their focus on patient care. This argument was colloquially termed the '*too posh to wash*' scenario (Hall, 2004). A subtler point was advanced by the Head of Nursing at Unison, who expressed her concerns that the move may have led to a decrease in the number of registered nurses and a move to a focus on supervisory, rather than direct patient care delivery (Martin, 2009). The Willis Commission (2012) however, described the case for moving to an all-graduate nursing profession as essential, finding it illogical to claim that by increasing the intellectual requirements for nursing, that recruits would be less caring or compassionate. Hence, there continues to be debate over what makes a good nurse, and whether graduate nurses' lack care and compassion compared to their diploma colleagues. Clearly the binary of caring diplomats and non-caring graduates is unsubtle. There is no evidence that having a degree stops a nurse from caring (RCN Wales, 2013).

One of the objectives of this study was to identify if there is an overall perceived difference in the nursing skills in practice of staff that hold a degree rather than a diploma. Girot (2000) used standardised instruments for measuring critical thinking and 'decision-making in practice' skills, to compare graduate nurses with non-graduates. In a total sample size of 82, their direct comparison showed no difference in the critical thinking domain, but did identify better practice-based decision-making skills among graduates.

The study did not endeavor to measure the real lived experience of the participants and utilised a questionnaire based approach. There was no opportunity for the researcher to

go back to the participant for greater depth of response. It was difficult for the authors to reconcile their findings, as their original hypothesis was that a difference in decision-making would correlate with a high degree of critical thinking. Hence, their conclusion noted that “exposure to the academic process”, correlated with development of better decision-making in practice. Their ability to explore further was limited by their questionnaire-based design. This study aimed for richer data informed directly by nurse’s voices.

The National Nursing Research Unit (NNRU) commissioned a comparative study to explore the move to an all graduate nursing profession at registration, looking at the potential effects on workforce profile and quality of care (Robinson and Griffiths, 2008). A number of now dated studies were compared looking at competencies of qualifiers from three and four year degrees, with those of qualifiers from the diploma course. The introduction of the graduate only approach to nurse education raised two main questions for the authors of the study reviewed. They set out to explore what might be the impact on the size and profile of the nursing workforce and how the quality of care delivered by nurses might be affected. No significant differences emerged between the two groups during the first three years after qualification, when background variables were controlled. The research identified that members of the nursing profession who participated in the study remained divided on the issue (Robinson and Griffiths, 2008). Two inter-related questions were felt pertinent to the effect that a move to an all-graduate profession might have had on recruitment, what the effect might be on absolute numbers of qualifiers and what might happen to the diversity of qualifiers following its introduction. It concluded that there was mixed evidence on the impact of graduate programmes on diversity. There were no differences in the proportion of members of ethnic minority groups in the two groups of qualifiers (5% or less) and the graduate group had slightly fewer men than the diploma group.

Reasons cited for entering the profession and views on the nurse’s role, show that students’ motivations and perceptions focus on nursing as a caring, rather than a technical profession (Crick et al, 2014). Crick et al (2014) concluded that nurses entered the profession with a strong desire to care and to make a positive difference to people’s lives, contrary to concerns raised. The study highlighted another potential issue in relation to

the move to all graduate. This was that entry requirements, being higher for degree courses might disenfranchise potential students. In order to explore this idea it is necessary to review the impact that this may have on nurse education applications. Literature reviewed for this study indicated that that the move to an all-graduate entry, had not resulted in fewer mature students entering the profession and that the courses were still attracting those with access qualifications and those who are the first in their family to come into higher education (Crick et al, 2014). This challenges the Martin (2009) and Hall (2004) images of graduate nurses as academically and career focused and “too posh to wash”. There is much debate over what makes a ‘good nurse’, and whether graduate nurses lack care and compassion compared to their diplomate colleagues. Many described their motivation as coming from having experienced or witnessed positive examples of nursing care, with some influenced by working alongside nurses, or having a nurse in the family. Within a media climate that seems to consistently highlight poor care and lack of compassion (Coward, 2013; Francis, 2013; Berwick, 2013; Prior, 2014), the majority of new student nurses would appear from this study, to have been influenced by good care and positive role models.

Overall, the studies in the NNRU review were varied in size with sample sizes ranging from 12 to 6526 participants. The overarching direct comparison between studies is that there was no clear tangible difference in the graduate and non-graduate nurse, although some of the studies postulated that there might be ‘possible’ advantages with degree programmes. One cited the combination of a graduate status and prolonged experience, improving the critical thinking skills of the graduate compared to a diplomate (Swindells and Wilmott, 2003; Rambur et al, 2005), whilst Girof (2000) refuted this idea. The studies were also a mix of both international and British based research; caution should therefore be exercised in making comparisons. British nursing voice was demonstrated by only 12 of the 21 studies reviewed, with 9 studies being undertaken across both the United States and Canada. Studies considered in this review date from 1992 to 2008. British nurse’s voices in post 2008 studies are lacking. The originality of my study is that I enable nurses to give voice to their daily experiences in relation to experience and approaches to nurse education and perceived impacts on the front line. The term ‘good nurse’ requires further consideration, and would form a basis for participant questioning in this study.

The studies in the review investigated outcomes from different nursing preparation programmes, some of these included nurses who have taken degrees after registration (Bartlett et al, 1999; Bartlett et al, 2000; Giro, 2000; Swindells and Willmott, 2003; While et al, 1998). While and colleagues compared senior students on four-year integrated degree courses with three year diploma and certificate course students (While et al., 1998). Bartlett and colleagues compared nurses graduating from a four-year degree with those from a three-year diploma at qualification, six months and one year (Bartlett et al, 1999; Bartlett et al, 2000). The studies undertaken by Giro and Swindell's entailed cross-sectional comparisons of groups at different points in their career and both included people who had taken a degree after registration (Giro, 2000, Swindell's and Willmott, 2003). Giro's study included first and final year students on a four-year degree, mature graduates who had taken a post-registration degree and non-graduates (Giro, 2000). In Swindell's study, the graduate group mainly comprised those who had taken a degree post-registration and the graduate and the diploma group included nurses from various specialities as well as midwives (Swindell's and Willmott, 2003), whereas the other studies included general/adult branch nurses only. This needs careful consideration when drawing parallels with the three-year degree programme. The originality of my study was that all participants were relating their experiences to the 3 year diploma and degree programmes.

## **2.5 The 'Good Nurse'**

Within various documents, including NMC directives (NMC, 2015), the idea of 'the good nurse' occurs without necessary a deep level of critical reflection about what this actually means. It is relevant to this study to critically explore the concept of a 'good nurse'. The nursing workforce professes to care with compassion, dignity and respect (DH, 2012). Whilst an abundance of literature exists to support the need for expert practice within nursing (DH, 2012: DH, 2016), there is little consistency between various literature in terms of criteria employed for identifying expertise or expert practice. There has been much debate about the wisdom of the move to degree-only courses over the last thirty years. A key aspect of this debate has been the understanding of what makes 'a good nurse'. In contemporary educational parlance, this understanding is often framed in terms of key 'nursing competencies'. The debate surrounds which educational programme is most capable of developing nurses, who can meet the demands that will be made of them in

the clinical setting. Competences are arguably easier to measure than more subjective qualities such as compassion, with defined parameters and expectations. Compassionate skills however with main elements identified as being empathy, recognising and ending suffering, being caring, communicating with patients, connecting to and relating with patients, being competent, attending to patients needs/going the extra mile, and involving the patient, are more subjective and ill defined (Papadopolous, 2016).

Given the importance afforded to the acquisition of skills and competencies required to become a 'good nurse', nurse education of the future must ensure that it equips students with the necessary skills and competencies to meet the needs of the patients in their care. There are a number of models which describe approaches to skills acquisition and skill development which would further inform. The Dreyfus brothers' model of skill acquisition (1980), demonstrates how students acquire skills through formal instruction and practice. This model proposes that students pass through five distinct stages: novice, competence, proficiency, expertise, and mastery. In the novice stage there is non-situational recollection, decomposed recognition, analytical decision and monitoring awareness. Competence comprises situational recollection, decomposed recognition, analytical decision and monitoring awareness. Proficiency then leads to situational recollection, holistic recognition, analytical decision and monitoring awareness, progressing to expertise where there is situational recollection, holistic recognition, intuitive decision, monitoring awareness, finally moving to mastery. A criticism of Dreyfus and Dreyfus's model has been provided by Gobet and Chassy (2008) who also propose an alternative theory of intuition which is currently missing. According to these authors, there is no empirical evidence for the presence of stages in the development of expertise, more that there are a multitude of influences on competency acquisition.

Eraut (2008) found that most learning occurs informally during normal working processes and that there is considerable scope for recognising and enhancing such learning. Although the workplace appears to be primarily concerned with capability (what they do and how they perform), it is equally important to be able to do the right thing at the right time. In practice this means that nurses have to understand both the general context and the specific situation they are expected to deal with, be able to decide what needs to be done by self and others, and to implement what has been decided, individually or as a

group through performing a series of actions. All three of these processes contribute to perceived competence. Intangibles however are less easy to define and teach, such as bedside manner, empathy and compassion and there is a dearth of studies exploring these skills. There has been little exploration of such competencies and skills acquisition in relation to the graduate only programme. This study would give new opportunities to how such skill acquisition may be influenced or impacted on by a new graduate only approach.

Fry and Johnson's (2008) understanding of nursing competence is holistic. It embraces aspects of knowledge, understanding, performance and practice. Eraut (1998) explored different sociocultural constructs of competence. He draws distinction between competence – “the ability to perform the tasks and roles required to the expected standard”, a socially situated, job-referenced concept – and capability – “what a person can think or do that is relevant to the work of a particular profession” - an individually situated, profession-reference concept. Hence, the development of graduate programmes for nursing education sought to develop nurses who were both clinically competent for their first nursing job – ‘ready for practice’ – but also capable of adapting to the wider context of modern nursing, including in future roles. It is here that we may begin to understand how ‘graduateness’ applies in terms of competence and capability. Graduates must be competent to undertake the modern role of nurse, which includes the capability for providing compassionate care, a skill that was found to be significantly lacking in both the Francis and Berwick reports (2013). However, the capabilities of critical thinking and advanced clinical decision making are also seen as important for ‘practice-ready competence’ when a nurse graduates and in their future career. Such capabilities are understood to be the imperatives of the modern clinical context of multi-disciplinary teams, high degrees of specialisation, higher-intensity centrally managed care, and globalisation (Wolff, 2009; Hayes, 2012).

Some have reasoned that nurse intuition is a product of an interaction of knowledge, expertise and experience (McCutcheon & Pincombe, 2001). In this model, development of intuition requires extended contact with patients and considerable context-bound experience (Manley & Garbett, 2000). Aristotle (in Ross, 1998) viewed experience as foundational to any knowledge of the world. The knowing that results from nurse intuition has been described as pragmatic, specialised nursing knowledge in a particular domain

(Effken, 2007). This implies therefore that it is not the theoretical component of nurses' training alone which develops nursing expertise. A criticism of the NMC's belief that the graduate-only programme will develop newly qualified staff who are ready and able to take on both their qualified nursing roles and function at a higher level, could be that it neglects the importance of such experience. The NMC's stance argues that expert nursing intuition is a form of direct perception and as such, is information-based rather than experience-based (Effken, 2007). Whilst there are strong proponents of this view, there is wide long-standing acknowledgment that it needs to be married to an in-depth experience-based knowledge, informed by past situations (Benner, 1984). This approach mirrors that of a constructivist approach to learning, where significant knowledge base is required to enable students to problem solve. Students will be constructing knowledge for themselves from an interaction between their experiences and their ideas, actively constructing or building new ideas or concepts based upon current and past knowledge or experience drawing a parallel with the works of Dewey (1939/91) and Piaget (1972). This approach also focuses on preparing the learner to problem solve in ambiguous situations.

Manley & Garbett (2000) suggest that experience is required as a basis for expertise. This is supported by Sutton & Smith (1995) who also theorise that individuals become experts as a result of experience, enabling people to develop specific skills and dexterity. One interesting analysis held that nurses who become experts through experience have a clear focus on nursing issues, and are more reflective and analytical, developing more new nursing knowledge than their colleagues (Castledine, 1995). Literature goes on to illustrate that that such expert practice has influence that spreads as far as implementing and instigating change at organisational levels, such as service developments (Manley et al, 2004), key goals of the move to graduate-only nursing. However, other aspects of nursing expertise, namely intuition, caring and empathy do not have such an overarching influence (Manley & McCormack, 1997).

There is no one shared meaning or definition of the 'good nurse'. The NMC defines the professional standards for nursing and cites that skills, knowledge, good health and good character is required to enable nurses to do their job safely and effectively (NMC, 2015). Whilst good health and good character are identified as requirements in professional standards, precise definitions of a 'good nurse' are less accessible. There is the belief that 'good nurses' are smart and knowledgeable about current trends in health care, both

medically and technologically. These 'good nurses' know how to operate and translate the information relayed from new medical devices and can apply the medical results to a current care plan that is in a patient's best interests (Graham et al, 2004). An effective nurse has been defined as caring, understanding, non-judgmental and has a strong ability to empathise with patients from all walks of life (Jacksonville, 2018). 'Good nurses' know how to perform all of their responsibilities with the utmost accuracy and detail (Jacksonville, 2018).

A phenomenological study undertaken by Burhams (2008) attempted to identify the lived meaning of quality nursing care for nurses, enlisting 12 participants and identified that this could be found by meeting human need through caring, empathetic, respectful interactions within which responsibility, intentionality, and advocacy form an essential, integral foundation. It was felt that the lived experience of quality nursing care resided within nurse-patient interactions and was demonstrated within the art of nursing rather than with the science of nursing. The definition of care and the 'good nurse', is further postulated by Watson (2008), who identifies good care as being a core concept for nurses and the people they interact with, however acknowledges that "care" is one of the field's least understood terms. Watson (2008) reflects on the universal effects of caring and connects caring with love, as the primordial moral basis both for the philosophy and science of caring practices.

It is acknowledged that being a 'good nurse' is itself challenged by a multitude of environmental factors. One study undertaken by Bournemouth University in 2004, identified blocks to being a 'good nurse' including the demanding reality of workplaces, poor system design and workplace bureaucracy. These challenges are ongoing and evident in the current healthcare arena (Tringle, 2017), the concept of the 'good nurse' therefore cannot be considered in isolation, but is influenced by other environmental and influencing factors. What is evident is that there are broad ranges of definitions of what a 'good nurse' is. There is an element of subjectivity involved but compassion and arguably the idea of a good nurse, should not be difficult to articulate. Compassion can be measured through care that is given through relationships, based on empathy, respect and dignity; it has also been described as intelligent kindness and is central to how people perceive their care (NHSE, 2016). Individuality is important but there is considerable common ground in relation to key competencies and attributes such as compassion. Contentiously there is

some evidence that the core idea of a good nurse appears relatively unaffected by the acquisition of a degree rather than a diploma.

## **2.6 Historical context and professionalisation of nursing**

One of the objectives of this study was to identify whether there is an overall perceived difference in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff. In order to inform this objective some historic perspective is necessary. I felt it important to gain an understanding of the past history of nurse education and the impact that gender, power and ethnicity has had on nurse education historically, to ascertain how these influences may continue to impact today. This further informs the concepts of power and influence in the NHS since its inception and unearths some of the influences in terms of the nursing profession's ability to influence and drive forward the NHS care agenda.

Since the NHS started in 1948, healthcare has been free for all at the point of delivery (DH, 2012). More recently, greater emphasis has been placed on the delivery and quality of healthcare and the patient experience, with the quality of healthcare provision considered as important as the quality of the treatment provided (DH, 2012). Patients' experiences of their own journeys through the healthcare system are influenced by the environment, the healthcare staff that they come into contact with and the humane skills with which their care was delivered (DH, 2012). The NHS requires the right number of staff with the right skills (DH, 2012). The Government, Health Education England (HEE) and NHS England have a duty to ensure that sufficient staff are available to meet the NHS's needs now and in the future (Berwick, 2013).

In order to gain an understanding of what nurse education wants to achieve today, the inception of nursing in the NHS needs brief exploration. It would appear that the development of the NHS in 1948 was largely down to negotiations between the government and consultant doctors, the most influential and politically powerful group in healthcare at that time. This group of professionals were given an exclusive role in the development of NHS policies, in partnership with the government and its bodies. This was clearly demonstrated by Aneurin Bevan, the Labour Minister for Health, who was instrumental in securing power for hospital doctors in this new environment (Abel-Smith,

1964). Doctors were held with high regard and nurses played a secondary role with regard to service development; one report notes nurses were “treated as handmaidens” (Pascall, 1997). Nurses were perceived as subservient to doctors, not only by the public and medical staff, but also by nurses themselves – a role some have theorised was supported by gender norms and politics of the time (Pascall, 1997). The personal service that women provided in their caring role was seen as an extension of their role in the family, and this had an impact on the value given to nursing as a profession (Land & Rose, 1985). This argument gives some support to the theory that nurses have generally been afforded a low status in society, arising from the profession’s links to femininity and care for others (Masterton & Maslin-Prothero, 1999). Nurses were not actively involved in the process of any political or health-related negotiation. It was understood that nurses would accept and be happy with anything that was asked of them (Masterton & Maslin-Prothero, 1999).

This patriarchal philosophy continued into the 1980’s with the introduction of general management to replace the profession-specific management that had developed since the 1950’s. It was following the Griffiths enquiry (Department of Health and Social Security (DHSS), 1983) that nursing lost a large amount of its representation at management level. This government-wide approach saw a decrease in the status of senior nursing, and the career structure that had been exclusively available for nurses was removed (Walby et al, 1994). Griffiths did not perceive nurses as instrumental in decision making (Davis, 1995). A consequence was that it was more difficult for nurses to achieve success in leadership roles. Evidence from varied research substantiated that this continues to occur in today’s NHS (Castille, 2014).

Nursing continues to be challenged by negative stereotypes and not all nurses are empowered (Kelly et al, 2011). If this is the case, then the issue of how they come to gain power is an interesting one (Bradbury and Jones et al, 2007). The concept of power and empowerment is one that nursing education has historically overlooked (Masterton and Maslin Prothero 2002). Power has been closely linked to knowledge, with greater knowledge ensuring greater power (Foucault, 1973). In medicine, knowledge historically has enabled medical doctors to exercise power through scientific knowledge (Walt, 1994: Peckham & Exworthy, 2003), and this has manifested in the important role they undertake

within policy formation. Conversely, nursing as a profession has been less influential (Northouse, 2004). Graduate skills, namely critical analysis, are seen as integral to developing the influence and future of nursing (Appelbaum et al, 1999: NMC, 2010b: Hayes, 2012).

Importantly, the development of graduate skills within the nursing workforce has been linked with the empowerment of nurses to effect change within their contexts (Hayes, 2012). Manojlovich (2007) argues that in the modern context, powerless nurses are ineffective nurses; they need power to be able to influence patients, physicians, other healthcare professionals and each other. Others have reported that nursing is still challenged by negative stereotypes and nurses are not empowered (Masterton and Maslin Prothero, 2012). Such a shift would represent a change in nursing identity – alignment towards a “management culture of performance-performativity” and away from “individual care and compassion” (Hayes, 2012). Chowthie Williams (2013) identified that in the pursuit of professionalisation and improved status, nurse education has moved away from mainly encompassing practical knowledge to increasing theoretical knowledge. She stipulates that the debate about whether nursing is a science or a practice continues to rage in the literature. Burnhams (2008) would argue that it is the practical component of nursing that makes the ‘good nurse’, with less focus on the scientific element of the programme. The proposed study would further explore nursing voice and perceptions of these influences.

## **2.7 Evidence for the impact of graduate-only nursing**

At the time this study was undertaken, there was conflicting empirical evidence as to whether graduate nursing was achieving its expected outcomes of developing a workforce knowledgeable, compassionate and confident nurses.

The concern that graduate level course entry requirements may be prohibitive is important, because it has implications for the size of the future nursing workforce; this is a current issue with an identified fall in nursing student numbers for the second year running in England (Mitchell, 2018). However there is evidence from English universities that there was also a fall in student nurse applications in 2012, before the introduction of graduate only programmes and the Council of Deans indicate that that there have been a high

number of good quality applications (Adams, 2017) . This would appear to suggest that this concern does not have strong foundations. This fall in nursing degree applications, runs in parallel with a fall in applications to all undergraduate courses following the BREXIT confirmations. Current figures do reveal a small fall in the number of nurses in England in August 2018 (Ford, 2018c).

A study undertaken at the University of Derby (Crick et al, 2014) examined the demographics of the degree student group that were similar to those of past cohorts of diploma students. 115 students completed a questionnaire on their first day of study on their nursing programmes. The data revealed that reasons participants cited for entering the profession were similar between the two groups. Importantly participants' motivations to become nurses were largely vocational; the primary motivator for these student nurses to enter the profession was given as a desire to care for others. Hence, the characteristics of the degree students, their strong motivation to care and perception of nursing in altruistic terms contradict the image of degree nurses as being primarily academically, technically and career driven.

Methodology in this instance requires further critique. This study used a questionnaire as the research tool and these are not without limitations. Questions are closed with no opportunity for participants to expand on responses, to give greater depth, context and understanding in relation to their response and the richness of the data is therefore limited. Questions cannot be expanded upon if there is misinterpretation, and consequently responses may not be pertinent or applicable to the question being asked. The point at which the questionnaire was distributed should be considered. In this study, the questionnaires were given to students on their first day of study in their nursing programmes. Students may be influenced by other factors when completing this questionnaire that may affect responses, in this case anxiety and nervousness, feelings that can be felt when entering a new environment and social situation. They may be wanting to please the researcher, not wanting to say anything that may influence their training moving forward. There is also a level of researcher imposition when developing the questionnaire, the researcher is making their own decisions and assumptions as to what is and is not important, and may miss something that is of importance. The study undertaken for the purpose of this author's thesis, would utilise a 1:1 style of interviews

with participants allowing further exploration of participant's experiences and enabling a rich in-depth understanding of experience.

Via a discourse analysis of the online forum of the Royal College of Nursing (RCN) website, Hayes (2012) explored the dichotomy surrounding graduate-only nursing between the vision of the caring bedside nurse and the nurse as a care manager in the modern context. Hayes (2012) identified discussions surrounding what nursing as a profession was "lacking" and how 'graduateness' could develop the profession to be fit for its current and future context. Her critical discourse analysis was centered on power and identity. Hayes emphasised how some nurses saw 'graduateness' as a mechanism for the development of nursing's position in terms of cultural and social capital, while others lamented the loss of the traditional nursing identity that such a move necessarily entailed. The limitations of using purely textual data need to be acknowledged. These include; lack of opportunity to witness the non-verbal cues and nuances that participants often display with one-to-one or group interviews or to challenge the participant to explore further their thoughts and feelings. Further, in the Hayes (2012) study, there were participants who emailed the researcher personally to provide their responses, not feeling comfortable to post in an open forum where issues of confidentiality posed a concern for some. This factor may also have influenced previous postings and signals a further potential limitation on overall analysis.

## **2.8 Participation in nursing education**

One of the objectives of this study was to identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity. An important concern of nurses with the shift to graduate-only training is the effect it may have on participation within the profession (Hayes, 2012). Historically nursing has tended to recruit entrants from a relatively narrow population. O'Donnell (2010) observed that trainee nurses often did not have the necessary qualifications for entry into education programmes or careers perceived as more elite. It has been theorised by (O'Donnell, 2010; Hayes, 2012) and others that moving to degree-only courses has been to the detriment of traditional nursing applicants who feel threatened by the academic nature of the courses. A drop in nursing course applications for the second year running (Mitchell, 2018) further supports this contention.

## 2.9 Recruitment

O'Donnell (2010), Hayes (2012) and others argued that nursing has now become more elitist, discouraging access by groups of people who may well be excellent care providers, but who are disenfranchised by higher academic entry requirements. The work of the DH (2010b) articulates an opposing view, with guidance provided to widen participation in nursing and consideration of workforce development models. One of the objectives for this study was to identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity, to see if this was borne out in practice.

In meeting the stipulated Equality Act (2010) standards on widening participation and access to programmes, the NMC were required to set and publish quality objectives outlining how they will meet the requirements of the Act (NMC, 2012). Within this document, the NMC identified embedding diversity, as number one of four quality objectives. The NMC acknowledges that it has an important role to play in promoting equality and diversity throughout the nursing profession in the UK (NMC, 2011). It professes to value accountability, fairness, professionalism, progressiveness and inclusiveness (NMC, 2011). It aims to be an example of good practice within healthcare regulation, by eliminating discrimination and advancing equality and diversity in the workplace (NMC, 2011).

The broader higher education agenda is relevant to this study. Russell Group Universities are facing mounting pressure to reform admissions processes for students from disadvantaged backgrounds. Some are considering lowering entry requirements to achieve this aim (Kentish, 2017). Fewer than one in five young people from the most disadvantaged areas enter higher education, compared to more than one in two for the most advantaged areas (Kentish, 2017). Concerns arise from these studies about the impact of access to a graduate only programme on applicants to nursing programmes and the participation rate of disadvantaged young people.

