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## **What is a nurse? The Francis report and the historic voice of nursing**

### **Abstract:**

Following the Francis report into shockingly deficient standards of care at an English hospital, this paper examines UK nurse education and revisits the premises on which the professional narrative of nursing was built. The UK government's response to the report is to introduce the 'associate nurse' role, to be nationally trained to do fundamental care in place of the registered nurse, and a nursing apprenticeship scheme - on the job training for a nursing degree. UK nursing bodies do not address the report's recommendations in regard to registered nurse education rather they advocate a further perpetuation of the current system. This shows deep uncertainty about what the 'true' nurse is. To those familiar with the Nightingale model that characterised nursing in England and elsewhere for a century before the introduction of Project 2000 in 1986, there is an intriguing historical echo in the Francis report. One might wonder whether Francis is really recommending a return to a virtue-based, practice-driven, nationally standardised version of nursing education developed by Nightingale and evidenced in nursing syllabuses in England and Wales 1860-1977. This paper supports this position, and shows from a review of historical and contemporary evidence that this Nightingale model has current relevance.

## **INTRODUCTION**

The Francis report (2013) highlights serious concerns about UK nursing. The current model of nurse education replaced the Nightingale model of nurse training thirty years ago. This virtue-based, practice-driven model underpinned UK nursing for a century until it was rejected. It is a model that seems to echo in the Francis report's recommendations on nurse education. This paper will review the Nightingale model and consider its relevance not only for the UK but internationally.

### **Background and context**

In 2013 the public inquiry into serious shortcomings in nursing care at Mid-Staffordshire Hospitals NHS Trust, chaired by Robert Francis QC, published its three volume report (Francis, 2013). The report identifies shocking deficiencies in basic standards of care. Patients were left thirsty, in their own faeces, ignored and without call bells. Nurses lacked compassion. These were not isolated incidents but widespread over a sustained period. One example: a patient with terminal cancer was given oxygen to assist his breathing but this ran out within ten minutes. He had to 'resort to chewing the tops off water bottles' in order to get a drink as the staff failed to help him. He was rarely washed and was found on the floor on two occasions as staff said he was too heavy to lift (Francis, 2013, p. 208). 'It is appropriate to echo a statement made by Florence Nightingale 150 years ago: It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm' (Francis, 2013, pp.396-7).

Amongst many other recommendations, the Francis report recommends an increased focus on nurse training, education and professional development on practical requirements of delivering compassionate care in addition to the theory (Francis, 2013, pp.1540, 185). Nurse training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards. There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. The UK Nursing and Midwifery Council (NMC), which regulates the profession and accredits nursing courses, should work with universities to consider the introduction of an aptitude test exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values. The report also recommends that the NMC and other professional and academic bodies work towards a common qualification assessment/examination and that there should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care (Francis, 2013, p. 1542).

Francis's recommendations on nurse training come three decades after the major change to UK nursing education, Project 2000 (UKCC, 1986), a less prescriptive, more flexible, mode of nurse training based in higher education institutions, in which students, doing clinical placements were no longer to be employees, but to have supernumerary status. Project 2000, gradually introduced throughout the UK from 1986, removed the majority of the nursing workforce, student nurses, into a supernumerary role as nursing students. They could no longer be counted in the workforce during their placements. This was costly to the National Health Service (NHS) because the student nurse was no longer paid to work as part of the

salaried health care team (National Audit Office, 1992) The change also distanced responsibility for training standards from the health care institution to the higher education academy. Project 2000 has been succeeded by all degree training as the system for training nurses in the UK.

Current NMC standards for pre-registration nursing education are not detailed prescriptions (NMC, 2010a,b). The NMC (2010a) stipulates that approaches to learning should be flexible, using a variety of unspecified learning methods and modes of delivery in both the academic and practice settings. Learning should be increasingly self-directed and independent. It is the education institution that should determine the nature of theoretical learning, which may include independent study. The NMC set no specific requirements for the nature or range of practice learning, other than that it must enable the competencies to be acquired. Most practice learning is required to be undertaken in direct care of clients, although up to 300 hours of practice learning may be undertaken through simulation. The only stipulation is the requirement for 50 percent theory (2300 hours) and 50 percent practice (2300 hours), but with some flexibility in each part of the programme.

