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AN ANALYSIS OF THE DEVELOPMENT OF FAMILY HEALTH NURSING IN SCOTLAND THROUGH POLICY AND PRACTICE 1998-2006

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ABSTRACT

In 1998 World Health Organisation Europe outlined a vision of a new community-based nurse called the Family Health Nurse (FHN) who would help individuals, families and communities to cope with illness and to improve their health. Scotland was the first European country to develop this idea through policy, education and practice. The two phase national pilot project (2001-2006) primarily involved remote and rural regions.

Despite its vanguard position, Scottish family health nursing has been subject to little in-depth critical analysis. This thesis addresses this deficit by analysing why and how family health nursing developed in Scotland. The research methods used are: critical review of textual sources; empirical research into policy, education and practice; and critical review and application of relevant theoretical perspectives to enable interpretation. Grounded primarily in constructivism, this approach builds explanation of the development of family health nursing in Scotland as a phenomenon in contemporary nursing history.

This explanation highlights the importance of key factors and processes, particularly: agency at policy formulation level; use of the piloting mechanism to mediate knowledge production, containment and expansion; tensions between generalism and specialism as manifest within the promulgated FHN concept, the educational programme, and the FHN role as it was variously enacted in practice; related difficulty in engaging substantially with families; and the strong influence of local context on the nature and scope of FHN role development, especially in terms of situated power and embedded culture of place.

The explanation is summarised as a synoptic story. A new integrative, explanatory model of the development of family health nursing in Scotland is also posited. This knowledge is then examined in relation to contemporary community nursing and primary care in order to understand influence and implications. This highlights the importance of the development of family health nursing in shaping the new Community Health Nurse (CHN) role which emerged from the Review of Nursing in the Community in Scotland 2006.

The new explanatory model constructed within the thesis is then applied in its more generic MAPPED format (Model for Analysing Policy to Practice Executive Developments) to analyse the new policy formulation advancing the CHN role and to anticipate key developmental factors and processes. On this basis, the thesis argues that the MAPPED model is potentially valuable for the analysis of developments that require purview from policy through to practice. The thesis concludes by summarising its contributions to understandings of community nursing policy, practice, research and theory, and makes a number of related recommendations.

Key words**:** *Family Health Nurse; community nursing development; policy and practice; constructivist analysis; remote and rural; Scotland; WHO Europe.*

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Finally, I dedicate this thesis to my parents, Lillias L. M. Macduff and Dr. Iain B. Macduff whose loving natures and wise nurture have been my strongest foundation.

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Annex 2: MACDUFF, C. and WEST, B., 2004a. *A Supplementary Resource for "Evaluating Family Health Nursing through Education and Practice".* Aberdeen: The Robert Gordon University.

Annex 3: Key informant interviews 2005: details of methods used and resultant findings (relating to Chapter 8 of the thesis)

BOUND-IN PUBLISHED PAPERS

Paper 1: MACDUFF, C. and WEST, B., 2004b. An evaluation of an educational programme to prepare family health nurses. *Nurse Education Today*, 24, pp.575-583.

Paper 2: MACDUFF, C. and WEST, B., 2005**.** An evaluation of the first year of family health nursing practice in Scotland. *International Journal of Nursing Studies*, 42, pp. 47-59.

Paper 3: MACDUFF, C., 2006a. A follow-up study of professionals' perspectives on the development of family health nursing in Scotland: a questionnaire survey. *International Journal of Nursing Studies,* 43, pp. 345-356.

Paper 4: MACDUFF, C., 2005. The progress of family health nursing in remote and rural Scotland. *British Journal of Community Nursing,* 10 (12), pp. 558 – 562.

Paper 5: MACDUFF, C., 2006b. An analysis of a typology of family health nursing practice. *Nurse Researcher,* 14 (1), pp. 34-47.

GLOSSARY OF KEY TERMS, ABBREVIATIONS AND ACRONYMS

ASLIB: Electronic data-base of UK theses.

ASSIA: Applied Social Sciences Index and Abstracts.

Calton Hill: prominent elevated location within central Edinburgh where the Scottish Executive Health Department is based.

Caseload: a list of people receiving professional intervention for health or illness related matters. The list usually includes summary details of why they are being seen and how frequently. This report is mostly concerned with family health nursing and district nursing caseloads, but has also considered health visiting caseloads. For further information on the difficulties of the concept please see Annex 3.

Castlebay: The main village in Barra, the smallest of the main islands that comprise the Western Isles. Despite Barra's direct air link to Glasgow, Castlebay is archetypal of a remote and rural community.

CINAHL: Cumulative Index to Nursing and Allied Health.

Community nursing: a broad term denoting varied nursing activities that can take place in settings that range from small community hospitals/doctor's surgeries to work in people's homes. The term can include work done by District Nurses, Health Visitors, Practice Nurses, Midwives and a range of other (often specialist) nurses.

Community specialist practice qualification: a qualification that denotes ability to work at a higher level of practice within the community than a registered nurse. In the UK eight such qualifications are recognised and these include district nursing and health visiting.

Community Staff Nurse (SN): a registered nurse who does not have a specific specialist qualification to work in the community but whose work involves caring for those on the district nursing caseload.

Core Primary Health Care Team (core PHCT): a group of health care professionals whose everyday work is focused mainly or exclusively on the provision of primary care services for the population of the FHN site. The core PHCT usually comprises all the nurses involved in the care of the DN caseload(s), all Practice Nurses and GPs from all the practices within the FHN site. It may include the Health Visitor and Midwife(s), but this tends to depend on whether they are based within the FHN site or not.

District Nurse (DN): a registered nurse who has a specific specialist qualification to carry out home visiting nursing work. Traditionally this work has involved caring for those suffering from illness or disability.

Double duty nurse: a nurse whose job combines 2 distinct professional roles. In remote and rural Scotland traditional combinations are District Nurse and Midwife; Community Staff Nurse and Midwife; or District Nurse and Health Visitor.

Ecomap: a diagram of a family's contact with others outside the immediate family. It is intended to give an overview of the family's social interactions and involvements.

Family: a group of individuals with relational connections that may be emotional and/or biological and/or legal in nature. WHO Europe's HEALTH 21 framework equates families with households, but a broader view can also be taken involving family self-definition (i.e. the family is what individual members say it is).

Family focused care/ family centred care: general terms**,** denoting a care approach where the whole family is seen as the principal unit of care/the client, and care is organised to reflect this priority. This also applies to the terms **family nursing/ family focused nursing/ family centred nursing**. Differs from **family as context** where the individual's needs are predominant, and the family is seen as the context for this (most commonly as a supportive network).

Family Health Nurse (FHN), WHO Europe concept: a "new type of nurse" proposed by WHO Europe in 1998. Their envisaged role is community based and multifaceted. It includes helping individuals, families and communities to cope with illness and to improve their health. There is particular focus on holistic family care and a public health orientation. The full WHO Europe role definition is given at the start of Chapter 1.2 of this thesis.

Family Health Nurse (FHN) concept, Scottish interpretation (SEHD): based on the WHO Europe concept, but highlighting 4 principles in particular i.e. a skilled generalist role; a model based on health rather than illness; caring for families rather than just individuals; the nurse as first point of contact. The Scottish educational programme drew extensively on North American **family systems nursing (see below)** where the family is the unit of care/client.

Family Health Nurse site (FHN site), Scottish pilot: a distinct geographic area whose population are served by one (or occasionally two) district nursing team(s) within which an FHN is working. Other health professionals whose work involves the provision of primary care services to the population of this site are known as the Primary Health Care Team. Following the educational course, some of the FHNs were allocated a specific "patch" within the overall site and they practised family health nursing only within their given patch. By contrast some other FHNs were responsible for delivering a family health nursing service to a whole site.

Family health nursing: a new type of professional nursing based on the WHO Europe FHN concept. The term is used in this thesis in a generic way that may incorporate any or all of the following aspects, depending on context: the related policy initiatives at European or Scottish levels; the FHN concept, its related body of knowledge and educational programme; professional aspirations and related political dynamics; role enactment in practice.

Family systems nursing: primarily North American term associated with Wright and Leahey (1994). This is family nursing explicitly based on assumptions from: systems theory; cybernetics; communications theory and change theory. Family is the focal unit of care, and distinctive family assessment and intervention models have been created.

General Practitioner (GP): an independent contractor who personally provides primary care medical services to a local population. Some GPs still describe themselves as family practice doctors but this title has declined in usage over the past two decades.

Generalist/generic nurse: pertaining to knowledge and/or practice that is not distinctive in its boundaries and requires broad understandings across a range of subject areas. Generalist nurses typically care for patients with diverse conditions and/or undifferentiated problems.

Genogram: a diagram of the family constellation which depicts the relationships among family members for several generations. Their structure resembles conventional genealogical family tree diagrams and they often include the mapping of health status/issues.

Health Visitor (HV, or Public Health Nurse): a registered nurse who has a specific specialist qualification and additional registration to carry out health promotion and monitoring work within communities. In the past two decades this work has predominantly involved contact with mothers and children (e.g. developmental screening) but recently the public health aspects of the role have been highlighted for priority.

IBSS: International Bibliography of the Social Sciences.

MEDLINE: International Journal data-base of published medical and health science research.

NBS: National Board for Nursing, Midwifery and Health Visiting now incorporated into NES NHS Education Scotland.

NMC: Nursing and Midwifery Council. The regulatory body for Nursing, Midwifery and Health Visiting which replaced the UKCC

Nurse practitioner: a nurse who acts as first point of contact to provide health care advice and treatment to select client groups. This usually involves strong elements of autonomous and advanced practice

Objective Structured Clinical Examination (OSCE): a method of measuring clinical competence that usually involves observation of students' skills when dealing with a variety of standardised clinical problems within a controlled environment.

Practice Nurse: a registered nurse who is employed by a GP practice to provide a range of services within the GP surgery. These vary in nature and scope but usually involve screening programmes and chronic disease management. The Practice Nurse may have a specific specialist qualification, but this requirement is not mandatory.

Primary Health Care Team (PHCT): a group of health care professionals whose work as individuals involves some provision of primary care services for the population of the FHN site. For some (the core PHCT, typically DNs, GPs, Practice Nurses) their everyday work is focused mainly or exclusively on the FHN site. For others (typically HVs, Midwives, Community Occupational Therapists, Community Physiotherapists, CPNs) their work also involves substantial provision of services to other populations.

Primary prevention work: health care input whose main purpose is to prevent the occurrence of disease (e.g. teaching young children about healthy eating).

SCOTCAT: an acronym for Scottish credit and accumulation transfer and refers to the academic levels of learning that students have undertaken.

Scottish Executive Health Department (SEHD)

Secondary prevention work: health care input whose main purpose is to reduce the prevalence of disease and shorten the course of illness (e.g. screening those thought to be at risk of disease; vaccination programmes).

Specialist: pertaining to knowledge and/or practice that is distinctive in its boundaries and requires in-depth study and understanding. Often requires educational input at advanced level. Specialist nurses usually have differentiated caseloads in that they care for those within specific diagnostic groups or in very specific contexts.

Stakeholder: a term generally used to denote a person who has an interest, share or investment in something. In this study the "professional stakeholders" at each site comprised all health care staff in the core Primary Health Care Team and all other relevant health, community and social care staff involved closely with the PHCT. "Lay stakeholders" were defined in the much more general sense of any member of the public living within the FHN site and registered on one of the relevant electoral rolls.

Team Leader: a term used to describe a health professional who has a leadership role. In community nursing in remote and rural Scotland this can involve "leading" one other colleague or a large number of people. As such it has limited value.

Tertiary prevention work: health care input whose main purpose is to minimise the effects of the disease for the individual and others, and to promote rehabilitation and adaptation (e.g. education work with a person with newly diagnosed diabetes).

Triple duty nurse: a nurse whose job combines three distinct professional roles. In remote and rural Scotland the traditional combination is District Nurse, Midwife and Health Visitor.

UKCC: until recently the regulatory body within the UK for nursing, midwifery and health visiting practice. It is now called the Nursing and Midwifery Council (NMC).

Web CT: an internet resource devised by the educational provider to facilitate flexible on-line learning. Students can access a range of educational materials and participate in on-line discussions.

WTE: Whole time equivalent. Used in relation to the hours worked by one full time worker in the NHS.

ZETOC: Electronic Table of Contents from the British Library.

CHAPTER 1

INTRODUCTION TO THE THESIS

Overview of this chapter

This chapter introduces the reader to the purpose and subject matter of the thesis, and explains why an analysis of the development of family health nursing is both necessary and important. Following overview of the nature and scope of the enquiry, an outline of family health nursing development in Scotland is presented in order to provide initial thematic orientation. In turn, this sets a context for explaining the rationale behind the study and the five research questions at its heart. These questions drive the enquiry and provide structure for both the research and its presentation. The chapter concludes by explaining this structure and illustrating it diagrammatically in order to orientate the reader to the distinctive design of the thesis.

1.1 THE THESIS: AIM, AMBIT AND ASPECTS FOR ANALYSIS

This thesis aims to analyse and explain a recent community nursing development. The particular development in question is that of family health nursing in Scotland between 1998 and 2006. Scotland has been the first country to develop the World Health Organisation (Europe) Family Health Nurse (FHN) concept through policy, education and practice, and this thesis aims to make a useful academic contribution by undertaking in-depth, systematic analysis of this phenomenon. The thesis will seek to explain *what* family health nursing is, and *why* and *how* it developed in Scotland during this period. This will also entail consideration of the *where*, *when* and *who* of the process. Through critical review and application of relevant theoretical perspectives, the thesis will build further explanation of *why* family health nursing developed in the way that it did. The meaning and significance of the development as a whole will then be examined by considering its relationship with other contingent health care developments. In this way, it is hoped to achieve a contemporary historical perspective which will yield knowledge of value to nursing in particular and to health services more generally.

Addressing a national development that has evolved from an international one brings not only wide geographic scope to the enquiry, but also a number of different levels for analytic focus. Accordingly it is important to point out that this thesis aims to examine the evolution of an idea from its origins in Europe, through its formulation and advancement as a Scottish policy initiative, into its enactment in the form of an educational programme and a practice-based role. As such, *development of family health nursing in Scotland* is used in this thesis in a generic way that includes conceptual, policy, managerial, educational and nursing practice aspects. Thus the thesis has a broad and ambitious ambit that is concerned, to varying degrees, with all of these five aspects.

Where a specific aspect is being examined this will usually be indicated by using relevant terms such as *the FHN concept*, *the FHN policy initiative*, or *the FHN role.* However such distinction has not always been evident during the evolution of family health nursing itself, and this is reflected in official documents that provide data for this enquiry, as well as in the discourse of those who have had engagement with family health nursing and have participated in this research. Historical, linguistic and genealogical approaches to concept analysis are used in the thesis to clarify and counteract this tendency to view family health nursing as axiomatic.

Policy analysis is another major aspect of the explanation building in the thesis, involving both public policy and health policy analysis approaches. Analysis of the related managerial aspects of family health nursing development in Scotland is also undertaken, but is much more limited in scope. The educational aspect of the development is analysed in some depth via an

evaluative approach, but is considered primarily in terms of its ultimate purpose of preparing FHNs for practice, rather than as an end in itself.

Indeed, analysis of family health nursing practice is the other major aspect of explanation building in the thesis. Within this context there is particular emphasis on analysis of the FHN role as enacted in practice. As role itself is a concept with many different facets, it is necessary to note that analysis in this thesis is mostly concerned with role in terms of its: content (activities actually undertaken in practice); form (professional domain(s), identity and associated cultural meanings); set (the nature and scope of relations with patients, families and other professionals and the associated expectations in regard to function, status and power); and development (expansion or extension of content, form, and/or set as gauged by normative or ipsative criteria).

Having outlined the aim, ambit and main aspects for analysis in the thesis, it is time to look to its particular subject matter.

1.2 BACKGROUND: AN OUTLINE OF FAMILY HEALTH NURSING DEVELOPMENT IN SCOTLAND

In 1998 World Health Organisation (WHO) Europe outlined their vision of a new community-based nurse called the Family Health Nurse (FHN). The concept was presented as a possible means of developing and strengthening family and community oriented health services within the European region (WHO 1998a). Within the HEALTH 21 health policy framework it was proposed that this new type of nurse would make a key contribution within a multi-disciplinary team of health care professionals to the attainment of the 21 health targets set in the policy. Specifically, the FHN and the Family Health Physician (FHP) were posited as the key professionals at the hub of a network of primary care services.

The full definition of the new role stated that the Family Health Nurse can:

> "help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family's health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise" (WHO Europe 1998a; p. 139).

Thus the envisaged role of this FHN was multifaceted in nature, and the community health dimension of the role was subsequently further emphasised in a more detailed conceptual framework and curriculum document which was developed in 2000 in order to underpin impending enactment of the role (WHO 2000a). In this regard it was announced that 18 European countries (Table 1.1) would develop the role through linked, parallel processes of education, practice implementation and evaluation. These "pilot" projects would run concurrently between 2001 and 2003.

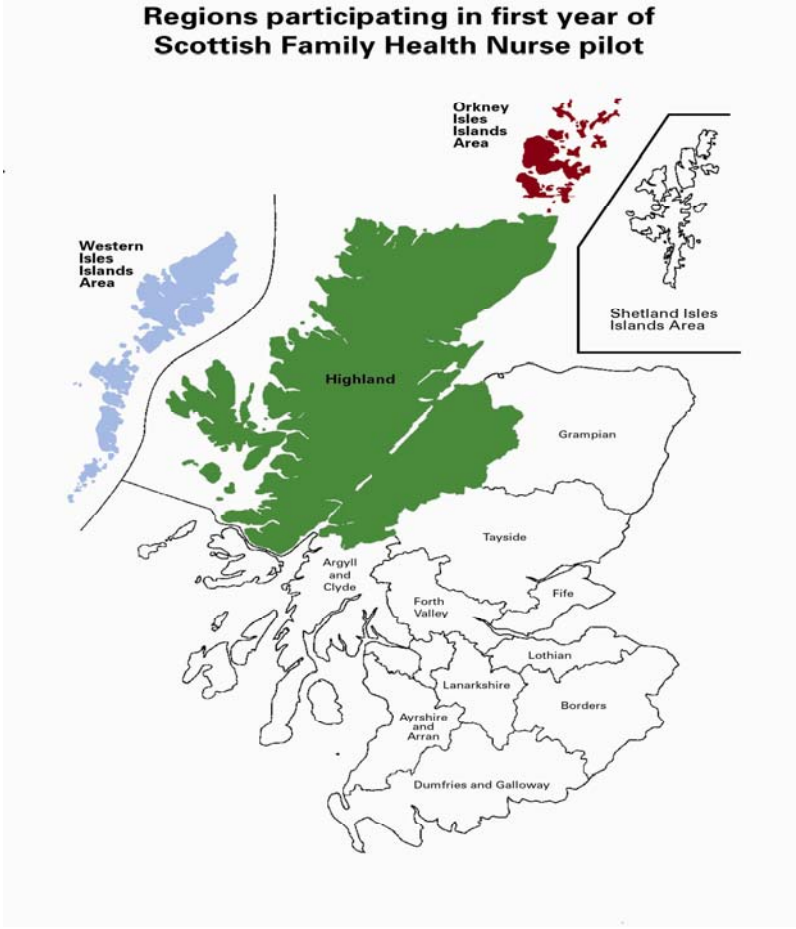
Table 1.1: Countries that expressed an initial intention to participate in the WHO Europe FHN pilot project

Andorra	Lithuania
Armenia	Poland
Austria	Portugal
Belgium	Republic of Moldova
Denmark	Scotland
Estonia	Spain
Finland	Slovenia
Germany	Sweden
Ireland	Tajikistan

Detailed analysis of Scotland's reasons for participating in the pilot project will be presented in Chapter 4 of the thesis but, in summary, the Scottish Executive Health Department (SEHD) saw the FHN as a potential solution to some of the problems of providing health care in Scotland's remote and rural regions. Within these regions populations are characteristically sparse, ageing and declining in numbers. Health profiles are often poor, with high incidences of cardiovascular disease and cancer, and socio-economic problems such as unemployment and poverty are relatively widespread. Geographic isolation is associated with transport difficulties, and the regions suffer from migration of the young to urban towns and cities. Recruitment and retention of skilled nursing staff has become increasingly difficult.

Thus during 2000 the SEHD began preparatory work for a Scottish pilot project. Three regions were initially involved in this work (Figure 1.1), with a fourth (Argyll and Clyde) joining the project in 2002. A Project Officer was appointed to co-ordinate national and regional activities, and to liaise with other European countries. A National Steering Group was convened and met regularly during the course of the project, and local Steering Groups were also set up at regional level. In order to prepare selected nurses from these regions for the role the SEHD commissioned Stirling University to provide a degree-level educational programme that was congruent with the WHO curriculum.

Figure 1.1: Regions participating in first year of Scottish FHN pilot



Following a process of competitive tendering the Centre for Nurse Practice Research and Development (CeNPRaD) at the Robert Gordon University, Aberdeen was commissioned by the SEHD to undertake an independent research evaluation. The study's remit was to evaluate the operation and impact of family health nursing in these remote and rural areas. This included evaluation of the educational programme and the identification of implications for extending family health nursing into other Scottish regions.

The 40 week degree level educational programme started in February 2001 and was completed by eleven students (Cohort 1) who subsequently returned to their practice areas early in 2002 to work as qualified FHNs. The evaluation studied this first year of the new role in practice, focusing on the eleven FHN sites as the principal units of analysis. A further 20 students (Cohort 2) undertook and completed the course in 2002.

In October 2003 the evaluation report of the Scottish pilot project was published (Macduff and West 2003) and its recommendations informed a subsequent second phase of the FHN project in Scotland. Phase 2 ran from late 2003 to mid 2006 and involved the education of 18 more FHNs. This phase had the aims of: consolidating FHN practice in remote and rural areas; testing the suitability of the role in an urban setting; developing the educational programme; and informing the development of Scottish community nursing education and practice.

1.3 RATIONALE FOR A MORE COMPREHENSIVE ANALYSIS OF FAMILY HEALTH NURSING DEVELOPMENT

What the foregoing event-focused outline fails to mention, however, is what did not happen. By the start of 2004, Scotland was the only country to have completed a pilot project (Phase 1) and was far ahead of all other countries in terms of enacting the role. Although the thesis will examine the origins of the WHO Europe FHN project, analysis of its subsequent development and the relative progress of other countries is outwith its scope.

Rather the thesis focuses on the Scottish experience because of its significance as the first substantive and sustained attempt to develop the new family health nursing concept. As such, it seems important that this episode in contemporary nursing history is subjected to sustained critical analysis in order that:

- aspirations and underlying assumptions can be examined and explained

- key contexts, processes and outcomes, and the dynamics of its development, can be identified and understood in relation to relevant nursing and social science theory

- the consequent implications for future nursing and primary care service development at national level and beyond can be identified and explored.

To date, however, such an analysis and synthesis has not been attempted. Indeed the development has been subject to little in-depth critical scrutiny. While the commissioned evaluation study undertaken by myself and Dr Bernice West offered the first in-depth empirical research on family health nursing education and practice, its scope was limited by its evaluative remit, prescribed objectives and coverage of one year of practice only. Accordingly this thesis incorporates important knowledge from the seminal published study, but seeks to move well beyond it in order to construct a substantive explanation of the development of family health nursing in Scotland. In effect this enterprise has been driven by a need to seek answers to five fundamental questions that emerged during and following the commissioned evaluation study.

1.4 THE RESEARCH QUESTIONS AND THEIR ORIGINS

These central research questions are:

1 Why develop family health nursing?

2 How did family health nursing develop in remote and rural Scotland between 2001 and 2004?

3 Why did family health nursing develop in the way that it did in Scotland?

4 What does this mean in terms of the development's influence and implications?

5 What significance has the resultant analysis for understandings of nursing and health care policy, education, practice, theory and research?

The origins of the first question can be traced back to my initial exposure to the FHN concept on receiving an invitation to tender for the SEHD evaluation research contract at the end of 2000. My initial reaction was one of curiosity at this conjunction of concept with time and place. What was family health nursing, and why develop it now in remote and rural areas of Scotland? As a nurse researcher with a background in hospital-based nursing, I had no particular pre-existing view on the relative merits or demerits of family health nursing. However, as Daley (2001) shows, there was significant questioning of, and resistance to, the concept by groups of community nurses in Scotland during 2000, particularly amongst Health Visitors. Dougall (2002) also explicitly questioned the need for this new role from a district nursing perspective.

As such, the *why* question seemed very pertinent, but was not one of those explicitly included in the commissioned evaluation remit. Rather, the focus was on *how* family health nursing developed in terms of its operation and impact. This relates to the second question being addressed in this thesis. During the evaluation research process I developed increasing fascination with the subject matter, with seemingly constant iterative attempts to make sense of a complex, unfolding reality. The net effect was a sustained desire for more in-depth understanding and explanation of the development in the belief that some valuable learning may be transferable (i.e. questions 3, 4 and 5 above). As this persisted well beyond the professional evaluation contract, there was recognition of an ongoing affliction which only a doctoral study might cure.

Streubert and Carpenter (1995) describe how:

> "the naturalistic[1] domain dictates an emergent design because of a belief in phenomena as consisting of multiple, context dependent realities. Only after these realities become apparent can the most appropriate design for the study be determined" (p. 249).

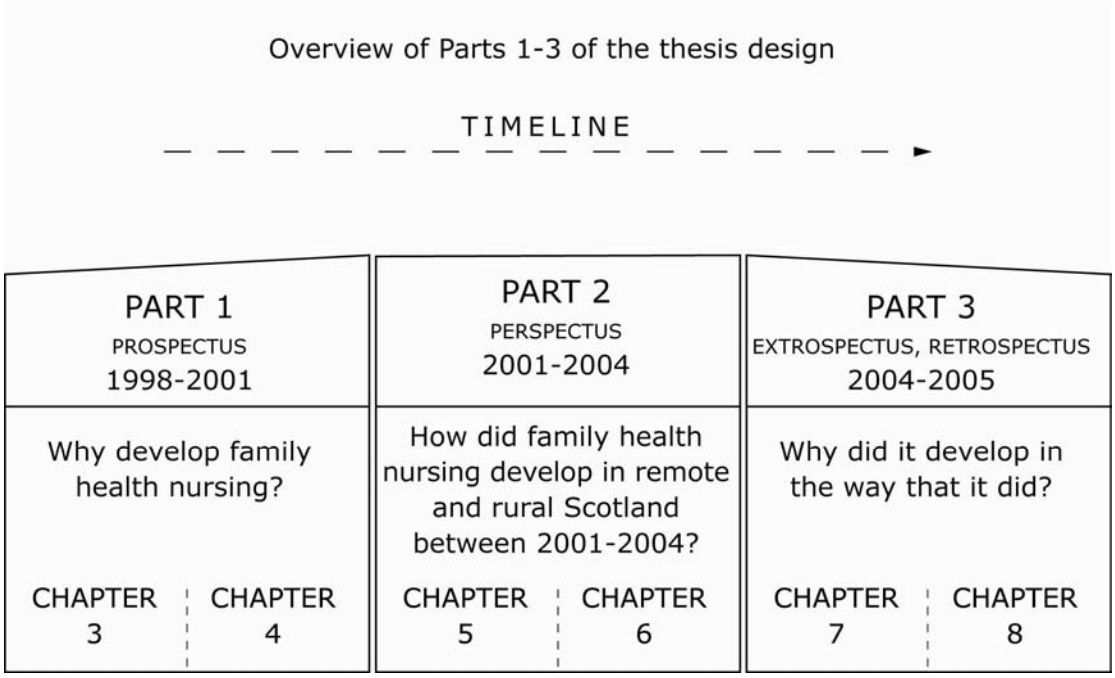
This resonates with the nature and process of developing the design of the present enquiry. For it was only after evaluative field research investigating the multiple, context dependent realities of practice at particular FHN sites that the need for more fundamental enquiry came clearly into focus. Thereafter the five central research questions began to emerge, along with a design through which to address them.

[1] "naturalistic" is being used here in the sense of a domain that is concerned primarily with understanding meaning. This should not be confused with the "natural sciences" which are primarily concerned with proof and prediction

1.5 DESIGN STRUCTURE OF THESIS AND OVERVIEW OF CONTENT

These five central questions drive the enquiry and provide structure for both the research and its presentation. Accordingly, following Chapter 2 which deals with methodology and main methods, the thesis is structured in five sequential parts that aim to convey both the chronological progression of the development itself and the conceptual progression of my own related research. In order to orientate the reader to this distinctive design, it is firstly useful to provide visual overview of Parts 1-3 of the thesis (Figure 1.2).

Figure 1.2: Overview of Parts 1-3 of the thesis design



As Figure 1.2 shows, Parts 1-3 can be visually represented using the medieval "triptych" format, whereby three hinged picture panels are combined to produce a work that is greater than the sum of its parts. In the threefold representation of Figure 1.2, chronological narrative and conceptual progression proceed from left to right, utilising different ways of seeing and thinking about the subject matter of family health nursing.

In this way Part 1 uses the idea of "prospectus", in the sense of looking ahead to a proposed venture and describing its chief features. This is applied to the European and Scottish family health nursing ventures respectively in Chapters 3 and 4. Thus Part 1 comprises two chapters of the thesis and primarily considers the time period from 1998 up to early 2001. As Figure 1.2 indicates, the enquiry in Part 1 is driven by one central question, *why develop family health nursing*? This fundamental question is tackled by addressing a number of its component questions such as: *what is family health nursing?; where did it come from?; why did it*

emerge?; and *what was it trying to achieve*? Initial answers to these questions are outlined in Part 1, as understood through interpretation of relevant documentary evidence.

Part 2 of the thesis uses the idea of "perspectus", in the sense of looking through. Here the development of family health nursing in Scotland between 2001 and 2004 is viewed through the lens of my empirical research into education and practice. The fundamental question driving this part of the enquiry is: *how did family health nursing develop?* Chapter 5 provides summative description of the most relevant parts of three linked research studies which examined remote and rural family health nursing practice during this period. This includes material from the commissioned evaluation study. The full evaluation report is included on the accompanying CD Rom as Annex 1, while a related supplementary report focusing on the evaluation's methodology is also included therein as Annex 2. Both of these Annexes provide further contextual and methodological detail for validation and reference purposes. Three published papers relating respectively to the evaluation of education (Macduff and West 2004b), the evaluation of practice (Macduff and West 2005), and the typology of practice constructed during the evaluation (Macduff 2006b) are also bound-in at the end of the thesis for similar purposes.

The second study which is summarised in Chapter 5 followed up professionals' perspectives on the development of family health nursing in remote and rural areas during 2004. A published paper that gives more details of this study is also bound-in to the thesis (Macduff 2006a). Finally a third, smaller, study informs Chapter 5. This draws on the perspectives of three Family Health Practice Development Facilitators who were appointed by SEHD to support practice development in remote and rural areas during Phase 2 of the FHN project. Again more comprehensive details are available in a bound-in published paper (Macduff 2005).

In order to draw this material together, Chapter 6 firstly considers the limitations of these empirical studies, before synthesizing a set of primary understandings about how family health nursing developed in practice between 2001 and 2004. In this way Part 2 provides a basis from which further, enhanced interpretation can proceed.

This challenge is taken up in Part 3 (2004 – 2005) which is concerned with building a comprehensive explanation of *why family health nursing developed in the way that it did in Scotland*. This is undertaken by firstly looking outwards ("extrospect") from family health nursing itself in order to identify relevant theoretical perspectives which might usefully illuminate the understandings derived from documentary evidence in Part 1 and the understandings from empirical research in Part 2. This process is applied in Chapter 7 to construct a retrospective explanation of the enactment of family health nursing in local practice contexts in remote and rural Scotland.

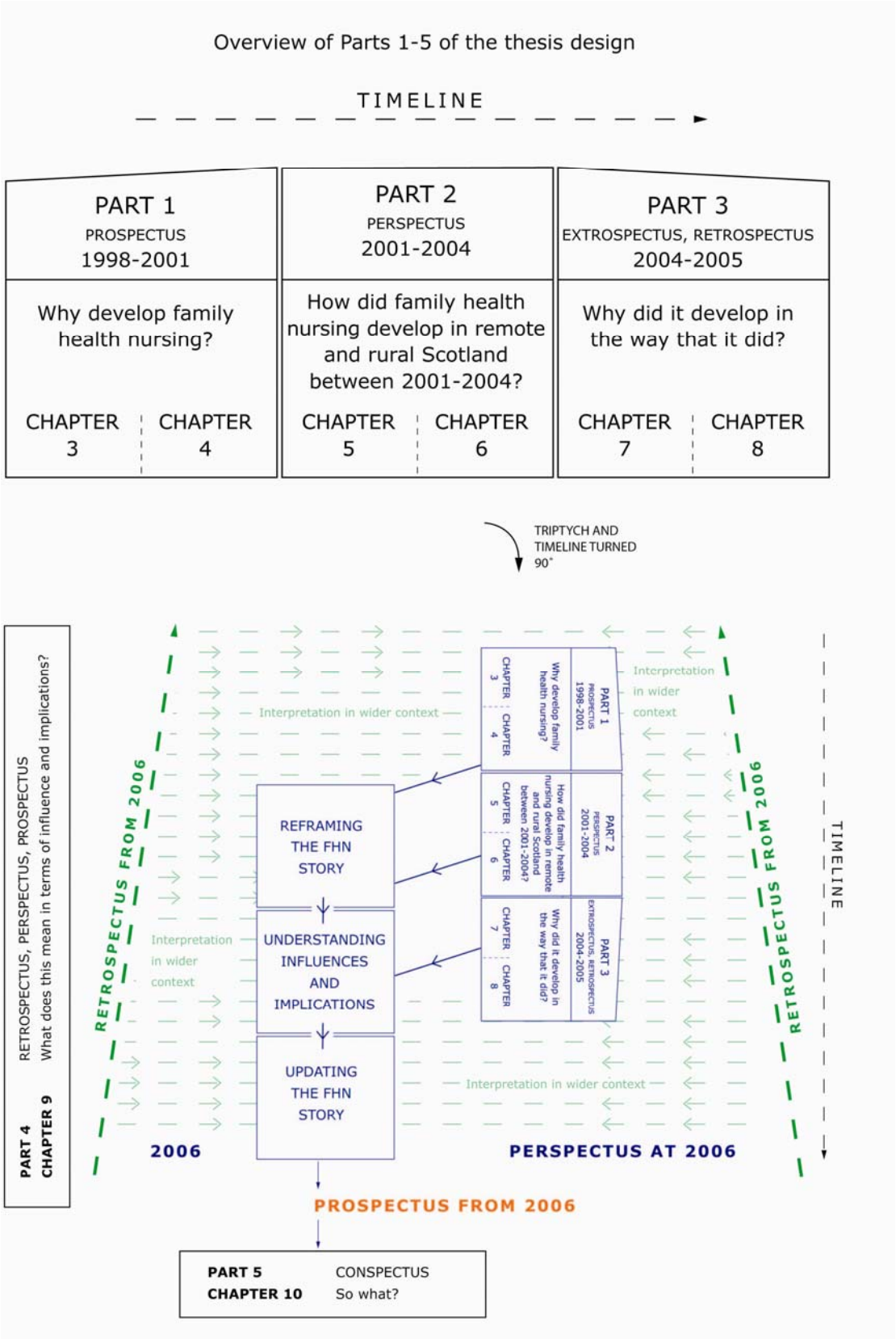
This explanation is further developed in Chapter 8 in relation to the formulation of family health nursing as policy at central Scottish government level and the subsequent mechanisms through which this was taken forward. Here analysis is substantially informed by further empirical research that the author carried out with a few key policy informants. Full details of these interviews and related analytic processes are provided in Annex 3 (CD Rom) for validation and reference purposes. At the end of Part 3 of the thesis the resultant integrated explanation of family health nursing development from policy through to practice is presented in the form of a synoptic story and a new model.

At this point in the thesis (Part 4; Chapter 9) it becomes necessary to, metaphorically, step away from the triptych in order to view and review it in a wider context. This process is illustrated diagrammatically in Figure 1.3 where the triptych (and its inherent timeline) is turned through 90 degrees to the right. This spatial and temporal manoeuvre allows the triptych's explanation of the development of family health nursing up to 2004 to be viewed and reviewed from a 2006 vantage point. As Figure 1.3 shows, this firstly involves retrospectus i.e. reviewing the most significant contingent concurrent developments within health and social care between 1998 and 2006 that influenced family health nursing's own development. In addition to review of direct influences, this includes consideration of some of the contextual policy influences not covered previously in Chapters 3 and 4.

This process not only enables "re-framing" and enhancement of the *how* and *why* explanation built previously, but also allows updating of the triptych story to include more consideration of *how* Phase 2 developed (see Figure 1.3). This brings the reader to the writer's present perspectus, writing late in 2006 as a major Review of Nursing in the Community in Scotland has just been completed. Consequently this affords opportunity to examine the influence of the development of family health nursing itself on the outcomes of the Review. Analysis is enhanced by applying the new integrative model from Part 3 in order to explain antecedents of the Review and to consider its implications. In this way, Chapter 9 finishes by looking to prospects ahead.

Part 5 also comprises just one chapter. In concluding the thesis, Chapter 10 provides "conspectus", or summary, of the knowledge that has been built in the thesis and its significance. Essentially this involves addressing the question: *so what*? This question is addressed by reviewing what has been learned about the development of family health nursing in Scotland and how this contributes to understandings of community nursing/primary care in general. Finally the value of the thesis's distinctive approach to exploring the history of an idea is suggested.

Figure 1.3: Overview of Parts 1-5 of the thesis design



As can be seen, Figure 1.3 provides overview of all five parts of the thesis design and the way in which they are sequentially related.

In concluding this introductory chapter, it is useful to draw the reader's attention to some aspects of presentation that may differ somewhat from "conventional" thesis formatting. While Chapter 2 explains the constructivist – interpretive methodology that underpins the study as a whole, it only provides overview of the main research methods and approaches to data collection, analysis and synthesis used within the thesis. More particular details relating to specific methods are reported in context as they relate to the particular enquiry within each chapter. Similarly there is no one literature review chapter. Again the nature and scope of literature review is reported in context in relation to the particular enquiry within each chapter. It is contended that this structure is more suited to the ambitious scope of a thesis that aims to explain a multi-faceted development from its conception at policy level through to its detailed enactment in specific locations.

Overviews at the beginning of chapters and summaries at the end are used to maintain continuity and to focus narrative. Orientation is also aided by the inclusion of visual icons at the start of Chapters 3-8. These are designed to remind the reader of the current position on the "map" that is Figure 1.3. A glossary of key terms is provided at the start of the thesis, along with a list of abbreviations and acronyms. Quotations of more than one sentence that are derived from textual sources such as books, published papers and relevant documents are indented within the thesis text. Quotations from the interviews, questionnaires and field notes that formed part of this enquiry are handled similarly, but are distinguished by the use of italics.

CHAPTER 2

METHODOLOGY AND METHODS

Overview of this chapter

This chapter explains the methodological foundations of the enquiry and describes the main methods used in the five parts of the thesis. Firstly the contemporary historical approach is considered, along with researcher values and beliefs. This leads to an examination of the epistemological and ontological underpinnings of the thesis. The constructivist methodology at the heart of the enquiry is then explained. The chapter goes on to give an overview of the methods employed to address the central research questions that drive and link each of the parts of the thesis. In doing so, the primary cognate areas and associated research questions within each chapter are mapped. Finally, there is summary of the overall strengths and limitations of the approach taken.

2.1 METHODOLOGICAL FOUNDATIONS

2.1.1 A contemporary historical approach

The five main parts of the thesis portrayed in Figure 1.3 are bound together logically and sequentially within an enquiry that is concerned to build, through interpretation, an explanation of a phenomenon in contemporary nursing history. Before considering the nature of interpretation and explanation in more depth, it is firstly useful to highlight the use of the phrase "contemporary nursing history" as opposed to "contemporary nursing". Ostensibly this may seem an unusual way of thinking about a phenomenon that started relatively recently and has continued to develop in Scotland through to the present time of writing. In terms of history, this is history of the very recent past. Moreover the writer has been actively involved in researching the phenomenon as it has unfolded and, as an evaluator between 2001 and 2003, had some influence on the development of the phenomenon itself.

Justification for adopting an overtly historical research approach rests on three main points. Firstly, study of events that have very recently become the past is recognised as legitimate contemporary history. If Carr (1987)'s view that "history is an unending dialogue between the present and the past" is accepted alongside Dewey's dictum that "all history is necessarily written from the standpoint of the present" (cited in Newall 2005), then close temporal and personal proximity to the subject matter can be seen as valuable in informing this dialogue. This type of engagement also brings its own challenges, however, as Bennett (2004) points out. Secondly the time period covered by the study has inherent meaning and significance in that it runs from the "birth" of the development in Scotland through to the 2006 Review of Nursing in the Community which, arguably, serves its death notice. Finally, the discipline of modern historical research emphasises the need for reflexivity so that the researcher gives time to conscious consideration and acknowledgement of the nature of personal involvement with the subject matter being studied (Carr 1987).

Within this context, the thesis aspires to achieve Rafferty's (1997) goals of "writing, researching and reflexivity in nursing history" (p.5). This approach recognises explicitly "how historiography in nursing, the method and interpretive approach to data analysis, has been shaped by the politics and values of its authors" and that it is "as crucial to understand the context in which an account is produced as its content" (Rafferty 1997; p.9).

Accordingly it is acknowledged that the explanation offered herein is one situated in time and place, and is the result of viewing the world through a particular personal lens. As Holmes (1997) points out, "the historian exercises a personal judgement as to what will count as

relevant data" and "what counts as relevant data is historically and culturally embedded" (p.31). With this in mind, and in the interests of reflexivity and rigor, it is useful to try to make my personal position more explicit.

2.1.2 Personal position driving this approach

As a health service and nursing researcher for the past 10 years, I have accumulated extensive experience in evaluating different aspects of community nursing. This work reflects a personal and professional commitment to development of the theory and practice of nursing within the ambit of health care research and service delivery. This particular lens recognises the potential importance of research-based evidence but also the importance of contextual and social influences on practice, and the art involved in applied nursing action. Accordingly I concur strongly with Dingwall, Rafferty and Webster (1988)'s contention that the history of the development of nursing cannot be entirely understood from within the discipline.

This has undoubtedly influenced the selection of relevant data for the present study. For the thesis argues that in-depth understanding of the development of family health nursing can only be achieved through examination of relevant aspects of: wider health and social care policy; nursing and social science theory; and historical and cultural influences within the practice context.

Moreover I share Silverman's position (1993) that the context, nature and style of the researcher's engagement with the subject matter substantially influence data generation and processing. For example, the commissioned evaluation role brought with it particular tensions between getting close enough to the development's participants to understand experiences and attributed meanings while maintaining independent critical perspective. These are reflected on in greater depth within Annexes 1 and 2, and within Chapter 7 of this thesis. As importantly, the role of the evaluation itself within the development of family health nursing in Scotland is critically examined within Chapters 7 and 8. This is a key reflexive strategy within the thesis.

2.1.3 Epistemology

Underlying much of the foregoing section on personal reflexivity is a concern for the primary epistemological question: *how is it possible to know about the world (of family health nursing)?* The approach taken in this thesis is essentially *interpretive* in this regard in that it is underpinned by basic assumptions that characterise the interpretivist position on knowing within the social world. Snape and Spencer (2003) summarise these as:

- "the researcher and the social world impact on each other
- facts and values are not distinct and findings are inevitably influenced by the researcher's perspective and values, thus making it impossible to conduct objective, value free research, although the researcher can declare and be transparent about his or her assumptions
- the methods of the natural sciences are not appropriate because the social world is not governed by law-like regularities but is mediated through meaning and human agency; consequently the social researcher is concerned to explore and understand the social world using both the participant's and the researcher's understanding" (p. 17)

It is customary at this point to set up *positivism* as a polar opposite to interpretivism in order to tilt at the "straw man" of reason and realism who believes in control and the hegemony of the natural sciences. This will be resisted because I do not subscribe to absolute versions of either position. For example it seems true to say, as above, that the law-like regularities of natural science do not apply in the same absolute way within the social world, but it is important also to recognise that socially derived knowledge (such as theory about social behaviour, and the structures and processes associated with inequalities in health) can have high explanatory value and currency across contexts and cultures. This rejects an extreme *relativist* position often associated with interpretivism and constructivism which is found in Guba and Lincoln (1989)'s contention that: "phenomena can be understood only within the context within which they are studied; findings from one context cannot be generalised to another; neither problems nor their solutions can be generalised from one setting to another" (p. 45). While I believe that phenomena are *best* understood within context and that any generalisation should be cautious and be supported by explicit reasoning, it is difficult to endorse such a restrictive view on the transfer of ideas.

2.1.4 Ontology

Much of the above discussion pertains to the underlying primary ontological question: *what is the nature of the world and what can we know about it?* A similar Punch and Judy show is perpetuated in the literature between *relativism* and *realism*. Again Snape and Spencer (2003) summarise the key beliefs of relativism as:

- "reality is only knowable through socially constructed meanings
- there is no single shared social reality, only a series of alternative social constructions" (p. 16)

In contrast, they summarise the beliefs of realism as:

- "an external reality exists independent of our beliefs or understanding
- a clear distinction exists between beliefs about the world and the way the world is" (p. 16)

As White and Stancombe (2002) point out, much of the confusion here is about what kind of things might be held to exist independent of our understanding of them i.e. it depends what you are talking about. To me it seems difficult to deny that such things as the rocks, water and heather of the Highland landscape exist independently of our understanding and language. However their collective situated meaning when perceived is a matter of personal interpretation which will also be contextually and socially mediated. Similarly I believe that mental health problems exist as one of the more prevalent health issues in the Highland and Islands, but it is only our naming, framing and understandings of them in certain contexts (i.e. our dominant social, linguistic and cultural constructions) that bring them into existence as real within society.

Thus, again, an absolutist position on either side is rejected. Indeed, if pressed, I would admit to affinity with Hammersley (1992)'s *subtle realist* position where he states:

> "we can maintain a belief in the existence of phenomena independent of our knowledge claims about them…. without assuming that we can have unmediated contact with them and therefore that we can know with certainty whether our knowledge of them is valid or invalid" (p. 50).

Interestingly Schwandt (1994) notes how relativists like Lincoln and Guba (1985) are:

> "somewhat equivocal on this issue. They claim to be drawn to the position that all reality is created by mind, yet are willing to settle for a less radical view of 'constructed realities'. They hold that constructions are invented or created, yet those constructions are related to 'tangible entities' - events, persons, objects. If these tangible entities are not solely creations of mind, then they must be ontologically 'real'.

> The distinction they draw here seems to be one of a difference between experiential reality (constructions) and ontological reality (tangible entities)" (p. 134).

Accordingly it is difficult to escape the ironical conclusion that some of the differences between relativism and realism are more imaginary than real. Cromby and Nightingale (1999) provide astute summation:

> "The history of critical thought shows that both realism and relativism are typically deployed strategically. Writers ground their critiques in aspects of the world which they wish to make or remain real and, from this grounding, relativise aspects of what they want to question or deny. Which aspects of the world are to be relativised and which 'real-ised' is a choice typically shaped by moral, political or pragmatical precepts, not epistemology or ontology" (p.8).

Nevertheless I believe that reflexive examination of the epistemological and ontological assumptions underlying the thesis is necessary and useful. It is necessary because as Hammersley (1992) states "there is no escape from philosophical assumptions for researchers" (p. 43). Although I believe that nursing's insecurity as a relatively new intellectual discipline has led to a tendency for self-flagellation in this regard, awareness of assumptions is useful to guard against error (Hammersley 1992).

2.1.5 Constructivism, explanation building and the nature of truth

Having established that the thesis is grounded ontologically on the relativist side of subtle realism, and grounded epistemologically in interpretivism, it now remains to explain the study's methodology. The strongest onwards link in this regard is from interpretivism. Having made liberal use so far of the notion of building knowldege, and having mentioned the concept of constructivism in the passing, it is timely now to locate the study more firmly within what Denzin and Lincoln (1994) would term the "constructivist-interpretive paradigm" and explain the predominantly constructivist methodology that is employed within the thesis.

Firstly, as noted, the thesis is grounded in what Schwandt (1994) would call "everyday constructivist thinking" i.e. that the mind is active, forming abstractions and concepts so that we "do not find or discover knowledge so much as construct or make it" (p. 125). This lies at the heart of the attempt to construct an explanation of what family health nursing is considered to be, how it developed, and why it developed in the way that it did. I think that it is simplistic to believe that a set of pure, impartial facts exists out there which simply have to be vacuumed out from their sources and re-assembled, jigsaw-like, in order to re-complete the one essential, true picture of family health nursing development as it evolved between 1998-2006.

Rather the task in hand is to engage with and to try to understand individual and/or group constructions relevant to the enquiry (as found in studying the perceptions of nurses, other health professionals, patients, family members, members of the general public and a wide range of textual material). Through a process of interpreting this material, privileging some accounts more than others, and bringing personal accumulated knowledge to bear, a new interpretation and explanation will be created and proffered.

This is consistent with contemporary historical research approaches whereby the historian is seen to unavoidably apply his/her hierarchies of significance to the interpretation of patterns in apparently contingent events (Munslow 1997; 2001). Moreover it is also consistent with the constructivist methodology detailed in Guba and Lincoln (1989)'s landmark work entitled "Fourth generation evaluation". Schwandt (1994) helpfully draws together some of the properties of constructions that Guba and Lincoln posit within this book. These include:

- "Constructions are attempts to make sense of or to interpret experience, and most are self-sustaining and self-renewing.
- The nature or quality of a construction that can be held depends upon the range or scope of information available to a constructor, and the constructor's sophistication in dealing with that information
- Constructions are extensively shared, and some of those shared are disciplined constructions, that is collective and systematic attempts to come to common agreement about a state of affairs, for example, science
- Although all constructions must be considered meaningful, some are rightly labeled malconstruction because they are incomplete, simplistic, uninformed, internally inconsistent, or derived by an inadequate methodology" (p. 129)

Thus the goal for the thesis is to create the best possible explanation within the limits already detailed. Although I see myself as well placed in terms of range and scope of available information, I would recognise the potential value of other interpretations of the phenomenon under study. Tuchman (1981) cites a lion in one of Aesop's fables telling a man "there are many statues of men slaying lions, but if only the sculptors were lions there might be quite a different set of statues" (p. 19). Ultimately, within the constructivist paradigm, "truth is a matter of the best-informed and most sophisticated construction on which there is consensus at a given time" (Schwandt 1994; p. 128).

The juxtaposition of the last two quotations highlights an issue on which constructivism has tended to be weak: the issue of differential power. Put bluntly, the lions and their slayers might struggle to agree on truth by consensus. One academic response to this has been to let them get on with the fight and claim to be sculpting it impartially from the sidelines (or academic highground). Another, which is developed by Guba and Lincoln as the logical enactment of

their methodology in evaluation research, is to jump into the arena and persist in trying to broker concensus (what Pawson and Tilley (1997) satirise as the "ethnographer/ringmaster" role, p. 18).

The approach within this thesis is located somewhere between these positions. As stated before, a key strategy is a reflexive analysis of the role played by the commissioned evaluation in giving a version of the "truth" of what happened in terms of family health nursing development during 2001-2003 (i.e. acknowledgement and analysis of the part played when in the ring). However the author is now sculpting from the sidelines without claiming complete impartiality.

2.1.6 Trustworthiness of the enquiry

Consideration of how explanation is built and the nature of its truth lead naturally to the question of the trustworthiness of any enquiry that is primarily constructivist in design. In this regard, Lincoln and Guba (1985) propose a set of four criteria for summative evaluation of the trustworthiness. Although these have been criticised for paralleling positivist criteria (Schwandt 1994), they remain a potentially useful framework for the self-assessment of qualitative enquiry. They are *credibility* (paralleling internal validity)*; transferability* paralleling external validity); *dependability* (paralleling reliability); and *confirmability* (paralleling objectivity). These criteria will be used in the next section of this chapter which gives overview of the main methods used and related ethical considerations.

2.2 OVERVIEW OF MAIN METHODS

From the overview of design structure and content in Chapter 1.5, it may already be apparent to the reader that a range of research methods were employed at *micro* level within the thesis in order to build knowledge that would constitute a *macro* explanation. In order to argue for the ultimate *credibility* of this approach, it is necessary first to explain the methods used in each of the five parts of the thesis, before looking at them in combination. As alluded to in Chapter 1.5, particular details of methods are either presented in context at the start of each chapter (e.g. literature search strategies in Chapters 3 and 4), or are made available to the reader through reference to one of the published papers or Annexes (e.g. the questionnaires relating to Chapter 5 can be found in Annex 2, and the interview schedules relating to Chapter 8 can be found in Annex 3).

2.2.1 Methods used in Part 1: an overview of research methods, principles and processes

2.2.1.1 *Overview of Part 1 methods*

Table 2.1 provides overview of the main methods used in Part 1 to address the central question: *why develop family health nursing?*

Table 2.1: Overview of main methods used to address: *why develop family health nursing?*

Chapter	Primary cognate area	Associated questions	Main research methods and data sources
3	WHO Europe FHN concept	*What is it? What is it not?* *Where did it come from/what are its origins?* *How and why did it emerge?* *What were the political processes and influences involved in its evolution?* *What is it trying to achieve?* *What preparations were made for enactment of FHN in Europe?*	Analysis of relevant WHO publications; European nursing and primary health care policy and practice literature (*mainly from 1998 onwards*)
	North American Family Nursing	*What is it and what is its relationship to the FHN concept?*	Analysis of North American nursing literature (*mainly from 1990 onwards*)
	UK community nursing and primary care provision	*How does the FHN concept relate to established UK community nursing and primary care provision?*	Analysis of relevant UK nursing, medical and health services management literature (*mainly from 1990 onwards*)
4	Scottish health and social care policy	*What are the key trends that might help explain the emergence/adoption of the FHN concept in Scotland i.e. fit with policy?* *How was the FHN concept interpreted, operationally defined, and presented at SEHD level?* *What preparations were made for enactment of FHN in Scotland, and how were these understood nationally?*	Analysis of SEHD publications, other relevant policy, and critical reaction/analysis in published works *(mainly from 1997 onwards)*. Daley's thesis (2001) on the organisational challenge of the FHN concept.
	Remoteness and Rurality: the Highlands and Islands context	*What features of the remote and rural Highlands and Islands context are important influences on the organisation and delivery of primary health/social care services ?*	Analysis of relevant Scottish, UK and international literature on remote and rural healthcare and the importance of place (*mainly from 1995 onwards*)
	Community nursing care provision in the Highlands and Islands of Scotland	*What is the history and culture of community nursing in these regions?* *What recent trends are evident in community nursing development in these regions?* *What is the fit between the FHN concept and the Highland and Island community nursing context?*	Analysis of relevant Scottish and regional cultural history; relevant medical and nursing literature; relevant local "grey literature" where available (*mainly from the last 20 years, but also selected seminal texts)*

2.2.1.2 *The nature of texts*

As Table 2.1 shows, the enquiry in Part 1 spanned a range of primary cognate areas and involved a number of associated questions. It is also apparent that the analysis in this part of the thesis focused exclusively on textual material[2]. This is because, on a purely practical basis, textual material is the foundational data resource for any researcher seeking answers to Part 1's central and associated questions. Through such text the researcher can access (albeit in a limited way) representations of the FHN concept in Europe and Scotland, and relevant contextual literature. As Chapter 1.5 has indicated, direct access to key informants at education, practice and policy levels was possible in Parts 2 and 3 of the thesis.

The search for, and selection of, relevant textual material was driven by the questions associated with each primary cognate area. Subject specific search strategies are described in Chapters 3 and 4 but, in terms of principles and common processes, this typically started with a general thematic analysis screening texts in terms of their potential to answer particular questions e.g. what are the key documents that will give insight into *how and why the development emerged*? These were then classified as being of focal, related or contextual relevance.

Further general categorisation was applied relating to the purpose and nature of the text. These main categories and examples of texts of focal, related and contextual interest are given in Table 2.2. Not all of the categories are entirely mutually exclusive.

[2] Although in the course of the research I undertook contextual review of some videos, DVDs and a radio programme relating to family health nursing, the textual material analysed in this thesis almost exclusively comprised printed words on paper. For this reason the terms "text", "literature" and "document" are used synonymously in the thesis to refer to relevant English language books, reports, journal articles, published papers (e.g. web based), unpublished theses, and "grey literature" that has had limited circulation but is or has been available to health service professionals and/or the general public. Although research interviews in this study were audio taped then transcribed onto paper for further analysis, these are treated distinctly in the thesis and transcript code numbers are given when citing extracts from particular interviews.

Table 2.2 General categorization of texts by purpose and nature (example pertaining to *how and why did the development emerge in Europe*?)

Category	**Focal relevance**	**Related relevance**	**Contextual relevance**
Policy report	WHO (1998a) *HEALTH 21: the health for all policy framework for the WHO European Region*	WHO (1993a) *Health for all targets. The health policy for Europe.*	
Position paper/ promotional paper	WHO(2000a) EUR/OO/5019309/1300074 *The Family Health Nurse: Context, Conceptual Framework and Curriculum*	WHO (1998b) EUR/ICP/DLVR040101 *The WHO framework for development of general practice/family medicine in Europe*	
Report of a meeting	WHO (1999) EUR/ICP/DLVR 02 01 06 *Seventh Meeting of the Government Chief Nurses of the WHO European region*	Alexander, M., 1995. World Health Organisation, Europe and Nursing: the view from Glasgow Caledonian University. In*: Report of the Masterclass on Nursing and Europe*. Edinburgh: Scottish Office Department of Health	Pritchard, P (1995) *The European Union: structures, processes and opportunities for nursing* in Report of the Masterclass on Nursing and Europe Edinburgh: Scottish Office Department of Health
Textbook		Salvage, J and Heijnen, S (1997) *Nursing and Midwifery in Europe* in Nursing in Europe: a resource for better health (Salvage, J and Heijnen, S eds) Copenhagen: WHO Europe	Whyte, D (1997) *Explorations in Family Nursing* London: Routledge
Promotional journal article	Asvall, J., 1999. Good news for nurses and midwives. *Nursing Management,* 6 (6), pp. 37-38	Lipley, N and Scott, G (2000) Family fortunes *Nursing Standard* 14 (41) 13-14	Oulton, J (2002) The time is now for strong, sustained WHO nursing leadership *International Nursing Review* 49; 207-208
Text informed by a recognisable but minimally explained data collection, analysis and synthesis process	McHugh, M; Cotroneo, M (2000) Family Health Nurse Concept: what the literature offers Copenhagen: WHO Europe		
Text presenting detailed evidence of a systematic process of data collection, analysis and synthesis		Whyte, L (2000) *Community nursing and midwifery In Europe/analysis* Copenhagen: WHO Europe	Hennessy, D and Hicks, C (2003) The ideal attributes of Chief Nurses in Europe: a Delphi study *Journal of Advanced Nursing* 43 (5) 441 - 448

As Table 2.2 suggests, texts pertaining to many of the important questions about the development of the FHN concept in Europe varied in purpose and nature, However those of focal relevance tended to be aspirational, promotional papers. There was little research-based evidence, even of related relevance. Accordingly the enquiry had to work with texts of variable quality. This is not unusual. Historical enquiry, in particular, deals with the art of the possible and the available, when building knowledge (Rafferty 1996).

2.2.1.3 *Processes and principles of analyses*

Analyses of the textual material were driven by the central and associated questions outlined in Table 2.1. Many of the texts informed enquiry as contextual, background knowledge. Where this was the case the main emergent themes were noted and the material kept for future reference. Where texts proved of related or focal relevance, they were scrutinised using a process of qualitative content analysis of documentation similar to that outlined in Bryman (2001). Relevant emergent themes were mapped on to large matrix sheets. One matrix sheet was maintained and updated for each associated question. The relevant texts formed the demarcations on one axis of the matrix, while the other axis facilitated listing of emergent themes, reference details and key quotations from each text (within-case analysis). In turn this facilitated cross-case analysis (e.g. comparison of two texts' perspectives on a particular issue). This is consistent with specific techniques recommended by Miles and Huberman (1994).

A detailed example of utilising these techniques with interview material can be found in Annex 2, Part 3.2.2. The matrix sheets were always works-in-progress and were necessarily messy and complex. For example, themes from one text sometimes generated new associated questions, or texts were of relevance to more than one question, meaning that they appeared on several sheets. However the net effect was to offer a reasonable means of marshalling the meaning extracted from wide-ranging, iterative enquiry.

Through this process, a few texts emerged as being of key importance. These were studied in more detail through a narrative analysis technique that can be characterized as "holistic – content" (Lieblich, Tuval-Mashiach and Zilber 1998). Here "the researcher analyses the meaning of the part in the light of content that emerges from the rest of the narrative or in the context of the story in its entirety" (p. 13). This was very useful for analysing the way family health nursing was being represented in key texts as it developed in temporal and conceptual terms. Examples of this type of analysis occur in Chapter 3 (in relation to Asvall 1999) and Chapter 4 (in relation to Proctor 2000), where sections of key texts are quoted. These sections fulfill a narrative function in themselves but are followed by interpretation of the text's internal validity (*credibility*) and/or its role within the emergent story of family health nursing.

Finally, the principle of "template analysis" (Miller and Crabtree 1992) was used in this part of the thesis (and extensively in Part 3) as a secondary level analytic approach. In this way Walker and Avant (1995)'s concept analysis framework was applied as an analytic template that helped to summarise and give overview of the FHN concept. Wright and Leahey (1994)'s genogram template was also used to similar effect in Chapter 3.

In summary, two main analytic techniques were deployed for primary analysis of texts within this part of the thesis, as appropriate to the degree of relevance of each text to the question. One main approach was taken to secondary analysis.

