Evaluation of how a curriculum change in nurse education was managed through the application of a business change management model: A qualitative case study

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SUMMARY

Background: Curriculum changes are a regular feature of nurse education, yet little is known about how such changes are managed. Research in this arena is yet to emerge.

Objective: Evaluation of how a curriculum change in nurse education was managed through the application of a business change management model.

Method: A qualitative case study; the single case was the new curriculum, the Primary Care Pathway.

Participants and Setting: One executive, three senior managers, two academics and nineteen students participated in this study in one faculty of health and social care in a higher education institution.

Results: The findings suggest that leadership was pivotal to the inception of the programme and guiding teams managed the change and did not take on a leadership role. The vision for the change and efforts to communicate it did not reach the frontline. Whilst empowerment was high amongst stakeholders and students, academics felt dis-empowered. Short-term wins were not significant in keeping up the momentum of change. The credibility of the change was under challenge and the concept of the new programme was not yet embedded in academia.

Conclusion: Differences between the strategic and operational part of the organisation surfaced with many challenges occurring at the implementation stage. The business change model used was valuable, but was found to not be applicable during curriculum changes in nurse education. A new change model emerged, and a tool was developed alongside to aid future curriculum changes.

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Introduction and Background

Curriculum change has become a key feature of nurse education in the United Kingdom (UK) and is driven by health care policies. A shift in UK government policy away from acute hospital care towards primary and community care (Department of Health [DH], 2001, 2003, 2008) opened up the opportunity for one faculty of Health and Social Care in a higher education institution (HEI) to develop and implement a pre-registration programme for student nurses, the Primary Care Pathway (PCP), the first programme of its kind in the UK, which prepared students to take up a newly qualified nurse’s role in primary care and community.

The purpose of this paper is to report on an analysis of how this nurse education curriculum change was managed, through the retrospective application of Kotter’s business model of change. The paper will also discuss how a proposed new change management model and a tool developed from the study’s findings might inform future curriculum changes, and could be applied in other settings retrospectively, prospectively or in real time.

Background Literature

A major change in the UK’s pre-registration nursing curriculum, referred to as ‘Project 2000’, took place in the 1990s, and was a change in philosophy of nurse education from an apprentice-style training to an education-led one (United Kingdom Central Council [UKCC], 1987). Nurse education was thus transferred into HEIs and a new curriculum with a more holistic focus on patient care, including care in the community setting was instituted (Hart, 2004). However, concerns at the failure of the new curriculum to prepare practitioners for their future role, led to further curriculum changes (Department of Health, 1999).
Since then, there have been new curriculum changes reflecting developments in health care policy towards primary and community care (Department of Health, 2003, 2008, 2010) and the introduction of an all-graduate profession (Nursing and Midwifery Council [NMC], 2010), with universities currently implementing these changes.

Curriculum changes require strategic and operational management of wide-ranging adjustments, both within academia and in the practice setting, as an equal amount of time is given to theory and practice in UK nurse education (Nursing and Midwifery Council, NMC, 2010). This kind of change might include setting out a vision, changing philosophy, introducing new teaching and learning, and academics developing new skills and expertise. Academics feel at ease in their field of expertise and teaching approaches. Change can be alarming and resistance can emanate, as fear of the unknown and the inability to preserve influence becomes evident. Thus expert use of change strategies is likely to ensure success (Brady et al., 2008). Curriculum change can be eased through the use of approaches that help to comprehend and work through the process. Equally, a tool that forecasts problems and gives strategies for addressing emerging issues can heighten success (Hull et al., 2001; Kramer, 2005). The challenges of the recent changes to UK nurse education have led to employers developing strategies to help manage this change (NHS Employers, 2012).

Despite the many changes in nurse education curricula over the last few decades, how curriculum changes are managed in the UK appears unknown. Studies undertaken to evaluate curriculum changes have focused on evaluating the content, process and outcomes of curriculum changes. Roxburgh et al. (2008) undertook a substantive review of curriculum evaluation in UK nurse education. Though the aim was to examine how these evaluations were approached, what the work does show is that none of these studies examined how the various curriculum changes were managed in nurse education. Earlier studies similarly concentrated on changes to practice, role of mentors, community experience and change in philosophy as new curricula were introduced (Clarke, 1996; Hallet, 1996).