This means that there are no UK national standards of nurse training. And it seems clear that the Francis report was concerned with this. Following the Francis report, Health Education England (HEE), the NHS body concerned with overseeing training of the workforce, commissioned a review of the future education and training of registered nurses and care assistants. Chaired by Lord Willis (2015) this recommends listening to the public, valuing the care assistant, widening access for care assistants, developing a flexible training model, assuring high quality ongoing learning, research innovation, funding and commissioning.

Although references are made to the Francis report (2013) these do not address Francis's specific recommendations. The Willis review (2015) coincides with a survey of health care assistants by a trade union which finds that many of them, without training, are doing what was previously considered to be nursing work (Unison, 2016). The outcome of the Willis review (2015) is a proposal for a new nursing associate role, identify its scope, and develop a national curriculum for it (HEE, 2016).

At the same time, in January 2016, the NMC approved plans to undertake a review of the competencies for new nurses entering the profession (Council of Deans, 2016a). According to the Council of Deans, the voice of UK university nursing faculties, current pre-registration standards for nurse education were found to be overly complex and too focused on processes rather than outcomes. The Council of Deans make no mention of the Francis report (2013). Their own discussion paper, 'Educating the Future Nurse' (Council of Deans, 2016b), focuses on outcomes that it identifies from a changing society and changing health care system, but admits it lacks detail. Broad generalisations refer to globalisation, possible future demography, and health care needs, the need for the nurse of the future to be flexible and knowledgeable, a decision-maker, a communicator, a scholar and scientist, resilient, innovative and entrepreneurial, a delegator.

The Council of Deans (2016b, pp.16-17), contradicts the Francis report recommendation for more practice learning. It states that there is 'no evidence to support input hours as a proxy for quality of education/output and there is a tendency to confuse the amount of time in practice with the amount of learning in practice.' Its only detail is in the aspiration that the nurse will have 'higher level skills', prescribing, assessing complex needs and diagnostic

skills of administration of intravenous additives, diabetes management and chest/lung assessment. How the nurse should be trained and assessed as competent is not discussed.

Indeed the Royal College of Nursing (RCN, 2012), a trade union, whose purpose is to work for the nursing profession, is not a body that monitors standards of care for patients. It sought to pre-empt the recommendations of Francis by publishing its own report on nurse education before Francis was published. This report, also chaired by Lord Willis, states that it finds no shortcomings in nurse education that could be held responsible for poor standards of care. Nor does it find any evidence that degree-level registration is damaging to patient care. On the contrary, 'graduate nurses have played and will continue to play a key role in driving up standards and preparing a nursing workforce fit for the future' (RCN, 2012, p.2). Recommendations focus on improving the current system through closer integration, raising morale and staffing numbers, and by changing what the report considers to be a misguided public perception about nursing.

The current discussions about the future shape of UK nurse training reveal confusion. The government are aware of problems but seem unable to identify their causes or solutions. In 2016 the government announced on the job training apprenticeships towards a nursing degree qualification, but gave no details (DH, 2016). The government's chief nurse in England announced a pilot scheme to train a new type of health care worker, the nursing associate (Cummings, 2016, p.1). The nursing associate would have the training and skills to bridge 'the gap between what Health Care Assistant colleagues routinely do and the practice that is undertaken by a RN'. What is perhaps most revealing is her statement that the role is designed to enhance the quality of personalised care, and to reduce 'the reliance and

dependency on RNs to undertake elements of care that others can be trained to understand and do.’ No further details are given, but what is striking is this admission that the role of the registered nurse is no longer to be about the fundamental elements of patient care, so much of which is the focus of the Francis report. This raises questions about the very purpose of nursing itself, and above all, about the needs of patients for nursing care.

Hence, this analysis takes an historical perspective to contextualise and respond to the current issues regarding nursing by focusing on UK nurse education 1860-1977. Nineteenth and twentieth century British nursing syllabuses and related documentation form the basis of this analysis. By examining the content of syllabuses 1860-1977 principles and practices are explored and their possible significance and contemporary relevance clarified. The particulars in the syllabuses will be deliberately presented in some detail because they provide insight into the orientation of nursing.