2.2.1.4 *Processes and principles of synthesis*

It was necessary to take into account the variable purpose, nature and quality of texts when synthesizing answers to questions. One of the basic techniques to enhance the *credibility* of this part of the study was the use of triangulation of textual data sources. This is seen within Chapter 3 where two key official WHO documents contradicted each other in relation to the date of the first public naming of the family health nursing concept. Accordingly a search began to find more reliable points of textual reference that could be used systematically in various combinations to locate a definitive position in regard to this particular event. This exemplifies a basic form of triangulation for confirmation (Begley 1996) that is one of the hallmarks of traditional historical research (Marwick 1970). Triangulation for confirmation is consistent with the constructivist paradigm here in that it relates to a particular event.

Interestingly, resolution in the above example was only obtained in Part 3 of the thesis when comparing the accounts of key informants with each other and with the textual sources. This exemplifies triangulation of multiple data sources which is a key strategy within this thesis, but is used primarily for purposes of completeness (Breitmeyer, Ayres and Kanfl 1993). The latter strategy will be explained in more detail in relation to Parts 2 and 3. Nevertheless this example has also served to highlight some of the difficulties experienced in synthesising the limited representations of family health nursing that were available through text alone. This is one of the limitations of this part of the study. As has been indicated, however, this part of the study prepares the ground for more detailed enquiry.

2.2.1.5 *Ethical aspects*

As indicated in Footnote 2, the textual material analysed was either publicly available or was "grey literature" that had limited circulation to relevant professional groups, but was not of a confidential nature.

2.2.2 Methods used in Part 2: an overview of research methods, principles and processes

2.2.2.1 *Overview of Part 2 methods*

Table 2.3 provides overview of the main methods used in Part 2 to address the central question: *How did family health nursing develop in remote and rural Scotland between 2001 and 2004?*

Table 2.3: Overview of main methods used to address: *how did family health nursing develop in remote and rural Scotland between 2001 and 2004?*

Chapter	Primary cognate area	Associated questions	Main research methods and data sources
5	Development and delivery of the FHN educational programme 2001-2002	*What were the key characteristics of the programme? How did these differ from other relevant programmes? What were its strengths and weaknesses?*	Multiplex empirical evaluation including interviews, questionnaires, observation and documentary analysis (as detailed in Annexes 1 and 2). Analysis of relevant journal articles.
	Operation and impact of the FHN role in practice during 2002	*How did the role develop in practice? How was it perceived by professional colleagues, patients and the local public?*	Multiplex empirical evaluation including interviews, questionnaires, observation and documentary analysis (as detailed in Annexes 1 and 2). Analysis of relevant journal articles.
	National development of the FHN initiative beyond Phase 1.	*What was the relationship between the commissioned evaluation study's findings and the plan for a Phase 2 of FHN development?*	Analysis of relevant SEHD literature, conference proceedings and press publications.
	Development of the family health nursing role in practice 2003-2004	*How did the role develop in practice and why? How was it perceived by professional colleagues?*	Questionnaire and telephone interview based follow-up study, focusing on professionals' perceptions. Related further questionnaire study, focusing on Family Health Practice Development Facilitators' perceptions.
6	The development of family health nursing in Scotland 2001-2004	*What were the limitations of the three empirical studies?* *Taken together, what has been learned from these studies?*	Reflexive analysis on the strengths and weaknesses of the studies. Synthesis of findings into a set of primary understandings

2.2.2.2 *Overview of methods used in the commissioned evaluation study 2001-2002*

As Table 2.3 shows, the commissioned study undertaken between 2001-2002 was a multiplex empirical evaluation using a mixture of methods. Full details of these are available in Annexes 2 and 3. As the thesis is concerned particularly with practice, details of the main methods used to study practice are included in Chapter 5, along with relevant findings. As the thesis considers the educational programme primarily in terms of its impact on the FHNs, only a summary of the main findings from the educational evaluation is given in Chapter 5.

At this stage it is useful to give overview of the study's design and methods. The evaluation had the following six objectives:

1 To evaluate the education programme curriculum and consider how well it fits into the Scottish context.

2 To evaluate the learning experience and preparation of FHNs and the support provided to them in placements, focusing in particular on the role of mentors and differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course.

3 To compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN.

4 To explore the operation of the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites.

5 To identify relevant stakeholders' perceptions of the FHN model.

6 To draw out implications from the study's findings for the future provision of education for FHNs and for the extension of service provision to other areas of Scotland, including urban areas.

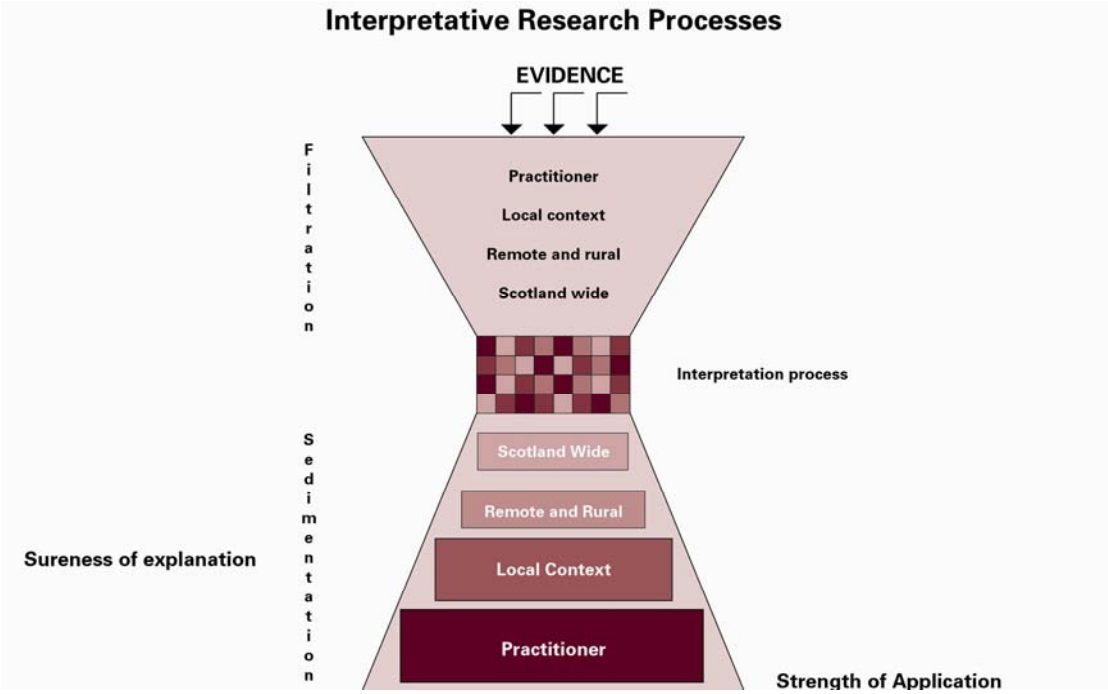
In addressing the objectives, the evaluation design sought to sustain research interpretations at four levels of analysis:

1. Application to the education and practice of community-based nurses, Health Visitors and midwives across Scotland.
2. Relevance to remote and rural health care provision in Scotland

3. Application and relevance to the particular local contexts where the Family Health Nurses had been working
4. Application and relevance to direct face to face experience of education and in practice.

Figure 2.1 presents a model of the interpretative research processes which were followed in order to articulate explanations.

Figure 2.1: Interpretative research processes used in the evaluation study



The most useful parts of two key approaches to evaluation research (Pawson and Tilley 1997; Guba and Lincoln 1989) were combined in order to make this possible. Evaluation of the educational preparation of the FHNs entailed a systematic collection of evidence pertaining to comparative educational processes, participant experiences and performance. As Table 2.3 indicates, methods included interviews, questionnaires, observation and documentary analysis

In evaluating practice the overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot. This approach adapted Pawson and Tilley (1997)'s realistic evaluation framework in order to clarify what FHN practice was in these settings, and then clarify how, and to what extent, the FHN role worked under various circumstances. Again, interviews, questionnaires, observation and documentary analysis were all utilised. The limitations of the evaluation study are discussed in terms of remit and outcomes in Chapter 6 and in terms of design and methods in Annex 2.

2.2.2.3 *Overview of methods used to follow up FHN practice 2003-2004*

Professionals' perspectives on the development of family health nursing in remote and rural areas were followed up in 2004. This study principally used survey methods. The survey was based around an enhanced version of a questionnaire that had been used on the evaluation study. Eight telephone interviews with selected FHNs were also undertaken. Details of data collection and analysis methods are included in Chapter 5, along with the main findings.

2.2.2.4 *Overview of methods used to study the perceptions of the Family Health Practice Development Facilitators*

As this was a questionnaire study of three people, Chapter 5 presents a summary of the main findings only and Chapter 6 discusses limitations. Full details of the study are given in the relevant published paper (Macduff 2005).

2.2.2.5 *Synthesis and trustworthiness*

Synthesis of data within, and across, these three linked studies has principally been based on triangulation of data sources. In this way, evidence from texts, FHNs, other professional colleagues, patients, family members and the general public have all been used in various combinations to examine aspects of the same phenomenon. This use of multiple sources is a key strategy in historical methodology (Lusk 1997) and exemplifies what Breitmayer, Ayres and Kanfl (1993) describe as triangulation for completeness. Triangulation of methods (e.g. in-depth interviews and survey questionnaires) has also been used towards this end in the Part 2 studies.

Credibility can be enhanced by combining these various ways of looking at dimensions of the phenomenon so that a more complete understanding is achieved (Denzin 1989). It is necessary however to recognise Sandelowski (1995)'s objection that this eclecticism contrasts with triangulation's origins in trigonometry/navigation and its related value as a metaphor. In the present thesis, the multiple triangulation strategies might be pictured more as the building of multiple triangles which can be combined in three dimensions as a strong, yet flexible, methodological scaffolding from which to view various aspects of the phenomenon and construct a separate explanation.

This is a view that anticipates divergence as well as convergence around aspects of the phenomenon. One of the key practical questions in a multi-data source, multi-method enquiry is: *what accounts do you privilege (and why)?* Or put in the context of this study, *how do you weigh the local Health Visitor's account of family health nursing against the account of the local Family Health Nurse?* Constructivism is helpful in several ways here. Firstly accounts are

simply different, stemming from different contexts and perspectives, and do not necessarily have to be weighed in opposition. All are meaningful in their own terms. However some contrast and comparison is essential in order to ascertain if accounts are incomplete, simplistic, uninformed, internally inconsistent, or derived by an inadequate methodology (see Schwandt's previous summary of Guba and Lincoln's ideas).

In practice the researcher has to design-in a balance of perspectives and be reflexive during the conduct of the study. Thus when studying practice within FHN sites for the evaluation it seemed reasonable to aggregate quantitative questionnaire data from a number of informants, in the knowledge that this was tempered by insights from qualitative information within individual questionnaires, individual interviews, study of documentation and limited observation of practice. In this way such aggregation was only one of a number of methods used to build interpretation (see Figure 5.2 for a diagramatic representation of this). This addresses Silverman (1993)'s concerns about method triangulation as an indicator of validity, in that it respects the importance of context and recognises that each method produces situated accounts that can be used to make better sense of the other (e.g. to compare FHNs' public versions of practice in promotional journal articles and their private versions elicited during interviews).

In this respect it is acknowledged that the follow-up study of FHN practice conducted during 2004 (see Chapter 5) was weaker in that it was very much more reliant on questionnaire survey data representing exclusively professional perspectives. Although this was mitigated to some extent by selective follow-up telephone interviews with FHNs, and there was some pre-existing knowledge of context from previous site visits, I was often aware of the limitations when trying to interpret questionnaire data and build better informed interpretations.

The three studies were linked so that cumulative explanation could be built. The typology of FHN practice that was constructed from the study of individual FHN sites during the evaluation might be termed *micro-theory* or, in Lincoln and Guba (1985)'s term, a "working hypothesis". Such a construction allows the reader to make their own judgement as to the potential *transferability* of certain features. The follow-up study specifically invited FHNs and their colleagues to assess the typology in terms of its relevance to their own site (see Chapter 5).

Lincoln and Guba (1985) recommend that *dependability* and *confirmability* are enhanced through the development of an audit trail during the process of enquiry. This would include recording decisions taken, process notes, records of interviews and examples of analysis. In this regard Annex 2 is substantive. For each of the methods used in the evaluation study there is textual commentary explaining reasons for use, contextual information (e.g. explanatory

letters), examples of the data collection tools, analyses carried out, and reflections on the strengths and weaknesses of each approach.

2.2.2.6 *Ethical considerations*

Annex 2 also gives details of the process of obtaining ethical approval for the evaluation from four NHS Local Research Ethics Committees. One of the main considerations in a study of this type was to avoid identifying individuals in the reporting of the study. Where individuals were potentially identifiable (e.g. in the two in depth case studies of practice in Annex 1), their prior consent was sought. The other two linked studies also received approval from the relevant NHS Local Research Ethics Committees and from the School of Nursing and Midwifery Ethics Review Panel at the Robert Gordon University.

2.2.3 Methods used in Part 3: an overview of research methods, principles and processes

2.2.3.1 *Overview of Part 3 methods*

Table 2.4 provides overview of the main methods used in Part 3 to address the central question: *Why did family health nursing develop in the way that it did in Scotland*?

Table 2.4: Overview of main methods used to address: *why did family health nursing develop in the way that it did in Scotland?*

Chapter	Primary cognate area	Associated questions	Main research methods and data sources
7	Role development in nursing	*What do we know about role development that helps explain the way the FHN concept was enacted as a role in practice in Scotland?*	Analysis of relevant UK nursing literature but also international perspectives (*mainly from 1990 onwards*)
	The nursing process, nursing models, and nursing theory	*Can previous experiences of implementing the nursing process and nursing models help explain the way the FHN concept was enacted as a role in practice in Scotland?* *How can nursing theory inform explanation building?*	Analysis of relevant international nursing literature (*from 1980 onwards*)
	Community nursing: issues of identity, culture, differential power, and place	*What is known about the culture and context of community nursing that might help explain enactment of the FHN concept at local PHCT sites?*	Analysis of relevant UK nursing literature, but also some international health and social care perspectives (*mainly from 1990 onwards*). Limited review of literature on social geography and place.
8	Family health nursing as a policy initiative in Europe and in Scotland	*Where did it come from/what were its origins?* *Why did it emerge and what were the political processes and influences involved in its evolution?* *What was it trying to achieve?* *Why did it develop in the way that it did in Scotland?*	Empirical research interviews with four key informants who had detailed knowledge of policy formulation and enactment processes. Comparative analysis of the views of key informants with the understandings derived from literature (Part 1) and empirical research (Part 2)
	Policy analysis	*What do we know about policy analysis that helps explain the formulation and advancement of policy relating to family health nursing in Europe and Scotland?*	Analysis of international policy analysis literature covering public policy, healthcare policy and nursing policy. Particular focus on relevant UK perspectives (*mainly from 1990 onwards*)
	Policy implementation/ enactment processes	*Can previous research into policy implementation help explain the processes and dynamics of FHN policy enactment in Scotland (at both macro and micro levels)?*	Analysis of relevant health and social care implementation and evaluation literature (*mainly from 1990 onwards*)

2.2.3.2 *Methods used in Chapter 7*

As Table 2.4 shows, the research process undertaken in Chapter 7 primarily involved analysis of nursing literature that might inform explanation building. The search for, and selection of, relevant textual material used similar principles and processes to those described for Part 1. However the textual material of relevance to this part of the study was typically very different in purpose and nature. Textbooks and peer-reviewed journal articles predominated. Although the primary cognate area and associated questions drove this search for relevant theoretical perspectives, some other criteria were important in determining those that were selected. Specifically I was looking for credible research that had:

- used broadly comparable methodology
- built understandings that were extensively informed by practitioner perspectives
- ideally involved longitudinal study
- attempted to link theory and practice

Analysis of the selected material was less involved than the procedures described for Part 1. The key technique was the application of this new material (e.g. the selected typologies in Chapter 7) as analytic templates to enhance understandings of family health nursing. This involved processes of extraction, comparison, differentiation, interpretation, integration and illustration. In this way, the explanation of family health nursing practice at the end of Chapter 7 was built.

2.2.3.3 *Methods used in Chapter 8*

Explanation of the development's policy dimensions was considerably enhanced by the interviews with four key informants undertaken in 2005. Full details of the methods used for these interviews are given in Annex 3. However it is important to point out that the participants agreed to the interviews being "on the record", in the sense that material from them could be specifically attributed at an individual level. The rationale for this approach is fully explained and discussed in Annex 3, along with related ethical considerations.

These interviews were part of another example of method triangulation within the study, in that interpretations of relevant texts relating to the WHO Europe concept were put to some of those involved in authoring them. This combination of methods yielded greater depth of insight into the phenomenon, its public and private accounts, and exemplified what Rafferty (1997) describes as "triangulation in the multiple realities of historical retrieval" (p. 7).

This cumulative building of knowledge was then progressed by further application of relevant theoretical perspectives on policy analysis and policy implementation. As Table 2.4 indicates, this firstly involved extensive review within nursing and more generally within public policy literature. Although the primary cognate area and associated questions drove this search, some other criteria were important in determining the theoretical frameworks that were selected. Specifically I was looking for credible research-based frameworks that:

- focused on the dynamics of policy formulation and advancement
- had broad cultural fit to the world of UK nursing policy
- related to some of the emergent themes within this PhD study

This led to the selection of two models which were again applied as analytic templates (see Annex 3). Again this involved processes of extraction, comparison, differentiation, interpretation, integration and illustration. Through these processes it was possible to finalise Part 3's explanation building in the form of the synoptic story and the new theoretical model of family health nursing development. This model can be seen as "mid-range theory" (Merton 1968) that identifies and relates key factors and processes.

2.2.4 Methods used in Part 4: an overview of research methods, principles and processes

Table 2.5 : Overview of main methods used to address: *what does this mean in terms of the development's influence and implications?*

Chapter	Primary cognate area	Associated questions	Main research methods and data sources
9	WHO Europe and the European context since 2001	*What is known of the development of family health nursing in other European countries, and how does this compare with Scotland?*	Analysis of most recent WHO Europe publications; journal articles; conference proceedings (*from 2001 onwards*). Review of relevant recent European nursing journal publications and books.
	UK health and social care policy and practice (1998 onwards, but mostly since 2001)	*What is the nature of the contemporary UK policy context and how is this influencing practice? How does family health nursing fit with this picture?*	Analysis of relevant recent UK health and social care policy literature and research into practice (*mostly from 2001 onwards*). Particular focus on recent developments in UK community nursing policy and practice.
	Scottish health and social care policy and practice since 2001	*What is the nature of the contemporary Scottish policy context and how is this influencing practice? What is the place of family health nursing within this picture? What is the future for/legacy from family health nursing in Scotland?*	Analysis of relevant recent Scottish health and social care policy literature and research into practice (*from 2001 onwards*). Particular focus on recent developments in Scottish community nursing policy and practice.

As Table 2.5 indicates, the research in Part 4 mainly involved review of contingent developments between 2001 and 2006 in order to further explanation building and to gauge influence and implications. Literature search, selection and analysis procedures were broadly similar to those undertaken in Phase 1. Policy literature was predominant.

Processes of extraction, comparison, differentiation, interpretation and integration were again deployed extensively in this part of the study. Template analysis was again a key strategy and this culminated with application of the new "MAPPED" model to analyse the antecedents and outcomes of the Review of Nursing in the Community 2006.

2.2.5 Methods used in Part 5: an overview of research methods, principles and processes

Table 2.6 : Overview of main methods used to address: *what significance has the resultant analysis for understandings of nursing and health care theory, practice, education, policy, and research?*

Chapter	Primary cognate area	Associated questions	Main research methods and data sources
10	Nursing and primary health and social care	*How can this new knowledge be used? What is the original contribution of the thesis?*	Reflexive analysis and synthesis of main findings of the thesis. Consideration of relationships with relevant theory, practice, education, policy, and research.

Reflexive analysis and synthesis were the methods used to achieve conspectus and conclude the thesis.

2.3 SUMMARY OF METHODOLOGY, METHODS, STRENGTHS AND LIMITATIONS

The preceding section makes clear the range of methods that were used in order to address the five research questions and their many component parts. The strength of this approach relates to its ability to examine the many dimensions of the family health nursing development from a number of different angles. As Chapter 1.1 makes clear, the enquiry has a broad and ambitious ambit. The combination of methods enhances the completeness of the research in terms of its breadth and depth. Moreover, the design of three related empirical studies facilitates longitudinal examination of the phenomenon so that cumulative understandings can be built and theory generated.

These methods are bound together in the methodology of constructivism. This provides a theoretical foundation that can support a structure made of many different materials and made with many different skills. By considering processes of synthesis and criteria for trustworthiness, this chapter has explained the "methodological mortar" that binds these elements together.

Nevertheless the ambit of the study and the approach also bring limitations. The design is complex and the combination of methods is relatively eclectic. Its scope tends to privilege knowledge from some actors (professionals) more than others (patients and families). Moreover it examines some time periods in more depth than others.

Other limitations for a thesis of this sort relate to the dangers of retrospective wisdom and the requirements of format. In summarizing methods there is inevitably an extent to which the messy lived experience of research is tidied up. This masks the iterative nature of the research process, and the way that serendipity can lead to breakthroughs or blind alleys. While recognising the importance of criteria for trustworthiness, it is also important, in the re-telling, to avoid over-zealous perpetuation of what Mitroff (1974) describes as the "scientific fairy tale", with its relentless linearity.

Indeed, in concluding this chapter, it is useful to linger longer on the idea of how things actually happen. For this thesis endorses Holmes (1997)'s rejection of a "mechanical model of history" which involves "spelling out step-by-step the precise causal mechanisms which give rise to particular components in historical events" (p.35). Rather it endorses Guba and Lincoln (1989)'s notion of *mutual simultaneous shaping* where a number of contingent factors typically prefigure and concurrently influence any given action or outcome. Thus the task of the historical researcher is to try to identify the most influential factors and gauge their mode of action and sphere of influence.

No less importantly, a final task for the historical researcher is to try to tell a good story. As Hewitt (1997) points out, “the historian bridges the restrictive standards of scientific research and the artistic standards of narration” (p. 19). The story now begins by turning to WHO Europe in order to examine: the nature of the FHN concept itself; why it emerged; what it was trying to achieve; and what the prospects were for this particular venture. In short, why develop family health nursing?

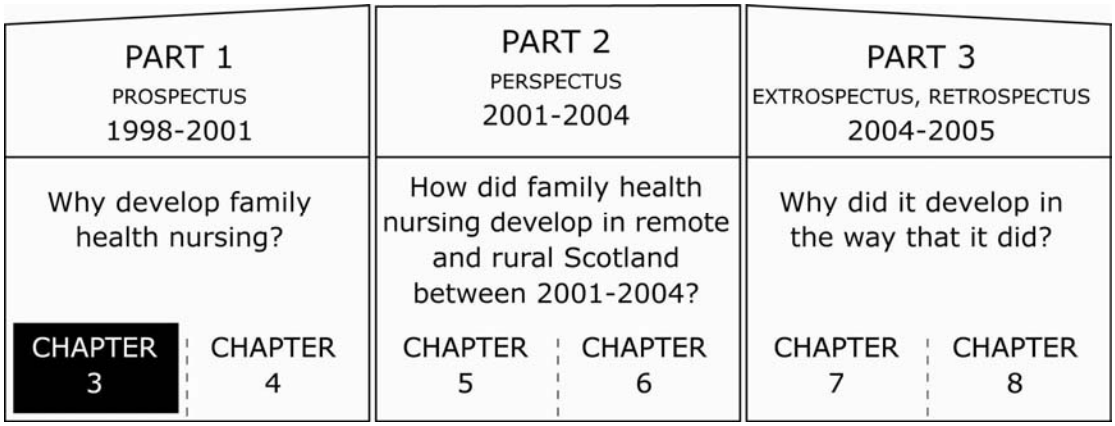
PART 1

PROSPECTUS

An analysis of the proposed family health nursing venture's emergence in Europe and Scotland between 1998 and 2001, as seen through the lens of documentary evidence.

"Anticipation forward points the view"

"The Cotter's Saturday night", Robert Burns (1786)



CHAPTER 3

THE FAMILY HEALTH NURSE CONCEPT: FROM COPENHAGEN TO CALTON HILL

Overview of this chapter

This chapter primarily addresses the question: why develop family health nursing in Europe? Following a description of the particular research methods used within this chapter, the thesis embarks on the quest to understand the nature, origins, contextual dynamics and aspirations of the Family Health Nurse concept as promulgated by WHO Europe. This journey starts with the idea's birth announcement in 1998 in Copenhagen, then travels back in time to Vienna and Alma Ata in order to try to trace its conception and process of gestation within the policy context. Four critical questions emerge from this enquiry and these are systematically addressed within subsequent subsections of the chapter. This process includes consideration of: nursing's influence at European policy level; the "generalist" and the "Health for All Nurse"; European community nursing during the 1990's; and in-depth analysis of the Family Health Nurse concept itself.

This historical, document-based, approach to analysis of the FHN concept is then augmented by linguistic and genealogical approaches. The latter process involves a brief, tangential departure to explore the concept of family nursing as promulgated in North America. Returning to Europe, the enquiry then examines WHO planning for role enactment of the Family Health Nurse concept. Within this context, the chapter concludes by considering the nature and scope of UK community nursing in the 1990's and the possible relevance that family health nursing might have. In this way the chapter's journey ends on the steps of the Scottish Executive Health Department at Calton Hill, Edinburgh.

3.1 RESEARCH METHODS

The journey outlined above is, like much historical enquiry, primarily an act of the author's imagination. Travel developed between the fixed navigational points provided by dates and places of key events. As described in Chapter 2, knowledge of these key events was gleaned primarily through related textual sources.

Given the nature of its subject matter, the chapter is consequently very dependent on WHO literature as the basis from which key interpretations are made. In this regard repeated efforts were made during the study to obtain the most relevant, up to date, WHO documentation via the WHO media office and the WHO Europe website (http://www.euro.who.int/InformationSources/Publications/20010827_1). There is also a substantial amount of WHO Europe "grey literature" relating to individual projects such as the FHN pilot. This often does not get formally published but is distributed to interested parties as required.

In order to study interpretations of the WHO concept within nursing and primary care based literature, the primary strategy was to search the following electronic databases using the search terms "family health nurse": CINAHL, MEDLINE, OVID full text, Nursing Collection, and British Nursing Index. This search for journal articles was carried out initially and repeated regularly throughout the duration of the thesis. Unsurprisingly initial searching yielded little of direct relevance, but showed that the term had been occasionally used by family health nurse practitioners in North America, especially in publications in the 1980's. What is perhaps more surprising, and significant, is that nearly 6 years after the concept was launched (mid 2004), the most productive database (OVID full text) yielded fewer than twenty citations directly relating to the WHO FHN concept. Accordingly the search terms "community nursing"[3] and "family nursing" were also applied in combination within these databases in order to explore potential relevance. This yielded a large amount of citations, but the relevance of material, as evidenced by abstracts and/or full text, proved very mixed.

In this regard it is important to note that the thesis consciously considers "family nursing" as it may be variously understood in Europe, North America, Australia and New Zealand. It is acknowledged that this excludes insights from other cultures where different family nursing models have been developed, such as Thailand and other South East Asian countries. Nevertheless, in order to make the scope of the thesis manageable, it was necessary at an early stage to assess and prioritise the potential relevance of particular family nursing models to the analysis of a very particular Scottish development. While review of the primary journal

[3] Please see the glossary of key concepts for an operational definition of this broad term.

literature suggests that there is scope for an international, cross-cultural, comparative study of family nursing models, this is beyond the scope of the present thesis.

A similar journal article searching strategy was employed less regularly with a number of other potentially relevant electronic databases i.e. ASSIA, ASLIB, IBSS, Social Science Citation Index, ZETOC, and COCHRANE. Moreover there was regular scrutiny of the nursing press and the COPAC university libraries system to learn of, and access, relevant policy and research reports from around Europe and the UK. A similar strategy was implemented in regard to relevant published books. Those which informed the content of this chapter typically fell into one of three categories:

1) Published textbooks on European nursing from 1990 onwards (only 2 of much relevance found)
2) Published textbooks on family nursing (predominantly North American literature which yielded over twelve relevant texts since 1990)
3) Published textbooks on community nursing and primary care in the UK from 1990 onwards (large number of texts found, most of which contained some material of relevance to community nursing context/family nursing ideas)

These primary, systematic literature search strategies engendered secondary activity whereby promising cited references were pursued. Moreover, such searching was supplemented by a myriad of chance encounters with potentially relevant material. This often happened when involved in other, ostensibly unrelated, nursing/health service research activities.

3.2 THE POLICY CONTEXT

The World Health Organisation is a United Nations specialised agency which focuses on public health issues from an international perspective. In September 1998, at its headquarters building in Copenhagen, the WHO Regional Committee for Europe approved HEALTH21: the health for all policy framework for the WHO European Region (WHO 1998a). This set out 21 targets intended to provide a common framework for action that would guide the health policies and strategies of each of the 51 WHO European member states at the time. The target subject areas are summarised in Table 3.1.

Table 3.1: HEALTH 21 target subject areas

1 Solidarity for health in the European Union	12 Reducing harm from alcohol, drugs and tobacco
2 Equity in health	13 Settings for health
3 Healthy start in life	14 Multisectoral responsibility for health
4 Health of young people	15 An integrated health sector
5 Healthy ageing	16 Managing for quality of care
6 Improving mental health	17 Funding health services and allocating resources
7 Reducing communicable diseases	18 Developing human resources for health
8 Reducing non-communicable diseases	19 Research and knowledge for health
9 Reducing injury from violence and accidents	20 Mobilising partners for health
10 A healthy and safe living environment	21 Policies and strategies for health for all
11 Healthier living	

Within the document the family is identified as the single most important unit in society that needs nurturing and support to ensure its healthy growth and development. Within this context, Target 15 specifies that by 2010 people in the region should have much better access to family and community orientated primary health care, supported by a flexible and responsive hospital system. Moreover, within the context of Target 18, the Family Health Nurse and Family Physician are singled out as the key primary care professionals who will take the policy forward within a multi-disciplinary team approach.

The full definition of the Family Health Nurse which is cited in the HEALTH 21 document (see Chapter 1.2) is preceded by the following sentence: "A well trained family health nurse, (as recommended by the 1988 Vienna Conference on Nursing), is another key PHC professional who can make a very substantial contribution to health promotion and disease prevention, besides being a care giver" (WHO Europe 1998a; p. 139). This is ostensibly very significant in that the origins of the concept are being specifically traced to a nursing conference a decade earlier.

On closer scrutiny of the Recommendations from the Vienna Conference (WHO 1989), however, there is no mention at all of a "family health nurse". This is curious and begs a number of fundamental questions about the concept, the time and nature of its conception, and the context of its gestation. In order to start to investigate these questions it is useful to map out the key European health policy developments which form the context for enquiry. These are presented in Table 3.2.

Table 3.2: Key policy developments related to the origins of the FHN concept

1978	WHO Alma-Ata Declaration puts primary health care at the centre of global strategy. Followed in 1979 by launch of "Health for All by the year 2000" strategy
1984	Member states of the WHO European Region adopt 38 targets for health for all
1988	The first WHO European Conference on Nursing is held in **Vienna** and all member states of the European Region are represented. Outcome is the Vienna Declaration on Nursing in Support of the European Targets for Health for All. The recommendations include the restructuring of all basic nurse education programmes to produce generalist nurses able to function in both hospital and community.
1993	WHO re-names the generalist nurse as the "Health for All Nurse"
1998	In **Copenhagen**, WHO European Region launches its HEALTH 21 strategy which is an evolution and refinement of the previous European Region Health for All targets. Includes the naming of a new concept called the "Family Health Nurse".
2000	The second WHO European Conference on Nursing is held in **Munich**. Ministers from 49 member states sign the Munich Declaration. This urges relevant authorities in WHO European Region to strengthen nursing and midwifery by taking a number of key measures. These include: "seeking opportunities to establish and support family-focused community nursing and midwifery programmes and services, including, where appropriate, the Family Health Nurse"

Table 3.2 is useful for a number of reasons. Firstly, as indicated by the bold lettering, it highlights two decade-cycles of relevant policy development. The first, between 1978 and 1988, represents the time taken for European nursing as a body to formalise a response to Health for All. The second, between 1988 and 1998, represents a period in which the "generalist nurse" changes to the "Health for All Nurse" and eventually gives way to the "Family Health Nurse". It is important to recognise that the latter development is synchronous and integrated within new, wider WHO European Regional health strategy (i.e. HEALTH 21). Moreover the second European Conference on Nursing follows on within a relatively short period of time.

Secondly, Table 3.2 facilitates identification of four key critical questions that require to be asked in relation to the origins of the family health nurse concept. These are:

1. What is the nature of European nursing representation at European policy level and what are the key processes linking it to member states and thence to community nursing practice?

2. Why did the “generalist nurse” concept give way to the “Health for All Nurse”, and to what extent did either of these actually exist or develop within European community nursing practice during the 1990s?
3. Why did the change of emphasis to family occur in the naming of the new FHN concept?
4. What are the underlying conceptual differences between the Health for All Nurse and the Family Health Nurse as promulgated?

These questions are now systematically addressed.

3.3 ORIGINS OF THE FAMILY HEALTH NURSE CONCEPT

3.3 1 Nursing at European policy level

In regard to the first question, there is the Standing Committee of Nurses of the European Union (PCN). This committee comprises representatives of those national nursing organisations of E.U. which are members of the International Council of Nurses (ICN). Accordingly it draws from a smaller constituency than the wide ranging WHO Europe region, which at time of writing has 53 member states. PCN’s mission is to promote and defend the interests of the nursing profession in Europe, with particular reference to the E.U. However, historically, the PCN has struggled to influence the European Commission and Parliament to anything like the degree that the medical profession has achieved (Pritchard 1995).

The same would appear to be historically true for the relative power and influence of nursing and midwifery within the WHO Europe Regional Office in Copenhagen. In this regard the main post is the Regional Adviser for Nursing and Midwifery, but historically the postholder has had minimal administrative support and a series of transient seconded professional advisers. The contrast between the number of people involved in providing nursing services within Europe (around 5 million) and the size and staffing of this tiny European office has been described as shocking (Alexander 1995). In effect the work of this office has depended on the support of Chief Nurses (CNOs) from the member states and the WHO Collaborating Centres (CCs) for Nursing and Midwifery located mainly in universities around Europe. The work of the Copenhagen office consists primarily of procuring and providing information, networking and facilitation, and project work (Beerling 1997).

This lack of resource, the essentially advisory role of the WHO, and the mediation of its work through CNOs and CCs, necessarily makes it difficult for the WHO Europe Regional Office Nursing and Midwifery programme to impact directly and visibly on the working lives of community nurses in individual countries. Nevertheless, during the 1990s two successive Regional Advisers were very active in driving forward the work of the Office.

3.3.2 The "generalist nurse" and the "Health for All Nurse"

The first of these Regional Advisers, Jane Salvage, played a key role in marshalling knowledge of the nature and scope of nursing within the "New Europe" that was emerging as a result of political regime change in central and eastern regions during the first half of that decade. Her influence is written large in the "Nursing in Action" publication (WHO 1993b) which details the main issues from that time. This publication gives very useful insight into the second question identified i.e. why the generalist nurse gave way to the Health for All Nurse.

Salvage highlights how the Vienna recommendation on the generalist nurse (see Table 3.2) was not welcomed in some countries where there were first level training programmes to prepare, for example, psychiatric and pediatric nurses. However she goes on to stress that WHO recommendations are only guidance, and that each country should "find the solution most appropriate to its health needs" (p. 7). Thus, to avoid the impression that the generalist nurse was being promoted "in opposition to, or in preference to, the specialist nurse" (p. 7), this publication states that "WHO has replaced the confusing term generalist nurse with the ′health for all nurse′" (p. 8).

While guidance on the role of the generalist nurse had been minimal in the 1989 Vienna recommendation, by 1994 the re-named role was the focus of a WHO Europe Nursing and Midwifery Office and Chief Nursing Officers meeting in Glasgow. This agreed that:

> "the role of the Health for All Nurse, as outlined in the Declaration, is to help people throughout their lifespan, as individuals, families and groups, to determine and achieve their physical, mental and social potential, and to do so in the context of the environment in which they live and work. This requires nurses to develop and perform functions that promote and maintain health as well as prevent ill health. Nursing also includes the planning and giving of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying" (cited on p.264, Salvage and Heijnen 1997).

Here we now see a comprehensive, multidimensional (and inherently generalist) nursing role being posited through rhetoric (note the move into upper case lettering). However it is important to ask whether the Health for All Nurse (and its proxy progenitor) had any substance in European nursing practice during the 1990's.

3.3.3 European community nursing during the 1990s

During the 1990s the WHO Europe Regional Office for Nursing and Midwifery undertook a four year information gathering exercise across member states (Salvage and Heijnen 1997). While this work was limited in terms of method, it provides the best available evidence from which to overview enactment of the Health for All Nurse around Europe.

Two of the main groupings of regions in Europe, namely the Countries of Central and Eastern Europe (CCEE) and the Newly Independent States of the former USSR (NIS), were found to have relatively few nurses working in the community. However in both regions (particularly within NIS) there were feldshers, whose working role lay somewhere between the traditional roles of the nurse and the doctor. Typically the feldsher can carry out health assessments; diagnostic and therapeutic care; examinations and tests; recommend treatment plans; and provide first aid. Some can prescribe medication under certain restrictions; some combine their role with midwifery; and some have a very strong prevention and public health focus to their work.

Accordingly the scope and substance of the feldsher role seems to be very congruent with the Health for All Nurse. As Salvage and Heijnen (1997) and Alexander (1995) note, however, the role and numbers of feldshers were actually diminishing in the 1990s as health care reforms evolved in these regions.

Within the other main regional grouping in Europe, namely the Countries of Western Europe, the development or maintainance of community nursing, including home visiting, generally had much more priority. Some countries had established systems whereby one type of nurse (such as a Public Health Nurse or Health Visitor) undertook preventative health promotion work while another type (e.g. home care nurse/district nurse) undertook care of ill persons. Denmark, Hungary, Norway and UK all exemplify this approach. Other countries had established systems that were much more analagous to the comprehensive promulgated role of the Health for All Nurse. Those with most ostensible resemblance might be seen as the Finnish Public Health Nurse and the Irish Public Health Nurse. In the case of the latter role, however, it was recognised that health promotion work could tend to be subsumed by the demands of curative care (Government of Ireland 1994) and Mason (2001) notes the trend towards greater nursing role specialisation in that country.

Given the diverse nature and scope of primary care services across Europe during the 1990s, and their changing political contexts, it is difficult to come to a definitive generalisation about manifestations of the Health for All Nurse. At a very basic level however it seems safe to say

that none of the countries was inspired to actually give a group of their community nurses this title. This is not a flippant point. As this thesis will argue, the act of naming can be important and have significant sequelae. One of the cardinal lessons to emerge from any grand tour of European nursing is not to assume that similar names and/or terms denote similar functions. The difference in role between the UK Public Health Nurse (i.e. Health Visitor) and the Irish Public Health Nurse exemplify this.

On the basis of Salvage and Heijnens' work, there did not seem to be evidence of a significant trend within Europe to move to a more highly educated all-in-one community nursing role. However, Whyte (2000)'s more recent survey of community nursing in Europe paints a rather more promising picture in this regard. Although wider forces such as political change and economics were found to have limited the development of primary care systems in many CCEE and NIS countries, some areas were investing heavily. Slovenia, in particular, had recently developed a new community nursing role that combined a wide range of functions and delivered care across a wide spectrum of ages.

Twenty of the 32 countries that responded (63%):

> "identified the community nurse as a 'generalist' who carried out a range of designated care interventions and health promotion activities across a spectrum of ages. These countries defined the 'specialist' nurse as having expertise in specific clinical conditions i.e. diabetes. Other countries defined the community nurse as a 'specialist' who carried out well-defined activities related to specific client groups" (p. 4).

Fifteen countries reported some change to their educational preparation of community nurses within the last 3 years (usually extending existing courses or developing a new post-registration course). However the majority of those countries with a generalist community nursing role did not require that incumbents have a specific community nursing qualification. Broadly speaking, Whyte also found that education was valued more within specialist rather than generalist community nursing practice.

Thus a mixed picture of generic and specialist type community nursing roles seems to have prevailed across European nursing at the end of the 20th century when the Health for All Nurse concept was superceded by the Family Health Nurse concept. Having already established some common generalist lineage, analysis now shifts to address what distinguishes the two concepts.

3.3.4 Distinguishing the Family Health Nurse concept: general nature and scope of the proposed role

Comparing the full definition of the Health for All Nurse from the Glasgow 1994 quotation with the full definition of the Family Health Nurse within HEALTH 21, reveals some tangible differences and some more subtle shifts of emphasis. A major difference is that the new concept does not mention working with groups as such. Moreover, although the new concept mentions prevention and detection functions, it is less overt in suggesting a health promotion function. Finally, the new concept highlights the FHN's co-ordinating role as lynchpin between family and Family Health Physician, and even overtly suggests possibilities for limited role substitution.

Thus what emerges is a slight shift away from the very broad, health dominated, aspirational language of the Health for All Nurse concept towards a new concept that is trying to be more focused on role and function. Although "Health" is retained in the new title (along with the upper case formulation), there is overt new emphasis on the role addressing the needs of families. In order to try to understand why this act of naming developed, it is useful to look beyond nursing.

Taken at face value, the emphasis on family reflects the value WHO ascribes to this very important unit in society. Moreover it is interesting to note within the FHN definition that the other key role within the primary care system also acquires a different title i.e. the Family Health Physician. Ostensibly this seems significant because, from a UK perspective, it seemed that the title "General Practitioner" had largely superceded the more old-fashioned term "Family Doctor". While "Physician" might have been used in both secondary and primary care settings, it would certainly be novel to have the word "Health" overtly placed within such a key professional medical appellation.

As such it seems reasonable to ask if such a change in medical moniker was intended to signify a shift in emphasis towards family health care within medical practice in primary care. The simple answer to this appears to be "no". Scrutiny of the contemporaneous WHO Framework for Professional and Administrative Development of General Practice/Family Medicine in Europe (WHO 1998b) reveals no mention of the "Family Health Physician". While advocating a family-orientated approach, it is clear that the individual has primacy, e.g. "general practice addresses the health problems of individuals in the context of their family circumstances" (p.5).

This impression is sustained in analysis of a promotional article by Dr JE Asvall, Regional Director of the WHO Regional Office for Europe (Asvall 1999). Speaking around a year after

the launch of HEALTH 21, Dr Asvall makes no mention at all of the Family Health Physician. In contrast he is effusive in shedding more light on the intended role of the FHN:

> "Until now, however, very few countries had a well-thought strategy to reach every family, as well as the different family members. Individual members will be able to turn to family health nurses with issues that may be difficult to discuss openly within the family. Trained to spot early signs of emerging problems, the family health nurse will be able to give early help or referral to more specialised care, so that problems can be 'nipped in the bud'. A trusted confidante, the family health nurse will also gently coach the family to act better as a network, taking up their health problems jointly and helping them make a clear agenda for mutual support towards healthier lifestyles. Family Health Nurses need training in public health thinking so that they can identify elements in the local community that influence the health of families. They should be active participants in local community health programmes to build community action, an essential element of primary health care" (p. 37).

This text is significant for two reasons. Firstly it clearly implies an in-depth family service with universal coverage. Secondly it clearly adds a large community-focused element to the role described in the Health 21 definition. As such the FHN concept seems to be expanding substantially. Such an interpretation is sustained in analysis of the Family Health Nurse: Context, Conceptual Framework and Curriculum document which was developed during 1999 (WHO 2000a). This document is very important in that it represents a sustained attempt to develop the concept in more detail so that the role can be enacted along with a supportive educational curriculum.

A key passage from the document underscores the WHO aspiration for a broad generalist role:

> "The WHO European Regional Adviser for Nursing and Midwifery, speaking to the European Forum of Nursing and Midwifery Associations and WHO, saw the Family Health Nurse as having a role along the whole continuum of care, including health promotion, disease prevention, rehabilitation and providing care for those who are ill or in the final stages of life. While the title 'Family Health Nurse' suggests that the focus of the nurse is only on people who live within families, as this concept is generally understood, the role embraces much more than that and includes all people in the community, whether they are living with others or alone, whether they have a home or are homeless and/or marginalised in some way, and it also includes the community itself" (p. 2).

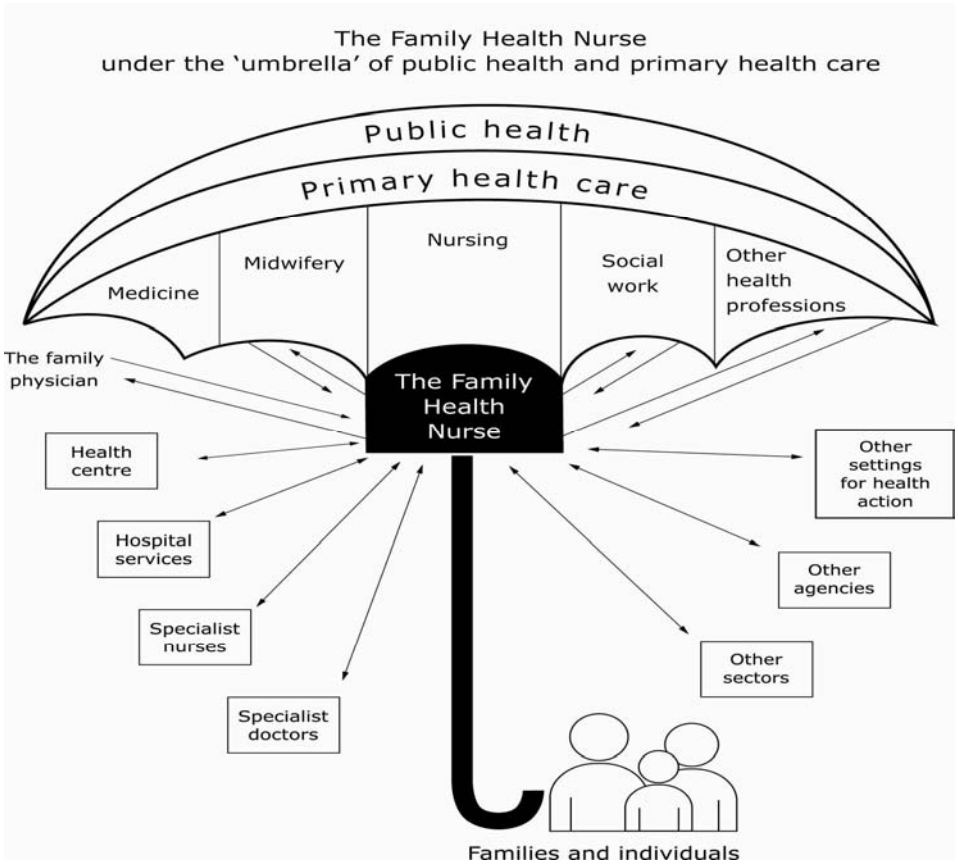
The above passage is significant for two reasons. Firstly it gives voice to, arguably, the key player within the development of the Family Health Nurse concept at European level. Ainna Fawcett-Henesy took over the post of Regional Adviser in 1995 and was thus also involved in the formulation of the HEALTH 21 strategy. Secondly, the above passage provides evidence of her concern that, by highlighting the word "Family" in the title, the role will be misconstrued as being narrowly focused. Here we see, somewhat ironically, concern to reaffirm the role's generalist credentials. Moreover we hear distinct echoes from the name-dropping episode previously cited from "Nursing in Action" (WHO 1993b).

The WHO 2000a document is also useful in that it attempts to explain what is new about the concept. In this regard it states:

> "The role and functions of the Family Health Nurse as described above contain elements which are already part of the role of several different types of community nurse who work in primary health care across the European Region…..What is new in the concept of the HEALTH 21 Family Health Nurse is the particular combination of the various elements, the particular focus on families and on the home as the setting where family members should jointly take up their own health problems and create a 'healthy family' concept" (p. 2).

The juxtaposition of the foregoing two key passages from the document highlights internal tension between the new focus on family health in the home and the continuing wish for a very broad generalist role in primary health care. The document goes on to locate the FHN role within the public health and primary care system by means of a diagramatic depiction. This is reproduced in Figure 3.1.

Figure 3.1: The Family Health Nurse under the "umbrella" of public health and primary health care (from WHO 2000a)



This is a significant depiction in that, instead of the duo of FHN and FHP supporting primary health care, the FHN is portrayed as the central stanchion of the whole system. The family physician (rather than Family Health Physician) is peripheral. Taken at face value this would suggest the FHN as the fulcrum of entire primary care and public health systems. For countries with very underdeveloped, or non-existent, primary care systems this might seem a very interesting and exciting nursing role development. If well resourced there could be an opportunity for nursing to play the key role in service co-ordination and delivery, and to grow the superstructure which it will end up supporting. For countries with established primary care superstructures (e.g. the UK) however, this represents a vision of radical change. Immediate questions arise about the displacement of GPs from their present central role and about the ability of the FHN to bear the weight of the system.

Interestingly the idea of GP displacement, or even replacement, feature within contemporary reactions to the WHO FHN concept in the nursing press. For example Lipley and Scott (2000) state that "family health nurses could in time replace the GP, the traditional 'gatekeeper' of health services, as the first port of call for everyone's health needs, with referrals to a doctor only if necessary" (p. 13). Within the same article Ainna Fawcett-Henesy, is reported as saying that even the most developed countries' nurses are too often seen as subservient to doctors.

These possibilities of a more radical agenda for the development of the FHN concept into practice will be returned to later in the thesis. Likewise the metaphorical umbrella will be folded away for later examination in the context of the prevailing climate in the Scottish Highlands and Islands. For the main part of the WHO 2000a document is concerned with a more immediate framework i.e. the conceptual framework for family health nursing itself.

3.4 THE FAMILY HEALTH NURSE CONCEPT: FURTHER EXPOSITION AND ANALYSIS

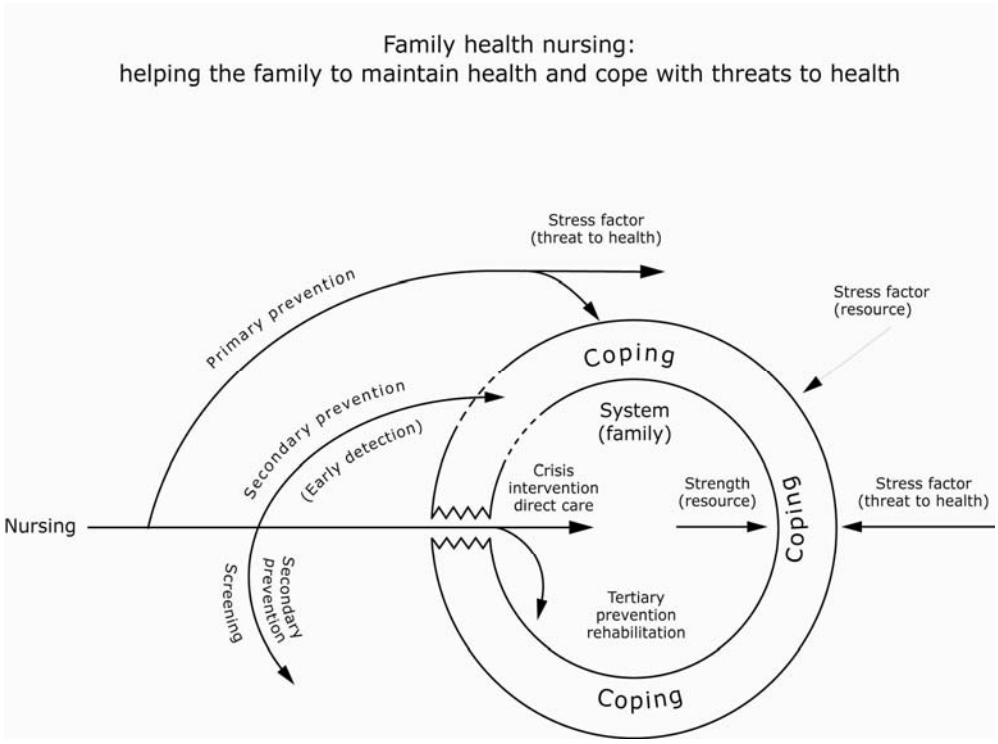
3.4.1 Conceptual framework/theoretical underpinnings

The published framework (WHO 2000a) draws on "systems theory, interaction theory and developmental theory" (p. 4) in order to bring together the key concepts of family, health and nursing. This is no small task as, although the three concepts generally have positive connotations, they are each notoriously difficult to define. The definition of family has already been alluded to in regard to a desire to keep it broad and inclusive. However it is important to note that the WHO operational definition used in the HEALTH 21 document is simply "households". Thus there is some inconsistency on family definition and no more exact definition is attempted within the WHO 2000a document. This is surprising in that there is no shortage of more inclusive definitions such as "Two or more persons who are joined together by bonds of sharing and emotional closeness and who identify themselves as being part of a family" (Friedman 1992; p. 9) or "a group of individuals with relational connections that may be emotional and/or biological and/or legal in nature" (Macduff and West 2003; p. ii).

What the family is seen as in the WHO 2000a document is a system operating within a context or environment. Health is viewed as the dynamic equilibrium which is maintained between the family and the environment. The system is seen as changing over time (developmental theory). The work of the FHN is posited as interactive activity in which the nurse and family are partners (interaction theory). The goal of FHN activity is seen as maintaining, and if possible improving, the family's equilibrium or health status by helping the family to avoid or to cope with stressors or threats to health. This may involve primary, secondary or tertiary prevention inputs.

These ideas are brought together into one key conceptual diagram which is reproduced in Figure 3.2.

Figure 3.2: Family health nursing: helping the family to maintain health and cope with threats to health (from WHO 2000a)



Interestingly this diagram and much of the associated explanation comes directly from one of the FHN curriculum planning group (Professor June Clark)'s model for health visiting published in 1986. The roots of the model itself can be traced back to Betty Neuman's systems model for nurse education and practice (1982) which in turn is based on the Von Bertalanffy (1968)'s general systems theory and Antonovsky (1979)'s ideas on stress and coping. As such, it can be seen that the conceptual framework for the proposed role focuses on family and health, but is neither new nor grounded exclusively in nursing.

3.4.2 Exemplars of the role for practice

However the WHO document goes on to provide examples of how this might translate into FHN practice by providing 14 detailed case scenarios. The scenario topics are diverse and include: care of a family with mental health and alcohol-related problems; chronic disease prevention and management for Type 2 diabetic patients; accident prevention/inequalities in health; care of an ethnic minority refugee family; care of a family with a heavy smoker who wants to stop; care of a teenager who is pregnant; care of a family where a mother has breast cancer; and care of an elderly widower with multiple disease pathology.

On the basis of these examples, the document suggests that the FHN will be in a position to contribute significantly to reaching 20 of the 21 targets in HEALTH 21. The scenarios are

presented to "illustrate what might be part of a typical caseload for a Family Health Nurse" and, in doing so, to aid understanding of the "breadth, depth and scope of their role" (p. 6).

The latter dimensions are incontestable if the scenarios are read in detail. However the serious question that arises immediately after such a reading is: "what is not family health nursing?". Although the scenarios often involve bringing in the wider multi-disciplinary team (e.g. midwives), their hallmark is sustained personal input by the FHN with no mention of service withdrawal. So, while these examples comprise an impressive array and promote the FHN ideology by suggesting its almost universal utility, they make for an exceptionally wide-ranging generalist nursing role with potential for intra-role conflict if they formed one person's caseload. Accordingly, critical analysis suggests some inherent and fundamental tensions within the role description being promulgated by the WHO 2000a document.

3.4.3 The proposed educational preparation

Despite the tensions noted above, the WHO 2000a document does, however, represent a substantial development of the FHN concept. Not least an educational curriculum is articulated, based on five core FHN competences, namely: care provider; decision-maker; communicator; community leader; and manager. Key features of the WHO FHN curriculum are summarised in Table 3.3.

Table 3.3: WHO Europe Curriculum

Curricula academic level	**Module content**	**Duration**	**Assessment techniques**
Post-graduate level		**Total of 40 weeks**	Essay, exam, course work practical assessment
Academic award plus specialist practice award	Concepts, practice and theory	2 weeks	
No core modules	Provision of care working with families	10 weeks	
	Decision making	4 weeks	
	Information management &research	6 weeks	
	Provision of care working with communities	10weeks	
	Managing resources	4 weeks	
	Leadership and multi-disciplinary working	4 weeks	

Not surprisingly, this constitutes a wide-ranging syllabus, and examples of module content are provided. Although half of the Curriculum Planning Group were from the UK (3 UK members; 2 Nordic members; 1 Slovenian), the curriculum does not replicate all features of UK community nursing specialist practice qualification courses. In particular it is interesting to note that it is pitched as a postgraduate award rather than a post-registration award.

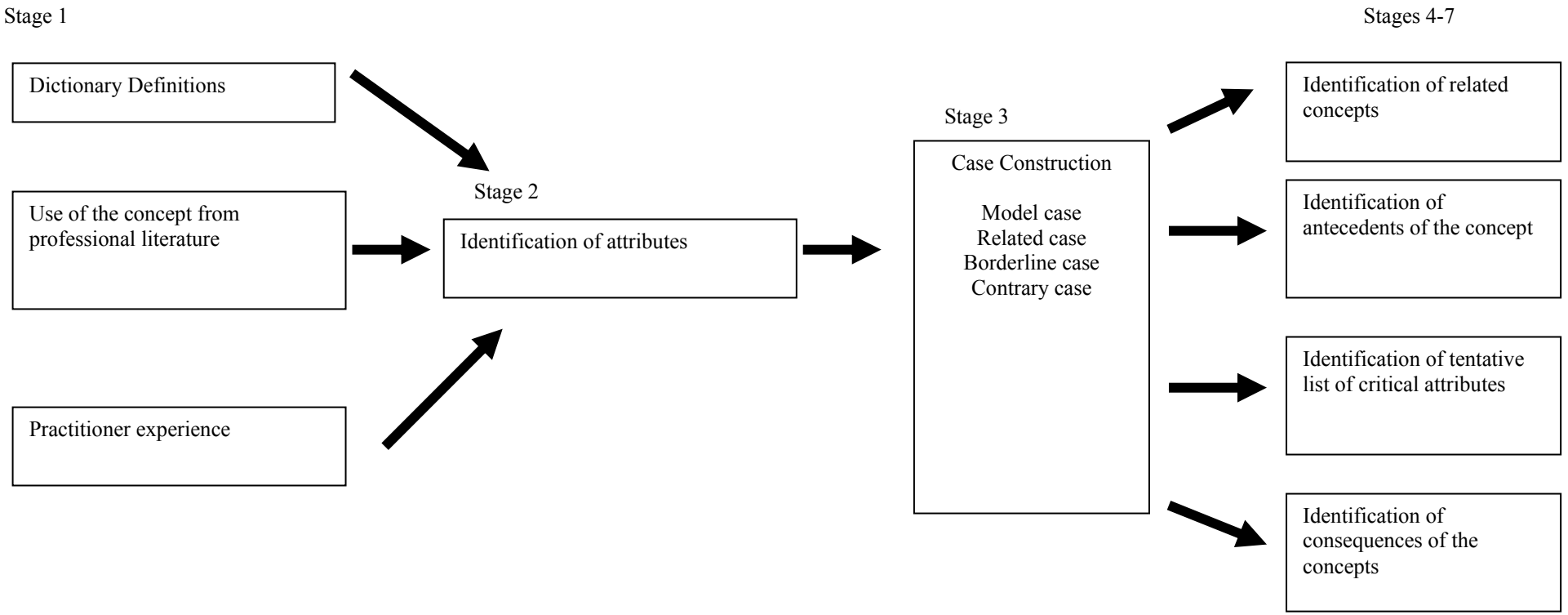
3.4.4 Taking stock using Walker and Avant's concept analysis framework

Having examined the FHN concept in terms of its origins, promulgated nature and scope, theoretical underpinnings, practice exemplars and educational preparation programme, it is useful to take stock. To this end summative overview can be achieved by using a limited application of ideas from Walker and Avant (1995)'s method for concept analysis.

Drawing extensively from the seminal work of Wilson (1963), Walker and Avant suggest an eight stage process through which a concept can be examined and described. This process has been used extensively within nursing literature to try to clarify concepts as a precursor to building theory based upon them. Paley (1996) highlights a number of fundamental problems with the latter approach, including lack of consistent criteria for determining critical attributes, and a tendency towards semantic regression. With this in mind, the present application seeks only to examine and "lay open" the main features of the concept using some of the main stages of Walker and Avants' process.

These selected stages are usefully summarised in a diagram by Unsworth (2001). This is reproduced in Figure 3.3.

Figure 3.3: Main stages of concept analysis (after Unsworth 2001, and Walker and Avant 1995)



As Figure 3.3 indicates, the first stage involves identifying all uses of the concept from literature and practice. In the case of the WHO Europe FHN concept this is simplified because pre-2001 no practice had occurred, and the literature was restricted to that already reviewed. Nevertheless, in applying this framework, Stage 1 yields a broad range of uses of the concept, as summarized in Figure 3.4.

