The captive market in nurse education and the displacement of nursing knowledge

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BACKGROUND AND INTRODUCTION

The market reforms of the British National Health Service (NHS) together with the emergence of the diploma-level nursing curricula (Project 2000) have influenced the setting and future direction of nurse education (Elkan et al. 1993, Elkan & Robinson 1993, Jowett et al. 1994, Walby et al. 1994, Elkan & Robinson 1995, Ramprogus 1995, Camiah 1996, Clifford 1996, Humphreys 1996a, 1996b, Macleod Clark et al. 1996, Phillips et al. 1996). In particular, the emergence of the Project 2000 nursing curricula (United Kingdom Central Council for Nursing, UKCC 1986) and the move of nurse teachers into the university setting may redefine the role of nurse education (Ramprogus 1995), affect the clinical activity of nurse teachers (Elkan et al. 1993, Elkan & Robinson 1993, Jowett et al. 1994, Elkan & Robinson 1995, Camiah 1996, Clifford 1996, Macleod Clark et al. 1996, Phillips et al. 1996) and potentially change the character of nurse education and nursing knowledge (Ramprogus 1995). Furthermore, following the National Health Service (NHS) market reforms and the emergence of Project 2000, a fine balance has arisen in the market for the commissioning of nurse education. This is a balance between the NHS need for nurse education to enhance services on the one hand, and its need to control the commissioning of nurse education for service enhancement on the other (Humphreys 1996b). However, senior executives in service provision perceive this market as favouring ‘vested professional interests’ (Humphreys 1996a p.165) without offering any ‘reality of control’ (Humphreys 1996b p. 1293) to further encourage NHS trusts’ involvement in the commissioning process for nurse education. Thus, senior executives perceive the market infrastructure for commissioning nurse education to be imbalanced. In this paper...
a critical examination analyses the influences causing this imbalance, namely the NHS market reforms and recently cited changes in nurse education (Macleod Clark et al. 1996). A framework of empowerment is utilized for developing an approach to commissioning nurse education in the context of the market imbalance described. Reference is made to relevant aspects of both pre- and postregistation nurse education in order to develop a generic approach to commissioning nurse education, even though each of the former warrant separate inquiry.

**Theoretical framework**

The conceptual perspective for this examination is based on the work of Anthony Giddens (Giddens 1991). He argues that the self is not a passive entity shaped by external influences but is created by ourselves through a form of control or mastery, termed empowerment. In Giddens’ discussion of the self, empowerment is a reflexive process produced partly by the modern day expansion of ‘expert systems’ (Giddens 1991 p. 18), which embody modes of technical knowledge and whose validity is independent of the clients and practitioners utilizing them. Giddens conceptualizes these expert systems as permeating our social life, social relations and the ‘intimacies of the self’ (Giddens 1991 p. 18). The expansion of such systems produces increasing ‘quanta of power’ which afford individuals ‘the power to alter the material world and transform the conditions of their own actions’ (Giddens 1991 p. 138).

Thus, empowerment is not just a re-appropriation of knowledge and control (or power), but forms part of a ‘dialectic of control’ which produces ‘opportunities previously not available in prior historical eras’ (Giddens 1991 p. 139). Consequently, the nature of human empowerment is seen as the ability of individuals to constitute and reconstitute the social world ‘in their actions’ (Giddens 1991 p. 175). Empowerment leads individuals to re-skill as, for example, in the workplace where new skills are constantly created or even produced ‘by those whose activities are de-skilled’ (Giddens 1991 p. 138). This perspective on empowerment corresponds with recent professional guidance encouraging British nurses to re-skill in order to meet clients’ changing health needs (UKCC 1992). Thus, Giddens’ work offers some utility for developing an approach to commissioning nurse education which focuses on nursing practice and policy guidance, the exercise of professional agency, and the nature of skilled clinical knowledge.