### **Nightingale’s principles on which the professional narrative of nursing would be built**

Nightingale’s principles may have been developed almost two centuries ago, but they are relevant today because they resonate with recommendations made by the Francis report (2013). Indeed the report introduces its conclusions by reference to Nightingale (1859). In 1851 Florence Nightingale visited Kaiserswerth, a German Lutheran religious foundation that cared for the sick, to learn about nursing. There she came to realise that the demanding work of nursing depended for its quality on moral motives: love rather than money. This conviction underpinned her motivation to change the haphazard nursing system in England



which she said was epitomised by Dickens in his character in David Copperfield, Sairey Gamp. Nightingale (1851) observed that nurses were drunk, fell asleep at night and neglected patients. She thought this inevitable if the hard work of nursing was done for money rather than for love. In her obituary of the first matron of St Thomas's Hospital, Nightingale (1892, p.1448) wrote that by setting up her nurse training school she intended 'the extinction of Mrs Gamp'.

Nightingale set out her principles for nurse training in a medical textbook in 1882 (Nightingale, 1882). The nurse must think of nothing else but the patient's good, be always kind and never emotional. Because all the patient's needs should be met, the patient should hardly be aware of the nurse. Here there are clear resonances with the service ethic proposed by Francis (2013). A statistician herself, Nightingale believed that nurse training should be based on a sound medical knowledge, taught by a doctor, and examined both orally and in writing. The nurse would learn about her own patients by careful observation, recording notes on her patients and reading doctors' comments. Nightingale's intention was to develop the nurse to train others. To achieve this, Nightingale, echoing Francis, believed that carefully selected probationers should be trained in hospitals and should live in homes to train their characters for a disciplined moral and spiritual life under the auspices of a home sister. A trained matron or superintendent was to have undisputed authority over nurses and trainees. A planned course of theoretical and practical training was to be given, the latter in the hospital where the school was connected.

Nightingale's principles became the basis for her training school at St Thomas's Hospital, which began in 1860. She reiterated them to probationers in annual letters thereafter

(Nightingale, 1873-1897). And these two principles are the same principles recommended by Francis (2013) that there should be better selection of nursing students for attitudes and values, and a practice-based training under the supervision of a registered nurse.

Probationers were recruited by advertisements in the public papers in May 1860. Applicants for training, aged between 25 and 35, applied to the matron, with a certificate of age as well as a testimonial of character. The term of the probationer's service was one year. They were expected to stay for the period but could withdraw on three months' notice, in exceptional circumstances. They could be discharged by the matron at any time for misconduct, inefficiency or negligence in their duties. They would be eligible for permanent appointment as extra nurses at St Thomas's Hospital, during this year, upon proof of competency.

Probationer nurses were paid for their service, albeit with different rates according to their class, and in line with existing Victorian class structures. It is notable that probationers came from all classes including the upper classes.

Probationers were required to follow a strict timetable that was supervised and certified by trained nurses, the 'ward sisters' (Seymer, 1960). Duties of the probationer are listed in a chart: 'Monthly state of personal character and acquirements of nurse during her period of service' (Baly, 1986, pp. 230-1). The chart is headed by the nurse's name, age, marital state and date of appointment, by whom she was recommended, the sisters she had served, and her religion. Categories record the nature of her duty during the year, the number of nights and days she worked, time off duty for illness and the nature of the illness. Alongside these are moral character requirements, specified as sobriety, honesty (especially in not taking petty bribes from patients) and truthfulness. It is specified that from the first year, or shorter period

if dismissed, the nurse's character should be stated; positively; no degree is admissible, and first dereliction ensures dismissal.

Beneath these headings are two sections. The first lists behaviours: punctuality; quietness; trustworthiness; personal neatness and cleanliness; ward management or order. Sister is told to state monthly the amount of excellence or deficiency in three degrees: excellent, moderate or zero. The second section is headed dressings, applying leeches; enemas, trusses and uterine appliances and their management, rubbing, helpless patients, bandaging, making beds, waiting on operations, sick cooking, keeping ward fresh, cleanliness of utensils, management of convalescents, observation of the sick.