Figure 3.4: Main features of the FHN concept as illuminated by concept analysis

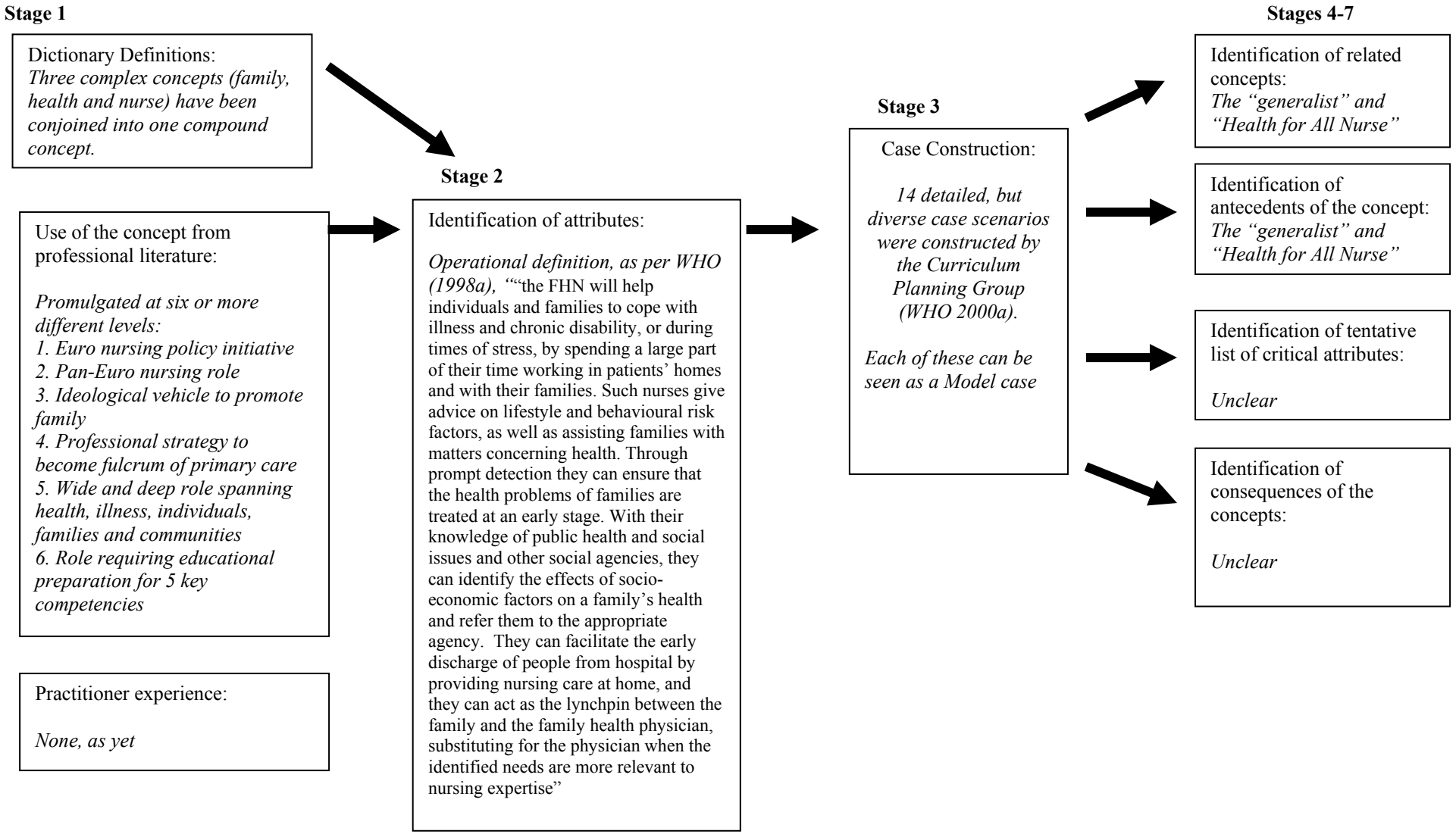


Figure 3.4 (Stage 1) highlights that the FHN comprises three conjoined concepts and is thus an example of a compound concept or "concept synthesis" in Walker and Avants' terms. Equally striking are the number of different levels at which the concept is promulgated. In this way the FHN is simultaneously:

- an aspirational pan-European community nursing role
- a policy initiative across Europe and within different countries
- a vehicle for an ideology that privileges family as the most important unit in society
- a professional position as the fulcrum of primary health care and public health delivery systems
- a role of breadth, depth and scope spanning health and illness, individuals, families and communities
- a role comprising five key professional competencies for which an educational programme of preparation is required

In a sense the above listing could also be seen as part of Stage 2, where identification of defining attributes is undertaken. For the purposes of this analysis, however, it is necessary to highlight how WHO Europe have undertaken this through their operational definition of the FHN.

Stage 3 in the process involves constructing model cases, related cases, borderline cases and contrary cases. Walker and Avant posit the model case as "an example of a use of the concept that includes all of the critical attributes of the concept" (p. 42). Or, citing Wilson (1963)'s criteria: "if that isn't an example of it, then nothing is" (p. 42). A related case is held to have related ideas to the concept being studied, while lacking the critical attributes. A borderline case contains some of the critical attributes, but not all of them. Finally a contrary case is clearly not an instance of the concept.

Figure 3.4 indicates that WHO Europe's 14 role exemplars, or case scenarios, effectively comprise 14 instances of the model case. As indicated in previous analysis, this makes for impressive scope, but concurrently obscures what the critical attributes of the role should be. Thus Stage 6 of Figure 3.4 cannot be addressed from the evidence reviewed so far, as the WHO Europe literature does not give a clear idea of what related, borderline or contrary cases would/could be. However the overview of European nursing conducted earlier in this chapter does highlight that the generalist nurse and the Health for All Nurse are both related and antecedent concepts (Stages 5 and 6, Fig. 3.4).

This limited use of Walker and Avant's concept analysis is useful for summarising understandings of the promulgated FHN concept in terms of what it is on paper, and what it aspires to. The next part of this chapter uses a genealogical approach to concept analysis to offer a different perspective. In order to do this it is necessary to leave Copenhagen and make a brief visit to Calgary in Canada.

3.4.5 Genealogical concept analysis via North American family nursing

Although family nursing is practiced in many different forms in countries outside Europe, its conceptual and practical development is predominantly associated with North American countries. Lorraine Wright and Maureen Leahey from the University of Calgary have been particularly influential in this regard, through their development and publication of the Calgary Family Assessment Model (CFAM) and the Calgary Family Intervention Model (CFIM) (see Wright and Leahey 1984 and 1994). These authors call their particular approach *family systems nursing* to emphasise that the focus is on the whole family as the unit of care, and to highlight the models' grounding in Von Bertalanffy's systems theory (Wright and Leahey 1990) and family therapy (e.g. Minuchin 1974;Tomm 1980).

Wright and Leahey also contrast their approach with others where the individual is the focus and the family is the context, or where the family is the focus rather than the individual. Rather their family systems nursing purports to focus on the whole family as the unit of care by considering both the individual and the family simultaneously.

Towards this end their CFAM offers an approach to in-depth assessment of family power structure, dynamics, strengths and weaknesses. It makes particular use of two distinctive tools, the genogram and the ecomap. The former is a diagram of the family constellation which depicts the relationships among family members for several generations. Its structure resembles the conventional family tree diagram, but is designed to map health status and issues. The ecomap is a diagram of a family's contact with others outside the immediate family. It is intended to give an overview of the family's social interactions and involvements. These tools are also designed to involve the family members so that they are empowered to act on issues that are relevant for them.

As Gillis (1991) comments, the nature of nursing engagement proposed by Wright and Leahey and other leading family nursing proponents such as Friedemann (1989) indicates a level of specialism in nursing practice. Indeed Wright and Leahey (1994) make a clear distinction between generalists as "nurses at the baccalaureate level who are predominantly using the conceptualisation of the family as context", and specialists as "nurses who are at the graduate

(master or doctoral) level who are predominantly using the conceptualisation of the family as the unit or client of care" (p.11). Moreover the applications of family systems nursing cited in its associated literature (e.g. Bell 1997) tend to focus on specialist units rather than generalist work in the community.

Perhaps this association with specialist practice was a factor that mitigated against any explicit reference to North American nursing models like the CFAM in the WHO 2000a conceptual framework and curriculum document. However it is important to note that the model at the heart of the WHO FHN conceptual framework (i.e. June Clark's health visiting model) shares a common theoretical foundation with the Wright and Leahey model (i.e. Von Bertalanffy's systems theory).

Indeed it is useful to deploy a Wright and Leahey influenced genogram format to make the genealogy of the WHO FHN concept more explicit (Figure 3.5).

Figure 3.5: Genogram of the genealogy of the WHO Europe FHN concept

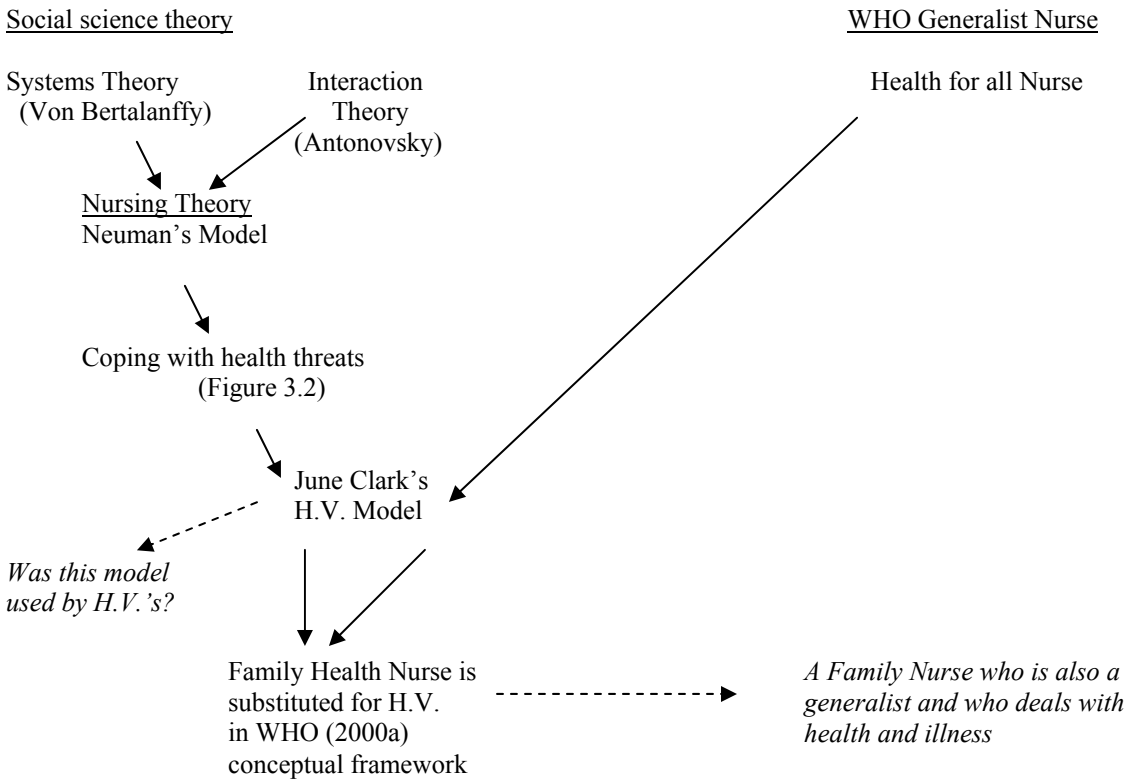


Figure 3.5 illustrates how selected social science theory is present in the WHO concept's family tree, has been mediated to some extent by nursing theory, but has been harnessed to one UK health visiting model aimed at family healthcare. This is then brought into conjunction with the evolving concept of a generalist European nurse who will aspire to address health and illness issues for individuals, families and communities. In terms of resultant theoretical offspring, the net outcome is that the new FHN title simply replaces the title "Health Visitor" in

the derived diagrams which constitute the conceptual framework document (WHO 2000a). Within the UK, this raises a question about whether this amounts to a "christening" or a "re-christening" (i.e. to what extent did this HV model influence practice/develop in practice in the UK?). Authors such as Baggeley and Kean (1999) would argue that UK health visiting in the 1990s focused too exclusively on the mother-child dyad.

Importantly, Figure 3.5 shows the theoretical development of the FHN concept coming to a point where the family and its health are focal and, to some extent, explicated. In genetic terms it might be said that the genes relating to family and health have been predominant in determining the development of the head of the new Family Health Nurse model. Ostensibly this seems entirely appropriate.

It is vital to note, however, that the envisaged *role* of this new nurse (i.e. the sphere wherein the whole FHN body has to act as exemplified by the 14 case scenarios) is very considerably broader than that of the UK Health Visitor role, in that the new FHN has also to address ill health directly. In effect this is the genetic inheritance from the right side of Figure 3.5 and raises questions about whether the new FHN will have sufficient leg power to enact the new role.

Having analysed and summarised the FHN concept through linguistic and genealogical approaches, it is necessary now to turn to consider how WHO Europe went about advancing this concept as a policy initiative.

3.5 WHO EUROPE PLANNING FOR POLICY ADVANCEMENT AND ROLE ENACTMENT

In this regard a significant WHO Europe convened meeting was held in May 1999 in Helsinki. This was the Seventh Meeting of the Government Chief Nurses of the WHO European region (WHO 1999). This meeting focused on means to realize the nursing and midwifery contribution to HEALTH 21 and on preparations for the Second WHO Europe Conference on Nursing and Midwifery to be held in Munich in June 2000.

The meeting considered a commissioned paper on what the literature said at that time about the family health nurse concept (McHugh and Cotroneo 1999). Perhaps unsurprisingly their search produced a diverse range of material on families in Europe but yielded little evidence of nurse-family collaboration or commonalities relating to family health nursing itself. Rather the paper cited a very wide range of reported community nursing activities in European countries that are broadly relevant to the FHN role.

Critical review highlights a tendency within the paper to equate all such activities with family health nursing. Moreover, it becomes difficult to separate aspirational representations of practice and policy invective from what might reasonably be held to be common practice in the countries involved. There is little sense of how the many cited initiatives and schemes fit in with mainstream service provision. To a large extent this is symptomatic of the lack of research-based evidence on actual community nursing practice within Europe. However, the lack of critical purchase in the paper is also likely to be related to the context of its commissioning and its use in promulgating the FHN concept.

Following presentation of the initial paper in Helsinki, the meeting participants decided that they should seek supporting literature from within their own countries. There was also agreement on “a need for pilot or demonstration projects where the family health nurse concept could be operationalised, the family health nurse education programme could be delivered (in total or in the relevant parts), and the new role evaluated either as a part of the existing primary health care teams, or ab initio where no such teams existed in a country’s health care system”. At this stage it was also recognized that “all should be aware of, and prepare to cope constructively with the potential, perhaps inevitable, interprofessional conflict likely to arise as the concept of the family health nurse is translated into reality” (p. 4).

The latter theme again surfaced in the course of a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis relating to enactment of the FHN concept. Although this sort of analysis necessarily represents a snapshot from one meeting, the main themes that emerged give some useful insights into thinking at that time. These are presented in Table 3.4

Table 3.4: Main themes that emerged from SWOT analysis

Strengths	Fit with WHO and government policy, particularly public health system reform across Europe. The preparation work already done, such as competencies. A broad approach that can improve equity and continuity, and extend the scope of practice. Willingness; belief in a positive health promoting vision
Weaknesses	How was the need identified?; what is the evidence to support change? Unclear image and overlapping scope; paternalistic approach. Different organizational structure of the health care system within the country. Possibility of conflict between nursing and other professions and within nursing.
Opportunities	Claim it is an enhancement/improvement of contribution. To use/introduce reforms in curriculum. To use best evidence to prove cost-effectiveness of FHN. Twinning (collaboration between countries). Patient involvement; feedback from clients. Career development for nurses
Threats	That we claim it is new. Title-confusion (definitions); lack of common language. Lack of evidence; lack of coordination. Growing demand for financial resources. No need to do new things GP

Table 3.4 shows the range of issues facing the CNO's and other participants at this point in time. What this summary, based on a WHO Europe report of the meeting, cannot show or know is the political dynamics informing or underlying the discussion.

The final part of the meeting asked for the identification of action steps to take the FHN project forward towards its nursing launch at the impending Munich Conference. The main action steps arising are summarized in Table 3.5

Table 3.5: Action steps identified

Cross-institutional action; mobilize nursing and midwifery lobbying potential
Multi-media interest
Set up multidisciplinary steering groups within countries
Identification of needs (situation in the country)
Estimate costs, sources of funding
Plan and identify the alliances (public, political, professional); make the concept known
Talk outcomes
Choose the place for demonstration and the best people for the project; attract sponsors
Create collaboration between the demonstration site and key stakeholders
Strategic plan for implementation

At this point it is important to take stock of what the Helsinki meeting appears to have achieved, namely ostensible agreement among the attending CNOs to enact the FHN concept as the leading edge of nursing's contribution to the HEALTH 21 policy initiative (although UK CNO representation at the meeting was limited to the Assistant Chief Nurse for England). Given the diversity of existing community nursing systems in Europe and the diversity of interests represented, this seems a significant achievement for the Regional Adviser and advocates of the new role. In this regard, the "identification of needs in individual countries" step listed above in Table 3.5 seems to have been superceded by general acceptance of the virtue of the new role.

However this interpretation emerges as rather naïve in view of the eight principles of the Munich Declaration that 49 national health ministers (or their representatives) subsequently signed up to in June 2000 (WHO 2000b). As such they committed to "seek opportunities to establish and support family-focused community nursing and midwifery programmes and services, including *where appropriate* the family health nurse" (p.1). I have added the italicized emphasis in order to stress how two words ensure that enactment of the concept is not binding in any European country. It seems no accident that ministers ensured such a "get-out" clause, and informed accounts corroborate that several dissenting countries secured this.

Notwithstanding this, the Munich Conference represents a considerable political achievement for European nursing and in particular the Regional Adviser. As Ainna Fawcett-Henesy herself stated "At a similar event in Vienna in 1988, only the Austrian health minister attended" (Lipley and Scott 2000; p. 14).

Thus the stage was set for each European country to decide on its individual response to Munich and whether to become involved in enacting the FHN concept. The final leg of this chapter's journey takes the reader to the UK to briefly consider the conditions awaiting the FHN concept therein.

3.6 UK COMMUNITY NURSING IN THE 1990s AS A CONTEXT FOR ENACTING THE FHN CONCEPT

Within the UK, community nursing denotes a very broad range of activities which can take place in a variety of settings (e.g. small community hospitals/doctor's surgeries; peoples' homes; the streets of large cities). Nurses working in these settings in the UK must be registered with the National Nursing and Midwifery Council (NMC; formerly known as the UKCC) who regulate standards of practice. In addition many nurses will also hold a community specialist practitioner qualification. These include:

- District Nursing (Nursing in the Home)
- Health Visiting (Public Health Nursing)
- General Practice Nursing
- Occupational Health Nursing

Other specialist nurses working in communities may have expertise in the care of people with specific disease (e.g. Macmillan Nurses for cancer care; Diabetic Specialist Nurses). Midwives are also active in UK communities, caring for women through pregnancy and childbirth. This diverse array of professionals has evolved in an attempt to meet the health care demands of varied populations

Traditionally District Nurses have cared for those suffering from illness or disability, by visiting them in their own homes. Originating in the sanitary reform and public health movements of the late 19th century, health visiting has developed primarily as a universal home visiting service focusing on the mother and child dyad (Watkins 2003; Baggaley and Kean 1999). This work has comprised health education, promotion and monitoring elements, but in recent years the public health aspects of the role have once again been highlighted for priority. Practice Nurses are a more recent phenomenon, being employed directly by General Practitioners (GPs) to provide preventative and curative nursing care primarily within the GP practice premises.

As Mason (2001) notes, the UK is possibly at the extreme end of the spectrum in terms of having a wide range of specialist community nurses. Ostensibly this range would seem to cover most, if not all, of the functions expected of the new FHN. Accordingly, it is necessary to question why the latter role should have any appeal at all for UK primary care. To begin to answer this question it is necessary to delve deeper into the state of community nursing in the UK at the end of the 20th century.

For in the late 1990's each of these three main community specialisms felt under pressure and some might be said to be suffering simmering crises of identity. The latter seems particularly true for District Nurses whose role and remit had been particularly affected by the Community Care reforms of the early 1990's. These had the effect of dividing health from social care on the basis of types of tasks, leaving many DNs lamenting the loss of holistic care for patients and their families (Kesby 2002; Goodman et al 2003). Simultaneously DNs were expected to adopt a much more overt care management role, devolving much of the hands-on care to registered nurses (community staff nurses), nursing auxiliaries and home carers. Finally the shift away from long stay hospital treatment implemented during this period led to a great increase in the numbers of patients with complex care needs and treatment regimes who required to be nursed at home.

Many UK commentators (e.g. Kelsey 1999; Mason 1988) have noted how Health Visitors have often been beset by doubt about their role and future. During the early 1990's there was particular tension between their primary care and public health work as GPs and health authorities came to purchase health visiting services and make different demands. To some extent this was resolving by the late 1990's with a "New Labour" government very publicly committed to a range of public health programmes (Watkins 2003; Poulton 2003). However, previous experiences had left many in the profession waiting to see if the reality would match the rhetoric.

Evaluating the effects of policy development on nursing, Robinson (1997) concludes that, historically, one group of nurses tends to benefit from change at the expense of another. If District Nurses were the main losers in the 1990's Practice Nurses were the main beneficiaries. As Carey (2003) notes, the introduction of the GP contract in the early 1990's led to a vast increase in Practice Nurse numbers and to extension of their role. Initially this extension was in the field of practical tasks (Mackereth 1995), but increasingly they developed their role in managing chronic disease and health promotion. However many Practice Nurses felt uncomfortable that GPs were dictating the boundaries of their practice, with a consequent lack of confidence in any distinctive underpinning nursing knowledge base (Carey 2003).

The above overview is of course a simplification, and analysis of UK community nursing (particularly district nursing) will be undertaken in greater depth within Chapters 7-9 of this thesis. Moreover the above overview stays very much within the realm of professional nursing perspectives. As such it overlooks one of the main arguments that can be advanced for a move away from multiple specialisms, namely that patients, families and communities are receiving a fragmented service that encourages duplication and lacks personal continuity (Hyde 1995).

In the wake of the 1998 announcement of the FHN concept, Sheila Kesby deployed the above argument to try to raise the generalist FHN flag within the UK (Kesby 2000; Kesby 2002). In doing so she offered an interesting historical analysis, pointing out that the idea of a family nurse had been originally been launched in 1967 by Joan Gray, who was Chief Nursing Officer of the UK Queen's Institute of District Nursing. Kesby (2000) describes how the vast majority of community nurses were against the idea at the time as they felt district nursing, health visiting and community midwifery were distinct roles that did not overlap or interrelate in practice. Accordingly the opportunity passed and community nursing developed an even more specialized superstructure which was later reified by the introduction of the UKCC community specialist practice educational framework introduced in 1994.

Nevertheless, Kesby argues that the increase in integrated community nursing teams during the 1990's presents a platform for the urgent introduction of family health nursing within the UK. Within her ambitious prescription of 7 steps on the road to family health nursing, she calls for FHNs to be the leaders of these teams and for FHNs to have equal status and autonomy to GPs.

However, Kesby's radical vision does not seem to have been shared within the UK nursing establishment. In fact review of UK community nursing literature in the years following the announcement of the FHN concept would suggest that most managers, educationalists and clinicians were looking in other directions. In short, there is a dearth of interest and critical engagement with the idea. One of the possible explanations for this is that at the time family was not particularly emphasized within the UK health care political agenda. Rather it tended to be subsumed within public health policy initiatives. As such, if health care professionals did engage with the new concept, the legitimate questions would be: why family and why now? This questioning of need in turn highlights the unresolved issue of why the "Health for All Nurse" became the "Family Health Nurse".

In one of the few substantive UK nursing press reports on the Munich Conference (Lipley and Scott 2000), the General Secretary of the RCN, Christine Hancock, is quoted as saying that the concept "could work well in the UK as long as it is allowed to evolve from existing roles". In a corollary she suggests that "the ideal places for family health nurses in the UK would be rural areas such as the south west of England and northern Scotland" (p. 14). The latter comment was not accidental, as the article also reports that a pilot study will be carried out in remote areas of the Highlands and Islands through backing from the Scottish Executive.

Thus the FHN concept completes an initial journey from the Copenhagen headquarters of WHO Europe to the headquarters of the Scottish Executive on Calton Hill, Edinburgh. The reasons for its arrival, and the course of its further Scottish travels, will be explored in the next chapter of this thesis.

SUMMARY

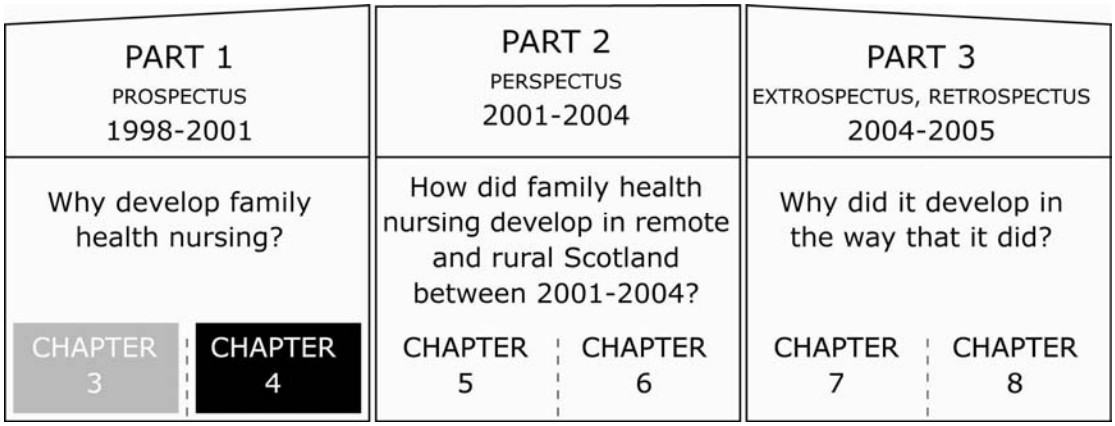
Through analysis of relevant, available literature, this chapter has examined the emergence of the FHN concept at European level and attempted to answer the question: why develop family health nursing? Some insights into this complex question have been gained by addressing subsidiary questions about the origins and nature of the concept. In this way it has been possible to establish that the origins of the generalist and public health elements of the concept lie in its predecessor, the aspirational "Health for All Nurse". However the origins of, and rationale for, the decision to highlight "family" were not clear within WHO publications. Indeed enquiry identified significant confusion in this regard, and a lack of any associated emergence of an articulated Family Health Physician concept. As such, the reasons for the emergence of family health nursing could not be fully deduced from review of relevant literature.

Analysis of the FHN concept in terms of its nature and scope, theoretical underpinnings, practice exemplars and educational curriculum, showed that it was being promulgated at a number of different levels ranging from policy to projected practice. This analysis helped to unpack the concept but, in doing so, revealed its very broad (almost universal) scope and inherently ambitious aspirations. In effect it was difficult to distinguish what family health nursing was not and what it was not trying to achieve within the field of community nursing. In turn, this highlighted associated difficulties in operationally defining the concept in such a way that it might translate into a recognisable and manageable practice role. In this regard, potential for intra-role conflict due to possible role overload was identified.

One of the main assessment tools from North American family nursing, the genogram, was then deployed to analyse the genetic make-up of the WHO Europe FHN concept. This highlighted tension between the family health "head" inherited by the concept (i.e. specialist knowledge) and the inherited generalist nurse "legs" (i.e. need for wide knowledge and capacity to fulfill an extremely wide role function within primary care delivery).

Following review of WHO Europe strategy for advancing the FHN concept through policy, the concept's fit with established UK community nursing and primary care provision at the end of the millenium was considered. This tended to highlight the relatively specialist nature of UK community nursing and a lack of emphasis on family as a primary focus for service delivery.

Accordingly the chapter has set the scene for examination of the Scottish context and its particular prospects, but has also left a number of unresolved issues in relation to the overall venture and the central question: why develop family health nursing?



CHAPTER 4

THE FAMILY HEALTH NURSE CONCEPT: FROM CALTON HILL TO CASTLEBAY AND BACK AGAIN

Overview of this chapter

This chapter primarily addresses the question: why develop family health nursing in Scotland? This is tackled by analysing literature relating to four main cognate areas: relevant policy; the remote and rural Highland and Island context; primary care and community nursing therein; and preparations for policy enactment. Following description of the particular research methods used within this chapter, analysis begins by focusing on two papers which outline the first Scottish policy ideas in relation to family health nursing. This leads to wider examination of Scottish health and social care policy literature in order to understand the context for the initiative as promulgated from Calton Hill.

The proposal to enact the pilot specifically in remote and rural regions necessitates some scrutiny of the physical and social dynamics of these settings, and this is taken forward through exploration of the importance of place. Having established locus, focus is then brought to bear on remote and rural primary healthcare, and in particular the provision of community nursing services. A brief review of the history of community nursing in the Highlands and Islands of Scotland leads to examination of contemporary remote and rural community nursing at the end of the 20th century and its suitability as a crucible for testing family health nursing. The chapter ends by reviewing the preparations that were made during 2000 for enacting the FHN concept into practice, the reactions of a key group at this time, and the publication of *Nursing for Health*.

4.1 RESEARCH METHODS

Like the preceding chapter, this chapter addresses its questions entirely through critical analysis of relevant literature. As such, the main methods for analyses are essentially the same as those detailed in Chapter 3. However a clear difference between the chapters is evident in relation to the nature and scope of the literature reviewed. While Chapter 3 was primarily reliant on core text generated from WHO Europe, examination of the Scottish context entailed engagement with a more diverse array of sources and resources.

Some literature reviews bring to mind the metaphor of textual traverse along a stacked, sequenced and level shelf, buttressed at either end by a weighty introduction and conclusion. Although the critical review in this chapter is secured at beginning and end in the relatively firm ground of policy analysis, the journey in between is undertaken over more varied terrain, and when passing through some cognate areas it will be seen that both glut and dearth of relevant literature can make critical purchase more difficult.

Review began with collation of all major nursing and midwifery policy reports published by the Scottish Executive between 1995 and 2001. The same strategy was adopted in relation to major health and social care policy documents. This facilitated selective insights into the prevailing UK policies when devolution led to the creation of a Scottish Parliament in 1997. The latter process included devolved legislative powers in the area of health, and this led to a flurry of related policy making in the ensuing five years. Accordingly there is a substantial Scottish health policy literature which can be examined in order to understand the context for introducing a family *health* nursing pilot. Sourcing of these documents initially relied on Scottish University libraries, but increasingly the various Scottish Executive websites have emerged as invaluable portals for direct access.

A similarly high level of strategic activity prevailed across other key devolved policy areas such as education, housing and the environment during this period. A more limited review of major reports in these areas has been undertaken, primarily in order to understand implications for health and health care provision. However this has also enabled review of relevant family policies in these areas. As Wasoff et al (2002) point out, some areas of family-relevant legislation such as social security are “reserved” by the UK parliament, but many are devolved. This makes analysis of the Scottish policy context for *family* health nursing important. In this regard research papers accessed from the web pages of the Edinburgh-based Centre for Research on Families and Relationships (http://www.crfr.ac.uk) proved very useful.

Indeed this chapter regularly draws on web-accessed research papers from several Scottish University research centres (e.g. the Arkleton Centre for Rural Development Research at the University of Aberdeen) and government funded initiatives (e.g. the former Remote and Rural Areas Resource Initiative). As the examples suggest, this is particularly the case when the Scottish remote and rural context is being considered. The currency of critical purchase provided by this type of academic literature is very useful, as such papers usually take longer to find their way into journals and books.

Understanding of the Highland and Island remote and rural context entails engagement with a much wider literature comprising a mix of social, economic, political, cultural, geographic and historical elements. In recent years academic and popular publications which combine these in various ways have flourished under the broad ambit of "cultural history". The work of James Hunter typifies this trend, from his seminal and very influential 1976 academic treatise on "The making of the crofting community" through to recent examinations of the Highland diaspora presented in more populist style (e.g. Hunter 1995).

Thus the challenge for the researcher has not been how to access such material as it is widely available in large quantities in local libraries and bookshops. Rather the task has been to filter out the main lessons relevant to the thesis. The technique of thematic mapping onto matrix sheets described in Chapter 2 proved useful in this regard, as did opportunistic note-taking around the bookshops of Scotland. Nevertheless it is difficult to articulate this cumulative acquisition of understandings from such a diverse literature as one systematic process. As experienced researchers in the Highlands and Islands, Munro and Hart (2000) capture the resultant feeling well when at times they describe themselves as in "a no-man's-land between academic research and general knowledge" (p. 9).

One of the themes to emerge from analysis of this body of material was the importance of place and this was followed up by accessing a number of general academic texts on the subject.

A rather more concise, if multi-faceted, core search strategy was feasible when focusing on primary care and community nursing provision in the Highland and Island remote and rural context. The following key search terms were used in various combinations to search potentially relevant electronic databases such as. ASSIA, ASLIB, IBSS, Social Science Citation Index, ZETOC, and COCHRANE:

- Remote/rural health care
- Scotland
- Highlands and Islands

- Primary care
- Medical services
- Community nursing
- District nursing
- Health Visiting
- Midwifery
- Triple-duty nursing
- Double-duty nursing
- Combined duties nursing

No limitations on dates were imposed as there was a concern to capture the historical context of service provision. The same terms were used in combination to search the COPAC university libraries system for relevant policy and research reports and published books. Again these primary, systematic literature search strategies engendered secondary activity whereby promising cited references were pursued.

What emerged from this strategy were a very small number of texts of primary relevance. Two government reviews of health services across these regions, one undertaken in 1912 and one in 1995, provide key points of reference within this material. Moreover, local historical perspective is provided within two academic theses, one on the Scottish roots of the NHS and the other on the oral history of Scottish district nursing. Five more recent papers from academic journals were found to be concerned with care provision in remote and rural regions of Scotland, but usually the focus was on GP experiences rather than global service evaluation studies.

The most striking aspect to emerge from this core search was the dearth of substantive published academic research that takes community nursing in the Highlands and Islands of Scotland as a central theme. This is corroborated in an incidental review of literature undertaken by Drennan and Williams (2001) while seeking exemplars for combined health visiting/district nursing roles in London. Indeed I was able to find only one academic study of the triple duties nurse in the Highlands and Islands (i.e. where one individual combines health visiting, district nursing and midwifery roles). Perhaps when one considers the historical marginality of nursing research within the north of Scotland this should not be surprising. Nevertheless the search strategy did yield one core research paper on Scottish rural district nursing by Lauder et al (2001).

A primary aim of the review was to source any evaluative material that could shed light on pre-existing community nursing delivery in regions where family health nursing would be enacted.

Thus the search strategy turned to the "grey literature" of unpublished internal reports carried out by local Health Boards/Divisions. This involved contacting these organisations directly, contacting archivists in regional libraries, and using a network of pre-existing professional and personal contacts in these regions. Again the fruits of these efforts were relatively meager, but recent relevant reports were obtained from each of the two main remote and rural regions involved.

Finally, the main source of literature relevant to the preparations for enactment of family health nursing was the project proposal document drawn up by two Directors of Nursing from Highland region and the Western Isles in conjunction with the SEHD. Insights into the perceptions of the Directors of Nursing and the reactions of Scottish Health Visitors to the proposal during 2000 were obtained through scrutiny of a Masters thesis by Daley (2001). This was generously offered by its author.

4.2 EMERGENCE OF THE FAMILY HEALTH NURSE CONCEPT IN SCOTLAND

4.2.1 Background

In the latter half of the 20th century, the trend in Scottish community nursing was clearly towards single duty roles for different specialities such as district nursing and health visiting, rather than combining these aspects within one role (Fulford 1992). Periodically, however, the generalist flag was raised. Thus in 1987, the report of a Nursing Colloquim (Scottish Office 1987) ventured that "consideration be given to the introduction of a community generic nurse instead of the current Health Visitor/District Nurse division (p.21)". However, little definitive action appears to have ensued from this. Accordingly, as noted previously in Chapter 1, there was surprise in many quarters when the generalist nurse flag was raised again in Scotland in 2000, this time in a new variant called family health nursing.

4.2.2 The "Proctor" position paper

Reflecting on the Scottish Family Health Nurse pilot project in 2003, Chief Nursing Officer Anne Jarvie recalled an initial meeting taking place in autumn 1999 to discuss whether the WHO Europe FHN concept had potential for remote and rural areas (SEHD 2003). The first related position paper (Proctor 2000) emerged in March of the following year. This was presented at a multi-disciplinary conference (organised by the Scottish Council for Postgraduate Medical and Dental Education) that aimed to seek solutions in relation to education and training for remote and rural practice.

A significant part of this paper presents the FHN concept as a potential solution to problems of nursing recruitment, retention and skills maintenance in rural areas where double and triple duties nursing had become increasingly difficult to sustain. Indeed this is taken further in the paper's rhetorical title: "The future of community nursing?" However, the paper also strongly suggests that the proposal may be a solution to pressure on rural GPs, viz. its opening line: "What is happening to make life as remote or rural GPs a bit better?" (p. 1). This thrust is maintained throughout the paper. It takes an interesting turn, however, in a key passage which attempts to explain the concept's fit to the current Scottish context:

> "The *family health nurse* concept was developed primarily for those parts of Europe which do not currently have primary care services. The *family health nurse*, as a skilled generalist, would work alongside a *family health doctor* to meet the health needs of a community. The generalist *family health doctor* equates very well with current models of UK general practice, but the *family health nurse* concept is quite different from current models of nursing practice." (p. 2)

Although this passage may appear anodyne to the casual observer, it in fact contains three highly contentious assumptions that require closer scrutiny because they relate to the central question of the need for the concept in Scotland. The first sentence is surprising more because such a purpose is not stated explicitly in the WHO Europe literature. Rather the literature review in Chapter 3 would suggest that the concept is presented as having potentially equal utility and relevance across all European health care systems. Secondly it is at least very debatable to suggest that *family* and *health* are defining features of current UK general practice i.e. in the light of the fundholder incentives of the 1990's the case for *individuals* and *illness* can be seen as much stronger (Peckam and Exworthy 2003). Finally, and conversely, it is possible to argue that the *family health nurse* concept equates well with at least parts of current UK models of nursing practice. For example, District Nurses can make claims to being generalists who take a holistic view of home and family health (e.g. Lauder et al 2001), despite their post-registration qualification being deemed specialist.

The issues around the first two assumptions will be revisited later in the thesis. For the moment, however, it is useful to seek greater clarification in regard to the third assumption. The paper goes on to attempt this, and to this end it is useful to quote a passage at length (use of italics is reproduced as published):

"The *family health nurse* role is different from existing community nursing roles in the following respects:

- It is a skilled generalist role – the family health nurse would undertake a broad range of duties, dealing as the first point of contact with any issues that present themselves, referring on to specialists where a greater degree of expertise is required.

- It is a model based on health rather than illness – the family health nurse would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.
- The role is founded on the principle of caring for families rather than just the individuals within them – the family health nurse would expect to look at the needs of the family in a holistic way, rather than looking at individuals or their conditions in isolation. An example might be that a single family could currently have a health visitor visiting a mother with a young baby, whilst a CPN visits the alcoholic father and a district nurse visits to dress the grandmother's leg ulcer. Not only is this wasteful in resource terms, especially in remote and rural areas, but it results in a fragmented approach to addressing the health needs of the family, whose real problem might not be related to any of the individuals' health problems.
- The *family health nurse* would know, and be known by, the community in which she worked – in many respects this mirrors the sort of relationship established by the former triple duty role. It implies a long-term relationship with the community and the sort of detailed knowledge of its needs which is difficult to maintain if nursing roles are divided.
- The family health nurse could operate as a first point of contact with the public, dealing with undifferentiated presenting problems – the proposal from WHO Europe is that the *family health nurse* would be the first point of call, referring on to the family health doctor those calls that required medical intervention. Although it is unlikely that we would wish to go so far down this line, there is an obvious attraction in remote and rural areas, where a single nurse might work with a single doctor, to have a degree of interchangeability of roles". (p.2)

The above passage is highly significant as it sees the first articulation of the Scottish Executive's interpretation of the FHN concept. Four principles are extracted from the WHO concept and highlighted, namely generalism; health basis; family focus; and first contact. There is then limited exploration and exemplification of how these might translate into a practice role in the contemporary Scottish context. While the triple duty role receives passing acknowledgement as an example of how these substantial elements might combine, it is referred to in the past tense.

Nevertheless the articulation of how this new FHN role might be operationalised in the existing primary care system is very limited. In this regard it is interesting to note how the prospect of some expansion of the nursing role in regard to first contact is offered to GPs in a way that suggests personal benefits but no challenge to medical authority. No similar assurances are offered in relation to consequences for the other health or social care professionals that may be affected by the new FHN role (e.g. those visiting the family in the example cited).

The Proctor paper acknowledges that it raises a number of similar unresolved issues, but is significant because it outlines key principles and parameters, and indicates the initial direction for a new nursing policy initiative in Scotland. This direction is mapped in more detail and justified more substantially in the project proposal document of June 2000 (Spratt and Adams 2000).

4.2.3 The project proposal document

This paper sets out the case for Scotland conducting a pilot project within the terms proposed by WHO Europe. Following iteration of Scotland's commitment to the HEALTH 21 strategy, two principal reasons for the pilot are posited. These are:

- "to move to a health improvement rather than sickness management model for nursing interventions
- to address the difficulties associated with increasing specialisation" (p. 3-4).

Both reprise elements from the earlier paper, but some further justification is also given. Thus in relation to the first point the aspiration is for a flexible, integrated approach that will meet health needs and "address the population's expectations of empowering, supportive and enabling approaches to social care" (p.3). This widens the scope of the envisaged role somewhat beyond that outlined in the first paper which focused more on aspects of primary care service maintenance.

The latter concerns are reflected in the second point where the negative effects of increasing specialization on recruitment and retention are again cited. However further justification for a different new role is also given:

> "Scotland's present community nursing services do not have the value of a single, recognizable individual working within an identified community and therefore do not encourage the development of trusting and supportive relationships between the family unit and the nurse" (p. 3)

This adds another contentious assumption to those identified in the Proctor paper. Firstly it is a major leap of logical inference to view trusting relationships between patients and nurses as being necessarily dependent on the presence of one particular community nurse. Secondly, no evidence of Scottish nursing's failure to encourage requisite relationships with families is offered.

Accordingly, on the key issue of need for a new nursing role, this paper raises the stakes somewhat by being more openly critical of the quality of pre-existing services.

The paper also details the remote and rural regions that will take part in the pilot: Highland, Western Isles and Orkney. In addition to citing increasing problems with delivering health care services in these regions, the paper lists a range of health related issues that comprise the wider local contexts:

- Sparse, declining, ageing populations
- Small island communities and geographical isolation
- Poor health profiles and indicators of deprivation
- Transport difficulties – infrastructure and availability
- Migration of the young to urban towns and cities
- Increasing percentage of non-indigenous population
- Erosion of extended family infrastructure

These issues are acknowledged as challenges, but are set in the context of new government policy strategies designed to tackle them.

Having looked in detail at the two key papers proposing the piloting of family health nursing, it is now useful to examine the wider policy context that prevailed at this time. In this way it may be possible to shed more light on why the concept was adopted on Calton Hill as a policy initiative to be piloted in remote and rural regions. In turn this should provide a frame for closer examination of these regions and places within them, in terms of their suitability as contexts for the enactment of the FHN concept as a practice role.

4.3 THE SCOTTISH POLICY CONTEXT

In her incisive examination of power, politics and policy analysis in nursing, Robinson (1997) states that "unpacking the various dimensions of any one situation requires first and foremost a crucial awareness of the social, political and economic culture within which particular health policy initiatives take place" (p. 267). As has been alluded to earlier, in 2000 the Scottish Executive Health Department was still in the midst of an intense period of articulating key policies following devolution. This had started in 1997 with *Designed to Care* (SEHD 1997) which raised the profile of patient/public involvement in health services, and promoted ideas of social justice, inclusion and equity in health care provision. As has been seen, some related ideas around population expectations are evident within the FHN proposals. A further important health service document was *The Acute Services Review* (SEHD 1998) which, amongst other issues, highlighted difficulties of access to acute services in the Highlands and Islands.

Towards a Healthier Scotland (SEHD 1999a) was the key strategic document outlining wider policy on the health of the nation. This emphasised health promotion and illness prevention activities and set a range of related targets. The Chief Medical Officer's *Review of the Public Health Function in Scotland* (SEHD 1999b) followed on closely to iterate a refocusing on public health. A new NHS plan, *Our National Health – A Plan for Action, A Plan for Change* (SEHD 2000a) then set out a range of initiatives to improve service delivery, and many of these sought to address difficulties in remote and rural regions that had previously been highlighted. Indeed the FHN pilot is mentioned in this context.

During this time the Chief Nursing Officer (CNO) Anne Jarvie and her staff were engaged in articulating nursing's contribution within this policy context. A major Review of the Contribution of Nurses, Midwives and Health Visitors to improving the public's health was ongoing during 2000. This involved over 200 members of these professions in reference group and sub-group activity, and led to the publication of *Nursing for Health* (SEHD 2001a). This key document will be analysed at the end of this chapter, but during 2000 it was clear that the public health function of the nurse was being moved towards the centre of Scottish nursing policy. *Caring for Scotland* (SEHD 2001b) then drew together the strategy for nursing and midwifery in Scotland and set out a programme of action points which included disseminating and building on models of practice arising from the FHN pilot.

Thus it can safely be asserted that Scottish policy was focusing energy on public health and the redesign of health services, and the FHN concept's emphasis on health ostensibly fits well within this ambit. However it is now necessary to ask if the same can be said about one of the other key dimensions of the FHN concept, namely its focus on the family.

Detailed review of all the above documents published up to and including 2000 shows family to be very much an implicit theme that is subsumed within an emphasis on the health of communities. Although *Towards a Healthier Scotland* introduces the "Starting Well" health demonstration project focused on young children there is no sustained development of a wider, whole family theme. This is also true of *Our National Health – A Plan for Action, A Plan for Change*, although a range of small, explicitly family focused initiatives are scattered throughout the document.

As Wasoff et al (2002) note, review of Scottish policy in other relevant areas such as community care and education shows a broadly similar picture. While the policy consultation document *Helping the Family in Scotland* (SEHD 1999c) takes family as its main focus, this is exceptional. More usually policies are described as being family orientated, having an indirect or partial family dimension. Again Wasoff et al (2002) provide useful summation: "Despite its growing visibility, family policy is an ambiguous and complex policy area, partly because of contested definitions of the family and partly because of ambiguity about the definition and scope of family policy itself" (p. 4).

Accordingly it is clear that the FHN pilot proposal did not fit into a major ongoing wider campaign to focus explicitly on the health of whole families. Neither, however, was it totally at odds with health and social care policy. Rather, within the more specific world of primary care delivery, it was unusual to see a new mainstream generalist role so explicitly "badged" with a family focus.

As review of the major health and health care strategy documents has suggested, the proposed remote and rural setting for the FHN pilot project fitted in with more general initiatives to redesign health services in these regions. Such initiatives complemented other evolving Scottish Executive developments in these regions which were committed to the economic, social and environmental development of remote and rural communities (Scottish Executive Rural Affairs Department 2000).

This sets the scene for a more sustained analysis of remote and rural issues in the Highland and Islands, and the consequences for health care delivery.

4.4 THE REMOTE AND RURAL CONTEXT

4.4.1 Remoteness and rurality: some general issues

Before focusing specifically on the Highland and Island regions, it is necessary to address the more general issue of what remoteness and rurality means. In Godden and Richards (2003)'s words, "a single, generally accepted definition of rurality is not yet available and indeed may be unachievable" (p.11). However, indicators of population density, distance from major conurbations, and socioeconomic status usually form the basis for current classification systems. The concept of remoteness shares similar difficulties due to its inherent relativity. Attempts at operational definition usually centre on accessibility, and in Australia sustained development work has produced ARIA, the Accessibility/Remoteness Index of Australia (Trewin 2001). Within Scotland, the General Household survey classification scheme (SEHD 2000b) is less sophisticated but remains a useful starting point. Under this scheme locations are remote and rural if their main settlements have a population of less than 3000 and are more than a thirty minute drive time from a settlement of 10,000 people or more. This applies to many parts of the Highland and Island regions.

Beyond the level of understanding provided by such classification systems there are more profound issues about the psychological meaning of remoteness and rurality, and the social construction of reality (Berger and Luckman 1972) in such locations. These will be explored in more depth in the next section, but before doing so it is timely to recognise the dangers of generalising about remote and rural communities. As McKie and MacPherson (1997) point out about the Scottish context:

> "the reality is one of 'diversity': rural communities can be thriving and well resourced or decaying and resource impoverished. Remoteness is not necessarily geographical but relates to access, to information, and centres of decision making. Rural society is heterogeneous leading to different abilities and ways of coping with the realities of rural circumstance" (p. 296).

4.4.2 Remoteness and rurality: the Highlands and Islands context

The foregoing quotation should also be borne in mind when considering the long list of difficulties in the Highlands, Western Isles and Orkney that are cited in the FHN pilot project proposal. Behind these general trends lie a myriad of more mixed local situations. In order to unpack these, we not only have to be aware of prevailing social, political and economic culture (as Robinson (1997) suggests), but also consider distinctive conjunctions of geography and history.

Highland region comprises around a third of the land mass of Scotland but is very sparsely populated (total = 208,700). Within the past 15 years there has been very significant economic growth and related expansion within its hub city, Inverness (population around 50,000). Although this has brought some general benefits to the region, it has emphasised differences within it, particularly in regard to the depopulation of remote and rural areas. Many of the latter are in the region's northern periphery (see Figure 1.1)

Beyond this northern periphery lies the Orkney islands archipelago (total population around 20,000). The Orkneys have a distinctive history of Norse influence and the fertile soil in the region has enabled a relatively rich sustainable agricultural industry. Nevertheless many of the more remote outlying islands have struggled to maintain viable community infrastructures in recent years.

The latter difficulty has been a prominent feature of life in the Western Isles in the past 150 years. This chain of islands on the north west periphery of Scotland have seen a series of socioeconomic initiatives and experiments come and go during this period. The current total population stands at around 26,500 and the main local employment sectors are public administration, education and tourism. The main town Stornoway lies towards the north of the island chain, and again there can be tension between this administrative centre and more remote settlements such as Castlebay which is situated near the southern tip.

The finer points of centre-periphery tensions within these regions are subsumed when they are collectively described as the Highlands and Islands. As a phrase, Highlands and Islands, has come to be redolent with connotations. One of the main recurring motifs is that of magnificent elemental landscapes. This has generally positive connotations but is also historically associated with a highly romanticized view of life in these regions. At the other extreme lies the enduring notion of "The Highland Problem" (Munro and Hart 2000) wherein the Highlands and Islands are characterised as a development problem which has been ongoing for central government since at least the nineteenth century. This takes in periods of neglect where the

regions have been thought of as “a cultural museum” (Burnett 2001; p. 35), and periods where new economic initiatives have been tried with varying degrees of success.

Hunter (1976) analyses the making of the crofting community in the midst of such neglect, romanticism and, most commonly, active exploitation. The history of crofting in the Highlands and Islands is bound up with the clearance of people from the land to make way for sheep. The Scottish poet Norman MacCaig evokes the ongoing impact of this:

> “Sutherland, the county, the whole of it, was most shamefully treated in the clearances. And it’s a beautiful, beautiful countryside. But it’s also very sad, because there are hardly any people in the place. And you keep coming across ruins of what used to be crofts, in the most unlikely places, from a time when the population was much bigger than it now is. So it’s a sad landscape in that way. You can walk for miles and miles and miles and never see a house, let alone a person. It’s got that sadness in it, and you can’t help being afflicted by that history in that landscape, because there it is under your eyes” (cited in Hunter 1995, page 139).

Such conjunction of geography and history as sense of place can exert a powerful influence on personal and community identity (Lippard 1997). Hunter (1975) notes this amongst crofters in the Highlands and Islands where intense emotional attachment to the land has been a persistent trait throughout numerous hardships. This is not to argue for some all-pervasive psychological context for local enactment of the family health nursing concept. Rather it is to suggest that place is an important living cultural factor and that the regions involved may be thought of as having very distinctive “communities of place” (Munro and Hart 2000; p. 6) within them. In short, it may be the difference between living in Castlebay and living on Calton Hill.

4.5 HEALTH SERVICE PROVISION AND COMMUNITY NURSING IN THE HIGHLANDS AND ISLANDS

4.5.1 The general provision of health services in the Highlands and Islands

Within these remote and rural communities of place health professionals play key roles. As Farmer et al (2003) argue, this goes beyond the remit of providing specific services. Rather their presence and wider contributions can be a defining factor in the ultimate sustainability of small communities. Research by Lauder et al (2001) identifies the "community embeddedness" of rural District Nurses, whereby there is a characteristically high degree of integration with place and people in the community in which they practice (and very often live). The same may be said for the local GP who is usually seen as at the core of such communities (Hope, Anderson and Sawyer 2000; Clark 1997).

This integration has become particularly deep rooted in the past 90 years since the Dewar report (HMSO 1912) identified widespread and severe difficulties in remote and rural health care provision and addressed these by instigating what McRae (2001) argues was the first comprehensive medical service in Britain. This service, known as The Highlands and Islands Medical Scheme, is widely seen as the blueprint for the NHS (RARARI 2002a). The Dewar report marshalled a fascinating range of qualitative evidence to argue that the nature of the Highlands and Islands merited exceptional arrangements such as reduced doctor's fees for those not covered by the National Insurance Act. Moreover the value of nursing and its public health role was repeatedly asserted, with Lord Lovat saying that "the medical salvation of the Highlands lies in organised nursing" (HMSO 1912; paragraph 76). The report's recommendations led to gradual improvement of nursing provision and organization (Gibb 1992).

Thus these communities became used to more comprehensive health service provision with doctors and nurses at the core. Nevertheless, as Godden and Richards (2003) indicate, the gap between supply and demand had always been an issue and became worse in the 1990s with ageing of the population and increasing expectations of health care. A further major review was led by Sir Thomas Thompson in 1995 (HMSO 1995) which focused on: accessibility; continuing care services; staffing, recruitment, education and training; and new technology and telecommunications. While a number of recommendations were made in these areas, few were acted upon (RARARI 2002a). The section on nursing recognizes the potential to expand the role of the nurse, citing procedures such as immunisation, venepuncture and suturing. However the tone is very much that of slow, incremental development and there is no specific mention of recruitment or retention difficulties in relation to community nursing.

4.5.2 Community nursing in the Highlands and Islands: a cultural heritage

Because of the absence of a comprehensive study on this interesting topic, it is only possible to gain critical purchase by assembling a number of rather fragmented sources which give a series of historical snapshots. The pre and post Dewar report years are covered by Gibb (1992) who charts gradual development from very inadequate beginnings when there were large variations in the level of training of local nurses and service coverage was fragmented. By 1937 coordination had improved and there were more than 200 trained District Nurses working in the Highlands and Islands. Dougall (2002)'s history of Scottish district nursing (1940-1999) is a rich source of oral testimony as a number of the interviewees recount experiences of remote and rural work in the Highlands and Islands. The multifaceted role of the triple duty nurse is described in vivid detail, with the themes of professional self-reliance, continuity of care, and intimate knowledge of family and community life coming through very strongly:

> "The triple-duty nurse knew everybody on her district because you're working with the whole lot right up until they die …we had more contact with the folk somehow or other … folk confide in you an they get to know you an they tell you things you wouldnae breath to another soul…" (extract from interview; Dougall 2002, p 70)

> "The mother called you when she was expecting her baby, you attended her through ante-natal time, through the birth, you saw the child the first five years of life until they went to school, you followed them through school … and then perhaps this young one went off and she maybe left the village for a while but she came back and she would come and have her baby that I've delivered many a baby's baby … that was fun" (extract from interview; Dougall 2002, p 70)

Moreover, Dougall highlights how the triple duty nurse has a key place in district nursing's own collective image of its definitive characteristics. In the course of the thesis Dougall also argues that district nursing practice was relatively autonomous, especially in remote and rural areas where some islands had no resident doctor. She notes some change in this in the 1960's when District Nurses started to become "GP attached" so that they drew their caseload directly from a GP's patient list rather than from a geographically bound district. "GP attachment" has since become relatively common in the Highlands and Islands, but various arrangements prevail in remote and rural areas depending on available accommodation, topography, and established practices.

A study of island health care by Bloor et al in 1978 also highlights the crucial role of district nursing/triple duty nursing in island communities. A more recent, primarily quantitative, study of triple duties nursing in Scotland (Fulford 1992) is helpful in giving overview of prevalence of the role, caseloads/workloads and perceptions of advantages and problems. Thus, by 1990 triple duty nurses had declined to 3% of the Scottish community nurse population from a figure of 49% in the 1960s. Most of this remaining cadre of 110 were based in rural areas, with 35 in

Highland region, two in Orkney and none in the Western Isles. The double duty combination of District Nurse and Midwife roles was common in the latter region and also elsewhere across Scotland. Caseloads and related workloads were found to vary very widely, but district nursing activities typically accounted for around half of all triple duty nurses' work. Triple duty nurses saw the main advantage of their role as delivering holistic care, often with an emphasis on family care. The main disadvantage related to having less time for health visiting if the overall caseload was too large.

These insights are important for understanding the historical and cultural heritage of community nursing in the Highlands and Islands. Resident nurses in local communities have often been long serving, bringing personal continuity of care. Nevertheless, updating of skills for combined duties nurses has long been recognised as a problem. As mentioned earlier, it was hoped that there might be some research evidence in relation to contemporary local community nursing practice around the time when the FHN pilot was mooted. Two relevant documents from different regions were found that, to varying degrees, used systematic approaches. These are now reviewed.

4.5.3 Community nursing in the Highlands and Islands in the 1990's

Highland is the largest of the three relevant regions. In 1995 it undertook a review of district nursing, health visiting and school nursing services (Gent 1995). The main data collection method involved collating information from workshop sessions. These were held in different localities and involved a total of 103 community nurses and six managers. This generated a substantial number of themes which are presented in "SWOT" analysis format in the report. A selection of those of most relevance to the impending FHN pilot are compiled in Table 4.1

Table 4.1: Selected themes from Highland review of community nursing in 1995

Strengths	Provision of a comprehensive range of high quality services. Community nurses are relatively autonomous and are able to prioritise health needs and be innovative in their practice in meeting individual needs. In general the workforce is stable with a low turnover. The service is accessible with an open referral system. Continuity of care and the development of close relationships with clients, especially by nurses with double/triple/quadruple duty roles.
Areas needing review	Health promotion and screening for well adults e.g. stopping smoking, heart disease prevention etc. Services may only be provided by community nurses to individuals and their families in an opportunistic , rather than a structured way. In addition there is confusion as to the role of Practice Nurses, GPs, Community Nurses and the Health Promotion Department. Clarifying definitions of what constitutes "health" and "social" care. The advantages and disadvantages of generic and specialist nursing. Community nursing practice tends to focus on "structure" and "process" rather than "outcomes".
Opportunities for development	Development of the "public health" role and "community development" type approaches to working. Compilation of Community Health, GP practice and School Health Profiles to assess local health needs, and to ensure effective targeting of resources.
Threats to development	NHS reforms including the Purchaser/Provider split, GP fundholding and Community Care Legislation leading to a perceived fragmentation of services. A perceived lack of clear strategic direction for nursing within the Trust. Continuing reduction in resources in real terms. Confusion and conflict as to the roles of District Nurses, Health Visitors, School Nurses, Midwives and that of Practice Nurses, GPs and Clinical Medical Officers/School Doctors. Difficulties in demonstrating the value and effectiveness of community nursing and "health outcomes".

Table 4.1 reflects many of the difficulties that community nurses all over the UK were experiencing at the time, in reacting to other powerful agendas such as GP purchasing and increasing care in the community. Prominent amongst the local issues is the stability and low turnover of the workforce, and there is absolutely no impression of an impending recruitment and retention crisis within the review.

In mapping the Highland review against the four principles of the proposed FHN role outlined in the Proctor paper, it is firstly apparent that there do seem to be problems relating to the number of different specialist nurses (several examples of duplication are cited in the report). In contrast the generalist combined duties nursing model emerges strongly. In fact the report recommends exploration of the idea of developing the triple/quadruple role into that of a Community Nurse Practitioner who would have a care management role and support from a more junior nurse or nursing assistant.

Secondly there seems desire to move towards a more structured, health orientated model of practice, although several constraints are noted (see Table 4.1). The need for more structured health promotion for well adults and their families matches well with FHN principles, but otherwise the family unit as a whole is seldom mentioned within the report and there is little sense of any need for the family to become more focal. The issue of first point of contact is also notable by its absence and community nursing services are presented as accessible.

Thus there seems fertile ground for developing community *health* nursing, but to some extent the *generalist* already seems to exist in the combined duties roles. Interestingly the strategy recommended by the document is for local health needs assessments that will provide a basis for rationalising the respective roles of District Nurses, Health Visitors, School Nurses and Midwives via a subsequent skill/grade mix exercise led by new "Team Leaders".

Although the Highland report provides a useful snapshot, it has a number of limitations. It is essentially a view from nursing only and provides no specific data on processes or outcomes. Thus when it is asserted that services are comprehensive and of high quality, no other evidence is presented to support this. This reflects a more widespread dearth of data in Scotland in relation to the quality and outcomes of community nursing. Indeed it is very important to emphasise that the new FHN role was being introduced into a pre-existing system where there was little systematic evidence about service quality and performance.

The second report is a substantial community health profile of the Uists and Barra (combined population around 7000) in the Western Isles (Hope, Nolan and Dewhurst 1997). This is useful because it goes on to evaluate current district nursing activity in relation to this picture of local health needs. In addition to the collation of detailed information on district nursing activities and caseload analysis, the study seeks other primary care and social care professionals' perceptions of the match between services and needs.