**Nursing practice and policy guidance**

Official guidance may either limit or expand the possibilities for professional practice, depending upon where mastery or control is situated. For example, the guidance about the NHS provision of home-based intravenous therapy favoured the acute sector for provision of this service (Department of Health, DoH 1995), whilst overlooking the existing proficiency of community nursing in this domain (Corbett et al. 1993). Thus, the purchasing decision in favour of the acute sector was experienced as removing the nursing influence over resources and thus limiting the practice of community nurses. In contrast, policy guidance may also be seen in a political sense as an ‘agency of emancipation’ (Giddens 1991 p. 211), which liberates individuals from constraints placed upon their actions. An example of such a liberating framework is the guidance about nursing practice in the *Scope of Professional Practice* (UKCC 1992). It sanctions practice premised on independent judgement and ‘sound principles rather than specific tasks’ (UKCC 1992 p. 2). Therefore, the UKCC guidance appears as a framework of liberation by its advocacy of clinical decision-making and autonomy in nursing practice. Thus, this guidance expands the possibilities for practice and hence professional agency.

**Professional agency**

Practitioners may exercise a variable degree of professional agency within the differing health care bureaucracies, where newer practices are constantly being mastered and older ones discarded, for example, the changing childbirth initiatives (Department of Health 1993). The UKCC understanding of the professional nurse (UKCC 1992) corresponds with that of the empowered individual who can take responsibility to reconfigure their repertoire of skills in order to meet new needs (Giddens 1991). Furthermore, the UKCC promotes such an understanding by dispensing with the prior system of ‘minute certification’ (Walby et al. 1994 p. 82) associated with task-driven practice (UKCC 1992). Thus, the UKCC appears to sanction the exercise of greater professional agency, which in itself may be restricted by a lack of professional influence over the resources and the decision-making processes, for example, the previous description of community nurses and NHS purchasing decisions on home-based therapies.

**Skilled clinical knowledge**

Skilled clinical knowledge is dissimilar to psychomotor or practical skills. Skilled clinical knowledge is defined as experiential knowledge which is ‘almost wholly irreducible to objective measurement strategies’ (Benner & Wrubel 1981 p. 12). However, psychomotor skill is the objective ‘formalization or specification’ (Benner & Wrubel 1981 p. 12) of performance ability, which is refined by feedback and the self-efficacy of the performer (Bandura 1977, Corbett 1992). Thus, psychomotor skills are those which can be ‘objectified and qualified’ (Benner & Wrubel 1981 p. 12). In contrast, ‘skilled (clinical) knowledge’ (Benner & Wrubel 1981 p. 11) is acquired through clinical experience in similar learning situations and not from the ‘mere passage of time or longevity’ (Benner & Wrubel 1981 p. 11) in a clinical setting. It forms the practical
The captive market

sense of defining the role and value of education in terms of missioning may be described as ‘instrumental’, only in the health needs based on utilizing accrued skills and clinical change (Fletcher 1997) and effect creative solutions to be approached in terms of developing an awareness of the reformed NHS, comprises a service which provides regis-

vice delivery, specifically the ability to accommodate Consortia are composed of local trusts who jointly com-

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nature of empowerment, clinical experience is mediated by the individual whose social world is constituted and reconstituted through personal action (Giddens 1991).

Therefore, the commissioning of nurse education may be approached in terms of developing an awareness of the traits of the educated practitioner more desirable for service delivery, specifically the ability to accommodate change (Fletcher 1997) and effect creative solutions to health needs based on utilizing accrued skills and clinical experience (Benner 1984). Such an approach to com-

missioning may be described as ‘instrumental’, only in the sense of defining the role and value of education in terms of its utility for service delivery (Humphreys 1996a). Thus, the quality of such education should be judged with regard to its impact on practitioners’ ability to deliver health services (Humphreys 1996a) as part of a ‘flexible and competent workforce’ (Department of Health 1997a p. 2).

NHS market reform and the development of nurse education

Macleod Clark et al. (1996) investigated perceptions con-

cerning the recent development of Project 2000. The politi-
cal and economic factors influencing the NHS reforms and nurse education were seen as impacting on two levels, the ‘macro-level’ and the ‘micro-level’ (Macleod Clark et al. 1996 p. 196).

Macro-level factors

Macleod Clark et al. (1996) described the factors in the NHS market reforms which affected the NHS workforce and resources. These include the reduction in the contracted hours of British junior doctors, the ‘purchaser-provider’ split (Department of Health 1989a) and the NHS and Community Care Act 1990 (Department of Health 1990). Reducing the excessive contracted hours of junior doctors has produced a ‘boundary change’ (Walby et al. 1994 p. 25) between the practice of doctors and nurses. It has facilitated more devolution of medical procedures to nurses including, the administration of intravenous and epidural medications as well as the suturing of wounds (NHS Management Executive 1991, Standing Committee on Postgraduate Medical Education 1992).