## 2.10 Attrition

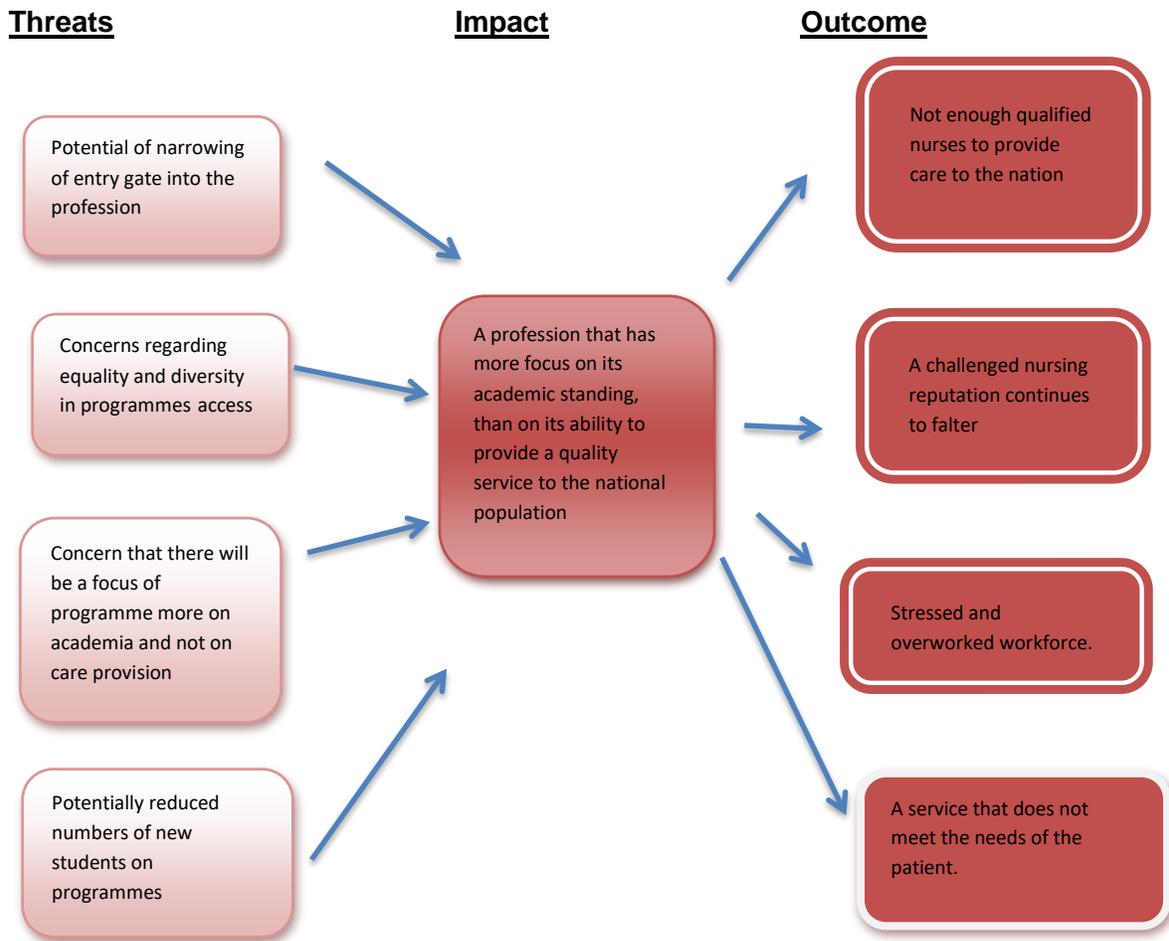
Solely based on the attrition statistics, there are major concerns for the future supply of a nursing workforce that has coincided with the move to graduate-only nursing. 23,000 nurses allowed their registration to lapse between 2012 -13. This occurred at a time when organisations were already experiencing great difficulty in recruiting to vacant posts (Linten, 2013). Numbers of nurses opting to retire also increased 128% from 2009 to 2013 (Linten, 2013). There are already multitudes of issues influencing the supply of nurses to the future nurse population. The introduction of higher entry requirements creates challenges in terms of access for all. Logic suggests that this may further compound the problem of diminishing numbers of nurses in the healthcare system. Unfortunately, research to evidence these claims is limited and further investigation would be useful.

An urgent reassessment of attrition rates in nursing programmes was called for to ascertain the reasoning behind such large drop outs from nursing degree programmes by Willis (2014) who advocated using a standardised tool for exit interviews. An independent report has found that a quarter of nursing students are dropping out before graduating (Jones-Berry (a), 2018) .Students cite; personal reasons, family difficulties, academic issues, lack of support from tutors/mentors and financial problems as reasons for leaving (Merrifield, 2015). There is limited research about student's decisions to withdraw which are likely to be complex and involve multiple issues. Misconceptions of nursing and nursing education as a career are commonly cited grounds for attrition (Willis, 2014): making the 'wrong career choice' is among the top five reasons for attrition. An absence of graduate only programme attrition numbers reveals that there has been no research undertaken to date into why attrition may occur specifically amongst nurses taking degrees. There is some evidence that some Universities are already working hard to reduce attrition (Jones-Berry (b), 2018). The Council of Deans of Health (CoDoH) have developed a project relating to student nurse leadership, where student mentors provide a key support mechanism to listen to struggling students so they do not feel so alone. Willis (2014) suggested that HEE needs to acquire greater understanding of the data, and of the rationale for attrition, in order to make changes and effectively support universities, providers and students to maximise student retention.

In light of the absence of research in this area, a two-year study, called Reducing Pre Registration Attrition and Improving Retention has been developed (REPAIR) (HEE, 2017). It will look at the experiences of nursing, midwifery and therapeutic radiography students from the point they apply, up until the end of their first year in practice. The study will collect data on attrition rates from more than 50 universities for the cohort of students that completed training in the academic year 2013-14. Concerns regarding the numbers of students completing programmes and therefore the supply of nurses for the future, is further identified as an issue of concern in the author's research study. It was hoped that participant's responses would further address this issue. This report is due for publication so implications in practice of recommendations are not yet known.

### **2.11 Conceptual framework**

The researcher's role within any qualitative research is to gain a holistic overview of the context under study, its logic, its arrangements and its explicit and implicit views (Miles and Huberman, 2013). In aiding this process the following conceptual framework was developed based on a critique of the literature available (Figure 1). This emergent conceptual framework was used to explore the main areas to be studied throughout the research process; it identifies the key factors, constructs or variables and the presumed relationships between them (Miles & Huberman, 2013).



Utilising a conceptual framework for the study enabled me to be selective in deciding which variables were the most important, which relationships most meaningful and therefore which information was to be collected and analysed (Miles & Huberman, 2013). Selection was dependent upon the impact of the variable and the influence that it could have on nursing care delivery. The factors identified within the framework as threats, were to be further explored within the interview process undertaken for this study. As the researcher, I was influenced in this process by my ongoing experiences as a health services lead. I am acutely aware of the challenges I experience in my role and acknowledge my own ontological position and the influence that this could have on the research undertaken.

## **2.12 Summary:**

In summary this chapter has systematically and critically explored existing knowledge available relating to the aim set for this study. In doing so I identified gaps in relation to an absence of nurses' voices pertaining to the introduction of a graduate only approach. I also detected gaps in the literature and evidence of current perception of a group of nursing professionals, which were not informed by previous studies. Concepts relating to the inception of the NHS and the role that nursing played at that point, up to current day practice, have been explored and discussed critically in relation to the influence of power and nursing voice in today's rapidly fluctuating NHS environment. This review was used to build a conceptual framework which has been developed for the research study and carefully explained. It was intended that the study undertaken would further inform and explore, the outcomes of the graduate-only route approach.

As a researcher, I was interested in understanding what drives the nursing education agenda and whether there was a need for change in the previous educational approach. The study coalesces around a robust research question, with achievable aims and objectives. These were identified as:

### **Research questions**

Key questions would be posed to gain the experiences of current healthcare staff:

What was the perceived view of graduate and diplomate nurses of the impact of their qualifications on care delivery?

What was the perceived difference in experience of senior nurses working with the graduate vs diplomate nurse?

How do registered health care staff view the new entry criteria to nurse education?

What is the perceived difference in the nursing abilities between a degree vs diploma qualification in practice?

### **Aim**

The aim for this study was identified in order to make a broad statement of the desired outcomes and intention, emphasizing what was to be accomplished by the study:

- To explore the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care.

**Objectives:**

- To explore graduate and diplomate nurses own perceptions of the impact that a graduate only qualification may have on nursing care delivery.
- To explore nurses experiences of working with the graduate vs diplomate nurse, to ascertain ways in which they may perceive difference in ability
- To identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity
- To identify any overall perceived differences in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff.
- To explore participants perceptions of the 'good nurse'

## **Chapter 3 – Methodology**

### **3.0 Methodology**

This chapter explores the methodology chosen in relation to its fitness for the purpose of addressing the research questions identified. A rationale for the methodology will be defended in relation to the choice of approaches. The use of interpretive phenomenology will be deliberated and justified.

#### **3.1 Research Question/Aims/Objectives**

##### **Question:**

*Nurse Education: Graduate Versus Diplomate. Does having a nursing degree make you a better nurse?*

##### **Aim:**

The **aim** of the study was to:

- To explore the impact that the introduction of an all-graduate nursing programme may have on the provision of nursing care.

##### **Objectives:**

The following **objectives** were identified:

- To explore graduate and diplomate nurses own perceptions of the impact that a graduate only qualification may have on nursing care delivery.
- To explore nurses experiences of working with the graduate vs diplomate nurse, to ascertain ways in which they may perceive difference in ability
- To identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity

- To identify any overall perceived differences in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff.
- To explore participants perceptions of the 'good nurse'

### **3.2 Epistemology/Ontology/Methodology**

This study was designed to look at the lived experience and the day-to-day reality of the nurse education arena and the impact that this has on the nursing profession. In order to gain the perspective of participants, a research approach was required that would ensure that rich and pure data was obtained. Rich data describes data that should reveal the complexities and richness of what is being studied. Pure data is defined as “basic” or “fundamental” research which is exploratory in nature and is conducted without any practical end-use in mind. It is driven by gut instinct, interest, curiosity or intuition, and simply aims to advance knowledge and to identify/explain relationships between variables. This study therefore utilised a qualitative research design within a naturalistic paradigm, with patterns of interconnected themes and processes, obtained from semi-structured interviews with participants, used as a means of understanding the whole incident reporting picture (Pollit & Beck, 2010). The merits of such an approach allow for the observation of natural behaviours, giving the opportunity for participants to share real lived experiences and perceptions. Limitations are acknowledged and it is understood that individuals experience things differently and draw very different conclusions from apparently similar situations. Naturalistic enquiry is criticised for subjectivity however I felt well suited to this research study.

Qualitative methodological approaches to this study were considered at length from the outset. Attention was paid to ontological and epistemological factors. Based on the research questions and aims, interpretative phenomenological analysis was chosen as the methodology because it seemed to offer as a suitable way to study the lived experience and the day-to-day reality of nursing education and practice. In this chapter, I explore the ontological and epistemological implications of this methodology and how it led directly to the development of my specific methods for this research question.

Philosophical paradigms in research are sets of beliefs and practices that regulate inquiry within a discipline. They can provide lenses and different conceptual models with which to view how a study is carried out (Edwards, 2008). This study utilised the naturalistic paradigm of inquiry attempting to explore the real life, lived experiences of participants facing the everyday complexities of the nurse education arena. The approach is designed to capture behavior as it really is in everyday clinical practice. Qualitative approaches to research are systematic, interactive and subjective and used to describe life experiences and give them meanings. These meanings can then be applied to the research in question. The ontological standpoint adopted is based on the notion that there is no single universal reality, because everything is open to interpretation by various agents. The research strives to encompass multiple realities for the phenomenon in question (Speziale & Carpenter, 2003). Epistemological theory approaches research from the standpoint that the knowledge is developed from subjective observation (here applied to day to day work related experiences of the participants). Rich description and in-depth understanding can be gathered via such an approach (Speziale & Carpenter, 2003). Philosophy of qualitative research places significant importance on the subjectivity of any study. Qualitative researchers believe that truth is both complex and dynamic and can be found only by studying persons as they interact with and within their own settings (Creswell, 2003). In this instance nursing staff working in their day to day environments and well suited therefore to this research question exploring the real complexities in daily nursing practice in a busy NHS Trust.

Qualitative data has strong potential for revealing complexity, by providing vivid description which is nested in real context (Miles & Huberman, 2013). The need for such an approach to research was originally identified by the social scientists and was developed due to the frustration and recognition by a number of researchers, that unlike quantitative data collection, some phenomena are not amenable to simple measurement (Husserl, 1931; Heidegger, 1962). Investigators began to recognise that to care for people and consider behaviour change, methods that employed listening, observing and interacting were needed (Spielberg, 1975; Parahoo, 2014). This approach therefore was well suited to a study of nursing practices, which are in themselves embedded in a broad range of complex communication exchanges.

Interpretive enquiry, a tradition based on assumptions that in order to make sense of the world, human behaviour should be interpreted in interaction with others (Gerrish & Lacey, 2010), was utilised in this study in an attempt to use interpretation and personal or theoretical sensitising, to highlight important themes (Gerrish & Lacey, 2010). This approach allowed for the collection of data regarding the perceptions of both student nurses' and qualified nurses experience, which enhanced exploration of the phenomenon in question (Todres & Wheeler, 2001; Arrigo & Cody, 2004).

Qualitative interviewing was undertaken in this instance as it is attractive to researchers who want to explore voices and experiences which they believe have been ignored, misrepresented or suppressed in the past (Byrne, 2004). This approach to data collection is therefore well suited to the research in question, as current understanding of degree versus diploma practice in nursing is not well documented. Qualitative approaches have been increasingly utilised to undertake nursing research in recent years and have been identified as important approaches to further develop nursing knowledge and practice. It lends itself to elucidating human responses to actual or potential health and health care related problems (Ploeg, 1999). Qualitative research is used to gain insight into people's attitudes and behaviours, exploring their value systems, concerns, motivations and aspirations and is therefore well suited to the nursing profession. This study focusses on authentic voices from those staff experiencing the introduction of the graduate only nurse in practice and is unusual in that it is in real time, during what is an historic change in nurse education approach and can therefore claim originality.

A quantitative approach in any study whether that be health related or not, primarily uses post-positivist claims for developing knowledge (Creswell, 2003). Opposed to this is the qualitative approach employing naturalistic inquiry, which always takes place in the natural setting, indeed this study was undertaken within a daily functioning NHS clinical care setting. Naturalistic studies should result in rich, in-depth information with the potential to illustrate the multiple dimensions of the phenomenon in question (Cresswell, 2003). This interpretive approach began with the acknowledgement that there is a gap in our understanding of graduate versus diploma nursing in daily practice and that clarification of current practice would be of benefit for future nurse education and current nursing practice

(Hancock, 2002). Employing such a design does not necessarily provide definitive explanation to the posed research question, but any data obtained does raise awareness and increase insight (Bowling, 2014). Some nurse researchers however, continue to raise epistemological issues about the problems of objectivity and validity of qualitative research findings (Altheide & Johnson, 1994). However, as researcher I felt it important in this instance, to utilise an approach that would provide reflection on real time, daily experience of the phenomenon in question, so felt therefore that this would be well suited.

The use of phenomenology in nursing research is a popular one, this could be due to its parallel with nursing values, in that it considers the whole person and places importance in their experiences. Nurses often relate to the phenomenological approach because it values the individual's experience and they may feel they already have some of the necessary skills, such as interviewing and understanding (Balls, 2009). These are skills that nurses are familiar with and use on a daily basis whilst undertaking patient care. As investigator, I felt it important not to lose the individual voice of participants in the research undertaken and therefore chose to employ the workings of Heideggerian Phenomenology (1962).

The aim of interpretive phenomenology/hermeneutics is to describe, understand and interpret the participants' experiences. There are a number of concepts in interpretive phenomenology 'being-in-the-world' (Dasein), 'fore-structures', 'life-world existential themes' and the 'hermeneutic circle'. Dasein Reed and Ground (1997) stated that Dasein means that being human is a situated activity, a situation in which things are encountered and managed. Heidegger's understanding of Dasein means that we are 'always already embedded in a world of meaning' (Van Manen and Adams, 2010). The focus of interpretive phenomenology is to explore the lived experience; therefore, it is important to consider that people's realities are influenced by the world in which they live. I kept this influence in mind when employing the chosen methodology and considered how this may influence bias in participant's responses. Previous experiences of the participants in their own working practices could influence on their own responses during interview. Researchers employing this methodology need to understand that experiences are linked to individual social, cultural and political contexts (Flood, 2010).

Herein consideration needs to be given to the concept of bracketing in phenomenology. The notion of bracketing is compatible with interpretive phenomenology because although no one can avoid being influenced by factors in their lives, the aim is to be aware of these factors and realise that they may influence how we understand or interpret something (Flood, 2010). Interpretative phenomenologists believe it is impossible to rid the mind of preconceptions and approach something in a completely blank or neutral way. They believe that we use our own experiences to interpret those of others. A core aspect of interpretive phenomenology, is that the researcher is considered inseparable from assumptions and preconceptions about the phenomena under investigation, and that these must be acknowledged and integrated into the research findings (McCance and Mcilpatrick, 2008). I had 32 years of experience in nursing and nurse education that required consideration when undertaking the study. Researchers cannot detach themselves from what they know or think (Flood, 2010). It is important therefore to acknowledge and identify pre-research understandings, so that readers of the research are clear about the study's context and possible influencing factors. As researchers, we interpret something in which we ourselves exist; therefore, we have no detached standpoint (Koch, 1995; Lopez and Willis, 2004). Participants too are influenced by their experiences and individual standpoints. Acknowledgement of subjectivity in this research was paramount,

### **3.3 Limitations and Strengths of the Qualitative Approach**

There is a belief that qualitative research is difficult to define due to the absence of a common unified set of techniques, philosophies and underpinning perspectives (Mason, 1996). A key criticism of qualitative design studies is that they are not scientific, that they are anecdotal and can be impressionistic (Parahoo, 2014). The term 'scientific' in this instance relates to numerical information that can be statistically analysed. It was key to this research therefore that the information obtained was rich and reliable, and central to the process was the need for research to be conducted rigorously and systematically. Nurse researchers raise epistemological issues about the problems of objectivity and the validity of qualitative research findings (Cutliffe & McKenna, 1999). This research study relied on the participant's experiences; these were real time/current and obtained from a

range of participants immersed in everyday nursing practices, with varying degrees of experience, different bandings and a combination of Child/ Adult/ Mental Health and Learning Disabilities nurses. This was seen as a real strength in this phenomenological approach, which demonstrated an in-depth understanding of individual phenomena, achieving rich data from the experiences of individuals. There are no claims for generalisation to the wider nursing population and this data was applicable to this particular area of study; however, the study has merit in that the graduate only approach has been implemented across England in an NHS culture that is experiencing the same challenges.

The researcher acknowledges that this was a small sample size, however it has fuelled the basis for further research studies and identified real implications for clinical practice and nurse education and the future preparation of the nursing workforce. This study could easily be applied to a larger multi centered study, which would further explore the phenomenon in question and expand on the themes already identified. Data saturation was reached at a point in the study when 15 participants had shared their experiences, Lengthy discussion and consideration with the academic supervisor for this study concluded that data saturation had been reached, there was enough information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012), it had obtained additional new information (Guest et al, 2006), and further coding was no longer feasible (Guest et al., 2006). Data saturation is hard to define due to the fact that there is no one universal study design, however the data achieved in this study was felt to be rich and detailed.

Consideration should also be given to the fact that the research was undertaken, some 4 years prior to this thesis completion. While I have attempted to bring the literature search up to date in the light of the time lapsed since the interviews were undertaken, revisiting participants to collect new data was unrealistic. Some staff had left the organisation and would not be able to be found. However because the study is methodologically sound, it has merit and claims a contribution to knowledge in that it was undertaken during infancy of the introduction of the new educational approach A repeat of this study now, would further draw on the impact that the degree only nurse has had on the provision of front line nursing care delivery.

The study was piloted as part of the taught component of the EdD programme of study and submitted as part of an educational requirement. This pilot study assignment was very positively evaluated by the academic reviewer, providing validation in the method and process of the study being undertaken. The pilot provided insight into the need to ensure that protected time was given to participants and the need to ensure that studies were undertaken in participants own clinical surroundings, primarily to support participation in what would otherwise pose a challenge to participate, but also to ensure that participants felt comfortable and safe in participating. Reducing anxieties and unknowns.

The subject of validity and reliability requires careful consideration with qualitative interviews being used for data collection. Reliability reflects the accuracy of the data collection in a semi structured design and relies on the researcher having a consistent approach during each interview and having a well designed schedule (Gerrish & Lacey, 2006). Validity represents how true the data is, with consideration being given to Gerrish & Lacey's (2006) recommendations when ensuring validity:

- Has the sample any built in bias
- Are the questions posed addressing the participants concerns, views and experiences?
- Have the interviewees been given the opportunity to adequately present their views within the interviews.
- Has the researcher led or influenced the participants in any way. It is very important for the interviewer to remain impartial and not influence any bias on the interview responses in any way.

There is an enhancement of validity in semi structured interviews as respondents can be assisted to understand the questions and interviewers can be asked for clarification and have the opportunity to probe for further responses (Parahoo, 2006). Validity can also be enhanced by the presence of an interviewer, by picking up on non verbal cues when a participant is unsure or not understanding of a question (Parahoo, 2006) and further clarification can be offered. Content analysis is a particularly reliable means of analysing qualitative data, in that reliability of coding decisions can be confirmed by revisiting previously coded data to check the stability (Priest et al, 2002).

Claiming that research has construct validity, is claiming that researchers understand how constructs or theories of programs and measures operate in theory and we claim that we can provide evidence that we behave in practice the way we think they should (Messick, 1980). The researcher provides evidence through observation that the programs or measures actually behave that way in reality. Undertaking the research whilst immersed in clinical practice, enhanced that overall validity of the study. Construct validity claims that our observed pattern, how things operate in reality, corresponds with our theoretical pattern or how we think the world works. This can be referred to as process pattern matching, and is thought to be the heart of construct validity (Messick, 1980). Claims that the findings extend beyond the specific context are not made because the research was undertaken within one large organisation and at one point in time, however the methodology utilised allows for replicability and can therefore be tested following some time lapse.

Credibility, neutrality or confirmability, consistency or dependability and applicability or transferability are to be the essential criteria for ensuring quality in any qualitative research study quality (Lincoln & Guba, 1991). Dependability in qualitative research closely corresponds to the notion of reliability in quantitative research (Lincoln and Guba, 1991). The concept of dependability is endorsed with the concept of consistency or reliability in qualitative research Clont (1992) and Seale (1999). The consistency of data is achieved when the steps of the research are verified through examination of such items as raw data, data reduction products, and process notes (Campbell, 1996). If the validity or trustworthiness of any qualitative study can be maximised or tested, then more credible and defensible results are achieved. The quality of a research study is related to the generalisability of the result and thereby to the testing of the study, increasing the validity or trustworthiness of the research (Patton, 2002). The methodology adopted in this study whilst limited to organisation and point in time that it was undertaken, is potentially generalisable to other areas where nurses are part of the workforce and if different findings are found in different contexts, this in itself would be illumination giving further insight into the current situation. Maxwell (1992) observes that the degree to which an account is believed to be generalisable is a factor that clearly distinguishes quantitative and qualitative research approaches. Although the ability to generalise findings to wider groups and circumstances is one of the most common tests of validity for quantitative research,

Patton (2002) states generalisability as one of the criteria for quality case studies depending on the case selected and studied. In this sense the validity in quantitative research is very specific to the test to which it is applied – where triangulation methods are used in qualitative research. Triangulation is typically a strategy (test) for improving the validity and rigour of a study. Onward progression of this study would further validate the methodology and may generate findings, which mirror those of this study or indeed contest them.

The subject of rigour in any study requires careful consideration with qualitative interviews being used for data collection. Validity also requires consideration and represents how true the data is, with consideration being given to Gerrish & Lacey's (2010) recommendations when ensuring validity:

- *Has the sample any built in bias?*

These biases needed to be acknowledged within the study, including participant and researcher bias. The researchers previous experiences and influences and the participants previous nursing experiences. Whilst bracketing has been discussed previously in this text, the influence that previous experience has on any research needs consideration. Unconscious bias was also considered.

- *Are the questions posed addressing the participants concerns, views and experiences?*

The benefit of utilising a semi structured interview was the ability to adapt questioning to address each individual participant experience. The researcher in this study was able to explore in depth each participant's experience, drawing on the individuality of each participant.

- *Have the interviewees been given the opportunity to adequately present their views within the interviews?*

In this study each participant was given the opportunity to add anything that they may have missed in the interview at the end before interview closure.

- *Has the researcher led or influenced the participants in any way? It is very important for the interviewer to remain impartial and not influence any bias on the interview responses in any way.*

The interview questions posed were open ended and indirective. The interviewer tried to leave personal bias and influence in relation to the participant's responses, as bias can affect the validity and reliability of findings. Moderator bias was mitigated as much as possible, body language and tone was kept neutral. Questioning within the interview was directive with care taken to ensure that no influence was exerted on the participants by the researcher (Streubert Speziale & Carpenter 2007), interviewer bias being the subconscious or conscious effort of the interviewer to bias respondents to answer in a certain way (Bowling 2014). Key questions asked in the initial interviews were drawn from the small amount of available literature and were also influenced by the objectives of the study. Consideration needed to be given to recall bias within the data collection and analysis of the study, being the selective memory of participants in recalling past events, experiences or behaviour (Streubert Speziale & Carpenter 2007) and reporting bias being the failure of respondents to reveal the information requested. With note taking there is also a risk of bias as the note taker is likely to make notes of the comments which make immediate sense, or that are perceived as being directly relevant or particularly interesting to the researcher (Hancock 2002). The data collected in this study has taken the form of narrative information (Pollit, Beck & Hungler 2010).

### **3.4 Study Design**

#### **3.4.1 Context/Sampling**

Purposive sampling was utilised for this study. This ensured that respondents with particular characteristics were selected, to ensure that information-rich interviews focused on the experience of nursing were achieved (Patton, 2002). This type of sampling has often been referred to as theoretical sampling. Bowling (2014) warns that purposive sampling has been criticised for the fact that results may not be generalisable to the wider population, unless random sampling has been employed. For this study, it was felt important to obtain a representative sample of students and registered staff from different

nursing specialties to gain as much knowledge as possible about the phenomenon in question. Experiences within specialities may bring an altered perception of the graduate nurse, roles may have been deployed differently in different specialist settings. It was felt important that a range of nursing knowledge and experience be sought and part of the research interview, this would give a varied perception in terms of experience, organisational memory (organisational meaning health care provision) to form a comparison of experiences. The researcher felt it important to gain insight into the experiences of a broad range of nursing services, including, children's nursing staff, adult nursing, mental health nursing and learning disabilities nurses. Experiences within these nuances may alter the overall perception of the graduate only approach to nursing.