During the year of training lectures of a practical nature were given to the probationers by members of the medical staff. The syllabus of medical lectures was prescribed by a surgeon, John Croft, in 1873. He gave twenty-two weekly lectures to the probationers on subjects common to medical and surgical nursing. These were published. Croft (1873, pp. 3-4) tells the nurse to learn by heart that 'a nurse is by thinking and acting for a sick person'. Nursing does not simply mean making a patient neat and tidy, giving food and medicines, putting on poultices and emptying slops, and that sort of mechanical work, it is in anticipating the patient's needs and acting for him. A good theoretical and practical knowledge base was needed to do this, and observation was essential.

The matron of St Thomas's Hospital, Sarah Wardroper, wrote a memorandum in 1879 which instructed ward sisters on the duties of probationers. This gives a glimpse into how

probationers were trained at St Thomas's. Every new probationer was to be shown by the ward sister or staff nurse how to do her work to the ward sister's satisfaction: 'to be shown not only what things are to be done, and how they are to be done; but guarded against how they are not to be done' (Wardroper, 1879; Seymer, 1960, pp. 163-165). Details of what the probationer should be taught included the storage cupboards, ward cleaning, cleaning bedpan, urinals and the lavatory, how to wash a helpless patient carefully, sensitively and without exposure.

The probationer was to be shown how to lift and move helpless patients, how to make her patients teeth clean; how to feed and how to administer medicine to helpless patients; how to prevent and report bedsores, how to change beds, and how to do dressings, injections, enemata, splints and how to insert catheters. The probationer was taught sick cookery. Sister was to explain the reason why medicines were given and why they were altered, as well as the reasons for dressings. The probationer was taught how to read 'cards' at the head of beds, and was questioned, if possible, on special cases after the round of the attending physician or surgeon. She was also taught to describe the different patient conditions, excretions and secretions. Sister was taught how to instruct nurses to instruct probationers. As it was impossible for the sister, with her sister's duties, to have time to show the probationers all she needed to know, the sister was to question the probationer. Probationers were encouraged not only to keep case papers, but to jot down at the time any special thing she had learnt or done in the ward during the day.

In this system the trained nurse was primarily the person who cared for the sick patient, whether the sickness was physical or mental. This was her role and function, and nurse

training was a preparation for this role and function. This new British nursing system had an international influence. In Australia, in another memorandum, published in the Sydney Morning Herald in 1867 the matron of St Thomas's commented on the new plan to improve nursing at the Sydney Infirmary (Wardroper, 1867). In her view the trained superintendent or matron was the missing link. This person was required to be educated with a full and practical knowledge of all requirements of the sick. Her role was to work with the sisters to train the probationer nurses. Mrs Wardroper is explicit in the details of the staffing of each ward and the skills required. She specified that matron was required to supervise the housekeeper and cook, the provision of food, and mending linen.

But this system not only had international relevance at the time, it was to have a far reaching influence on future horizons. As nursing developed in the twentieth century there was a dialectical conversation between developments which constantly referred back to Nightingale's principles and practices, enshrined in St Thomas's Hospital probationer training syllabus. Nightingale's syllabus, and the principles and assumptions underpinning it, was reinterpreted by nursing educationalists for the twentieth century and formed the basis of future nursing syllabi. Nightingale's principles are also echoed – unknowingly- by Francis (2013) in the recommendations that nurse training be built on trainees selected for moral values of care and compassion, and that nurse training be reviewed to ensure objective national standards that ensure competence.

### **'Making the Future Nurse': Training developments in the twentieth-century**

By the late nineteenth and early twentieth century, as parliamentary select committee reports show (House of Lords, 1890,1891; House of Commons, 1904,1905), Nightingale's influence had become a normative in hospital nursing throughout the UK. In 1919, after much factional disagreement, the Nurses' Registration Act was passed. This vested authority in a General Nursing Council to make rules requiring candidates for admission to the Register. They must have undergone a prescribed training and possess a prescribed experience in the nursing of the sick. A national training syllabus and examination was needed to do this.

The first syllabus was drafted by the General Nursing Council (GNC), chaired by the matron of St Thomas's Hospital, Alicia Lloyd Still and presented at the Ministry of Health in 1921 (GNC, 1921). The recommendations were formally adopted. Every applicant for entry to the state examination was required to pass through the educational curriculum prescribed by the Council and was of good character. This was certified by a schedule signed by the hospital chairman and matron or poor law infirmary medical superintendent and matron. Hence the system used at St Thomas's Hospital, originated by Nightingale, now under the auspices of Alicia Lloyd Still, would have far-reaching influence on UK nursing as it was developed into the national standard.