Furthermore, the NHS reforms created markets in the education of NHS professionals and the provision of health services (Humphreys 1996b). The NHS and Community Care Act 1990 created the ‘internal market’ in NHS pro-

vision. It separated (‘split’) the purchasers (the health auth-

orities) from the providers (‘NHS trusts’). Another market was established for pre- and post-registration nurse edu-

cation by the guidance in Working Paper 10 (‘WP10 market’) (Department of Health 1989b). The latter rec-

ommended a simpler ‘ring-fenced’ system of purchasing for nurse education resulting in the formation of local Education Consortia (‘Consortia’) (Humphreys 1996a). The Consortia evolved out of government policy which devolved NHS functions to the lowest possible level, including the commissioning of services (Department of Health 1989a). Nurse education, within the context of the reformed NHS, comprises a service which provides registered nurses for the NHS trusts. Thus, the Education Consortia are composed of local trusts who jointly com-

mission nurse education. In this manner, Working Paper 10 politically facilitated the integration of nurse education within the reformed NHS (Davies 1994).

The captive market

The workings of the Consortia are overseen by the Regional Education Development Groups (REDGs) (Humphreys 1996b). The Consortia work under the auspices of the REDGs and within the budget allocated by the NHS Management Executive (NHSME). Within this infrastruc-
ture the local Education Consortia consensually review proposals, establish priorities and authorize contracts. However, the WP10 market actually prevents the local Education Consortia from devolving a share of the overall budget to each NHS trust or individual purchaser/consumer. Thus, the purchasers are not consumers in the sense of truly holding a devolved share of the resources.

The contradictions in the ‘local-central relations’ (Walby et al. 1994 p. 163) governing the reformed NHS are illustrated by the WP10 market. For example, the local-central relations determine the strict central control over funding for education and training by the NHSME. This impacts on the local Education Consortia through their relationship with the NHSME’s Regional Offices and the REDGs. This situation contrasts with the different relationship of the trusts to the NHSME concerning the funding of service delivery because such service funding is locally devolved to the trusts. Thus, the WP10 market is a captive market in two senses. Firstly, it prevents the trusts from exerting individual control over a devolved share of the available resources for education and training. Secondly, its political framework of local-

central relations can frustrate true consumer choice. Furthermore, such a captive market may lead to conflict between consumers (Walby et al. 1994) and to percep-
tions of vested interests (Humphreys 1996b). The WP10
market is perceived as impeding change and protecting education providers' interests' (Humphreys 1996a), thus, it is not a 'market' in the 'free market' sense (Walby et al. 1994).

**Imbalance in resources and skills**

The reduction in junior doctors' hours heightened the awareness about the skills of health professionals (Walby et al. 1994). Whilst diploma-level nursing curricula are seen as educationally advantageous (Davies 1994), doubts have surfaced in the NHS trusts about the value of Project 2000 and diplomates’ practical skills (Humphreys 1996a). Research into the Project 2000 programmes reports several perspectives on the practical skills of learners and qualifying practitioners ('diplomates'). In one study, educationalists considered basic practical skills were less important, earlier in the course, than interpersonal or communication skills, whereas NHS trust staff emphasized basic skills from the start (Elkan et al. 1993). This 'unfortunate split' between interpersonal and practical skills, relegated practical skills to a position of 'secondary importance' (Elkan et al. 1993 p. 36). Also, Ramprogus (1995) found academic progress overly emphasized separating 'academic and professional knowledge' (Ramprogus 1995 p. 79). A similar difference in emphasis is reported in recent research showing diplomates are theoretically sound, but have 'initial skill deficits' (Macleod Clark et al. 1996 p. 184, p. 206).