With no literature found on how curriculum changes are managed in nurse education in the UK, it is not known how such changes were managed, whether a change management model might help manage change effectively, or whether models, theories, and approaches developed by other disciplines could be valuable in nurse education.

When compared to other sectors, for example business or healthcare, there are gaps and limitations around theory, research and evidence in managing curriculum changes in nurse education. The field is yet to develop or test models, theories or approaches that might be particularly relevant as curriculum changes occur constantly.

With no change management models developed in nurse education and Kotter's model addressing change from its conception to implementation; together with universities now becoming more entrepreneurial, it seems apt to use this business change model as the theoretical underpinning for this study.

### The Eight Steps for Successful Large Scale Change

Kotter and Cohen (2002) change model (see Fig. 1) emanates from the Emergent approach, which views change as complex, chaotic, and challenging and which should be driven from the bottom (Pettigrew et al., 2001) and which cannot be pre-planned (Kanter, 2008).

Based on empirical research internationally, it is a pragmatic model underpinned by the philosophy that transforming organisations through a step-by-step approach, occurring sequentially and completed within a reasonable time, is key to successful change. Steps one to four help to unfreeze the resistant and embedded status quo, and get people to accept the realities of change. Steps five and six help implement and introduce new practices, whilst the remaining steps consolidate and embed the new ethos (Kotter and Cohen, 2002). Alongside using the steps, this model stresses that the key to effective change lies in addressing people’s feelings. Leadership at differing levels has also been emphasised as important to successful change (Kotter and Cohen, 2002).

### Study Aim

The aim of this study was to examine how a curriculum change was managed in one HEI in the UK, through an analysis using the retrospective application of Kotter’s business model of change across the organisation.

### Method

A qualitative design using a case study approach was adopted. The single case under exploration was the new pre-registration programme, the PCP, developed at one HEI. A case study approach enabled the exploration of change management and the context in which it was occurring (Yin, 2014).

### Setting and Participants

This study took place in a Faculty of Health and Social Care in a HEI in England and four Primary Care Trusts (PCTs) [now Clinical Commissioning Groups (CCGs)].

The sample was selected purposively to capture the key players involved in the change across the HEI and included executives, senior managers, academics, and students.

### Data Collection

#### Change Management

Data was gathered through semi-structured interviews, focus groups and documentary analysis. Questions based on Kotter’s model were devised for different participants, with the aim of capturing change across the organisation. An interview schedule was developed each lasting up to an hour. Documentary analysis examined documents such as minutes of meetings from the curriculum steering groups, curriculum planning groups, working papers and departmental meetings.

#### Ethical Consideration

A University Research Ethics Committee application was approved. All participants were sent invitation letters with information sheets that provided details about consent, benefits and harm, confidentiality, data protection and the right to withdraw. All participants gave written consent. Different consent forms were designed for academics and seniors managers, in light of issues of confidentiality. All data were anonymised and secured safely on a password-protected computer.

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**Fig. 1.** Eight steps for successful large-scale change (Kotter and Cohen, 2002).
Data Analysis

Data analysis began with familiarity with the transcripts and documents followed by coding (Kotter and Cohen, 2002), and further analysis as suggested by the case study approach; finally pattern coding (Punch, 2005; Yin, 2014). The themes were then developed from the results of the transcripts and documents.

Findings

This study used a business model to examine how change was managed during the development and implementation of a new curriculum, the PCP. The result is presented using Kotter’s Eight Steps for Successful Large Scale Change and exemplars support the analysis, and discussions and are coded based on participant groups (Table 2). (See Table 1.)

Increase Urgency — Step 1

Leadership at the executive level played a key role in both driving and leading the development of the PCP. From its conception to its establishment, leadership was central through creating the vision and the strategic direction. This led the rest of the organisation towards the establishment, leadership was central through creating the vision and the strategic direction. This led the rest of the organisation towards the establishment of the new curriculum.