There is no exact way of determining the right sample size in qualitative research. Sample size depends on consideration of a number of factors including the quality of data obtained, the scope of the study, the nature of the topic and research question, the amount of useful information obtained from each participant, the number of interviews per participant, and the qualitative method and study design used (Morse, 2000). The size of this study was determined by data saturation. When the same themes and repeated responses were being provided, the researcher felt that at that point the research was unlikely to obtain any new concepts.

A study that is broad in scope may require greater number of participants than one that is narrower in focus (Morse, 2000). Another aspect to consider was the ethics process that the researcher had to complete to undertake the study within an NHS trust. The ethics process was long and arduous and whilst university ethics was obtained in a matter of weeks, Trust Research and Development (R&D) approval took 8 months to achieve. NHS and university ethics had been granted for a one centre study and research time was limited and bound by the completion of the thesis. The timing and number of participants, the investigator believes, was adequate for answering the research question. When responses became repetitive, the researcher felt that data saturation had been achieved and therefore suspended any further interviewing.

### **3.4.2 Recruitment**

Once ethical approval had been gained from the trust research and development department, emails were sent to all relevant service leads to inform them of the research and the need to source participants. Service leads were asked to distribute this email within their teams and participants were asked to contact the researcher directly to express their interest to participate, this could either be by email or telephone. Appropriate measures were taken to obtain informed consent from all participants (RCN, 2015). For the purpose of this study a consent form in line with NRES (2015) guidelines was developed for completion prior to interviews (Appendix 1). Participants were informed of the need for consent in the information leaflet (Appendix 2), inviting them to take part in the study outlining the nature of the research. Potential participants were then given time to read the participant information leaflet and decide if they would like to continue.

From the outset of the interview, participants were asked not to name work areas or members of staff. It was outlined to all, both within the information leaflet and at the beginning of the interviews, that should they identify a work area or staff name, that the researcher who is also a nurse would have to adhere to the NMC Code (2015) and may have to contact the staff member or placement areas employer to inform them of practice that has occurred. During the course of the research no participants identified any staff or work area names. Issues pertaining to confidentiality were paramount within this study due to its sensitive nature.

### **3.4.3 Data Collection/Interviewing**

There are many ways of collecting data if researchers want information about the lived experience of a phenomenon from another person, one such approach is the traditional face-to-face interview, and another where researchers can ask for a written accounts of the experience (Giorgi, 2009). There is no one identified assurance to the quality to a good interview, however there is one main criterion according to Giorgi (2009) which is as complete a description as possible of the experience that a participant has lived through. The face-to-face interview is often longer and thus richer in terms of its content and depth. The shorter written descriptions Giorgi (2009) believes are useful for undergraduate

research projects or workshop material. Although there is the potential to recruit larger numbers of participants in collecting shorter description, there may be many nuances usually gained in the longer face-to-face interview that would be lost in pure written description. The design of this study was one that emerged as the research progressed; allowing the researcher to make ongoing decisions about the study, through reflecting on what had already been learned (Lincoln & Guba, 1991).

A popular alternate form of qualitative interview is a group format in which participants share and discuss their views of a particular topic, allowing access to a large number of possible views and a replication of naturalistic social influence and consensus processes. However, for this study there were time and access constraints to staff, who were already challenged in terms of commitment in practice, to attend face-to-face interviews. IPA was utilised as it is also suited to individual interview, due to its focus on in depth analysis of an individual's experience. The undertaking of focus groups and taking numbers of staff away from practice at any one time, would have had clinical practice implications and was therefore not utilised in the study, at the time that it was undertaken. There were severe clinical pressures on the healthcare system, and to deplete the workforce, removing large numbers of staff at any one time, would have compounded the issue. There have also been a number of disadvantages identified to the utilisation of focus groups, groups can become influenced by one or two dominant people in the session making the output biased, this requires skilled moderation (Doody et al, 2013). Focus Groups may also not be as effective in dealing with sensitive topics; it could be difficult to have the participants share their real feelings towards some sensitive topics publicly. This can in turn influence the output data, indeed given the nature of the research in question and considering work colleagues of both degree and diploma would be in the same discussion, the participants may feel restricted in their discussion, which may limit the responses.

Qualitative interviews were deemed appropriate for this study as they are distinguished by their deliberate giving of power to respondents. The interviewer empowers participants to take the lead and to point out important features of the phenomenon as they see it. Utilising this strategy has been shown to yield richer and more balanced pictures of the phenomenon (Gerrish and Lacey, 2010).

Semi-structured questions were used for this study in one to one interviews with participants, providing the opportunity to share their experience using their own vocabulary (Gerrish & Lacey, 2010) (Appendix 4). A more structured interview would have been utilised if the subject matter required less exploration, however as little was known about the phenomenon in question, a semi-structured approach was more suited (Gerrish & Lacey, 2010). There was the opportunity to change questions as the research study progressed, depending on the cumulative data obtained. The inquiry was then based on the realities and viewpoints of those participating in the study, realities and viewpoints that may not have been known at the outset (Lincoln & Guba, 1991). Data was continually examined and interpreted to make decisions about how to proceed, based on what has already been disclosed (Pollit & Hungler, 2010). In order to achieve rich data collection, the keynote was in the active listening skills of the interviewer, in which the interviewee felt that they had the freedom to talk and ascribe meanings to what they are saying (Noakes & Wincup, 2004).

Semi-structured interviewing, according to Bernard (1988), rather than unstructured or structured is best used when you will not get more than one chance to interview someone. Semi-structured interviews are often preceded by observation, informal and unstructured interviewing in order to allow the researchers to develop a keen understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions (Bernard, 1988).

The inclusion of open-ended questions and the training of interviewers to follow relevant topics that may stray from the interview guide does, however, still provide the opportunity for identifying new ways of seeing and understanding the topic at hand (Appendix 4). Although with semi-structured interviews there are a list of pre-determined questions, the conversation can unfold offering the chance to further explore and discuss issues raised (Clifford et al, 2010).

A total of fifteen individual semi-structured interviews were undertaken in this study, participant characteristics were as illustrated in Appendix 5. One-to-one interviews were used, to ensure the collection of rich data, with care taken by the interviewer to be non-directive and non-judgmental throughout the process (Bowling, 2014). Qualitative

interviewing is attractive to researchers who want to explore voices and experiences which they believe have been ignored, misrepresented or suppressed in the past (Byrne, 2004). Questioning within the interview was directive with care taken to ensure that no influence was exerted on the participants by the researcher (Hancock, Speziale & Carpenter, 2007), interviewer bias being the subconscious or conscious effort of the interviewer to bias respondents to answer in a certain way (Bowling, 2014). Key questions asked in the initial interviews were drawn from the small amount of available literature and were also influenced by the objectives of the study (Appendix 4). Care was taken to ensure that the interview schedule was not too tightly structured, as this may not enable the phenomena in question to be explored in terms of either breadth or depth (Hancock, 2002); an hour was allocated to each interview that took place, although they rarely took this amount of time.

Semi-structured interviews tend to work well when the interviewer has already identified a number of aspects that need to be addressed. The interviewer can decide in advance what areas to cover, but is open and receptive to unexpected information from the interviewee (Hancock, 2002). The issues to be addressed were incorporated within the interview questions. The interviews conducted were recorded and saved in a password protected file. Transcripts of the discussions were transcribed after the event; this was a laborious task and took some time to complete. Interviews were recorded so that the interviewer could concentrate on listening and responding to the participant. There was less distraction by trying to write down what the participant had said. The decision was made not to have a note taker within the interview process. With note taking there is also a risk of bias as the note taker is likely to make notes of the comments which make immediate sense, or that are perceived as being directly relevant or particularly interesting to the researcher (Hancock, 2002). The data collected in this study has taken the form of narrative information (Pollit & Hungler, 2010).

Consideration needed to be given to the influence of the researcher/participant power dynamic, on resultant data collected. The power dynamics between staff and researcher needed careful consideration, as the researcher was the line manager of some of the participants and also working within a leadership role in the trust that the research was undertaken. It is suggested that power in discourse is constantly negotiated and

constructed between participants (Thornborrow, 2002). The researcher considered at length the influence that the power dynamic may have had on participant's responses. Fairclough (1992) defined power as controlling and constraining the contributions of non-powerful participants in discourse by powerful participants. The researcher gave careful consideration to the way that the interviews were conducted, attempting to create a level playing field. Within the interview methodology power has several features including, controlling and constraining others' views and achieving one's goal by enforcing one's will on the other's opinion (Wang, 2006). The researchers own leadership style was one of a democratic approach and not autocratic and therefore unthreatening in practice. A belief in confidentiality also played a part in participant's responses and by them believing that confidentiality would be maintained, interview questioning responses were open and without boundary. It has been postulated that power in the interview can be built up and determined by socioeconomic status, educational or professional background, and gender or ethnic identity of the parties involved (Wang, 2006). During data collection, power shifts back and forth between interviewers and interviewees hence the asymmetrical power relation of the interview (Brinkman & Kvale, 2005). Interviewers are however expected to learn to be able to control the shift of power during data collection. Oakley (1981) acknowledged that the goal of a perfect and equal relationship in the prospects of the qualitative research interview seem unrealistic.

Data collection was originally planned to continue until relative thematic saturation was achieved, being the repetition and confirmation of previously collected data (Morse, 2000). This point was reached after 15 interviews, responses were tending to focus on the same view points and beliefs, therefore following discussion with the research supervisor, a decision was made to stop the research at that point. The employment of 2-10 participants or research subjects is sufficient to reach saturation; with long interviews recommended with up to ten people for a qualitative study (Cresswell, 2003). Saturation is used as a marker for sampling adequacy (O'Reilly and Parker, 2013). Questions have been raised however as to the accuracy of saturation in qualitative research. How does the researcher know that the next person sampled may have a very different experience, the exploration of data saturation and its influences has been called for (O'Reilly and Parker, 2013).

Data such as participant codes, consents and transcripts, were stored within a password protected computer file. The researcher only, had access to password coded information. Each participant was allocated a participant number and was identified by this number only throughout the research process. Data storage was planned for a total of two years, data protection guidelines were adhered to (NRES, 2015).

#### **3.4.4 Analysis**

One of the most challenging aspects of conducting qualitative research lies in the analysis of the data (Priest et al, 2002). Therefore crucial to the success of any qualitative study is the identification of a robust system of data analysis. The purpose of content data analysis within this study was to preserve the uniqueness of each participant's lived experience whilst permitting an understanding of the phenomena in question (Banonis, 1989), the data obtained then became increasingly focused and purposeful as the theory emerged (Pollit & Hungler, 2010). In terms of practical steps there is no one way to undertake an interpretative phenomenological analysis. Smith (2009) stresses that the emphasis with such an analysis should be on the focus of such analysis – on a commitment to understand lived experience of participants.

Content analysis is used to study the content of communication, it is the study of the content with reference to the meanings, contexts and intentions contained in messages given through the interviewing process (Berelson, 1952). Holsti (1968) says that it is any technique for making inferences by systematically and objectively identifying specified characteristics of messages. Kerlinger (1986) defined content analysis as a method of studying and analysing communication in a systematic manner. This method was utilised within this study, allowing for the subjective interpretation of data through the classification process of coding and identification of themes and patterns (Bryman, 2001: Pollit & Hungler, 2010). Exploratory studies particularly lend themselves to content analysis method, in that it gets the answers to the question to which it is applied (Carney, 1973).

Having originated in the 1950's (Berelson, 1952), this method of data analysis was originally used for the interpretation of quantitative data, however that approach was challenged, with arguments made in relation to the loss of meaning from text in the

reduction of distinct words; the need for a more qualitative approach encouraging meaning to be extracted from text more holistically was indicated (Kracauer, 1953). From this, a new form of content analysis, qualitative content analysis was developed (Altheide, 1996). Content analysis uses inductive reasoning by which themes and categories emerge from raw data, a set of systematic procedures/steps are then used for processing that data (Miles and Huberman, 2013; Bryman, 2001); it were these steps that were followed for the purpose of this data analysis (Fig 4): The text below is an excerpt from the transcription of interview 3, and will be used as a worked example to demonstrate the analysis of the data obtained.

***Do you have any thoughts on the new entry criteria in to Nursing?***

*I think a lot of people won't consider going in to nursing now. I think it will weed out a lot of people who genuinely want to care for people, but don't have the academic ability. The pupil nurse level.*

***Do you think there is a need for graduate nurses?***

*I think there is but I think there is not the need for everyone to be graduate nurses. There are those who genuinely want to care and look after people on the manual side of it. I don't mean to be detrimental but they are happy to care for people and not look to a career progression.*

***What do you perceive that those graduate skills should be?***

*I don't think that there is necessarily any nurses, any differentiation between nurses, but the graduate is looking more at career progression and not at providing the basics initially. I think graduate nurses are potentially more career driven and looking at going further up the pile. I don't necessarily, they will be there to provide the hands on care. They will be looking at managerial side of things.*

Step 1	Transcribing and reading data :
Step 2	Initial exploratory noting of 1 case
Step 3	Developing emerging categories/themes, and subsequently connections between/across these. <ul style="list-style-type: none"> <li>• Some people won't apply now.</li> </ul>

	<ul style="list-style-type: none"> <li>• Some won't have academic ability</li> <li>• Miss out on people who really want to care</li> <li>• Graduates may be looking more to career progression</li> <li>• Concern about hands on care delivery.</li> <li>• Graduate nurses more managerial</li> </ul>
Step 4	Repeat for subsequent participant
Step 5	Integrate patterns between participants
Step 6	Access coding consistency. The transcripts are to be read for significance and patterns of interconnected themes and processes identified as a means of informing the understanding of the whole phenomena (Pollit & Hungler, 2010).
Step 7	<p>Draw conclusions from coded data, making sense of generated categories</p> <ul style="list-style-type: none"> <li>• Concern in relation to missing out on potential good nurses who don't apply as don't meet academic requirements</li> </ul>
Step 8	Report findings.

Content analysis pays particular attention to validity by making inferences from observed communications in their context and is a crucial point in research generally (Silverman, 2006). To ensure the trustworthiness of data analysis, it was imperative that the researcher return to a selection of the participants and ask if the description reflected their experience, if this is found to be validated by the participant; the trustworthiness of the data was further established (Streubert Speziale & Carpenter, 2007). Lincoln & Guba (1991) suggest that there are four criteria for establishing the trustworthiness of qualitative data, credibility suggesting that there will be increased credibility with prolonged engagement and sufficient time spent in data collection to gain an in-depth understanding of the phenomena in question and which includes activities that increase the probability that credible findings will be produced. Dependability, looking at how dependable the results are, there can be no dependability without credibility (Streubert Speziale & Carpenter, 2007). Confirmability

being the way researchers document the confirmability findings, within this research the process of the study can be followed at all times. Finally transferability referring to the probability that the study findings have meaning to others in similar situations, can this be applied to other clinical practice settings and work environments nationally. Consideration need be given to the phenomenology of researcher and the influence of unconscious bias. Methodology can be replicating but might not be able to be generalised across contexts.

Following the transcriptions of the 15 interviews from the participants involved in the study, NVIVO was used to assist with the process of coding the text. An initial training session on the use of NVIVO within the university setting, promoted the use of the software to enable and assist with the data analysis. The initial use of the software and process posed further questions around its functionality for the researcher and the researcher's individual needs. A second taught session was then attended and issues with regard to the researchers own ability to function with the tool, to ensure it served as an active addition to the data analysis, was discussed with the trainer.

Whilst the use of NVIVO was initially thought to be an assistant in the content analysis process and would make the process less time consuming, the researcher felt that it detracted them from the real content of the data and became more of a task focussed

exercise, rather than allowing infusion with the richness of the data. There is much debate for and against the use of qualitative data analysis (QDA) software in qualitative research (Bergin, 2011). Consideration has been given to whether or not using the program distances researchers from their data (Bong, 2002) and thereby impedes or distorts analysis (Bourdon, 2002). The researcher felt detached from the real data and somewhat removed from its meaning, whilst reading it directly from the computer screen. Indeed it has been postulated that it is not the computer that interprets the text but the person (Gibbs, 2006). The researchers own learning styles and methods of reading and understanding, were then brought in to question and reviewed. Whilst all data was passed through NVIVO, the researcher felt it necessary to follow up NVIVO analysis, with self-led coding of the transcribed interviews, to immerse them more in the feeling of the data. This added to the time spent on data analysis, on reflection NVIVO whilst acknowledged as a

tool for content analysis, would not be one that the researcher would enlist the use of in any further research analysis. It has been suggested that the computer needs to be used as a tool purely for data administration and archiving and not for analysing the data (Kelle, 2004). The investigator as discussed above found this to be true in this instance.

### **3.4.5 Reflexivity and Researcher Positioning**

Patton (2002) suggests that credibility is dependent on the credibility of the investigator and that the researcher needs make explicit what they bring to the research in terms of experience, qualifications and perspective. The researcher has been a nurse for 32 years and for the duration of that time student nurse education has been a large part of any role that has been undertaken. A PG Cert in Education and a PG Dip in Strategic Leadership and Expert Practice (Education) and an MSc in Education, has heightened awareness of the development of the future nursing workforce. Having completed the previous five years as an Integrated Care Services Manager managing District Nursing, Respiratory, Community Matron and Diabetes Nursing services within a borough of a large inner city foundation trust and 10 years prior to that spent in a role in nurse education for an NHS trust, working both within the Trust and the university setting, had given an in-depth insight in to student nurse education and the preparation of future practitioners and factors that impact upon the student pre-registration experience and subsequent post registration practice. Now undertaking an Assistant Director for Patient Safety role, there is a broader more strategic view of the influence of nursing and the delivery of nursing care and the impact that this can have upon patient safety when the quality of that care is compromised. 32 years of nursing experience brings with it influences and pre-conceived ideas and it is important to be acutely aware of these influencing personal and professional pre-conceptions to ensure that these did not influence the interview process.

Consideration needed to be given to recall bias within the data collection and analysis of the study, being the selective memory of participants in recalling past events, experiences or behaviour (Streubert Speziale & Carpenter, 2007) and reporting bias when respondents do not reveal the information requested. As previously discussed, it was felt by the researcher that there was impact from reporting bias on the resultant findings due to the relationships between myself and participants involved being from different areas. I held

a managerial and leadership position and some of the participants were staff working within the areas that I managed. Consideration was also required in relation to the participants own phenomenology.

### **3.4.6 Ethical Approval**

The personal nature of qualitative research results in several ethical considerations. Unlike quantitative research there is no way of knowing exactly what might transpire in an interview and issues of privacy are paramount (Bowling, 2014). The dignity, rights, safety and well-being of participants must be the primary consideration in any research study (RCN, 2011). The University Ethics committee, in which the study was being undertaken, was approached and ethical approval obtained, this process was streamlined and relatively short (Appendix 6). NHS Research and Development (R&D) approval was also required and sought from the Trust where the research was undertaken (Appendix 7). This process took a total of eight months to acquire and was hampered by alterations in the trust R&D approval process and document requirements and also by the researcher's workload demands and pressures. Time was limited and prioritisation of need took the forefront. NHS R&D approval also required confirmation from university research and ethics approval and also from supervisors and course leaders, acquiring all of these documents took some time.

Following initial submission and approval of the RES 2C (Appendix 8), ongoing monitoring from the University Research Team had to be adhered to with yearly RES 3B (example of in Appendix 9 and 10), RES 3C (example of in Appendix 11) and RES 4 (example in Appendix 12). Following initial completion of the NHS IRAS research application and acceptance process, ongoing monitoring from the Trust research and development team was also required and regular updates and sharing of this research was provided by the researcher to the Trust. Presentations were provided on the development and ongoing management of the research study (Appendix 13), for the trust Research and Development days for all staff, this was shared across trust teams.

The interpretation of data from any study is also an ethical concern (Parahoo, 2014). Interpretation of the interviews should be checked with a selection of the participants for accuracy. Following this study, transcribed interviews were shared with individual

participants and checked for accuracy. Coding was used to interpret the data obtained in this study. Silverman (2006) warns of one of the disadvantages of coding schemes used in content analysis in that they are based upon a set of categories. This furnishes a powerful conceptual grid, from which it is difficult to escape, whilst the grid is helpful in organising the data, it also deflects attention away from categorised activities. However an advantage for researchers is that it offers convenience in simplifying and reducing large amounts of data in to organised segments (Silverman, 2006).

Interviews were undertaken within the practice setting as it was anticipated that staff may have felt more comfortable in surroundings that were familiar to them, comfort is an important issue to consider during the research interview process (Gerrish & Lacey, 2010). Consideration was also given to the fact that taking staff from practice would have an impact on service provision, so meeting staff in their own environment would release them to go back to work immediately following the interview. It was important for the researcher therefore to ensure that the participant was not interrupted during the interview. It was ensured that the rooms in which the interviews were conducted were kept private and interruptions were prevented taking in to consideration confidentiality which was of prime importance in this study (Bowling, 2014). Interviews should feel as though the participants are participating in a conversation or discussion rather than a formal question and answer situation (Hancock, 2002). Achieving this informal style was dependant on careful planning and on the skill in conducting the interview. The presence of recording equipment within the interviews may have intimidated students somewhat; however equipment was kept to a minimum in an attempt to reduce anxiety.

It was of paramount importance that all participants were informed of their right to withdraw from the study at any point (Parahoo, 2014), either during or following data collection and the researcher and researcher's supervisors names were given to them as points of contact should they wish to withdraw (Appendix 2). There was no contact from any of the participants following their participation in this study

### **3.5 Summary**

In summary this chapter has explored methodology and established that a phenomenological methodology was deemed most appropriate. This interpretivist stance

was felt most suited to obtain real time experiences of front line staff who face the day to day challenges in delivering quality care to patients. Issues of design, sampling and data analysis have been discussed and the importance of conformability, transferability and dependability identified. Rigour of the study has been discussed and challenges posed by the research explored. This approach was deemed suitable for the research question posed and aimed to understand and interpret participants' experiences, to determine the meaning of the experiences. I felt that the approaches chosen suited that of my own ontological standpoint and met the needs of the data collection and subsequent analysis. This thesis goes onto analyse the results and data achieved from the study giving voice to the participants experiences. The applicability of the study is examined and strengths and limitations identified. Data analysis and interpretation of data is also discussed in some length, to give credibility and trustworthiness to the data obtained, whilst considering the subjectivity of any research.

## **Chapter 4 - Findings**

This chapter explores the participants' responses and the results achieved from the research. It discusses four emerging themes from the data analysis and explores the potential impact that this could have on the future of nurse education and nursing care delivery, whilst drawing on concepts identified within the literature search for this study.

### **4.1 Findings and Discussion**

The analysis of the data obtained revealed four major themes in relation to the experience of the introduction of graduate-only nursing programmes for the participants. These themes are delineated briefly below, which precedes a detailed presentation of the analysis:

#### **Theme 1: Differences in performance and expectations-**

The majority of participants were unable, in a clinical setting, to determine the difference between graduate and diplomate nurses. This is important, because clinical performance on the ward was understood as the primary focus of nursing. They also thought any differences outside this context would be irrelevant to patients, an aspect that further emphasised the importance of the clinical setting. However, there were differences in the expectations of graduate nurses in other domains, notably academic (as opposed to practical) knowledge, and career-mindedness.

#### **Theme 2: Changes to the quality/qualitative nature of healthcare following the introduction of a graduate-only profession**

Participants held a strong shared understanding of nursing as a vocation, and the skills required to be a 'good nurse'. Furthermore, they expressed concern at how moving to degree courses may detract from nursing's vocational nature and that students might embark on courses for the wrong reasons.

### **Theme 3: Equity in education and access to nursing**

Participants held concerns that the introduction of a graduate-only programme would decrease the numbers and diversity of potential applicants to nursing programmes.

### **Theme 4: Supply to healthcare of caring nurses**

Participants raised concerns regarding the profession missing out on potential excellent nurses who may not be as academically able, having repercussions for recruitment and retention within nursing.

In order to extract and emphasise the individual participant's experiences within this results section, each participant has been assigned a pseudonym (Appendix 3):

Nurses are categorised into Agenda for Change (AfC) (DH, 2004) pay bands. Those who participated in this research were from bands 3 to 8b, this range added to the richness of the data. AfC is the system of standardised pay, terms and conditions for all NHS workers. When it was implemented in 2004, AfC was the largest overhaul of the NHS pay terms and conditions in over 50 years, the AfC (DH, 2004) system allocates posts to set pay bands, using the Job Evaluation Scheme. The pay system was designed to deliver fair pay for non-medical staff based on the principle of 'equal pay for work of equal value', provide better links between pay and career progression and harmonise terms and conditions of service such as annual leave, hours and sick pay, and work done in 'unsocial hours. Staff were placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job. The assessment of each post determined the correct pay band for each post, and therefore the correct basic pay. As staff successfully develop their skills and knowledge, they progress in annual increments up to the maximum of their pay band.

## 4.2 Themes

### Theme 1: Differences in performance and expectations

The study participants were from a broad range of nursing grading/bands and had a broad range of nursing experience. Despite this range, there was a shared difficulty expressed in terms of identifying the difference between diplomate and graduate nurses. The interview excerpts that follow illustrate this point, of note is the fact that the participants range from a student nurse to an experienced AfC Band 8b nurse manager.

When asked if there were differences participants described very little difference in the practical delivery of care.

Interviewer: Have you ever witnessed practice that would lead you to think that individual nurses had achieved either a degree or a diploma?

*'No'*

Interviewer: In your role at present, you see a lot of student nurses. Can you see any differences in the students you are seeing at present?