However, Project 2000 diplomates only spend 20% of their course time in rostered clinical service, compared to 60% in the previous apprentice-style ('traditional') courses (Elkan et al. 1993). Thus, the DoH expected diplomates would be 'less efficient' (Elkan et al. 1993 p. 6) than the traditional learners, hence the DoH Project 2000 Implementation Group’s 'inefficiency factor' in the funding of Project 2000 schemes (Elkan et al. 1993). Furthermore, as students progressed through the Project 2000 schemes, worries over practical skills lessened (Elkan & Robinson 1995, Jowett et al. 1994) and links between academic studies and practice placements became clearer (Elkan & Robinson 1995). Also, studies on Project 2000 (Elkan et al. 1993, Jowett et al. 1994, Ramprogus 1995, Camiah 1996, Macleod Clark et al. 1996) did not quantify skills-deficits between the traditional learner and diplomate, so making retrospective comparison difficult. Thus, compared to the renewed interest in skill-level in the NHS (NHS Management Executive 1991, Carr-Hill et al. 1992, Walby et al. 1994, Humphreys 1996a, 1996b), Project 2000 appears to have developed, at least initially, a more theoretical focus, given its legitimate 'overriding aim' (Elkan & Robinson 1993 p. 295) of educational enhancement of basic nurse education (Davies 1994). Therefore, some basis exists for service-provider doubts over diplomates' practical skills.

Furthermore, the NHS trusts perceive the WP10 market as protecting nurse education purchasing from the realities of the NHS reforms (Humphreys 1996b). For example, the current purchasing mechanism for post-registration education sets block contracts for the trusts whereby the full quota of contracted student places may not be utilized by each trust. Thus, the WP10 market resembles a wasteful bureaucratic mechanism in respect of utilizing resources, unlike that of a ‘true market’, which seeks to maximize resources (Walby et al. 1994). Furthermore, NHS trusts perceive the WP10 system and its strict control over funding as impeding change (Humphreys 1996a). This perception may underpin the reported emergence of post-registration training units from the budgets of the acute sector in order to address skill-deficits in the NHS workforce (Humphreys 1996a). Therefore, the degree of imbalance currently existing in the WP10 market is seen in the development of education initiatives funded locally by the NHS trusts (Humphreys 1996a).

**Micro-level factors**

Macleod Clark et al. (1996) described the diploma-level curriculum and the transfer of nurse teachers to higher education as affecting the organization of nurse education and facilitating Project 2000. However, nurse education is variously described in its relation to clinical teaching and the clinical skills of nurse teachers. It is described as, either distancing itself from health care delivery by incorporating into higher education and leading to clinical de-skilling of nurse teachers (Camiah 1996), or undergoing a period of integration with higher education which is compatible with retaining a commitment to clinical practice for research (Fletcher 1997). The literature on teaching students in the practice setting (Department of Health For Scotland 1955, Morgan 1958, Alexander 1983, Robertson 1987) shows how clinical teaching and the preservation of the clinical skills of nurse teachers require better organizational structures and more sustainable funding efforts. Also, the value nurse teachers place on clinical practice may represent a ‘cultural challenge’ for those wishing to fully integrate with higher education (Fletcher 1995a).

However, a greater negative orientation of nurse teachers to clinical-based activity currently is viewed as contributing both to the clinical de-skilling of nurse teachers (Camiah 1996) and the future uncertainties over their role (Clifford 1996). These latter trends are complicated by issues such as the breadth of teaching commitments (Elkan et al. 1993, Jowett et al. 1994, Elkan & Robinson 1995), role perceptions (Crotty 1993) and the demands of higher education (Fletcher 1997). Thus, nurse education’s move away from health care delivery has to some extent influenced both nurse teachers’ perception of nursing practice and the future direction of nurse education.

**The displacement of nursing knowledge**

Macleod Clark et al.’s discussion of service-practitioners’ duty to teach student nurses, and the meaning embodied
in Macleod Clark et al.’s utilization of the term ‘clinical skills’ (Macleod Clark et al. 1996 p. 169), have implications for practice-based teaching and nursing knowledge.