‘Not so much a sense of urgency but more of us taking a pro-active lead, we were not being asked to do so by PCTs at all, but I certainly wanted to do something novel and innovative.’ (SM4)

The perception of managers was that of keenness by one individual to try out pioneering ideas, and as the opportunity in relation to new health care policy arose, the initiative was taken to influence and persuade key people such as Chief Executive Officers of PCTs, the NMC, and Commissioners to support the programme.

Build the Guiding Team — Step 2

Guiding Teams (GT) managed the change but did not lead. They felt that they had clear roles in relation to the curriculum change, and thus were empowered with devolved responsibilities from the leadership with a host of activities.

‘I had full responsibility and was able to make decisions about who would run the units; who would be involved or not.’ (SM5)

The leadership allocated GTs to project manage the development of the curriculum and deliver it within a specific time scale. With such directive, a limited time scale and deadlines at different stages, managing the change appeared to be the priority for the Guiding Teams.

Get the Vision Right — Step 3

The vision, though pertinent and pioneering, did not appear to reach the frontline mentors who supported the students. The view from managers and academics was that the vision was well promoted across the four PCTs and academy and communicated with enthusiasm. Students’ perception was that academics seemed negative about the new programme, and were not fully aware of the nature of the programme or the rationale for its development.

‘When I first joined the primary care course when I was talking to a non-Primary Care lecturer she was horrified, she thought it wasn’t a real course … Oh what do you want to do that for?’ (FG2).

Students and managers felt that some mentors did not seem informed about the programme and had little understanding of it, whilst others appeared to feel threatened by the new students on the PCP.

Communication for Buy-in — Step 4

Executive and senior managers held regular meetings, chaired groups in the PCTs and made visits to established practice groups specifically to promote the new curriculum, making efforts to encourage engagement and involvement. However, there was limited buy-in from these communication activities.

‘This communication activity was completed before Christmas with less engagement from PCTs than we hoped for. Despite a great number of visits and much dialogue with education champions in the four PCTs, the workshop was poorly attended.’ (DA2)

Students reported that some mentors showed poor knowledge about the PCP, whilst other mentors were not aware of its development and implementation.

‘I think that people did not understand what the PCP was all about. They felt that we were coming to take their jobs; that we were being trained up to be district nurses; there was negativity surrounding it.’ (FG1)

The academics’ perception was that more time should have been spent promoting the programme to get commitment, but they also felt that the lack of mentor capacity showed practitioners had other priorities.

Empowering Action — Step 5

Empowerment was high amongst stakeholders and students. However, academics expressed that they felt disempowered during the planning phase of the PCP, even deliberately excluded from the curriculum planning group, despite some of them being primary care trained and keen on the new curriculum.

‘There was a feeling of exclusion and lack of acknowledgement of individuals’ experience, expertise and role within the institution.’ (AC2)

A project leader with primary care expertise was appointed to plan the curriculum. With the autonomy to appoint a working team and develop the new curriculum, decisions on the curriculum team lay with the project leader.
Create Short-term Wins — Step 6

Creating short-term wins was not significant in keeping up the momentum of change. Any wins were viewed as a normal course of events as the programme was being implemented.

There were regular briefings about the progress of the programme through the various quality assurance groups in academia, the strategic health authority, and with commissioners.

Don’t Let Up — Step 7

The credibility of the change in relation to the perception of nurse education was under challenge. The concept of a good nurse was viewed as one where skills and expertise gained only through an acute care-based curriculum, was the only legitimate way to become a nurse.

‘You still get nurses out there saying that we should have hospital training.’ (FG2)

The general perception of both mentors and academics was that a primary care focused, pre-registration curriculum was not sufficient preparation for a qualified nurse to take up a post in primary care.

Make Change Stick — Step 8

The concept of the PCP was not embedded across the academic setting. The perception from managers in academia was that the new change towards the concept of primary care nursing for pre-registration nurse education was not yet rooted in the organisation.

‘There is a feeling of confusion out there, I think, in primary care, all that empowerment stuff, it’s much easier to be in control in a ward environment.’ (SM4)

Inadequate perceptions of primary care existed amongst academics. There was reluctance to be engaged in the programme and they did not appear to understand primary and community care nursing, nor the settings in which it is practised.