It is noteworthy that Lloyd Still, even in the 1920s, held to the same principles first inaugurated by Nightingale some sixty years earlier. As matron of the same hospital, she had not broken with these understandings. She stood within a tradition which she wholly understood and embraced, although not without updating changes. Hence, this first syllabus resonated clearly with what Nightingale and Mrs Wardroper had laid down for the training system at St Thomas's Hospital.

This can be clearly seen at the informal conference convened by the Ministry of Health under the auspices of the GNC (1921, p. 498) to discuss the exact content of the first syllabus of training. This would be 'the largest, most representative and most important' informal conference of hospital matrons and sister tutors. Entitled 'Making the Future Nurse' it was held in April 1921. Alicia Lloyd-Still introduced the conference by saying that, in the national interest it was now necessary to unite behind a definite system of teaching and training that developed the nurse's mind as well as her heart and hand under the auspices of an organised body. The system that produced the best kind of nurse would need to avoid a too theoretical training, and pitfalls likely to produce either a clinical assistant or an automaton at the expense of the vitalizing spirit.

The aim of the syllabus, according to Lloyd Still, was to develop in the nurse an extensive knowledge of relevant scientific, social, and practical subjects and to train her mind to an open outlook beyond the institutional, and so combine preventative and curative work in order to foster the nation's health. This would allow the nurse, at the end of her training, to choose various branches of future work. Nurse training was now to be systematised into one national syllabus of apprenticeship training for all to follow. The syllabus was to cover the three year training period. The first year would start with a preliminary course of six to eight weeks. Teaching would connect various subjects, ensuring continuity. Hence, for example, anatomy, physiology, elementary science and food values could be explained and linked to theoretically and practically.

The first syllabus was published by the General Nursing Council in 1923. This syllabus of training was advisory, rather than mandatory, and was based on the subject content discussed at this conference (GNC, 1921). All nurses, wherever they trained, would have introductory lectures on anatomical structures. This would be relevant to a lecture on the practical care of the patient. Knowledge of infecting agents, tissue reactions, disinfection and sterilisation methods would be followed by teaching on how instruments are prepared and wounds dressed. Warming and ventilation of the ward would provide natural illustrations for knowledge and understanding of the principles of impurities of air, atmospheric pressure and heat. Knowledge and understanding of the structure and function of the alimentary canal, food values and residue and the nature and character of water were needed to understand the treatments of gavage and lavage. Explanation of the therapeutic action of drugs should be preceded by knowledge of the processes of absorption and metabolism. To administer drugs correctly, the nurse needed to be able to read the prescription, measure the dose accurately and know whether the measure used was imperial or metric, and should be given a practical demonstration of the local application of drugs, and various methods used. All these subjects were in close continuity. Hence, the widespread prevalence of venereal disease warranted knowledge and understanding of its effect on the community and its treatment and presumed an understanding of the reproductive system and of gynaecology.

Lectures and practical demonstrations would not rob the ward sister of her vital teaching role or impose a method on her that she would not necessarily have chosen. The teaching and personal approval of the ward sister were to form the basis of the nurse's practical training, guaranteed by the nurses' chart, a schedule of practical experience, accompanying the syllabus. Exclusively oral instruction could not replace practical teaching and ward experience. Indeed, some hospital authorities might use the ward method exclusively; they



could use the syllabus as a guide to systematic teaching and subsequent examination. That the ward sister was responsible for training nurses follows Nightingale's system and Wardroper's memorandum (1867). It also foreshadows Francis's recommendation in 2013, that the student nurse should be trained practically under the auspices of a registered nurse.

Second and third years of training were to be taught mostly by specialists. General headings rather than specification for curriculum content allowed for variation. There were diverse suggestions as to the curriculum content: some suggested *materia medica*, bacteriology, hospital economy; others wanted the focus to be on diseases and respective nursing care, for example the eye, ear, nose and throat or orthopaedics. The examinations had not yet been worked out but it was anticipated that they would begin in 1923 as voluntary examinations, and would become compulsory after July 1924 for all nurses desiring to register. Fourteen examination centres were approved.