The report identifies a number of perceived gaps in service provision. The health needs assessment shows a need for much more activity to prevent ill-health and promote behaviour change, but it finds that District Nurses neither report health promotion as a major activity, nor see it as an integral part of their role. Interestingly it concludes, "District Nurses are ideally placed to gauge both the learning needs of patients and family members and the most appropriate way of providing health education, but may not at present have the confidence or skills to address what can be sensitive behavioural issues" (p. 62). The report also found lack of clarity and disagreement amongst District Nurses in regard to their role addressing another local health priority, namely mental health.

Again there was a background of constraints on district nursing time due to perceived lack of staff to provide terminal care and activities that were perceived as inappropriate (e.g. bathing patients whose needs were "social" rather than health-related). The need to support carers more was also raised but the issue of wider family needs usually remained implicit.

In summation, analysis of the Western Isles report identifies a clear need for a more health focused approach and the potential for this to be more family focused. However it is unclear whether the local District Nurses had the means or desire to expand their role in these directions.

Before concluding this section, it is important to note Lauder et al (2001)'s research which interviewed District Nurses working in rural settings in the Highlands. This focused on their perceptions of contact with people with mental health problems. The study found that DNs had a more extensive role than had previously been identified, and that they conceptualised mental health care in the context of families and communities rather than at the level of the individual. Often support was provided informally and the person was not added to the caseload. Alternatively visits to people with mental health problems were legitimised by recording them as "supervisory" visits and using a more minor physical need as the focal problem. This provides some support for the argument that District Nurses in these regions already had a holistic approach to family care at the end of the millenium.

Finally, it is useful to present a numerical perspective on Highland and Island community nursing at the start of the new millenium. Although the ISD Scotland workforce statistics for HVs and DNs in these regions are not available for 2000 (ISD 2007a), the figures for 2003 give a reasonable indication of the number of staff with an HV and/or DN community specialist practitioner qualification around this time (based on their G grading or above). This information is presented in Table 4.2.

Table 4.2: Indicative numbers of qualified HVs and DNs in 3 regions (2003)

Region	Health Visitors (WTE)	District Nurses (WTE)	Combined duty (typically DN and Midwife, occasionally triple duty) (WTE)
Highland	51	49	38
Orkney	6	3	11
Western Isles	14	4	13

These qualified staff were typically supported by teams which included community staff nurses and nursing assistants.

4.6 THE MATCH OF CONCEPT TO CONTEXT

The foregoing analysis has been concerned to gauge the match between the WHO FHN concept as interpreted by the Scottish Executive in 2000, the prevailing context for healthcare service delivery in remote and rural Highland and Island regions, and community nursing practice therein. The limitations of attempting this through literature review relate to the variable scope and quality of textual material available. Nevertheless, it is possible to take stock at this juncture.

Firstly the need for nursing that addresses health needs comes through strongly from local review. What is much less clear is whether this should be "a model based on health rather than illness" as promulgated by SEHD. The point here is that the limited role guidance from SEHD indicates that illness-related work would continue and the need for this also comes through very strongly from local review. Thus outstanding questions remain about how a fundamental conceptual shift could and/or should be translated into activity within pre-existing systems.

Secondly the case for a generalist nurse emerges fairly strongly from local review. However it is clear that a well regarded model already exists in the form of combined duty nursing. The problems of duplication stemming from several single duty specialist roles also supports the generalist case, but the outstanding question is: how would the FHN fit in/over/round existing specialist roles?

Thirdly, as has been seen, the evidence on how well family needs are currently met by community nursing in these regions is either unavailable or equivocal. Dougall (2002) highlights how rural District Nurses in Scotland have traditionally claimed to have close involvement with their patients and, in many situations, a particularly close knowledge of the families on their district. However, the prospect of a new role (FHN) that focuses on care for whole families rather than the individuals within them, raises questions about how this would be operationalised under the prevailing primary care system.

Finally, the issue of the nurse as first point of contact was seldom overt in the review. This is because some remote and rural nurses already potentially had this function for any wider health care needs (e.g. those on islands with no GP) or those elsewhere knew that their community nursing service could be accessed openly by the public. The question that arises is whether a more fundamental change was being proposed that would see the FHN potentially being first point of access for any health care need. The Proctor (2000) paper suggests not, but keeps the option open.

Consequently it can be seen that there is some congruence between concept and context but the match is not completely clear. Moreover, from the review of the literature it is hard to gauge the extent of any "felt" need amongst community nursing staff for the sort of new role being proposed. This relates to the fact that what was being proposed at the time was primarily a theoretical concept and the role to be enacted in practice was not entirely clear to its proponents.

In turn this raises questions about what, if any, associated change was being proposed for other professional groups by the SEHD. Scrutiny of other relevant literature suggests that there was uncertainty over this during 2000 due to ongoing review processes. Thus there was ongoing review of midwifery services in Scotland (SEHD 2001c) and this included consideration of moving away from combined duties roles in remote and rural areas towards teams of single duty midwives. By 2000 difficulties in recruiting and retaining GPs in remote and rural areas had become acute and widely publicised. This contributed to the establishment that year of The Remote and Rural Areas Resource Initiative (RARARI) which had a remit to promote new service development, education for health care professionals and research into the full spectrum of rural health issues (Godden and Richards 2003). RARARI then set up a review of potential solutions to problems of health care delivery, and this was to include fundamental review of the GP role. Finally, as mentioned previously, the role of health visiting was then also being considered within the ongoing Review of the Contribution of Nurses, Midwives and Health Visitors to improving the Public's Health.

The overall conclusion to be drawn from this is that the FHN pilot proposal was introducing a partially developed concept for a role at a time when there was a great deal of uncertainty surrounding the future of many contingent professional roles. Accordingly the SEHD attempted to consult and involve appropriate professional bodies in the pilot project. This process was part of the preparations for the pilot which are summarised in the following section.

4.7 PREPARATIONS FOR THE FHN PILOT: STRUCTURES AND PROCESSES

The June 2000 project proposal document (Spratt and Adams 2000) outlined structures, processes and a timetable for taking forward the pilot. One of the key structures was to be a National Steering Group with a broad range of representation from professional associations for Nurses, Midwives, Health Visitors, District Nurses and GPs. Chaired by the Chief Nursing Officer, this would also include patient representatives from Health Councils. It was also envisaged that local project teams in each of the three regions would meet regularly to anticipate and address implementation issues.

The National Steering Group also included representation from Stirling University who had recently been appointed to provide an appropriate educational programme for the FHNs based on the WHO Europe curriculum. It was envisaged that nurses who already had a Community Specialist Practitioner Qualification (e.g. as a District Nurse or Health Visitor) would have their skills and knowledge assessed against the competency framework (WHO 2000a) and would undertake a programme of three months duration or more depending on need. A full-time 12 month programme would be available to non-specialist nurses who had a minimum of two years post-qualification experience. The target start date for the first run of the programme was February 2001. A similar start time was anticipated for evaluation of the pilot. This would be undertaken by an independent organization that would be selected following competitive tendering.

The project proposal document also outlines the main challenges facing the pilot project. These are listed as:

- "Changing the approach and range of practice of experienced registered nurses
- Gaining the support of all stakeholders – professionals, organizations and the public
- Mobilising current resources to re-design established services
- Ensuring accreditation and recognition of qualifications gained by nurses across Scotland
- Addressing expectations of local communities
- Ensuring recommendations from the evaluation can be and are implemented
- Obtaining sufficient resources to fully fund all aspects of the pilot
- Sustaining the pilot in fragile communities" (Spratt and Adams 2000; p. 8)

It is noteworthy that many of these challenges involve major activity at national level, although the pilot was to take place in remote and rural regions. It is also interesting to note that the idea of using these regions to test out new ideas/systems has a long history (McRae 2001).

4.8 INITIAL SCOTTISH REACTIONS TO THE FHN PILOT PROPOSAL

Useful insight into one professional group's early reactions to the proposal is provided by Daley (2001). In December 2000 she invited members of the Community Practitioners and Health Visitors Association (Scotland) to a Professional Briefing event focusing on the FHN concept. Forty three urban based and 17 rural based Health Visitors attended, having been given the WHO (2000) FHN Context, Conceptual Framework and Curriculum document as prior reading. Following a presentation by SEHD officers on the Scottish pilot project, four concurrent focus workshops were held and the discussions were audiotaped.

Overall reactions were clearly negative, with many HVs perceiving that there had been a lack of consultation about the project. Many felt threatened by the concept and were resistant or hostile towards it. The theme of "role" emerged strongly, with many feeling the FHN role was uncertain, or ambiguous. The potential for role overload for FHNs was highlighted along with associated role conflict. Some HVs felt that they already did family health nursing, but this was not a view shared by all. The perception that the FHN was a "fait accomplit" that would be implemented more widely regardless of the pilot findings was also openly expressed.

As a second stage to this, Daley asked the Directors of Nursing from the three regions involved in the pilot to complete a questionnaire which presented 23 statements from the workshops (based on the themes which had emerged). Responses to ten of these statements are summarized below in Table 4.3

Table 4.3: Responses from three Directors of Nursing to selected statements (from Daley 2001)

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
There is no difference between the double/triple duty nurse and the FHN					3
There is not a problem with recruitment and retention of nurses				1	2
The FHN is not addressing the real problem of a GP shortage	1	1			1
The FHN title is inappropriate in our society	1		2		
Health Visitors locally feel comfortable with the FHN concept		1	1	1	
Don't need an FHN as the different roles within the primary care team complement each other				3	
Integrated Nursing Teams would be a better solution to the FHN			2	1	
The FHN will be a mini GP		1		1	1
Educationally you cannot equip such a generalist with education/skills within the designated time scale		1	2		
It is difficult to see how the FHN will fit into existing systems		2		1	

These ten statements are highlighted because of their particular relevance to analysis of concept and context so far. The responses reveal that the leaders of nursing in these regions perceived a problem with recruitment and retention of nurses, but the majority didn't see the FHN as a solution to GP shortage. The doubts about the FHN title, the educational programme and the fit of the role into existing systems are all striking. The latter aspect is particularly significant bearing in mind that these leaders would soon be engaged in actively managing the development within their respective regions. As such, this gives insight into the relatively high level of uncertainty around the pilot project early in 2001.

4.9 A TWIST IN THE TALE

During the latter part of 2000, the three regions involved were engaged in efforts to encourage nurses to consider becoming FHNs. This was assisted by the SEHD's pledge to provide monies so that existing community nurses' jobs would be "backfilled" by other staff while they undertook the course full-time. Moreover, the students' fees and travel to Stirling University's Inverness campus would also be paid. This represented substantial incentive since potential students on other Community Specialist Practitioner Qualification courses (e.g. district nursing) very often self funded and studied part time.

Nevertheless there were still logistical difficulties in enabling release of selected students, and the first cohort of FHNs which started in February 2001 was smaller in number than had been hoped. The eleven experienced community nurses who started comprised five from the Western Isles, four from Highland and two from Orkney. At the end of the same month the Centre for Nurse Practice Research and Development at Robert Gordon University was commissioned to undertake the independent evaluation of the pilot project.

The beginning of the FHN pilot also co-incided with publication of *Nursing for* Health: *a review of the contribution of Nurses, Midwives and Health Visitors to improving the public's health* (SEHD 2001a). This policy document set out a range of new roles and ways of working that were intended to address the largely unco-ordinated and opportunistic nature of nursing's public health contribution. Two primary aims were to enable Health Visitors to focus much more on community development work, and to increase the number of School Nurses with a community specialist qualification. To this end the SEHD pledged to support 60 new Health Visitors and 30 existing School Nurses to undertake a new Public Health Nurse educational programme with a revised focus.

The work of Health Visitors with families with young children was to move from surveillance and monitoring for all towards more targeted activity. This was to include Family Health Plans

which would be developed with the family through assessment and discussion, and a clear set of goals and actions would then be set out. The FHN pilot project was also highlighted in the document, and the following recommendation was made:

> "The Scottish Executive will review with all interested parties the outcomes of the new public health and family health nurse programmes with a view to having only two routes to community specialist practice – the Family Health Nurse and the Public Health Nurse" (p.39)

Although couched in terms of review, this statement is very significant for several reasons. Principally, it is the first specific articulation of an intent that goes beyond the context of a potential solution to remote and rural regional problems. Rather what is being posited is the possibility of a revised and simplified system for higher level community nursing in Scotland. Moreover this immediately raises implications at UK level as such a change would need to be sanctioned by UK nursing's governing body (at that time the UKCC). Indeed within the document a possible mechanism for such a change is presented:

> "One possible model would be to have two routes for community specialist practice: the Family Health Nurse, focusing on families and the Public Health Nurse with a focus on populations and communities. Within this model the existing specialisms of health visiting, district nursing and practice nursing would be incorporated primarily into the family health nurse route, but with some health visitors and all school nurses following the public health route. The specialisms of community psychiatric nursing, learning disability nursing and childrens nursing would follow one of these routes dependent on the focus of their work, but bringing an existing area of specialism with them. Occupational health and infection control nursing would become specialist branches of the public health route." (p.38)

Thus, in effect, a blueprint was being offered for the revision of UK community nursing's superstructure. Consequently this might be seen to add weight to the fears articulated by Scottish Health Visitors that the FHN pilot project was only the visible face of a development that was already a "fait accomplit". However the irony is that the arrangements outlined above could be seen as threatening other community nursing specialisms more than health visiting. On the contrary, it appeared to offer Health Visitors the chance to choose between the new focus (or re-focus) on the community health aspect of their job or a more family visiting type of remit. Indeed *Nursing for Health* clearly saw health visitors as a key group of workers whose future might be developing slightly differently, but was nonetheless assured.

Accordingly the publication of *Nursing for Health* at the very start of the FHN educational programme set an enhanced national context for the pilot project and its evaluation. The next chapter will focus on empirical research into the enactment of family health nursing between 2001 and 2004. In this way it will address the central question: *how did family health nursing develop in Scotland during this period?*, and give some initial pointers as to why it developed in the way that it did.

SUMMARY

This chapter has taken the FHN concept on a preliminary journey of reconnaissance from Calton Hill to Castlebay and back again, in order to address the question: why family health nursing in Scotland? As was the case in the preceding chapter, documentary analysis yielded partial insights in this regard.

The FHN concept was found to fit well with concurrent Scottish public health and remote and rural healthcare policy. The FHN concept's explicit emphasis on family contrasted with the implicit family focus in most health and social care policy. The SEHD presented the idea of a pilot of family health nursing in remote and rural regions as a possible solution to emerging recruitment and retention problems in nursing, and of possible benefit to General Practices where recruitment and retention problems tended to be longer established. The FHN concept was defined by the SEHD in terms of its embodiment of four principles: skilled generalism; basing work on a health rather than an illness model; caring for families rather than just the individuals within them; and being a first point of contact with the public.

As the test-bed for family health nursing, the remote and rural Highlands and Islands regions were seen to have a number of distinctive contextual features related to history, geography, and social/cultural issues. Review of the cultural history of community nursing in these regions, and contemporary developmental trends, highlighted a lack of robust evidence about the nature and effectiveness of community nursing, past and present. However the case for a generalist health nurse emerged strongly. What was less certain was the extent to which such a nurse already existed at the end of the millenium. The latter could also be said in relation to the aspiration to care for whole families. As Dougall (2002) points out, this has been held to be one of the particular features of Highland and Island community nursing in the recent past. Felt need for a key new community nursing role of this type was hard to discern in the documents reviewed. Moreover, at the time of preparations to enact the FHN concept, the Directors of Nursing in the regions involved still had a number of significant doubts about how it would work as a new role in an established system.

The concurrent launch of *Nursing for Health* in 2001 very explicitly raised the prospect of family health nursing being much more than a localized regional solution to recruitment and retention problems. Rather it suggested that family health nursing may be a more fundamental initiative to change the structure and nature of community nursing throughout Scotland. However the need for this change, and its envisaged nature, remained substantially unclear at the start of 2001, causing anxiety amongst other colleagues about the future of their professional roles.

This was the nature of the prospectus as the new venture began in earnest at the start of 2001.

PART 1: A BRIEF REFLEXIVE RECAP

Through analysis of relevant literature, Part 1 has attempted to answer the question: *why develop family health nursing*? Although the quality of available literature has varied considerably, it has usually been possible to productively analyse the *context* for such a development, both in Europe and in Scotland.

Analysis of the *text* of the concept's development has generally proved more difficult, and has often failed to resolve questions. For example, the critical attributes of the FHN concept have proved difficult to discern and its aspirations have emerged as many and diverse rather than focal. Thus questions remain about what family health nursing is and what it is trying to achieve.

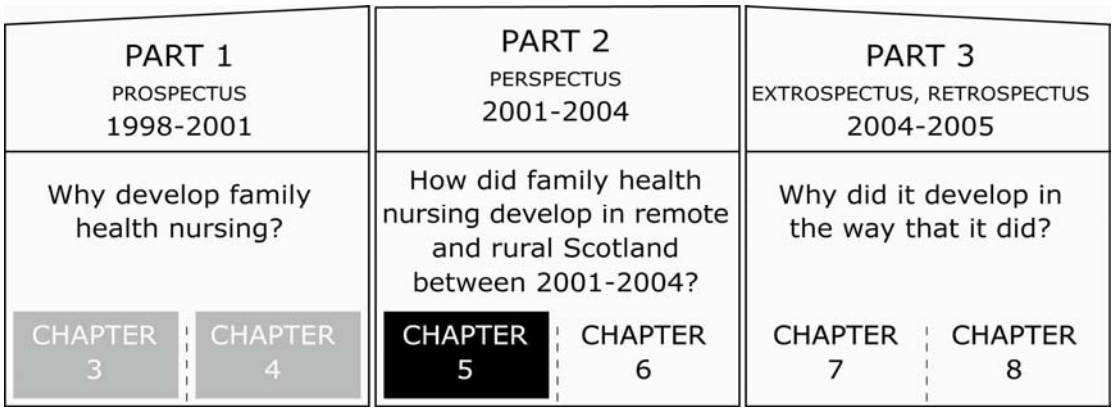
While considerable insights have been gained into the origins of the concept and how it developed at European policy level, a number of fundamental questions remain about why *family* health nursing came to be developed as a prospective venture in Europe. In this regard, analysis of the literature has offered only fleeting and partial insights into the *sub text* of the development (e.g. the political dynamics between different interest groups).

In transposing the FHN concept to a UK context, further questions about the fit of, and the need for, the development have also been highlighted. Although the match of concept to the contemporary Highland and Islands context has emerged as reasonable in terms of the inherent generalism and related flexibility of the proposed FHN role, the question of need is difficult to answer through the literature alone. Finally, the publication of *Nursing for Health* raised the prospect of more radical revision of community nursing. While radical reform had previously been a conjectured *sub text* of the new Scottish venture, in 2001 it became an explicit part of its *text* and *context*.

PART 2

PERSPECTUS

The development of family health nursing in Scotland between 2001 and 2004, as seen through the lens of empirical research into education and practice.



CHAPTER 5

THE DEVELOPMENT OF FAMILY HEALTH NURSING IN SCOTLAND 2001-2004

Overview of this chapter

This chapter primarily addresses the question: how did family health nursing develop in Scotland between 2001 and 2004? As explained in Chapter 1.5, this development is viewed through the lens of empirical research into education and practice. To this end, Chapter 5 provides summative description of the most relevant parts of three linked research studies which examined remote and rural family health nursing practice during this period.

The commissioned evaluation study undertaken by myself and Dr Bernice West between 2001 and 2003 is the most substantive part of this trilogy. After a brief summary of that study's findings about the educational programme for FHNs, a summary of the main findings in relation to practice during 2002 is presented. The reader is referred to Annexes 1 and 2, and to the first three published papers bound-in at the end of the thesis, for comprehensive details of the evaluation study methods and findings. The study's conclusions and their impact on the SEHD's plans for a second phase of the pilot project are then summarised.

The second study followed up professionals' perspectives on the development of family health nursing in remote and rural areas during 2004. The main methods and findings of this study are presented in this chapter. A bound-in published paper gives more details and features further discussion of its implications (Macduff 2006a).

The final study in the trilogy draws on the perspectives of three Family Health Practice Development Facilitators who were appointed by the SEHD to support practice development in remote and rural areas during Phase 2 of the FHN project. As this study was small, only the main findings are presented within the body of this chapter. Again more comprehensive details of methods are available in a bound-in published paper (Macduff 2005).

The chapter summary draws together the main methods used and the main findings from these three linked studies.

5.1 THE COMMISSIONED EVALUATION STUDY

5.1.1 Overview of remit, governance and timing of the study

The overall aim of this study was to evaluate the operation and impact of family health nursing in specific remote and rural areas within Scotland. This included the evaluation of the new educational course devised to prepare FHNs for practice. The overview of the design of the evaluation study given in Chapter 2.2.2.2 also includes details of the six objectives that were specified by the SEHD.

Contractual arrangements for the conduct of the study were issued through The Scottish Executive Central Research Unit which managed the contract and acted in an internal brokerage capacity during the research. The Principal Research Officer from the Health and Community Care branch of this Unit convened a small Research Advisory Group which comprised the client (Scottish Executive Nursing Primary Care Division) and CeNPRaD as the external contractor. This group met regularly during the study and acted as a forum for exchange of information relating to the conduct and progress of the research.

Thus, while the research was necessarily dependent on the existence of the Family Health Nurse pilot project and had to adapt to its unanticipated developments, it is important to emphasise that its conduct and administration was independent from the project's National Steering Group, local project teams, sites and ongoing implementation mechanisms.

The evaluation started in February 2001. Following relevant ethical approvals being obtained, data collection started formally in May 2001 and ran until December 2002. A draft final report was submitted in March 2003 and the final report was published In October 2003.

5.1.2 Evaluation of the educational programme

5.1.2.1 *Summary of evaluation methods*

Evaluation of educational preparation involved the collation and analysis of evidence from a number of sources. Firstly there was systematic collection of structured information pertaining to comparative educational processes (e.g. review of relevant curricula) and to Stirling University's own internal course evaluation processes (e.g. summative evaluations of modules). Enactment of the curriculum was investigated primarily through observation of teaching and assessment, and review of course work. Participant experiences were explored through semi-structured group interviews with students and with supervisors during the course, and semi-

structured individual interviews with teachers at the end of the course. A key data collection tool was a questionnaire designed so that students and supervisors could summatively evaluate a number of aspects of the whole educational experience.

5.1.2.2 *Profile of the students and the curriculum*

As mentioned in the preceding chapter, 11 students undertook the 40 week programme which ran in 2001. A further 20 undertook the programme that ran in 2002. These 31 nurses were typically middle-aged with very considerable experience of nursing in general, and of community nursing in their particular remote and rural location. Twenty were midwives. Twenty had no specific community specialist nurse qualification and were employed in E or F grade posts. Nine already had a District Nurse qualification and three already had a health visiting qualification.

During 2001, the programme was validated by the National Board for Nursing, Midwifery and Health Visiting Scotland. Importantly, negotiations with the UKCC led to Family Health Nursing becoming a specific, recordable Community Specialist Nursing Qualification on the register. A scheme for Accreditation of Prior Learning (APL) was developed by 2002 (the second year in which the course ran). Eleven of the Cohort 2 students obtained some exemption under the scheme.

The main features of the programme curriculum are summarised in Table 5.1.

Table 5.1: **Stirling University Family Health Nursing Curriculum 2002**

Curricula Academic level	**Specialist module content**	**Duration (full time: 40 weeks total)**	**Assessment techniques**
SCOTCAT Level 3 APL and APEL limited applicability. BN and Specialist practice award No core modules	Working with families in the community Communication Advanced Family Health Nurse practice Research, decision making and evaluation in clinical practice	15 weeks *(concurrent with)* 15 weeks 13 weeks 12 weeks	Case study, exam, video presentation and analysis, community portrait, Objective Structured Clinical Examination (OSCE), case reports

Within the curriculum documentation the rationale for the content and the integration of theory, practice and assessment was addressed in a complex conceptual framework based on ideas from WHO Europe and Family Nursing ideas from North America. Compared to the module

descriptors in the WHO Europe curriculum (see Table 3.3), the modules in the Scottish course placed less overt emphasis on decision making, managing resources, leadership and multidisciplinary working. Rather there was more influence from North American models of family assessment and intervention, such as the Calgary model (Wright & Leahey 1994).

The students attended full time and progressed through a fixed schedule of modules. This contrasts with the part-time mode of study typically seen on other community specialist practice award programmes in Scotland where students usually shared a number of core modules with those on other nursing, health and social care programmes.

Thus, in overview, the new FHN curriculum developed for the Scottish pilot project had a number of key differences from other community specialist practice programmes, and also differed from the WHO Europe curriculum. As such, the FHN curriculum was strongly influenced by the needs of the pilot project and the nature of remote and rural nursing in Scotland. In short it was a customised degree programme.

5.1.2.3 *Summary of the educational evaluation findings*

A summary of the programme's strengths and weaknesses is presented in Table 5.2.

Table 5.2: Strengths and weaknesses of the Scottish FHN programme

Strengths	**Weaknesses**
Type of students attracted to the course.	Breadth of content
Theoretical framework	APL/APEL procedure
Family assessment process	Too much assessment
Balance in modes of delivery	Sequence and content of modules
Tailoring of course to specific market	Preparation of supervisors

Several of the main weaknesses of the programme were essentially procedural in nature (e.g. APL/APEL; assessment; supervisor preparation arrangements) and were typical of the sort of issues that arise for many new programmes. The difficulties in balancing breadth and depth of content, however, seemed symptomatic of a more fundamental problem in reconciling specialist and generalist agendas.

The balance between campus attendance and distance learning emerged as a real strength of the programme. Other strengths included the learning of communication skills in the context of family health assessment. Indeed the new family health assessment /promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) were valued very highly and these were seen as central to creating a distinctive new professional identity.

The latter aspect was also tied to the concurrent development of policy and practice. The focus of evaluation now turns to the first year of family health nursing practice.

5.1.3 Evaluation of the first year of family health nursing practice (2002)

5.1.3.1 *Summary of methods for evaluating practice*

5.1.3.1.1 *Overview of methods*

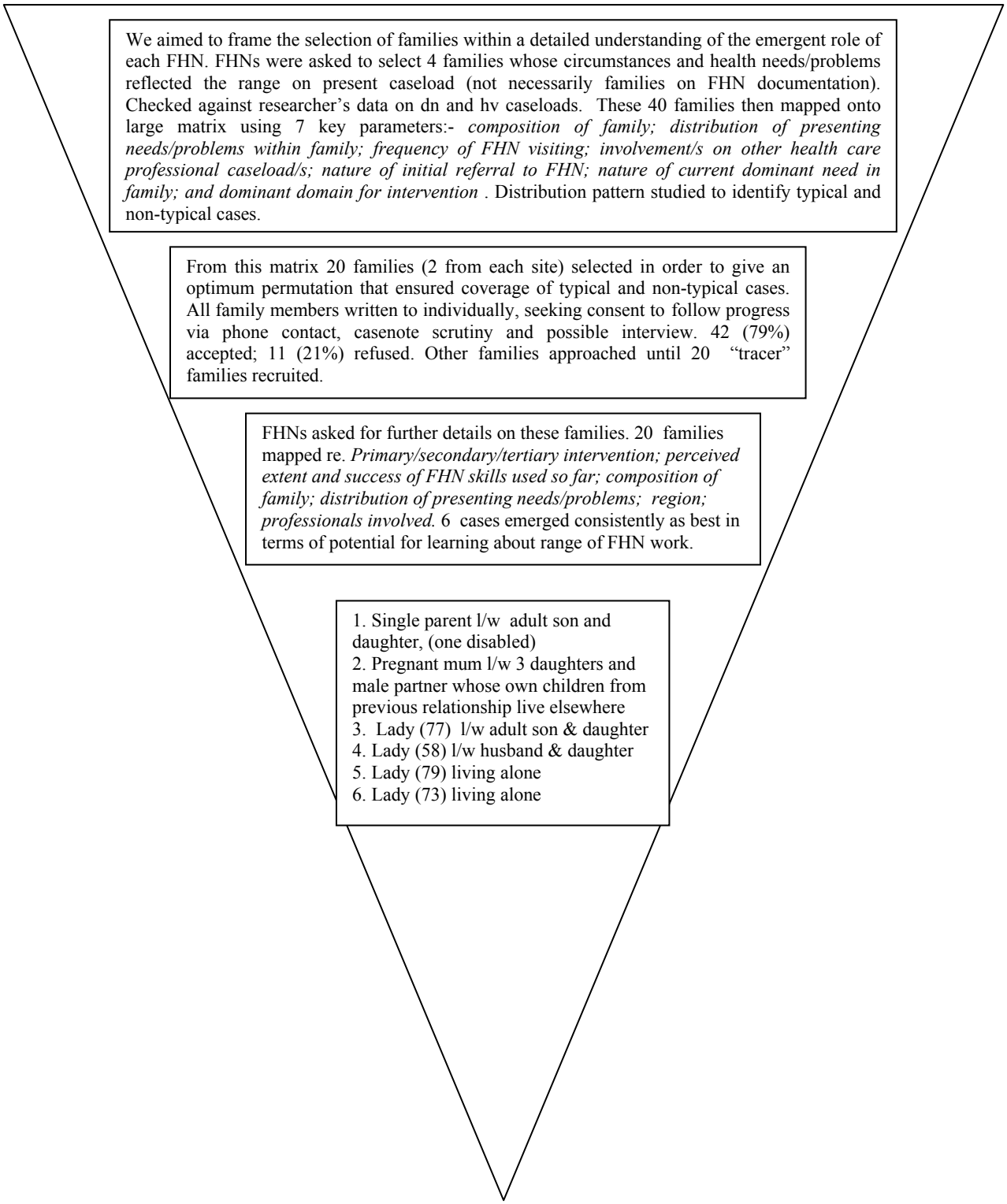
The first cohort of students completed their course at the end of 2001 and commenced work their work as family health nurses at the start of 2002. The evaluation studied this first year of practice up until December 2002. In evaluating practice the overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot (i.e. context of development; process of engagement and outcome of practice). This approach adapted Pawson and Tilley (1997)'s realistic evaluation framework so that process rather than mechanism was studied. The goals were to clarify what FHN practice was in these settings, and then clarify how, and to what extent, the FHN role worked under various circumstances. As such, the ten FHN sites active during 2002 were seen as the main units of analysis in this study[4]. Explanatory case study methodology (Yin 1994) also informed this approach and knowledge was built at two distinct levels in order to explore the operation of the FHN model and draw comparisons between the pilot sites.

5.1.3.1.2 *Data collection*

Firstly, at the micro level, a set of case studies was conducted which focused on the care received by six families in different locations where FHNs were employed. This involved in-depth, semi-structured interviews with family members, the FHN and a maximum of two other key health care professionals involved in delivering care. These cases were selected from a pool of 20 "tracer families" (2 for each FHN site) whose progress was followed during the latter part of 2002. Details of the selection of tracer families and case study families are given in Figure 5.1.

[4] Please see the glossary of key concepts for an operational definition of FHN site.

Figure 5.1: Process of selecting "tracer" and case study families



Study of the operation of family health nursing was further contextualised through the researchers making several visits to each site during the course of the project. This aspect of the study design was influenced by ideas from fourth generation evaluation (Guba and Lincoln 1989), particularly in regard to stakeholder consultation. Profiles of these sites were constructed from the following data sets:

- Available documentation on the epidemiology and demography of each site location, including any extant health needs assessments
- The FHN students' community portrait documents
- Summary profiles of all health care staff comprising the core Primary Health Care Team (PHCT) for each site. Summary profiles of all other relevant health, community and social care staff involved closely with the PHCT at each site (e.g. social workers; voluntary sector workers; teachers). Together these groups comprised the "professional stakeholders"
- Community nursing caseload and mix data available from routine collations (very variable in quality) and specifically obtained in-person by the research team
- Field notes from interviews with key site personnel. These gathered details of cultural context; working practices; referrals; and local resources
- Field notes from telephone discussions with practising FHNs (made throughout project)
- Field notes from direct observations of FHNs' work with selected families
- Scrutiny of the nursing case notes of the 20 "tracer families"

Late in 2001 questionnaires were mailed to professional stakeholders at each site seeking their baseline perceptions of the imminent FHN role. The questionnaire included a number of questions that used the semantic differential technique (Osgood, Suci and Tannenbaum 1957) to gauge anticipated magnitude of practice change and impact. This was repeated a year later using a very similar questionnaire to gauge perceptions of the actual development in practice. A similar, but more restricted repeated consultation exercise was conducted with twenty randomly selected members of the public ("lay stakeholders") at seven of the FHN sites. One regional research ethics committee refused permission for lay stakeholder consultation at the three FHN sites within their jurisdiction.

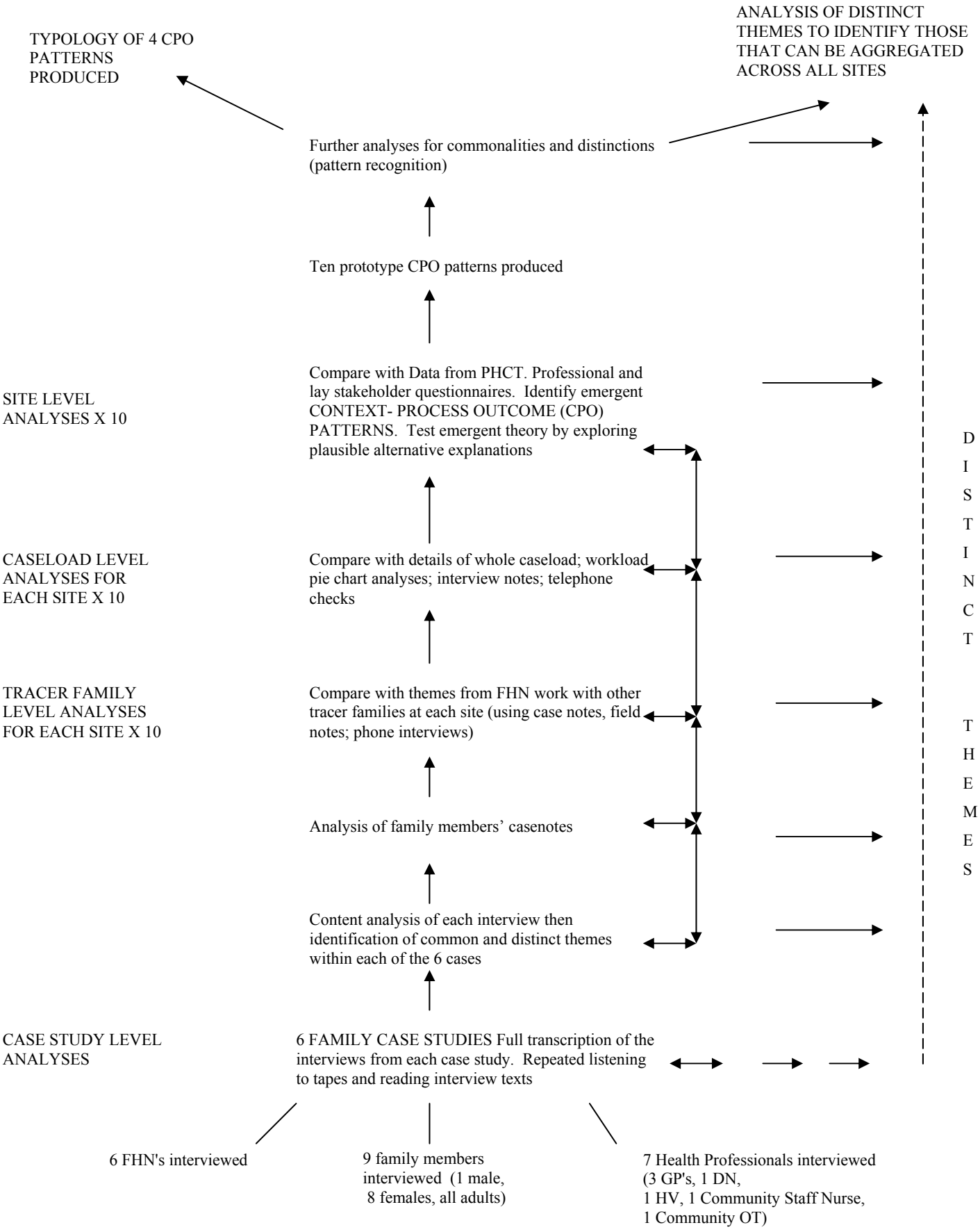
5.1.3.1.3 *Data analysis*

Data from these questionnaires were entered on to SPSS V10 databases and data entry checking was undertaken. Frequencies were generated in order to summarise and describe quantitative data. Textual comments were collated and analysed in terms of content frequency and thematic coverage. Secondary analysis examined the reliability of the questionnaires in terms of internal consistency using the alpha co-efficient.

Qualitative content analysis (Bryman 2001; Priest, Roberts and Woods 2002) was applied to all the family case study interviews so that the emergent themes within each family case could be mapped in terms of which were common to all interviewees and which were distinct. Figure 5.2 gives an overview of how this process informed the overall process of analysis and synthesis of FHN practice data.

As Figure 5.2 shows, it was possible towards the end of 2002 to draw on all the data sets in order to analyse emergent patterns of practice at each FHN site in terms of context of development, process of engagement and outcome. This in turn allowed knowledge to be built at the macro level whereby the ten, site-specific case studies could be compared and contrasted. In this way a typology of family health nursing practice was constructed. Moreover it was possible to gain an overview of family health nursing practice by drawing together the common themes that emerged across the ten sites.

Figure 5.2: Process of analysis of data on FHN practice



5.1.3.2 *Findings*

5.1.3.2.1 *Context of practice*

During 2002 there were ten sites where an FHN sustained activity over the whole year. All ten FHN sites fitted the Scottish Household Survey (SEHD 2000b) definition of remote and rural, in that their main settlements all had a population of less than 3000 and were more than a 30 minute drive time from a settlement of 10,000 people or more.

The ten FHNs all returned to work at home bases where they had previously worked primarily as community staff nurses or District Nurses. The predominant contextual influence on the operation of the new FHN role tended to be the locus of established district nursing services. Thus, during the first year of practice, the FHN site was defined as a distinct geographic area whose population were served by one (or occasionally two) district nursing team(s), within which an FHN was working. Other health professionals whose work involved the provision of primary care services to the population of this site were known as the PHCT. At nine of the ten sites the new FHNs inherited either a part of a large district nursing caseload, or the whole of a small one. From this basis the new role was then developed.

Close scrutiny of pre-existing district nursing caseloads revealed very wide variation across sites in regard to what constituted a caseload (e.g. what people were visited for; frequency of visiting; entry and exit from caseload lists). This made meaningful comparison very difficult. Routinely collected data on nursing activity was virtually worthless in this regard as recording practices varied so widely. This problem has long been recognised within UK community nursing (Goodman et al 2003). At the end of the day, perceived burden of caseload (i.e. “non-heavy” or “heavy”) proved as useful a proxy indicator as any, especially since this was cross-checked with other members of the PHCT. Accordingly this indicator was used in constructing the typology of practice.

5.1.3.2.2 *Typology of practice*

As Figure 5.2 shows, the typology of practice was built through analysis and synthesis of a range of data. Table 5.3 presents the resultant typology. This summarises details of the four distinct practice types which emerged, in terms of their constituent context-process-outcome patterns. Further explanation of each type is now given.

Table 5.3: Typology of family health nursing practice (*table continues on next page)*

Type name	Characteristic context/process/outcome pattern (CPO)	Evaluators' judgement	Site codes
High scope-slow build	**Context** Small, stable caseload. High pre-existing scope for nursing autonomy and practice development **Process** Gradual introduction by FHN only, with little/no change in other professionals working practices **Outcome** Positively viewed by the limited number of families who received the service, but not seen by colleagues and general public as substantially different from pre-existing service. More satisfying for FHNs , but also more demanding	**Partial FHN role development**	**A, B**
Slow build-key ally	**Context** FHN role super-imposed on "non-heavy" district nursing caseload within established and functional medium sized PHCT **Process** Gradual introduction by FHN with active, focused support from at least one other professional within the core PHCT **Outcome** Positively viewed by the limited number of families who received the service (often specific types of client group). "Normal" district nursing services maintained. FHNs generally feel they are making progress	**Partial FHN role development**	**C, D, E**

Table 5.3: Typology of family health nursing practice (*continued)*

Slow/ No go	**Context** FHN role super-imposed on "heavy" district nursing caseload within established and functional medium sized PHCT **Process** Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices **Outcome** No substantive change in practice. "Normal" district nursing services maintained, but remains stressful for FHN and colleagues	**Very little/ thwarted FHN role development**	**F, G, H, (J*)**
Bold build	**Context** "Heavy" district nursing caseload within established and functional medium sized PHCT, but FHN role **not** super-imposed **Process** New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some frictions at boundaries of other professionals' roles. Tensions within the core PHCT **Outcome** Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. "Normal" district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for FHN but much more demanding	**Substantial FHN role development**	**I**

*Site J presented a slight variation of the *Slow/No go pattern* in that the role was super-imposed on a local management role (lead nurse) at a time of managing change towards an integrated hospital/community team. The FHN role was never developed in this context as it was felt that other work needed priority

.

The High scope-slow build pattern of practice was found in two small island sites with very small PHCTs. The FHNs "inherited" district nursing caseloads that were small and had relatively few patients needing regular, intensive nursing input. Workload fluctuated but on the whole there was high scope for autonomous practice development. On the other hand there was the responsibility to provide nursing services for the whole island population and this brought with it the particular demands of being almost constantly on-call and being expected to deal with a very wide range of clinical eventualities. Thus context tended to be the predominant aspect in this pattern. Stakeholders perceived little change:

> "*FHN could have been modelled on what was happening here before i.e. District Nurse always providing a high level of care due to the exceptional circumstances of a small isolated community*" (lay stakeholder)

The predominant characteristic of the Slow build-key ally pattern was the presence within the core PHCT of at least one fellow professional who recognised the need for the role and actively supported it through routine working practice (e.g. by referring families to the FHN). The three sites that shared this pattern covered large, sparsely populated geographic areas and it was notable that the key allies were always based in the same specific geographic patch as the FHN, rather than at a different base within the whole PHCT site. At one site the FHN already had a small pre-existing midwifery caseload and expanded her health work with these families through very active support from a Health Visitor colleague. Typically this pattern featured small scale expansions into areas where there was an opportunity for service development and/or an acknowledged local gap in services.

The Slow/No go pattern was seen in a variety of geographic contexts, but the predominant characteristic was the super-imposition of the role on to a heavy district nursing caseload, combined with an underlying lack of active support for the new role within the core PHCT. Other team members generally did not engage with the role to the extent that it could be seen as at all integrated with team practice. Rather there was pre-occupation with the maintenance of existing services and service priorities. Often this reflected persistent professional perceptions that there was no clear need for this sort of new role.

> "*Existing team networks well and has staff who are motivated and continuously professionally develop. We should concentrate on development of existing team*" (professional stakeholder)

Consequently these FHNs struggled to introduce the role, and development of family work was sporadic and difficult to sustain.

The distinctive Bold build pattern was unique to one site. Unlike all the other sites, the FHN role was not super-imposed on the pre-existing district nursing caseload. Rather the FHN built up a group of clientele "from scratch", primarily through active referrals from other health and social care professionals, but also through direct self-referrals from local people. As the year progressed the FHN developed work with a core group of around 20-25 families at any one time.

Such work often involved regular and sustained input, with intervention visits typically lasting between 60 to 90 minutes. Some colleagues saw this as a positive response to a real gap in service provision, but there was also some concern about who should receive this new service and whether a "two-tier" situation might be arising. These concerns were related to perceptions that the FHN caseload was separate and finite, and that the role was not integrated in the sense of being a necessary part of an open, on-call primary care service that would have to respond to the full range of community nursing and/or medical priorities. In this regard some colleagues questioned whether an FHN could truly be the first point of contact for local families.

As the year progressed the FHN vigorously developed more broad-based community work that focused on health promotion and empowerment. This came to assume around 30% of the FHN workload. This work was particularly well received by professional stakeholders within the wider health and social care community at this site.

> *"In area my local FHN works there are many medical/social interlinked problems which don't fit neatly into any "box". She has been aware of "bigger picture" and improved care/support"* (professional stakeholder).

Within the core PHCT however, some concerns remained that these FHN services were being developed in isolation from overall PHCT services.

> *"I am not sure if it's about creating a further role to DN and HV or about ensuring that the FHN role is accepted as being the way DNs should work, and their role changed accordingly"* (professional stakeholder).

Anxieties over infringement of role boundaries remained a persistent feature during the first year of FHN practice at this site.

5.1.3.2.3 *Overview of family health nursing practice*

Although the emergent typology showed four distinct patterns of FHN practice, the majority shared a significant common feature: the pervasive influence of the traditional work and concerns of the District Nurse role. During the first year of practice the majority of families who had involvement with an FHN did so because a family member was on the district nursing caseload. Where the FHN role failed to thrive that involvement remained focused predominantly on the individual and was virtually indistinguishable from "normal" district nursing. However it is important to note that all the FHNs felt that they were seeing these families much more as a whole and that this gave their practice a different quality. The difficulty was that this was not tangible for many of their close professional colleagues. To some extent this relates to the more general problem of the invisibility of nursing work conducted in peoples' homes (Goodman et al 2003).

Across the ten sites there was an embedded "bottom line" that the introduction of the new role should not adversely affect the pre-existing level of district nursing service and should be sustained within pre-existing budgetary resources for nursing staff. This meant that where the role was developed it almost always supplemented rather than supplanted existing service.

The family health nursing documentation used by the FHNs in practice during most of 2002 was developed during the educational course in 2001. The documentation incorporated in-depth assessment sections based on the Calgary Family Assessment Model (Wright and Leahey 1994). This featured the use of a genogram (diagram of the family constellation which depicts the relationships among family members for several generations and includes the mapping of health status/issues); an ecomap (diagram of a family's contact with others that gives an overview of social interactions and involvements); and in-depth questions on family power structure, dynamics, strengths and weaknesses. Such assessment was found to be a time consuming process that typically involved a number of lengthy home visits. During 2002 the FHNs all made extensive individual adaptations to the documentation in the light of practice. This resulted in a range of hybrid case notes that generally incorporated elements of pre-existing standard community nursing notes. It was notable that family–related documentation such as genograms, ecomaps and related plans were usually retained by the FHNs and seldom resided in clients' homes.

Preventative work usually involved FHN input at secondary and tertiary levels for couples of the same generation, two generational families, and single people living alone (i.e. the typical client groups for district nursing). However most FHNs had ongoing input with at least one family with young children and some of these families had more complex structures. The input here was usually primary prevention relating to common aspects of family living (e.g. diet; exercise). Operationalising the family-as-client philosophy became more difficult where several households

were involved, but this does not mean it was easy within single households. The logistical difficulties of seeing members of a family group individually and in combination cannot be overstated.

As the typology indicates, however, family health nursing was generally very well received by the families who had contact with the service. Some FHNs reported encountering families/family members who didn't wish to participate in the sort of in-depth assessment being offered, and this was usually because they found it intrusive and/or didn't see why it was needed. These sort of overt refusals were relatively rare and this is almost certainly attributable to the fact that the FHNs were very experienced community nurses who used their inter-personal skills to tailor the assessment content to the situations encountered.

5.1.3.2.4 *Lay stakeholders' views*

By aggregating responses from lay stakeholders across the ten sites it was possible to obtain overview. The useable response rate to the pre-implementation questionnaire was 42% (59/140). The useable response rate reduced to 35% post-implementation (45/130). Table 5.4 shows data from the 34 individuals who responded on consecutive occasions.

Table 5.4: Lay stakeholders' views

I think the FHN will deliver (delivers*) a **different** type of service to what is currently available		Unsure		I think the FHN will deliver (delivers*) a **similar** type of service to what is currently available	
Pre	Post	Pre	Post	Pre	Post
7 (21%)	**6** (18%)	**14** (41%)	**11** (35%)	**10** (29%)	**10** (29%)

I think the FHN will **take away** (has taken away*) from existing local services		Unsure		I think the FHN will **add to** (has added on to*) existing local services	
Pre	Post	Pre	Post	Pre	Post
3 (9%)	**3** (9%)	**19** (56%)	**15** (44%)	**11** (32%)	**9** (27%)

I think the FHN development is **well suited** to our local context		Unsure		I think the FHN development is **not well suited** to our local context	
Pre	Post	Pre	Post	Pre	Post
19 (56%)	**15** (44%)	**10** (29%)	**9** (27%)	**3** (9%)	**3** (9%)

I think the FHN development will lead to an **improvement** in local health service		Unsure		I think the FHN development will lead to a **deterioration** in local health service	
Pre	Post	Pre	Post	Pre	Post
12 (35%)	**12** (35%)	**20** (59%)	**15** (44%)	**1** (3%)	**1** (3%)

(* denotes wording used when questionnaire sent post FHN introduction). Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 34 this indicates that the remainder of the respondents did not answer that particular question.

Table 5.4 shows little change in these respondents' views. They remained unsure about several aspects of the FHN development but they also maintained a generally supportive attitude towards it. Respondents' written comments were often very insightful:

> *"If prevention is the aim, how is this to be delivered? Are families to be chosen on perceived socio-economic criteria or some other at-risk category, and once selection is made, how will subject be broached? I would rather see those in need of care get it as priority over some service that could be delivered in an intrusive and ad-hoc manner".*
> (lay stakeholder)

5.1.3.2.5 *Professional stakeholders' views*

A similar aggregation was made of professional stakeholders' responses. The useable response rate to the pre-implementation questionnaire was 74% (110/149) and this reduced to 68% post-implementation (88/129). Alpha coefficients of 0.79 and 0.87 respectively suggest that this questionnaire has a satisfactory level of internal consistency. Table 5.5 presents professional stakeholders' responses to a number of statements in the follow-up questionnaire. The table is based on responses from the FHNs' 78 professional colleagues.

Table 5.5: Professional stakeholders' views

I think the FHN delivers a **different** type of service to what is currently available	Unsure	I think the FHN delivers a **similar** type of service to what is currently available
12 (15%)	**35** (45%)	**29** (37%)
I think the FHN has **taken away** from pre-existing local services	Unsure	I think the FHN has **added on** to pre- existing local services
7 (9%)	**46** (59%)	**22** (28%)
I think the FHN development has involved **substantial change** in the way that services are delivered to patients	Unsure	I think the FHN development has involved **minimal change** in the way that services are delivered to patients
6 (8%)	**34** (44%)	**33** (42%)
I think the FHN development has involved **substantial change** in way professions work together	Unsure	I think the FHN development has involved **minimal change** in way professions work together
10 (13%)	**31** (40%)	**33** (42%)
I think the FHN development is **well suited** to our local context	Unsure	I think the FHN development is **not well suited** to our local context
23 (29%)	**31** (40%)	**19** (24%)
I think the FHN development will lead to an **improvement** in local health service	Unsure	I think the FHN development will lead to a **deterioration** in local health service
26 (33%)	**41** (53%)	**5** (6%)
I think the FHN development is **succeeding** locally	Unsure	I think the FHN development is **not succeeding** locally
16 (21%)	**37** (47%)	**17** (22%)

Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 78 this indicates that the remainder of respondents did not answer that particular question.

These results show that professional colleagues were still unsure about the impact of many aspects of the FHN development, but also that the status quo had not been substantially altered so far. Few saw the FHN as taking away services and engendering deterioration. A comparison was also made using data from the 53 professional stakeholders who responded on both occasions and this showed very little overall shift in these stakeholders' perceptions.

At follow-up we also asked professional stakeholders whether they saw the need for a distinct FHN role locally. Thirty one percent responded affirmatively, 33% negatively, and 36% were unsure or gave no clear answer. Other professional nursing groups at the core of PHCTs tended to be less receptive to the new role than the wider spectrum of professional colleagues.

5.1.3.2.6 *Summary of findings from evaluation of practice*

Although the ten individual FHN sites were the primary units of analysis in the study of practice, the above aggregations of questionnaire data helped to inform the construction of an overview of the first year of practice. Within this picture the dominant themes were:

- Individual FHNs attempted to enact new role but typically had to do this on top of pre-existing district nursing caseloads
- The supplementation, rather than supplanting, of pre-existing services
- FHNs approached their own practice differently
- Family assessment was time-consuming and documentation was unwieldy
- Families who received the service generally appreciated it
- PHCT colleagues were often unsure of the nature of the new role and the need for it
- There was little evidence of the development being detrimental to service provision
- Four distinct patterns of practice developed, as outlined in the typology

Further analysis within the evaluation report posed the question: what factors make an FHN role work? Examination of commonalities and distinctions within the typology, and consideration of these in the light of the broader evaluation findings, led to two basic factors being suggested: *the perceived scope and space to encourage implementing this approach*; and *the local presence of at least one active supporter who changes their own practice*. The presence of at least one of these factors appeared to be a necessary condition for progress. Where neither of the foregoing conditions existed, family health nursing failed to thrive. During the evaluation it was also clear that the individual creativity and drive of the FHN were influential factors.

5.1.4 Conclusions of the evaluation and suggestions for further development

In light of these findings the evaluation concluded that the role had potential, but required development in a number of areas if this was to be realised.

Firstly the Scottish educational programme emerged as substantially different from other specialist community nursing programmes, and thus provided a precedent for other educational providers in the UK to reconsider their approach to specialist practice degree level education. However, the evaluation report made a number of suggestions for further development, and these are summarised in Table 5.6.

Table 5.6 Suggestions for the development of the family health nursing curriculum

Area for development	Suggested actions
APEL and APL processes	• Develop these processes in order to offer full credit exemption
OSCE	• Develop this assessment process in conjunction with the development of the Advanced Family Health Nurse practice module
Clinical Assessment	• Develop tool to reflect the idea of a negotiated learning contract which is student centred and which focuses distinctively on clinical learning outcomes as pertaining to the skills workshops and specialist activity (e.g. family assessments; goal setting and evaluation of interventions).
Module sequence	• Consider re-designing the programme along the lines already suggested to allow for credit exemption and the sharing of content with other community nurses
Preparation of supervisors	• Develop the support mechanisms for supervisors

A number of suggestions were also made in relation to developing the role within the remote and rural regions where FHNs were already working. In particular the evaluation concluded that more work was needed with core PHCTs so that focus on family and health could be integrated and systematic, thus enabling the FHN role to merge with current service provision in a more meaningful way. Specifically, it was suggested that four activities were worth developing, as they had largely been absent during the first year of family health nursing practice. These were:

- a programme of support and facilitation of the development at site level.
- active team review of case loads and working practices to improve effectiveness and efficiency.
- concurrent review of nursing resources and staff skill mix.

- delegation of family health nursing work (possibly by putting FHN in a form of "triage" role, or as an active team leader).

These would ideally be underpinned by concurrent efforts to engage patients and the wider community so that they would expect, accept and value a family health orientated approach.

In regard to the application of family health nursing to other remote and rural areas of Scotland or to urban areas, it was felt that careful consideration was needed. While a multi-skilled generalist nurse who can provide a range of services should be suited to remote and rural areas of Scotland, it did not necessarily follow that the optimum knowledge and skill-base for this individual should be premised on family health nursing. Rather it was suggested that four phases of analysis be considered before deciding to introduce Family Health Nurses into the workforce:

1 Situational analysis: What needs require to be addressed and why? What are the current gaps in service provision? What type of FHN role would best meet these needs/fill these gaps? Could this be done by other means? What do others think of current services? Which aspects of current service provision will need to be modified to accommodate the new role?

2 Role analysis: What work will be done in the new role? Who will they work with? What type of person is best suited to the role? What education and training do they need? At what level in the organisation will they be employed?

3 Cultural analysis: What is the organisation's approach to health care? Is this understood by service providers? How will this new role be perceived? How will it fit with current understandings? Will the new role be accepted and supported by professionals and communities?

4 Business analysis: What resources are available for the development, support and facilitation of the new role? What resources are needed to sustain the development and allow for growth?

The rationale was that consideration of each of these questions would promote clarity of purpose for role development and would facilitate the customised integration of new roles into current service provision. These considerations would have relevance to urban applications and also enhance the potential of the FHN role to be a solution to the particular problems of recruitment, development and retention of staff in remote and rural areas.

5.1.5 The SEHD report and future plans

A first draft of the evaluation report had informed a large SEHD Family Health Nursing workshop event in March 2003 and its findings were subsequently incorporated in an SEHD report on the pilot project which was published in October 2003 (concurrently with, but separately from, the full Macduff and West final evaluation report). This *Family Health Nursing in Scotland* report (SEHD 2003a) not only summarised progress with the pilot, but also set out a programme for a second phase of the FHN project in Scotland. The programme's five objectives and associated actions are summarized in Table 5.7.

Table 5.7: SEHD plan for the second phase of the FHN project in Scotland

Objective	Associated action
1 To consolidate the practice of family health nursing within the primary health care team in each of the four pilot regions	An active change management programme will be developed in each of the pilot regions as part of an overall action research project. This will mean the recruitment of a local facilitator in each of the regions who will work with local PHCTs to support change and to develop the full potential of family health nursing within the team. This will start in October 2003 and the local work will be linked into a nationally focused action research project to assess impact and potential.
2 To test the suitability of the role in an urban setting	An additional arm of the pilot will involve all of the nurses within a defined locality in NHS Greater Glasgow. Public Health Nurses will develop a population based approach, with FHNs working alongside Family Doctors as originally envisaged by WHO Europe in Health 21.
3 To review and develop the educational programme based on competencies for family health nursing practice	Clear competencies for family health nursing will be developed and the curriculum framework re-structured to address the weaknesses identified by the evaluators, whilst maintaining the notable strengths. The revised programme will form the basis of the urban pilot. A key component of this work would be the development of a short conversion course that would allow existing community specialist practitioners to become FHNs.
4 To apply learning from the FHN programme to help shape the future of community nurse education	The FHN pilot and its related publications will inform the NMC consultations on the future regulation of community specialist public health nursing in the UK
5 To promote debate on the future development of FHN practice in Scotland and the UK	Promotion of wider debate in Scotland, the UK and Europe will be taken forward through the publications on the pilot and an international conference in October 2003.

Thus it can be seen that the evaluation study's suggestions on education and practice development were quickly incorporated into plans for imminent action. The next section of this chapter presents findings from a study which followed up the progress of remote and rural Scottish family health nursing during 2004.

5.2. A FOLLOW-UP STUDY OF PROFESSIONALS' PERSPECTIVES ON THE DEVELOPMENT OF FAMILY HEALTH NURSING

5.2.1 Rationale for a follow-up study

As described in the previous chapter, ten of the original 11 FHN graduates were active in developing the role at their local Primary Health Care Team (PHCT) sites during 2002. A further 20 FHNs graduated at the end of that year and started practicing in 2003. This included three graduates who were already qualified as Health Visitors (HV) and would be returning to implement the role in the context of a continuing health visiting commitment. This was novel as all the other graduates had previously worked as community staff nurses (with basic registration qualification/s but no community specialist practitioner qualification), Community Midwives, District Nurses, or various combinations thereof. Indeed the influence of the traditional work and concerns of district nursing had been found to pervade the first year of family health nursing practice. Thus, with the critical mass of active FHNs increasing considerably and evolving in nature, there seemed good reason for further study of the development of practice across a wider range of contexts.

Moreover, in December 2003, the SEHD appointed three part-time regionally-based Family Health Practice Development Facilitators to work over an 18 month period. This responded to the suggestion in the evaluation report that there was a need for facilitation of the FHN role and family health orientated approaches with local PHCTs. Again it seemed that there was a useful opportunity to gauge any early impacts from this work.

Accordingly, I conducted a follow-up study between April and December 2004, having obtained relevant ethical approvals from the four respective regional NHS Research Ethics Committees and associated local NHS management bodies. The study was more limited in scope than the previous evaluation study, in that it did not seek to directly access perspectives from patients and/or members of the general public. While the latter information had proved very valuable in the previous study, its systematic elicitation would have entailed a much more substantial and involved study than the author was in a position to undertake. Moreover there was awareness of the potential burden that such a study might impose on participants so soon after the major evaluation study. Accordingly it was decided to limit the study to professionals' perspectives and to use a research method that would minimize demand on their time. The inherent limitations of this approach in terms of engagement with practice context are acknowledged.

5.2.2 Aim and objectives

The research aimed to conduct a follow-up study of professional perspectives on the development of family health nursing in order to gain further understanding of recent practice.

The four objectives were:

1) To identify Family Health Nurses' (FHN) perceptions of their own practice since the beginning of 2003.

2) Where possible, to identify FHN's professional colleagues' perceptions of practice during this period.

3) To investigate new patterns of practice and further develop the practice typology which emerged during 2002.

4) Where appropriate, to directly inform local practice development work relating to family health nursing

5.2.3 Methods

The study had primarily a survey design and comprised two main linked elements: (i) a survey of FHNs' perceptions of their recent practice, with the option of telephone interviews for selected FHNs, and (ii) a linked survey of the perceptions of their professional colleagues in regard to the same subject. As identification of, and potential access to, relevant professional colleagues was only possible through the auspices of the FHN at each site, the second element of the study could only proceed at each site with the consent and facilitation of the relevant FHN.

Thus each FHN was invited to choose the nature of their participation as follows:

- To take part only in the first element (survey and phone interviews with FHNs)

- To take part in the first element (survey and phone interviews with FHNs) and to facilitate the second element (survey of colleagues) on the understanding that resultant anonymised site-specific findings would not be made available to inform local development of the FHN role.

- To take part in the first element (survey and phone interviews with FHNs) and to facilitate the second element (survey of colleagues) on the understanding that resultant anonymised site-specific findings would be made available to inform local development of the FHN role

- To take part in neither of the elements of the study

The questionnaires sent to the FHNs and their professional colleagues shared common core content. This consisted of substantial parts of the "stakeholder" questionnaire used during the previous evaluation study. The relevant parts of that questionnaire had proved both valid and reliable with a similar population (Macduff and West 2004a, Annex 2).