Discussion

This study sought to explore how a new curriculum for pre-registration nurse education, the first of its kind in the UK, was managed in one faculty of Health and Social in an HEI. The study used Kotter’s business model to analyse how the curriculum change was managed throughout the organisation.

Curriculum changes are driven by health policy, though at the time of the establishment of the PCP, it was not yet a policy directive, but a request from a leader in a higher education organisation in light of primary care policies to create a new pre-registration programme. A directive is an imposition of change; conversely driving and leading the change is about academic leadership (Ramsden, 1998). However, at the operational level both in academia and in PCTs, many issues emerged from this study. Guiding Teams managed the change, but did not take lead. Kotter and Cohen (2002) argue that Guiding Teams needed to be empowered to lead. Managers in this study felt that they were empowered to lead. Guiding Teams, however, need leadership capacity, credibility, and the ability to handle specific change (Kotter and Cohen, 2002). Teamwork could be a factor in building Guiding Teams, helping to establish boundaries, and removing hierarchical structure (Terblanche, 2003).

The vision, although pioneering, did not reach frontline practitioners, and equally the communication strategies in place failed to reach the practice setting. Wanberg and Banas (2000) agree that communicating information is crucial during change, and that openness to change can be linked to the receipt of information. Communication about the PCP was focused, multi-faceted and undertaken by a range of people to accommodate the different groups. Lui and Perrewé (2005) suggest that managers need to adjust their timing and content of delivery in order to get change accepted, because of the emotional impact of it.

The credibility of this change in relation to the concept of nurse education was under challenge, and the concept of the new PCP was not embedded across academia. At the time of the introduction of the PCP, new competencies for students instigated by the NMC (Nursing and Midwifery Council, NMC, 2004) were in progress; and coupled with continuous National Health Service (NHS) changes to shift the focus onto primary care (Department of Health, 2001, 2003, 2008), may
have posed unique challenges. Academics may have feared that a change in focus from acute care towards primary care would mean having to become versed in different ideas (de Jager, 2001). Resistance or reluctance could have also been factors (Piderit, 2000).

This study found that there were differences in how curriculum change was managed in different parts of the organisation. At the strategic part of the organisation there appeared to be few challenges, if any, but at the operational part, during the implementation stage of the new curriculum, many issues arose.

A limitation of the study was that it was undertaken in one Faculty of Health and Social Care in one HEI in the UK, and so applicability to other settings may be limited. Participants were purposefully selected in order to gain a range of opinions.

New Change Management Model

Kotter and Cohen’s model could be seen as having a limited applicability in a largely top-down initiative, within the kind of organisations in the public sector and higher education investigated during this study. Therefore, following on from the analysis conducted in this study, a new change management model has been developed (see Fig. 2).

Tool for use when analysing organisational change prospectively, in real time or retrospectively,

Develop leadership skills across the organisation
Was there leadership in the organisation during the recent change?
Was this leadership evident across all parts of the organisation?
Was there a leader in your department?
Can you identify that person/role/position?
How did these leaders display their qualities and skills?
Did the leaders consider your feelings about the change?

Develop leadership and management skills of Guiding Teams
Were there Guiding Teams in place during the change?
Did these teams manage or lead the change or both?
What skills did the leaders of the Guiding Team display?
Did these Guiding Teams consider people’s feelings about the change?

Build the right vision with inter-organisational wide engagement and involvement
Were you aware of the vision for the change?
Were you aware of organisation strategy?
Were you invited to meeting about the proposed change?
Were you consulted about the change?
Were practice colleagues present at these meetings?
Were the feelings of academics and clinical colleagues considered?

Create inter-organisational communication forums in the frontline
How was the change communicated to you?
Were there forums for you to attend?
Were you invited to hear about the change?
Were there practice partners at these meetings?
Did change agents consider the feelings of academics and clinical colleagues about the change at these forums?

Create an empowering environment
Do you feel empowered in your organisation/department?
What would help you to feel empowered?
What makes you feel dis-empowered in the organisation?
How you feel when you are empowered/dis-empowered?