Participants at the conference hoped that the proposed syllabus would raise the standard of the nursing profession and standardise nurse education. Lloyd-Still herself believed that the moral ethos of service was absolutely fundamental: 'We realize that the finest, most fruitful work is done when the spirit of service is the energising force, and we would foster that spirit that we may not fall short of the great traditions of our predecessors' (GNC, 1921, p.498)

The proposed training and experience was set out by the General Nursing Council in 1923 (GNC, 1923a), and it approved a large number of institutions in which the prescribed training could be carried out. Unlike the syllabus of training, the syllabus for examination produced

the same year was mandatory (GNC, 1923b). The syllabus for examination was to cover three years (GNC, 1923b). The council stated that lectures and teaching by fully trained nurses: matrons, sister tutors and ward sisters were very important, because their personal knowledge and practical experience provided the true nursing outlook. Notwithstanding, the council recognised the value of special subjects taught by medical practitioners and other experts. Attendance was compulsory. Personal supervision at all stages of training, revision classes and note book correction were also required.

The examination was divided into two parts. All probationers, in the general and supplementary part of the register would take the preliminary examination any time after the first year of training. This examination comprised anatomy and physiology, hygiene and the first part of the theory and practice of nursing. The rest of the syllabus, including most subjects in the attached nurses' chart, was contained in the final examination for general nurses. After the sister had marked it, the nurse was required to retain the nurse's chart and deposit it in the matron's office at the end of her work in each ward.

There was some flexibility about where subjects were to be taught. Ward management, including methods of cleaning and disinfection, could be taught under the categories of hygiene and practical nursing. Elementary hygiene and household science might, for example, include hospital economy. A course on chemistry or elementary science or hygiene might introduce public sanitation and public health. More definitely, a course on hygiene and public health should include communicable diseases in the first year and taught again in medical lectures in the second and third years in relation to pathology. Diseases and feeding

of infants and children should have a place in the syllabus in all three years and not necessarily be treated as a separate subject.

The nurses' chart, included at the suggestion of training schools, was appended to the examination syllabus. It is a single sheet of paper, divided into columns. Along the top of each column is written the type of each ward. At the side of the columns are listed the procedures which the nurse was expected to become proficient in. Examples are: domestic ward management, bed making, bed bathing, artificial feeding, enemas, injections, infusions, drug administration and dressings. After the sister had taught the nursing skill she marked the relevant column with one stroke. After the nurse was assessed as being proficient in the skill the sister marked the relevant column with another stroke, making a cross, and initialised it. The syllabus was signed by the Minister of Health in 1923.

This prescriptive national system continued until 1977 with little change (GNC, 1921-1977). The syllabus and record of practical instruction from 1967 looks very similar to Nightingale's nurses' chart as does the syllabus (GNC, 1967). The student nurse was an employee, an essential part of the work force which staffed the NHS, under the direct supervision of the ward sister. She was taught in blocks in the classroom by sister tutors and a range of eminent surgeons and physicians. At the end of three years she sat the national state examination.

It seems to be a similar prescriptive national standardised system that Francis (2013) is envisioning in his inquiry recommendations. The Francis report (2013) recommends that the NMC and other professional and academic bodies work towards a common qualification

assessment/examination, and it recommends national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care (Francis, 2013, p. 1542). This is precisely the system that the GNC inaugurated in 1921.

### **The end of a national system of nurse education**

By the time of the Francis report there had been no national system of nurse training for three decades. This had implications for standards of care as is clear to the House of Commons (2013) health committee following the publication of the Francis report. England's chief nurse appeared as a witness before the committee and was asked where continence care appeared in the educational curriculum as this had been found to be a major failing in the report (Q 92, 93). 'Jane Cummings: I do not know the answer to that question so I would have to go away and look. I can also ask the question about what happens in undergraduate training because I do not have that level of detail with me.'