As part of the common core content of the FHN and professional colleague questionnaires, the typology of practice that had emerged from the evaluation study (Table 5.3) was reproduced. Potential respondents were invited to review this typology and indicate which, if any, of the patterns best summarised FHN practice at their particular PHCT site. If they felt that a feature of their selected pattern did not apply, they were invited to delete the appropriate part of the text. A large "Other" box was also provided so that respondents who felt that none of the four patterns applied could summarise key features of context, process and outcome at their local site.

Indeed the study sought to build from previous methods and findings. Thus where new or different practice patterns were seen to emerge, or where contexts were found to be markedly different to those studied before, further investigation was undertaken by inviting the FHN to take part in a tape-recorded telephone interview. These interviews explored aspects of context, process and outcome at the FHN's local site and attempted to elicit reflections on development of the role.

Resultant audio recorded data was transcribed and examined using qualitative content analysis technique (Bryman 2001; Priest, Roberts and Woods 2002) so that more in-depth understandings of practice at particular sites could be constructed. The main unit of analysis within the study was each PHCT site where the FHN (or occasionally FHNs) practiced. This maintained the original evaluation study's emphasis on trying to understand the meaning of practice in context, although the follow-up study did not include site visits or interviews with patients and families. Thus survey findings were collated for each site.

It was also deemed appropriate to aggregate the survey findings for the FHNs as a group, given their common educational experiences and their common status as pioneers of the new FHN role. Across-site aggregation of survey responses from FHNs' professional colleagues was also undertaken, but interpretation of resultant findings has been cautious due to a number of factors (e.g. overall responses rate being lower than previously; the tendency of aggregation to hide and/or

distort significant local trends). Accordingly these results are used sparingly, either to highlight a very strong trend that is evident across sites, or to highlight inconclusive results that require site-specific interpretation. Quantitative data is primarily summarised in terms of descriptive statistics such as frequencies and percentages.

5.2.4 Findings

5.2.4.1 *Response rates*

At the time of the FHN survey (April 2004), 26 of the original 31 FHNs were working in that role (three had left for other jobs and two had not had a chance to consolidate their practice due to illness). Accordingly questionnaires were sent to 26 FHNs and 23 were returned completed (88%). Six of these respondents chose to take part only in the FHN survey, while the remaining 17 also wished to facilitate survey of their professional colleagues in such a way that anonymised site-specific findings would be made available to inform local development of the FHN role. The 17 FHNs worked in 15 PHCT sites.

Thus survey of professional colleagues took place at 15 sites. Due to advice about data protection from one of the NHS Ethics Committees (which later turned out to be erroneous), the FHNs themselves were asked to distribute the questionnaires. The target population was all members of the PHCT at their site and all other community and social care staff with whom they had regular work-related contact. The researcher had access to a list of job titles only. However these site listings were also cross checked for completeness against job title listings generated by the new Family Health Practice Development Facilitators.

A total of 168 questionnaires were distributed in this way, with target populations at local sites ranging from 4 to 22 colleagues**.** A total of 88 questionnaires (52%) were returned. This is a substantial reduction from response rates achieved in two surveys that were part of the previous evaluation study (79% and 74% respectively). These surveys had used direct mailing and the change in method may account for some of this reduction, along with a perception (widely voiced by the FHNs themselves) that some professional colleagues were fatigued by questionnaires in general and the particular emphasis on family health nursing development. Response rates for individual sites ranged widely from 25% to 100%. However the returned questionnaires were generally well completed, and yielded a range of very useful qualitative and quantitative data. The paired statements part of the questionnaire (see Table 5.5) again proved reliable, with alpha coefficients of 0.84 and 0.81 when used with FHNs and colleagues respectively.

Eight of the FHNs working within these 15 sites were approached to take part in subsequent telephone interviews. All agreed to participate. These interviews typically lasted between 30-80 minutes.

5.2.4.2 *Family Health Nurses' perceptions*

The 23 FHNs' perceptions are summarised under three themes: evaluation of the local FHN service; professional and personal impacts; the nature of the work itself.

A number of questions asked the FHNs to evaluate aspects of their service delivery in terms of magnitude of practice change and the nature of its impact. Practice change was very much seen as gradual, but suited to context and enhancing the existing service as a whole. Within questionnaire responses, FHNs cited a range of examples of practice change such as:

> *"Individuals/families receive services which previously were not offered"*
>
> *"Providing care to families under 65 and prior to a medical need"*
>
> *"More focus on patient/family empowerment/health promotion"*
>
> *"Even taking a traditional DN caseload and applying FHN theories opens up the potential of work and exposes issues not previously seen as obvious. I always try to involve others in the family – sometimes don't succeed"*
>
> *"Where possible, extra nursing time is made available to families with problems"*

Ten FHNs (44%) clearly stated that they were delivering a different type of service in comparison to pre-existing care provision. Unsurprisingly there was also a very strong belief that local PHCTs needed to deliver a more family health orientated approach (91%). However there was a little more uncertainty about the role of the FHN within such a scheme (70% felt there was a need for a distinct FHN role locally). At the time of survey the programme of site-based support for the role was generally seen as evolving. The three regionally-based Family Health Practice Development Facilitators had a remit to lead change management activities, building on family health expertise within each PHCT. This usually involved regular site visits to meet team members and to facilitate review of working practices. At the time of the survey, however, little had yet been achieved in terms of team review of caseloads, work practices, skill mix, resources and delegation of FHN work.

In terms of the professional and personal impact of the development for each FHN, most had predominantly positive experiences. Only three (13%) reported an overall worsening of relationships with colleagues and worsening in general job satisfaction. However nine (39%) did perceive worsening in general job stress. This was usually attributed to the pressures arising from

implementing the new role, but other concurrent organisational changes were also cited in this regard. By contrast a further six FHNs (26%) perceived improvement in their general level of job stress, and the remaining eight (35%) either reported no change or were unsure. When asked for summative evaluation of the impact of the role development on overall quality of working life, a majority of FHNs (13; 57%) perceived improvement, with only four (17%) indicating that their lot was worse.

Variation in perceptions amongst the FHNs tended to be most pronounced when asked to describe and/or categorise the nature of the work itself. Previous evaluation (Macduff and West 2003) had identified tensions between the FHNs' aspirations to engage with local communities on health promotion issues and their ongoing commitment to deliver services to those with ill-health (e.g. chronic disease problems; palliative care). Accordingly in this follow-up the FHNs were asked to differentiate whether their current role tended to be concerned with health matters or ill-health matters. While five (22%) opted for the former, the same number opted for the latter, and the large remainder opted for an "in-between" position.

Similarly, the previous evaluation had identified tension between generalist functioning (e.g. providing a wide range of primary care services to a wide range of clients) with specialist functioning (e.g. providing in-depth and highly developed care packages to a specific clientele). Therefore in this follow-up study the FHNs were asked whether they saw their current role as primarily generalist or specialist. Only one respondent opted for the specialist description, while 8 (35%) clearly saw themselves as functioning as generalists. Again the majority of respondents were unable to clearly differentiate.

A more specific breakdown of working practices was sought by asking the FHNs to estimate the proportion of their work currently occupied by each of the three core primary care nursing functions posited in the "Liberating the Talents" English policy document (DOH 2002). An "other" category was included for estimation of the remainder of their time taken up by other functions. Results from the 22 FHNs who completed this question are presented below in Table 5.8 (figures represent proportion of work in percentage terms).

Table 5.8: FHNs' estimations of proportion of work (%) occupied by 3 core functions

	First contact/ acute assessment, diagnosis, care, treatment and referral	Continuing care, rehabilitation, chronic disease management	Public health/ health protection and health promotion	Other remaining functions aggregated
FHN 1	30	20	20	30
FHN 2	25	35	20	20
FHN 3	10	50	38	2
FHN 4	50	40	10	0
FHN 5	25	25	25	25
FHN 6	30	40	15	15
FHN 7	0	10	90*	0
FHN 8	25	10	60	5
FHN 9	25	25	50	0
FHN 10	30	30	10	30
FHN 11	20	40	20	20
FHN 12	20	60	20	0
FHN 13	10	50	20	20
FHN 14	40	40	20	0
FHN 15	50	25	25	0
FHN 16	30	30	20	20
FHN 17	46	50	4	0
FHN 18	10	10	5	75**
FHN 19	30	50	10	10
FHN 20	20	70	10	0
FHN 21	20	20	60*	0
FHN 22	10	50	15*	25

* denotes FHN with HV background who resumed HV caseload on return to practice after FHN course
** reflects FHN's partial secondment to community needs assessment work at time of survey

Given that the FHNs were not asked to keep detailed activity logs and that many activities would involve a combination of the core functions, the above responses necessarily reflect notional approximations. Nevertheless these results give a useful overall insight into the relative dominance each of the FHNs ascribed to each of these core functions. While continuing care related functions tended to predominate (reflecting the strong district nursing legacy inherited by most new FHN postholders), the diversity of what can be said to constitute FHN practice is most striking.

This diversity is highlighted in the case of the three FHNs who had a Health Visitor (HV) background and who resumed an HV caseload on return to practice after the FHN course. As Table 5.8 shows, two of the three reported high proportions of public health/health protection and health promotion work. In contrast, the remaining FHN was returning to a triple duty nursing role (Health Visitor, District Nurse and Midwife) in which the continuing care work associated with district nursing tended to predominate. It is interesting to note that this nurse was now in effect enacting four roles simultaneously.

Indeed the vast majority of FHNs were still trying to develop the role in the context of continuing service provision to inherited district nursing caseloads. This usually made progress gradual:

> *"Difficult to implement FHN due to lack of time given for this. I came back into the same post and, although reviewing and reducing the caseload has allowed time for FHN, it is not enough and DN duties still have priority. Lack of line management support"* (response from questionnaire).

> *"FHN role is developing slowly. Time is a big issue when carrying out assessments. Documentation is difficult to deal with. Using for a complex family is cumbersome"* (response from questionnaire).

Often there was underlying tension between the new role and inherited role:

> *"The patients - the families I should say – I've been in district nurse mode the day"* (extract from telephone interview 04/4)

However there was usually a sense of some consolidation and local development:

> *"I feel that the project is developing slowly but in recent months there has been more of a positive response. Other team members are very slowly grasping the concept of family nursing and the FHN role"* (response from questionnaire).

Moreover, most FHNs felt that the new role was making a positive impact by offering enhanced or expanded services:

> *"It takes in households that up till now did not seem to be being met by any other professionals. More comprehensive and holistic"* (response from questionnaire).

> *"The genogram and ecomap make the big difference"* (response from questionnaire).

> *"They* (clients) *do have problems, and you wonder if you are opening up, but I do think they need. Well for instance depression needs to be identified. These things that maybe wouldn't get asked. You know you don't have to ask them that for the GMS* (General Medical Services) *contract"* (extract from telephone interview 04/3).

Nineteen of the 23 FHNs' (83%) indicated that one of the four previously identified patterns of practice was characteristic of current practice at their own site. Table 5.9 gives details of these responses.

Table 5.9: Characteristic patterns of practice at sites, as perceived by FHNs

Pattern of practice	Number of FHN responses in this category
High scope-slow build	8 (35%)
Slow build-key ally	8 (35%)
Slow/No go	2 (9%)
Bold build	1 (4%)
Other (as described by FHN)	4 (17%)

The other patterns described by FHNs tended to be variants of one of the original four patterns, or to involve combinations of elements from several of the original patterns. This suggests a basis for some refinement of the original typology, but overall the four patterns were seen as relevant and meaningful in characterising current practice. The domination of the two *Slow build* patterns is consistent with other findings relating to evaluation of practice. The main difference between these two patterns is that *High scope-slow build* is characterised by little/no change in other professionals' working practices, while *Slow build-key ally* reflects active, focused support from at least one other professional within the core PHCT. The two FHNs who characterised their sites as *Slow/No go* had only been able to introduce family health nursing in a very limited, sporadic fashion. The *Bold Build* site was seen to have maintained its characteristic pattern since the original evaluation.

5.2.4.3 *FHN's professional colleagues' perceptions of practice*

Across-site aggregation of 88 professional colleagues' responses showed a broad range of opinons about family health nursing development in terms of magnitude of practice change and the nature of its impact. The FHN role was seldom seen as taking away from pre-established service provision, but perceptions varied widely about: whether it was substantially different from these services; what criteria should be used for judging its success; and whether it was in fact proving successful to date.

The overall picture was slightly more positive than that obtained in the original evaluation study. Responses to the *Is there a need for a distinct FHN role locally?* question reflect this, with 43% saying *Yes*, 27% saying *No*, and 25% saying *Don't know*. However this also illustrates the range in responses and, when this is considered alongside the reduced overall response rate, the need for local, site-specific interpretations of such findings is highlighted.

The strongest positive trend emerging from the aggregation was that almost two thirds (64%) of respondents felt that their own PHCT needed to have a more family orientated approach. While this suggests a good deal of fertile ground for the FHN role, a question remains about the level of priority that such a family approach is ascribed within everyday PHCT practice. Many colleagues

reported referring individual patients to their local FHN, but referral of whole families was still relatively rare.

Sixty two respondents (70%) indicated that one of the four previously identified patterns of practice was characteristic of current practice at their own site. Table 5.10 gives details of these responses.

Table 5.10: Characteristic patterns of practice at sites, as perceived by FHNs' colleagues

Pattern of practice	**Number of responses in this category**
High scope-slow build	36 (41%)
Slow build-key ally	9 (10%)
Slow/No go	14 (16%)
Bold build	3 (3%)
Other, or combination of elements from above patterns	15 (17%)
No response to this question	11 (13%)

The other patterns described by FHNs' colleagues again tended to be variants of one of the original four patterns, or to involve combinations of elements from several of the original patterns. Again, *Slow build* patterns predominated, but it is notable that the *key ally* type was less in evidence. In this regard it must be noted that around a quarter of the respondents had less than monthly contact with their local FHN, so that their knowledge of working practices and alliances may not have been substantial. Cross-tabulation of responses showed a slight trend to support this interpretation, but numbers were too small to infer any statistical significance.

5.2.4.4 *Site-specific analyses*

In the initial evaluation study, FHN sites were sub-divided into three categories according to common contextual features. For the purposes of this follow-up study, a revised and simplified categorisation was produced in relation to the 15 PHCT sites where survey of colleagues was facilitated. This is presented below in Table 5.11, along with a breakdown of the number of sites within each category. All sites were remote and rural, as defined by the Scottish Household survey (SEHD 2000b).

Table 5.11: PHCT sites categorised by common contextual features

Category	Common contextual features	Number of sites in this category
Small island	Small island with population under 500 people	2
Small villages, big country	Country setting comprising a large geographic area within which a small, scattered population lives (usually below 4000). Small villages predominate and travelling times within the site are often substantial.	10
Small town	Small town setting where total town population is between 5000-10,000. The PHCT may also serve some people in the surrounding countryside, but the focal point of service provision is within the town.	3

Site specific aggregations of findings for the two *Small island* sites yielded little that was different from the initial evaluation study, in that there was gradual development of the role in settings which had high pre-existing scope for autonomous practice.

As Table 5.11 indicates, most of the sites studied fell into the *Small villages, big country* category. Site specific aggregations of findings for these ten sites showed a varied picture.

Several such sites had struggled to develop and consolidate the role to any significant extent. FHN practice was typically seen as very similar to pre-existing district nursing. Usually the FHNs felt that their personal way of approaching care delivery was different, but they felt frustrated that colleagues were not giving more priority to a family orientated approach. In some cases overt colleague resistance to the FHN role remained, and this included sites where an FHN had been practicing since 2001.

At other *Small villages, big country* sites there was a greater sense of progress in regard to the consolidation and development of the role. At two of these sites the respective FHNs functioned more independently from the traditional district nursing role, in that they had not inherited a DN caseload and they had more scope to develop autonomous practice. The typical numbers of families

each of these FHNs' had as a caseload were 20-25. However, just prior to the follow-up study, local circumstances required that one of these FHNs moved to an adjacent site and inherited a small district nursing caseload. Similarly, it was unclear whether funding for the other more independent FHN role would continue beyond May 2005. Thus there was little sense of any momentum behind the development of an FHN role that was independent from local district nursing caseloads.

None of the ten sites that had been studied in the original evaluation fell into the *Small town* category. Accordingly this follow-up study has offered an opportunity for new insights into FHN role development in these areas of larger, more concentrated, populations. Again there was variation in perceived progress amongst the three sites studied. Indeed there was often variation in perceived progress within particular sites. This is exemplified below in the collation of comments from colleagues at Site X.

Collation of comments from Site X

"The comprehensive assessment tool offers a different focus, but the rest of the work follows the same approach to health visiting or holistic district nursing; FHN expands community nursing and has added to its public health focus; locally it has not been established in what ways they (FHNs) *will be using their skills; more FHNs are needed for it to succeed; FHN and health practice staff have worked productively on a number of issues; most of the FHNs seem to be trying to do a normal community caseload and therefore have not been allowed the time/freedom or opportunity to develop role; family now has one nurse involved with all of them if they wish; unsure if patients/families distinguish between community nurses and FHN; beneficial for very small proportion of families-in many instances duplicates HV role; increases the services offered to patients and allows other health professionals to target them more appropriately; FHNs have widened their expertise, enhanced professional development, increased job satisfaction; there is recognition of significance but little resources to meet whole family issues; project strongly facilitated at present involving a lot of paperwork-unsure of long term outcome".*

5.2.4.5 *Summary of findings from the follow-up study of professionals' perspectives*

The findings of this follow-up study confirmed the essentially mixed picture that emerged in the original evaluation study. Within this picture the dominant theme was that of gradual positive development that tended to maintain established service provision, yet also supplement this with a limited expansion of family health services and public health activities. One of the most striking findings from follow-up was the flexibility and wide scope of the role in terms of providing generalist community health nurse practice. However, capacity to engage with whole families was found to vary widely in practice.

5.3 A STUDY OF FAMILY HEALTH PRACTICE DEVELOPMENT FACILITATORS' JUDGEMENTS ON THE PROGRESS OF FAMILY HEALTH NURSING IN REMOTE AND RURAL SCOTLAND

5.3.1 Rationale

By the end of 2004 each FHPDF had been in post for a year, during which time they had sought to facilitate FHN role development and family health orientated approaches within the relevant PHCT sites in their own regions. This involved five sites in Orkney, eight sites in the Western Isles and eleven sites in the Highlands/Argyll and Clyde region. The nature of this engagement with different sites put them in a unique position to compare and contrast FHN practice development. As such, there seemed a good opportunity to seek their judgements on progress.

5.3.2 Summary of method

This was addressed by means of a short postal questionnaire which was designed to build from the previous evaluation findings. The questionnaire asked the FHPDFs to rate for each site in their region:

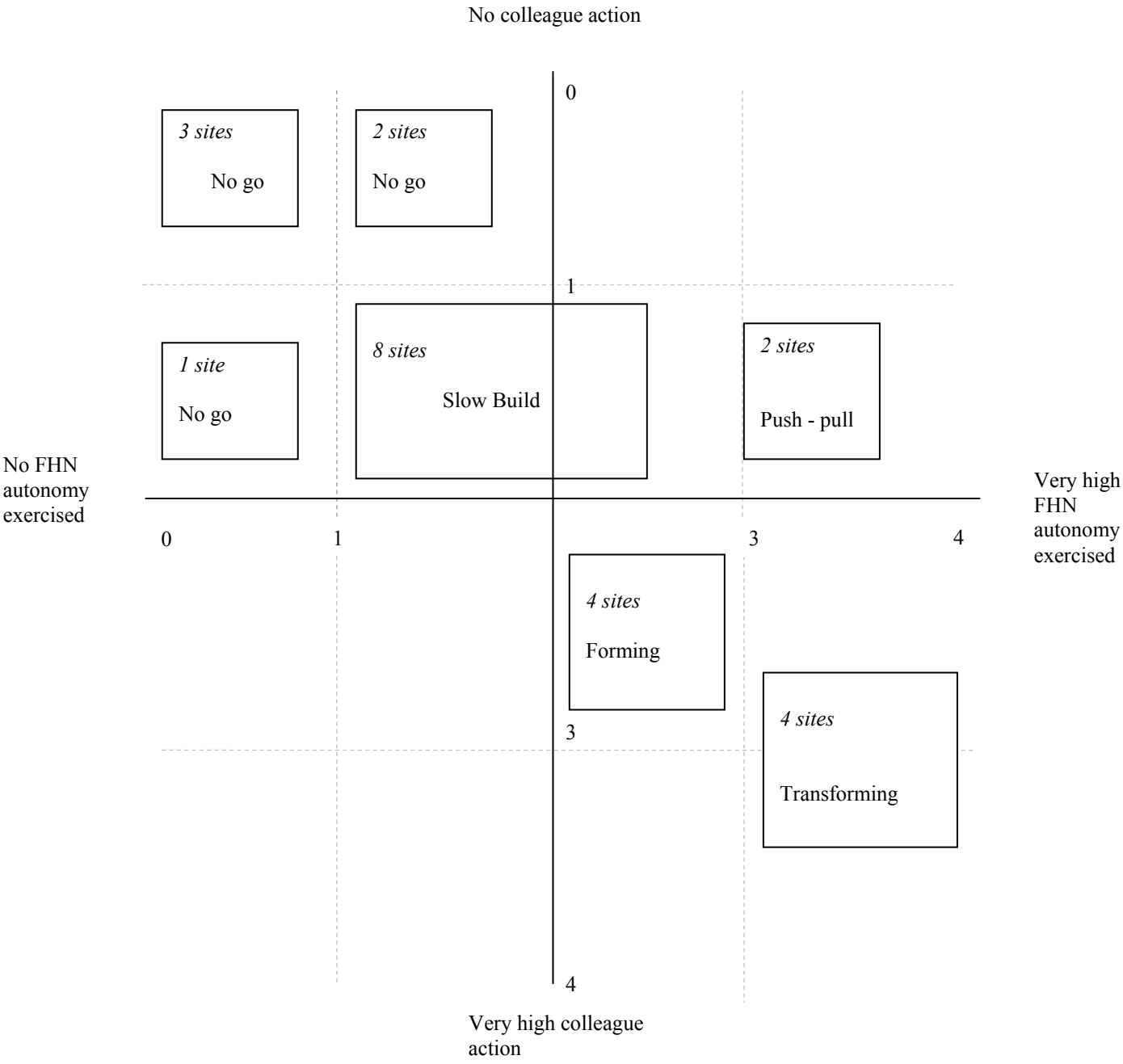
- the extent to which FHN autonomy was actually being exercised to develop practice that was consistent with family health nursing, rather than any other professional discipline
- the extent to which other professionals' had acted in order to support and develop a more family health orientated approach within the PHCT

Full details of the questions and rating scales are given in the relevant bound-in publication (Macduff 2005). The FHPDFs were invited to map the two ratings they had made for each site onto a quartered matrix (see Figure 5.3).

5.3.3 Findings

All three FHPDFs responded to the questionnaire. Their ratings of progress at each site are collated in Figure 5.3. which also posits a new typology of family health nursing development. In the remainder of the thesis this new typology will be referred to as Typology 2 to distinguish it from the original typology (Table 5.3) which will be referred to as Typology 1.

Figure 5.3: Collation of ratings presented as a new typology of family health nursing practice development



As the diagonal trend in Figure 5.3 suggests, there was usually correlation between ratings of the degree of autonomous development of family health nursing practice and ratings relating to the degree of action colleagues had been taking to support and develop a more family orientated approach within the PHCT as a whole. This is perhaps not surprising in that these were the perceptions of the FHPDFs who, during 2004, had invested much time and effort at local sites towards making such simultaneous development happen. In this regard it is notable that family-orientated colleague action only rose above a moderate level if, and when, FHN practice was substantively developed (i.e. the left lower quadrant in Figure 5.3 was empty). This suggests that

the FHNs and the FHPDFs were instrumental in driving forward family orientated services at the sites where such services were becoming more developed.

In this new typology of family health nursing practice development the sites forming the upper left hand corner of Figure 5.3 can be termed *No go*, as there was typically neither enough FHN autonomy nor active colleague support to generate any substantive forward momentum. At these sites there had been a change in name to FHN but almost no change in individual nursing function or overall service delivery. The *Slow build* types showed somewhat more promise in this regard, but seemed unlikely to develop substantively until FHN autonomy and colleague action both rose beyond moderate levels. The two sites at the right of the upper right quadrant showed moderate to high FHN autonomy in developing practice, but less active support from colleagues. This was characterised as a *Push-pull* pattern, in that typically the individual FHNs were consistently active in pushing the autonomous development of their new role, but were still struggling against the pull exerted by the traditional role expectations of colleagues.

The lower right quadrant showed four sites moving towards high FHN practice development and colleague action. This represented more significant and more balanced consolidation of family health nursing. As such, these sites were characteristic of a *Forming* pattern, whereby the respective FHNs were establishing a distinctive new approach that was valued and actively supported by colleagues (e.g. through appropriate referral of whole families). The four sites that were further towards the lower right hand corner of Figure 5.3 indicated progression from the *Forming* pattern towards a *Transforming* pattern. The distinctive feature of the latter pattern seemed to be a high level of active support from colleagues that was enabling more substantive change to the nature of overall service provision (e.g. whereby colleagues own practice had become more family health focused).

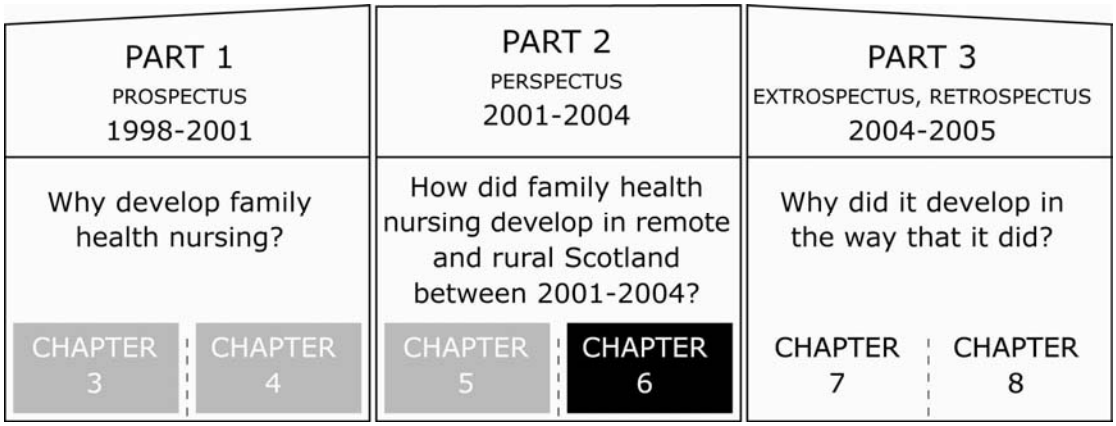
SUMMARY

This chapter has summarised empirical research from three studies of family health nursing which give perspectus on the development of practice in remote and rural regions of Scotland between 2002 and 2004. One of the studies, the commissioned national evaluation, was significantly larger in scale than the others and included evaluation of the new educational programme for FHNs. The design for this study incorporated triangulation at a number of levels, including methods of data collection and data sources in order to enhance completeness. As has been seen, the evaluation's findings provided the first systematically compiled picture of the operation and impact of family health nursing. Moreover these findings had a significant and swift influence on the further development of family health nursing as a SEHD policy initiative.

The 2004 follow-up study was more limited in ambition, but built on the first study by developing one of the original questionnaires and incorporating Typology 1. The findings of this follow-up study confirmed the essentially mixed picture that emerged in the original evaluation study. Within this picture the dominant theme was that of gradual positive development that tended to maintain established service provision, yet also supplement this with a limited expansion of family health services and public health activities. While the FHN role was typically flexible and provided wide-ranging generalist community health nurse practice, capacity to engage with whole families was found to vary widely in practice.

The overview afforded by the final small study of FHPDFs confirmed that at the end of 2004 family health nursing was developing gradually in remote and rural areas of Scotland. As such, there were only a few sites where family health nursing was beginning to have a transforming influence on the overall nature of service delivery by the PHCT.

Indeed the strength of the three linked studies is that they comprise a coherent and unique body of knowledge relating to the development of family health nursing practice in Scotland between 2001 and 2004. In the next chapter of the thesis these findings are interpreted and a set of primary understandings is synthesised in order to harness the benefits of longitudinal overview.



CHAPTER 6

BUILDING PRIMARY UNDERSTANDINGS OF PRACTICE

Overview of this chapter

This chapter is concerned with building primary understandings of family health nursing practice, based on the three linked empirical research studies summarised in Chapter 5. As the strengths of these studies have been alluded to in the preceding chapter, this chapter starts by reflecting on their limitations. This is followed by the presentation of an integrative narrative summary of the primary understandings built from the three linked empirical research studies. Again a concept analysis framework is used to distinguish envisaged enactment of the FHN concept from actual enactment of the FHN as a practice role. These synthesised understandings are summarised in the form of a table at the end of the chapter.

6.1 THE LIMITATIONS OF THE EMPIRICAL RESEARCH INTO FAMILY HEALTH NURSING 2001-2004

6.1.1 The commissioned evaluation study

The final report of the commissioned evaluation research study was launched at an international conference at Heriot Watt University, Edinburgh on 31st October 2003. The conference was attended by around 200 participants from the UK and eight other European countries. In his conference address Malcolm Chisholm, the then Scottish Minister for Health and Community Care, stated:

> "In reflecting on what has been achieved, the independent evaluation by researchers from the Robert Gordon University has been a key element of the learning process. The complexity of undertaking a study across 4 NHS Boards is an achievement in itself. When we started the pilot we did not have a clear idea of the outcome. The researchers had a formidable task which they have addressed with a mixture of true professionalism and good humour. They have produced an in-depth analysis of the first 2 years of the education programme and practice model. An honest account of the reality of family health nursing, highlighting both its strengths and weaknesses. Providing us with vital evidence which will help inform our next steps and a good example of decision-making based on sound empirical evidence. I hope all of you will learn something from the evaluation of this pilot and will share the findings of the research report with colleagues" (transcript obtained from SEHD in 2003).

From the researchers' perspective, the length and strength of this testimonial were quite unexpected. While such affirmation from the client was indeed very welcome, it should not be seen to mask the limitations of the study. Indeed, somewhat perversely, such a testimonial would usually make a seasoned evaluator suspicious. This is because, as Taylor and Balloch (2005) point out, "evaluation itself is socially constructed and politically articulated" (p.1). The FHN evaluation was constructed to look at operation and impact, and was articulated as six specific objectives. Taylor and Balloch (2005) highlight the consequent concerns: " ...since so much of evaluation is commissioned by policy makers, how far does it confirm the framing of policy issues within dominant political discourse?" (p. 5).

Van Teijlingen and Huby (1998) graphically exemplify the practical issues involved when evaluation is used as a means of political legitimisation. The role of the evaluation within the development of family health nursing will be returned to in Chapter 8 of the thesis, but for the present it is sufficient to note that the dominant political discourse in the above extract from the Minister's speech is clearly that of evidence-based policy making. In this regard it is significant that the more fundamental underlying question of *why family health nursing at all?* was not an explicit part of the evaluation remit. Yet Dougall (2002)'s question of the need for family health nursing in remote and rural Scotland was one that recurred for the evaluators throughout the study. Again Taylor and Balloch (2005) provide useful summation: "Evaluators have some opportunities

for asking *how?*, but are more limited in their options for saying *what* is to be evaluated and *why*" (p.5).

To a large extent the present thesis is driven by curiosity arising from such unfinished business.

The Ministerial speech also includes the reflection that "when we started the pilot we did not have a clear idea of the outcome". From the evaluators' perspective this would be to understate a related lack of clarity about content and processes. When the evaluation was designed in response to the invitation to tender for the work, some contextual information was provided along with the aim of the evaluation and the six objectives. Design was made difficult, however, due to the following factors:

- Little was known about the nature of the educational course
- Very little was known about the students who might undertake it (e.g. how many would undertake the course and what would their backgrounds and motivations be?)
- The FHN model was hypothetical but the hypotheses were general and sketchy
- Consequently there was very little known about the actual role that they would undertake in practice
- The participating regions were known but the geographic locations where FHNs would practice were not known

In effect it was clear that many of these questions would be addressed and clarified as the project progressed. Accordingly the evaluation design had to build in a significant degree of flexibility.

In order to structure reflection on the limitations arising from the study's remit and related design, I retrospectively applied Ovretveit (2002)'s Evaluation Feasibility Assessment (EFA) tool. This invites evaluators to score their prospective evaluation in relation to nine preconditions for a successful evaluation. Although the result can be seen as indicative and general in nature, the FHN evaluation emerged as in the medium to high difficulty range due mostly to poor definition of the role at the centre of the project (the "intervention") and lack of clarity about the intended "targets" and desired outcomes of the intervention.

Thus the technical feasibility of the evaluation was closely related to the nature of the subject being evaluated. In this regard the fundamental question *what is being evaluated?* recurred throughout the study i.e. is it a concept, a model, an aspiration, a role, a policy initiative, or various combinations of all five of these things?

Finally, having outlined inherent limitations relating to the evaluation's nature and scope, it is also proper to acknowledge that some may stem from the evaluators' stance and related research design. Reflections on the former can be found on Pages 1 and 12 of the evaluation report (Annex 1), while reflections on the latter can be found in Part 5 of the Supplementary Resource (Annex 2).

6.1.2 The follow-up study

The limitations of the follow-up study are explained in Chapter 5. To recap, these primarily related to the focus being on healthcare professionals' perspectives obtained via questionnaires. The other limitation may be seen as the relatively low questionnaire response rate from professional colleagues (52%).

6.1.3 The FHPDF study

The limitations of predicating a research study on questionnaire responses from three individuals are manifold. While these individuals were in a unique position to compare and rate sites within their region, it cannot be assumed that their judgements were definitive. However the FHPDF study was essentially an adjunct to the larger follow-up study, and this meant that a substantial body of concurrent evidence provided a counterpoint to the perceptions of the three FHPDFs. This enabled comparison and less cautious interpretation.

6.2 INTEGRATIVE SUMMARY OF UNDERSTANDINGS BUILT FROM THE EMPIRICAL RESEARCH INTO FAMILY HEALTH NURSING 2001-2004

The main findings from the three linked empirical research studies are valuable because they can be combined to give both overview of, and insight into, how family health nursing developed through education and practice between 2001 and the end of 2004 in remote and rural regions of Scotland. Accordingly it is useful now to facilitate this contemporary historical overview by presenting an integrated summary of the understandings that have been built from these empirical studies. By making associations and mapping contingencies, the summary starts to build a platform for Part 3's in-depth analysis of why family health nursing developed in the way that it did.

Taking the educational programme as a starting point, it is not surprising that some difficulties arose, given the nature of the challenge which the educators faced. In essence they had to accommodate the need for a range of relevant generic content while developing a distinctive new specialist focus that also satisfied the requirements of the UKCC (now NMC) framework. This was a tall order and tensions between generic and specialist content were probably inevitable.

In comparison to other Scottish community nurse specialist practitioner courses on offer the FHN course emerged as much more focused on its speciality, being theoretically grounded in an ideology of nursing which combined elements of Family Nursing from North America with the promotional ideas from WHO Europe. The former elements tended to have most impact on the students as these new family health assessment /promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) were valued very highly and these were seen as central to creating a distinctive new professional identity. This is an important point in that a range of other professionals were already associated with the rhetoric and role of health promotion, but none in Scotland used this distinctive way of focusing on the family as a whole.

In effect the Scottish FHN curriculum emerged as focused on the first three of the WHO Europe core functions (i.e. care provider; decision maker; communicator) rather than the others (community leader; manager). The WHO Europe curriculum has more emphasis on management and leadership. Indeed advocates of the FHN role (e.g. Kesby 2002) see the FHN as a nurse leader on equal partnership status with the GP. However the latter interpretation was not what this curriculum was aiming for. Rather these very experienced community nurses were educationally prepared in such a way that they would be enabled to personally deliver this particular family health nursing approach within their communities.

The findings from the evaluation of the first year of practice tended to confirm that the core functions emphasised in the educational programme were functional priorities in the enacted FHN role, especially care provision. This conjunction between preparation and practice may have arisen

because it was generally anticipated that the first cohort of students would return as new FHNs to their local settings to work with pre-existing community caseloads (i.e. the SEHD did not seem to be offering increased funding that would enable their work to be independent of these caseloads and any such arrangement would have to be negotiated within local PHCTs). However this would be to understate the prevailing level of uncertainty about such matters during 2001. As Lauder, Sharkey and Booth (2004) point out, "the concept (*FHN*) as it was to be implemented on the ground was plagued by a lack of clarity and detailed planning" (p. 40). In effect, this distinctive Scottish educational hybrid programme was preparing the students for a hypothetical new role whose parameters and priorities were to be constructed in the crucible of practice.

As a basis for understanding what ensued it is useful to map progress against the principles of the FHN role as posited by the SEHD. The findings show that during the first year the FHNs usually functioned as skilled generalists encompassing a range of duties, but the traditional work and concerns of the District Nurse role remained pervasive influences. During the first year of practice the majority of families who had involvement with an FHN did so because a family member was on the district nursing caseload. However the FHNs felt that they were seeing these families much more as a whole and that this gave their practice a different quality. The difficulty was that this was not tangible for many of their close professional colleagues. Moreover, across the ten sites there was an embedded "bottom line" that the introduction of the new role should not adversely affect the pre-existing level of district nursing service and should be sustained within pre-existing budgetary resources for nursing staff. This engendered tension with the development of in-depth family-as-client work.

There was usually little change in terms of the FHNs being first point of contact (i.e. some FHNs were necessarily the first point of contact as there was no other type of nursing service immediately available; others would potentially be the first point of contact for their "inherited" district nursing caseload patients and a small number of other families). There was evidence that typically the FHNs were active in making referrals where more particular expertise was required.

Study of the first year of practice showed that all the FHNs actively tried to take forward some work encouraging healthy living and preventing ill-health. Often this addressed perceived gaps in service coverage. For most, however, the main part of their job remained caring for ill members of the community requiring nursing care. This made it difficult for them to really develop a lead role in preventing illness and promoting community health at their home sites.

In effect it was found that the role could be developed in a limited way on top of a district nursing caseload and within pre-existing resources. As such the FHN role typically supplemented, rather than supplanted, pre-existing services. Its introduction in these circumstances officially legitimised

and raised awareness of nursing with a strong family and health orientation in general. However many colleagues felt that this orientation already existed and consequently found it difficult to engage with, and understand the need for, this particular new approach. Hence it struggled to become a role in the sociological sense. Even where it was legitimised through recognition of its value (e.g. through referral of families) it could not necessarily be prioritised if traditional primary care provision was to be maintained unaltered.

Thus what emerged overall from the 2001-2002 evaluation was a mixed picture where FHNs were able to enact some of the principles more readily than others. It is important to recognise the tensions that existed in practice between these principles, particularly between the generalist primary care role predicated on the care of individuals and the distinctive family focus.

It is also important to recognise that family health nursing developed in several different ways during the first year of practice. In this regard Typology 1 highlighted a spectrum of possibilities. The Bold build pattern represented one end of the practice spectrum. This cast the FHN as a further specialist community nurse whose work involved more in-depth programmes of care for families than those typically offered by District Nurses and Health Visitors. Therefore if this role were to be developed in other villages or cities, with no concurrent revision of existing roles, an extra service would be created with consequent cost implications.

At the other end of the spectrum the FHN was virtually synonymous with the District Nurse. In this context the research showed that sustained development of family health care programmes was difficult if all other existing services remained unchanged. This was the case even where teams and caseloads were relatively small and stable.

The construction of a typology during the evaluation study provided a classification which helped clarify thinking about emerging family health nursing practice. Indeed the thesis enquiry has given rise to a general paper examining the use of typologies in nursing (Macduff 2007) and a specific paper presenting in-depth analysis of the development and use of the first family health nursing typology (Typology 1: Macduff 2006b). The reader is referred to these for further detail. However, before moving on from discussion of the original FHN typology, it is worth highlighting two significant points.

The first is that Typology 1 was essentially a typology of practice *development* rather than family health nursing practice *per se* i.e. the dimensions which underlay the discrimination were concerned primarily with the "how" of development rather than the focus/content of practice. This was reflected in the category descriptors which always featured the nature or speed of progress e.g.

Slow build. Typology 2, which emerged from the FHPDF study, was simpler in format but was also essentially a typology of practice development.

Secondly, despite being derived from empirical research into practice, both typologies were analyst-constructed (Patton 2002) and to some extent presented "ideal types". The latter phrase is important to understand as it was originally coined by the sociologist Max Weber (1864-1920), who developed classic typologies of social action and power stratification. His constructions were made through the "ideal type" method which "involves building abstractions which simplify and exaggerate traits found in reality into a more logically coherent pattern than can ever be found in the world" (Hughes and Sharrock 1997; p.101). The consequent caveat is that the categories will not necessarily exactly correspond with experiential reality. The follow-up study and the FHPDF study were unusual in that they explored this correspondence and found that the patterns described in Typology 1 remained largely relevant and meaningful in characterising more recent practice.

Indeed the patterns identified in Typology 1 can be integrated into a wider concept analysis framework (Table 6.1) to distinguish aspects of envisaged enactment of the FHN concept from aspects of actual enactment of the FHN as a practice role.

Table 6.1: Concept analysis framework comparing FHN as envisaged and enacted

Envisionment of enactment		**Enactment as a role in practice**					
Stage 1: the concept	***Stage 2: attributes***	***Stage 3: case construction in practice (as summarized in Typology 1), and analysis of these cases using different criteria***					
"The envisaged enactment of the FHN concept in Scotland as a practice role".	The 4 principles prescribed by the SEHD: *Health model* *Family focus* *Generalist model* *First point of contact*	**Stage 3.1** **The four constructed cases (Typology 1):**	**Stage 3.2** Analysis of **extent of enactment of the 4 SEHD principles from 2001**	**Stage 3.3** Stage 3.2 classified using Walker and Avant case criteria	**Stage 3.4** Stage 3.2 analysed in relation to **emergent SEHD criteria of 2003** (i.e. role developing but fitting easily with practice) & classified using Walker and Avant case criteria	**Stage 3.5** Stage 3.2 analysed in relation to the **dominant principles within the education programme** & classified using Walker and Avant case criteria	**Stage 3.6** Stage 3.2 analysed in relation to the **evaluators' judgement on extent of role development** & classified using Walker and Avant case criteria
		High scope-slow build	Generalist and first point of contact principles to the fore, but limited progress/change in relation to family and health principles	Borderline case	Borderline case	Borderline case	Borderline case (partial role development)
		Slow build – key ally	First point of contact variable, but inherently generalist. Slightly more sustained enactment of family and health principles	Borderline case	**Model case**	Borderline case	Borderline case (partial role development)
		Slow/No go	Inherently generalist, and sometimes first point of contact. Much difficulty enacting the family and health principles	Borderline/ Related case	Borderline/ Related case	Borderline/ Related case	Related/contrary case (very little/thwarted role development)
		Bold build	Vigorous and sustained enactment of family and health principles. However, specialist tendency, rather than generalist. First point of contact variable.	Borderline case	Borderline/ Related case	**Model case**	**Model case** (substantial role development)

Table 6.1 provides a useful summative overview of the progress of family health nursing by 2003. On the left side of the diagram it can be seen that in 2001 the SEHD identified four principal attributes as the basis for enactment of the FHN concept as a practice role. On the right side of the diagram Stage 3.1 uses Typology 1 to represent the cases constructed in practice. Thus it can be seen that none of the four types consistently contains all of the prescribed SEHD attributes/principles (Stage 3.2). Hence most of the types can be seen as borderline cases of family health nursing, and none of the four types obviously constitutes a model case using the SEHD attributes/principles (Stage 3.3).

However, by 2003 it had become much clearer that the SEHD would require the FHN role to be developed from within pre-existing financial resources at each site/in each region and to fit relatively easily into existing structures and processes of service delivery. In turn this made it clear that the *Bold Build* type, with its supernumerary and more specialised features, did not fit with the SEHD vision of service development. Accordingly it emerges as a borderline/related case when seen in the light of the SEHD's own evolving attributes and overall position (Stage 3.4). This also views *Slow/No go* similarly, but privileges *Slow build-key ally* as a model case in terms of its optimal fit with service delivery structures and processes.

The irony here is that in many ways the *Bold build* type can be seen as a model case of enactment of the educational programme's predominant attributes/principles for family health nursing (Stage 3.5). The *Bold build* site was often used in this way by the SEHD and educators to model advanced development of family and health approaches (e.g. Wright 2002). Moreover in the judgement of the external evaluators this was the only site where substantial FHN role development took place (Stage 3.6).

In effect Table 6.1 shows how, by 2003, a number of different attributes characterised the FHN practice role as it was variously enacted, and the identification of critical attributes (see Figure 3.4, Stage 6) would depend on which of the criteria (i.e. Stages 3.2-3.6) prevailed politically. This can be seen as a natural consequence of the SEHD leaving the initial construction of the role in practice largely to the individual FHNs and their immediate colleagues, without specifying clear criteria for success or self-assessment of progress. This point echoes the findings from application of the Ovretveit EFA tool i.e. poor role definition and lack of clarity about intended outcomes.

As has been seen, the four guiding principles/attributes that were specified were not necessarily mutually compatible in practice. However, during 2003 it became clearer that the SEHD would tend to privilege the generalist attribute over the family focused attribute, in view of its better fit with a primary care system predicated on the care of individuals. Thus, by this time, there was

just a little more clarity emerging in relation to the fundamental question: what are the critical attributes that would indicate success in terms of enacting the FHN role in Scotland?

Faced with this situation, the evaluation report took a practical approach and used Typology 1 as a basis for identifying two generic factors that appeared to make an FHN role work at local site level: *the perceived scope and space to encourage implementation of the FHN approach* and *the local presence of at least one active supporter who changes their own practice*. The presence of at least one of these factors appeared to be a necessary condition for progress. It is significant that both these factors are rooted essentially in local context, although the latter factor implies development of a process.

As Chapter 5 demonstrates, the return of the second cohort of FHN students to practice after completing the educational programme at the end of 2002 presented further opportunities to study enactment. The findings of the follow-up study confirmed the essentially mixed picture that emerged in the evaluation study. Within this picture the dominant theme was that of gradual positive development that tended to maintain established service provision, yet also supplement this with a limited expansion of family health services and public health activities. Interestingly by 2004, many colleagues saw the need for a distinct family health nursing role and the need for their PHCT to have a more family orientated approach.

One of the most striking findings from follow-up was the flexibility and wide scope of the role in terms of providing generalist community health nurse practice (see Table 5.8). Such provision was generally valued by colleagues and there was little evidence that the development of family health nursing had been detrimental to service delivery. Rather the effect was more often service enhancement or expansion. Despite the pressures such a wide remit might have been expected to bring, the majority of FHNs found that their own job satisfaction and overall quality of working life improved.

As predicted (Macduff and West 2003), the diversity of family health *nursing practice* grew in relation to the pre-existing roles of the second cohort of FHNs and associated local contextual influences. However, family health *service expansion* was mostly confined to client-specific services delivered by the FHNs themselves. While some sites made sustained progress in this regard, others struggled to develop the role to any substantive extent despite a limited programme of facilitation. As such, the extent of individual FHN's capacity to engage with whole families seemed to vary widely in practice, and was usually dependent on the following key factors:

- ensuring the delivery of nursing to a caseload of individual patients
- the inclination of colleagues in the PHCT towards enacting a family orientated approach, in the absence of financial and policy incentives
- the scope for nursing to operate autonomously
- the ability of the individual FHN to influence the approach taken by community nursing colleagues and others at the core of PHCT provision
- the personal motivation and commitment of the individual FHN towards developing care for families

These understandings from the follow-up study were supplemented by the overview provided by the FHPDFs in the final empirical study. The new practice development typology (Typology 2) provided useful summation, highlighting how any change towards a more family health orientated approach at PHCT sites was usually being driven by the FHNs and FHPDFs. Indeed this suggested that substantive change to the overall nature of service provision was occurring at a few sites.

However Figure 5.3's map of progress up to the end of 2004 predominantly shows a picture of what Watzlawick, Weakland and Fisch (1974) would characterise as "first-order change". As Hartrick (1997) explains, this involves "the incorporation of new elements into an already existing system while the system itself remains unchanged. In contrast, second-order change involves transforming the structures that give rise to the system so that the system itself is changed" (p. 60).

In concluding this integrative summary it can be seen that the three studies built on each other and provided sufficient data convergence to enable a coherent narrative description and initial explanation of how family health nursing was enacted in Scotland between 2001 and 2004. Within this narrative, the main foci have been:

- the nature and scope of family health nursing education and practice
- the processes and modes of operation of family health nursing education and practice
- the impact of family health nursing education and practice on FHNs; their colleagues; and, to a lesser extent, their clients and communities

The resultant primary understandings are now summarised in Table 6.2.

Table 6.2: Primary understandings derived from empirical research 2001-2004

1	Within the Scottish educational programme there were significant (and inevitable) tensions between generic and specialist content.
2	The educational programme focused on three of the WHO Europe core functions (care provider; decision maker and communicator) but the concurrent incorporation of elements from North American models of Family Nursing gave the FHNs a distinctive new professional identity.
3	The FHN concept proved difficult to explain and operationally define. The SEHD identified four principal attributes as the basis for enactment of the FHN concept as a practice role, but otherwise FHNs were left to interpret and construct the role without clarity about desired outcomes. There was some initial confusion and resistance from colleagues. By 2004 there was some evidence of increased recognition of need for the role within participating PHCTs.
4	Local PHCT context was a potent influence on the nature and scope of FHN role enactment, particularly in terms of the "bottom line" that the new role should not adversely affect pre-existing district nursing service provision.
5	This tended to inhibit the development of in-depth family-as-client work and community health promotion work, but some expansion of such work into local gaps in service provision took place.
6	The FHN role typically supplemented rather than supplanted pre-existing services.
7	Four typical patterns of practice development emerged in 2002 and these continued to be largely relevant and meaningful in characterising practice up to the end of 2004.
8	Either of two of these types could be seen to represent the model FHN practice role, depending on which set of critical attributes were being used as criteria i.e. whether the priority was fit with the family health principles of FHN as promoted in the educational programme (*Bold build*), or optimal fit with prevailing service delivery structures and the FHN generalist principle (*Slow build-key ally*)
9	Two factors appeared to be most influential in making an FHN role work in practice. One was primarily contextual: *the perceived scope and space to encourage implementation of the FHN approach*. The other was related to both context and process: *the local presence of at least one active supporter who changes their own practice.*
10	Enactment of the FHN role in practice typically had to be done within pre-existing resource constraints
11	The families that received FHN services during 2002 generally appeared to be very satisfied with them.
12	The diversity of family health nursing practice grew as more FHNs qualified. The flexibility and wide scope of the role in terms of providing generalist community nursing practice was striking.
13	The extent of individual FHN's capacity to engage with families continued to vary widely in practice and tended to be dependent on prior fulfillment of other PHCT priorities.
14	At the end of 2004 a mixed picture of family health nursing practice development was evident. A few sites had made substantial progress and were beginning to develop more family health focused services across the PHCT. Most, however, had struggled to progress beyond "first-order change".

SUMMARY

Following reflection on the limitations of the empirical research studies, a set of primary understandings about the development of family health nursing between 2001 and 2004 were derived. Through this interpretive analysis, some useful initial insights were generated into why practice developed in the way that it did.

In this regard three related aspects may be seen as particularly significant. Firstly the nature of the enactment of the FHN concept in practice was influenced by the lack of a clear operational role definition and a related lack of clarity about desired outcomes. Interpretation and construction of the role were very much left to the individual FHNs, and this meant that the shaping influence of practice context tended to predominate.

Secondly, during 2003, it became clear that the SEHD saw the FHN role's fit with prevailing service delivery structures as a critical attribute for optimal development. In turn, this tended to suggest that the SEHD valued the generalist nature of the role above enactment of the principle of caring for whole families.

By the end of 2004, the role had manifestly wide scope and flexibility in terms of providing valued generalist community health nurse practice, but the extent of individual FHN capacity to engage with whole families varied widely in practice. Overall PHCT service provision at a few sites had become more systematically family health focused, but at most sites "first order" change was as much as could be achieved..

These three points highlight the essentially intra-professional nature of the family health nursing development and the strong influence of established work systems, context and culture.

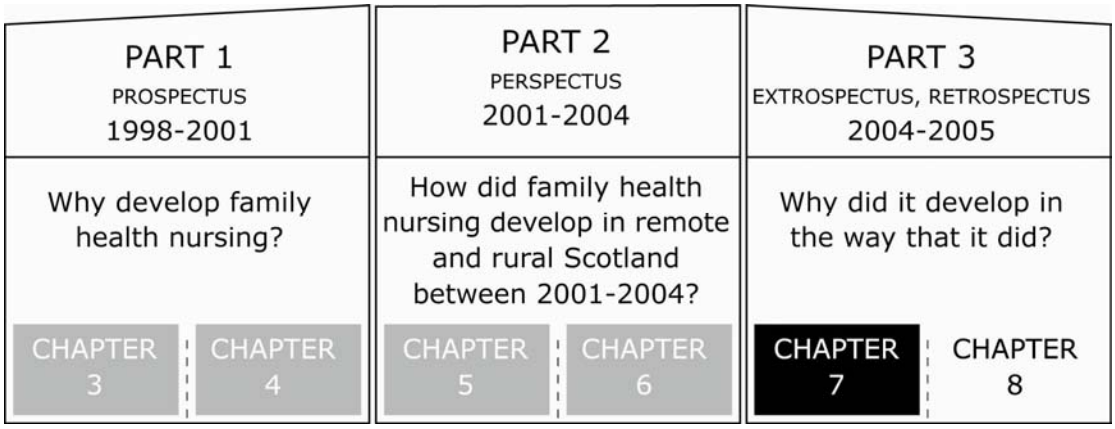
PART 2: A BRIEF REFLEXIVE RECAP

The two chapters that form Part 2 have combined to yield substantial insights into how family health nursing practice developed between 2001 and 2004. In the process of building these primary understandings, some insights have also been generated into why family health nursing practice developed in the way that it did. The next Part of the thesis is concerned with addressing this question and building further explanation by examining these understandings in the light of relevant theoretical perspectives.

PART 3

EXTROSPECTUS, RETROSPECTUS

An explanation of the development of family health nursing in Scotland between 1998 and 2004, constructed through the application of relevant theoretical perspectives to understandings derived from published documentary evidence and new empirical research.



CHAPTER 7

EXPLAINING THE DEVELOPMENT: PRACTICE LEVEL

Overview of this chapter

This chapter addresses the question: why did family health nursing practice develop in the way that it did in Scotland between 2001 and 2004. Accordingly the focus is primarily on the enactment of the FHN concept into a role in practice. The chapter starts with a brief recap on the interpretative methods being used. This sets the scene for identification and application of relevant theoretical perspectives in order to develop explanation. In this way, understandings from the wider literature on role development, the nursing process, nursing models, community nursing and primary care are sequentially brought to bear on the set of primary understandings constructed previously. The chapter concludes by presenting a summative explanation of the enactment of family health nursing at local PHCT level between 2001 and 2004. A model which accommodates other contingent, concurrent developments is also posited, namely the Living Plaid model.

7.1 RESEARCH METHODS

An overview of the methods used in this chapter is presented in Chapter 2.2.3.2. To recap, the search for relevant theoretical perspectives was undertaken within three primary cognate areas and was concerned to address several associated questions (see Table 2.4). Table 7.1 gives overview of the areas within which textual sources were reviewed.

Table 7.1: Cognate areas providing theoretical perspectives for analysis of the empirical research on FHN development

Cognate area	Indicative sources reviewed and time period
Role development in nursing	Analysis of relevant UK nursing literature but also international perspectives (*mainly from 1990 onwards*)
Nursing models and the nursing process	Analysis of relevant international nursing literature (*from 1980 onwards*)
Community nursing: issues of identity, culture, differential power, and place	Analysis of relevant UK nursing literature, but also some international health and social care perspectives (*mainly from 1990 onwards*). Limited review of literature on social geography and place.

Within these areas, I was looking for relevant and credible research that had:

- used broadly comparable methodology
- built understandings that were extensively informed by practitioner perspectives
- ideally involved longitudinal study
- attempted to link theory and practice

Analysis of the selected material primarily involved its application as analytic templates to enhance understandings of family health nursing. This involved processes of extraction, comparison, differentiation, interpretation, integration and illustration.

7.2 ILLUMINATION FROM NURSING ROLE DEVELOPMENT LITERATURE

Nursing role development may involve expansion of core nursing activities (e.g. where skills and knowledge from within the discipline are developed in such a way as to create new dimensions of practice and expand disciplinary boundaries), extension (e.g. where a nursing role is extended to incorporate an area of practice or skill conventionally associated with another professional domain), or both (Frost 1998). In the context of pre-existing community nursing in the UK, the new FHN role can be seen primarily as a role expansion project, in that the skills of a mixed group of remote and rural nurses have been enhanced with a view to carrying out a new generic role addressing health and ill-health related needs of individuals, families and communities. However it is important to note that the specific desire to focus on families may be seen as extension into the domain of other Community Specialist Practitioner Qualification holders such as Health Visitors and even other professions such as midwifery.

The "boom" in nursing role development that has been evident within the UK since the early 1990's (Read 2003) has engendered a profusion of new role titles, especially those featuring the word "specialist" (Tolson and West 1999). In the wake of this surge has come research that has classified role developments into types and/or evaluated progress with specific roles. Although these studies typically provide limited data on effectiveness, they yield a number of common findings about processes of new role development that are relevant to the FHN role:

- lack of clarity about the newly developed role may be common for both postholders and their colleagues e.g. (Cameron and Doyal 2000)
- intra-role conflict, overload, and/or problems of role boundary management are also all relatively common, especially during the initial enactment phase e.g. with Nurse Consultants (Guest et al 2001) and Modern Matrons (Scott et al 2005)
- processes to embed and sustain new roles are often inadequate at local level (Tolson and West 1999) and national level co-ordination of nursing role development has only recently started to be addressed (e.g. SEHD 2005a)
- new role development processes have tended to focus on acute care (Read 2003) and specialist practice rather than generalist practice (Castledine 2003)

Viewed against this background, the actual enactment of family health nursing seems fairly typical in terms of local role related struggles, but very atypical in terms of being a nationally co-ordinated development focusing on generalist community nursing practice.

Research classifying contemporary nursing role developments provides another lens through which to view the Scottish FHN. Roberts-Davis and Read (2001) used the Delphi technique to attempt to clarify the parameters of Nurse Practitioner roles and the parameters of Clinical

Nurse Specialist roles. Although they found more common competencies than differences, their resultant typology enables some initial mapping of the location of the Scottish FHN. The typology is reproduced in Table 7.2

Table 7.2: A typology of named innovative clinical nursing roles (Roberts-Davis and Read 2001)

Clinical Nurse Specialist domains of clinical activity	**Indicative examples**
Condition-specific domain	Breast Care Specialist; Stoma Care Specialist
Area-specific domain (differentiated)	Coronary Care Unit; Neonatal Unit
Client group-specific domain (differentiated)	Elderly mentally ill; Gerontological Specialist (where combined with condition-specific focus)
Nurse Practitioner domains of clinical activity	**Indicative examples**
Client group-specific domain (undifferentiated)	Homeless Persons; Gerontological Specialist (generic)
Area-specific domain (undifferentiated)	Accident and Emergency; Minor Injuries Clinic
Community clinical nursing domain (undifferentiated)	Family or General Practice/Primary Care Nursing
Public health nursing domain (undifferentiated)	School Health; Public Health (Health Visiting)

Within this framework, the FHN would map primarily to the Community clinical nursing domain (undifferentiated) but also to some extent to the Public health nursing domain (undifferentiated). This map is useful in that it enables distinction of generalist from specialist practice according to whether clients' conditions are undifferentiated or differentiated. This would tend to cast the FHN as a sub-variant of the Nurse Practitioner (NP) role. Indeed the case for such an association might seem to be supported when seen in the light of the International Council for Nurses (2007) definition of the Nurse Practitioner as expanded practice with the following key characteristics:

- Integrating research, education, practice and management
- A high degree of professional autonomy and independent practice
- Case management and own case load
- Advanced health assessment skills, decision-making skills and diagnostic reasoning skills
- Recognised advanced clinical competencies
- Provision of consultant services to health providers
- Plans, implements and evaluates programmes
- Recognised as a first point of contact for clients

While the above aspirations have much in common with those of the FHN concept as espoused at WHO Europe, however, it can be seen that they go beyond the SEHD vision for enactment of the concept in Scotland (particularly in terms of independence and "advanced skills" such as

diagnostic reasoning). Moreover, even where there is a match of aspiration, this would not necessarily be reflected in the reality of FHN role enactment in Scotland (e.g. first point of contact was only partially realised).

To some extent the latter differences relate to envisioned *levels* of practice (i.e. *relative depth*). However it should also be noted that the envisioned *nature and scope* of Scottish FHN practice (i.e. *relative breadth*, as manifest in the four principles) would typically go beyond that of the Nurse Practitioner role as it has tended to evolve in primary care within the UK. As Unsworth (2001) and Walters (2000) point out, the NP role has tended to focus on delivering expanded services for individuals within a medical milieu, with doctor substitution a prominent theme (Carlisle 2003). Interestingly there are a handful of Nurse Practitioners currently working in remote and rural Scottish communities (e.g. Perkins 2001), but lack of systematic study of these roles makes it difficult to meaningfully compare the level, nature and scope of their actual practice with that of the FHNs.