Create an academic culture of readiness for continuous change
How do you feel change should be managed in academia?
How does the organisation prepare you for new changes?
What preparations do you think you need to be ready for new changes?

Affirm and embed the direction of change on the frontline
How did you learn about the new programme and what details were you given?
What preparations did you receive for the new programme?
What preparations did mentors receive in order to support students?
Was there regular support for you in deliver of the new course?
What would have helped to manage this change in the frontline?

Develop organisational values that reflect the importance of all parts of the organisation
Do you feel valued in this organisation?
What makes you feel values?
Do you think all levels of staff feel equally values?

Use a model of change management that best fits the organisation’s business
How was the recent change managed?
Are you aware of models/approaches/theories of change?
Did the organisation use a recognised model of change management?
Was it effective?
Were their areas that you would have liked the change to focus on?

Consider human emotions during the change process
How did you feel about the change?
Do you think addressing feelings during change is important?
Were your feeling dealt with appropriately?
How were these feelings addressed?
What would you suggest the organisation needs to put in place to address people’s feelings during change?
Kotter and Cohen’s business model has been revised and re-shaped to form a new model, taking into consideration the wider context and focusing on addressing the emotional aspects of organisational change. The model is non-linear, non-sequential, analytical in nature and not prescriptive. It allows change agents to choose at what point in the model they wish to begin the change process, depending on the level and complexity of change to be undertaken, and can be adopted and adapted for organisations outside nurse education.

Accompanying the model is a tool to help put it into practice, and can be adapted for prospective, real time, and retrospectively change, whilst affording a central role to the understanding of emotions in the process of change (see Fig. 3).

**Rationale for the New Model**

Leadership was found to be at the heart of this curriculum change and not ‘increase urgency’, which was the first step in Kotter’s model; thus a need to ‘Develop leadership skills across the organisation’ is included in the new model. Steps two to five are retained in the new model, but in a different form. The focus, emphasis and values have changed. Managers managed the change; therefore, ‘Develop leadership and management skills of Guiding Teams.’ The vision, though pertinent and pioneering, did not reach frontline practitioners, creating the need to ‘Build the right vision with inter-organisational wide engagement and involvement.’ Communication failed to reach frontline practitioners, hence a need to ‘Create inter-organisational communication forums in the front lines’. Academics felt disempowered during the planning of the curriculum, therefore, ‘Create an empowering environment’, is another component in this new model.

The last three steps of Kotter and Cohen’s model were, from this study’s analysis, found to lack relevance as the credibility of the change was under challenge, and the new conception of nurse education as fit the organisation’s business. The study’s findings indicated a need to ‘Affirm and embed the direction of change on the front line’, ‘Create an academic culture of readiness for continuous change’ and ‘Develop organisational values that reflect the importance of all parts of the organisation.’

The other elements within the new model emanate from the literature. Change management advice is conflicting and contradictory, and change has a high failure rate (Burnes, 2014). Thus, ‘Use a model of change management that best fits the organisation’s business.’ In the centre of the model is ‘Consider human emotions during the change process.’ Though this study was not able to investigate the emotional aspects of change in depth, Kotter and Cohen’s model suggests that dealing with feelings, not just thoughts, are essential for successful change (Kotter, 2008).

**Conclusion**

Curriculum change is now a key feature of nurse education and requires change management both in academia and the practice setting, taking place in large, complex organisations across education and healthcare settings. This study sought to explore how a curriculum change was managed and highlighted that many issues posed a challenge at the implementation stage. Nurse education needs to be mindful that practice occurring mainly in the NHS is constantly under change, and thus practice colleagues have to deal with employers bringing about change, alongside those in nurse education. The business model used in this study to explore how change was managed on the introduction of a new curriculum was found to be valuable in evaluating curriculum change, but had limited applicability in the context of nurse education. A new change management model has since been developed together with a tool for managing future curriculum changes.

**Recommendation**

The new change model and tool would lend themselves to further research, development, and evaluation in relation to nurse education, higher education, and a range of other settings.

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**References**