Indeed she sent the answer two weeks later to the committee as supplementary written evidence (Cummings, 2013a). Her evidence reads:

'The current nurse undergraduate training programme includes training on continence and incontinence in learning modules on pressure area care, hygiene, dignity and hydration. There are many learning opportunities for student nurses on continence and incontinence both in the classroom and on the ward or in clinical area. The NHS Commissioning Board is working with Health Education England to review nurse-training programmes on continence and

incontinence to ensure there are explicit learning objectives. The learning objectives will include practical training within the clinical area where student nurses undertake 50% of their training. The NHS Commissioning Board and Health Education England are working with the Local Education and Training Boards to support provider organisations to train health care assistants in continence and incontinence and update qualified nursing staff as part of mandatory training and induction programmes.’

The chief nurse also makes reference to one subjective study which reports that health care workers considered they had adequate training in continence care (Cummings, 2013b). But the chief nurse cannot detail specifically when and where nurses are taught specific subjects. This is because there is no national standardised system as had been in existence under the GNC from 1923-1977. This standardised system of nurse training under the GNC seems to be in the mind of the Francis inquiry (2013) when they make their recommendations on nurse training. It is, however not explicitly mentioned. And it is not merely the national standardised system which is important for the Francis inquiry. The inquiry is also concerned about the attitudes and values of the nurse and how they were cultivated. This was the bedrock of the historic system of nurse training. From the inception of modern nursing in the nineteenth century, the trainee nurse needed to hold and demonstrate moral values of service above self. This is described by Alicia Lloyd Still as the vitalizing spirit. The nurse is to be neither an automaton nor a clinical assistant. Training under ward sisters was intended to induct nurses into what Lloyd Still described as, ‘the great traditions of our predecessors’.

Modern UK nursing has lost touch with its past. Nursing policy makers and educationists from the period after 1979 no longer take cognisance of past nursing history, which has been rewritten because it is considered to have no value for the present, for example by Davies (1980) and Salvage (1985). Since then, nursing leaders in the Willis report (RCN, 2012; Macleod Clark, 2012) and Department of Health (Cummings, 2013a,b) have been keen to emphasise the merits of the change and diminish the problems – despite admitting ‘that many educators have not been able to maintain their clinical credibility’ (Macleod Clark, 2012, p.7).

The Willis report (RCN, 2012) that pre-empted the Francis inquiry, finds no major shortcomings in nursing education and suggests the public needs educating against its misguided view of nursing. It does, however, recognise some shortcomings in the system. The chief nurse admits she did not know where, or if, specific subjects were taught (Cummings, 2013b) but seeks to defend the current imprecise curriculum by citing a study that states that health care staff feel they have adequate training. Notwithstanding questions about the reliability of this particular study, it must be asked whether subjective perceptions are equivalent to objectively measurable national standards, as under the GNC system. The chief nurse’s response to Francis’s concerns about the lack of compassion in healthcare was to publish a document on values required by health care workers (DH, 2012), but this document does not consider how these values might be cultivated.

The Council of Deans (2016b) disregard the Francis report. Their broad generalisation echoes the UKCC conception of the Project 2000 Nurse as the ‘knowledgeable doer’ (UKCC, 1986, p.40). Indeed, the Council of Deans (2016b) suggest a further move away from two

principles enshrined in Project 2000, themselves relics of the traditional syllabus: a competency based course and the mandatory defined number of hours students should work on practice placements. In their proposals for the future of nurse education, not only does the Council of Deans take no account of the historical voice of nursing, but they also seek a further move away from any inherited principles of competence and practice-driven training.

This approach not only contradicts the written evidence submitted to parliament by the chief nurse (Cummings, 2013b), it also contrasts with the Francis report's recommendations for prescriptive national standards of training and examination, based in practice and underpinned by compassionate values. Francis's (2013) recommendation that the newly qualified nurse should be competent to deliver a consistent standard of the fundamental aspects of compassionate care will be applied not to the registered nurse, but to the 'associate nurse', a further move away from the historic principle that the purpose of the registered nurse is to care for the whole person.

## **Conclusion**

Project 2000 was a rupture in a century-long nursing tradition that emphasized character, service, hands-on practice and a standardised curriculum. According to the Francis report this has had disastrous results. Perhaps unknowingly it is this historic system that the report has in mind in its recommendations for the future of UK nurse training. In light of the report's shocked findings and its recommendations, it is arguable that UK nursing should take the step of acknowledging it has a problem, and then should listen to its historic voice in

order to re-establish a nationally standardised, values-based and practice-driven model of registered nursing education.



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