Perhaps the key distinction between the FHN and the Nurse Practitioner in the UK, however, relates to the way that the former has been developed through one programme of educational preparation validated as a Community Specialist Practitioner Qualification recordable on the NMC register. This contrasts markedly with the history of the development of the Nurse Practitioner role in the UK which has been characterised by a profusion of different types and levels of educational preparation (Carlisle 2003) and associated evolutionary confusion around whether it is a generalist, specialist, advanced or higher-level role (Castledine 2003). Ironically, Castledine's conclusion is that Nurse Practitioner roles and Clinical Nurse Specialist roles should now be merged and recognised as "part of the specialist nursing movement in the UK" (p. 41). Thus, as with the FHN, it may be that a nursing role development with strong generalist credentials (Roberts-Davis and Read 2001) can only achieve regulation and validation under the rubric of specialism.

As can be seen, the use of Roberts-Davis and Read's typology necessarily entails wrestling with the confusion that has surrounded "specialist" and "advanced/higher-level" nursing role developments in the UK. Nevertheless, it has served to highlight key similarities and differences between the FHN and the Nurse Practitioner as understood in the UK context. This is important as the Nurse Practitioner is arguably the nursing role development with the most potential for autonomous practice within PHCTs in the UK (Chambers 2000) and may offer a way for more primary care nurses to become "nurse entrepreneurs" (Cook 2005) who are equal business partners with GPs. Comparison with the typology has also drawn attention once more to the need to distinguish between the aspirations/envisioning of any role, and what is known about its

actual enactment in practice. Certainly, in terms of its aspirations, the FHN role does not seem to sit comfortably in any of the established domains of recent UK nursing role development.

By focusing on function rather than domain, however, Scholes, Furlong and Vaughan (1999) produced a different typology that may have more explanatory potential for understanding enactment of the FHN role. This posited three roles as detailed in Table 7.3.

Table 7.3: Typology of role innovation (from Scholes and Vaughan 2002)

Type of role	Key features
Complementary	Where nurses had adapted aspects of their practice to meet changing patient needs and healthcare provision. These roles were characteristically independent and the postholder was not part of a named multidisciplinary team. Found in cancer nursing in large specialist hospital. Long history of development (25 years)
Substitution	Roles set up specifically to deliver a service traditionally undertaken by "doctors in training". Found in critical care services. 5-10 year history. Technical in nature and governed by medical protocols
Niche	Roles developed to fill in a gap in current service provision. Invariably developed because of the additional skills the practitioner had acquired as an adjunct, or to complement their existing professional role. Offered a "novel service" and did not necessarily encroach on activities previously undertaken by any one member of the healthcare team. In some cases they were an amalgam of activities together with some new aspects of practice. In others, they were completely novel to the service e.g. a physiotherapist who offered complementary therapies. Essentially non-threatening to other roles. Found in a medium sized District General Hospital, but a number of outreach and community based services developed over 2 years.

While the case studies that led to this typology were primarily hospital-based and did not focus exclusively on nursing roles, it is evident that the "Niche" type corresponds well with several patterns of FHN development at local sites. As has been seen, the "bottom-line" requirement that the new role should not adversely affect pre-existing district nursing services made fitting in and fitting around very important. At the *Slow/No go* sites the new FHNs returned with "niche knowledge" in the form of the family assessment and intervention skills but were unable to address relevant service gaps due to the perceived need to attend to traditional priorities. There was rather more success at the *High scope – slow build* sites where the FHNs were able to develop limited expansion of family and public health services. Importantly, however, these usually involved the FHN only and there was very little threat to other roles in the PHCT. At the *Slow build – key ally* sites the enrolment of a key ally tended to broaden the scope of development, but again initiatives usually addressed service gaps and were non-contentious. Indeed at the majority of sites in 2002 the FHN function can be characterised as "service maintenance with niche supplementation", and this seemed to remain largely true between 2003-2004.

The one site that was very different in 2002 had the *Bold build* pattern. Although this development did address a number of gaps in local service provision, it was considerably more independent in nature and therefore has strong elements of both the "Complementary" and the "Niche" types described by Scholes and Vaughan.

Thus the latter authors' typology is helpful in showing precedence for role expansion into niches following a line of minimal resistance. Nevertheless it is essential to note that the "Niche" type for Scholes and Vaughan involved opportunistic role generation by individual postholders who had identified gaps and acquired necessary skills. This is essentially "bottom-up" role development which contrasts markedly with the genesis and impetus of the FHN role in remote and rural Scotland. For, in effect, family health nursing was a "top-down" policy initiative which focused on the development of a new educational programme and a related new role. In fact this contrasts with much of the professional role development in UK nursing in the past 20 years in that local necessity has more often driven evolution, with professional education lagging somewhat behind (Cameron 2000, Spencer 2001). Again, the evolution of the Nurse Practitioner in the UK illustrates this vividly.

As such, it again seems difficult to find recent or contemporary national role development projects that share enough essential characteristics with the FHN initiative to make sustained comparisons fruitful. Consequently it is useful to look briefly to other relevant national nursing projects. In this regard there is scope to incorporate some of the understandings that have emerged through study of the nursing process as it has manifested within the UK.

7.3 INSIGHTS FROM INTRODUCTION OF THE NURSING PROCESS: TRANSLATION AND ENROLMENT

Although it was not a role development *per se*, the introduction of the nursing process into the UK during the 1970s and 1980s was widely seen as a "top-down" development (De la Cuesta 1983; Hayward 1986) superimposed on pre-existing workload (Lewis 1988; Nicklin 1984). By 1988, Dingwall, Rafferty and Webster were concluding that the impact on practice had been almost universally disappointing, despite it being imposed on the syllabi for most areas of nurse education. Hayward (1986) had found very few examples of successful implementation. However, as with family health nursing, it is necessary to question just what successful implementation would or should look like. While the nursing process could be seen as simply a four stage process of assessment, planning, implementation and evaluation (Yura and Walsh 1968), Walton (1986) found that it was interpreted at four different levels within nursing literature and often discussion took place at more than one level simultaneously. Walton's levels are reproduced in Table 7.4

Table 7.4: Levels of interpretation of the nursing process (Walton 1986)

Level 1	A system of recording
Level 2	A system of work organization, confusingly equated with systems of "patient allocation", "team nursing", "primary nursing", or various modifications/combinations of those systems
Level 3	A tool for education and for practice, aiming to bring the ideals of individualized care closer to reality
Level 4	An ideology: the level at which the process has become imbued with associated professional aims and aspirations for identity, status and autonomy

Walton's observations are important because they again raise the question of what is being implemented. While the WHO Europe FHN concept may not map exactly onto all of the levels identified by Walton, there are sufficient similarities to make the point that the FHN concept will be interpreted at different levels by a variety of key actors. Moreover, when this is considered alongside the inherent breadth of the four principles for the role posited by the SEHD, it seems even less surprising that no model implementation of the FHN concept (in terms of these principles) seems to have occurred.

Perhaps the key transferable lesson is identified by Latimer (1995) who understands attempts to enact the nursing process within the UK more as local processes of "enrolment and translation", rather than reflecting a model of knowledge "diffusion" and subsequent "implementation". Drawing on the work of Latour (1986) and Walton (1986), Latimer emphasises the active translation of new "technologies" like the nursing process or family health nursing into local context, culture and language: "the translations which occur are the effects of the particular configurations with which the actor(s) is associated: the meanings interpreted for artefacts, the

identities being constituted, the organizing being accomplished and the matters of interest involved" (p. 214).

This perspective is valuable for two reasons. Firstly, it resonates with the author's own observations from site visits studying how FHNs were trying to develop their role. In the context of remote and rural Scottish primary care, the idea that a relatively unmitigated process of direct implementation might be occurring would be fanciful in the extreme. Secondly, in avoiding the simplistic notion of implementation, the translation perspective also avoids viewing "unfaithful transmissions" as deviant. Indeed in this context Latour (1986) would see "faithful transmission" as requiring explanation. Latimer provides useful summation:

> ".....these technologies get generated and regenerated locally and specifically and diversely. In the face of diversity it becomes difficult to sustain a view which distinguishes between what are supposedly ′locally′ enacted versions of these as managerial products and what the products supposedly are in blueprint (and how or where they do in fact ′exist′, except as espoused theories or enacted practices). However, as already indicated there is a set of translations: in enrolling these as tools actors themselves are enrolled, they are reinvented, but not necessarily in line with any ′original′ programmes" (p. 217).

The latter concept of enrolment is also useful as it applies not only to the enrolment of ideas towards specific ends, but also to the enrolment of people as part of the process. This has particular salience when considering the process of "creating" FHNs and the processes through which the FHN Steering Group sought to involve key service managers, professionals and members of local communities so as to advance the policy initiative. An overview of these respective processes will be developed in Chapter 8. For the purposes of building explanation at the level of understanding why developments evolved as they did at local sites, analysis in this chapter continues by looking at the enrolment of individual FHNs and the associated psychodynamics involved in translating the FHN concept into a new role.

7.4 ENROLMENT AND TRANSLATION: FURTHER INSIGHTS AND INFLUENCES

7.4.1 The context for individual FHNs

As detailed at the end of Chapter 4 and in Chapters 5 and 6, the FHN policy initiative enrolled a total of 30 experienced remote and rural community nurses. Two thirds of this group had no pre-existing Community Specialist Practitioner Qualification. The level of practical support given to the students in both cohorts (in terms of payment of programme fees, travel and accommodation expenses, and monies to "backfill" their posts) was unusually generous in comparison with precedence and contemporary practices within the four regions involved. As such, strong enrolment incentives were offered to counter the possible inconvenience and professional risk associated with this unknown new role.

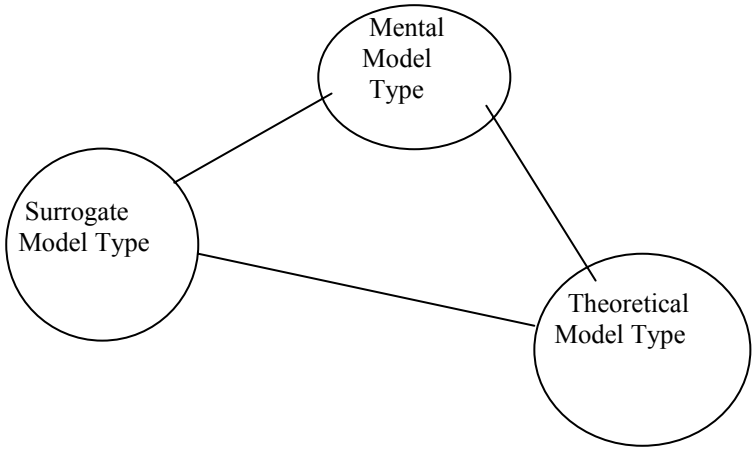
As has been seen in Chapter 5, during the year of the FHN programme the students were educated and socialised towards a different professional identity characterised by the distinctive family focus of the envisioned new role. Thus most returned to practice at their local site expressing a felt need to develop and operationalise the new ideas to which they had recently been exposed. As part of this process many sought to enrol key allies within the PHCT. In this regard some support (e.g. site visits) was given through the National Project Officer, Steering Group and Regional implementation groups during 2001-2002, and this was augmented between 2003 and 2005 by the Family Health Practice Development Facilitators. However, on a day-to-day basis, the FHNs were usually working on translation and enrolment on their own.

From my observations during fieldwork, FHNs approached this situation in a number of different ways. Most felt that their own practice had changed in terms of a gaining new awareness of family and health issues. However the big challenge was to make this visible to others in such a way that key allies would enrol in related service development. Inevitably the FHN documentation assumed an important role in making intent and activity manifest.

7.4.2 Insights from research into the meaning of nursing models

This scenario parallels the experiences that many nurses have had in trying to enact nursing models within the workplace, and Wimpenny (2002)'s research offers some potentially informative comparisons in this regard. Looking at the meaning that nursing models had for practising nurses, he found that these models often remained tangential and external. This contrasts with the apparently strong internalisation of FHN ideas and values that occured during the Scottish educational programme and was voiced by the FHNs in their new role. Nevertheless, Wimpenny's "model typology" (Figure 7.1) has relevance when trying to understand the professional (and indeed personal) dynamics that the FHNs experienced.

Figure 7.1: Wimpenny's model typology (2002)



In Wimpenny's typology the *Theoretical model* is an abstract and general conceptualisation developed by one or more theorists. The *Mental model* is "the personal pattern or schema of the individual nurse, built through personal experience and knowledge and represented in the way that nursing is described by the individual". The *Surrogate model* is a functional version of the theoretical model used in the clinical area as "a framework or structure around which nurses can collect data, communicate and through which the organisation can standardise and audit practice(s)" (p. 351).

As has been seen, the *Theoretical model* to which the Scottish FHNs were exposed combined elements from the WHO Europe FHN conceptual framework with North American Family Nursing models. The latter were potent in terms of the construction of a distinctive new professional identity and this was particularly evident when the new FHNs were describing their own views of nursing i.e. their *Mental models*. For most, their *Mental model* had changed and they felt that this affected the way that they saw their practice, particularly in terms of family and health orientated approaches. For some this had the character of a whole new way of seeing (i.e. a transformative quality). For perhaps more this took the form of significant incorporations and related adaptations to their *Mental model* (i.e. a formative quality).

In effect, a significant degree of congruence seemed to develop between *Theoretical* and *Mental* models in that most of the 30 new FHNs came to believe in family health nursing as an approach to care. Indeed they typically said it was what they were (in professional terms) and what they did (in functional terms). This relates closely to Argyris and Schon (1974)'s idea of "espoused theory" i.e. the theory of action to which a person gives allegiance and which they tend to communicate to others as representative of their approach.

Argyris and Schon go on to explain that there is usually some disjuncture between espoused theory and the tacit structures that tend to govern actual behaviour, which they term "theory-in-use" i.e. this usually manifests as a gap between what people say they do and what they actually

appear to do. This theory would certainly be supported by findings from empirical research into FHN practice during 2002, and the gap was often particularly evident when the *Surrogate model* and its use were scrutinised.

For in effect the *Surrogate model* is the textual manifestation of family health nursing intent and represented practice (i.e. the conjunction of the *Theoretical* and *Mental* models), and is also necessarily often its interface with the rest of PHCT practice (i.e. where it comes into contact with the other active conjunctions of *Theoretical* and *Mental* models within the PHCT and community). Thus this is where meaning and value for the FHN and meaning and value for others tended to come face-to-face. As has been described, the documents comprising the *Surrogate model* tended to change over the course of the first year so that the full Calgary Family Assessment and Intervention elements were substantially pared down in the face of competing demands for the FHNs to provide pre-existing primary care services to individuals. Moreover data from the follow-up telephone interviews during 2004 suggests that a similar process occurred in relation to the national FHN Steering Group's desired incorporation of the Omaha Activity Recording System. Many of the FHNs were actually simultaneously using several forms of documentation to record relevant aspects of their activities (e.g. FHN documentation; community nursing/DN notes; Single Shared Assessment documentation; HV notes; medical notes).

Furthermore, during 2002 very few of the FHNs who had carried out in-depth assessments with a number of family members actually left copies of the genograms or ecomaps with these people so that they could inform their understandings and/or activities. Again the follow-up telephone interviews during 2004 indicated that this had not changed.

In a sense the struggles with the *Surrogate model* are symptomatic of three deeper underlying difficulties. The first is an intra-role tension between aspirations for breadth and depth of practice in multiple domains (individual, family and community). The second is tension with pre-established primary care practices and service provision. The third is tension with other future visions for local community nursing and primary care practices.

7.4.3 The influence of embedded professional identity and culture

Accordingly, at this point it is useful to move outwards from consideration of meanings and related psychodynamics for the "translating" FHN to consideration of the way that community nurses typically construct their identities in relation to other key actors in the PHCT. Melia (1987) highlights the importance of understanding how nurses construct their role identity,

believing that "it is an occupation's ambition and self-image that will more than anything else shape the nature of the work it undertakes or the service it provides" (p. 187).

Given that the vast majority of the new FHNs were very experienced in delivering services within the remit of district nursing caseloads, the most relevant analyses here relate to district nursing identity. Underlying current (e.g. Bennett and Robinson 2005a and 2005b) and recurrent perspectives (e.g. McIntosh 1985; Audit Commission 1999) suggesting that district nursing is in crisis, there is persistent evidence that it has seen itself primarily as a victimised respondent to changes in policy and practice (e.g. Speed and Luker 2004), and that its culture is inherently non-challenging (e.g. Griffiths and Luker 1997). Perhaps some of the most telling commentary has come from analyses of the language that District Nurses use in regard to their role. The English National Board and Queen's Nursing Institute (2002) report District Nurses seeing themselves as "sponges" mopping up the tasks that other PHCT members couldn't or wouldn't undertake. Goodman (2001) found two prevalent metaphors: avoiding making waves/rocking the boat; and maintaining balance amidst the various demands of powerful professional colleagues, patients' needs and other elements of the job itself.

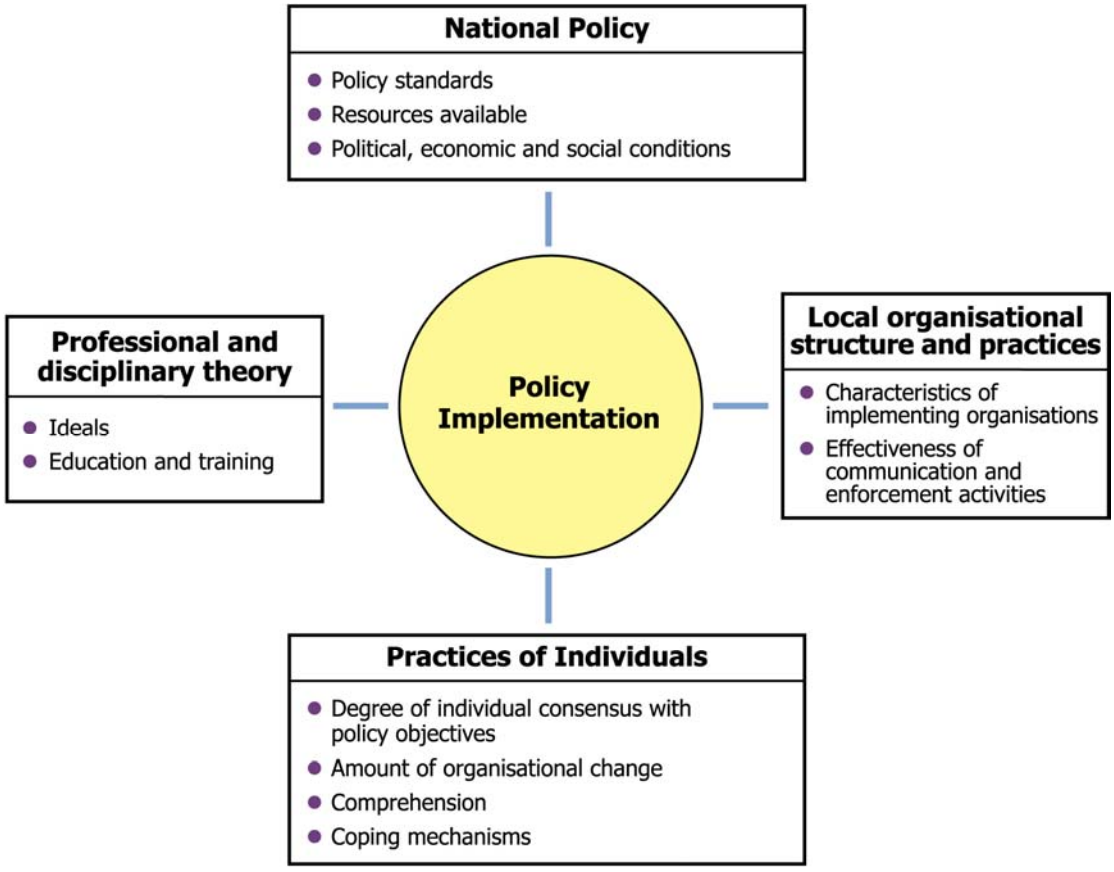
Although it is not axiomatic that these constructions of identity would be replicated across the Highlands and Islands, the author's experiences of field work certainly suggest that the dominant DN culture is predicated on co-operation rather than challenge. In order to explore this further a brief re-analysis of the language used by the FHNs in the eight telephone interviews from the 2004 follow-up study was conducted. This showed that the most usual ways of talking about family health nursing related to: "*incorporating it*"; "*fitting it in*" or "*addressing gaps*". A few more vivid metaphors were also mentioned, such as: "*jack of all trades, master of none*"; "*piggy in the middle*" and "*pulled both ways*".

When this is considered in the light of the analysis of remote and rural Highlands and Islands nursing in Chapter 4, it is reasonable to infer that there were strongly embedded psychological, cultural and contextual forces inhibiting these community nurses-turned-FHNs from progressing radical translations of the FHN concept into practice at local sites between 2002 and 2004. For, as with the introduction of the nursing process and nursing models, it seems that translations into the world of practice were influenced more by the "pull" of the receiving culture than the "push" of the returning believer. In order to develop this analysis further, and to bind together the blocks of explanation built so far, it is useful to consider a more encompassing explanatory model.

7.5 TOWARDS AN INITIAL EXPLANATORY MODEL OF FAMILY HEALTH NURSING DEVELOPMENT AT PRACTICE LEVEL

In order to examine the mechanisms by which government health and social care policies are translated into community nursing practice, Bergen and While (2005) draw on two well known theories: policy implementation theory, including the idea of "implementation deficit" (Van Meter and Van Horn 1975); and street-level bureaucracy (Lipsky 1980). The former theory arose from consideration of why participants at the "grass roots" level in organisations often did not comply "faithfully" with policy decisions. Van Meter and Van Horn proposed that implementation was likely to be most successful when only marginal change was required and consensus about goals was high locally. Lipsky studied public service employees working in bureaucratic structures to try to understand the routines and devices which they developed in order to cope with large and unpredictable client caseloads. He found that their capacity to exercise discretion in regard to the nature, amount and quality of interaction with clients gave them considerable power in the translation of policy into practice at "street level". Figure 7.2. reproduces Bergen and While's schematic combination of these two theories.

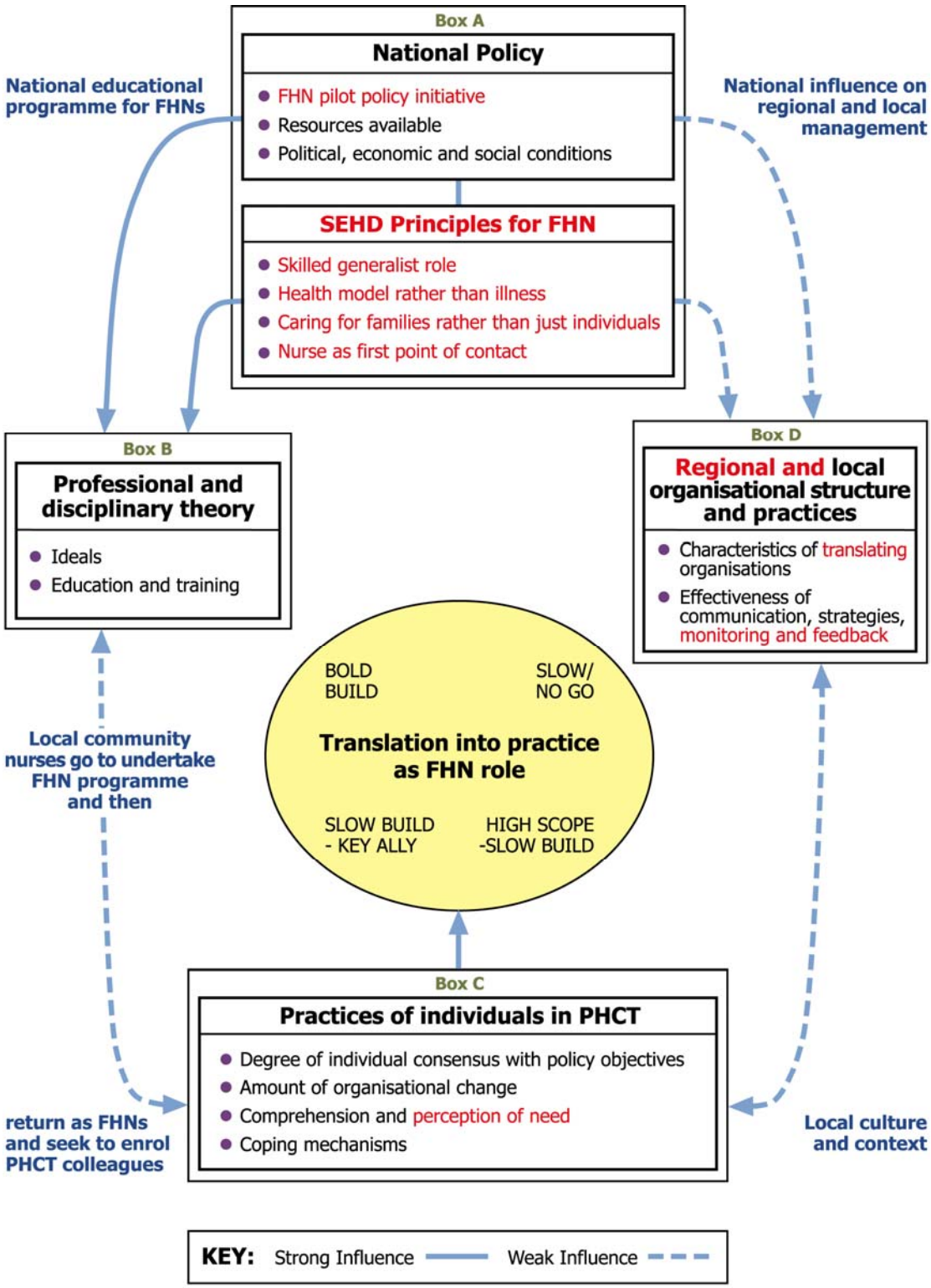
Figure 7.2: Bergen and While's model of practice response to policy change in community nursing (2005)



As can be seen, this model maps a number of key factors that are likely to influence the nature of policy implementation (or translation) at local level. As such, the model provides a basic

template upon which the emergent explanations from this chapter can be mapped. Figure 7.3 presents this process schematically, with modifications highlighted in red.

Figure 7.3: Adaptation of the Bergen and While model to incorporate emergent explanations



Thus, if Box B is seen as representing the professional and disciplinary theory of the FHNs, it can be seen that there is a relatively strong and direct link from the national policy initiative (Box A) by way of the customised, funded educational programme. The onwards link to Box C can be seen as representing the FHNs' attempts to seek enrolment of key individual allies within the PHCT. This link is presented as relatively weak, due to the struggle the majority of FHNs had in explaining the FHN concept and brokering consensus on the local rationale and direction for the role.

Although general government health policies would usually be seen as a substantial influence on regional and local organisational structures and practices, the specific link from the family health nursing initiative (Box A to Box D) is represented as weak. This is due to the lack of SEHD clarity about the FHN role and its intended outcomes, and an associated lack of linked policy imperatives and/or financial incentives to promote related multidisciplinary development at regional Health Board and LHCC levels. Further analysis of this linkage from the *macro* to the *micro* is undertaken in Chapter 8, but the focal activities linking these parts of the model may be seen as the supportive and promotional efforts of regional community nurse managers who were involved in the National Steering Group and/or Local Implementation Groups. The work of the Family Health Practice Development Facilitators was essentially targeted at practices within the PHCT (i.e. Box C).

The need for the FHPDFs suggests that the link between Boxes D and C can be provisionally characterised as relatively weak, albeit bi-directional. Given that the chapter has already identified local culture and context as particularly potent influences, Figure 7.3 provisionally locates these adjacent to the practices of individuals in PHCTs. However, this part of the model would seem to require further explanation and development.

Although all the key factors in Boxes A-D can be seen as influencing the local translation of policy that takes place in the central "arena", this thesis would argue that in remote and rural regions this is always mitigated through the individual practices of key PHCT members. Thus the "central arena" of policy implementation of Figure 7.2 is moved downwards in Figure 7.3 to reflect this. Within this sphere, the four main patterns of translation have been located adjacent to the factors with which they seem most closely associated. In this way it can be seen that the *Slow/No go* and *High scope-slow build* patterns are most closely associated with established structures, culture and practices. The *Slow build-key ally* pattern is associated slightly more with autonomy of individual practice, and the *Bold build* pattern is the one that is most closely associated with the ideals as promulgated by the Scottish educational programme (i.e. in terms of its ability to enact in-depth family assessment and intervention as per the Calgary model and to engage in sustained public health activities at community level). In this regard it is important

to note that none of the patterns align directly with the SEHD principles for policy translation (i.e. the four principles below Box A).

7.5 PLACE, POWER AND THE LIVING PLAID OF PRIMARY CARE

Thus the modified Bergen and While model provides useful summation of explanation building so far. As noted above, however, the powerful influence of local context and culture requires further exploration, explanation and incorporation within a model that attempts to explain why family health nursing developed as it did at local sites.

In this regard the recent work of Poland et al (2005) focusing on the importance of place is useful. As they observe, "there have been few attempts to systematically ′unpack′ those aspects of place that matter most to an understanding of the variability of health and social care practice, as well as to experiences of care, in a way that could directly impact policy, practice and research" (p. 171). Poland et al argue that place is more than a physical setting. Rather it is "culture manifest" in that "a distinctive culture of place emerges from the pragmatic and routinised interactions between engaged participants and social processes (various forms and levels of social structure)" (p. 172). For Poland et al, culture of place includes "the many ways in which place both represents and is represented within language, meaning, experience and subjectivity" (p. 172). This view links clearly with the initial analysis of Highland and Island "communities of place" developed in Chapter 4.

However Poland et al's work goes on to examine the emplacement of power relations within the set of "situated" social dynamics that constitute place. This view sees power as situational and relational: "Power is what allows the economic and social interests of some persons and social groups to (routinely) prevail over those of others. Power is embedded in ways of thinking and doing things, in mundane daily actions and interactions, as well as in institutional practices and broader social and economic policy" (p. 173). As Poland et al continue, "Most health and social care practitioners will be acutely aware of the extent to which settings are rife with power relations (who controls access, who sets the agenda, whose interest are served, how those lower in the social hierarchy are treated in ways that continually ′remind′ them of – and keep them in – their place etc.)" (p. 173).

Within UK primary care provision, GPs have for many years been at the top of local health and social care hierarchies (Peckham and Exworthy 2003). Their practice and concerns have very actively influenced the nature and scope of community nursing practice (Witz 1994). If there was ever any doubt about this it can be assuaged by study of national statistics. In an overview of primary care provision in Scotland since 1980, Ritchie (2003) notes that District Nurses'

home visits to those aged 75 and over increased by around 75%, and that this trend co-incided with the 1990 GP contractual requirement for the provision of systematic annual health checks in this age group. Even allowing for demographic shift in the age profile of the population, it is difficult to avoid the conclusion that community nursing activity is profoundly influenced by the interests of GPs.

This analysis is supported if Grabb (1977)'s three fundamental dimensions of power are considered. These are: control of material resources (means of production, wealth); control of human resources (labour, power); and control of ideas (ideology, hegemony, and cultural dominance). In the context of community nursing in the Highlands and Islands there has been increasing "attachment" of community nursing to GP practices. Although most community nurses remain employed by NHS Boards, at local level "GP attachment" has involved negotiating space and facilities with these independent contractors who have substantial control over much of the material resource. Moreover the rise in the employment of Practice Nurses directly by GPs has meant that they also have increasing control over the community nursing human resource. Finally the "biomedical model" focus on treatment of disease/health problems, with the GP at the centre as expert (Macdonald 1992), continues to be the dominant idea within primary care provision in the Highlands and Islands.

This is not to ignore significant historical narrative relating to holistic family and community care by GPs and nurses in the Highlands and Islands (Dougall 2002). However it is necessary to recognise how important the provision of accessible and safe medical treatment is to local communities. During the 2000-2004 there were several high profile disputes in the Highland region where communities successfully resisted the perceived withdrawal of their local GP service. Patient safety was usually at the heart of communities' fears. Thus public expectations in the Highlands and Islands, nourished over nearly 100 years since the Dewar Report, serve to re-inforce the power of the GP within the PHCT. As has been seen already in Chapter 4, through their "community embeddedness" (Lauder et al 2001), GPs also have a central role in the life of remote and rural communities (Hope, Anderson and Sawyer 2000; Clark 1997).

Accordingly, one of the central issues for FHNs seeking to translate this policy initiative into meaningful local practice was its interface with the situated power and interests of the local GP(s). As has been seen FHNs approached this in different ways, depending on individual confidence, established relationships, local priorities, local working practices and a range of other contingent variables. Nevertheless, it is easy to see why the vast majority of FHNs avoided radical interpretations of their new role that might be seen to involve significant disruption or change to pre-established primary care delivered by community nursing in line with GP expectations. Service maintenance with niche supplementation maintained balance,

avoided making large waves, yet could be seen to further individual development of family health nursing. Importantly, one of the consequences of service maintenance with niche supplementation was the striking diversity of FHN practice as evident in relation to the three core primary care functions (see Chapter 5).

Undoubtedly the other large influence shaping this approach was the expectations of the range of community nursing colleagues at local sites. Site visits by the author during 2001 and 2002 revealed that many of these colleagues found it hard to understand what the new role was and why it was needed. In this climate the need to maintain reasonable working relationships with colleagues was important. With the vast majority of the FHN students being drawn from roles that primarily serviced established (often embedded) district nursing caseloads, it was seen as a matter of priority by colleagues that these services should not be adversely affected. Where there was little pre-existing autonomy or "slack" for the incoming FHN, this "bottom line" usually thwarted individual development of the FHN role. This is vividly rendered in the *Slow/No go* case study at the end of Annex 1. However some of the FHNs returned to sites where they had previously already established substantial personal autonomy and/or "slack" (e.g. small island sites), and this facilitated development and enhancement of pre-existing services under the rubric of family health nursing. For many, *first level change* to their own practice became the realistic limit of their ambitions. For some, however, it was possible to enrol key allies towards more integrated family health service developments.

The above analyses of prevailing conditions at the *micro* site level show the general influence of local context over the way that the FHN policy initiative was translated into practice. Within this general picture, the specific notions of situated power, established service priorities and culture of place have emerged as offering useful explanatory potential. Drawing on the work of Poland et al, these elements are now incorporated into the evolving explanatory schema which also integrates elements of the second typology of practice development which emerged from the 2004 follow-up research (Figure 7.4).

Figure 7.4: Explanatory model of translation of family health nursing policy to and at practice level

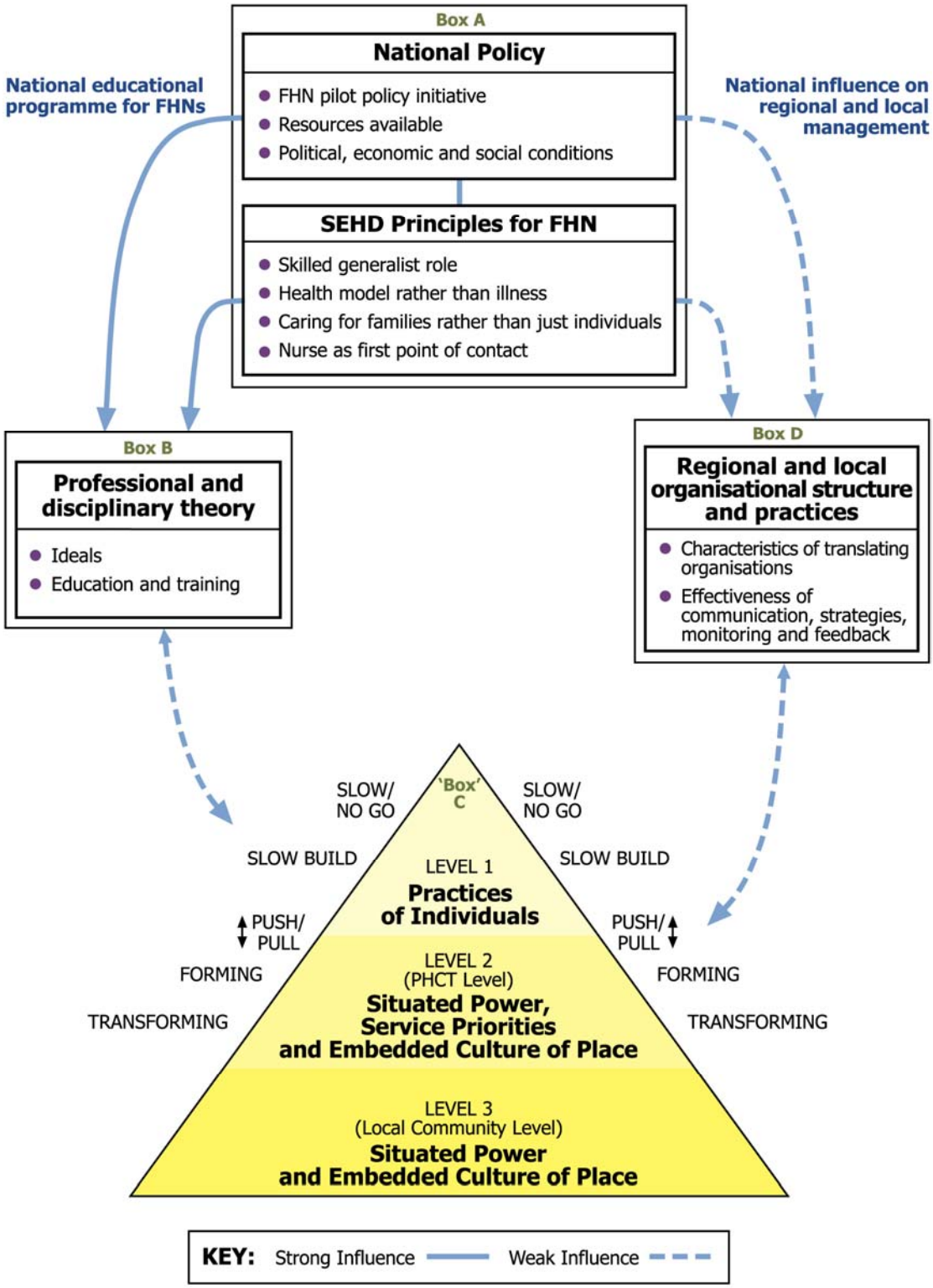
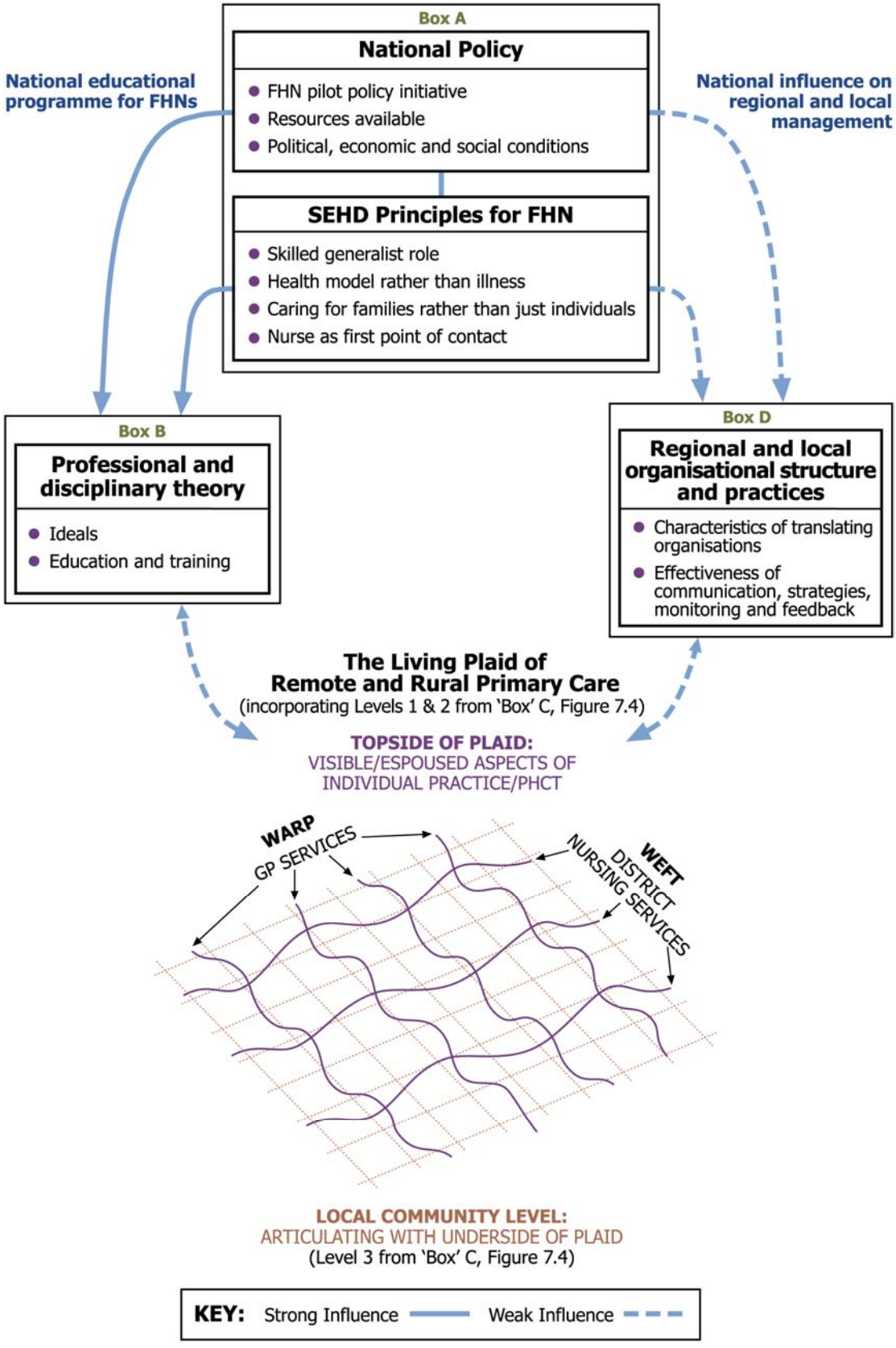


Figure 7.4 presents a pictorial overview of the major contingent factors, processes and findings that explain how and why family health nursing developed in the way that it did at local sites between 2002 and 2004. This carefully built construction offers an initial (and, at time of writing, a unique) theoretical explanation of the practice-based development of this historically important policy initiative in community nursing. However, it is important to locate this model in relation to wider perspectives. To repeat Dingwall, Rafferty and Webster's (1988) dictum, "the shape of nursing cannot be entirely understood from within" (p.228). For this reason the final part of this chapter attempts to build further explanation of the relationship between local family health nursing development and primary care provision in the Highlands and Islands.

For a range of other initiatives/developments will be impacting concurrently at any time at any one PHCT site. In this way, between 2000 and 2004, remote and rural PHCT sites in the Highlands and Islands were experiencing many translations and associated transitions, most notably in relation to: the new Local Health Care Cooperative structures; the new General Medical Services (GMS) contract; Single Shared Assessment for patients by health and social care services; review of midwifery provision; and development of the public health aspects of School Nursing and Health Visiting. Thus, if Boxes A-D of Figure 7.4 are seen as the irregular blades of the FHN windmill, it is possible to imagine an overall picture of many different sized windmills independently contributing to the generation of primary care. This metaphor has some topicality in the Highlands and Islands context. Nevertheless, on reflection, it fails to capture the inter-dependency and synergy between concurrent influences on contemporary primary care.

However, a different visualization can be achieved if Levels 1 and 2 within "Box" C of Figure 7.4 are seen as interwoven, constituting the "fabric" of local primary care provision. Drawing again on natural metaphor from the regions studied, this fabric may be seen as a sort of "living plaid". Figure 7.5 illustrates how GP services can be seen as the major warp threads and district nursing services can be seen as the major interlacing weft threads, together constituting the living heart of the fabric. It is noteworthy that this pattern was laid down by the Dewar Commission Report in 1912 and has remained largely unchanged since then.

Figure 7.5: Explanatory model incorporating the "Living Plaid of Remote and Rural Primary Care"



In this three dimensional metaphor, the topside of the plaid comprises those aspects of individual professional practice and PHCT functioning that are visible to the wider public and/or are espoused as representative (i.e. PHCT "face"). Implicit within Figure 7.5, and underlying this topside, is the substantive body (i.e. thickness, depth) of the fabric, which is largely invisible to the outsider. This relates to the dynamics of inter-professional team work and also, importantly, to the actual practice of individual professionals with patients, carers and families in their own homes (e.g. the "invisible" work of community nursing). The latter aspect in particular can be seen as part of the underside of the plaid, where services articulate intimately with (and within) local communities (Level 3, "Box" C, Figure 7.4),

Indeed, given the nature of remote and rural healthcare, there are likely to be many points where the underside of the Plaid may effectively seem inseparable/indistinguishable from the specific community that it covers. These "points of embedding" or "vertical adhesions" may occur when a GP and/or nurse lives and works in a very small, specific community. This relates clearly to the "community embeddedness" referred to by Farmer et al (2003) and the social capital dimension of rural nursing described by Lauder et al (2006). As has been seen, these communities all have their own embedded cultures of place.

Figure 7.6 now depicts the Living Plaid in more detail, illustrating some important contingent and concurrent processes.

Figure 7.6: Detail of the "Living Plaid of Remote and Rural Primary Care"

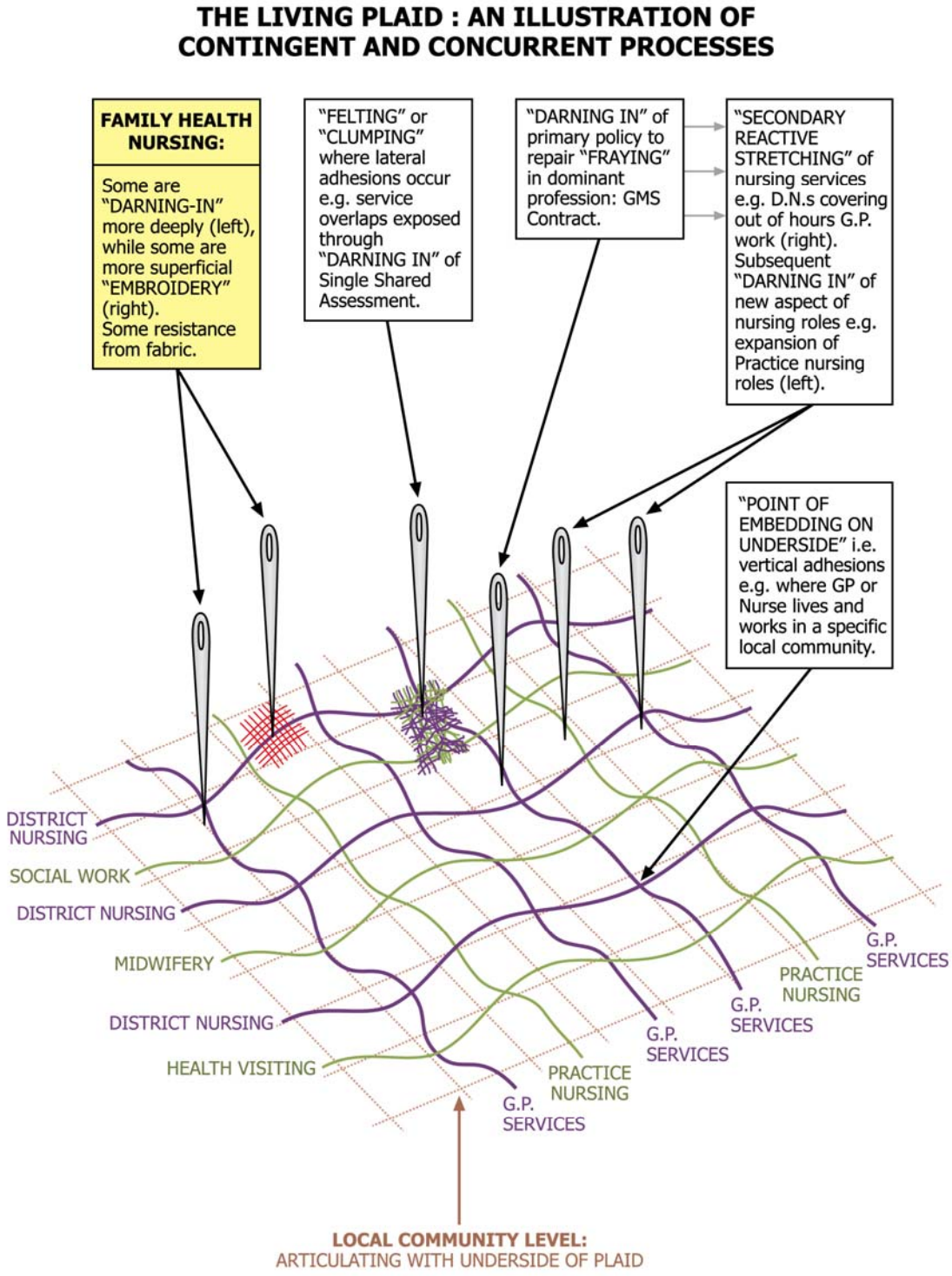


Figure 7.6 illustrates how the body of the fabric may absorb, generate and/or regenerate in relation to a range of external, and internal, influences. Thus, if each different but contingent initiative/development is seen as a needle pulling thread, there is the capacity for the plaid to simultaneously "darn in" and/or resist threads of different length, strength and hue, dependent on local need or local power interests. In turn this helps to explain the variety of very different local patterns on the living plaid of primary care that were routinely encountered when visiting PHCT sites.

The latter observation brings to mind another metaphor that is sometimes used to refer to the shape of primary care provision in the Highlands and Islands: the "patchwork quilt". While this captures some of the irregularity of the overall appearance of service provision, it fails to reflect the essential pattern that binds together the elements of primary care provision in these regions.

Thus "The Living Plaid" is posited as a potentially useful new metaphor for primary care provision in the Highlands and Islands. As with original Highland plaid, the primary care garment has typically been primarily designed for multi-function rather than show. In recent years, regeneration has become difficult when the fabric has worn thin or been laterally stretched in places, but the fabric's capacity for wear, tear and running repair has been its enduring quality to date. When Highland and Island primary care is considered in this way, it raises the question of whether history will view family health nursing as an enduring, strengthening repair or a foppish piece of foreign embroidery.

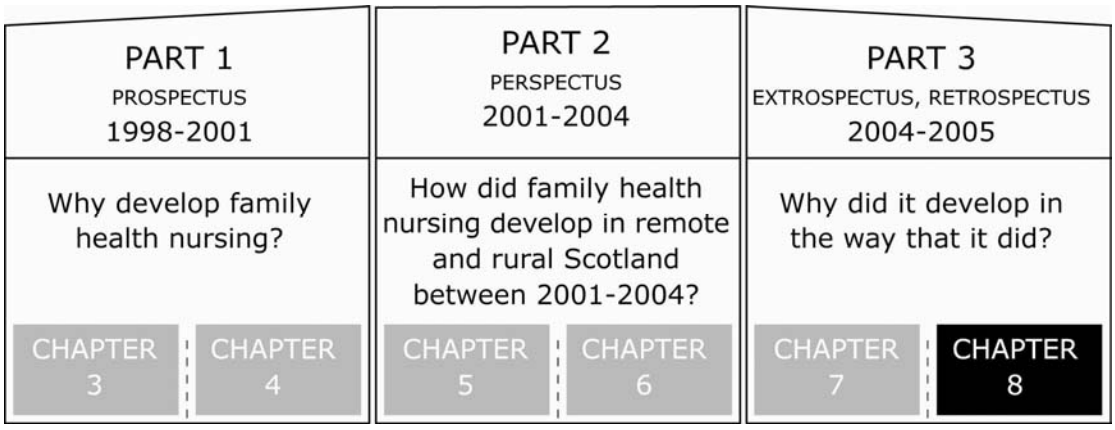
SUMMARY

This chapter has built explanation of why family health nursing practice developed as it did at local PHCT level, and has focused particularly on the enactment of the FHN concept as a role. To this end, the primary understandings from Part 2 were considered in the light of a number of relevant theoretical perspectives. The prevalent pattern of FHN role development reflected the "niche" type (Scholes and Vaughan 2002) and can best be characterised as "service maintenance with niche supplementation". However the FHN role development emerged as atypical in that it had been "top down", nationally co-ordinated, and had incorporated an educational programme and evaluation.

Insights from previous UK experiences with the nursing process showed the value of understanding local family health nursing development in terms of enrolment and translation processes, rather than implementation. A typology of nursing models was used to help explain the personal and professional psychodynamics of the translation of the FHN concept into a nursing role. Further illumination was afforded by relevant literature on professional identity and inter-professional relations.

These understandings were then integrated into an explanatory framework developed by Bergen and While (2005) to capture the mechanisms by which health and social care policies may be translated into community nursing practice. This framework itself was then further developed to take account of the particularly strong influence of established work systems, context, culture and place in the local development of family health nursing. This resulted in a new summative model of the main contingent factors and processes that together explain the nature of local development of family health nursing in Scotland up until 2004.

Although this new model could be seen as sufficient in terms of the scope of the thesis, it was recognised that it had limitations in terms of its ability to reflect the many other concurrent initiatives and policy translations ongoing at local PHCT level. In order to address this, an alternative adaptation to the model was developed using the metaphor of "the living plaid of remote and rural primary care".



CHAPTER 8

EXPLAINING THE DEVELOPMENT: POLICY LEVEL

Overview of this chapter

The focus in this chapter moves from local practice level back to national level in order to develop further explanation and build comprehensive understandings of why family health nursing developed as it did in Scotland. In doing so, analysis centres primarily on the formulation and advancement of nursing and health care policy.

A prologue to the chapter seeks to aid this transition from practice to policy by reflecting on the commonalities, as well as the distinctions, between the professional – personal worlds of the FHN, the researcher and the Chief Nursing Officer (CNO). By including dialogue from an interview with the CNO, the prologue also exemplifies the approach taken during interviews with four key policy informants who were involved in initiating and promoting family health nursing (see Annex 3 for full details). Undertaken in 2005, these interviews invited reflections on three of the central questions in this study, thereby interrogating cumulative understandings built up through literature review in Part 1 and through empirical research in Part 2. Accordingly this chapter draws extensively on understandings derived from these interviews.

Following description of interview, analysis and synthesis methods, the emergence of the FHN concept in Europe and its enactment into policy is revisited through understandings synthesised from the key informant interviews. Two relevant policy analysis frameworks are then applied in order to gain further insights into why events developed as they did. This process is then repeated in relation to Scotland, enabling a new explanatory model of the emergence of the FHN concept at both European and Scottish levels to be presented.

The next section of the chapter constructs a different model that explains the contingencies involved in taking the FHN policy initiative forward for enactment. This completes the link back to practice, and the chapter concludes by presenting a final integrated model of the main contingent factors and processes that explain the development of family health nursing in Scotland up to 2004.

8.1 PROLOGUE ON PROFESSIONAL - PERSONAL WORLDS OF PRACTICE: THE FAMILY HEALTH NURSE, THE RESEARCHER AND THE CHIEF NURSING OFFICER

In order to synthesise understandings about the development of family health nursing practice, the analysis in Chapter 7 primarily considered the local sites in overview. Before moving away from the realm of practice to the realm of policy, however, it is important to reflect on the professional and personal worlds of meaning that underlie both.

Interviews and observation of practice undertaken as part of site visits during the commissioned evaluation study yielded a large number of insights into the professional and personal worlds of FHNs and their clients. As the FHNs almost always lived within the small communities where they worked, the dividing line between the professional and personal was often very hard to discern. A passage from an interview with a very experienced community nurse who had recently started to work as an FHN gives a glimpse of the underside of "the Living Plaid":

> *".....You can't be a person who really wants their privacy. You are in a goldfish bowl. You have to be able to cope with people's interests. You also have to recognise, or to know, to have lived in an area, to be brought up in a country area, to know that this is how country areas live. Remote and rural areas. People do feel they own you. If you've lived in an area all your life there are people who see you as a baby. They maybe fed you a bottle, or changed your nappy, and from that they feel an ownership of you. And they feel it isn't just curiosity or nosiness. They want to know how you're getting on. They feel they've had a hand in bringing you up.....and this is how country people feel if you are part of a community and living there. And it also depends on the experiences you've been through with them. If you've been through a bereavement with them, either their bereavement or yours, these all make big connections in a remote and rural area, and its part of the trust that builds up between Family Health Nurse and the community"* (extract from interview 02/03).

Although particularly vivid, this passage is typical of the psychological and social context within which FHNs were working. It is interesting to note how similar this is to the experiences of the retired remote and rural DNs who informed Dougall's 2002 study. Some of the consequences are explored in a further extract from the same FHN interview:

> **FHN:** *".....you're living in an area for a long time and you have a lot of information also, a lot of which perhaps you cannot write down, its that sensitive. But you make connections in your head and you know how the whole community intermingles and you have got a picture of that. Its like the community portrait but its in your head. But there are some things you can't write down.*
>
> **CM:** *Yes, you see that interests me.*
>
> **FHN:** *See, I know some people who are not who they think they are*
>
> **CM:** *Right, even that fundamental?*
>
> **FHN:** *I know it but they don't*

CM: *You know that? You've lived in the area a while, and that's hearing from other people?*

FHN: *Yes* (extract from interview 02/03).

Given the nature of the family health nursing assessment process promoted by the educational programme, and its associated documentation, this raised potentially difficult issues for FHNs. Indeed several independently reported the experience of being privy to a different version of family history than the one that a family member had related during construction of the genogram. This usually seems to have been dealt with by the exercise of discretion and/or circumspection on the part of the FHN.

I observed another strategy during a field visit. The following account was developed, based on my research field notes taken at the time:

I set off early to meet Una (FHN). A series of tortuous single track roads led through, then over, the spine of the island until moor, bare rock, lochan and sky gave way to machair, sea and a scattering of crofts. I'd brought the address of the GP surgery where she was based, but I didn't have a detailed map and, anyway, there were rarely street signs in the island's villages. Only a stranger would need them, and then, not for long.

Una was going to visit the Ross family to try to continue the formal family assessment process. The Ross's comprised: grandfather; daughter; husband (away at sea); husband's 14 year old daughter from a previous relationship; and their two small sons. Apart from the five year old son's intermittent difficulties with wetting his trousers, there were no current "presenting" health problems.

I watched and listened as Una asked the mother questions in order to develop the genogram and ecomap. The process combined a search for new knowledge (e.g. about any illness on the husband's side of the family) with superficial checking of deep-rooted mutual understandings (Una and the mother both had children at the local primary school). The latter strategy was applied to some of the questions on family power structure and dynamics in the assessment tool, while the remainder were skillfully omitted by Una.

The mother also had some skilful response strategies. On the few occasions that questions overtly probed difficult areas (e.g. relationship with husband's daughter) she would deflect these by giving vague answers ("getting on well enough") or veering into copious and largely circumstantial detail about her husband's side of the family. I later heard this described by a university lecturer based in the Highland's as a typical local strategy of "polite non-co-operation". In turn, Una recognised the signals and always moved on to less threatening ground.

As I watched this lengthy and elaborate "dance" I was struck, as often before during the research, by the need to attend as much to what was not being said as to what was being said. I was also conscious of another recurring question: what was the need for this? Finally, I felt a strange mixture of wonder and puzzlement at how and why the family health nurse concept was being acted out in this way, in a remote croft hundreds of miles from Calton Hill and Copenhagen. All of these thoughts I kept to myself.

The above account changes some details in order to avoid family and FHN identification. However, it has been developed to show how my professional engagement with the world of FHN and clients led to a personal puzzlement about the transmission and translation of an idea. This puzzlement became the driving force for PhD study. As has been seen, this study not only tries to answer the seminal questions *why here, and why now?*, but it also attempts to answer *why has it happened as it has here?*, and to build an explanatory model of the Scottish development by linking this back to *why did it happen at all?*

Addressing the latter question requires a return to the policy formulation and enactment worlds of Calton Hill and Copenhagen. In order to try to overcome some of the limitations of doing this exclusively via literature (as evident in Chapters 3 and 4), the present chapter also draws on interviews with a few "key informants" who were involved in the FHN concept's initiation, policy formulation, and enactment. While the work context for these key informants was typically extremely different from the world of remote and rural FHN practice described above, nevertheless, it is important to recognise that there are similarities as well as differences in the professional-personal dimensions of these respective worlds. Similar tensions prevail in regard to what can be said and what cannot, and what is written down and what is never recorded. This is particularly important to remember when an historical research perspective is being adopted.

The following extract from the key informant interview with Anne Jarvie, Scotland's Chief Nursing Officer from 1992 to 2004, illustrates this point and sets the scene for the next section of the chapter:

> ***CM: "…****but it could be said that at the end of the day, if you haven't shifted the pre-existing roles, then you've just added another one.*
>
> ***AJ:*** *Absolutely. You see I had hoped, and I couldn't articulate this because this was what was making everybody feel very protective and sensitive who were not doing the FHN course. I had expected that in some areas in Scotland we would no longer have District Nurses and Health Visitors.*
>
> ***CM:*** *Mhmh. And did you have an inkling that that might ehm, you might have people that would help you in that, shall I say (laughs)?*
>
> ***AJ:*** *Yes*
>
> ***CM:*** *Right*
>
> ***AJ:*** *If it had worked out. And it may. I mean it is still quite early days. If it had worked out that this cohort of people were generalists, that they could be the gatekeeper, that they could ehm be the people who had the confidence to function to the level of their, the higher level, of their skill and knowledge, and could have been the referrer on to others without a middle man"* (extract from key informant interview 05/1).

In addition to yielding insight into the professional – personal dynamics of change management, the above interview passage also exemplifies the approach taken in the key informant interviews. The next section of this chapter gives more information about interview methods and more information about the interpretative processes applied to the understandings derived from the interviews.

8.2 RESEARCH METHODS

An overview of methods used in this chapter is given in Chapter 2.2.3.3. Moreover, a full account of the nature, scope, design, methods and findings of the key informant interview part of the study is given in Annex 3 to the thesis. At this point, however, it is useful to summarise the key informant interview approach and its underlying rationale, in order to make clear its part in the process of building an explanation of family health nursing development.