First, with respect to the teaching responsibilities of service-practitioners, nurse education is defined as ‘the theory and practice of nursing and the acquisition of skills’ (Phillips et al. 1996 p. 1087). This definition implies that nurse teachers have responsibility for the acquisition of practical or clinical skills. However, such an understanding contrasts radically with that of Macleod Clark et al. (1996) who consider the ‘duty’ or ‘major responsibility’ (Macleod Clark et al. 1996 p. 169) of the service-practitioner to be that of imparting practical skills to student nurses. Thus, Macleod Clark et al. appear to assume nurse teachers do not perceive themselves to be practitioners, partly confirmed by Crotty (1993). The latter contrasts with the UKCC assumption that nurse teachers would maintain clinical proficiency for more practice-based teaching post-Project 2000, anticipated as not falling ‘in such large measure to the ‘service staff’ practitioners’ (UKCC 1986 7.31 p. 58 emphasis in original). Unfortunately, the UKCC proposals for Project 2000 failed to prioritize the organization and funding of practice-based teaching (UKCC 1986). Furthermore, both nurse teachers (Crotty 1993) and senior education providers (Macleod Clark et al. 1996) evidence little professional responsibility for imparting practical skills to student nurses and display attitudes which effect the clinical de-skilling of nurse teachers.

Second, in relation to the development of clinical skills it is stated that clinical skills are ‘imparted’ (Macleod Clark et al. 1996 p. 169) by practitioners to student nurses. The inference is that this process resembles passing something on, or tuition in a psychomotor skill. Yet, skilled clinical knowledge is acquired through experience, which transforms ‘preconceived notions and expectations by means of encounters with actual practical situations’ (Benner & Wrubel 1981 p. 11). Thus, skilled clinical knowledge has to be cultivated in the practice setting and cannot be imparted, passed on, or transferred like a psychomotor skill.

Third, in relation to the meaning of clinical skills, Macleod Clark et al. appear to define clinical skills rather like tasks. For example, student nurses’ lack of instruction in ‘clinical skills’ is illustrated by their not being taught, ‘how to make a bed’ (Macleod Clark et al. 1996 p. 206). Furthermore, it is logical to assume that Macleod Clark et al. mean clinical skills in the nursing sense, i.e. ‘skilled (nursing) knowledge’ (Benner & Wrubel 1981 p. 11) which affords ‘the (nurse) clinician a perceptual grasp of a situation because of prior experience with similar situations’ (Benner & Wrubel 1981 p. 13) and not psychomotor skills. Thus, the meaning implied in Macleod Clark et al.’s use of the term ‘clinical skills’ differs from a nursing definition and understanding of skilled (clinical) knowledge.

Finally, the discourses on skills in Macleod Clark et al. (1996) have implications for the meaning of the term ‘clinical skills’. Firstly, Macleod Clark et al.’s utilization of the term ‘clinical skills’ implies an understanding and meaning distinct from the literature. Secondly, Macleod Clark et al. have redefined the term ‘clinical skills’ by displacing the essential meaning of the term. Ramprogus observed a similar characteristic in context of the newly implemented Project 2000 nursing curricula. It was termed, the ‘displacement of nursing knowledge’ (Ramprogus 1995 p. 132).

Empowerment and market performance

This paper previously described how official guidance may either limit or expand the possibilities for practice, depending upon where mastery or control is situated. Similarly, guidance on WP10 commissioning may be viewed as limiting or expanding the nature of the educational provision for pre- and post-registration nursing. The WP10 market may actually expand the prospects for such provision by offering potential opportunity for effecting control and influence during market negotiation. When trusts are explicit about their needs and the value of education and training, greater devotion of power to the Consortia may occur (Humphreys 1996b). Hence, the commissioning process also appears to ensure flexibility and responsiveness by education providers to NHS trusts’ needs when trusts commit to utilizing the potential embodied in the working operation of the market (Humphreys 1996b). Therefore, a greater understanding of the utility of the market for meeting service needs may empower such commitment by producing a sound basis for education commissioning and for redressing the imbalances described. If such an empowered commitment is to materialize, any understanding over market utility requires political consensus about the constitution of information, effectiveness, and evaluation (Fletcher 1995b). Furthermore, research indicates the potential trusts have for influencing the market on the basis of an explicit understanding about their corporate education needs, the market value of nursing, and the working opportunities between practitioners and academics (Humphreys 1996a, 1996b).