*'I don't think that there is any obvious difference'*

*Nita (Diplomate) - Band 5 Nurse*

Even those staff who had been in the nursing profession for some time, suggested that they had difficulty in identifying the proposed improved practice from graduate nurses. Louise a diplomate with 32 postgraduate years of clinical practice, could not identify any difference considering direct patient care:

*'No I can't, I can't tell any difference at all, other than asking them, no'.*

*Louise (Diplomate) - Band 7 Nurse*

Kathleen a diplomate candidate interviewed taking line management responsibility for around eighty staff, could not see a difference in either of the nursing qualifications in practice:

Interviewer: In your everyday working situations, can you tell which nurses hold diploma qualifications and which hold degrees:

*'No I couldn't tell, I mean I would know by their age if they had a diploma, but I couldn't tell you if you are asking by their practice'.*

Interviewer: Have you ever witnessed nursing care or act which makes you think one nurse could hold a diploma or a degree?

*No, I have never differentiated between them. It has never crossed my mind.*

*Kathleen (Diplomate) -Band 8 Nurse*

Interestingly Anna, a graduate programme student nurse interviewed as part of this study, also could not differentiate between any of the qualified nurses that she had been in contact with whilst undertaking clinical placements, in terms of their academic qualification:

*'On placement, there is no way of knowing who the nurses are who have got a degree. The only way I would get to know would be to ask'.*

*Anna (Graduate Course) - Student Nurse*

Similarly, Nita a diploma qualified nurse of six years, was also unable to identify who of the nurses that she worked with, held a degree or a diploma.

*'It's not something that I have ever needed to think about really. I wouldn't check with any nurse what qualification they had, there is no need... in fact I couldn't tell you now who had a degree or who had a diploma on my ward'.*

*Nita (Diplomate) – Band 5 Nurse*

This research aimed to explore the move to an all graduate profession and any impact that this could have on the provision of care. The majority experience of this small but diverse sample of nurses, was that it was impossible to tell from working with early career nurses, who had a degree or who had a diploma. When respondents were asked to be more specific about whether they perceived any difference reflected in the care that was

provided directly to the patients, they reported little perceived difference. This was a highly relevant point because of the emphasis put on patient-centred care by the NMC as a key rationale for the graduate-only reform (NMC, 2008; Hayes, 2012). Not only could participants not identify a major difference, but any differences that were noticed, were framed as relatively unimportant because they did not result in differences in patient care. This is a crucial aspect of the data as patient care is fundamentally important. These findings appear to echo the discourse identified by Hayes (2012). In her analysis of nursing policy documents, she concluded that the move to an all graduate nursing profession could be seen as more than simply recognition that nurses need 'better' education. Participants framed their responses chiefly in regard to care provision. Blessing, the Health Care Support Worker (HCSW) interviewed, had worked with many student nurses and commented on her experience.

*'I know the new student nurses are probably doing the degree, because I know that is the new programme they follow now. I haven't seen any difference in the sort of care that they provide though, I wouldn't be able to tell the difference between students doing the new or the old programme'.*

*Blessing (unqualified) - HCSW*

Some participants went further to express how the mode of training a nurse had undertaken was irrelevant to the patients. Again, care delivered was deemed the most important factor regardless of how their approach had been instilled.

Interviewer: Do you think patients can tell the difference between nurses with a degree or a diploma?

*'No, they don't even ask for a start. I don't think they [patients] understand the training you do. They ask, "Do you go to university?" and you answer, "Yes". I don't think there is a difference. I can't tell, a lot of the better nurses are actually Diploma Nurses. It's more about the person than qualification I think'.*

Interviewer: Do you think that patients can tell the difference?

*'They don't really care. I think they think more about if you can care, although I can't speak for patients'.*

*Amber (Diplomate) – Band 6 Nurse*

Amber a diplomate felt that there was very little difference between a graduate and diplomate nurse, with academic background being the only defining difference:

*'In my experience, nothing, regardless of academic background. If you can care for someone in my opinion, it doesn't make a difference. One of my colleagues I work with, actually has a master's degree, she trained up north and we are both earning exactly the same amount of money, doing exactly the same job.'*

*Amber (Diplomate) – Band 6 Nurse*

Interesting to note is the difference between this and the perceptions of a graduate nurse interviewed, Charlotte, as opposed to the perception of the diplomate nurses interviewed in the efficiency of the new programme.

*The students that do the degree have a higher knowledge of anatomy and stuff like that.*

*Charlotte (Graduate) – Band 5 nurse.*

The authenticity of participants voices reflected in their detailed comments, has enabled me to present rich and detailed data to underpin arguments about the unique contribution of this study. Considering perspectives of graduate and diplomate nurses highlighted interesting differences between the view of Charlotte a graduate nurse and diplomate nurses which merits further discussion. The graduate nurse indicated that they tended to hold the programme in high regard and felt that it can make a real difference. This was in some contrast to the diploma nurses who could not see a difference in any nursing practice between the two. The graduate nurse was very positive about the change in programme, whereas the diplomate nurses could not generally see a benefit in altering the academic standing of the course.

Although participants did not identify differences in the care delivered by graduate and

diplomate nurses, they did have different perceptions and expectations of the graduate nurse. Personal bias may have contributed to participant's responses in that those who had undertaken the graduate route, were more positive about the introduction and those who had undertaken the traditional diplomate route, were less positive. This contested issue merited careful consideration as part of the analysis of the data. The profession is operating with graduate and diplomate nurses working side by side and currently exists within a liminal state. A period of transition will be required to support the move to an all graduate workforce and this will take some time to achieve. This theme supports the findings of O'Donnell (2010) and Hayes (2012) who identified risks associated with an all graduate approach to nurse education. These have been discussed in the literature review. Mitchell (2018) and others theorised that the move to degree only may have been to the detriment of traditional nursing applicants, who could be threatened by the academic nature of nursing and associated higher entry requirements. Data from this study tends to support the idea that some applicants could not meet the new entry grades.

### ***Theme 1.2 Difference in perceptions of knowledge***

Participant diversity of this study allowed for practitioners with varying degrees of experience and with differing qualifications, to share their experiences from their day-to-day practice. Diverse perspectives added to the richness of the data, capturing participant voices in some detail via face to face interviews. This has enabled the research to contribute to knowledge in a way that studies which didn't undertake individual interviews could not. Although variable, graduate nurses were expected by the diplomates interviewed to have more knowledge, and be more analytical than their diplomate peers. They were also understood to be more career minded by Amber and Kathleen.

Interestingly, Tricia a newly qualified graduate Band 5 staff nurse who had followed the adult branch of study and had undertaken the graduate programme, felt that although there was no difference in clinical practice, there was indeed a difference between the graduate and diplomate in terms of academic knowledge,

*'I would know by their age if they had a diploma, but I could tell you if you are asking by their practice. The students that do the degree have a higher knowledge of anatomy and stuff like that'*

*'Yes sometimes, when it comes to patients' illnesses you can tell, but some of that is to do with the experience. Some people want to be knowledgeable because of their experience and can understand some illnesses quite well. From recently qualified nurses you can tell those who do and don't have a degree over the last 2 years or so I would say'.*

*Tricia (Graduate) – Band 5 Nurse*

Tricia a graduate related her perception of the differing academically trained nurse, to the 'practice' that she had been witness to. In this instance Tricia is referring to the clinical care that these nurses of differing academic ability had delivered. Tricia expressed a belief that those nurses who had completed the degree pathway were more knowledgeable in terms of anatomy and the physiology of care. Benner's (1984) works delineating from novice practitioner to clinical expert, supports the perception that the depth of nursing knowledge is also married with the amount of experience that the nurse has, aligned with intuitive understanding, which comes with continued exposure to a situation.

Conversely despite the expectation of higher academic knowledge, some participants expected degree nurses to be less practical when it came to ward skills. When asked if Naz, a diplomate Band 7 team leader had experienced any practice, not necessarily just within their team that would indicate whether or not a nurse had a degree, the response was:

*'I suppose possibly there may have been occasions where I have thought that a nurse was more competent or knowledgeable but I would not necessarily mean that they would have a degree. I do know people who have had a degree who may not be very practical or competent with some skills'... 'I know which of my nurses have a degree and which don't but I've trained with them, they are all excellent nurses'.*

*Naz (Diplomate) – Band 7 Nurse*

Hence, expectations of a nurse's performance in a clinical setting were framed in part by their academic background. Tricia a graduate agreed, but reiterated that often this expectation did not translate into an observable difference:

*'No, I know I have only been qualified for six months but I have not yet seen anything clinical that would make me think that yes that nurse has a degree or that nurse has a diploma. We all learn the same when it comes to clinical practice; it is only the academic work that the degree staff have to achieve more in'.*

*Tricia (Graduate) – Band 5 Nurse*

These quotes, then, share an underlying assumption that degree training is perceived as more knowledge-driven by Tricia a graduate and Naz a diplomate, and that people might expect graduates to have more knowledge. In practice however and through the responses of some of those interviewed, the direct impact that may be expected from this increased focus on academic input and knowledge base, does not appear to have always become apparent in clinical practice. Naz a diplomate goes on to share her experiences and states the expectation, but also that it is not always the case:

*'I guess sometimes you talk to the nurses and they are really informed and knowledgeable, but then in some instances I have gone on the ward to find out that in practice, they are not that good and don't know a lot about nursing. I might think that some nurses have a degree and then it turns out that they don't'*

*Nita (Diplomate) – Band 5 Nurse*

Tricia a graduate herself shares her experiences of instances where graduate student nurses have lacked knowledge (contradicting the expectation), whilst further delineating the underlying expectation that they will have more knowledge than their diplomate counterparts.

Interviewer: Is there a difference in the first year do you think? Did you notice any difference in the types of students?

*'No not really. Talking about that I wouldn't know if the degree improved in such a way. I meet a lot of degree students' who have asked me to provide them with support. Some of them the knowledge is still not there and they are doing the degree. So that quite surprises me. I don't know how they are teaching them, but*

*I would have expected them to be a bit more knowledgeable you know. I think maybe they are already struggling, that is why they are asking for my support... ‘*

*Tricia (Graduate) – Band 5 Nurse*

This perception may have been influenced by Trisha’s pre-conceived expectation of what she thought a graduate nurse should be/do in the practice setting and by her own personal biases relating to her graduate programme completion. She may have been expecting the graduate nurse student to have more knowledge at that particular point in their programme.

### **Theme 1.3 Difference in perceptions of professionalism and career-goals**

Not only were there differences in perceptions of academic knowledge held by graduate nurses, but also of them having a more professional outlook, being more organised, and being more career-minded. ‘Graduateness’ places an emphasis on critical thinking and leadership, assertiveness, reflective and critical skills. One participant Lindsey was a Band 7 nurse, who herself had undertaken a graduate programme. Lyndsey a graduate herself, had a very positive perception of graduate nurses in terms of the impact that the new programmes have had on the development of new nurses within the profession.

Interviewer: Now you have been qualified for ten years, within your everyday working day, are you able to identify those nurses that have qualified with a degree and those who have been awarded a diploma?

*‘Not always, however the people who had done the degree would stand out. I found them to be more professional and have more analytical skills’.*

Interviewer: When you say more professional, what do you mean?

*‘Better in the patient approach, prioritise their work better. I saw a lot of this when I worked as a professional development nurse in nine different units. I would wonder why some people approached things in a certain manner. The longer I worked with them, I realised that they had come into the profession at another level’.*

*Lindsey (Graduate) – Band 7 Nurse*

Interestingly this recollection is in contrast to Tricia's experiences of the graduate nurse.

Tricia herself a graduate nurse, suggests that this is not always borne out in practice

Perceptions varied between participants about what the graduate nurses' aims were in their role. Amber a diplomate nurse considered why people follow a degree pathway.

*'I don't think that there is necessarily any differentiation between nurses, but the graduate is looking more at career progression and not at providing the basics initially. I think graduate nurses are potentially more career-driven and looking at going further up the pile. I don't necessarily think they will be there to provide the hands-on care. They will be looking at managerial side of things.'*

*Amber (Diplomate) – Band 6 Nurse*

Key drivers for the graduate only approach have been discussed and the need for more critical and analytical thinkers identified (NMC, 2013), in practice however there were concerns shared in relation to impact that Amber felt this would have on practical care delivery:

Theme 1 focused on the expectations, knowledge and skills of diplomate and graduate nurses. While participants emphasised that they could not observe differences between types of nurses in terms of care delivery, there were concerns that differing expectations had potential to change the qualitative nature of nursing as a profession. The concept of gradueness and employability come into play in this instance. The key question which emerged is are we now educating the future nursing profession to be one that can challenge the inequalities of hierarchy in the NHS, or are we developing skilled care givers equipped with all the skills and competencies to be able to meet the increasing complexities and demands of the UK's patient population. It is this theme that is explored in the next section.

This study identified through a comprehensive literature review focussed around the research questions, that there were potential risks to recruitment for the profession following a graduate only entry route. The literature identifies issues in relation to

accessibility and social mobility and the influences that they may have on access to nursing programmes.

## **Theme 2: Changes to the quality/qualitative nature of healthcare following the introduction of a graduate-only profession**

Participants in the study held the quality of care delivery in high regard. What was evident from interview data was that there was little correlation in the experience of participants between students undertaking graduate programmes and improvement in the quality of nursing care delivered by this group of nurses. There was little empirical evidence from the interviews undertaken, to suggest that the introduction of the graduate-only approach was, or will enhance or affect the quality of care being provided. A qualitative difference emerged however between graduate and diplomate nurses in their perception of care delivery. Arguably this could be partially explained by participants own experiences in their nurse education programmes. These findings would not have been revealed without the close questioning in this study, which enabled participant's to be open and honest in relation to their experiences and feelings. A claim for uniqueness made in relation to this study, is that the methodology enabled participant and nursing voice giving lived experience to explore the research question.

### **Theme 2.1 Nursing as a vocation**

There was a strongly held shared understanding among participants that nursing was a vocation – a caring, practical profession to which you dedicate your life. Here, Amber a diplomate gives her account of what is important to the vocation of nursing. She contrasts themes of the expectations of degree and diplomate nursing training raised in Theme 1. Amber a graduate begins to raise concerns of the effect of degree training on the qualitative nature of nursing care, which is discussed in this section of the results.

Interviewer: How do you think the introduction of the degree-only programme will impact on the quality of care delivery?

*'My own personal opinion is that I don't know why they have gone down that route. I think it's a balance between academia, having the skills you need, but there is*

*also a humanistic side. People can care for people if they don't have a degree. It concerns me. It also concerns me that some people can't now come into nursing. I came in to nursing when I was 18. I think the problem is that the balance has been lost from hands-on common sense, knowing that they have compassion, having empathy, to being a job and a career. I struggle to understand how nursing can be a degree course, when it is more of a manual vocational type job. I do think that, well I don't know, but there may be an expectation that these are degree nurses who are coming in who may not be expecting to wash. That's my opinion.'*

*Amber (Diplomate) – Band 6 Nurse*

Whilst the NMC (2010a) identified the need to move the previous pre-registration preparation programmes from one of diploma to degree, not all participants were in agreement with the need in practice. Amber related her thoughts to her own understanding and expectations in relation to nursing expertise and what the 'good nurse' is.

There were also other core beliefs about the values required to be a 'good nurse' and that the ability to care was absolutely central to these.

*'Without knowledge, it would be unsafe practice, you need to know what you are doing... Education and knowledge are important, but not as much as caring and compassion. That is more important than knowledge.'*

*Louise (Diplomate) – Band 7 Nurse*

The concept of the 'good nurse' Louise a diplomate attributes to those core values identified within the 6 'C's – Compassion, Courage, Communication, Care, Competence and Commitment (DH, 2012), making a correlation between competence and these 6 core attributes.

In particular, the nurse was seen as the embodiment of a practical hands-on approach to patient care. When asked about what quality care meant to them Amber answered:

*'Interpersonal skills, the way I may come across as caring, the way I care, what is my body language, do I express myself well enough for patients to feel safe enough to tell me what their problems are. I don't think you can really teach that in a*

*classroom, no. I think you can have things in place for me to enhance my ability to use those skills, but I think you are born with them or not. I don't think anyone can teach me that in three years. If I don't have those skills, then we should have strategies in place to develop self-awareness for me to realise.'*

*Amber (Diplomate) – Band 6 Nurse*

Interestingly, Amber a graduate identifies a correlation between 'classroom' and 'academia', relating the graduate programme and increased emphasis on theoretical knowledge, to the ability to teach core values and skills.

In summary, participants relayed that compassion and caring were fundamental attributes required in a 'good nurse' and cautioned that there was potentially a risk of eroding these core values, via the transition to graduate-only nursing. This perception was more strongly held by Amber and Louise both diplomates. Arguably this was because they were both diplomates who held traditional nursing values with high regard. Graduates and diplomats work side by side in clinical practice and development of the graduate nurse runs linear to the diplomate nursing population. Some of the diplomate nurses interviewed showed concern about this impact in practice.

## **Theme 2.2 Graduate nursing as a threat to nursing values**

Degree nursing was seen by some participants as posing a threat to the core values of the nursing vocation, with concern shared regarding the loss of compassionate care provision, a desire to care holistically for patients, being 'too posh to wash' and the concern that the course may be a 'means to an end' and not as a vocation. Some participants expressed concern that some people could enter nursing degree programmes simply to get a good degree, and without understanding what being a nurse involved. Hayes (2012) also comments on this in her thesis questioning whether the move to an all graduate profession is a 'symptom' of an imposed change in the nursing professions reason to 'be'. Hayes (2012) cites an erosion of the role for the 'Nurse' and questions if nurses are marching towards becoming orchestrators of care and cheap 'replacement' medics rather than 'care givers'.

There was concern raised by participants that people would enter the programme for the wrong reasons (i.e. not to deliver patient care), and one diplomate Kathleen a diplomate felt that the graduate programme may attract the wrong type of candidate.

*'I think that people might go on a degree programme just for the qualification, but not necessarily to learn how to give good patient care. We have seen that before, people come to do the course, get the qualification and then leave nursing all together to do something else. They have the qualification to get into something else then'.*

*Kathleen (Diplomate) – Band 8b Nurse*

This sentiment was expressed repeatedly, reiterating that a nursing degree should translate to becoming a nurse and providing patient care, and was not simply a qualification to obtain.

Interviewer: What skills do you think a nurse needs to make them a good nurse then?

*'I think they have to want to do the job and not just for the qualification. We have had students who have not been committed to it at all. We had a point that I am getting a degree for the sake of getting a degree. That could be there'.*

*Amber (Diplomate) – Band 6 Nurse*

Amber a diplomate identifies motivation as a driver to becoming a 'good nurse'. She makes a claim that some students who undertake a nursing degree may be doing so just for the qualification and not necessarily be doing so to address the desire to become a nurse.

Interviewer: What skills do you need to be a good nurse?

*'You need to be able to identify with patients. You need to do the basics, wipe bums and clean things like that. Along with the high-tech proactive stuff, but you have to be able to be prepared to do the basic nursing care. That's what I think has gone now. The emphasis is no longer on basic nursing care'.*

*'I suppose you could say that we are being educated very highly, are still going to be as important. It's the old too posh to wash thing isn't it. We are educated to do certain things, then the normal tasks will be given to the unregistered workforce. You don't need to be a trained nurse to wash somebody'*

*Naz (Diplomate) – Band 7 Nurse*

Naz a diplomate has refocussed nursing back to the 'basic' needs of the patient, whilst the NMC has identified a need for nurses to become more autonomous, questioning and critical thinkers (2016), the patient will always require care to meet their daily functional needs. It was the opinion of Naz here, that these needs may not be met by the new critical thinker.

Concern was shown by a number of participants with regard to quality of care. Amber felt that the move to degree-only may attract the wrong type of person into the profession and possibly for financial reasons.

*'Yes, people are not seeing nursing as a vocation, they are seeing it as a long term career pathway. Whereas when I did my training it was because we wanted to care to make a difference. Now it is, like, if I can get a degree, I will earn more money'*

*Amber (Diplomate) – Band 6 Nurse*

Amber a diplomate related motivation here in terms of monetary gain. Participants have referred to motivation, this is one example where the motivation to undertake the course may have been for the wrong reason. This supports the theory that Glover, Law and Youngman (2002) postulated in the literature review for this study, where they suggest that some may view a nursing degree course as a means to an end.

Some participants shared these concerns with regard to the perceived loss of core professional nursing values with the introduction of a graduate-only programme. They shared a sense of professional pride in the altruism associated with entering into nursing as a vocation, and expressed anxiety at the appearance of other motivations that were perceived as less noble.

Repeatedly, participants expressed concerns about degree trained nurses not being taught, nor learning to value the practical skills needed to deliver front line patient care. When asked if the degree will make a difference to the quality of care that the nursing profession provides, Amber reflected:

*'I remember being on the ward and there was a third-year student nurse in her final placement, who was not able to make a bed. Was she doing degree or diploma, I don't care. I just wanted to make sure she was of a good enough standard. How could she get to the end of her training without being able you provide at least basic care.'*

Interviewer: Do you think that the acquisition of a degree and not a diploma will influence nursing care delivery in any way?

*'I don't think it will, well I don't know, when we moved away from the pupil and the student, we moved away from... the pupil was always there on the front-line, they did all the care. With the diploma students, they always seemed to be slightly above those providing the care. So, I would think that the degree nurses will follow the same sort of path – not doing the basics'.*

*Amber (Diplomate) – Band Nurse*

Here, Jennifer a diplomate discusses how moving the setting for which nursing education is delivered from the wards to the classroom, has potential to disrupt the apprenticeship model through which these fundamental nursing skills were traditionally learnt. Concerns were raised by some of the participants in relation to the type of applicants nursing has attracted in its degree-only approach.

Interviewer: Do you have any views on why nursing may have moved to degree-only? How do you think it may influence nursing?

*'I have a concern that they may not get the right people on the courses. They might have the right academic skills in that they inherently want to be a nurse. We have to remember it is a free degree. Many people may hop on to a free degree, we have had a few students who have been through, who have not had that care and*

*compassion who have come through. There is a concern that they will be our nurses of the future. You have to have that passion for it. It's like being a teacher, if you don't like children, don't teach. If you don't want to be caring professional, don't go into a caring profession. So, I think there is a danger with some are picked up.*

*Jennifer (Diplomate) – Band 7 Nurse*

Changes to the nursing pre-registration bursary are also potentially relevant. It was removed (DH, 2017), and replaced with a student loan approach with some means tested additions. This is directly relevant to my research as bursaries were available at the point that the research was undertaken. The introduction of the bursary means testing only, could put an additional emphasis on the application to nursing and the desire to undertake nursing programmes. Applicants now have to take into consideration the financial implications that this may have when considering a nursing programme. Jennifer's response to the interview question was provided prior to this change and influence in terms of monetary gain in this instance is now removed. Despite recent challenges to the removal of the student bursary, the government has defended its decision after a petition calling for the grants to be reinstated attracted widespread support (Mitchell, 2018d).

Amber a diplomate felt a need to safeguard the profession; the threat of the erosion of caring as central to nursing, caused concern that the future generations may lose sight of the patient as the focus of nursing, Hayes (2012) supports this concern to the nursing profession. Amber considered compassion in future nurses. Further, this nurse articulates that although both knowledge and compassion are needed to nurse, the priority should be on selecting candidates with the right qualities and values as the knowledge can be taught to anybody.

*'No I don't think you can teach people compassion, that's why I think that nursing is a vocation, you either love it or hate it. Most people I know don't understand why I do it. I tell them day-to-day and they say like, "Why do you do that?" I don't think you can do that. But you obviously need Maths and English and a Science background. It's weighing up the two. If you are a kind and compassionate person you can learn the other things, but you can't do it the other way round'.*

*Amber (Diplomate) – Band 6 Nurse*

Some of the participants raised concerns with regard to the current support of students by lecturers who themselves may not have had any front-line care delivery experience for some time. This posed questions for some regarding lecturers' clinical knowledge and currency when teaching nursing programmes. Nursing, framed as a practical vocation, was thought to be better learned from clinically competent supervisors in a clinical setting. There was a sense that you could not discursively be a nurse without a patient to care for as the focus of your efforts. This meant that non-clinical nurse lecturers were somewhat lacking in clinical legitimacy, in the eyes of the participants, despite being the new primary providers of nursing education.

Interviewer: What are your thoughts on lecturers supporting and teaching our students?

*'That's a concern. If I don't know what's happening in real life, how am I preparing these people to go out and work in that world. Having said that though I think that you don't have to be in everyday practice. But I have contacts, who come out to practice areas. I know in the past I have worked with people who are link lecturers who never come out into practice. It's a shame, how then are the students going to feel supported? There is something about students seeing you come out and meet them in practice. It helps them believe a bit more that you are a nurse. I remember when we used to have clinical lecturers who used to come out and spend time with us on the ward. Then when we went back into the university, they met us again. They have now cut the numbers of lecturers'*

Interviewer: Has anything changed in terms of the lecturers in the universities delivering the programme to the new graduate students?

*'Yes I think there are more requirements for lecturers with a PhD. Not only lecturers, now if you are advanced in a role you need to have an MSc. I know some trusts who have told everyone that they need a degree as a bare minimum. If anyone feels that they have done 35 years and are near retirement and don't want to study, they have been told that it is a requirement'*

*Jennifer (Diplomate) – Band 7 Nurse*

Nita a diplomate questioned her own abilities and compared them to the new graduate nurse. The introduction of the degree programme has led to discomfort amongst some of the diploma-qualified nurses. There are now concerns with regard to the qualification that they hold and the future with both diplomate and graduate nurse working alongside each other.

Interviewer: You told me that you are a diploma nurse. Do you think the fact that you hold a diploma and not a degree makes you any different a nurse than those who hold degrees?