8.2.1 Interviews with key informants

As has been seen in Parts 1 and 2, the emergence of family health nursing and its subsequent enactment were primarily studied by reviewing extant literature and conducting primary empirical research into education and practice in Scotland. Through a combination of these primary and secondary research strategies, a set of advanced understandings about family health nursing had been constructed by 2005. However, one prime source of knowledge about the development remained untapped, namely, the small group of people who were instrumental to the initiation and promotion of the concept i.e. the "key informants". Accordingly, during the summer of 2005, I sought to elicit the perceptions of these key informants in relation to the three main research questions at the heart of the study. These were:

- Why develop family health nursing?
- Why did family health nursing develop in the way that it did in Scotland?
- What does this mean in terms of the development's influence and implications?

In addition to seeking general reflexive overview on these questions, I was also:

- seeking answers to a number of specific questions which had arisen from prior analyses of literature and empirical data (e.g. how, when and why did the "family" part of the FHN concept arise?)
- checking emergent understandings against key informants' interpretations of events, underlying motivations, and related personal explanations (e.g. the SEHD policy on family health nursing being essentially ambivalent in that more individual-focused community nursing roles such as practice nursing were simultaneously being promoted)
- jointly exploring the possible explanatory value of theoretical frameworks for policy analysis (e.g. discussing application of Rafferty and Traynors' Context-Convergence-Contingency model to the evolution of family health nursing policy)

Thus, to some extent, the interviews were part of a process of authentication.

In-depth interviews were carried out with two individuals who were central to the initiation and policy development of family health nursing in Europe and Scotland respectively:

- Ainna Fawcet-Henesy (AFH), WHO Europe Regional Advisor for Nursing from 1995 onwards. During 2005, AFH was on extended leave due to illness.
- Anne Jarvie (AJ), Chief Nursing Officer for Scotland from 1992- 2004. AJ had recently retired.

Interview with AFH was undertaken by telephone, while interview with AJ was undertaken in-person.

More limited interviews were undertaken via e-mail with two key informants who had particularly important input into the development of the FHN conceptual framework and curriculum. These were:

- Professor Margaret Alexander (MA), who was Director of the WHO Collaborating Centre at Glasgow Caledonian University during the period when the FHN concept was developed
- Majda Slajmer Japelj (MSJ), International Manager in the WHO Collaborating Centre for PHC Nursing in Maribor, Slovenia, during the time when FHN was being developed. MSJ also worked for WHO Europe in Copenhagen as Temporary Adviser/Short term consultant for transition countries.

All four interviews were designed to cover a core set of questions related to those driving the thesis, but each interview schedule was also customised in order to address specific questions of particular relevance to the professional role of the interviewee. Interviewees agreed to resultant dialogue being "on the record", with their contributions being attributable and identified with them personally. This direct-attribution approach was chosen because these informants' involvement at the core of policy development was a matter of public record, and attempts to anonymise their contributions seemed both futile and inappropriate. Annex 3 presents more detailed reflections on the ethics, merits and demerits of this approach.

Annex 3 also presents examples of core, relevant narrative from these interviews along with the main themes derived by myself and informed by critical review from my supervisor. These comprised a first stage of data analysis and the reader is referred to these for detailed and particular insights. The second stage of analysis involved comparison of narrative across the four different interviews to examine points of convergence and divergence. In this way it was

possible to synthesise a summative narrative (see Table 8.1 below). A third stage of analysis extracted core ideas from each individual interview and set out the consequent understandings derived (see Table 8.2 for an example). The fourth and final analytic approach involved the identification and application of relevant theoretical perspectives on policy analysis and policy implementation.

8.2.2 Identification and application of relevant policy analysis and policy implementation frameworks

As Table 2.4 indicates, this firstly involved extensive review within nursing and more generally within public policy literature. Although the primary cognate area and associated questions drove this search, some other criteria were important in determining the theoretical frameworks that were selected. Specifically I was looking for credible research-based frameworks that:

- focused on the dynamics of policy formulation and advancement
- had broad cultural fit to the world of UK nursing policy
- related to some of the emergent themes within this PhD study

This led to the selection of two models which focused primarily on analysis of policy formulation and initial advancement. These were applied as analytic templates (Miller and Crabtree 1992; see Table 8.3 for an applied example) to interrogate both the understandings already derived from prior stages in analysis of the interview material, and the understandings already derived from review of relevant literature. This involved processes of extraction, comparison, differentiation, interpretation, integration and illustration. A further model was subsequently selected to help explain the way in which the FHN policy initiative was taken further forward towards enactment in Scotland. Again this was applied as an analytic template (see Table 8.10).

Through these methods the chapter takes forward the process of building further explanation of the formulation, development and enactment of family health nursing policy. The next section considers policy formulation and development at European level.

8.3 THE EMERGENCE OF THE FHN CONCEPT IN EUROPE AND ITS ADVANCEMENT INTO POLICY

8.3.1 A synthesised narrative, plus the core ideas of the key informant

This part of the chapter revisits the FHN concept's Copenhagen cradling in the light of the findings from the key informant interviews. As Table 8.1 shows, it was possible to construct a summative synthesis of narrative across the four interviews which shows convergence around one central explanation of events, while also highlighting two areas where there was divergence of emphasis.

Table 8.1: Summative synthesis of narrative across four interviews*

Convergence/corroboration around a central narrative	Divergence/distinct difference in emphasis within the narrative
The Health for All Nurse concept was the core from which the FHN concept was developed. However there was no FHN as such in the Vienna 1988 Declaration	
Dr Asvall (JA) initiated the new (1998) emphasis on the family, and developed the concept with AFH	
While JA was a major advocate of the FHN concept, AFH was the main driver of its subsequent development	
HEALTH 21 was a timely opportunity to advocate, develop and attempt to embed modern public health nursing across Europe	Distinct differences in emphasis emerged in regard to the centrality and importance of family within the FHN concept. AFH saw it as foundational and focal, while the other interviewees saw it as important but placed less emphasis on it. There were some tensions around this issue amongst the senior nurses involved in developing the concept at WHO Europe level, but these didn't last long due to a recognised need to move quickly to grasp the HEALTH 21 opportunity. For Anne Jarvie (AJ) the emphasis on family was not seen necessarily as permanent and immutable.
The drive from the two central figures (JA and AFH) was essential, but in itself could not guarantee desired outcomes	
The matched Family Health Physician (FHP) concept never developed due to the lack of a champion (other than JA)	
Indeed there was active opposition to the FHN concept from GPs at WHO Europe level who saw it as encroaching on their territory	There seemed distinct differences in emphasis about the extent to which the FHN should be seen/presented as a catalyst for provoking wider systems change. Although all interviewees wished this to happen, AFH stressed the FHN role itself more as an autonomous entity. Perhaps this reflected engagement with developing countries where primary health care systems were less established and embedded. AJ acknowledged that, since retirement, she was rather more explicit about the desire and need for the FHN to help change existing PHCT approaches than had been possible during the earlier stages of the developing FHN initiative.
Slovenia, the UK and Scandinavian countries were the main influence on the development of the conceptual framework and curriculum for the FHN	
The envisaged scope of the FHN role was ambitious but necessary and legitimate	
There was some significant opposition to the FHN development at European level from health visitors and midwives	
Scotland has been exemplary in progressing the FHN from concept into enacted role, but remains far ahead of other interested countries	
Many European countries still lack infrastructure and legislation for development of nurse education and nursing practice	

*The interview schedules had some core common questions, but were individually tailored to optimize learning opportunities from key informants with distinctive roles in the initiation, promotion and enactment of the FHN concept. Therefore cross-case analysis and subsequent synthesis of perspectives has only been undertaken where appropriate. This has been almost entirely in relation to the core common questions on the emergence and development of the concept at European level.

Table 8.1 shows the value of the key informant interviews in answering many of the questions that emerged from review of the WHO Europe literature on family health nursing. In effect it is clear that:

1) The 1998 allusion to there being a Family Health Nurse in the 1988 Vienna Declaration was factually incorrect, but was meant to refer to related ideas implicit in the Health for All Nurse
2) Dr Jo Asvall (JA) initiated the new emphasis on family in 1998
3) The Family Health Physician concept was never developed due to the lack of a champion (other than JA), and there was active opposition from European GPs to the FHN concept

None of these points could be deduced from the WHO Europe literature due to its inherently promotional/aspirational nature.

While review of the literature had shown Ainna Fawcet-Henesy as the main driver of the FHN concept's policy development, the key informant interviews also highlight her initial role in fostering the concept with Dr Asvall. Indeed her own account of the evolution and subsequent development of the FHN concept provides considerable insights into her beliefs, motivations and political strategies. A summary of these "core ideas" is presented in Table 8.2.

Table 8.2: Core ideas which emerged from interview with AFH

CORE IDEA	DERIVED UNDERSTANDING
1) The opportunity and imperative for a public health focus	This idea was central to the "macro" approach AFH took forward through WHO Europe and HEALTH 21, and was also central to the FHN concept and envisaged role. It was seen as imperative that nurses had a good educational preparation for meeting the considerable public health challenges across Europe. There was doubt that many of the existing primary care systems, dominated by disease-focused medicine, could meet these challenges.
2) The family as the single most important unit in society	This phrase was stressed several times during the interview, and was a key belief that AFH saw as underpinning all nursing activity. As such, the "family" focus in the FHN title was seen as reflecting a primary purpose in itself (i.e. being alongside the family) rather than simply a means to the end of getting public health embedded into community development.
3) The FHN as a development from the Health for All Nurse	These two ideas were seen as sharing a similar core, with the main difference being that the FHN was more developed as a concept, with a specific conceptual framework and educational curriculum. The decision to foreground family as a key element had been initiated by Dr Asvall and developed jointly with AFH.
4) Need for legislation and education to address poor infrastructure for nursing in many European countries	This was seen as the main big issue for nursing to address. AFH felt that the only way to effectively do this was for nurse leaders to engage politically and try to influence Ministers. Poor funding was linked to nursing's low status. These problems were the main cause of the slow progress of many countries involved in the FHN pilot.
5) Importance of good project preparation and adequate funding	Multinational pilot projects like the FHN need some substantial core funding and good preparatory work to ensure a critical mass of success. Nevertheless, in the absence of more funding, positive action is still needed as nothing will happen if we wait for money. In this regard, leadership, inspiration and good core teamwork are essential.
6) Tensions and frictions are inevitable if anything is to change	Although regrettable, tensions and frictions are inevitable when change is being introduced. Opposition from professional self-interest groups has always been a factor in any major reform. There is a need to focus on the over-riding aim as the key outcome that will ensure better care. Healthcare practice can be most fundamentally improved through policy influence.

In addition to highlighting AFH's strong and long-standing belief in the need for a form of public health nursing that works with families, Table 8.2 also conveys some of her deep conviction that strong political leadership from nursing is the cardinal means by which nursing practice in Europe will be improved. In this regard all the key informants emphasised that her role in leading the WHO Europe FHN project was central and crucial.

8.3.2 Application of Kingdon's model

In order to gain further critical purchase and to stand back somewhat from the personal perspectives which were elicited, two theoretical frameworks from policy analysis were applied to the interview findings. The first, Kingdon (1995)'s agenda setting model, is drawn from analysis of public policy in general, while Rafferty and Traynor (2004)'s Context-Convergence-Contingency (C-C-C) model has been developed primarily through analysis of policy relating to nursing education and research.

Kingdon's model is well summarised by Peckham and Exworthy (2003), and it is worth quoting their description of it:

> "Kingdon's model examines how issues get on to the policy agenda in the first place and how they become translated into policy *(Kendall 2002)*. The various streams must be connected before the "policy window" opens. The model is useful in explaining how opportunities for policy formulation and implementation are created and destroyed. The *problem stream* comprises evidence of the nature of an issue which becomes defined as a problem amenable to policy interventions. This evidence might be crisis incidents, research results, patient feedback or performance indicators. The *policy stream* consists of proposals, strategies and initiatives to address the problem. These often pre-date the problem being recognised and circulate in a "primeval soup" awaiting their identification. This requires a critical mass of stakeholders to appreciate the merits of the policy. The merits must include an accordance with (political or organisational) values, a technical feasibility and a recognition of future constraints. The *politics stream* comprises party politics, organisational power struggles and interest groups. These three streams may be connected by natural cycles (such as elections), crises or the actions of a policy entrepreneur, an individual or individuals who invest their reputation, status and time in joining the streams in order to open and keep open the policy window. Natural cycles, complacency or the entrepreneur's departure might force the window to close" (p.38).

As Hill (2005) notes, Kingdon's model is derived specifically from analysis of public policy in the USA. The combination of the soup, stream and window metaphors is a rather uneasy one, but its application may usefully highlight possible explanations of how and why the FHN concept was moved onto central agendas and promoted. The emergence of the FHN concept is viewed through this lens in Table 8.3.

Table 8.3: Application of Kingdon's agenda setting model to the European emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Problems	Presenting problem for WHO Europe: Despite Vienna Declaration, the Health for All Nurse was never really enacted in European countries. Most remained hospital-dominated and both primary care and public health nursing were slow to develop. However, unclear to what extent individual countries really saw these matters as problematic. Underlying problem: In many countries there was a lack of infrastructure and legislation that would enable nursing education and practice development.
Policies	In WHO terms the key policy had been Health for All 2000. However, national governments determined nursing policy in individual nations, and cost containment policies were common in the 1990's. At WHO Europe level HEALTH 21 offered a new chance to push for better public health care across Europe. Within HEALTH 21 the FHN can be seen as a nursing policy development of the Health for All Nurse, with specific new foregrounding of a family element.
Politics	In WHO Europe AFH focusing nursing efforts on public health and primary care. Key ally in JA. Therefore strong personal medical-nursing alliance, and FHN idea developed together. However, context of opposition from European GPs to nursing expansion. Also intra-professional tensions within nursing and midwifery when FHN concept announced.
Policy entrepreneurs	AFH and JA were the two policy entrepreneurs working vigorously to align the perceived problem with the impending policy, and to lobby for political support within governments and professions. AFH's strategy twin-pronged in this regard: involving CNOs in the FHN development to promote ownership and trying to "sign up" individual Health Ministers from across Europe to attend the Munich Conference (a "Ministerial" Conference).
Windows of opportunity	The HEALTH 21 launch in 1998 marked the initial opening of this window of opportunity, and the Munich Conference of 2000 was designed to thrust then wedge it open.

The *problems, policies* and *politics* dimensions of Kingdon's model, as applied in Table 8.3, provide useful foci for considering insights derived from literature review and the key informant interviews. In this way, the analyst is directed to such fundamental agenda setting questions as:

- what problems was the European FHN project actually addressing?
- was the Health for All Nurse a dormant nursing policy initiative waiting for the *window of opportunity* presented by the renewed "problematisation" of public health service delivery within HEALTH 21?
- in this context, was the FHN an opportunistic (and arguably peculiar) "re-badging" of the Health for All Nurse?
- what were the attendant political dynamics and strategies?

The answers, as manifest in the understandings in Table 8.3, suggest that the European FHN project was addressing problems that were very general in nature (i.e. under-capacity in primary care and public health nursing) and there was a lack of a more precisely defined focal problem necessitating this particular new solution. Moreover, there appeared to be a lack of accord in the extent to which different countries actually saw existing primary care and public health nursing as problematic. Accordingly the limitations of viewing the FHN project primarily as a response to one problem tend to be exposed through the lens of the Kingdon model. Rather this lens suggests that HEALTH 21 provided a re-focusing of attention on public health generally, and within this ambit the FHN nursing policy initiative sought to enrol Ministerial support so as to give it the momentum and sustenance that the Health for All Nurse never achieved. This emphasises the aspirations of JA and AFH and their seminal roles as policy initiators, *policy entrepreneurs* and strategists. Accordingly the application of the Kingdon model to this particular example of policy agenda setting would give more weighting to the *policy entrepreneurs* dimension than the *problems* dimension, and view these entrepreneurs more as an antecedent force than opportunistic respondents who reactively brought the problems, policies and politics streams into confluence.

8.3.3 Application of Rafferty and Traynor's C-C-C model

Rafferty and Traynor's Context-Convergence-Contingency model provides a different lens for policy analysis. The model was outlined in a study of international trends in nurse education (Traynor and Rafferty 1999):

> "Attempting to identify the key ingredients of successful nursing educational reform in different countries has suggested that three sets of conditions need to be satisfied for change to follow. These relate to context, convergence and contingency. Context refers to the creation of a positive climate of opinion or a case and pressure for change. Convergence refers to the fortuitous fusion of professional and government agendas. Contingency provides the unforeseen consequence, the spark that ignites a political change. Well articulated, rational arguments within the profession appeared necessary but not sufficient to move largely indifferent governments until the moment that some contingency arose. The latter might be an unforeseen policy imperative, largely unconnected to the original content of nurses' lobbying." (p.91)

The model was developed further when analysing UK research policy (Rafferty and Traynor 2004). Here the consequences for nursing's political leadership were highlighted:

> "....successful policy change in nursing requires the sometimes serendipitous synchronisation of professional and government agendas. This has been evident in case studies in the past *(Rafferty 1996)*. Three sets of conditions need to be satisfied. First, the context needs to be "primed" for the proposed change to happen; secondly, the priorities of government and the profession need to converge and thirdly, the role of

> contingency or some fortuitous factor such as timing needs to be right. The role of political leadership in this process relies upon several interrelated activities; first the ability to "read" the policy environment; second to identify targets for influence and third to mobilise the resources and champion the case for change" (p.258).

As can be seen, the C-C-C model shares some of the Kingdon model's key elements, such as the notions of deliberate alignment of key elements and related action. However Kingdon's model focuses more on agenda setting and policy formulation, whereas Rafferty and Traynor's model takes analysis slightly further towards consideration of policy enactment. The C-C-C model also has a much more overt focus on the role of fortuitous timing in determining successful policy change. Perhaps this reflects nursing's relative unimportance within the power hierarchies of UK healthcare planning and provision (Robinson 1997; Davies 2004).

Application of the C-C-C model to the European emergence of the FHN concept is presented in Table 8.4.

Table 8.4: Application of Rafferty and Traynor's C-C-C model to the European emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Context	The context/case for changing primary care nursing to make it more public health focused seems to have been accepted by a core set of people at WHO Europe, and various Chief Nursing Officers from different countries. However the "priming" for the proposed change was inadequate. Insufficient preparation time was cited as a factor in this, but it remains unclear whether there was ever going to be enough positive multi-professional support for this sort of initiative. No obvious "sea-change" in incentives since the relative failure of the Health for All Nurse.
Convergence	Thinking of the "push" from the profession in Europe and the "pull" from individual national governments, it is clear that sufficient momentum was generated to produce convergence on paper. In this way Ministers signed-up for a (watered-down) declaration and a pilot project was launched. However a great deal of the push towards alignment was coming from AFH and JA. Few individual nations have subsequently been able to sustain significant convergence between their professional and governmental agendas in such a way as to develop family health nursing substantially.
Contingency	Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at European level, it may be argued that JA and AFH's concept was unforeseen by many and they attempted to spark the concept and kindle it towards ignition. However, to date, it has not caught fire. As such, looking at the bigger picture, it must be argued that no significant contingency has arisen to fan its flames. Health policy across Europe has not changed decisively towards nations investing primarily in public health and primary care. GPs across Europe have not decided to make family care their priority. Nursing interest in family care remains more of a speciality area than a primary focus.

Reflecting on the application of the C-C-C model in Table 8.4, it can be seen that the *Context* dimension provides a very general means through which to identify relevant influences. In effect this would seem to subsume the *Problems, Policies* and *Politics* dimensions of the Kingdon model. Both the *Convergence* and *Contingency* dimensions encourage more particular analytical thinking. The former tends to highlight the extent to which JA and AFH worked to actively engineer policy convergence that might enable the "christening" of family health nursing. What is absent, however, is any sense of this convergence being fortuitous. The same can be said for the *Contingency* dimension in that no unforeseen spark has kindled the project and no political wind-of-change has fanned its flames.

In effect the WHO Europe FHN project emerged as a policy *initiative* but the three conditions that Rafferty and Traynor see as necessary for successful policy *change* have not as yet been sufficiently satisfied. In this way the C-C-C model raises questions about:

- subsequent maintenance and sustenance of initial policy convergence
- possible over-dependence on a tiny group of policy entrepreneurs
- the prospect of dependence on fortuitous contingency for success

Perhaps the key question to emerge here is: *did this initiative really matter, and continue to matter, to many other people, particularly those in positions of influence?*

Thus the C-C-C model provides some interesting ways of thinking about the relative success and/or failure of the FHN initiative both in terms of its initial formulation as a key policy for European nursing, and in terms of its subsequent enactment. Nevertheless, as with the Kingdon model, it is useful as much for highlighting what has not happened in the course of policy evolution as what has happened. As such there seems scope for some adaptation of the model to more closely reflect the main dimensions apparent in the evolution of the FHN concept into a policy initiative.

This assertion is now explored further during the course of using both theoretical frameworks to analyse the emergence of the FHN concept in Scotland.

8.4 THE EMERGENCE OF THE FHN CONCEPT IN SCOTLAND AND ITS ADVANCEMENT INTO POLICY

8.4.1 The core ideas of the key informant

This part of the chapter revisits the FHN concept's Calton Hill cradling in the light of the findings from the key informant interviews. In doing so it draws very extensively on the key informant interview with Anne Jarvie. While the other key informants were asked for their reflections on the emergence and advancement of the FHN concept within Scotland, their knowledge of these aspects was necessarily limited as their personal involvements had primarily been at WHO Europe level.

Anne Jarvie was purposively targeted as the key informant for the concept's Scottish emergence for two reasons. Firstly, other SEHD staff (e.g. Lead Nursing Officer and Project Officer) and NHS staff (e.g. Regional Directors of Nursing) with key involvement in the project had been interviewed during the previous evaluation study. Secondly, by 2005 the set of understandings constructed by the author all conclusively identified Anne Jarvie as a crucial and unique source of knowledge about the subject due to the nature of her involvement.

Annex 3 presents examples of core, relevant narrative from the interview with Anne Jarvie, along with the main themes derived by the author. The core ideas underpinning her thinking are now summarised in Table 8.5, as understood by the present author.

Table 8.5: Core ideas which emerged from interview with AJ (*continues on next page*)

CORE IDEA	DERIVED UNDERSTANDING
1) Advocacy	This idea related to influential policy initiatives/directions being developed by key professional peers. An important part of a leader's ability was seen as anticipating these, or at least recognising these, and planning ahead accordingly. Used in relation to policy at WHO Europe and Scottish government level.
2) Tackling the big, core issues first	This idea was central to AJ's approach. If the fundamental foundations were put in place, it was felt that more specialised or ambitious projects could build from these. The Public Health review and the FHN initiative were seen as examples of the latter. In policy evaluation terms this approach incorporates elements of both *rationalism* and *incrementalism*.
3) Modernising	A recurrent idea used in a general way to meet perceived imperatives e.g. to make educational programmes or health services more responsive to current needs. Often involved a related perceived need for "new thinking".
4) Anticipation and the importance of timing	This was seen as the cardinal lesson from 12 years as CNO. It was vital to know or sense in advance when something might be possible, and then seize the opportunity if/when it came. This involved prior development of ideas (e.g. potential value of a more generalist community nurse incorporating public health nursing) and sometimes nurturing these until the time was right. Converging policy agendas (e.g. public health and remote and rural agendas) could provide such opportunities. By implication from the interview, these abilities developed during the job. However there was no explicit exploration of whether such abilities could be taught.
5) Core political support; consultation with key professional peers; and team building	These related ideas were strong motifs. It was important to build networks, ensure core political support, and gauge the thinking of key professional peers prior to fully developing policy initiatives. Thereafter it was important to build a core development team with key known individuals. There was recognition that the FHN project had particular personal significance for the core team members.
6) Weighing risks and benefits	It was recognised that some degree of risk was inevitable when developing policy initiatives, and the important thing was to try to identify what these were likely to be and to weigh them against likely benefits. This process was seen in relation to anticipating opposition to the FHN concept, and also commissioning the educational programme and external evaluation.
7) The value of generalism in nursing	This idea was recurrent, but was applied mostly to the context of the FHN being a generalist role that might sustain public health and community nursing in remote and rural regions. The word "hybrid" was sometimes used in this context as well. The key nursing values were seen as versatility and responsiveness to public needs. There was a measure of concern that nursing had become over-specialised and, at times, task-orientated.

Table 8.5: Core ideas which emerged from interview with AJ (*continued*)

8) Remote and rural regions as a suitable test-bed for FHN	Scotland's remote and rural regions (in particular the Highlands and Islands) were clearly seen as suited to the FHN pilot and offering the best chance of identifying both specific and potentially transferable learning. The suitability of the Highlands and Islands for experimentation related to their geography, demography and the diverse nature of their health service provision.
9) The need for drive from the centre and regional leadership	These were seen as necessary and mutually dependent. The need for central control over a funded policy initiative was recognised, but, perhaps more importantly, there was a need to drive progress from the centre initially.
10) The need for new educational thinking and the need for evidence from an external evaluation	These two related ideas became evident through the commissioning activities early in the evolution of this policy initiative. AJ felt that the potential benefits offered by Stirling University (local knowledge and a novel educational approach) outweighed risks. The notion of an externally scrutinised pilot that would produce evidence also mitigated this risk and the risk of introducing a new role.
11) The FHN as a catalyst for change	The word "catalyst" was used several times to suggest that the FHN initiative should potentially provoke change in others' practice. This was seen as almost overt within the profession (e.g. to help change health visiting and district nursing approaches) although it had been necessary to modulate the intensity and frequency of such a message depending on the prevailing national and local political sensitivities. The aim of catalytic change within the PHCT (e.g. to change doctors' behaviours) was less overtly stressed but present nonetheless. In both contexts, the implied meaning seemed to be that the FHNs themselves have undergone change through an educational course, so that when they are re-introduced to the crucible of the PHCT, a reaction between other elements may be provoked. The extent to which this can be said to have happened is a key element for discussion in the present thesis. Moreover there is the question of the extent to which the FHN could (like a catalyst) remain unchanged if such a reaction ensued. In the latter regard, AJ clearly felt further contingent development of the FHN role would be useful, and the role had to keep evolving. Thus, the catalyst analogy was being used more to refer to the process of provoking initial reactive change within the PHCT.
12) The FHN as an evolving and adapting role	The value of the new way of preparing these community nurses was seen as substantial, and many transferable lessons had emerged. Nevertheless the future of the FHN as a particular individual discipline was still seen as rather uncertain. AJ was clear about the need and scope for a new generalist community nursing role in Scotland. She was less certain that this needed to hinge on the family as the central defining concept.
13) Redesign	A recurrent and pervasive idea used in relation to structuring health care services in a way that will meet newly recognised needs. In this sense, often used alongside "modernisation". Redesign was usually seen as necessary and far-reaching in scope (e.g. to realise the benefits of the FHN role, or to truly integrate a public health approach, fundamental redesign was needed so that the practice and skills of all professions were reconsidered as part of the process). There was now scope for more regional initiatives in this regard.

As Table 8.5 suggests, the interview with Anne Jarvie was particularly wide-ranging and yielded considerable insights into the beliefs, motivations and strategies of the person at the heart of this policy development in Scotland.

8.4.2 Application of the Kingdon model

Table 8.6 now presents analysis of derived understandings by applying Kingdon's agenda setting model.

Table 8.6: Application of Kingdon's agenda setting model to the Scottish emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Problems	At CNO level there was a perceived need to modernise community nursing services to meet changing health needs of the Scottish population. Desire to integrate a public health approach within generalist nursing roles. General problems arising in sustaining health service provision to remote and rural areas. Within nursing profession broad assent for an increased focus on health if feasible. Beginnings of perception of problems in sustaining nursing services in remote and rural areas. Little evidence that community nursing care for families was seen as inadequate and/or a priority problem.
Policies	Huge raft of health and social care policies since Scottish devolution. Particular emphasis on promoting health and preventing disease. Family care an implicit theme, but rarely focal. Recent reviews of public health function of medical and nursing professions. Remote and rural issues becoming more central in health and social care policy papers. Scotland enthusiastic signatory to European HEALTH 21 but providing context rather than a focal policy driver.
Politics	Advocacy for initiatives to address health promotion and disease prevention. A time of change and optimism. Governmental support for nursing development. Advocacy for initiatives to address remote and rural concerns. Proactive Health Minister. However GPs very influential on remote and rural issues and public anxiety to retain GP services. Also anticipation of intra-professional tensions within nursing and midwifery if/when FHN concept announced.
Policy entrepreneurs	One policy entrepreneur only: AJ. Recognised that health and remote and rural agendas could be aligned. Had nursed the idea of a more generalist community public health nurse for a number of years. After emergence of FHN concept at European level, worked to align this and achieve confluence of this "third stream".
Windows of opportunity	Having tackled a number of more general, fundamental issues during the 1990's (e.g. nurse education into HEIs), in 1999 the timing was right for AJ to push on the FHN. It seemed that problems, policies and politics were sufficiently aligned to make a pilot project possible. This would involve some risk but a number of measures could be taken to balance these with likely benefits.

Again the *problems, policies* and *politics* dimensions of Kingdon's model emerge as useful foci for analysis. While it seems clear that the nursing profession in Scotland broadly supported the increased focus on health in general policy, it is less clear that they shared AJ's view that there was a major problem in community nursing's ability to deliver a modern public health approach. Similarly, although some concerns were evident about over-specialisation in Scottish community nursing towards the end of the 20th century, there was no consensus on a need for a new generalist community nursing role. Thirdly there was little evidence that community nursing care for families was seen as inadequate and/or a priority problem in any region in Scotland.

Thus, as with the emergence of the FHN concept in Europe, there appeared to be a lack of one precisely defined and widely acknowledged problem necessitating this particular new solution. Once more, the limitations of viewing the FHN project primarily as a response to a problem tend to be exposed through the lens of the Kingdon model. However it can be argued that a generic policy solution (i.e. the generalist community nurse of the Health for All Nurse) had been circulating amongst a network of interested European Chief Nursing Officers for many years, and that AJ was particularly astute in recognising remote and rural nursing recruitment and retention as an ostensibly suitable problem necessitating the "new" solution (i.e. the FHN as updated HFA nurse). In AJ's view (see Annex 3) this gave her a "lever" that the other UK CNOs did not have. It is notable that there was always vagueness about how the FHN would actually ameliorate remote and rural recruitment and retention problems.

Certainly, AJ's role as the sole Scottish policy entrepreneur is emphasised in that her previous experiences and interests (and the agency inherent in her professional role) put her in a unique position to creatively align aspirations for the FHN concept with current Scottish advocacy around health and remote and rural agendas. In the light of prevailing political concerns and the need to manage risk, however, the resultant policy initiative was placed on to the Scottish agenda as a regional pilot project subject to external evaluation.

The application of the Kingdon model to this Scottish example of FHN policy agenda setting would again give more weighting to the *policy entrepreneur* dimension than the *problems* dimension, and view AJ more as an antecedent force than an opportunistic respondent who reactively brought the problems, policies and politics streams into confluence.

8.4.3 Application of Rafferty and Traynor's C-C-C model

Application of Rafferty and Traynor's C-C-C model to the Scottish emergence of the FHN concept is presented in Table 8.7.

Table 8.7: Application of the C-C-C model to the Scottish emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Context	The context/case for changing primary care nursing to make it more public health focused had been "primed" to some extent by the publication of policy documents and the review of the public health role of the nurse. However there was widespread unease amongst Health Visitors who felt threatened by the nature and pace of change. Therefore there was some professional momentum for more proactive community nursing development in Scotland, but any pressure for change was certainly not focusing on the care of families. Some leaders of nursing in remote and rural regions were looking for possible solutions to perceived problems of nurse recruitment, retention and sustaining service provision. GPs in remote and rural areas were becoming more vocal re. need to maintain cover and improve their quality of life: widespread public support. Experienced CNO looking to foster more specific nursing developments.
Convergence	As the above context suggests, good possibilities of governmental "pull" for a policy initiative in remote and rural community nursing. Health and remote and rural policy agendas were converging, but family care was again an implicit theme. Professional "push" was somewhat mixed across the above areas. There was scope for an initiative, but also scope for significant intra and inter-professional friction. AJ successfully secured political support and funding first then worked to build a team that would help to bring about convergence of the new FHN concept with the other main policy agendas. General reaction was surprise/puzzlement in Scotland on announcement of pilot project, particularly in relation to the "family" emphasis. However sufficient convergence had been engineered for a substantive pilot of the concept and associated role. The extent to which the FHN can align with current policy agendas and sustain itself beyond the pilot and remote and rural regions is a central concern of Chapter 9 of this thesis.
Contingency	Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at Scottish level, it is clear that AJ's importation of the concept was unforeseen by most observers. It is clear that such a development would not and could not have happened without her agency. By securing key political support and a core development team AJ attempted to spark the concept and kindle it towards ignition. By her own admission there was always some doubt about whether the development would catch fire and in what direction it would travel. The key premise however was that the process would shed some light for the future. Undoubtedly Scotland has been a beacon for the other interested countries in Europe. However it is necessary to ask not only what has been learned but also what, if any, significant contingency will fan and fuel its flames in the future. As indicated above, this is a central concern of Chapter 9 of this thesis.

Reflecting on the application of the C-C-C model in Table 8.7, it can be seen that the *Convergence* and *Contingency* dimensions again provide the most productive foci. What these tend to highlight is the unexpected way in which AJ aligned the FHN concept with the health and remote and rural policy agendas. Initially this was her sole doing and, as is made clear in the interview excerpts in Annex 3, she was under no pressure to act in this way. In effect she was the one person who saw the possibility for this triple convergence as a possible way of realising a long-held aspiration. Crucially, through her own agency, political support and funding were successfully secured before work started to build wider collective agency that would help to bring about more tangible convergence of the new FHN concept with the other main policy agendas. As the records of the FHN Madrid meeting (WHO 2003) show, this ability to secure substantive political support and funding for the initiative made Scotland unique amongst the participating European countries. Thus, although clearly couched as a pilot project, the FHN concept was placed onto the Scottish national nursing agenda as a "fait accompli" formulated policy initiative. Moreover, due to the prevailing regulatory structures for Community Specialist Practitioner Qualifications, this necessarily placed the concept on to the UK national nursing agenda.

AJ's very active work in securing this initial convergence emerges clearly as deliberate rather than fortuitous. To many external onlookers this appeared as an unforeseen "sparking", but it can be argued that only one initial candle (i.e. the pilot project) was lit. Rather the *Contingency* dimension of the C-C-C model is primarily concerned with the extent to which any unforeseen (and fortuitous) political wind-of-change fans the policy flames from initial ignition so that they successfully spread and sustain. It is this feature of the model that draws the analyst further towards consideration of policy enactment and evaluation than does the Kingdon agenda setting model.

As with the FHN concept's evolution in Europe, it can be said that in Scotland it emerged as a policy *initiative* but the three conditions that Rafferty and Traynor see as necessary for successful policy *change* have not as yet been sufficiently satisfied. Again the C-C-C model raises pertinent questions about:

- subsequent maintenance and sustenance of initial policy convergence
- possible over-dependence on one policy entrepreneur
- the prospect of dependence on fortuitous contingency for success

Again, in policy analysis terms, the following question seems as apposite for Scotland as for Europe: *did this initiative really matter, and continue to matter, to many other people, particularly those in positions of influence?*

Once more the C-C-C model yields valuable perspectives on the relative success and/or failure of the FHN initiative both in terms of its initial formulation as a key policy for European nursing, and in terms of its subsequent enactment. Nevertheless, as with the Kingdon model, it is useful as much for highlighting what has not happened in the course of policy evolution as what has happened.

8.5 AN EXPLANATORY MODEL OF THE EMERGENCE OF THE FHN CONCEPT INTO POLICY IN EUROPE AND SCOTLAND

The preceding analyses show that both the Kingdon and Rafferty/Traynor models have much to contribute to understanding of the policy dimensions of the emergence of family health nursing. Yet neither of these models captures all of the essential characteristics of the evolution of the FHN policy initiative. While the Kingdon model has been widely seen as ground-breaking (Hill 2005), it gives limited consideration to the processes of collective agency through which policy initiatives are initially taken forward for enactment. In contrast, the Rafferty and Traynor model tends to underplay the role of individual agency and over-emphasise the role of fortune when applied to the FHN policy initiative.

Following reflection on the application of these models, a new explanatory model of FHN policy formulation and advancement entitled the "Agency model" is now posited. This draws on: understandings synthesised from literature review; the discourse and core concepts of the key informants; central ideas from both the Kingdon and Rafferty/Traynor models; and the tradition of alliterative presentation seen in such policy analysis models. The seven elements of the new model are presented in Table 8.8, along with explanatory notes.

Table 8.8: The Agency model of FHN policy formulation and advancement

Agency	Defined as "the power/force through which a result is achieved", the idea of agency is posited as the central dynamic within this model. In this thesis the individual agency of AFH is seen to drive the evolution of the FHN concept at European level. The same is true in relation to AJ's role within Scotland. However the collective agency of key strategic allies also emerges as necessary for policy formulation and advancement. The following six elements are associated with this agency and can be seen as the key characteristics of FHN policy formulation and advancement.		
Aspiration	Both AFH and AJ had longstanding aspirations which they sought to realise through the FHN initiative. For the former it was definitive development of public health nursing across Europe. For the latter it was the integration of public health within a new generalist community nursing role. Both these aspirations had roots in the Health for All Nurse, which was more a paper policy initiative than an enacted one. As such, the HFA Nurse can be seen as a dormant "proto-policy" waiting to be re-kindled by those with agency who could (re)align it into the up-draught of other advocated agendas.	INDIVIDUAL AGENCY	COLLECTIVE AGENCY
Awareness and anticipation of opportunities	Both AFH and AJ highlighted the need to be alert in order to recognise potential opportunities through which to realise aspirations. AJ talked of well developed "political antennae".		
Alignment around advocated agendas	Related to the above, was the ability to align any new policy initiative with other relevant influential political agendas that were currently being advocated. This was seen as one of the arts of leadership. For AFH this meant alignment with the HEALTH 21 policy framework. For AJ this meant alignment with wider health and remote and rural agendas in Scotland.		
Authority	Importantly AFH and AJ each had some authority through which to advance their aspirations into policy. For the former, this was mostly personal/professional authority exercised at the inter-personal level through lobbying and networking. It is important to note that AFH did not have the organisational authority associated with directing a large staff or budget. While AJ's team and budget were rather larger, her main advantage was that her professional position carried much more executive power in relation to nursing affairs.		
Alliances for advancement	In order to advance their policy interests, both AFH and AJ ensured support from key strategic allies. For AFH this was with JA, interested CNOs around Europe, and latterly European Health Ministers. For AJ this was with the Scottish Health Minister, Directors of Nursing, and latterly a specially formulated multidisciplinary Steering Group.		
Advantageous adaptation	This was a necessary tactic for advancement of the FHN concept as a policy initiative. At European level the established format for WHO Europe Nursing Conferences was adapted to make the 2000 Munich event a Ministerial one. At Scottish level the FHN concept was adapted by ensuring that its advocacy of equal partnership with GPs, and associated ideas of GP substitution, did not form part of the principles of the pilot project. This minimised the risk of active GP opposition.		

The six key characteristics in Table 8.8 are presented in a sequence reflecting "best-fit" with understandings of ordering derived from the key informant interviews. In particular, AJ tended to stress that certain basic elements had to be in place before others could happen. However it is recognised that some of the ordering in Table 8.8 is probably a product of the broadly chronological framework underpinning the interview schedules. Moreover post-hoc analyses have also contributed to an impression of logical progression through a series of linear steps. While this has superficial explanatory appeal, it is important to stress that the Agency model should be interpreted in the same way as the Kingdon model i.e. it is assumed that in reality key characteristics manifest and interact in different temporal sequences. For example, many of AFH and AJ's key personal/professional alliances pre-dated the attempted advancement of the particular FHN policy initiative.

Nevertheless the creation of the Agency model is significant because it represents a culmination of the explanation building started in Chapters 3 and 4 of the thesis. In effect it distills answers to the first of the three central questions at the heart of the thesis i.e. *why family health nursing?* Through a process of systematic enquiry it has become clear *why* the concept emerged in Copenhagen in 1998. Essentially it was the aspiration of Dr Jo Asvall and Ainna Fawcet-Henesy to develop public health nursing across Europe and to this end the Health for All Nurse concept was re-developed with a new emphasis on family. Through their agency these actors advanced the new FHN concept into a policy initiative that would be piloted in a number of European countries. Table 8.8 shows *how* this was primarily achieved i.e. through: aspiration; awareness and anticipation of opportunities; alignment around advocated agendas; authority; alliances for advancement; and advantageous adaptation.

Similarly it is clear *why* the FHN concept came to be adopted on Calton Hill and subsequently enacted in Scotland. Essentially it was Anne Jarvie's aspiration that a relevant public health approach could be integrated within a generalist community nursing role, and in remote and rural regions she saw an opportunity to try this in the form of the new FHN role. Primarily through her individual agency, the new FHN concept was then advanced into a policy initiative that would be piloted in three Scottish regions. Again Table 8.8 shows *how* this initial policy formulation and advancement was primarily achieved i.e. through: aspiration; awareness and anticipation of opportunities; alignment around advocated agendas; authority; alliances for advancement; and advantageous adaptation.

These explanations are important because their construction has arisen through a process of systematic, critical enquiry that is at present unique in this particular field i.e. to date the vast majority of literature on the WHO Europe FHN concept and project is promotional and aspirational. What is striking about the above explanations is the crucial role of just two

individual actors in initiating the FHN concept and formulating it into WHO Europe policy, and the crucial role of just one actor in re-formulating it into the Scottish policy arena.

However, no policy initiative can be advanced, developed and enacted without support from others, and the Agency model shows how initial processes of collective agency were fostered. The next part of the chapter attempts to explain how these processes were further developed in Scotland.

8.6 TAKING THE POLICY INITIATIVE FORWARDS FOR ENACTMENT IN SCOTLAND: AN EXPLANATORY MODEL

Having analysed local enactment at PHCT level in Chapter 7, and having synthesised understandings of policy evolution and formulation at SEHD level in the first part of this chapter, it is now necessary to gain critical purchase on the "linkage" between these elements i.e. the Scottish national and regional processes of collective agency that were involved in taking the new policy initiative forward. A model that is potentially helpful in this regard has been developed by May et al (2003) through studies of telehealthcare implementation and evaluation in the UK. Although their focus on this particular form of health technology assessment may initially seem an unlikely source for analogy, May et al's model, reproduced in Table 8.9 offers a useful analytical framework based on mapping contingencies.

Table 8.9: May et al (2003)'s contingency model

Level of analysis	Mode of technological development	Mode of knowledge production	Mode of containment	Mode of strategic expansion
Ideation	**1.1 Idea of new technology:** expectation of applications of new technology to clinical settings, concepts of utility and effectiveness.	**1.2 Notion of research/evaluation:** Normative expectations about the production and circulation of generalisable and reliable knowledge	**1.3 Judgements about value:** Expectations of intellectual and other kinds of capital, and constructs of the social worth of a technology (what's better, what works?)	**1.4 Key actors:** work to champion technology and construct a persuasive field of possibilities; link in to polocies and programmes of R&D in design and manufacturing sector
Mobilisation	**2.2 Constructs of appropriate design and operation:** translation of expectancies into plans, technical decision making systems thinking	**2.2 Constructs of research/evaluation methodology:** normative models of transferable knowledge circulating within communities of practice, subject to the elision of contingency	**2.3 Selective enrolment into communities of practice:** recruitment and integration of actors into networks; entry criteria and control over activities; contextualisation of fields of agreement and disagreement	**2.4 Emergent practitioner communities:** organise expectancies into programmes of work; contest patterns of infrastructure organisation and resource allocation; organise the market place to receive technology
Clinical Specification	**3.1 Technical implementation:** system intended to structure contingent practice within a framework of reliable clinical knowledge	**3.2 Research/ Evaluation protocol:** specific instrument intended to structure otherwise contingent processes of knowledge production within a framework of reliable practice	**3.3 Structural constraints on dynamic instability:** fixes technologies and techniques in place, forces the elision of contingency of interpretation	**3.4 Practitioner groups reify possibilities of technology:** construct ideal forms of specific application organise resources and infrastructure situate dynamic activities in specific settings
Specific application	**4.1 Clinical intervention:** activities leading to the organisation of clinical procedures about which claims of reliability can be made, and which are intended to meet the normative expectations of external adjudicators	**4.2 Research/ Evaluation application:** activities leading to the production of knowledge about which claims of reliability can be made and which are intended to meet normative expectations of external adjudicators	**4.3 Attempts to prevent interpretive flexibility:** act to place restrictions on creative modification of systems in play, intended to frame standardised and generalisable products of clinical evaluation and practice	**4.4 Possibility of Normalisation:** Conventional processes of reporting and publication; informal diffusion through networks of practitioners; social construction of localised possibilities

As May et al explain, their model provides:

> "a conceptual framework that elucidates a set of *contingent* points on a map of social practices. The model locates actors and activities against these contingent points – and in doing so, sets out the points of resistance and constraint that appear as new technologies are brought into the play of service development and evaluation practice, as well as the points at which strategic and local expansion of opportunities are situated" (p. 701).

In this regard it is important to emphasise that the authors are using "contingent" in the sense of *conditional, dependent and related,* rather than in Rafferty and Traynor's use of "contingency" as *unforeseen consequence*.

May et al's framework is apposite for a number of reasons. Firstly, it highlights that evaluation is increasingly a "normative political expectation, as discourses of ′evidence-based′ practice run through health policy in the UK and elsewhere" (p. 697). As such, evaluation research is framed as the dominant mode of knowledge production within the social enactment of healthcare technology and new policy initiatives. This has clearly been seen in relation to the FHN initiative in Scotland, as reflected in the words of the Scottish Health Minister quoted in the preceding chapter. Moreover the FHN initiative was couched as a "pilot", suggesting scientific notions of testing, control and manipulation. Again, May et al's model offers a framework for more detailed analysis of the dynamics of control of containment and expansion that were possible under the rubric of "pilot project". Finally, their framework is useful in separating out different levels of analysis, from ideation through mobilisation to more specific application. As has been noted often within the thesis, the nature of the family health nursing development in Scotland frequently made it difficult to be precise about what was being evaluated i.e. was it a concept, model, aspiration, role, policy initiative, or all five?

Table 8.10 presents the summary mapping that arises from the application of May et al's contingency model to the FHN pilot (viewed as a healthcare technology).

Table 8.10: May et al (2003)'s contingency model applied to the FHN pilot in Scotland

Level of analysis	Mode of technological development	Mode of knowledge production	Mode of containment	Mode of strategic expansion
Ideation	**1.1 Idea of new technology:** The idea that the WHO Europe FHN concept would be useful in remote and rural regions, and possibly elsewhere in Scotland.	**1.2 Notion of research/evaluation:** Normative expectations that a pilot project with inbuilt external evaluation would produce generalisable and reliable knowledge to inform further action i.e. evidence-based policy making.	**1.3 Judgements about value:** Pilot confined to remote and rural. Related notions of value in addressing recruitment and retention problems. "Pilot" suggests control, safe testing, and management. Pilot managed nationally to minimise potential conflicts with other professional groups.	**1.4 Key actors:** Small band of champions at national and regional levels (CNO and DoNs). Steering Group mixes enthusiasts with interested insiders. National publicity for initiative is frequent but tempered to some extent by recognition of professional sensitivities.
Mobilisation	**2.2 Constructs of appropriate design and operation:** SEHD translation of the FHN concept into 4 principles that would characterise the FHN role. Commissioning of the educational programme informed by WHO FHN curriculum. Stirling University also, however, incorporated North American family nursing models which gave FHNs distinctive professional identity.	**2.2 Constructs of research/evaluation methodology:** prescribed evaluation brief concerned with the operation and impact of FHN, and the educational experience. Acknowledgement that a mixture of qualitative and quantitative approaches might be necessary.	**2.3 Selective enrolment into communities of practice:** recruitment of 3 Directors of Nursing providing regional management. Variable subsequent involvement of local managers. Variable criteria for FHN student selection. Deliberate and inclusive selection of members for national Steering Group.	**2.4 Emergent practitioner communities:** 3 DoNs primed local nurse managers and staff about the pilot. However, the concept was sketchy and time was short. Selection of FHN students was often influenced more by personal interest and local expediency, than by planning for long term service development.
Clinical Specification	**3.1 Technical implementation:** development of initial FHN clinical documentation during educational programme (e.g. genograms, ecomaps). Seen very much as *formative*, however.	**3.2 Research/ Evaluation protocol:** RGU team articulated an evaluation framework to structure data collection. A variety of standardised instruments were used or devised to study education and practice.	**3.3 Structural constraints on dynamic instability:** appointment of national Project Officer and creation of regional implementation groups to integrate development approaches.	**3.4 Practitioner groups reify possibilities of technology:** There were a number of promotional publications during the pilot. FHNs enthusiastic but still found it difficult to clearly articulate the concept and to agree on one preferred example of enactment of the role in practice.
Specific application	**4.1 Clinical intervention:** nature of application and related interventions left almost completely to the new FHNs. Issues of reliability and fit to normative expectations seen as primarily the concern of the local PHCTs and the evaluation team.	**4.2 Research/ Evaluation application:** Context-Process-Outcome framework particularly useful: gave overall structure enabling researchers to compare FHN practice at PHCT sites. Production of final evaluation report in 2003.	**4.3 Attempts to prevent interpretive flexibility:** later attempts (through implementation groups) to get agreement on one set of FHN documents and to incorporate the OMAHA outcome measurement system. Attempts mostly unsuccessful.	**4.4 Possibility of Normalisation:** At the end of the evaluation, SEHD held conference. Pilot deemed encouraging; potential for normalisation but still provisional (Phase 2 of pilot announced, with city testsite). Options kept open.

The application in Table 8.10 is useful as it maps important underpinning ideas, processes for their advancement and some related outcomes. In doing so, it tends to highlight considerable central (national level) activities that were designed to shape and control the evolution of the pilot as an enacted policy initiative. The setting of its boundaries and the avoidance of major conflicts with other professions were clearly of much initial importance. This makes for considerable contrast with the relative latitude that existed in relation to any national clinical specification for family health nursing and for specific application in terms of local interpretation and enactment. This was recognised by the Steering Group later in the evolution of the pilot project, but the resultant regional implementation groups usually struggled to achieve significant standardisation of FHN practices in the face of diverse local PHCT contexts and needs.

Indeed as Table 8.10 hints, the role of regional/local community nursing management in the advancement of the FHN initiative tended to be one of linkage and general facilitation rather than vociferous promotion and/or proactive shaping of FHN development at local PHCT sites. There were a number of reasons for this, and these emerged during interviews with individual nurse managers during the commissioned evaluation study. Firstly, these nurse managers were few in number and usually geographically remote from the sites where FHNs were practising. Typically they had to manage a number of different professional groupings, some of whom felt very threatened by the FHN pilot due to its nature and implications being unclear. Moreover some of these managers admitted that they shared these concerns, had reservations about the need for the FHN, and felt that the project had been rushed and/or thrust on them.

The latter aspects had made it difficult for them to select suitable FHN students for the first educational cohort and difficult for them to articulate the place of the FHN in any longer term service development plan. Although the SEHD made “backfill” monies available to cover the students’ posts during their absences, there was usually no extra funding attached to the initiative. Under these circumstances it is not surprising that the public line taken by most regional/local nurse managers was one of cautious optimism while their private feelings were more ambivalent. Moreover, some “hedging of bets” seemed reasonable given that the FHN project was a pilot. While their Directors of Nursing also had to be seen to view the pilot as dependent on evaluation, they typically were much more prominent in their promotion of the FHN concept. In effect the pilot placed these DoNs on the national stage in a way that had not happened before, and accordingly they had much to gain through their direct alignment with the CNO.

Thus, while the regional DoNs emerge as key actors in advancing the FHN initiative, their community nursing managers are much more marginal figures in the story. To some extent this

may be due to the limitations of the research approach taken herein. While the managers were also included in the evaluation study's stakeholder questionnaire surveys, it must be acknowledged that their views were not sought in either of the follow-up studies conducted subsequently. Within the present study's large ambit of examining the development of family health nursing from policy through to practice, this would certainly be a point of weakness.

Nevertheless during five years of formal and less formal engagement with FHN developments in Scotland, I have neither heard nor seen evidence to suggest that nurse managers played a particularly influential role. Indeed, it was not uncommon for the regional DoNs and the FHNs themselves to have direct communication and they often appeared together at regional and national events. To some extent, the ostensibly limited influence of regional/local community nursing managers may relate to their small number and wide geographical remit. However the limited influence of community nurse managers is also a wider UK national characteristic identified by a number of authors (e.g. McMurray and Cheater 2004; McKenna, Keeney and Bradley 2004).

8.7 AN INTEGRATED MODEL OF THE DEVELOPMENT OF FAMILY HEALTH NURSING IN SCOTLAND 2000-2004

Reflecting on Table 8.10, it is evident that the four analytic levels all yield productive insights. The *ideation* and *mobilisation* levels give critical purchase on ways in which the pilot was actively constructed and controlled at national and regional Health Board/Divisional levels. Conversely, the *clinical specification* and the *specific application* levels tend to highlight interpretive flexibility at local PHCT level. Indeed in the context of diverse local practice development, there is a sense in which the evaluation research framework and data collection tools provided consistency and continuity for an ongoing initiative of this type. The model's depiction of research as an integrated, concurrent and contingent social practice is therefore very relevant to the FHN pilot. Indeed, the research evaluation can be seen as a key element that influenced articulation between policy and practice levels.

The latter relationship is depicted visually in Figure 8.1 which presents an overall model of the main characteristics of the development of family health nursing in Scotland 2000-2004. This links the explanation of policy formulation provided by the Agency model with the explanation of policy enactment processes provided by the adaptation of May et al's model. In turn these parts are linked onwards to the explanation of translation and enactment of the FHN role at local PHCT level (as developed in Chapter 7). In achieving this final linkage, some adjustments have been made to avoid duplication. To this end, the *specific application* level in the May et al model has been truncated, and parts of the *clinical specification* level have been merged with the Chapter 7 model to represent the key elements of the FHN initiative which influenced articulation between policy and practice levels (i.e. Part 3 of Figure 8.1).

Figure 8.1: An integrated model explaining the development of Scottish family health nursing

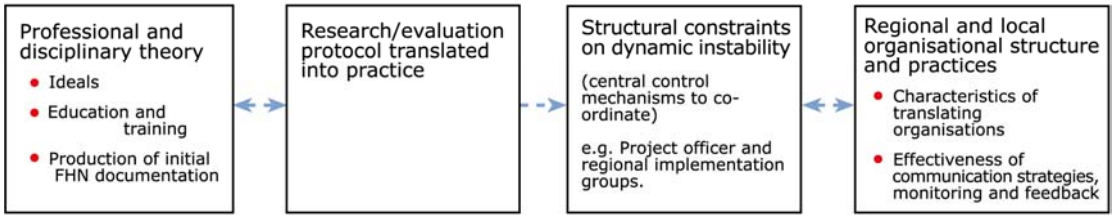
Part 1: Initial policy formulation and advancement

Agency		
Aspiration	Individual Agency	
Awareness and anticipation of opportunities		
Alignment around advocated agendas		
Authority		Collective Agency
Alliances for advancement		
Advantageous adaptation		

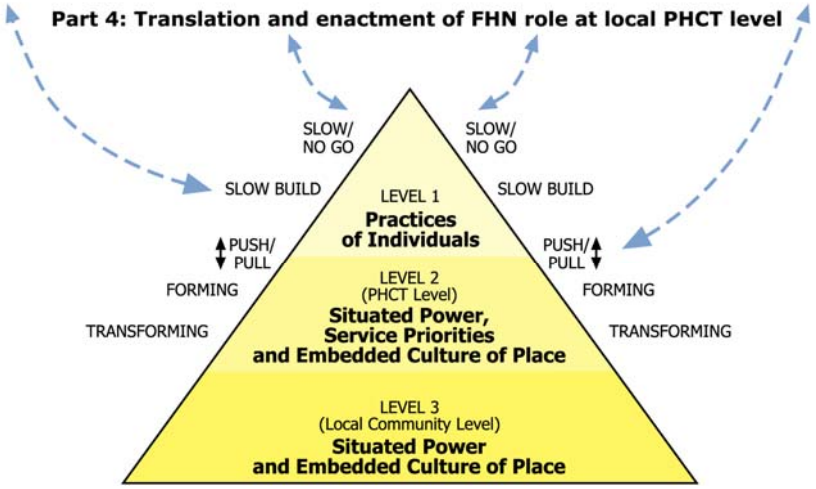
Part 2: Taking the policy initiative forward towards enactment

Level of analysis	Mode of technological development	Mode of knowledge production	Mode of containment	Mode of strategic expansion
Ideation	The idea that the WHO Europe FHN concept would be useful in remote and rural regions, and possibly elsewhere in Scotland.	Normative expectations that a pilot project with inbuilt external evaluation would produce generalisable and reliable knowledge to inform further action i.e. evidence-based policy making.	Pilot confined to remote and rural. Related notions of value in addressing recruitment and retention problems. "Pilot" suggests control, safe testing, and management. Pilot managed nationally to minimise potential conflicts with other professional groups.	Small band of champions at national and regional levels (CNO and DoNs). Steering Group mixes enthusiasts with interested insiders. National publicity for initiative is frequent, but tempered to some extent by recognition of professional sensitivities.
Mobilisation	SEHD translation of the FHN concept into 4 principles that would characterise the FHN role. Commissioning of the educational programme informed by WHO FHN curriculum. Stirling University also, however, incorporated North American family nursing model which gave FHNs distinctive professional identity.	Prescribed evaluation brief concerned with the operation and impact of FHN, and the educational experience. Acknowledgement that a mixture of qualitative and quantitative approaches might be necessary.	Recruitment of 3 Directors of Nursing providing regional management. Variable subsequent involvement of local managers. Variable criteria for FHN student selection. Deliberate and inclusive selection of members for national Steering Group.	3 DoNs primed local nurse managers and staff about the pilot. However, the concept was sketchy and time was short. Selection of FHN students was often influenced more by personal interest and local expediency, than by planning for long term service development.

Part 3: Key elements influencing articulation between policy and practice



Part 4: Translation and enactment of FHN role at local PHCT level



8.8 THE INTEGRATIVE MODEL AS A BASIS FOR EXPLANATION

The integrated model of Figure 8.1 gives a basis for definitively answering two of the central questions of the study: why was the FHN concept enacted in Scotland; and why did it develop in the way that it did? Table 8.11 now provides the other key part of this explanation by presenting a synoptic story which identifies and links together twelve factors that have emerged through this study as being particularly important. Taken together, Figure 8.1 and Table 8.11 provide summative explanation of the development of family health nursing in Scotland up until the end of 2004.

Table 8.11: Synoptic story of the development of family health nursing

1	The WHO Europe FHN concept was enacted in Scotland primarily because of its potential to meet with the CNO's aspirations in regard to integrating a modern public health approach into community nursing. The CNO's agency was seminal and crucial, and this is reflected in the "Agency" model of policy formulation and advancement posited in this thesis.
2	The SEHD's translation of the FHN concept into four principles for enactment made manifest a role description with significant potential for both internal (intra-role) tensions and external tensions (e.g. with existing primary care system and other professionals). The centrally managed pilot was designed to minimise the latter.
3	The commissioned educational programme for FHNs emerged as innovative. Its difficulties stemmed primarily from the requirement to promote the generalist WHO Europe curriculum within the ambit of a regulatory framework designed for specialist education.
4	The educational programme incorporated North American family nursing care models as they had more developed theoretical and practical bases. This gave the new FHNs distinctive assessment and intervention tools, which in turn became central to the construction of their new professional identity. The drawback was that these tools were labour-intensive and more suited to specialist practice.
5	The new FHNs returned to practice at their local sites and usually in the context of their pre-existing community nursing jobs. They attempted to enrol colleagues from many different disciplines to support their role and to develop more family-orientated PHCT approaches.
6	However, the FHN concept and the need for the pilot initiative were generally hard to understand for some staff at regional/local management level and for many staff at PHCT level. The need for family health nursing was by no means self-evident, and at all levels there was difficulty in clearly articulating the FHN concept and role.
7	Local interpretation/translation of the FHN role was mostly left to individual FHNs. Under these circumstances the influence of local context tended to dominate and the role usually developed by maintaining pre-existing community nursing services and supplementing them with limited, niche expansions. This minimised inter-professional conflicts while allowing some points of growth. FHN documentation was adapted accordingly.
8	The commissioned evaluation research played an important role in the construction of knowledge about the pilot project. Four initial patterns of FHN practice emerged in 2002. These tended to reflect internal and external tensions associated with the role as prescribed by SEHD. Most of the research report's suggestions for improvement were speedily enacted by the SEHD who announced a second phase of the pilot in 2003.
9	Further facilitation of the FHN role and related family orientated PHCT approaches took place in 2004, along with follow-up research. An updated typology of family health nursing practice development was subsequently constructed. The influence of local context, in terms of situated power and embedded culture of place, remained dominant.
10	In order to understand the influence of local context on the translation of the FHN policy initiative, it is necessary to acknowledge that many other policies were, and are, concurrently impacting at local level. This may be visualised by using the "living plaid of primary care" metaphor developed in this thesis.
11	Due to the influence of diverse local contexts, family health nursing in remote and rural Scotland has quickly become diverse itself. FHNs' capacity to engage with whole families on both health and illness matters is very variable, and is often at odds with the demands of a primary care system predicated on treatment of individual's problems.
12	The idea that family health nursing would be a solution to recruitment and retention problems in remote and rural regions emerges as something of a "red herring" in terms of the story so far. In contrast the idea of "family" as the central motif in the new role is crucial. This is because it was foundational to the Scottish educational programme but, arguably, marginal in terms of local PHCT service provision. Moreover, this study suggests that the family emphasis was less of a priority for the SEHD than other principles such as generalism and the health focus.