Corporate policy on nurse education and training

There are several approaches whereby the NHS trusts may attempt to influence education provision to enhance the skills of their workforce. For example, research shows that the contracting agendas of the NHS trusts place a low priority on the ‘strategic features of education’ (Humphreys 1996b p. 1295). The latter have implications for the content of education as they describe the resultant or output skills of practitioners following education. Thus, the trusts could develop corporate agendas for education contracting based on such strategic or output features. An explicit and
precise awareness of trusts’ skill deficits in such ‘output terms’ (Humphreys 1996b p. 1297) may enable negotiations to focus on the issues of strategic organizational development and health service quality within the trusts. Another approach is for the trusts to influence the process of curriculum planning and to affect the resulting skills of practitioners through participation in the process for developing educational courses.

In addition, it may be influential and politically astute to selectively disseminate the corporate skill deficits and needs. Trust-wide dissemination may prove influential in fostering a corporate awareness about service needs and deficits. It may resonate with the perceptions of the Project 2000 curricula, whose theoretical bias is likened to a ‘pendulum (that) has swung too far’ (Macleod Clark et al. 1996 p. 206). Astute or political management of such information is called for, given the market-style culture in health care, to prevent inappropriate exploitation, staff de-motivation and excessive competition (Fletcher 1995b).

Furthermore, the quality of re-skilling may be facilitated by more rigorous evaluation of education services. It would define the nature of education’s positive qualities (Humphreys 1996a) and identify what constitutes appropriate re-skilling. The latter would inform tailored programs to progress skills for service delivery linked to contracts between the practitioner and the employer. Thus, professional agency is enabled through such education, facilitating the qualitative features of nursing to ‘assist with the high rate of change’ (Humphreys 1996a p. 165) in the NHS trusts.

The value of nursing practice

The opportunities for practitioners to access education provision may depend on the trusts’ perceptions of the value of nursing practice in terms of its instrumental or qualitative features which impact on NHS trusts’ ability to deliver health services (Humphreys 1996a). Also, a focus on the value of nursing practice may emphasize the utility of nursing for service development and the ‘value-added’ quality of the educated practitioner to rapidly ‘adapt to changing circumstances’ (Fletcher 1997 p. 102). Thus, appropriate skills for managing the changeable environment of the NHS trusts may be afforded whilst facilitating future roles. For example, the availability of home-based therapy may draw client referrals into the community health services (Corbett 1997) whilst in itself such practice may help secure future development of community roles (Tomlinson 1992).

The market value of nursing practice is demonstrated in the rationale of NHS purchasers for funding clinical nurse specialists (CNS). This rationale was based upon purchasers’ positive perceptions of the competency of the CNS with the administration of home-based therapies (McCarthy & Layzell 1992). The skills of the workforce were enhanced through collaborative practice between the CNS and other staff (McCarthy & Layzell 1992). The universities and the trusts can organize locally based opportunities for developing such responsive services (Corbett et al. 1993), which may help to influence the value which trusts place upon nursing practice. Such opportunities can utilize the accreditation of shorter educational courses, study days and conferences which shift attention back onto the nature of practice and the acquisition of skilled knowledge.

The working interface between practice and academia

The ‘close business relationship’ (Humphreys 1996a p. 164) between the universities and the NHS trusts represents an interface for mutual exploitation and negotiation. Such relationships are in the context of service doubts about the value of Project 2000 and the professionalization effect following the shift of nurse education into higher education (Humphreys 1996a). However, a unitary design for nurse education where ‘clinical competence and credibility are integral parts’ (Clarke 1997 p. 45) could incorporate higher education, service delivery and nursing practice (Vaughan 1990). This approach would challenge the transfer of responsibility onto service-practitioners for students’ clinical proficiency. Thus, further opportunities would be sought for developing the practicum for academia (Read & Strange 1996) and conversely, the academic setting as an educational sphere for the service-practitioner (Clarke 1997).

Furthermore, the working interface is one where a corporate approach by the trusts could influence the outcomes from jointly funded clinical/academic appointments. Thus, the utility of clinical nurse lecturers and lecturer-practitioners is marketable in terms of quality standards, client services and the education and support of both practitioners and students (Vaughan 1990, Read & Strange 1996). The exploitation of the working interface has additional educational and clinical utility. For example, the clinical setting can be reconfirmed as the key to acquiring skilled clinical knowledge and a greater understanding of the essence of practice, rather than the ‘lecturer-only’ style of nurse education which neglects ‘the intuitive domain of the world of nursing practice’ (Burnard 1992 p. 5). Also, through retaining a firm commitment to clinical practice, both a context for research and a distinctiveness for its output are provided (Fletcher 1997). Thus, such developments may improve the practice-relevance and the professional perception of nurse teachers, whilst facilitating their clinical involvement.