*'I do think about it sometimes. I think I should have done the degree and would people think of me any less for not having one. That has crossed my mind, especially now. Are the new nurses going to look down on me? I think it's the experience you have since qualifying. I think now that there will be degree nurses, it will be like she is a diploma nurse or old auxillary nurse – that type of mentality may come around'.*

*Nita (Diplomate) – Band 5 Nurse*

Anxiety was also expressed that the change may devalue the existing expertise of nurses and nurse educators who had trained under the old diploma programmes. Concerns were expressed by Amber a diplomate, with regard to the skills that a compassionate nurse shows, reiterating the primacy of clinical experience above academic qualifications.

Interviewer: You mention compassion, the degree-only programme, do you feel that will influence the compassion that a nurse shows?

*'I think it is too early to tell. My personal view and a bit of a concern is that we might create a situation where the people who have experience begin to feel intimidated by the academic qualifications held by staff joining. We need to empower people. You can easily top up your qualification but the degree qualified staff would have to work very hard to top up their experience. We need to empower the workforce that we have, but we need to let the graduates now that actually they need the correct approach to learn the tools of the trade'*

*Amber (Diplomate) – Band 6 Nurse*

When asked what impact will there be with the delivery of a degree-only student nurse programme, Louise a diplomate one of the Band 7 nurses felt:

*'I think there will be more in-depth knowledge and skills base. They may question more. They may question around the quality of care and innovation and think more broadly about improving patient safety outcomes and quality. I don't believe it's going to make you a better nurse. There are inherent skills, communication, but you may feel more able to take on further training'.*

*Louise (Diplomate) – Band 7 Nurse*

There was hope illustrated in Louise's response, who saw positives to the new degree-only approach suggesting that the new graduate nurse may be able to influence care. It may encourage nurses who are more questioning and may look more holistically at a patient and the factors impacting on their treatment and recovery. This may be understood as the potential for a new discursive understanding of the good nurse arising from degree-only nursing programmes.

### **Theme 3: Equity in Education and Access to Nursing.**

Participants experienced strong concerns about how the changes towards degree-only nursing would impact people on an individual level. Their concerns were twofold: concerns that the academic entry requirements would exclude potential good nurses from access to nursing training, and concerns that the financial impact of undertaking a degree would have a similar excluding effect. As discussed in previous themes, nursing is seen as a vocation, with caring at its centre requiring dedication. The changes to training had the potential to make people with these qualities unable to enter the career because of boundaried entry requirements and inaccessibility. This is borne out in the voice of Louise a nurse with many years of experience shared her experience:

Interviewer: Is there anything else in relation to graduate nurses and diplomate nurses that you think would be pertinent to this study?

*Only that I think there will be a lot of hard-working, compassionate nurses that may not apply now. So, you might be missing out on really good potential nurses*

*because to do the degree, you have to have all the qualifications. I'm not saying it should be easy and anyone can come in, but I don't know. I would imagine that would be quite daunting for some. So, we may just get nurses who are more driven by just getting a degree than doing the job.*

*Louise (Diplomate)–Band 7 Nurse*

Louise's response would support some of these concerns in practice. This was identified as a risk in the literature review, posed to the NMC, where the move to a degree only programme is identified as a concern in terms of participation in nursing programmes. This aspect merits further consideration in a future study but could not be explored further here because of time constraints and time lapse.

### **Theme 3.1 Not getting the grades**

Despite the NMC reporting a year on year increase of applications to nursing (NMC, 2010b), participants expressed concern with regard to the potential impact that the new programme could have on the numbers of new recruits to nursing. The student nurse believed that:

*'there will be less people doing the courses as there won't be the high numbers of people with the proper academic grades to get on the course in the first place'.*

*Anna (Graduate) – Student Nurse*

Naz a diplomate Band 7 qualified nurse also supported these feelings expressing concern over the introduction of a degree-only programme, worried that it would:

*'mean that there will be less people applying to be a nurse. Not all people who would make good nurses, have the qualifications to get on the course anymore'.*

*Naz (Diplomate) – Band 7 Nurse*

Participants also expressed concern about their current status and role and stated that:

*'If it would have been degree-only when I was applying to be a nurse, I would never have got in with the qualifications I left school with'.*

A survey recently undertaken shows nurse staffing shortages are 'biting hard' (Ford, 2017) and the RCN has called for an urgent review. Participants with a diploma registration demonstrated a concern in relation to the impact of the introduction of the graduate only approach in this study, and in the 3 years since the interviews were undertaken, some of their concerns would appear to have come to fruition. With Brexit looming and a 96% drop in overseas applications to nursing posts (BBC, 2017), the nursing staffing shortage comes even more to the fore, however Brexit occurred sometime after data collection but has potential to impact greatly (BBC, 2017) and would form the basis for a future study.

Since 2013, nurse education has moved from one which took entry into nursing programmes from someone who held an NVQ Level 3 in care, to now requiring English and Maths GCSEs at grade C and above and UCAS credits which vary by university. A Band 8 participant acknowledged concerns with regard to the calibre of student that the nursing profession will now attract:

Interviewer: What impact do you think the new entry requirements to nurse education have on us as a profession?

*'I guess you could argue that we are narrowing the entry gates. We might just get people applying because of their academic ability, but we might not get the people that we want. It's a hard one. Do you take someone with a lower academic ability and work with me to top up my degree because I have the core skills, or do you take me because I will breeze through my dissertation? The truth is it is cheaper to take someone with their A-levels, than it is to take someone that you will have to work with to get me to Level 7. If we really wanted to take the first route, then we really should be working with these people. The lower Bands 1-4 so that we get that level.'*

Interviewer: Will the degree pathway have any sway on what you have just said?

*'Only that it will put people off who haven't got A-levels. Maybe they have not been fortunate enough to do the courses as they have had to get out there in the workplace. Also, people coming in to nursing, HCA's, nursery nurses who are not*

*used to writing or a degree, you will lose those people. They are very valued in the profession’.*

*Kathleen (Diplomate) – Band 8b Nurse*

Hence, diplomates shared their fear that the path of least resistance with a move to degree-only nursing was that it would be cheaper and easier to take fresh, more academically able candidates than investing in the existing care support workforce who may be less academically able. This was not a concern demonstrated by the graduate participants in this study. The rise in academic requirement runs contra to the issues that we are seeing in nursing presently, namely nursing skills shortages across the health economy. The entry requirements were also a concern for one of the Band 7 participants:

Interviewer: Do you think that the entry requirements for nursing will pose any challenges or will be good?

*‘I think for myself it would be challenging. HSCWs who are really brilliant, but may not be able to do the degree requirements which would be a shame to lose such brilliant HCSWs’.*

*Naz (Diplomate) – Band 7 Nurse*

Participants related accounts of people who had been affected by the move to degree-only nursing sharing perceived concerns, and anecdotal evidence drawn from their own experiences. Louise a Band 7 nurse with years of experience showed her concern:

Interviewer: How do you feel the introduction of the degree-only pathway may impact or influence nursing?

*‘My main worries are that I think there are people who may be educated well enough to become good nurses but do not necessarily have the academic abilities to do the degree programme. I have a friend in her forties, very competent, who has done a lot of things, very knowledgeable, not educated but very intelligent. Left school at 16 and doesn’t have any A-levels. She would love to be a nurse but she can’t do her training. So, it worries me that we are closing the door on people who*

*could become very good nurses and have the mental capacity to train.*

*Louise (Diplomate) – Band 7 Nurse*

The participants indicated seeing in practice, well able and competent potential candidates for nursing with apparent inherent skills of compassion and dignity, being excluded by entry requirements from applying for nursing programmes. This concern was held by the diplomates taking part in this study, interestingly the same concern was not shown by the graduates interviewed.

*It worries me that it might just attract people who do nursing as a way of getting a degree and not want to the nursing at the end of it. It worries me that there may be a lot of pressure put on nurses who have been working very well as staff nurses for a number of years, who do not have a first degree, they now think they need to get a degree. Maybe they have children under the age of 12, a husband who works shifts and an aging granny to look after. It goes beyond what we require to do the job. A diabetic course yes, a degree no.*

*Louise (Diplomate) – Band 7 Nurse*

Louise discussed her concerns above in relation to the need of existing diplomate nurses to top up their diploma. A diabetic course would take the maximum of 3 months, whereas topping up from Diploma to degree would take considerably longer. This could have a financial and personal impact on the nurse.

One of the Band 7 qualified nurses felt that:

*'The profession could potentially miss out on some very good nurses. I know of a couple of potentially good candidates who have been turned down by UCAS, because they didn't have enough credits to get on the courses. If they had applied last year they would have got on to the programme, that can't be fair, can it?'*

*Luke (Diplomate) – Band 7 Nurse*

Luke was able to identify the potential impact that these changes would have, however it has taken a total of 3 years for the full impact of this change to be acknowledged. The

supply of nurses has failed to keep up with this rapid growth in demand (NHS Improvement (NHSI), 2016), hospitals estimate they are 15,000 nurses short of what they need. There is now acknowledgement that growing shortages of qualified clinical staff have led providers to make increasing use of agency and other temporary workers to fill vacancies (NHSI, 2016). Large numbers of agency staff are now being employed to fill the gaps and this is having a financial implication of the future recruitment of substantive staff. This is a matter of concern to the NHS and trusts have been asked to urgently review the use of agency staff in a bid to save the NHS £480 million (Mitchell, 2018c). The literature review for this study, suggested caution in relation to potential attrition and reduction in nursing numbers following the introduction of a graduate only approach to nurse education. Some 3 to 4 years on following the interviews for this study, it would appear that this concern has come to fruition. Financial implications require further exploration in relation to pre-registration preparation and was a common thread within this study, this poses an area for further study.

### **Theme 3.2 Financial concerns**

Participants also shared concerns about the financial implications to nursing trainees of a degree-only pathway. Participants repeatedly raised their concerns with regard to the potential reduction in recruits that the graduate-only programme could have on the future of education, with entry requirements raised and the bursary removed. Lyndsey felt that the removal of the bursary would deter potential recruits. The bursary gave students an assured monthly income, which would not require paying back at the end of the nursing programme.

*Yes, being means-tested means that sometimes you might be right on the cusp, I don't think that is particularly fair either. So financially it might turn a lot of people off and stop people from coming into nursing. But on the other hand I guess maybe it's a good idea, if it's going to make people think that it is not that easy and if they want to do a degree, it might make people work harder.*

*Lyndsey (Diplomate) – Band 6 Nurse*

Amber expressed worries with regard to financial support for the programme and the impact that it could have. They frame the dedication to nursing as in terms of time, energy and finance.

Interviewer: With the degree-only programme comes the change in bursary

*'It may put people off if they don't have any support to do the qualification. I think that actually we are turning too many people away. We are making it harder for people to do. If we means-test the bursary, again we are not making it very attractive. We are a public service, you are working for less than the minimum wage as a student. No other profession asks you to do that. You are making beds, washing patients, tidying up, re-stocking, doing all that. Why would you want to do it for nothing? People have to live. We do not have enough time as it is to be in the NHS. We can't live on fresh air'.*

*Amber (Diplomate) – band 6 Nurse*

Whilst the bursary for nurse education may have now become means-tested, there was concern shown with regard to the influence that undertaking a 'free' degree may have on the applicants to the programme. A Band 7 nurse expressed her concern

*'The other thing now about the degree is that yes the bursary has gone but you do not have to fund the degree.*

*I think it should be free, do we need people in the profession, yes, how are we going to attract people into this profession. You need to have a financial incentive. Even when you qualify now, there are boroughs offering retention if you stay for 2 years. Maybe we need to look back at how it used to be when the Trust seconds you to do your training.*

*Amber (Diplomate) – Band 6 Nurse*

This could have a further impact on the supply to healthcare of caring nurses, an issue identified as a concern from the literature review for this study.

#### **Theme 4: Supply to Healthcare of Caring Nurses**

Diplomate students raised concerns regarding the profession missing out on potential excellent nurses who may not be as academically able, having repercussions for recruitment and retention within nursing.

Not only did participants have concerns about the fairness of access to nursing on an individual level after introduction of graduate-only programmes, they also had concerns about the implications to the NHS. This could be divided into concerns over recruitment, and concerns about retention.

I was interested in gaining the experiences that the participants had seen in relation to the nursing workforce and the role that the unregistered workforce have in the provision of care in nursing teams. A greater emphasis on the unregistered workforce has been considered and trialled in the NHS for a number of years, with the introduction of foundation degrees (DH, 2001). The actual recognition of this qualification and the implementation of this role within the workforce has yet to be recognised however. There was a major push on the assistant practitioner role and the introduction of Foundation Degrees in 2001 (DH, 2001). It was envisaged that the Assistant Practitioner would be at the forefront of care delivery, although named a Foundation Degree; the academic weighting of the programme was in fact delivered at level 5 of the qualifications framework at the time, the same level as a Higher National Diploma (HND). The vision was that registered nurses would be freed to focus on managing the wards and teams that they were in.

This assistant practitioner role did not take off and those who have undertaken the programme remain in a minority. NHS trusts have been supporting the unregistered workforce to undertake pre-registration programmes for a number of years (Wakefield et al, 2010). It is postulated that this has encouraged the development of roles and has seen investment in trust staff. There is now support for the unregistered workforce to access pre-registration programmes with the introduction of the nurse associate role, however concerns remained in some participants in relation to the supply of future workforce.

Interviewer: In your current position, what has the degree-only programme had on universities? What has been the impact?

*'Definitely, the numbers in some instances have halved. So far for instance, my university can only take in one cohort. We have had fewer students coming out into practice. That will impact on staff. We won't have as many mentors as we had two years ago as we won't have access to as many students. The NMC requirement for mentorship. We need to forward plan, we don't want to get up one day and realise that all our good mentors have left'.*

*Precious (Graduate) - band 8a Nurse*

As the graduate only approach has only been in place for the last 5 years, the majority of nurses in the NHS currently do not possess a graduate nursing qualification. Exact current figures are not available from the NMC - this not a statistic type which is searchable on the NMC register. Robinson and Griffiths (2008) as highlighted in the literature search, commissioned a study to explore the impact of the degree only approach on workforce profile and quality of care, no significant changes were identified between the degree and diploma nurses. This concerned some of the candidates in relation to the direct impact that this could have on the future applicants to nursing pre-registration programmes. A Band 8 nurse also expressed concerns about the potential impact the change will have.

Interviewer: To enter the degree programme, applicants will have to have five GCSE grades of C and above and also have A-level credits. How do you think that will impact?

*'You can have nurses who don't have academic ability, they can still nurse. I don't think it is good, it's going to be bad for nursing. We will lose a lot of people, nurses. Keogh, Darzi, Berwick? I don't know where this is coming from. Is it the universities? I would like to know'.*

*Kathleen (Diplomate) – Band 8b Nurse*

Kathleen felt that the nursing profession would miss out on number of potentially good students who would not have the appropriate academic requirements to enter the profession.

The frustration within this excerpt about potentially jeopardising the future workforce was strongly apparent. Despite the banding of the participants, the majority agreed that the new programme would deter potentially good nurses. A Band 6 nurse felt it would have an impact:

*'I think it will decrease the numbers of nursing students for the future. We will possibly turn away good caring people who don't meet the academic level to enter the profession now'.*

Interviewer: Is there anything else that you would like to add?

*'I think it is very unfortunate that it has become degree-only, because I think we are losing out on a population that would be very good and have always wanted to be a good nurse. Just because you don't have the academic ability doesn't mean that you would not make a good nurse. We will be excluding a lot of potentially good nurses'.*

*Louise (Graduate) - Band 7 Nurse*

The Band 8 nurse Jennifer discussed her concern in relation to seconded pre-registration nursing programme offered to staff:

Interviewer: Just thinking about nursing numbers and preparing the unregistered workforce, do you think that is something that we are addressing as a profession?

*'We have two people who have just passed their qualification. I don't think we are prepared for the issues that this might bring us. We would historically second a dozen people or so a year, but this year we couldn't because they didn't meet the academic requirements. And because hospitals are not academic centres it is very difficult to teach, that again requires money. It depends on people's personal motivation. Some people wouldn't want to spend a year getting their maths and English then go on to do another 3 years nurse training. Now we are asking them to do 4-5 years for all that responsibility and accountability. It might put some people off. You are doing all that preparation when you could lose your registration. Think of the Francis report, it might make some people think that they are happy*

*to stay where they are. Having said that I had a conversation with two HCSWs, one young and one older. The older one said if I was starting now, I would, but if you consider where the future lies, I think it is personal choice’.*

*Jennifer (Diplomate) – Band 7 Nurse*

Blessing a Health Care Support Worker interviewed stated:

*‘I believe there will be missed opportunities for candidates who are passionate about health care, but unfortunately not academically minded. They won’t be able to get on these programmes any more’. They went on to explain ‘I wanted to get on the seconded training programme, but won’t be able to now because I don’t have the proper qualifications. I think I would make a good nurse, especially as I have been a Health Care Support Worker for 10 years, but there will be no chance now, I am too old to do an access to nursing course’*

*Blessing – HCSW Band 3*

This quotation illustrates how the move to degree-only nursing may restrict this HCSW with significant experience and motivation from entering the nursing profession due to academic qualification.

Following the completion of this research study, the Nurse Apprentice role has been introduced to the NHS arena. This role may offer an entry gate to a non-professional unregistered role within healthcare delivery, however the fact remains that these staff will be part of the unregistered workforce and on lower AfC bands than qualified nursing staff. The financial impact that this exerts on candidates and staff is great. This is an area for future research which would further inform and appraise this element of the workforce.

#### **Theme 4.1 Attrition**

During the interview process, concerns were continually raised with regard to the current NMC registrants and the impact that the degree-only nurse introduction will have on the current diplomate nursing workforce. Within the narrative, Precious, herself a graduate, expresses anxiety about the future of nursing. She showed little faith that there was sufficient planning in place to secure nursing care via an adequate workforce. Participants

who held a degree qualification in general coalesced around the idea that a degree qualification brings a more knowledgeable and critical nurse, who will be able to influence care delivery. Diplomates on the other hand showed concern with regard to the graduate who may be less caring and more focussed on career progression. A possible explanation could be that diplomate nurses feel threatened by the new graduate nurse and concerned that their qualification may be looked on less favourably. This has been illustrated historically in nursing, where there have been divides of recognition for nurses, illustrated by the Registered General Nurse (RGN) and the State Enrolled Nurse (SEN). Further study could explore this concept with more depth. This study has contributed by laying the foundation for open discussion and acknowledgement of honest experiences of nurses, who are experiencing the impact of white papers and NHS change on a daily basis together linearly as diplomate and graduate nurses.

Interviewer: Is there anything else that you would like to discuss?

*I just have a question I would really like someone to answer. What are we going to do with the 6,000 plus people already on the register? Is anyone going to help them top up? Think of it. We have internationally educated nurses so we have had people who don't have a single entry requirement to come into nursing here now. We have a two-tier system, so some people can now not come here. What are they going to do? Where I come from people will struggle when they come over here. If we don't handle it properly we will have the people move up quickly without the experience. We are opening a can of worms.*

*Precious (Graduate) – Band 8a Nurse*

Recruitment and the potential students that the profession may be attracting was also questioned. The current situation was thought by Nita and Amber, both diplomates, to be becoming untenable with attrition being inevitable with the change in governance.

*I don't think we are attracting anyone into nursing full stop. This is something that I feel passionately about. We are going to be in a worse situation in a year's time. We know we have a shortage of nurses, there is no support there. There are not the people there to support you. Nothing is being done about it. So, you think if I*

*am running a caseload which is huge and it is affecting my health, not eating, no toilet breaks then I am going to go off sick which then has an impact when I return to work. I don't want to do this for much longer.*

*I think it will lead to high attrition rates, because some of the nurses have had to top up to do a degree and have pulled out. The Home Office the way they regulate overseas workers so that before we would go abroad to get nurses, we now have a problem.*

*Nita (Diplomate) – Band 5 Nurse*

This is further compounded by the impact that BREXIT may have on the nursing population. Simon Stevens (NHS England Chief Executive) has expressed concern in relation to leaving the EU, outlining how the move will present more risks than advantages for the health service due to a number of factors, including the potential loss of nurses and doctors (Hansard, 2016). The chair of a major assessment of nursing education and training commissioned by HEE - “the Shape of Caring” review - called for action to tackle high national attrition rates of around 20% in England.(HEE, 2013)

A newly qualified Band 5 nurse had concerns about the impact of the degree pathway on nursing numbers and therefore quality,

*‘My only concern is according to modernising nursing careers, they are trying to promote nurses to take on specialist and advanced roles. They will climb up the ladder and develop. Maybe degrees are required as we are getting more complex cases for us to be able to care. My concern is when nurses climb up the ladder, who is going to fill in the gap? Who is regulating that? They will be passing on a lot of duties to the HCSWs. We could be failing patients in the end’.*

*We all now have an aging workforce and that is because we have not attracted the numbers in to it for a very long time. Retention is very poor, we don't want to lose any more. Even now in your teams you don't get the time to check with your colleagues if they are OK, no nights out, no lunches, compared to private companies who get lunch paid for, they mean a lot. We are dealing with people every day and emotions. We just need to reflect and have an outlet and we can't*

*do that if we don't have the time to do that. I think that burdens people mentally'.*

*Tricia (Graduate) – Band 5 Nurse*

It has been acknowledged that the newly qualified nurse at the point of registration, is not the finished product, investment in the development of the newly registered nurses is important to ensure safe and quality care and to retain high calibre staff (Rafferty et al, 2015). Tricia a graduate, relates her concerns to post registration development and the gap that it may leave in its stead. Louise also demonstrated her concerns in relation to the speed at which staff may gain promotion and the depth of experience that these nurses may have.

Interviewer: You mentioned about HCSW and people coming in to nursing later on in life.

*'They can bring life experiences. I was talking last night to a colleague who came into nursing later in life and about her experience. The experience of how you can't be taught in a classroom, how to hold someone's hand, hug, a cup of tea, that takes time and experience to develop. If we are pushing people down this whole career pathway, get your degree, your masters, it's become a competition about who can step up the ladder the quickest. She was affected by someone who had got their Band 7 within two years of qualifying, having no other experience in healthcare before then. To me that screams danger. It should not be seen as promotion but that you have so much experience, not because I'm going to hop up and get promotion which is what it is now. Because of the cut backs people have been working very hard, only to be told sorry we have capped you now as we don't have any money. We are going to lose people very soon'.*

*Louise (Diplomate) – Band 7 Nurse*

The literature review for this study also identified the potential for issues with attrition following the introduction of the degree only approach. The media repeatedly highlight the issues of continually reducing nursing numbers and increased demands on the nursing workforce. Patient care is now more complex and care pathways more demanding and there is seldom a day goes by without a newspaper article, radio discussion or news item

covering this issue. Major concerns exist regarding the supply of nurses in the NHS and other non NHS healthcare providers.

Acknowledgement must be made at this point, of the fact that this study commenced in 2013 at the point of introduction of the graduate only approach to nurse education. As time has progressed much has changed and 6 years on we are now experiencing extreme workforce challenges. Whilst participants of the study foresaw that there would be an issue in terms of numbers of nurses on the 'shop floor', the study at its outset could not foresee the huge impact that we see today in the NHS. Staff are working under extreme stress with patient safety incidents on the increase (NRLS, 2019) and human factors having an impact more on front line care delivery. On reflection the original research study question was limited and targeted. The researcher could not have envisaged the challenges that are now posed and to the extent at which this influences practice today. To ask merely does having a nursing degree make you a better nurse, did not allow for the consideration of the other environmental and organisational issues that are also compounding the nurse education pathway and experience. To consider the degree pathway in its solitary could not give the entire nursing workforce picture. This is now a reflective acknowledgement of the researcher.

#### **4.3 Summary:**

This chapter has discussed the participant's responses and explored further the emergent themes that this study has identified. The study outlined how there were differences in the performance and expectations of the diploma and graduate nurse perceived by the participants. There was anxiety in relation to the quality of care that would be provided by the new graduate nurse and concerns were raised in relation to nursing as a 'vocation' as opposed to nursing as a 'means to an end'.

Concerns in relation to the diversity of nursing programmes were brought to the fore, some participants believed that the increased focus on academic standing would deter potentially good nurses without the academic requirements from becoming excellent nurses. All of the above it was felt, would have an impact on the numbers of nurses staffing the NHS and independent providers and there was apprehension demonstrated by a

number of participants regarding the vital supply of nurses being compromised. The RCN (2017) found one in nine posts in England is currently vacant with the NHS being 40,000 nurses short of what is needed. Recent figures demonstrate a sharp drop in nurses registering to work in the UK since the EU referendum (Tiggle, 2017). In July 2016 1,304 nurses from the EU joined the NMC register, compared to 46 in April 2017, this indicates a real time fall of 96%.The NMC have suggested that the introduction of English language testing for EU nurses is also likely to have played a role in the decline. It comes as the NHS is already struggling with nurse vacancies and, without this supply line, shortages could get worse.

At the point of data collection in 2013 the researcher acknowledges that the NHS and nursing staffing situation may have been in a very different position than it is in 2018. It may still be too early to see the overall impact that the introduction of the graduate only programme will have on nurse education as a whole. The NHS is a continual changing landscape and this needs to be taken into consideration when interpreting the data captured.

## Chapter 5: Discussion/Conclusion

### 5.1 Revisiting the question(s)

The aim of this study was to explore the perceived impact that the introduction of a graduate-only nursing programme may have on nursing care delivery. Fifteen participants were recruited to the study from a purposive sample, to obtain representation of people at the front line of nursing care. Both qualified and unqualified participants were included in the study, with a mixture of nursing/clinical practice experience. Contrary to the key drivers for this change in nurse education (NMC, 2010a; NMC, 2010b; DH, 2012), it would appear from this study, that the introduction of the graduate-only programme, may not, as yet, have the expected impact on the quality of nursing care delivery.

In 2008 the NMC announced that the minimum academic level for nurse qualification would from 2013 be a bachelor's degree (NMC, 2008). It stipulated that in order to meet the needs of complex care delivery in an increasingly fast paced healthcare system that demands flexible, responsive and highly skilled practitioners (NMC, 2008), nursing had to become a graduate profession. The NMC argued that this change reflected the gradual transformation of nursing practice through better evidence, stronger professionalism, developments in technology, scientific advances and responsiveness to individual and population healthcare needs (NMC, 2008). The UK government further endorsed the decision (DH, 2006), stating that degree-level education would provide newly graduate qualified nurses with the decision-making skills that they needed to make high-level judgments. These changes pointed to the perception by both nursing and government bodies that 'graduateness' encompassed important requirements for the improved delivery of future nurse education and should form the basis of all forthcoming nursing programmes.

The literature review reveals the limited extent to which the authentic voices of practicing staff with and without degrees have been interrogated within research and this study goes some way to addressing this gap. While no claims for generalisability are made, the approach could be replicated in different contexts and therefore provide a sound basis for further studies which engage directly with practitioners.

An interesting emergent finding which could be interrogated further is the possible

differences in perception between graduate and diplomate participants. Whilst in the main graduates believed that the move to an all graduate workforce would bring great advantages to the provision of nursing care, in contrast diplomates could not foresee how the change could bring benefit to the profession. Graduate versus diplomate divides in other professions, for example teaching (Education Times, 2012) may further illuminate the discussion about whether graduates somehow threatened and of less worth.

## **5.2 Conclusions to the research enquiry and reflections on theory**

The research identified 4 main themes:

### **Theme 1: Differences in performance and expectations**

This study would suggest that few participants perceived a difference between the diplomate and the graduate nurse in practice, although there was acknowledgement from some that they had witnessed practice which set apart the graduate nurse from the diplomate nurse. Interestingly those views were held on the whole by graduate nursing participants. Diplomate participants mainly reported that they were unable, in a clinical setting, to determine the difference in performance between graduate and diplomate nurses. The clinical performance of newly qualified graduates on the ward appears to those holding a diploma, to be unchanged at the time that this data was collected. However, nurse education has moved since initial data collection in 2013 and what may have been experienced at that point in time, may not reflect current practice and this may be a limitation to this study.

The emphasis on the theoretical component of nurse preparation at the point of this study, appears by some diplomate participants not to have had any direct impact on patient care delivery. This is despite the fact that the NMC believe that nurses educated to graduate level will be able to provide improved care, to practice more independently and to make autonomous decisions (NMC, 2010a; NMC, 2010b). To the contrast, the graduate nurses' responses eluded to some increase in knowledge.

An interesting finding is that some participants with a diploma felt that their qualifications may now be viewed as less favorable and initiates discussions and further exploration around professional status. These issues could usefully be unpacked further in a

subsequent study which may draw on other professions, such as teaching, in which the graduate diploma conundrum is relevant. If it does emerge that there are resentments on the ground between those with and without degree qualifications, this may be something which could have an impact on team performance and ultimately this could impact on patient care. Managers could benefit from understanding this influence further in order to address any local impact that this may have. While this study nods to a potential conflict, further investigations would be necessary to refute or discount these suggestions. This study, without claiming generalisability contributes to providing a platform on which to further debate such concerns. Replication in other contexts is possible from this study and this in itself strengthens the researchers claim for contribution to knowledge.

### **Theme 2: Changes to the quality of healthcare following the introduction of a graduate-only profession**

There was evidence that a graduate-only programme would not impact on the quality of care that is currently provided to patients. Initial experiences of the majority of participants at the time that the study was undertaken, did not demonstrate that the graduate nurse is delivering care to any better standard than that of the diplomate nurse in practice. Participants found it a challenge to ascertain which nurse in clinical care delivery held which qualification. The quality of compassion shown by some graduate nurses has been called into question, with a suggestion that this might be lacking in the new graduates (Ford, 2018 a/b). This was not a concern raised by any graduate interviewed as part of the study, however this concept was supported by some of the diplomate experience.

### **Theme 3: Equity in Education and Access to Nursing**

There was anxiety that the introduction of a graduate-only programme would decrease the numbers of potential applicants to nursing programmes. Some diplomate participants interviewed held strong views of how the move towards degree-only nursing, would impact people on an individual level. Their concerns were twofold: that the academic entry requirements would exclude potential good nurses from access to nursing training, and

that the financial impact of taking a degree would have a similar excluding effect. This was not a view displayed by the graduate nurses interviewed.

#### **Theme 4: Supply to Healthcare of Caring Nurses**

The study raised concerns from diplomates with regard to the profession missing out on potential excellent nurses who may not meet entry requirements for graduate nursing courses. Some participants' raised concerns that potentially excellent nurses may be ruled out of applying for courses due to their academic standing, despite having relevant life experience, excellent interpersonal skills and inherent values. One participant described this situation as an obstruction.

#### **5.3 Differences in performance and expectations**

The Willis Commission (2012) reviewed undergraduate registered nurse education and training and gathered evidence regarding the best methods of delivering pre-registration nursing education across the UK. The commission identified that pre-registration placements need to ensure that skills are gained as part of the practice experience, with the aim that they will already be mastered with confidence at the point of graduation and registration (Willis, 2014). In practice newly qualified nurses' experience of their first role is challenging and fraught with a number of hurdles and barriers and rarely feel confident in their new role (Kumaran and Carney, 2014). The results from the Willis review (2012) showed that the skills gained in graduate approaches to nurse education, cannot be differentiated from those demonstrated by the diploma student. This questions one of the NMC's (2016) key drivers for this study, stating that the new graduate nurse will be more autonomous, critical and forward thinking and will meet the demands of current complex healthcare. This study did indeed challenge the expected outcome of the graduate only approach to nurse education and provided insights into the care actually witnessed in clinical placement. Arguably, although this did not come out specifically in the data, graduate newly qualified nurses with little experience, may feel pressured by the additional expectations placed upon them because of their graduate status. This may be an area for further study for which this research has developed a useful foundation.

### 5.3.1 Consequences for the profession and practice?

The Health Select Committee (HSC) (2018) have identified that there are large numbers of nurse posts currently not covered, despite the use, at great expense, of many bank and agency staff. The NHS in England is unable to fill round 3,000 empty nurse posts despite the use of bank and agency staff according to a report by a group of MPs, which also raised concerns about the lack of robust national data on the shortage (Merrifield, 2018). The HSC is giving consideration to retention and keeping the current workforce, as well as looking at recruiting new nurses. While they believe that it is too early to draw conclusions about the withdrawal of bursaries and the introduction of student loans and apprenticeships, the HSC believe that are early warning signs of potential future problems. In 2018 the HSC advised that the government should explain its approach to monitoring this situation and consider what specific actions will be taken if applications, especially from mature students and to courses in shortage specialities, continue to fall. The issue of mature students and accessibility was a concern raised by many diplomate participants in this study and one which has now come to fruition

Attrition was also a major concern for the HSC (2018) which was particularly concerned that 30% of nursing undergraduates are not completing courses. Participants in this study raised the same issue when the data was collected some 4 years ago. The HSC is looking for further assurance from HEE that attrition rates have been taken into account in future workforce projections. Variation between universities was also a concern for the HSC who requested close monitoring and a call for action to reduce variations in attrition rates between institutions. The HSC will continue to review progress. Attrition was a concern raised within the study which, uniquely, considered the issue from a practice based perspective.

The Willis commission (2012) identified that students qualifying should be coming into their newly qualified roles having the skills and the underpinning theoretical knowledge to take a structured history and assessment of patients presenting with complex needs, deteriorating condition or psychological crisis. Willis believed that new qualified staff should have the diagnostic skills to identify and commence specified treatments. These

included: venepuncture, cannulation, administration of intravenous additive, diabetes management and chest/lung assessment and psychological solution focused therapies. It could be argued that the transition from student to qualified practitioner is indeed a vast one. In practice, rarely has the researcher seen newly qualified staff who take on the role for the first time and feel able to function fully. Results obtained from this study also identify that this increased academic input in nurse training is not openly observed when the new nurse takes up their first qualified role. Rather it is with ongoing exposure, role modelling and continued personal and professional development that the skills required to make someone a competent and compassionate nurse begins. This supports Benner's (1984) concept of skills acquisition from novice to expert and Dreyfus and Dreyfus (1980) concept of skills acquisition discussed in the literature review. Before this study, what has never been pulled out through research by engaging directly with the workforce, is the potential for friction between newly qualified graduates and highly experienced diplomats. This aspect, though emergent, was not fully covered here, but could form the basis for another study.

Nursing has traditionally been seen as a vocational career, with caring at its core (Williams et al, 2009). Karoz (2005) highlighted the importance of students having appropriate caring values and behaviours, while Fry and Johnstone (2008) believed that only people with the knowledge, skills and commitment to practise nursing in a clinically, culturally and ethically competent way should enter the profession. Concerns that nurses are "too posh to wash" (Hall, 2004) and that a higher academic entry level would lead to nurses being less caring (Adams and Smith, 2012) have been voiced since nursing programmes moved to higher education institutions. The suggestion is that nurses with higher educational qualifications are less interested in providing essential care. The results of this study would indicate that whilst the academic standing of nurse education has increased, the clinical care delivery aspect has not demonstrated an improvement practice to date. This study has not demonstrated that graduate nurses have shown any less care for patients in practice, yet it has highlighted however that there is a perceived drive to 'climb the ladder' and progress with their careers, than witnessed in the pre-2013 approaches to nurse education.

#### **5.4 Changes to the quality nature of healthcare following the introduction of a graduate-only profession**

The concept of 'Graduateness' in nursing, has been further explored in this thesis. 'Graduateness' has been termed a broad academic cultivation enriching students with the skills and knowledge of higher education systems and learning (Steur et al, 2012). Others perceive 'Graduateness' to be more of a tailored professional training with a strong emphasis on employability (Steur et al, 2012). It could be argued that there are distinct demarcations between 'graduateness' and employability, particularly when considering such approaches in nursing and pre-registration preparation. For some diplomates who participated in the study, it appeared that 'graduateness' focusses more on the academic components of nurse preparation, than that of the practical component of pre-registration education. This could be where the issues highlighted in some recent patient experiences, where nurses have been held to account for their action/inaction in the delivery of care (Francis, 2013), with poor practice being ignored and remaining unreported. Participants in this study expressed the same concerns and questioned whether in practice, the outcomes of the graduate-only approach concentrates more on the 'graduateness' and employability post registration of the new nurse, as opposed to the quality of the clinical care delivery that a nurse should show on registration. Indeed Willis (2012) raised concern about the preparedness of newly qualified nurses which were echoed in some diplomate responses.

A disconnect between familiar personal judgements of nurses and the education managerial and professional language of nursing (Sellman, 2011), could explain some of the participants concerns in this study. There seems to be an inability of nursing to define itself from the positioning of some practitioners who may wish to see nursing as more of a science in an attempt to mirror medical science. This could be applied to the new NMC approach to nurse education. Sellman (2011) believes that this poses a threat to nursing as a response to human vulnerability; nursing cannot be just a set of skills. Some participants predominantly diplomates with some degree of experience, questioned whether compassion, respect and dignity can be taught in the classroom, or whether these skills are inherent to each individual.

What was very evident was that participants held quality of care delivery in the highest regard, this was the view of both graduate and diplomate. There was little empirical evidence to suggest that the introduction of the graduate-only programme has at the point of research, enhanced the quality of care being provided. Karoz (2005) highlighted the importance of students having appropriate caring values and behaviors when entering nurse education, while Fry and Johnstone (2008) believed that only people with the knowledge, skills and commitment to practice nursing in a clinically, culturally and ethically competent way should enter the profession. Concern was shown by a number of participants with regard to the impact on the quality of care delivered.

There was a concern communicated by some participants that staffing numbers, financial constraints and ongoing quality issues, are affecting the ability of nurses to meet the fundamental needs of the patient and to provide good nursing care. The idea of a good nurse has been discussed earlier and encompasses inherent skills such as care, compassion and respect. In recent years, the human values at the heart of the nursing profession seem to have become side-lined by an increased focus on managerialist approaches to health care provision. It would appear that nursing's values are in danger of becoming marginalised further precisely because that which nursing does best - providing care and helping individuals through the human trauma of illness - is difficult to measure, and therefore plays little, if any, part in official accounts of outcome measures. (Sellman, 2011). If the NHS is to provide services that are safe, caring, effective, responsive and well led (CQC, 2015), thought needs to be given to future workforce planning, including what makes a good nurse and what makes a nurse able to meet the needs of the patient. No single definition of a '*good nurse*' exists and this perception, should be observed on an individual basis and dependent on individual patient need. Potentially the drive to educate to develop '*the good nurse*', may give way to an educational approach which develops the more easily measurable '*academically able nurse*' model.

The researcher is not arguing that there is such a thing as these 2 types of nurse. Data collected here does not suggest specifically that they may be distinctly different from each other. Findings from this study could however create a platform from which to interrogate further the notion of how to teach, develop, nurture the less easily measured aspect of the

good nurse. Knowledge of qualities required within the nursing profession is deemed critical to the NHS's success in any NHS Trust (Dumay, 2012). The NMC believed that if used effectively, the knowledge resources of its nursing workforce can be used to gain a competitive advantage over the other professional groups (Edvinsson & Malone, 1996; Youndt, Subramanian, & Snell, 2004) and therefore provide a platform for a more unified and equal contribution to patient care.

### **5.5 Equity in education, and access to nursing**

The Office for Fair Access (OFFA) Vision for National Strategy (2015) aimed to ensure student access and success in higher education. This vision sees that all those with the potential to benefit from higher education have equal opportunity to participate and succeed, on a course and in an institution that best fits their potential, needs and ambitions for employment or further study (OFFA, 2015). The OFFA 2 (2015) plan, appears to have two key aims. Firstly to increase the proportion of learners from disadvantaged backgrounds in higher education generally and secondly to specifically address the large participation gap between the most advantaged and the most disadvantaged, in the UK's most selective universities. The most disadvantaged 20 per cent of young people are still 6.8 times less likely to attend these universities, than the most advantaged 20 per cent (OFFA, 2015). With the introduction of the graduate entry programme only into nursing, this further delineates access margins for those wishing to enter the profession.

The issue of equality of access to higher education programmes was a concerning one for participants, primarily those with diploma qualifications. The Higher Education Council for England's (HEFCE) widening participation allocation, recognises the extra costs that institutions face to recruit and retain larger numbers of students from more disadvantaged backgrounds (BIS, 2015/6). For any given level of skill and ambition, regardless of an individual's background, everyone should have a fair chance of getting the job they want or reaching a higher income bracket (BIS, 2015/6). Issues of equality in academia has been discussed in previous chapters with concern raised as to the non-inclusive graduate entry requirements to programmes. Given the projected shortage of nurses, especially potentially post BREXIT this concern has been brought to the fore.

As discussed and highlighted in both the literature review and from participants responses, there are a number of experienced Health Care Support Workers who wish to enter nursing and the NHS needs to recognise the benefits they can bring to the nursing profession. As identified in this research, the move to a graduate-only programme has made it increasingly difficult to HCSW's to enter the nursing profession. The Shape of Caring Review (Willis, 2014) looked at developing an additional role for care assistants, targeted at Agenda for Change Band 3 and identify a clear training pathway and distinct qualification. The belief behind this is that this should allow registered nurses to be confident in delegating and patients confident in receiving care (Willis, 2014). This apprentice role continues to take shape, with courses being available since September 2017 (DH, 2016).

Evidence that the nursing workforce is ageing and a retirement time bomb is waiting to explode is worthy of consideration in terms of this research, there are around 45% of nursing staff over the age of 45 in current roles within the NHS (RCN, 2015). A real time staffing crisis is looming as there are large numbers of nurses set to retire over the next 5 years, with a major decline in nursing numbers as a consequence. A real concern is that there will not be the numbers of suitable applicants for courses which require consideration in any workforce planning. Subsequent recruitment into nursing to replace the numbers of nurses leaving (RCN, 2015), may well therefore be compromised to an extent which could impact on patient care. This has been evidenced recently with the NMC announcing that there has been a substantial drop off of older nurses revalidating (Merrifield, 2017c), further compounding the numbers issue, supporting concerns raised by participants.

The majority of nurses currently working in the NHS have not been educated to degree level. These nurses are at the forefront of care delivery and continue to practice. Some of these nurses have a sense of being 'left behind' and fear being undervalued as demonstrated in the research undertaken for this study by diplomates. On the ground there is real concern about what will happen to the current non-graduate nursing workforce working on a daily basis and these concerns were also bought out in this study by diplomates.

## 5.6 Supply to healthcare of caring nurses

The HSC report on the nursing workforce (2018) raised concerns regarding the current supply of nurses and they have advised that the nursing workforce must be expanded at scale and pace. There is recognition that there are not enough nurses and the ones that there are being demoralised because the NHS is not providing them with enough training, and many are working in dreadful conditions that means they cannot possibly provide care to the standard that is required and that they want to (Nursing Times, 2018).

Currently nurse recruitment presents a major headache for health boards and commissioners of educational provision, and there is little evidence that this will change significantly in the short-medium term (Stephenson, 2015). In September 2018, the London Mayor Sadiq Khan joined the fight against London's vacancy crisis, urging nurses of the future to work in the capital (Mitchell, 2018b). There are currently no national minimum academic entry requirements into nursing courses, so each higher education institution (HEI) sets its own criteria. This could have the potential from the outset, to develop hierarchical rankings for nurse education, in terms of where student nurses undertake their training. It could also develop into a hierarchy of university/hospital placement education if a student undertook their training with a university and in a hospital that required more UCAS credits. In such a case it could be argued that they were academically more able and therefore held a more esteemed nursing degree than individuals from other courses?

This could form a demarcation in nurse education provider institutions. Universities who have also been accused of taking students to fill 'bums on seat' through inter institutional competition may have indeed developed a cognitive capitalism (Harvey, 2010). Is nursing now pursuing a graduate-only stance since as it has been forced to mutate in order to survive (Moulier Boutang, 2012). Nurse education and nursing universities have also been criticised as being no longer a profession that ensures that training institutes influence knowledge production in student nurses, but merely focusses on ensuring that these students get jobs at the end of their training (Goodman, 2013). Plato postulated that education does not appear to be an end in itself, but a tool of social engineering – turning out the sort of people the state is going to need (Plato in Thompsen, 2010).

Whilst the NHS continues to struggle to cope with decreased funding for nursing posts and heavy cuts to nursing budgets, there will remain a tension between intellectual development and workforce development (Harvey, 2010). The NMC and other nursing organisations finding themselves challenged in the current competitive NHS market, are having to consider intellectual capital to forge the profession (Harvey, 2010). Intellectual capital being the combination of collective knowledge of individuals and structures in an organisation or NHS Trust (Business Dictionary, 2013). Determining how registered nurses and underlying knowledge influence the quality of patient care is crucial. Studies that have investigated the relationship between nursing knowledge and outcomes are often met with conceptual and methodological issues (Covell and Sidani, 2013). This has resulted in limited evidence of the impact of nursing knowledge on patient or organisational outcomes (Covell & Sadani, 2013). The nursing intellectual capital theory was developed to assist with this area of inquiry. Nursing intellectual capital theory conceptualises the sources of nursing knowledge available within an organisation and relates its relationship to patient and organisational outcomes (Covell & Sadani, 2013).

Intellectual capital is the combination of collective knowledge of individuals and structures in an organisation or society (Business Dictionary, 2013). Intellectual capital includes the knowledge of individual employees or groups of employees who are deemed critical to a company's continued success, and organisational structures that contain information about processes, customers or other information that contributes to improved business performance or profits (Dumay, 2012; Sullivan, 1998). Intellectual capital management is the process of effectively using these knowledge resources to gain a competitive advantage for the organisation (Edvinsson & Malone, 1996; Youndt, Subramanian, & Snell, 2004). The NMC would appear to be utilising this Intellectual Capital Theory by educating nurses to higher academic attainments with the hope that it will contribute to the effectiveness of the NHS.

Intellectual capital theory defines human capital as the knowledge, talents and experience of employees (Covell, 2011). Human capital is owned by the employee and is loaned to the organisation by them. It leaves the organisation when the employee separates from the organisation (Stewart, 1997; Sullivan, 1998). Human capital some believe within healthcare can be extremely important, as it reflects the work of highly knowledgeable and

skilled people caring for those in need of specialised healthcare (Peng, et al, 2007). This competitive professional market could also indeed be driven by the presence of a knowledge economy (Marginson, 2010). The knowledge economy gives value to an organisation or workers knowledge (intellectual capital) and is based on knowledge intensive activities. In the NHS this could be with a view to accelerating the pace of technical and scientific advance, where the NHS will give less significance to the physical input that staff are capable of providing, but give greater emphasis to the intellectual capabilities of the workforce. Research has been undertaken to look at growing inequalities in wages and high quality jobs (Powell and Snellman, 2014), where knowledge economies exist. In studies looking at the relationship between nursing knowledge base and nursing outcome, there is limited empirical evidence of the impact that increased nursing knowledge has on patient or organisational outcomes (Covel and Sidani, 2013).

Nursing human capital is the knowledge, skills, and experience of registered nurses (McGillis Hall, 2003). It is defined as the theoretical and practical knowledge registered nurses obtain from academic education, participation in continuing professional development activities and specialty training and work experience (Covell, 2008). It is operationalised as the proportion of registered nurses with degrees, proportion of registered nurses with specialty certification, hours of continuing education registered nurses attend per year, years of registered nurse professional experience, years of registered nurse unit tenure or seniority, and years of registered nurse experience in clinical specialty. The attributes of nursing human capital, nurses' knowledge or experience it is believed by some, have been empirically linked to better quality patient care; for example, lower rates of patient falls, patient mortality and failure to rescue (Aiken et al, 2011; Duffield et al, 2011; Tourangeau et al, 2007).

Nurses are now providing more hours of care, than they were in May 2010, this is despite the fact that they have seen a continued rise in demand for health care services. Nurses responded to this increase by working harder and delivering more for their patients despite some very challenging circumstances, which has taken its toll on staff morale. A workforce experiencing low morale is not believed to be sustainable over the long term (RCN, 2015). In 2014 the NHS staff survey results showed that 39.5 per cent of NHS staff suffered work-related stress in the past 12 months (Picker Institute Europe, 2015). A freedom of

information request by the showed that NHS staff absences for mental health problems, doubled over a period of four years (RCN, 2015). Staff morale and ongoing stresses may compromise the quality of care provided to patients.

The introduction of the nursing associate role, which was developed with the aim of creating a shift in the nursing and care workforce, may go some way to addressing the workforce issues highlighted in terms of providing an unqualified replacement (HEE, 2018). Bridging the gap between care assistants and graduate registered nursing, the programme aims to increase the supply of 'nurses' (HEE, 2018). This role indeed mirrors historical approaches to a 2 tiered nursing workforce, when there were registered nurses and state enrolled nurses, where registered nurses had completed a 3 year programme and state enrolled nurses a 2 year programme.

The study unearthed some unease at the all graduate approach to nurse education as well as highlighting some positive areas that may also develop following its introduction. What will be required is time to see exactly what impact this change will have on care delivery.

### **5.7 Revisiting the Research Methodology**

The methodology undertaken for this study was well suited. It supported the acquisition of rich data from role active participants, which was current and applicable to real time situations in nursing. There was a broad range of participants from various NHS bandings, this enhanced the depth of the data obtained and gave a varied overview of the questions posed by this research. Participants came with varied knowledge bases which further enhanced the overall data obtained.

This research study has limitations. Initial interviews were undertaken in 2013, consideration needs to be given to the fact that participant experiences may have altered somewhat some five years on from the original study. In order to support or dispute the findings a repeat multi centered study, using a triangulation of methodological approaches is proposed. Change is continual in the provision of healthcare and this research study can only be applied to the context in which it was undertaken.

## 5.8 Strengths, weaknesses and future research

A strength of the study is that it was completed during the overlap of the introduction of the graduate-only approach to nurse education. Hence, it was not a retrospective study but contemporaneous. It may be conceived as a reflection in action on the part of the researcher and the participants, given that they were living through the change under investigation (Schon, 1991). The fact that the researcher undertook a role that is being impacted by the direct application of the graduate-only approach to nurse education, also enhanced the study. This gave direct access to potential participants for the study (following NHS research and development ethical approval), reducing the preparation time and logistic issues that identifying and approaching potential participants would have. Whilst there was an abundance of literature to support or challenge the impact of the graduate only programme, no research had been undertaken to obtain the real lived experience of its introduction. Therefore there was a gap in knowledge and the study sought to inform that gap. Participants had experience of both the diplomate and Graduate approaches to nursing education, and this put them in an ideal position to be able to compare and contrast the two approaches and the impact that it has had on the direct delivery of care.

Following on from this initial research into the identified problem, a larger multi-centre study is now recommended which could further illuminate current practice within the wider healthcare arena, now that the graduate-only programme has been in existence since 2013. Triangulation is recommended utilising both qualitative and quantitative approaches to information gathering, employing the use of a semi-structured questionnaire with a large multisite sample. A triangulation of approaches would improve validity of the overall findings with both qualitative and quantitative approaches to the study. The use of triangulation in this study would contribute to the completeness and confirmation of findings and ensure that gaps in data would be filled (Streubert & Carpenter, 1999). Utilising a well-constructed semi-structured questionnaire within the study reduces unambiguous answers; making data analysis easier (Bowling, 2014). This approach would also facilitate large numbers of participants, enhancing the validity of the overall findings (Polit & Hungler, 1995).

The involvement of patients and their experiences of the nursing care that they receive from the new graduate nurse in comparison to the nursing care received from a diplomate nurse, would also further enhance the overall richness of data. The researcher in this study was advised against applying for NHS Ethics Committee approval for the involvement of patients, due to the length of time it would take to receive approval. Indeed research and development approval for the use of only NHS staff took a total of eight months to achieve through the NHS research and ethics process. The involvement of patients would have hindered the progression and timeliness of the study further.