DISCUSSION AND CONCLUSIONS

Following the implementation of the NHS reforms and Project 2000, the full responsibility for pre-registration
nurse education has shifted onto higher education (Humphreys 1996a). The resulting mismatch between the differing agendas of higher education and the NHS trusts has affected both the discourses on nursing practice (Macleod Clark et al. 1996) as well as the character and direction of nurse education (Ramporgus 1995). Project 2000 has successfully ‘uncoupled’ two sets of needs, those of service and education (Davies 1994), seen as necessary for enhancing educational standards and for the professionalization of nursing (Waldby et al. 1994). This uncoupling has led nurse education away from service delivery (Camiah 1996, Clifford 1996), so creating a gap in NHS provision at a crucial time of NHS reform and when the boundaries between British medical and nursing practice are changing (Waldby et al. 1994).

Furthermore, the uncoupling of nurse education and service delivery needs has facilitated both the clinical de-skilling of nurse teachers (Camiah 1996) and the unexpected shift of responsibility onto service-practitioners for students’ clinical proficiency (Camiah 1996, Macleod Clark et al. 1996). Moreover, the issue of responsibility for teaching students in practice remains unresolved (Elkan et al. 1993). The debates on the autonomy of medicine (Davies 1994), and its historical ability to surmount political challenge (Fletcher 1997), mostly assume the saliency of practice for that profession. If nurse teachers are to be ‘the epitomes of practice’ (Fletcher 1997 p. 101), the clinical de-skilling of nurse teachers needs to be re-addressed. In so doing, some of the ‘cultural’ potential for fragmenting nurse education within higher education may be reduced (Fletcher 1995a).

At present, the captive market in WP10 nurse education contracting prevents the NHS trusts from fully controlling the education budget and privileges theory-based education like Project 2000. The WP10 market may work more equitably through empowered market management, thus reconstituting the social world of the market through the negotiation process. In addition, the ‘New Labour’ government has an overwhelming electoral mandate to radically alter the basis of the NHS internal market (Leadbeater 1997). The proposed legislative reform in The New NHS (Department of Health 1999b), whilst still unfolding, may represent the advent of such change. The latter could enable more direct purchasing of post-registration education as the REDGs must ensure that ‘education responds to service needs and developments’ (Department of Health 1997b 6-36). More direct purchasing may facilitate change in the captive market by ensuring that the education cartels are truly responsive to service needs.

However, the new legal base for NHS purchasing allows the trusts to utilize private sector finance (Department of Health 1997b). The origin of such legislative change is not purely ideological as it appears to be premised on the truisms that ‘what counts is what works’ (Department of Health 1997b 2-5). Thus, the reform started by The New NHS is pragmatic. It aims to build upon the bedrock of the ‘mixed economy of care’ (Department of Health 1989c p. 23) as well as the purchaser-provider split from previous NHS reforms (Department of Health 1989a). Furthermore, the captive market of WP10 education contracting and the displacement of nursing knowledge both arose in context of the mismatch between the agendas of higher education and the NHS trusts. The rhetoric of the New NHS speaks of a greater unity between differing NHS professional agendas, whilst privileging practitioners by establishing ‘clinical governance’ through combining professional self-regulation and corporate governance within the clinical community of the NHS trusts (Department of Health 1997b). The aim is to develop a public service ethos which is more collaborative and less competitive than the commercial ethos ‘modelled on the private sector’ (Department of Health 1997b 6-38) instigated by former Conservative governments. Thus, the local Education Consortia are politically well situated whereby they can significantly affect the future character and direction of nurse education. However, the ultimate test of such pragmatic legislation lies in its ability to effect a greater integration of the divergent agendas arising from prior NHS reforms and Project 2000, for example, those of academic nursing and the NHS trusts. In this unfolding political context, the NHS trusts may benefit by developing empowering agendas and corporate perspectives which address the education and training of nurses.

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