The issue of the researcher being known to the participants required consideration and the influence that that may have had on overall responses to questions. Questioning within the interview was directive with care taken to ensure that no undue influence was exerted on the participants by the researcher (Streubert Speziale & Carpenter, 2007), interviewer bias being the subconscious or conscious effort of the interviewer to bias respondents to answer in a certain way (Bowling, 2014). While a pre-existing relationship between researcher and participants may have had an effect along these lines, this was balanced by the factor that participants felt more at ease and less under scrutiny whilst participating, which may have actually enhanced the responses received.

### **5.9 Recommendations: The future of nursing workforce policy**

The HSC (2018) recommend the development of a nationally agreed dataset to enable a consistent approach to workforce planning and an agreed figure for the nursing shortfall. The Department of Health and its arm's length bodies must ensure there is robust, timely and publicly available data at national, regional and trust level on the scale of the nursing shortage. They stipulate that future projections of need should be based on demographic and other demand factors rather than just affordability. They have requested that Health Education England (HEE) should publish detailed projections for nursing staff for the coming years — both numbers entering the workforce from different routes and the anticipated need for staff and must clearly set out the basis on which its future projections of need for nursing staff are made. The draft Workforce Strategy (HSC, 2018) describes

plans to improve workforce data. This is long overdue, and the Department and HEE will be asked to provide an update.

The NHS requires a workforce with the right numbers, skills, values and behaviours to deliver it, something it is struggling with currently (Stephenson, 2018). Whilst the nursing workforce struggles, there are potentially a large number of people who wish to enter the profession, but cannot. In 2012, the Willis Commission commenced a review of undergraduate registered nurse education and training gathering evidence on the best methods of delivering pre-registration nursing education across the UK. Given the capabilities of a graduate workforce, Willis believed that it is right for the public to have high expectations of the nursing profession (Willis, 2014). However, to support this, universities and professional bodies must explore how undergraduate education and preceptorship can raise the bar to deliver the advanced skills and knowledge needed by future registered nurses. Karoz (2005) highlighted the importance of students having appropriate caring values and behaviors, while Fry and Johnstone (2008) believed that only people with the knowledge, skills and commitment to practice nursing in a clinically, culturally and ethically competent way should enter the profession.

While the NHS struggles to cope with decreased funding for nursing posts and heavy cuts to nursing budgets, there will remain a tension between intellectual development and workforce development (Harvey, 2010). Is it that the NMC and other nursing organisations finding themselves challenged in the current competitive NHS market, are having to look to intellectual capital to forge the profession – intellectual capital being the combination of collective knowledge of individuals and structures in an organisation or NHS Trust (Business Dictionary, 2013). The knowledge of the nursing profession in these trusts has been deemed critical to the NHS's success (Dumay, 2012). The NMC, if used effectively, could use the knowledge resources of its nursing workforce to gain a competitive advantage over the other professional groups (Edvinsson & Malone, 1996; Youndt, Subramanian, & Snell, 2004).

This could be driven by the presence of a knowledge economy (Marginson, 2010). The knowledge economy values an organisation or workers knowledge (intellectual capital) and is based on knowledge intensive activities. In the NHS this could be with a view to

accelerating the pace of technical and scientific advance, where the NHS will give less significance to the physical input that staff are capable of providing, but give greater emphasis to the intellectual capabilities of the workforce. Research has been undertaken to look at growing inequalities in wages and high quality jobs (Powell and Snellman, 2014), where knowledge economies exist. In studies looking at the relationship between nursing knowledge base and nursing outcome, there is limited empirical evidence of the impact that increased nursing knowledge has on patient or organisational outcomes (Covel and Sidani, 2013).

The majority of nurses currently working in the NHS would not have been educated as a nurse to degree level, these nurses continue to practise. Some of these nurses have a sense of being 'left behind' and fear being undervalued (Metzger, 2016). Indeed this was one of the thoughts of one of the candidates interviewed for the study. Many, with the support of their employing organisations are topping up their education to degree level. Some of these nurses are having to self-fund these programmes as increasing financial restraints are being put on NHS training and development budgets (Nursing Times, 2018). It would seem reasonable for NHS institutions to support the development of its current nursing workforce, if the evidence showing that nurses educated to degree level are more critical and questioning is accepted.

Sellman (2011) believes that there is a disconnect between familiar personal judgements of nurses and the education managerial and professional language of nursing and calls for a renewed emphasis on personal wisdom. Nursing is struggling to define itself from the positioning of some practitioners, who wish to see nursing as a science in an attempt to mirror medical science and subsequently medical positioning. This poses a threat to nursing as a response to human vulnerability, as nursing cannot be just a set of skills (Sellman, 2011), and it also leads to the question can compassion, respect and dignity be taught in the classroom, or are these skills that are inherent to each individual? In recent years, the human values at the heart of the nursing profession seem to have become side-lined by an increased focus on managerialist approaches to healthcare provision. Nursing's values are in danger of becoming marginalised further precisely because that which nursing does best - providing care and helping individuals through the human

trauma of illness - is difficult to measure, and therefore plays little, if any, part in official accounts of outcome measures (Sellman, 2011).

Contrary to the key drivers for this change in nurse education (NMC, 2010a; NMC, 2010b; DH, 2012), it would appear from the responses to the questions asked within this study, that the introduction of the graduate-only programme, may not have the direct impact on the quality of nursing care delivery that was expected of it. It would appear however from this research study undertaken, that there exists a dichotomy between the NMC developing nurses who are academically more able and are competitive with their professional counterparts in the healthcare market and the need to ensure that there are the required numbers of appropriately qualified and skilled nurses with the relevant values with which to deliver a quality service to patients. The question remains if this approach has met the demands of the current NHS environment, with a continually increasing population, with the delivery of more complex healthcare, we have an NHS with ever decreasing staffing numbers under extreme stress facing continual financial constraints. These all pose challenges to the graduate only approach to nurse education and some of the effects of this are now being seen experienced by care providers on a daily basis.

### **5.10 Conclusion:**

There are currently around 11,500 nursing vacancies across Britain (Merrifield, 2017b), further compounded by the drop in available nurse education places (Merrifield, 2017a), and the nursing profession is presently experiencing an unprecedented shortfall. This shortfall in nurses is a major concern in the NHS.

The literature review undertaken to inform this research identified key points for consideration in this study (1) the concept of 'graduateness' required exploration, in the context of the NMC vision, together with the evidence of the impact of 'graduateness. (2) The decision to become a graduate profession raised questions as to whether a more academic nurse is synonymous with a good nurse and this would require further exploration. (3) Arguably, too, there were questions as to whether the push towards 'graduateness' was about improving the status of the profession in the current healthcare

environment. (4) There were potential risks in the NMC taking this route and the research was proposed to identify what these may be. The introduction and literature search at the outset of this thesis, drew on concepts such as 'Graduateness', 'the 'good nurse' and the 'nature of nursing expertise'. Through the process of this study, all of these concepts have been explored in an attempt to rationalise them to the data obtained from participants. As Britain has been ranked 30th in a global list of countries assessed for health care quality and access lagging behind many of its European neighbours (Harley, 2017), there is an unquestionable need for the provision of quality healthcare to be addressed. This thesis has questioned and sought to explore the rationale for the introduction of the graduate only approach to nurse education and has examined the immediate post introduction impact as experienced by practicing clinicians, an area not addressed previously by any study. What has been evident from the participant's responses is that key issues identified from the literature review, were supported or challenged by the data achieved.

The future of the NHS and care provision is uncertain, this study has raised some innovative and novel challenges to the current preparation of the UK's future nurses. What is certain however is that as nurses we all joined our professions to make a difference; we must never underestimate our significance. As health and social care changes, what does not alter is the fundamental human need to be looked after with care, dignity and compassion (DH, 2012).

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# Appendices:

**Appendix 1: Consent Form:**

**CONSENT FORM**

**Centre Number:**

**Study Number:**

**Staff Identification Number for this trial:**

**Title of Project:** Nurse Education – Graduate vs. Diplomate:  
Does having a nursing degree make you a better nurse?

**Name of Researcher:** Nerys Bellefontaine

**Initial box**

1. I confirm that I have read and understand the information sheet dated..... (Version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. The Investigator has explained the nature and purpose of the research and I believe that I understand what is being proposed.
3. I understand that my personal involvement and my particular data from this study will remain strictly confidential.
4. I understand however that if I disclose staff identifiable information which may pose a threat to patient safety, that these details may be further investigated by the trust and that trust representatives may need to be informed.
- 5 I have been informed about what the data collected in this investigation will be used for, to whom it may be disclosed, and how long it will be retained.
6. I have been informed that the interview will be recorded and the recordings used for the purpose of the research.
7. I understand that I am free to withdraw from the study at any time, without giving a reason for withdrawing.
- 8 I hereby fully and freely consent to participate in the study.

Participant's Name

Date

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of researcher

Date

Signature

## Appendix 2: Patient Information Sheet

### Participant information sheet (Questionnaire)

**1. Study Title:**

‘Nurse Education – Graduate vs. Diplomate:  
Does having a nursing degree make you a better nurse?’

**2. Invitation:**

I would like to invite you to take part in a research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Take time to read what the research is about and what it aims to do, feel free to discuss with others if you wish. If you would like clarification of any of the information please do not hesitate to contact me. Please take time to decide whether you wish to take part. This study is being conducted as part of a higher degree at LSBU and has been approved by LSBUREC.

**3. What is the purpose of the study:**

The purpose of the study is to ascertain whether nurses who have a degree qualification are perceived to provide better nursing care than those nurses who have a diploma. The duration of this pilot study will be 3 months, and all staff who participated in the study will be informed of the outcome of the research following data analysis.

**4. Why have you been invited?**

You have been approached to take part in the study as you are a member of staff who has had some experience of working with both groups of nurses in the clinical setting. Your views and experiences would make a valuable contribution to the collection of data for this research study.

**5. Do you have to take part?**

You have the choice to participate in this research or not. If you decide to participate you will be asked to sign a consent form. You will then be asked to participate in an interview which will take place at your workplace. You will not be disadvantaged in any way by participating in the study. If you decide not to take part you will be invited to give your reason(s) for declining but you are under no obligation to explain

**6. What will happen if you take part?**

In two weeks time you will be asked to give consent for involvement in an interview to be conducted on the same day, this day will be identified with you. Within the

interview I will be asking questions pertaining to the differences between qualified nurses who have a diploma and those who have a degree nursing qualification. The consent will ask for your permission for me to use the information that you may give during the interview process, to inform the research being undertaken. The interview will be one-to-one and take around an hour. The interview will be audio recorded

**7. Are there any disadvantages/risks to me taking part?**

There are no disadvantages to you participating in this, however the researcher asks that all information that you give during the interviews be kept anonymous (no names of staff or placement areas). If names are given to the researcher, who is also a registered nurse, they may have to be investigated further and reported to the relevant trust representatives.

**8. Are there any advantages to me taking part?**

The information you provide in the interviews will be used to ascertain any differences in the care that is provided by nurses who hold degrees and nurses who hold diplomas. This will assist in informing future practice of both qualified and pre-registration nurses.

**9. What happens at the end of the research?**

Once the research is complete the data will be analysed and the findings will be disseminated to staff and students. It is hoped that the findings will also be published in a professional journal. The information collected within the interviews will be kept for the period of the study and data analysis following which data collected will be destroyed.

**10. What happens when the research study stops?**

You will be informed of all the outcomes of the research study by the researcher.

**11. Will my taking part in the study be kept confidential?**

The information that is collected from you during interview will be stored in a locked cabinet which only the researcher will have access to. The information that you provide will be used to identify if there is a perceived difference between the nursing care given by graduate and diplomat nurses. The information gained from this pilot study, will also be used to inform a larger multi centred study in the future.

**12. Contact Details:**

If you have any queries or concerns please contact –

Nerys Bellefontaine  
Community Clinical Cluster Lead



[Redacted]  
[Redacted]  
[Redacted] Rd  
[Redacted]  
[Redacted]

Tel: [Redacted]  
Mob: [Redacted]

If you wish to make a complaint about the ethical conduct of the study please contact:

University Research Ethics Committee  
London South Bank University  
106 Borough Road  
LONDON  
SE1 0AA

Many thanks for your assistance .....

### Appendix 3: Participant Profile

	Participants (Pseudonym's)
1	<b>Anna:</b> A 2nd Year Student Nurse following the children's pathway – An unqualified student currently in year 2 of a 3 year nursing programme.
2	<b>Lucy:</b> A Registered General Nurse – This nurse had qualified as a diplomate. She had 6 years post qualifying experience and had progressed to a AfC <b>Band 6</b>
3	<b>Blessing:</b> A Health Care Support Worker- This participant had 10 years of experience working in that role within the NHS. She was an AfC <b>Band 3</b> support worker This is an unqualified role but integral to any nursing team.
4	<b>Kathleen:</b> An AfC <b>Band 8b</b> – Qualified in 1986 RGN. This nurse had a management responsibility within the trust. She had qualified with diploma.
5	<b>Nita:</b> An AfC <b>Band 5</b> Registered Adult Nurse 6.5 years' experience, Diplomate. Nita was on the verge of moving to another role within a community setting.
6	<b>Louise:</b> AfC <b>Band 7.</b> RGN BSc DN, Diploma in Health Education Studies. Qualified 1984. Diplomate, This nurse was very involved in student education and development and held a Specialist Community Practice Teacher qualification. This role supports practice students within the clinical setting.
7	<b>Naz:</b> RGN AfC <b>Band 7</b> BSc DN Qualified 20 years. Diplomate. Very experienced in his role and passionate about the development of nursing roles in the profession
8	<b>Bola:</b> AfC <b>Band 8b</b> RGN BSc DN. 1986. Diplomate.
9	<b>Tricia:</b> AfC <b>Band 5</b> BSc Nursing RGN Qualified 2013 Sep. Graduate. This nurse had post registration experience of working with student nurses both following the diploma and graduate routes
10	<b>Amber:</b> AfC <b>Band 6</b> qualified 2006. Children's Nurse Diploma Course. Graduate. This nurse was a health visitor who was moving on to a new role.

11	<b>Precious:</b> AfC <b>Band 8a</b> . RGN, Specialist A&E qualification MSc. 2003. Graduate Nurse. This nurse held an education role within the trust supporting students both pre and post registration
12	<b>Lindsey:</b> RGN AfC <b>Band 6</b> , DN, PGCE, pre 1983 qualified. Diplomate.
13	<b>Jennifer:</b> LD nurse AfC <b>BAND 7</b> , Certificate Course, No degree or diploma at that point. 1997. This nurse had an education role within the trust, supporting both pre and post registration nurses
14	<b>Luke:</b> AfC <b>Band 7</b> DN RGN. Diplomate. This nurse had progressed from an original pupil nurse, to a registered nurse completing the bridging programme and then progressed to a band 7 role in the trust
15	<b>Charlotte:</b> AfC <b>Band 5</b> Staff nurse, Graduate. 1 year post registration experience

## Appendix 4: Interview Questions

### Nurse Education: Graduate V's Diplome.

#### Does a nursing degree make you a better nurse?

Initial focus interview guiding questions:

1. Could you tell me what professional qualification you hold? If a nurse - degree or diploma in nursing?
2. How long have you been qualified?
3. Within your everyday working situation, are you able to identify which nurses hold diploma qualifications and which hold degree qualifications.
4. If yes: How are you able to differentiate between degree and diploma nurses?
5. In your experience have you witnessed any nursing practice that would lead you to think that a nurse holds a degree or a diploma in nursing?
6. How do you think the introduction of nursing degree-only programmes will impact on nursing care?
7. Non Nurses: What have your experiences been of working with both diploma and degree nurses?
8. To gain entry in to nurse education, applicants now require 4 GCSE's at grade C and above and A level qualifications. How do you think that this will influence the future of nursing?
9. Degree Qualified Nurses: How does having a degree qualification and not a diploma, impact on your ability to provide care?

10. Diploma Nurses: How does having a diploma and not a degree qualification, impacts on you ability to provide care

## Appendix 5: Participant Characteristics

Branch	Number of Participants
Mental Health	1
Child	3
Adult	9
Learning Disabilities	1
Other	1
	Participants
1	<b>Anna</b> - A 2nd Year <b>Student Nurse</b> following the children's pathway.
2	<b>Nita</b> - A Registered General Nurse – This nurse had qualified as a <b>diplomate</b> . They had 6 years post qualifying experience and had progressed to a AfC <b>Band 6</b> (Agenda for Change (AfC) 2004) pay scale.
3	<b>Blessing</b> - A <b>Health Care Support Worker</b> - This participant had 10 years of experience working in that role within the NHS. This participant was a AfC <b>Band 3</b> (Agenda for Change). This is an unqualified role but integral to any nursing team.
4	<b>Kathleen</b> - An AfC <b>Band 8b</b> – Qualified in 1986 RGN. This nurse had a management responsibility within the trust. They had qualified with <b>diploma</b> .
5	<b>Naz</b> - An AfC <b>Band 5</b> Registered Adult Nurse 6.5 years' experience, <b>Diplomate</b> . This nurse was on the verge of moving to another role within a community setting.
6	<b>Luke</b> - An AfC <b>Band 7</b> . RGN BSc DN, Diploma in Health Education Studies. Qualified 1984. <b>Diplomate</b> , This nurse was very involved in student education and development and held a Specialist Community Practice Teacher qualification. This role supports practice students within the clinical setting.
7	<b>Lindsey</b> - RGN AfC <b>Band 7</b> BSc DN Qualified 20 years. Very experienced in their role and passionate about the development of nursing roles in the profession. <b>Graduate</b> .

8	<b>Frankie</b> - AfC <b>Band 8b</b> RGN BSc DN. 1986. <b>Diplomate.</b>
9	<b>Charlotte</b> - AfC <b>Band 5</b> BSc Nursing RGN Qualified 2013 Sep. <b>Graduate.</b> This nurse had post registration experience of working with student nurses both following the diploma and graduate routes
10	<b>Amber</b> - AfC <b>Band 6</b> qualified 2006. Children's Nurse Diploma Course. <b>Diplomate.</b> This nurse was a health visitor who was moving on to a new role.
11	<b>Precious</b> - AfC <b>Band 8a.</b> RGN, Specialist A&E qualification MSc. 2003. <b>Graduate Nurse.</b> This nurse held an education role within the trust supporting students both pre and post registration
12	<b>Elliott</b> - RGN AfC <b>Band 6</b> , DN, PGCE, pre 1983 qualified. <b>Diplomate.</b>
13	<b>Jennifer</b> - LD nurse AfC <b>BAND 7</b> , Certificate Course, <b>Diplomate.</b> This nurse had an education role within the trust, supporting both pre and post registration nurses
14	<b>Louise</b> - AfC <b>Band 7</b> DN RGN. <b>Diplomate.</b> This nurse had progressed from an original pupil nurse, to a registered nurse completing the bridging programme and then progressed to a band 7 role in the trust
15	<b>Tricia</b> - AfC <b>BAND 5</b> Staff nurse, <b>Graduate.</b> 1 year post registration experience

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## Appendix 6: University Ethical Approval



## Appendix 7: Trust Research and Development Approval

Trust LOGO Removed

Research and Development Office

[Redacted signature block]

Date: 4<sup>th</sup>

October 2013

Dear Nerys Bellefontaine,

**Re: R&D ref no 2341 – Nurse Education: Graduate v’s Diplomate – Does having a nursing degree make you a better nurse?**

I am pleased to inform you that the above named study has been granted approval and indemnity by Professor [Redacted] Director of Research and Development [Redacted]. You must act in accordance with the [Redacted] NHS Foundation Trust’s policies and procedures, which are available to you upon request, and the Research Governance Framework. Should any untoward events occur, it is **essential** that you contact your Trust supervisor and the Research and Development Office immediately. If patients or staff are involved in an incident, you should also contact the Governance and Assurance department, in [Redacted] Hospital, and complete the Incident and Reporting Form, namely the IR1 form.

You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

[Redacted signature]

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Research and Development Manager, [REDACTED]

1 of 2

List of documents reviewed by [REDACTED] R&D Department

[REDACTED] Registration Form		
Research Proposal	V1	
Participant Information Sheet	V2	22 <sup>nd</sup> February 2013
Consent Form	V2	9 <sup>th</sup> July 2013
Interview guide	V1	22 <sup>nd</sup> February 2013
Checklist for ethics reviews		18 <sup>th</sup> October 2012
Application for ethical review		8 <sup>th</sup> July 2013
LSBU Ethics Approval		24 <sup>th</sup> September 2013
NHS R&D Form	108815/500190/14/443	2 <sup>nd</sup> October 2013
NHS SSI	108815/500191/6/358/161543/280883	15 <sup>th</sup> January 2013
Peer Review	[REDACTED]	30 <sup>th</sup> July 2013
Insurance and Indemnity		18 <sup>th</sup> July 2013
Sponsor Letter	LSBU – [REDACTED]	20 <sup>th</sup> September 2013
Confirmation of pre engagement checks		
CV	Nerys Bellefontaine	25 <sup>th</sup> April 2013
CV	[REDACTED]	
CV	[REDACTED]	
NMC – The Code		1 <sup>st</sup> May 2008

# London South Bank University

## Appendix 8: Example RES 2C

### Protection Act 1998

The data collected on this form will only be used for the purpose of student and course administration as required by the University and will be retained securely on your file.

1. THE APPLICANT		
Surname: Bellefontaine		Student No: 2053639
First Name(s): Nerys	Full/Part-Time: PT	Faculty: AHS
Current Address: [REDACTED] [REDACTED] [REDACTED]  Post Code: [REDACTED]		If in employment, present post and place of work: Community Clinical Cluster Lead [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]
Telephone: [REDACTED]	Telephone: [REDACTED]	
Email: nerys.[REDACTED]	Email: [REDACTED]	
Details of any scholarship held or financial support: NA  Details of any collaboration (contact name & address) NA  N.B. Applicants should additionally supply a letter of approval from the collaborating partner.		Details of Completed Taught Component  First 2.5 years of EdD – Education for sustainability, equality and diversity.   Course Director Signature:  [REDACTED]

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<b>2. PROGRAMME OF RESEARCH</b>
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2.1 Title of the proposed investigation (12 words maximum):  Nurse Education: Graduate vs. Diplomate
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2.2 Aim, objectives and desired outcome of the investigation (please be specific):

The aim of the proposed study is:

- To explore the impact that the introduction of an all graduate nursing programme may have on the provision of nursing care.

In addressing the research question and achieving the aim of the study, the following objectives have been identified:

- To explore graduate and diplomate nurses own perceptions of the impact that a graduate only qualification may have on nursing care delivery.
- To explore nurses experiences of working with the graduate vs diplomate nurse, to ascertain ways in which they may perceive difference in ability
- To identify the opinions of registered health care staff on the new entry criteria to nurse education, focussing on their inclusiveness or exclusivity
- To identify any overall perceived differences in the nursing abilities of staff that hold a degree vs. diploma qualification in practice, from both nurses and other health care staff.
- To explore participants perceptions of the 'good nurse'

---

2.3 Proposed plan of work, including its relationship to previous published academic work with **up to twelve** references. Please keep within a maximum of four sides of A4 in font 12 (new times roman or arial) otherwise the application will be returned.

Within the taught component of the EdD, I have focussed my studies primarily on pre-registration nurse education. My MSc studies also focussed on nurse education and the challenges that students experience during their training. This is very pertinent to the role that I currently undertake and I am passionate about ensuring that the right calibre of student is encouraged to join the nursing profession, for the right reasons.

It has been postulated that nursing practice must be based on evidence, knowledge and analytical and problem solving skills, therefore the Nursing and Midwifery Council (NMC), the governing body for nurses and Midwives have decided that by 2013 in order to meet these requirements, that graduate only pre registration nursing programmes will be offered in the UK (NMC 2010a). Literature addressing the impact that a degree only nursing programme will have and has had on the nursing workforce and quality of care provision is sparse and outdated. Therefore, it is acknowledged that there is a need for research to identify the full impact of this historic move and the proposed study has been developed to explore this shortfall in knowledge.

Concerns have been expressed about the move to a graduate programme, some believing that it could in fact harm patient care, if graduates are less willing to undertake menial tasks (Martin 2009, Patients Association 2009).. The hope is that those who reach the higher levels of education, understand that they are still responsible for providing basic nursing care (Martin 2009). One UK study has compared the competencies of qualifiers from both degree and diploma courses, showing that there was no significant difference between the two groups (Robinson & Bennett 2003). Another study has compared the critical thinking and decision making skills in both groups, again no differences were revealed between graduate and diplomate nurses (Giot 2000).

Both of these studies were undertaken some time ago and a more current study is required.

Questions have also been raised as to the equality of a graduate only programme and its apparent exclusivity. It has been acknowledged that requiring a degree for registration, may deter specific groups from entering the nursing profession, Bangladeshi and Pakistani populations are less likely to go into higher education generally (Higher Education Statistics Agency 2006/7). Evidence supports the fact that only 15% of students whose parents work in a manual occupation enter higher education, compared to 81% of students whose parents have professional backgrounds (Barr 2004). Black African students are less likely to be studying at 'A' level (8%), a required criteria of access to a nursing degree programme, whilst there are 21% of white students, 21% of Indian students and 23% of Pakistani students (Bhattacharya 2002, Aim Higher

2006). However, black Africans are more likely to be studying for degrees (36%) than white, Pakistani or black Caribbean students (Bhattacharya 2002, Aim Higher 2006). Concern has been expressed that nurses who are disabled or from ethnic minorities could face discrimination, after a report claimed that most NHS bodies treated duties to reduce inequalities as a "box ticking exercise" (Lewis 2011). Both class and gender attitudes continue to shape public perception of nurses' ability to be educated (Rafferty 2010).

As well as the existing barriers to access, it is also projected that there will be a decline in the numbers of young people by 2020, with estimates suggesting that there will be 600,000 fewer 15-24 yr olds in Britain. This in itself may pose problems for nurse recruitment of the future, although the NMC continue to report a year on year increase of applications to nursing, with requests for degree courses up by 74%.

### **Research Design**

The proposed study will utilise a qualitative research design within a naturalistic paradigm. This interpretive approach acknowledges that there is a gap in our understanding of the impact that graduate only education programmes will have on nurse preparation and that clarification of current practice would be of benefit for future nurse education and current nursing practice. Employing such a design will not necessarily provide definitive explanation to the posed research question, but any data obtained does raise awareness and increase insight.

Interpretive phenomenology has been identified for use in this study in an attempt to use interpretation and personal or theoretical sensitising to highlight important themes. This approach will allow for the collection of data regarding the perceptions of both graduate and diplomate nurses and staff working with them, which will enhance exploration of the phenomenon in question.

### **Sample**

It is proposed that purposive sampling will be utilised for this study ensuring that respondents with particular characteristics are selected, to ensure that information rich interviews are achieved. It is important to obtain a representative sample of graduate and diplomate nurses, senior nursing staff from the range of nursing branches and medical staff, to gain as much knowledge as possible about the phenomenon in question.

The aim of this study is to initially interview 15-20 staff; with the capacity for more should the data collected suggest that this need be the case. Staff will be invited to participate in the study via a letter of invitation/information sheet from the researcher as per National Research Ethics Service guidelines (NRES) (NRES 2011). This will be given to them when they meet with the researcher

to discuss participation in the study. The purpose of the study and the right to refuse to participate will be outlined within the information sheet, which will be given one to two weeks prior to the interviews being undertaken. This will allow the staff to make an informed decision about whether to participate or not. The invitation whilst giving information about the study itself, will discuss the need for informed consent from the staff member.

### **Research Instrument**

It is proposed that semi-structured questions will be used for this study in one to one interviews with participants, providing the opportunity for staff to share their experience using their own vocabulary. A more structured interview could be utilised if the subject matter required less exploration, however as little is known about the phenomenon in question, a semi structured approach will be more suited. There will be the opportunity to change questions as the research study progresses, depending on the cumulative data obtained. The inquiry will then be based on the realities and view points of those participating in the study, realities and view points that may not be known at the outset. Data will be continually examined and interpreted to make decisions about how to proceed, based on what has already been disclosed. Care will be taken to ensure that the interview schedule is not too tightly structured as this may not enable the phenomena in question to be explored in terms of either breadth or depth; an hour will be allocated to each interview taking place.

The interviews conducted are to be tape recorded and transcripts of the discussions are to be typed up after the event, allowing the interviewer to concentrate on listening and responding to the participant. Interviews will be undertaken within the participants' acute/community setting to minimize the amount of time that staff have to be away from the care setting. The presence of recording equipment within the interviews may intimidate staff somewhat; however equipment will be kept to a minimum in an attempt to reduce anxiety. It will be ensured that the rooms in which the interviews are conducted are kept private and interruptions prevented, taking in to consideration confidentiality which is of prime importance within any study. Data collection is planned to continue until data saturation has been achieved, being the repetition and confirmation of previously collected data (Morse 2000).

### **Data Analysis**

A content analysis will be undertaken in this study.

### **Ethical Issues**

I am in the final stages of acquiring NHS ethical approval via my organisations Research and Ethics Committee. University Ethical Approval will also be sought.

### **Summary:**

Little credible evidence exists to support the impact that this approach to nurse training has had on the quality of nursing care provided. It is hoped that this study would go some way to identifying the real impact that such an approach to nurse preparation has had on the quality of nursing care provided within 4 London boroughs.

---

**2.4 Details of resources required for the investigation (including funding, space and specialised equipment):**

- I shall be undertaking the research study within my current role as Community Clinical Cluster Lead, with the staff in the organisation. I have applied for access to identified locations and staff within the NHS ethical approval submission.
- No funding will be required for this study

**2.5 Research Ethics – please state whether you consider ethical approval to be an issue for the topic. (If so, then contact should be made with the LSBU Research Ethics Committee).**

- Currently applying for NHS organisational research approval, have completed IRAS documentation awaiting final sign off.
- Will be applying for university ethical approval immediately after acceptance of Application to Register for a Research Degree.

**2.6 Collaborative engagement – please state whether or not the proposal will involve any collaborative activity and, if so, where, of what nature, and with whom.**

NA

**3. KEY SKILLS SELF AUDIT**

Candidates should list relevant experience in the following categories. A maximum of two sides of A4 paper can be attached

In completing this section, please refer to the *Key Skills Handbook*, for an explanation of the information required in each section.

### **3.1 Research Skills (i.e. knowledge of research methodology)**

- I have undertaken a research study as a component of my MSc – Strategic Leadership and Expert Practice (Education). I have used the same methodological approaches within that study, as has been identified for this study. I was invited by the NMC to present my findings at their national conference in Liverpool. The finding subsequently influenced the development of NMC Raising Concerns guidance for student nurses.
- I have completed research modules in both the MSc that I have undertaken and as a component of the EdD 1<sup>st</sup> and 2<sup>nd</sup> years.
- I am involved in audit and research studies on a regular basis, as part of the role I undertake within the NHS.
- I sit on the Clinical Audit and Research group for [REDACTED]
- There are regular PhD forums offered by my organisation addressing research methodology and approaches.

### **3.2 Research Environment (i.e. context & demands of research programme)**

- Prioritisation of work/home and research demands.
- Effective timetabling to ensure all demands are met

### **3.3. Research Management (i.e. organisation and approach)**

- In the role of Community Clinical Cluster Lead for a heavily populated [REDACTED] Borough, I have to ensure that I have impeccable time management and organisational skills. Without these I would not be able to function in the role.
- I have undertaken a research study for my MSc and was able to manage the challenges that the study posed as well as being able to adhere to the established GANNT chart for the study.



### **3.4 Personal Effectiveness**

- Time management
- Project Management
- Previous experience and management of a research study
- Have faced the challenges of a research study and have been able to manage those

### **3.5 Communication Skills**

- I believe that I have mature communication skills and within my working and personal experience, have had to communicate to people and organisations at a wide variety of levels, both strategically and organisationally.

### **3.6 Networking/Team working**

- Access peer support through the organisations PhD support network.
- Peer support through the EdD group
- Support through others undertaking PhD research at present.
- Accessing managerial 1:1's
- Accessing clinical supervision



### **3.7 Career Management**

- I am currently undertaking a managerial post within NHS [REDACTED] services and have acquired all the required training, experience and knowledge, to ensure that I am able to function effectively within the role.
- There is scope to progress further within both the strategic and operational managerial echelons of the NHS, however I believe that the higher up the managerial ladder one progresses, that the further away from patients and the realities of day to day practice you become. The strong connection with patients, carers, staff and the multi disciplinary teams enhances communication and at this particular point in my career, I believe that it is important for effective management to remain patient focussed.

### **3.8 Project Specific Skills**

- I have undertaken a qualitative research study for my MSc.
- I am involved on a day to day basis, in NHS research and audits to enhance practice.



#### **4. KEY SKILLS DEVELOPMENT PROGRAMME**

Your programme of key skills development should be agreed with your supervisory team and listed here

##### **4.1 Research skills**

- NVIVO training to support the qualitative component of this research

##### **4.2 Research environment**

- Obtaining NHS research approval and have completed IRAS documentation

##### **4.3 Research management**

- To seek organisational support as required, as well as academic supervision from LSBU

##### **4.4 Personal effectiveness**

- Continuing personal and professional development as part of my clinical/managerial role

##### **4.5 Communication skills**

- Ongoing development opportunities within my current role

##### **4.6 Networking/teamworking**

- To continue to attend EdD support sessions with Peers.
- Attendance at PhD support sessions provided by the trust

##### **4.7 Career management**

Will be going through an organisation restructure Sep/Oct 2013. Career management/prospects will be re-visited on completion of the consultation.

##### **4.8 Project specific skills**

- Presentation of research proposal at organisational PhD support/facilitation sessions.





6.2 Date of Enrolment:
Approved start date (for office use only):

6.3 Part-time Students:  Please state average number of hours study proposed in each week (minimum 16): 20
--

**7. DECLARATION**

I wish to apply for registration of my proposed research project on the basis of the information given in this application. I confirm that the particulars given are correct. I understand that I must prepare and defend my thesis in English. I understand that my registration may only continue after the submission and approval of an Annual Report each year.

Signed (Applicant): [REDACTED] Date: 06/05/13

**8. RECOMMENDATION**

We support this application and believe that the applicant has the potential to successfully complete the proposed programme of work within the appropriate time limits. We recommend registration as a candidate for the indicated research degree. We confirm that where necessary approval has been/will be sought from the University Research Ethics Committee.

Signed: [REDACTED] Name: [REDACTED] Date: .....  
Director of Studies (First Supervisor)

Signed: [REDACTED] Name: [REDACTED] Date: .....  
Second Supervisor

Signed: [REDACTED] Name: [REDACTED] Date: .....  
Third Supervisor

**9. ENDORSEMENT BY THE FACULTY**

I endorse this application

Signed: [REDACTED] Name: [REDACTED] Date: .....  
Executive Dean or Nominee.

**10. CONFIRMATION BY RESEARCH DEGREES COMMITTEE**

I confirm that registration has been agreed by the Research Degrees Committee/Sub-Committee.

Date of Meeting:

Signed:

(Chair/Secretary)

Name:

Date:

**Office Use Only**

Application received:

Name:

Signed:

Applicant notified:

Name:

Signed:

Record amended:

Name:

Signed:





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## Appendix 9: RES 3B 1<sup>st</sup> Progress Report Approval

**London South Bank  
University**

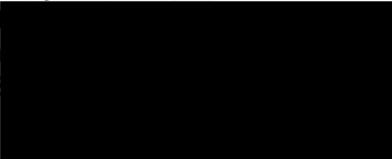
103 Borough Road London SE1 0AA  
T +44 (0)20 7815 7815 lsbu.ac.uk

Telephone Direct Line: 020 7815 5796  
Email: [goringbl@lsbu.ac.uk](mailto:goringbl@lsbu.ac.uk)

2<sup>nd</sup> December 2014

Ms Nerys Bellefontaine

44  
Lon  
E4 8



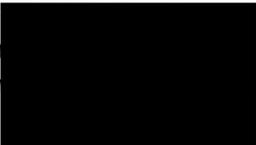
Dear Nerys

I am pleased to inform you that your 1<sup>st</sup> Progress Report has been approved. Please find enclosed Approval document, which you should retain for your records. A hard copy of these documents has been sent to your home address.

Yours sincerely

Dr  
Se



Cc: Dr  
Mr  
Mr  Central Research Support office

<b>RES3B 1<sup>ST</sup> PROGRESS REPORT ASSESSOR'S COMMENTS</b>	
<b>Student Name:</b> Nerys Bellefontaine	<b>Student No:</b> 2053639
<b>Title:</b> Nurse education: graduate v's Diplomate – Does having a nursing degree make you a better nurse?	
<b>To be completed on behalf of the Faculty Research Committee</b>	
Comments:  <b>The report is an extensive literature review with some brief indications of the plan for the research and of the data collected. The report follows the guidelines set out by the FRC but this reader was a little frustrated that the methodology is not included. Hence the connection between the concerns of the student that have led to the research and are revealed in the report and the research carried out are absent.</b> <b>Overall the literature review is very thorough and comprehensive and suggests that the student has a very good handle on the field and on the need for this research, giving confidence that an appropriate thesis will emerge on this most important topic.</b> <b>The literature reviewed ranges across all the areas I would expect: the history of nursing and nurse education; the policy goals and motives that have led to the change in nurse education; the various positions on what constitutes good nursing; the demands on health care and on nurses in particular in 21<sup>st</sup> century society; the problems faced by the change and the researcher's perspective; issues of equality and diversity and an evaluation of the various opinions in the field; theoretical literature that supports the research, including issues of power. There is some repetition and an absence of structure. Setting out at the start of the chapter what argument will be developed through the literature review, leading in the end to a rationale for the study in the light of what is absent in current knowledge, and reflected in headings of sections should help in this. It is clear as a reader when the researcher is expressing her own views and where she is reporting on the views of politicians and of writers but these should be clearly signalled by the structure.</b> <b>I recognise that the report presents a first draft of the chapter; the most important thing one needs to see is evidence of a good, thorough and critical knowledge of the field and a strong argument for this study and they are certainly present here.</b> <b>The data have been collected and the researcher has a plan for analysis, which has already begun. She has acquired the skills necessary, in this case of N'Vivo. I am happy to recommend approval and ask that these comments on the chapter be passed on to Nerys.</b>	
	
Signed: .....	Date: .....13/11/2014.....

A. We have read the attached report;	
B. An interview panel was / was not convened;	
C. We recommend the following: (Please tick as appropriate)	
<input type="checkbox"/>	The report is approved
	Feedback on the report is attached (if not included below): YES/NO
	The report is not approved but the candidate is allowed to amend the report in line with the attached comments
	Deadline for re-submission:
	The report is not approved and the student's registration should be terminated
<b>Final Decision by Faculty Research Committee</b>	
<b>Approved/Not Approved</b>	
Signed:	
Date:	
(Chair of FRC) Faculty of ...	

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## **Appendix 11: RES 3C**

### **What is the research trying to achieve**

Literature addressing the impact that the introduction of a graduate only nursing programme will and has had on the nursing workforce and quality of care provision, is sparse and outdated. Therefore, there is a need for a research study to identify the full impact of this historic change to nurse education. The present study was therefore developed to explore this current shortfall in our knowledge and understanding.

### **Research Works already completed:**

To secure approval for commencement of this study, the following achievements were made in the academic year 2013 – 2014:

- Funding was obtained from my trust for the EdD 3<sup>rd</sup> year, with the support of my Director of Studies
- Obtained Ethical Approval from London South Bank University (LSBU), following completion of Res 1 and 2, on the 4<sup>th</sup> September 2013
- Obtained Research and Ethics Department approval from my Trust (NELFT) for the study on the 4<sup>th</sup> October 2013. This took around 8 months in total to secure, addressing all of the criteria required for studies undertaken in any National Health Service (NHS) environment.
- I have undertaken a total of 14 face to face research interviews.
- These 14 interviews have been transcribed and are awaiting input into NVIVO for data analysis.
- I have met with my research supervisors once on the 4<sup>th</sup> April 2014, Elspeth Hill and James Giles. I have also been in e-mail contact with them and with my Director of Studies, Nicola Martin on a number of occasions.
- I have completed and submitted my Trust's Annual Research Report to the Research and Development Team on the 25/05/14.
- I have attended the support sessions provided by LSBU and the EdD team 25<sup>th</sup> November 2013, 11<sup>th</sup> March 2014 and the 6<sup>th</sup> May 2014. Unfortunately work commitments and demands have meant that I have not been able to attend all offered dates for supervision.
- I attended a training session on NVIVO at LSBU, organised by my Director of Studies
- I have obtained Peer supervision from the EdD group during these meetings.

- 
- I have applied for funding from the Trust, for the 4<sup>th</sup> Year of the EdD

I believe that I have developed in the following skills during the completion of the research study to date:

- Time management and prioritisation skills, these have been tested to the utmost in my current working environment (NHS) and role. Current work priorities have been impacting on the progression of the research and initial time frames for study completion.
- I have attended the NVIVO training and support sessions delivered by LSBU to facilitate my research data analysis. This has given me the insight and preparation for its use to support my study.
- Research skill development. Undertaking semi structured interviews, active listening and questioning and communication skills



removed

## Monitoring and Audit of Research Projects

Compulsory requirement of Research Governance

A separate form **must** be completed (on behalf of and signed by the **local principal investigator**) for each research project. Monitoring must occur annually and audit at completion of each study.

For ongoing research projects, please complete 1, 2, 3, 4, 5, 6, and 9.

For completed research projects, please complete 1, 2, 3, 7, 8, and 9.

**Please return to:** Research and Development Department, [REDACTED]  
[REDACTED] Tel: [REDACTED] ext. 4453, Fax: [REDACTED]  
**Thank You.**

1. Study details			
<i>Title of Study</i>	Nurse Education: Graduate v's Diplome – Does having a nursing degree make you a better nurse?.		
R&D Ref. no.	<b>2341</b>	REC ref. no.	UREC 1336
<i>Sponsor</i>	London Southbank University		
Project Status (please select)	<input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> In preparation <input type="checkbox"/> On hold <input type="checkbox"/> Abandoned		
Actual or expected start date at NELFT	October 2013	Actual or expected end date of project (end analysis)	End of May 2014 (Was due to complete march 2014)
If start / end dates have changed, please describe the reason / causes		Work/Research priorities posed a challenge and target date to complete research interviews over ran a little	
Has the research 'sponsor' performed any monitoring or audit of the research? <i>If yes, please enclose copy of the monitoring and/or audit report, including details of the resolution of any queries</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No Currently Completing 1 <sup>st</sup> Year end (RES4) report and due to

	submit RES3 in September 2014. I shall forward a copy when these are complete
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2. Recruitment	
Recruitment target (or equivalent) for the study	15
Recruitment achieved to date for the study	12
Recruitment target (or equivalent) for this site	15
Recruitment achieved to date for this site	12
Have there been any deviations from the agreed protocol? (E.g. inclusion / exclusion criteria, blinding, methods, etc.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, please explain:	

3. Adverse events or incidents	
Have there been any adverse events or incidents? (Please include any research misconduct or potential fraud)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes; to whom have these been reported to? <a href="#">If not reported to the Research Office; please attach details</a>	<input type="checkbox"/> Research Office <input type="checkbox"/> Trust incident reporting <input type="checkbox"/> Sponsor <input type="checkbox"/> Research Ethics Committee <input type="checkbox"/> MHRA (where applicable) <input type="checkbox"/> Other (please specify): ___NA_____ <b>Please provide any reference number:</b> _____



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## Appendix 13: Poster Presentation



Acrobat  
Document.pdf



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# Report:

## EdD: Critical Issues in Educational Change and Development: global sustainability, equality, diversity

**Student Name:** Nerys Bellefontaine

**Student Number:** 2053639

**Submitted:** 21<sup>st</sup> November 2018

**Word Count:** 1831



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**#The following text examines my personal journey through the EdD - Critical Issues in Educational Change and Development: global sustainability, equality, diversity completion. This report is a requirement in the completion of the EdD and a component of the assessment criteria.**

My enthusiasm to complete the doctorate, following successful completion of an MSc in Strategic Leadership and Expert Practice in 2008, was initially fuelled by my father, an avid philosopher and academic, prior to his diagnosis of Alzheimer's disease. His 60 year experience in teaching from primary schools to polytechnics and on to universities, inspired my desire to explore differing educational approaches, with a special focus on nurse education. His initial interest progressively waned with the progression of the disease and in honour of him, I was resolute about progressing through the doctoral programme to its final completion. I am hoping to be able to share the results of this thesis directly with him.

The quality of nursing care provided within the United Kingdom's (UK) National Health Service (NHS) has been identified as an issue of great national importance, especially over the last decade (Nursing and Midwifery Council (NMC), 2010a, NMC, 2016). The NHS has been subject to much negative press over recent years (Francis, 2013, Berwick, 2013, Crick et al, 2014), with healthcare quality under constant scrutiny. While the public generally have high regard for nurses, some high-profile examples of poor care have given justifiable cause for concern (Francis, 2013; Berwick, 2013; Crick et al, 2014; Care Quality Commission (CQC), 2015). Berwick (2013) places the quality of patient care, especially patient safety, above all other aims of the NHS and also places great emphasis on the growth and development of all NHS staff. There remains public interest in how nurses are educated and prepared for their roles (HEE, 2016, NMC, 2016), thus preparing future generations of nurses and safeguarding the health and wellbeing of the public is a central aspect of the NMC (HEE, 2016; NMC, 2016).

The promise that this historic step to improve healthcare, would enable students to cope better with increasingly complex challenges of the modern National Health Service (NHS) (Johnson 2009, NMC 2010a, DH 2010), was promising. It was the belief that graduate nurses would be thinking analytically and using higher levels of professional judgment and decision making, in an increasingly complex environment (DH 2010a; Johnson 2009; NMC 2010a; NMC 2010b; RCN 2010). Being a nurse, working within a nursing managerial role in the NHS and having undertaken a number of nurse education roles through my career, I had a vested interest in the new graduate approach to nurse education and the impact that it may have on the preparation of the future nursing workforce. The EdD would provide a conduit for me to

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explore, at front line of care delivery, the influence that this historic change could have on the provision of nursing care.

Undertaking the EdD from the outset highlighted that issues of sustainability seemed very detached from the current reality of modern NHS. Quite how I could make an impact on sustainability in its ecological sense from my role was bewildering. Whilst there was evidence to suggest that the NHS was attempting to address issues of sustainability at that time (World Health Organisation (WHO), 2009; Mayor, 2008; O' Dowd, 2007; Cootes, 2006), the real impact that these would have and the commitment that would be given to them, was questionable. There is an abundance of literature regarding ecological sustainability issues in school educational approaches, but a dearth however of nursing education literature relating to the same matter.

Completing the first 2 years taught component of the programme was enriching. Learning with non-healthcare professionals was refreshing and gave me an alternative insight into differing educational approaches. Considering the application of these alternative teaching and learning methods was exciting. What soon became evident was that the challenges facing the education of future nurses, was also evident in other professional groups. Challenges between diploma and graduate qualifications, were also being discussed in school education. The perceived disparity in status and position in educational discourse was identified by a number of preparatory programmes. This further fuelled my interest in nurse education power imbalance and its application to the workforce.

Power has been closely linked to knowledge, with greater knowledge ensuring greater power (Foucault, 1973). The research undertaken gave me the opportunity to explore this issue of power in healthcare and how it impacts on the nursing professions status. It was been suggested that it may well be more suitable for nurses to cultivate superiority than to play the superior at their own game (Foley, 2012) and nursing has battled to influence care from the inception of the NHS. One of the 7 deadly sins of social ranking has been identified as status (Foley, 2012). To have power over others is to be in a position to deprive them of choices options, to bend them to ones will to make use of them (Grayling, 2007). I wanted to explore the influence of power dynamics in healthcare further and consider if the new approach to nurse education may mirror the medical and allied health professional's education approaches, in an attempt to influence the nursing profession's position and status. The thesis would give me the opportunity to explore these power relationships from the inception of the NHS, in order to inform the current status. An iconic consequence of an equalitarian society is that it has made everyone equal, only in the right for them to feel superior (Foley, 2012).

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Importantly, the development of graduate skills within the nursing workforce has been linked with the empowerment of nurses to effect change within their contexts (Hayes, 2012).

The EdD programme would allow me to become more familiar with critical theory, a theory which would support some concerns and worries with regard to the implementation of a graduate only programme of study. Critical theory is concerned with enabling disenfranchised members to overcome domination (Appelbaum et al, 1999) and is based on the premise that certain groups in society are in a subordinated position. The controlling group has greater prestige, power and status than the oppressed group (Fletcher, 2006). In critical social theory, power is extra-personal, which means that an increase in power is compensated by someone else surrendering part of their power (Kuokkanen & Leino-Kilpi, 2000). From this perspective, empowerment is equated with liberation (Fulton, 1997) and involves a struggle because powerful people are not readily going to hand over resources, information or responsibility unless they see an advantage to doing so (Skelton, 1994). Along with identifying the impact that the new programme may have on the nursing workforce, I wanted to explore how the introduction of the graduate only programme may influence power dynamics in the workplace. The concept of '*graduateness*' and the '*good nurse*', would allow me to explore further nursing competence and skills acquisition, as well as considering the impact of intuition and experience in the provision of nursing care.

The process of gaining ethical approval at the outset of this study from the university and in parallel, research and development approval from the trust, was arduous. Whilst university ethical approval was relatively quick to gain, trust approval was challenged by organisation and national directives and a change in ethical R & D approval applications. This process took a number of months to complete and prolonged the commencement of the research. Reflecting now however I can acknowledge how the robustness and governance of these applications has to be assured and have advised anyone undertaking research studies to ensure that these applications are started early in any research project. This study provides a basis for a larger multi centered study and one which could include patient perspective, this approach would further inform the debate.

Accessing potential participants required careful planning, navigating through various NHS services spanning a number of boroughs, each with individual nuance in terms of accepted process. Heightened awareness of time management and planning became imperative to ensure that key time lines were adhered to. Undertaking the research interviews themselves, was an enriching process. I felt privileged to be given the opportunity to listen to personal accounts of nursing care from differing perspectives. It was heartening to hear the personal experiences of nurses, who showed real compassion, empathy and courage in their

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responses. Acknowledging that the nursing profession really 'cares' was emotive. I now acknowledge the need to be open to everyone's opinion and not to have pre conceived or pre-determined ideas.

Whilst subsequent data analysis was time consuming and required a lot of commitment to complete, I recognised my need to ensure that I was organised and structured with my time. Managing a full time demanding job and undertaking a part time research programme was no mean feat. Demands progressed with the need to compile the final thesis, when a number of personal challenges presented. Following an unsuccessful attempt at dissertation submission and viva completion in September 2018, I have now had time to reflect on the whole Educational Doctorate process and can acknowledge the vast amount of learning that has taken place for me.

On reflection I now realise that I rushed the penultimate stage of the doctoral process and submitted my thesis too early. This was due to a combination of personal factors, my ill health pre-ceding and following cardiac surgery and going through a period of mourning following the unexpected and untimely death of my brother. This was followed by another cardiac procedure and the death of my mother. Having the demands of young children and being a carer for my father, impacted upon my key priorities. In addition my Director of Studies was absent from work receiving cancer treatment, so not involved in the final read through.

I believe that the process of undergoing the viva illuminated the need for final reworking and consideration. The detailed feedback given by the examiners has been explicitly addressed in the re-draft, which I am presenting here and I have included the attached examiner feedback

It has been a journey filled with differing emotions and one that has posed a number of challenges both academic and personal, however with the guidance and support of a group of amazing university staff whose commitment has been admirable, I have finally been able to produce work which I am extremely proud of. I am extremely grateful to all who have supported this extended thesis completion.

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