As such, the thesis argues that this model and story facilitate understanding of an important formative episode in contemporary nursing history. However the Figure 8.1 model may have useful application beyond the particular world of Scottish family health nursing. Specifically it may offer a theoretical basis for prospective consideration of other community nursing developments which are essentially "top-down" in nature, are substantially driven at policy level by individual agency, and are predicated on the idea of pilot testing. This contention will be further explored through application of the model in the next Part of the thesis. Moreover, the essential pattern of contingent developmental factors and processes outlined in Figure 8.1 may have more wide-ranging transferable application. Family health nursing is by no means the only health service development which would benefit from an analysis that ranges from policy through to practice.

SUMMARY

This chapter has examined why family health nursing developed in the way that it did in Scotland, with particular focus on processes of policy formulation and enactment. Initial reflections on the professional – personal worlds of key actors highlighted the need to attend to what may not be able to be spoken or written down. Thereafter, understandings from key informant interviews were scrutinised in the light of two relevant policy analysis frameworks.

The emergence of the FHN concept at European level was re-visited and outstanding questions from Chapter 3 were answered. The policy entrepreneur roles adopted by Ainna Fawcet-Henesy and Dr Jo Asvall emerged as crucial, in terms of re-developing the Health for All Nurse concept, re-badging it as the FHN, and promoting it as a pan European policy initiative. These activities were driven by long-standing professional-personal aspirations to put family and public health at the heart of policy and practice. However the policy analysis frameworks highlighted lack of a focal perceived problem, lack of concurrent associated developments (e.g. Family Health Physician), and lack of any fortuitous political contingency to enable the initiative to gather momentum. As such, there was the risk that it didn't matter enough to enough people.

However Anne Jarvie's engagement with European nursing developments during the 1990's had fostered the aspiration to explore enactment of a generalist community nursing role with an integral public health approach. At the end of the decade she recognised her opportunity and was the crucial entrepreneur who engineered its alignment with prevailing policy agendas. Remote and rural health issues, and associated staff recruitment and retention problems, were the ostensible problem or "lever". Moreover she had the authority and alliances to ensure that the FHN concept could be advanced as a funded policy initiative, albeit in pilot format. Again, however, there was the risk that it wouldn't matter enough to enough people.

This synopsis of policy formulation and initial advancement incorporates substantial explanation of why and how family health nursing emerged, and why it developed in the way that it did at international and national levels. The "Agency model" has been developed within this chapter to synthesise these new understandings.

An adaptation of May et al's "Contingency Model" has also enabled overview of how the FHN policy initiative was subsequently taken forward towards enactment through collective agency. Mapping of knowledge production, containment and expansion at different levels from ideation through to application helped to explain the dynamics of the initiative. In this context the idea of "piloting" emerged as central, with its connotations of controlled, evidence-based development informed by a commissioned evaluation study. Moreover the model served to highlight: central

control mechanisms (which set boundaries and minimised intra and inter-professional conflicts); the relatively marginal role of community nursing managers; the breadth of the FHN role definition; and the related flexibility of local FHN interpretation and enactment of the role.

The chapter ended by linking all the elements of explanation building together into an integrated model and an accompanying synoptic story summarising the main contingent factors and processes involved in the development of family health nursing in Scotland up to 2004. The potential relevance of this new model to other related prospective developments was also suggested.

PART 3: A BRIEF REFLEXIVE RECAP

The two chapters that form Part 3 have combined to build explanation of why family health nursing developed in the way that it did in Scotland between 2001 and 2004. Analyses of family health nursing at practice level and policy level have been informed and enriched by the application of relevant theoretical perspectives. In turn this has facilitated the synthesis of an original, integrative explanatory model and story. In addition to offering a basis for explaining the development of family health nursing retrospectively, the new model offers a potentially valuable framework for prospective consideration of the contingent factors and processes that will influence similar types of development within and beyond nursing.

The explanation in Part 3 is the conclusion of the triptych formed by Parts 1-3 of the thesis. The next Part of the thesis is concerned to update and interpret the FHN story from a 2006 perspectus, in order to understand its influence and implications.

PART 4

RETROSPECTUS, PERSPECTUS, PROSPECTUS

A "re-framing" of the explanation in the light of contingent contemporary developments primarily between 2001 and 2006, enabling analysis of the influence of family health nursing and related implications for the future.

CHAPTER 9

INFLUENCE AND IMPLICATIONS

Overview of this chapter

This chapter examines the influence and implications of the development of Scottish family health nursing (i.e. research question 4). In order to make this possible, the chapter firstly undertakes a retrospective review. This looks back from 2006 on significant contingent, concurrent developments within health and social care since 1998, as understood through policy and research literature. This "re-framing" of the explanation constructed in Parts 1-3 of the thesis is required because, to re-iterate a key idea, "the shape of nursing cannot be entirely understood from within" (Dingwall, Rafferty and Webster 1988; p. 228). As Part 1 of the thesis focused on relevant policy up to 2001, this chapter places particular emphasis on subsequent developments. Selected European, UK and Scottish developments are thus considered in terms of their relationship to, and relevance for, family health nursing in Scotland. In turn this begins a process of building contextualized understandings of the relative significance and influence of Scottish family health nursing itself, and considering the related implications. Retrospective review also facilitates some updating of the FHN story within the context of Scottish developments between 2005 and early 2006.

This brings the reader to the "perspectus" part of the chapter, which views and reviews Scottish family health nursing in the light of four significant documents that were published in November 2006. Two of these documents provide summative perspectives on the development of family health nursing, while the remaining two set out a relatively radical new policy agenda for Scottish nursing. Accordingly, the perspectus part of the chapter seeks to analyse and explain the relationship between family health nursing (1998 – 2006) and the emergent new model for Scottish community nursing.

The last part of the chapter looks ahead to consider implications and future prospects. The explanatory model posited at the end of Part 3 of the thesis is deployed prospectively to map the contingent factors and processes that will be central to the future development of the new model for Scottish community nursing. Finally, other relevant models and wider visions of the future are considered.

9.1 RESEARCH METHODS

Overview of the research methods, principles and processes used in this chapter has already been given in Chapter 2.2.4 and has been summarized pictorially within Figure 1.3. Before proceeding, however, it is useful to recap particularly on literature selection and analysis procedures, and to explain the format used to present and discuss selected material.

The search for and selection of relevant textual material that would enable better understanding of influence and implications, was driven primarily by the associated questions listed in Table 2.5. In effect these interrogated contemporary health and social care policy and research into practice in order to identify ideas or developments of most relevance to family health nursing. While review of European literature was confined to WHO Europe publications, there was more extensive review of recent policy and research/review texts emanating from within the UK, and specifically from within Scotland. Following general screening, key documents were selected in terms of their:

- contextual relevance i.e. where a document presented policy ideas or research/review findings that were of key importance for understanding the context within which family health nursing was developing
- related relevance i.e. where a document presented policy ideas or research/review findings about a substantive development that was directly related to family health nursing and had an important contingent relationship with it
- focal relevance i.e. where a substantive document presented policy ideas or research/review findings specifically about family health nursing

Documents of contextual or related relevance were examined using thematic and qualitative content analysis techniques respectively (see Chapter 2.2.1.3). Key documents of focal relevance, such as the SEHD Final Report on the FHN pilot (SEHD 2006), were studied in more detail using the holistic-content narrative analysis technique described earlier in Chapter 2.2.1.3.

These processes facilitated summative interpretation of each key policy and research/review document (within-case analysis) and further comparative analysis of these documents (across-case analysis). This is reflected in the presentation of the material selected for inclusion in the next two sections of the chapter. Summary tables are used to present the name of each key document, its main purpose, and an interpretative synopsis of its relevance. Within each table there is typically progression from documents of contextual relevance to those of focal relevance, and ordering also seeks where possible to incorporate chronological progression. These tables serve as a basis for further integrative discussion of influences on, and from, family health nursing.

9.2 RETROSPECTUS

9.2.1 The WHO Europe context: what is known about progress up until 2006?

Since the launch of HEALTH 21 and the Family Health Nurse in 1998, WHO Europe has published a small number of documents that review progress. The most significant of these are presented in Table 9.1.

Table 9.1: Selected WHO Europe documents of relevance

Document	Purpose	Relevance and interpretative synopsis
The Health for All policy framework for the WHO European region: 2005 update (WHO 2005a)	Review and update of overall progress towards Health for All, as manifest in evidence of meeting the HEALTH 21 targets to date. Wide purview.	**Contextual relevance**. A very mixed picture of progress in relation to individual targets, and in relation to different countries. Emphasis on importance of governmental action, rather than the actions of specific groups of health service professionals. FHN not mentioned.
Analysis of implementation of the Munich Declaration 2004 (WHO 2005b)	Review and update of progress towards meeting the objectives in the Munich Declaration of 2000. Nursing and midwifery focus.	**Related relevance.** Again, a very mixed picture of progress in relation to individual objectives, and in relation to different countries. Despite the engagement of Ministers at Munich, governments have typically not been active in supporting the objectives in practice. In most countries, nurses and midwives lack political influence and are still not involved in planning health care priorities. The UK is seen as the major exception in this regard.
Fourth WHO meeting on FHN implementation in Europe (WHO 2005c). Held in Glasgow.	Formative evaluation of the progress made on family health nursing within, and across, the participating European countries. Designed to ensure that the multinational evaluation study could finally take place.	**Focal relevance**. The 12 remaining participating countries found to all be at very different stages of development of family health nursing. Scotland significantly ahead of all other countries in terms of enactment and evaluation processes. Out of the 12 countries, seven agreed to take part in the multinational evaluation study.

Perhaps inevitably, the cardinal theme to emerge from review of these documents is the variation across the different countries within WHO Europe, in terms of structures, systems, finance, and perceived healthcare needs and priorities. A major related theme is the relative lack of influence of senior nurses and midwives at policy formulation and enactment level. With the UK being seen as the major exception in this regard, there is a clear basis for explaining some of the stark contrast between progress in enacting family health nursing in Scotland and progress in almost all of the other participating countries. However it is also clear that the other UK countries chose not to engage closely with family health nursing. Accordingly the importance of individual CNO agency and political will, as examined in Chapter 8, should again be borne in mind.

9.2.2 The UK context: what forms the contemporary UK policy context, how does this influence practice, and where does family health nursing fit within this?

From a UK perspective, there is inherent irony in the idea that senior nurses and midwives should be seen as exemplars influencing healthcare policy. For scrutiny of UK healthcare policy analysis literature would tend to contradict this. Thus, Robinson (1997)'s incisive examination concludes that: "it appears that policy in relation to nursing almost invariably develops second-hand as a consequence of other actors' responses to health and welfare initiatives which, in turn, are developed elsewhere" (p. 277). Moreover, *"*without the analysis of the broad picture it would not have been possible to illuminate how relatively unimportant nursing is to government and to managers in comparison to medicine" (p.251).

While Robinson's analysis pertains to nursing in general and to the situation almost ten years ago, there is much to suggest its continued relevance to community nursing in the UK. This impression is sustained in Peckam and Exworthy (2003)'s examination of policy, organization and management of primary care in the UK. Like Walsh and Gough (1999), these authors persuasively argue that the domination of primary health care by primary medical care has been inherently damaging for community nursing. Even significant nursing role developments such as practice nursing and nurse practitioners are seen to have "co-incided with nursing's professionalisation rather than having been initiated by nursing" (Peckham and Exworthy 2003; p.171).

Indeed there is a strong argument that community nursing has been particularly subservient and impotent. In a wide ranging review, Kelly and Symonds (2003) conclude that: "the current constructions of the roles of community nurses have been seriously impaired by the actions of others, and that the focus on caring has been subjugated to the need for a flexible workforce whose purpose is to support medical and managerial goals rather than care for people's health and social needs*"* (p. 143).

Tracing the historical development of this situation, Walsh and Gough (1999) describe modern community nursing as a "commodity" brokered and traded by others. Unsurprisingly, an associated lack of nursing leadership within primary care is often identified. Importantly, empirical studies show that this is not only the perception of influential actors such as government policy makers and GPs, but that it is also shared by front-line community nurses and members of the public (McKenna, Keeney and Bradley 2004; McMurray and Cheater 2004).

Viewed against this rather gloomy context, Anne Jarvie's agency in championing a nursing-specific policy initiative with European associations, national UK implications (i.e. for the UKCC/NMC) and holistic aspirations seems somewhat exceptional. As has been seen, the particular focus on family was unusual in the UK context and the particular aspiration to integrate a modern public health approach into an inherently generalist community nursing role governed by a specialist regulatory framework (Mason 2001) was both bold and ambitious.

Between 2001-2006, many other contemporary UK healthcare policy reviews/initiatives had significance in terms of their actual or potential influence on the development of family health nursing in Scotland. Four of particular note are listed in Table 9.2, along with a summary of their purpose and relevance to this thesis.

Table 9.2: UK policy reviews/initiatives of particular relevance

Document	Purpose	Relevance and interpretative synopsis
NHS (Primary Care) Act 1997 introducing Personal Medical Services, and subsequent evaluation of pilot schemes (Lewis 2001)	Enabled new types of organizations (both public and private) to contract to provide primary care. Offered GPs more flexible employment (e.g. salaried options) aimed to improve GP recruitment and retention. Also to enable alternative sources of primary care such as Walk-in Centres and NHS Direct (Lewis and Dixon 2005). "The beginning of the end of GP's monopoly of primary care" (Pollock 2005).	**Contextual relevance.** Ostensibly opened up significant opportunities for other health professionals. However explicit government agenda of transfering some of GP workload to nurses and AHPs (Pollock 2005). Led to a few nurses employing doctors, but most community nurses still focused on clinical care provision and lacked capacity and/or interest in becoming "nurse entrepreneurs" (Cook 2005).
Liberating the Talents: (DOH 2002)	Presented a new framework for nursing in primary care in England that would help Primary Care Trusts and Nurses to deliver the NHS Plan. Posited 3 core nursing functions: first contact assessment and care; continuing care and disease management; and public health/health protection and promotion.	**Contextual relevance.** Very little mention of family. Community nursing defined and aligned in relation to government policy. Criticised for being tied to medical agenda and revised GMS contract (Howkins and Thornton 2003). However, a marked influence on definition of, and strategic direction for, community nursing in both Northern Ireland (NMAG 2003) and Wales (Williams et al 2004).
New UK GP contract, rolled out in 2004 in Scotland (SEHD 2004a). This is known as the General Medical Services (GMS) contract.	Transfered the ultimate accountability for primary care services from GPs to Primary Care Trusts. Differentiated between *essential* (core) services, and *additional* and *enhanced* services. This enabled GP's to opt out of the provision of "out-of-hours" care. Also created a Quality and Outcomes Framework with financial incentives.	**Related relevance.** "Family" almost entirely absent from the contract. Plethora of outcome indicators based primarily on the recording of tasks carried out in relation to the management of individual patients. Thus, within the contract at the heart of primary care provision, no overt incentive for provision of the holistic family health orientated approach to which FHNs aspire.
NMC revision of the UK nursing register (2004)	Opened a new three part register. Third part exclusively for "Registered Specialist Community Public Health Nurses". Family Health Nurses were "migrated" onto this part of the register immediately after Health Visitors.	**Related relevance.** FHN recognised at national level as a public health nursing qualification, but the way that it was "recorded" changed. Family Health Nurses by far the smallest sub-group on this part of the register.

The main theme to emerge from review of the documents in Table 9.2 is that the initial years of the new millennium have brought some radical changes to the nature of primary care in the UK and, by extension, to the context and content of community nursing practice. The nature and scope of GP work has always had potent influence on community nursing practice (Peckham and Exworthy 2003), and the recent developments highlighted above have specific significance for the future of family health nursing within the UK. For the role's particular emphasis on the family is being developed at the same time as the concept and practice of the "Family Doctor" (or "Family Physician" as posited by WHO Europe) is manifestly not. In Pollock (2005)'s view, "the potential to subcontract primary care services to numerous providers, however, clearly puts an end to the much-admired traditional model of UK family medicine, removing its holistic nature and giving up continuity of care" (p. 149).

Thus the FHN's family focus again emerges as being somewhat out of kilter with contemporary UK healthcare policy and practice development. This is reflected in the community nursing policy review documents (England, Wales and Northern Ireland) mentioned in Table 9.2. These contain little about engaging with families. While both the Welsh and Northern Irish documents give cautious acknowledgement of the FHN initiative in Scotland*, Liberating the Talents* makes no mention of it at all.

Indeed the English, Welsh and Northern Irish documents are all more guarded about any possible move away from current specialist community nursing roles towards greater generalism. Arguably, this relative caution is also evident in relation to public health nursing roles and functions. As Poulton (2003) points out, Scotland's *Nursing for Health* (2001) was far more radical in its recommendations. Interestingly the later Welsh review (Williams et al 2004) was not endorsed as policy by the Welsh Assembly Government. Williams et al conclude that "primary care and community nursing in Wales appears to be struggling to define its identity and contribution in the face of the current changes" (p. 8). This sense of community nursing being reactive and rudderless is apparent in many of the academic and popular UK nursing journal articles reviewed between 2001-2006 (e.g. Bennett and Robinson 2005a and 2005b.).

The latter trend co-exists with a significant aspirational literature which tends to focus on meeting challenges and exploiting related opportunities (e.g. Cook 2005). As Table 9.2 indicates, recent policy changes have the potential to enable more entrepreneurial and autonomous nursing practice. As Kelly and Symonds (2003) and Williams and Sibbald (1999) note however, there is a long history of nursing being "talked up" at such times, only for optimism to subsequently founder in the face of unchanged power relationships with medicine and managers. In this regard it is again important to note how the Scottish FHN development

was managed from the start to minimise challenge to existing medical and managerial hierarchies.

Indeed, review of UK community nursing policy documents tends to highlight how nursing's leaders conform to, and characteristically confine nursing within, prevailing policy parameters. As these documents are almost always managed and produced by government civil servants, perhaps this should not be surprising. Nevertheless, the sense of nursing doing what it is told is often so ingrained and pervasive that it appears unremarkable. While similar documents emanating from government-employed medical leaders will often present strategies which overtly require change to nursing roles, it remains almost unheard of for nursing policy to propose change for other senior professional groups. In effect the UK's Chief Nurses characteristically work within the confines of intra-nursing "how" questions. As such, and strictly within this ambit, the development of the FHN in Scotland is an example of an unusually bold and radical CNO-initiated policy. More often, in the words of Kelly and Symonds (2003), "optimism about nursing autonomy to create constructs that fit with their own philosophical paradigms of a caring profession is almost strangled at birth" (p. 136).

9.2.3 The Scottish context 1: what was the nature of the Scottish policy context up until 2005, how did this influence practice, and where did family health nursing fit within this?

While governance of health matters has been devolved to the Scottish Parliament since 1997, much of the major UK legislation on health applies to Scotland, either by direct adoption or adaptation. Nevertheless, as Pollock (2005) points out, some significant differences of approach are evident within the UK:

> "While England is fast becoming the laboratory and test bed for market-driven experiments, Scotland and Wales are currently trying to minimize the effects of the market forces that were unleashed throughout the 1990's – and with some success. Although the Treasury and Westminister have thrust upon Scotland and Wales the pernicious policy of public-private partnerships and private finance, both countries have begun to take small steps to undo the internal market, trying to strengthen public health functions and restore some basic planning functions." (p. viii)

The plethora of health and social policy making in Scotland post 1997 (analysed in Chapter 4) is evidence of the latter trend, and the FHN initiative occurred within this context. Interestingly, in 2004 and 2005, the vast majority of Scottish GPs (89%; ISD Scotland 2007b) remained part of the General Medical Services scheme. Personal Medical Services contracts remain rare in the Highlands and Islands of Scotland, and it is evident that the introduction of the new GMS contract in 2004 has been one of the major contingent influences on the development of the FHN role in these regions. At the most obvious level, the reduction in most GPs' out-of-hours commitments has had implications for the nature and format of community nursing in remote and rural areas in terms of cross-cover and teamworking practice. However, as suggested

previously, the contract's lack of any overt incentive to provide an holistic family health oriented approach poses a more pervasive and profound problem for the future advancement of family health nursing within PHCT service delivery.

In this context the SEHD anticipated further rise in the direct employment of Practice Nurses by GPs and engaged in concurrent efforts to develop a framework and competences for practice nursing (SEHD 2004b). However, one would look long and hard for any sustained emphasis on family care within practice nursing literature (e.g. Carey 2003), and in many ways practice nursing can be seen to have fundamentally more limited goals than the holistic family care espoused by family health nursing educators and practitioners. Accordingly there is some evidence that, since its inception, family health nursing has occupied an ambivalent position within the Scottish Executive's community nursing policy agenda. The impression of options being kept open is a theme that recurs within several Scottish FHN-related documents that were published between 2003-2004. Five of these are summarised in Table 9.3.

Table 9.3: Five key Scottish FHN-related documents 2003-2004

Document	Purpose	Relevance and interpretative synopsis
Nursing for Health: two years on (SEHD 2003b)	To review progress in relation to implementation of the recommendations of *Nursing for Health*. Used a "report card" format in relation to each recommendation. Progress very mixed. New structures had been set up, but working processes and culture slow to change.	**Related relevance.** Small specific section on FHN, but more emphasis on Health Visiting and School Nursing as merged within the new Public Health Nurse role. Two important points emerge to compare and contrast with FHN. Firstly, 172 of the new Public Health Nurses had been trained by 2003, but there was no evaluation of impact on practice. Secondly, much evidence of continuing tension between public health and the individual patient focus of PHCTs.
Voices from the front line: community nurses and the joint future agenda (RCN 2003)	RCN Scotland "snapshot" research study looking at community nurses initial experiences of joint working with social services as part of the Joint Future Agenda. Enabled by the Community Care and Health (Scotland) Act, Joint Futures aimed to achieve seamless service for patients so that duplicate professional assessments would be eliminated and one practitioner would co-ordinate service delivery.	**Related relevance.** This policy initiative was impacting throughout the development of FHN in Scotland. The Single Shared Assessment documentation was often the visible manifestation of this. This RCN research revealed some of the profound initial difficulties between nurses and social service staff relating to different working practices, professional identities and boundaries, status, and organizational culture.
Exploration of Attitudes towards Family Health Plans (NES 2003)	Health Education Board for Scotland commissioned research study looking at current and possible uses of Family Health Plans in Scotland, and public attitudes towards them.	**Related relevance.** Showed that there is no standard method of record keeping on child and family health in Scotland, and practice complex, multi-professional and diverse. FHN documentation reviewed: seen as practitioner-led and problem-orientated.
The *Family Health Nursing in Scotland* report (SEHD 2003a)	To draw together conclusions about the FHN pilot in Scotland, as informed by the Macduff and West evaluation. To set out the way forward in Scotland (Phase 2, as described in Table 5.7).	**Focal relevance.** SEHD felt it was not possible to draw a definitive conclusion about the future of FHN in Scotland. However, wished to continue development and set up Phase 2. This implemented many of the evaluation report's recommendations.
Partnerships in Education: guidelines for the design and delivery of Family health Nurse Education Programmes in Scotland (NES 2004)	Production of a revised curriculum to prepare any future cohorts of FHNs in Scotland, co-inciding with Phase 2. Informed by recommendations from the Macduff and West (2003) evaluation report, but also extensively by the ICN Framework and Competencies for the Family Nurse.	**Focal relevance.** Revised curriculum built on what had gone before, but introduced new element in the form of the ICN framework. Accordingly new programme mapped onto 3 frameworks: WHO; ICN; NMC. The strong and particular emphasis on family was, however, clearly retained. Only one Scottish University (Stirling) offered this new programme however.

The main theme to emerge from scrutiny of Table 9.3 is that of continuing limited development of family health nursing in Scotland, in the midst of other contingent health and social care developments. The SEHD position at the time is summarised in their *Family Health Nursing in Scotland* report (SEHD 2003):

> "With the evidence available to date, it is not possible to draw a definite conclusion about the future contribution of the Family Health Nurse as a generalist community nurse working with families. However, there is sufficient evidence of the value and potential of the role to continue to support its development and evaluate its impact. The overriding message from the pilot areas is that it would be undesirable, if not impossible, to dismantle this new approach to practice. Even though progress has been variable, the commitment to the model remains" (p. 23)

The above passage is noteable for its assertion that once family health nursing has been constructed in practice, it becomes difficult to dismantle. This highlights the extent to which the FHN initiative was an evolving social experiment at practice level, rather than a controlled catalyst which remained unchanged when tested within local PHCT "crucibles".

This point is, if anything, developed by other reflections within the *Family Health Nursing in Scotland* report (SEHD 2003): "The project steering group took the view at the outset that as a pilot project any outcome would be regarded as a success, so long as we were able to learn from it and apply the learning to the further development of community nursing practice" (p. 21)

This sentence is important as it demonstrates how the criteria for success were not only set very low (e.g. a common government response to disasters is to say that lessons will be learned), but also lacked focus and clarity in terms of specific desired care outcomes. Rather the pilot was predicated on the implementation of four broad principles. Accordingly, it is not surprising that some of the questions that recurred throughout the evaluation were: "why is this being done here?"; "what is the need?"; and "what is family health nursing trying to achieve?".

Nevertheless, substantial evaluation took place. As Table 9.3 shows, the same cannot be said in relation to a much larger simultaneous Scottish development: the education of the new Public Health Nurses and the subsequent impact of this on practice. *Nursing for Health: two years on* (SEHD 2003b) did, however, recognise that developing public health nursing roles often involved tension with the individual patient focus of primary care and medical priorities. During 2003 it was also becoming increasingly clear that community nurses were facing significant challenges in enacting the form of joint working with social services that the Government were advocating (RCN 2003). As Poulton (2003) notes, numerous studies have found evidence of interdisciplinary conflicts within PHCTs, but the RCN study illuminated the nature and extent

of the gulfs in culture between health and social care organizations at the start of the millennium in Scotland.

In this light, it is not surprising that University of Aberdeen researchers found the contemporary use of Family Health Plans (NES 2003) in Scotland to be fragmented, diverse and prone to duplication by different professional groups. Notwithstanding the difficulties that this kind of engagement with families had been found to entail, the revised curriculum guidance document for FHN programmes in Scotland (NES 2004) developed the family focus further by incorporating the International Council of Nurses Framework and Competencies for the Family Nurse. This introduced another element into the structure of the hybrid Scottish programme, which itself remained a very distinctive and different feature of the Scottish university nursing education scene during the first five years of the new century.

The latter point is worth emphasising because there is little evidence of any concurrent groundswell in interest in family nursing within Scotland during this period. Although a Family Nursing Network had been established in 1997 by a group of Scottish nurse educationalists (Claveirole, Mitchell and Whyte 2001; O'Sullivan Burchard, Whyte and Jackson 2002; Burchard et al 2004), this struggled to develop beyond a specialist interest group, and in 2004 could not attract sufficient numbers to sustain an annual conference event. In contrast, the Family Health Nurse initiative was promoted much more forcefully nationally due to high level support, and a number of promotional articles were published in the UK nursing press (e.g. Wright 2002). Nevertheless, as has been noted before, there have been very few articles about family health nursing in the UK nursing press. By the end of 2004 these totaled less than 20, and very few of this number could be said to contain substantive critical engagement and/or analysis. Accordingly, there is little evidence of Scottish, or European, family health nursing being a significant influence on mainstream UK community nursing discourse during this period.

9.2.4 The Scottish context 2: what was the nature of the Scottish policy context between 2005 and early 2006, and where did family health nursing fit within this?

The end of 2004 also marked the beginning of a new cycle of change within Scottish nursing and the wider health services. At this time a new Chief Nursing Officer, Paul Martin, took over from Anne Jarvie who retired after 12 years in the post. Moreover another major review of health service provision in Scotland was underway, led by Professor David Kerr. The subsequent report, *Building a Health Service Fit for the Future* (SEHD 2005b) led to a new raft of policy making and policy responding within Scottish health and social care. Table 9.4 summarises the two key documents at the heart of developments.

Table 9.4: Key Scottish policy documents published in 2005

Document	Purpose	Relevance and interpretative synopsis
Building a Health Service Fit for the Future (SEHD 2005b). Known as "The Kerr Report".	To address changing health needs by devising a 20 year plan for the NHS in Scotland. Particularly driven by more people living longer, with less people being available to care for them. NHS viewed as service to be delivered predominantly in local communities.	**Contextual relevance.** Substantial shift in rhetorical emphasis towards development of primary care. Focus on facilitating health maintenance in terms of preventive, anticipatory and patient/carer self care approaches, particularly in relation to long term conditions. Continued concern that remote and rural communities can sustain suitable services.
Delivering for Health (SEHD 2005c)	To set out a strategic framework and action plan to take forward the Kerr Report. Reproduces emphases on: local services; help for people with long term conditions; reducing inequalities; managing hospital admissions. Details service redesign priorities. Regional and local solutions encouraged.	**Contextual relevance.** Rather less emphasis on health improvement than many of its recent predecessors. Very little mention of families. Action plans show continued preoccupation with medical services. Nursing seen as developing "key clinical roles that will support the delivery of actions on unscheduled care, long term conditions, out-of-hours and emergency services, orthopaedic services and diagnostic waiting times". A review of community nursing will "develop a framework to ensure that community nurses are equipped to provide significant input to the care and treatment of vulnerable people".

Reviewing the two documents in Table 9.4, four general themes emerge as important:

- The much more vigorous policy rhetoric promoting local primary health care, with particular emphasis on health maintenance for vulnerable groups such as the elderly and those with long term conditions
- Related, significant concerns about the capacity of the Scottish healthcare workforce to meet imminent needs of communities
- Continued absence of "family" as a focal concern, but family usually referred to in their (valued) capacity as carers
- Nursing's supporting role in this reformulation of service provision

More specifically, *Delivering for Health's* requirement for a review of community nursing set a new context for the Scottish FHN pilot whose second phase was due to finish in 2006. During 2005 no substantive reports were made available on the progress of the urban piloting of the FHN role. However the final reports of the FHPDFs employed in the remote and rural regions emerged during the year (e.g. Dickson 2005; Caruana 2005). These advocated the relevance of the FHN role to the new policy context, but typically focused on description of the practice development work that had taken place in each region during Phase 2. There was particular emphasis on the introduction of "Plan-Do-Study-Act" cycles for implementing change, and description of new National Indicators that had been developed so as to benchmark FHN practice. It was anticipated that these practice indicators would inform the final evaluation of the pilot which was being conducted by the National Co-ordinator of the FHN Project (Lesley Whyte) and her colleagues from Glasgow Caledonian University.

Thus the stage was set for the publication in 2006 of a summative evaluation of family health nursing in Scotland, and a major review of Scottish community nursing.

9.3 PERSPECTUS

In fact during 2006 work was being undertaken in Scotland to prepare four publications of key importance to the subject matter, and to the conclusion, of this thesis. It is important to note that this work was co-ordinated at SEHD level to such an extent that all four documents were published within days of each other during November 2006. Accordingly, this section of the chapter views and reviews Scottish family health nursing from the overall current "perspectus" provided by these documents. Each of these documents is examined in turn, but interpretation and discussion is cumulative and integrated. This approach is well suited to the integration evident across the documents themselves.

9.3.1 The new overall framework for Scottish nursing 2006

Key aspects of the new 2006 framework for Scottish nursing (and midwifery and the allied health professions) are summarized below in Table 9.5.

Table 9.5 Key aspects of *Delivering Care, Enabling Health*

Document	**Purpose**	**Relevance and interpretative synopsis**
Delivering Care, Enabling Health (SEHD 2006a)	"Harnessing the nursing, midwifery and allied health professions' contribution to implementing *Delivering for Health* in Scotland". Making sure that "our direction of travel matches exactly that set out in *Delivering for Health*", and making the most of resultant opportunities. Building related culture, capability and capacity.	**Contextual relevance.** Explicit re-profiling of Scottish nursing in response to the new policy agenda. Emphasis on "core nursing values" such as caring for the elderly, and team work. Faithful reflection of other emphases in *Delivering for Health.* Main actions include workforce development plans, new models/frameworks (e.g. for anticipatory care, self care, and competencies). Related action points impacting on pre-registration educational courses in Scotland.

As indicated in Table 9.5, the new framework is defined by the NHS Scotland plan set out in *Delivering for Health*. Nursing capability is considered in relation to a new NHS which "will be a service primarily focused on helping older people to stay well and remain engaged with their communities and, if they fall ill, providing them with appropriate access to services locally or in specialist centres" (p.26). There is associated preoccupation with capacity issues and reference to ongoing national workforce planning initiatives. In this regard it is significant to note that, shortly after taking office, CNO Paul Martin had also been appointed as Interim Director of Human Resources for NHS Scotland. Within the new framework, the need for a flexible workforce is repeatedly emphasized, and it is made clear that health service career progression

will increasingly be predicated on the needs of patient care groups rather than the traditional expectations of distinct groups of health professionals. One of the most striking overall themes within the document is the extent to which nursing is being reformulated to conform to policy in such a way that it may ultimately be defined by it and measured against it.

9.3.2 The SEHD Final Report on the FHN pilot

Key aspects of the SEHD's final report on the FHN pilot are summarized below in Table 9.6.

Table 9.6 Key aspects of *The WHO Europe Family Health Nursing Pilot in Scotland Final Report*

Document	Purpose	Relevance and interpretative synopsis
The WHO Europe Family Health Nursing Pilot in Scotland Final Report (SEHD 2006b)	The *Final Report* does not explicitly express its aim, but it can be inferred that it purports to summarise what happened in Phases 1 and 2 of the pilot, and what has been learned overall. Within a glossy format, there is brief description of policy context, the WHO Europe initiative, the principle of the Scottish role, conceptual models, the education and research undertaken in Phases 1 and 2, and the new National Indicators. A further section of the report considers impact and outcomes in terms of criteria from *Delivering Care, Enabling Health*. A final section considers the learning and key messages that have emerged from the SEHD point of view.	**Focal relevance.** In summarising and re-presenting the five year pilot, the SEHD "re-frame" it in terms of its relevance to the central policy concerns set out in *Delivering for Health* and *Delivering Care, Enabling Health.* While some of the difficulties that emerged during both phases are cited (e.g. creating a generalist role within the context of existing specialist nursing roles), these tend to be glossed over through the presentation of individual FHN practice exemplars that promote the role and the value of the pilot. Considerable emphasis is placed on a new conceptual model of family-centred health care (Parfitt et al 2006) that emerged from the research conducted during Phase 2 by the team from Glasgow Caledonian University. The Foreword by the Chief Nursing Officer declares the FHN pilot project's "enormous influence" on *Delivering Care, Enabling Health*, and on the development of future community nursing models for Scotland. Thus the pilot project is strongly validated throughout the *Final Report*.

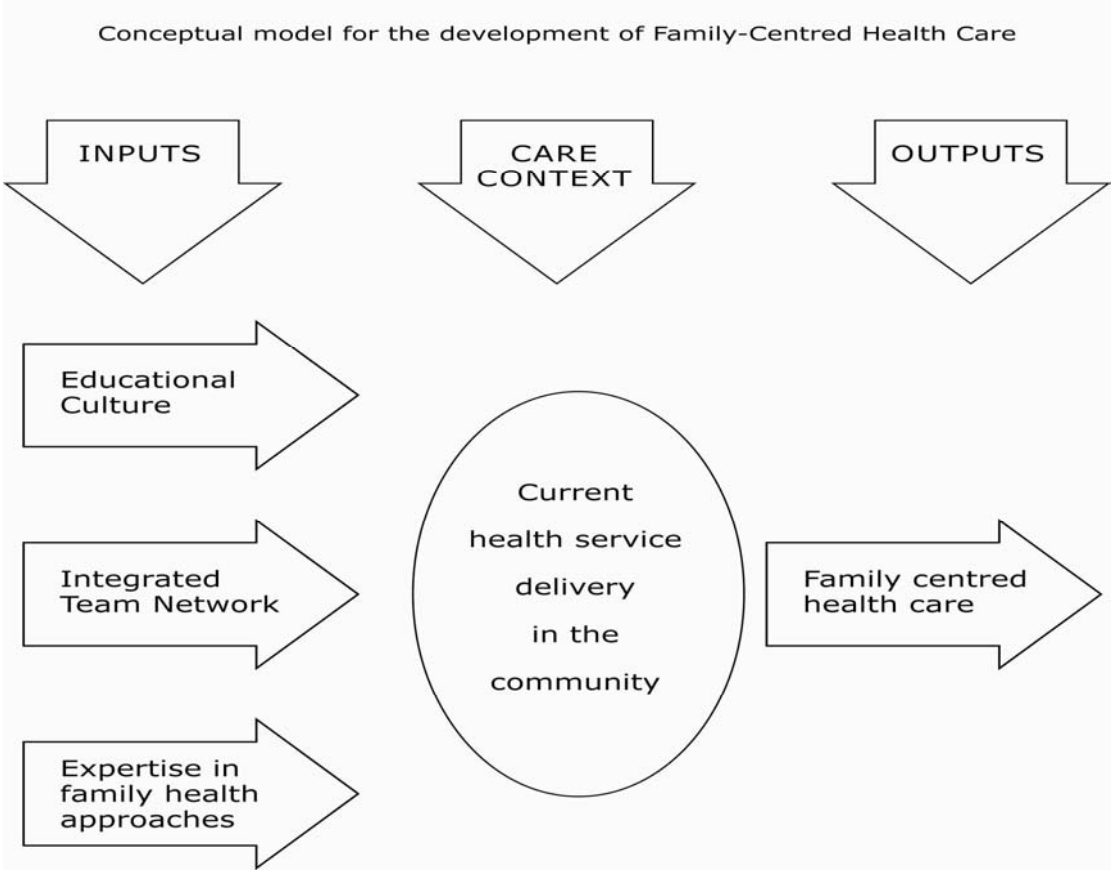
A key message from Table 9.6 is that the *Final Report* re-frames the Scottish FHN pilot project in terms of the new NHS Scotland and new Scottish nursing policy agendas. Thus the value of the role in meeting the needs of older people, providing anticipatory care, supporting self-care, and the other new policy preoccupations is promoted through the exclusive citing of examples

of FHN practice that have had positive impact. The document draws substantially on findings from the evaluation of the urban pilot (Parfitt et al 2006) showing that service users typically valued having the FHN as an identifiable single point of contact, and that this relationship often identified and addressed unmet needs.

However, the *Final Report* tends to gloss over the context of this relationship, mentioning once in the passing that "Family Health Nurses in the urban setting became additional members of nursing teams and established new client caseloads" (p. 13). In fact this supernumerary status is a key difference to the remote and rural FHN experience, and is one that requires further explanation in terms of its potential contribution to client satisfaction.

A more balanced and less superficial approach is evident in the document's discussion of learning and key messages, where there is consideration of what would have to change at PHCT level for family health nursing to thrive. In this context, considerable emphasis is placed on a new conceptual model of family-centred health care (Parfitt et al 2006) that emerged from the research conducted during Phase 2 by the team from Glasgow Caledonian University. This is reproduced below in Figure 9.1.

Figure 9.1: Conceptual model for the development of Family-Centred Health Care (Parfitt et al 2006)



Within the *Final Report* it is made clear that all of the three "interlocking" inputs depicted in Figure 9.1 would have to be present for family health nursing to evolve within PHCTs delivering "family centred" care. This is consistent with the suggestions made in the Phase 1 evaluation research report (Macduff and West 2003). Nevertheless, as this thesis has shown, this sort of productive conjunction of FHN and PHCT aspirations was relatively rare in remote and rural regions even where active external facilitation was taking place. With the GMS contract's focus on outcomes for individuals, the systematic embedding of such a family-centred care model would seem like a tall order indeed.

Notwithstanding this, the SEHD *Final Report* concludes that "The Family Health Nurse model underpins the development of family-centred care in a way that reflects the Scottish health policy focus on delivering care that is based on health improvement and disease management" (p. 30). Moreover, in his Foreword, the Chief Nursing Officer declares the FHN pilot project's "enormous influence" on *Delivering Care, Enabling Health*, and on the development of future community nursing models for Scotland. Ostensibly then, the *Final Report* appears to suggest a future existence for FHNs within family-centred Scottish community health care. Before examining the blueprint for the future that was concurrently being developed (i.e. the 2006 Review of Nursing in the Community in Scotland), it is useful to look in more depth at the research evaluation of Phase 2 of the FHN pilot.

9.3.3 An evaluation of the Family Health Nurse Role Phase 2

Key aspects of this document are summarized below in Table 9.7.

Table 9.7 Key aspects of *An evaluation of the Family Health Nurse Role Phase 2*

Document	Purpose	Relevance and interpretative synopsis
An evaluation of the Family Health Nurse Role Phase 2 (Parfitt et al 2006)	The Phase 2 evaluation had three objectives: (i) To understand the impact of the FHN role in an urban area during the first six months of practice from the perspectives of service users, FHNs and FHNs' professional colleagues. (ii) To follow up FHNs' experiences of the role after 3-4 years in remote and rural areas. (iii) To understand the factors that have helped or hindered the implementation of the FHN role.	**Focal relevance.** The remote and rural part of this study was broadly similar in nature, scope, methods and indeed findings to my own follow-up study (Macduff 2006b) of these regions. The key differences in the urban part of the study are (i) the supernumerary status of the FHNs, and (ii) the 20 interviews carried out with service users and carers. The resultant findings are very positive in terms of user satisfaction with urban FHNs. However, the report often fails to distinguish the urban experience in terms of its particular contexts and processes, so that insights for the reader about transferable understandings are limited. The report strongly advocates whole systems change towards the new model of family centred health care posited.

As Table 9.7 indicates, the remote and rural part of Parfitt et al's study was broadly similar in terms of its nature, scope, methods and findings to my own follow-up study. Indeed it used a questionnaire developed for the Macduff and West (2003) evaluation study.

Consequently the novel aspect of the Parfitt et al research lies in its study of the urban pilot. By giving more detail of the development and related research that took place during Phase 2, their report enables more critical purchase to be applied to the SEHD *Final Report*. Thus they clarify that:

> "In 2005, 15 FHNs qualified and worked for 6 months in an urban area. The key difference in the implementation was that in urban settings FHNs did not return to their previous caseloads (as happened in the rural areas), but were in supernumerary positions, working only in the FHN role. As such, their work depended on colleagues referring clients on to them" (p.2).

This casts the urban pilot as a very short term trial of a role that added distinct extra capacity on to local service delivery. Seen in this context it is not surprising that the 20 service users/carers typically valued having the FHN as an identifiable single point of contact (after initial referral

by another professional), and that this relationship often identified and addressed unmet needs. This is very different from the typical remote and rural FHN experience where servicing of pre-existing caseloads continued and the new role had to develop as an integral part of the PHCT service.

The main limitation of the Parfitt et al study is that it characteristically aggregates urban and rural findings, making it difficult to get a detailed understanding of the urban context(s) and the processes involved for the FHNs and other PHCT members. For example, the report gives details of the age distribution of clients on the caseloads of 23 FHNs who responded, but fails to distinguish which relate to the 10 urban FHN respondents. As there is huge variation across the 23 FHNs' replies, the reader must guess at the presence or absence of any urban trend. Similarly, although the report argues strongly for a new conceptual model of the development of family-centred health care, it gives no indication of how many of the urban FHNs actually were part of PHCTs where three inputs aligned as in Figure 9.1. Moreover, it is unclear exactly how this worked for urban PHCT members in terms of their contexts, integrated processes, and the nature of any related outcomes. This makes it hard to know: whether the model being advocated is derived directly from empirical evidence from the Scottish urban FHN sites; whether it is derived primarily from evidence from Scottish remote and rural sites; or whether it is primarily a new aspirational, theoretical construct.

The latter interpretation is possible, given that the new construct is presented as a conceptual model and that at least two of the report's authors have substantial experience of, and alignment with, developing family health nursing in other countries (notably Tajikistan). Certainly, the report is unequivocal on the need for major whole systems organisational change if the FHN role is to prosper in Scotland: "The process depicted in this model is the transformation of the current mode of service delivery in the community into a family-focused system of health care, in which FHNs play a full role" (p.31).

Specifically the report recommends that: strategic leadership at Community Health Partnership (CHP) level is required to instigate the required systems change; manpower modelling research is required to explore the practical feasibility of the FHN model; and that community nursing education programmes should be reviewed to ensure that all practitioners are familiarised with FHN concepts.

Thus the Phase 2 evaluation research report argues for radical change to systems within Scottish primary care, but yields limited understanding of the workings of the FHN role in an urban setting, making it difficult to gauge the extent to which findings may be transferable to other Scottish urban contexts. With these considerations in mind, it is time to examine the major national review of community nursing that was ongoing throughout 2006.

9.3.4: The 2006 Review of Nursing in the Community in Scotland

Key aspects of this document and its associated literature review are summarized below in Table 9.8.

Table 9.8 Key aspects of the 2006 Review of Nursing in the Community in Scotland

Document	Purpose	Relevance and interpretative synopsis
Visible, Accessible and Integrated Care: Report of the Review of Nursing in the Community in Scotland (SEHD 2006c)	The review's aim was to: "identify the core components of a modern community nursing service which is flexible and responsive to meet the needs of patients and communities in Scotland within a multi-disciplinary setting and make recommendations for the future delivery of care". It had four objectives: (i) To identify current arrangements/models for the provision of nursing in the community (ii) To determine future nursing requirements to provide modern nursing in the community and determine the impact this will have on other community disciplines. (iii) To identify effective practice (iv) To identify models of best practice	**Related relevance.** The review was explicitly driven by *Delivering for Health,* but its scope was extended beyond the care and treatment of vulnerable people. By May 2006, high speed review produced a controversial new draft framework for structuring delivery of community nursing in Scotland. District nursing, public health nursing and family health nursing were to be merged into a new, generalist Community Health Nurse role. Despite a large number of "serious concerns" being voiced during the consultation, and related adverse publicity in the Scottish press, the new framework was published with minimal changes in November 2006. The implementation plan for the new model involves a 2 year project with selected "Development Sites" that reflect the diverse nature of Scotland's geography and demography. This will "test and refine" the new model to ensure fitness for purpose. In this way, the concerns raised during consultation will be taken into account.
Nursing in the Community: a literature review (SEHD 2006d)	The literature review aimed to explore the evidence base for nursing in the community in relation to the key messages/themes within *Delivering for Health.* Specifically, for each of the main themes such as anticipatory care and managing long term conditions, there was also the requirement to identify any significant differences for nurses in urban or rural areas, and to "explore where on the continuum of generalist to specialist nurse any impact is most significant". Search, synthesis of findings and report production was to occur within three months.	**Related relevance.** The review team was set an extremely challenging remit which precluded a formal systematic review protocol. A very mixed literature from Europe, North America and Australasia was screened and assessed (164 papers) using a range of quality criteria. The evidence base for community nursing was found to be limited for most of the key themes at the heart of Scottish policy. A more general overview of nursing in the community was produced which highlighted some of the recurring themes within nursing research (e.g. difficulty of identifying the specific community nursing contribution to outcomes). The review does not substantively report on urban/rural or generalist/specialist differences despite its remit.

9.3.4.1 *Review aim, processes and politics*

Before looking at the Review's findings and outcomes in more detail, it is necessary to say more about the processes involved and the political context. The Review formally started work in January 2006, with the very ambitious target of reporting by the end of May 2006. As noted in Table 9.8, it is significant that the CNO set the Review's scope beyond the focus on vulnerable people that had been specified in *Nursing for Health*. Rather, the opportunity for a "full", but very rapid review, was recognised.

In this regard the Review's aim (see Table 9.8) contains a phrase of particular significance: "to identify the core components of a modern community nursing service which is flexible and responsive" (p. 36). "Core components" is noteworthy because it raises the prospect of common ground, with *Delivering for Health* as the rallying point. "Flexible and responsive" reflects not only the changing nature of patient needs, but also the workforce capacity concerns driving policy and presumably being highlighted for the CNO in his capacity as Interim Director of Human Resources for NHS Scotland. As Kelly and Symonds (2003) historical analysis shows, however, flexibility and responsiveness carry significant professional risk for community nursing in terms of likely concurrent supplication to medical and managerial agendas.

The Review's objectives were addressed through the literature review and a rapid series of regional workshops with: community nurses; NHS managers and other staff; and patient and carer representative groups. Moreover a National Conference was held in March and a Consensus Conference took place in May. While the former event (and the minutes of the Review's National Steering Group) gave little, if any, indication that radical change to a Community Health Nurse (CHN) generalist model was imminent, the May event was convened to consider a draft of just such a model (see CHN model in Figure 9.2 for reference). Professional reactions, as manifest in consultation responses to the first public draft of the report (Draft 5), were very mixed but typically included substantive concerns. A selection of these from the Review's website is given in Table 9.9.

Table 9.9: Serious concerns expressed by respondents during the consultation process

The move towards generic skills vs. specialisation among community nurses (jack of all trades with the associated dilution of skills and loss of specialist skills, master of none)
The "clinical" nature of a model which endeavours to give equal weight to health promotion and prevention and clinical care of unwell patients, with concerns that inevitably the needs of the sick individual would override the health promotion work.
The uni-disciplinary focus on nursing vs. a focus on multi-disciplinary integrated services
The impact of such radical proposals on the morale of an already demoralised, change fatigued workforce, with concerns that some would leave the nursing profession.
The place of children and young people within the proposal, with particular concerns around child protection issues.
The place of Practice Nurses within the model and lack of acknowledgement of their central role in managing long term conditions etc.
A lack of evidence for the recommendations and the proposed model.
Concerns about the transferability of qualifications between Scotland and the other UK countries and vice versa.
The inadequate consultation time around the recommendations and proposed model for such far-reaching changes.
A lack of awareness or acknowledgement in the report of the wider policy context and other national initiatives.
Geographical based teams vs. attachment to a primary care practice.
Training and competencies of nurses both initially and maintaining skills for the new role, with consequent concerns around patient safety.
Management issues – particularly how the consultant nurse role fits within the CHP structure and the CHP Lead Nurse, along with the affordability of the new structure.

In a subsequent draft of the report (Draft 6), and in the final published version, the SEHD addressed a few of these concerns. Firstly they added a new core element, "Adopting public health approaches to protecting the public" on to the six that they had already identified as being at the core of nursing roles in the community i.e. working directly with individuals and their carers; co-ordinating services; supporting self care; multi-disciplinary and multi-agency teamworking; meeting health needs of communities; and supporting anticipatory care. This addition was designed to assuage vocal concerns about child protection in particular.

More significantly, from the perspective of this thesis, the final published version explicitly cites the FHN model on several occasions as an example of what works in community nursing and as a major influence on the new service model that is promulgated in the Review. This fore-fronting contrasts markedly with the way that the FHN pilot project was kept very much in the background during the early stages of the Review. This thesis would argue that, in the face of charges of a lack of evidence for the recommendations and the proposed model, the SEHD was forced to become more explicit about the model's origins. This contention will be explored in more depth later in this chapter.

Despite pressure from the Scottish press for reconsideration, the final published version made few other changes in response to professional and public concerns. Indeed the final published

version is pared down from Draft 5 to such an extent that: basic definitions are omitted (e.g. what is meant by community nursing); the sources of evidence for the report's many generalisations are usually not made explicit within the text; and the finished document is slimmer than many executive summaries. While such conciseness has virtues, it makes it difficult for the reader to understand how and why the Review arrived at the findings and conclusions that it did.

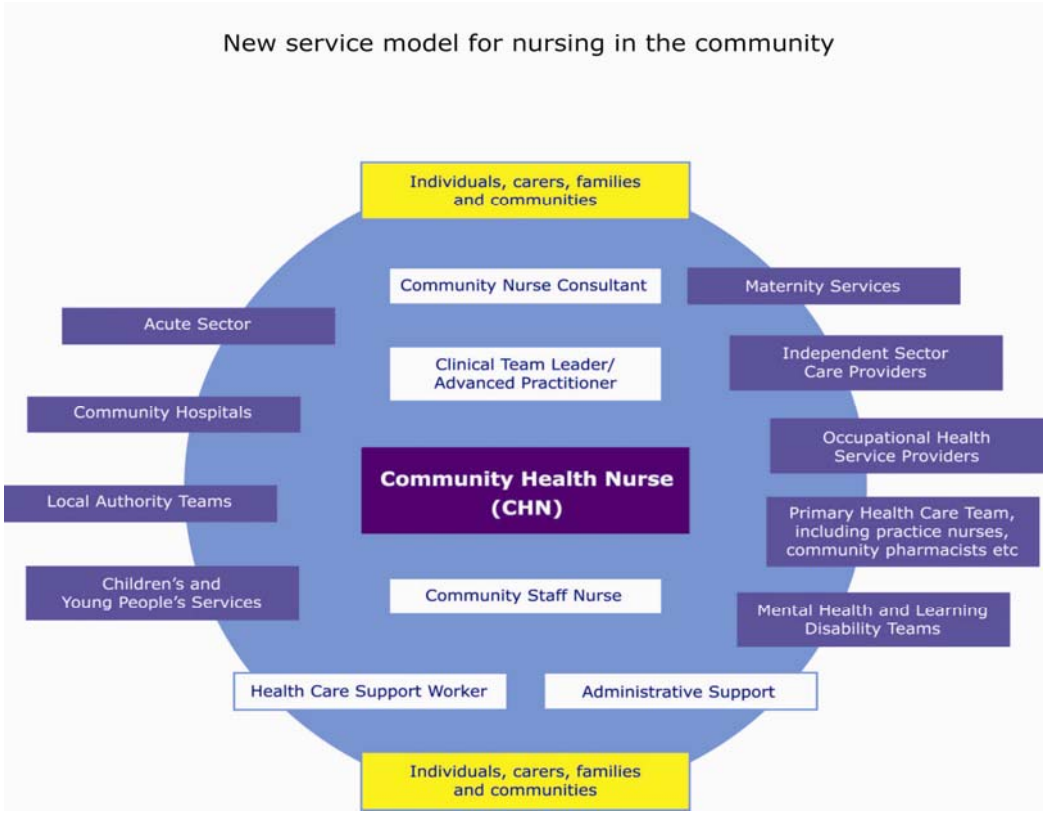
9.3.4.2 *Review findings and recommendations*

The findings of the Review firstly focus on the perceived strengths of Scottish community nursing in general. These are perceived to include knowledge and skill levels, problem solving and relationship building activities. On the distaff side, the Review argues that the profusion of community nursing roles and job titles is confusing for both the public and professionals alike. Moreover the latter groups were seen as wanting a single point of access to community nursing services, which at present could lack co-ordination.

The Review also argues that the "sporadic and inconsistent" (p. 12) implementation of the *Nursing for Health* (2001) recommendations that were intended to focus nursing's public health activities, means that: "Nursing needs to reclaim public health as a core function, with public health awareness and approaches being adopted as a kind of ′default position′ by each nurse working in the community" (p. 12).

On this basis the Review sets out a new framework aimed at clarifying the nursing role in the community, "to create greatest benefits to individuals, carers, families and communities" (p. 16). This new service model is reproduced in its final form in Figure 9.2.

Figure 9.2: The new service model for community nursing in Scotland (SEHD 2006)



As Figure 9.2 illustrates, at the heart of this model is the proposed new Community Health Nurse (CHN) role. The seven core practice elements listed above in Section 9.3.4.1 are not only seen as the foci for this role, but also for the activities of all nurses in the community. Thus the new CHN role is posited as the central structural component of the new service model. To start to make this possible:

> "The Review recommends that the disciplines of District Nursing, Public Health Nursing (Health Visiting and School Nursing) and Family Health Nursing be absorbed into a new, single Community Health Nursing discipline. The elements common to each of these disciplines will be assumed by the new Community Health Nursing discipline." (p. 15)

Apart from the obvious historical significance of ending distinct disciplines such as district nursing and health visiting in Scotland, with their long-established cultural identities, the above recommendation raises immediate practical questions about the mechanics of merging these disciplines. As Table 9.9 shows, the merger also raises many major questions about its possible impact, such as: *can public health really be enacted as a core function/default position within the CHN role*? As Table 9.8 indicates, the Review typically suggests that such questions will be addressed during the two year implementation project whereby selected Development Sites will

test and refine the new model to ensure fitness for purpose. This distinctly echoes the policy advancement and enactment strategies developed for the FHN pilot project.

There is, however, clarity about one group of nursing staff, in that the Review reports that it "has not been possible to identify Practice Nurses in the model due to the particular nature of their employment circumstances" (p. 15). This highlights a significant limit on the Review's scope and raises questions about the level and nature of GP support for the new model.

Related concerns are exacerbated in the final published version's description of how and where the new nursing teams will work. While Draft 5 had placed considerable emphasis on this responding creatively to local community needs and being contiguous with Community Health Partnerships, the final published document is much more guarded, stating that "It will be a matter for individual NHS Boards to determine whether group attached/aligned or geographically based services are selected for their areas" (p. 25). This puts a premium on local community nursing leadership to advocate the nursing case appropriately and forcefully. As this thesis has argued, this has not been a prominent feature of multi-disciplinary working at this level.

In summary, the Review sets out a radical new model for community nursing in Scotland, but only partially explains the origins of, rationale for, and means of enactment of this new model. While many of the associated arising questions must remain to be answered in the future, for the purposes of this thesis, it is now important to analyse in more depth the relationship between the envisioned CHN and the FHN as envisioned and enacted.

9.3.5 The relationship between the Community Health Nurse and the Family Health Nurse

In order to analyse this relationship, it is firstly useful to compare the newly envisaged CHN role with the FHN role as it was envisaged on Calton Hill five years previously. This can be done by once more referring to the four principles that the SEHD posited as core for the FHN role.

Firstly, it will be recalled that the FHN role was seen as "a skilled generalist role encompassing a broad range of duties". In essence the CHN appears to be a skilled generalist role formulated around seven core elements which represent a mixture of: long-established community nursing role expectations (e.g. working directly with individuals and their carers); more recently formulated community nursing role expectations (e.g. multi-disciplinary and multi-agency team working, meeting health needs of communities, co-ordinating services); and newly conceptualised community nursing role expectations (e.g. supporting anticipatory care, supporting self care). Clearly this would entail a broad range of duties of generally similar nature and scope to the FHN role as it was envisaged. The major differences are the particular new emphases on supporting anticipatory and self care, and the absence of specific reference to families.

It also seems clear that both roles share health as an envisaged core element, although the CHN role adds carers on to the FHN's remit to cover individual, family and community health matters. However the tenor of the 2006 Review suggests that the CHN role should reflect *Delivering for Health's* particular emphasis on the health of the elderly and those with long term conditions. Again this raises questions about whether such a large remit will compromise quality and prejudice care for specific groups (see Table 9.9).

Thus strong generalist and health elements are evident in both role templates, although there are a few distinct differences in emphasis. The notion of the CHN as first point of contact within the new service model reflects an aspiration that was also central to the envisaged FHN role. This type of generalist model is, however, contingent on support from specialist practitioners. The major difference in the new model is that the CHN merges several of the existing specialist roles (i.e. DN; HV; FHN), while the FHN was essentially adding on another type of role.

From the above analysis it becomes increasingly clear that the core difference between the two roles, as envisaged, relates to family. This is obvious at the level of naming, whereby "Family" gives way to "Community". However, more in-depth scrutiny of the Review and the proposed CHN role shows that family care is not a focal concern. Rather it is typically couched within a recurring aspiration to care for "individuals, carers, families and communities". This contrasts with the explicit statement in 2001 that the FHN was to be a "role founded on the principle of

caring for families rather than just the individuals within them". Moreover it contrasts with the current argument for PHCT whole systems change towards family-centred care advanced in the Parfitt et al (2006) report and ostensibly endorsed in the SEHD's Final Report on the FHN pilot (SEHD 2006).

Having (i) established that there is one core conceptual difference and three core conceptual similarities between the envisaged new CHN role and the original FHN role template, and (ii) noted CNO Paul Martin's acknowledgement of the FHN pilot's enormous influence on "developing future models for the delivery of nursing care in the community" (SEHD 2006b, p. 2), it is necessary to ask why the SEHD dropped the emphasis on family. This issue is neither explicitly acknowledged nor addressed in any of the four key documents whose publication was co-ordinated by the SEHD in November 2006. Yet the natural question that arises from reading them together is: *if family health nursing is so good, why drop the emphasis on family*?

As this thesis has shown, the answer that the SEHD has been reluctant to publicly acknowledge to date is that enactment of meaningful family-centred PHCT service delivery to both well and unwell persons is extremely difficult within the present system. Specifically the thesis has found that the aspiration to engage with whole families was often difficult to enact, was usually not a priority within overall PHCT service delivery, and was not incentivised in overall primary care policy and planning. Moreover, as the interview with Anne Jarvie in this thesis has shown, the SEHD's attachment to family as a core element of the role was never absolute, despite its promotion through the pilot.

This contrasts with Anne Jarvie's (and, by extension, the SEHD's) more longstanding and deep-rooted commitment to the idea of a generalist community nursing role with health as a core focus. The evidence on FHN role enactment in remote and rural regions showed that most FHNs were able, at the least, to supplement their existing duties with some distinct health-focused activities. This also seems to have been the case for the supernumerary urban FHNs. Perhaps most tellingly, however, the remote and rural follow-up study confirmed the flexibility and wide scope of the FHN role in terms of providing generalist community health nursing services (Macduff 2005; Macduff 2006a). While the latter publications reported the diversity of what could be considered family health nursing practice, they also highlighted that the inherent flexibility and wide scope of the role was generally valued by colleagues and seen to enhance service provision. As noted above, the aim of the 2006 Review was to ensure a flexible and responsive community nursing service.

Accordingly, this thesis argues that it is likely that the SEHD has quietly dropped the family emphasis due to recognition that it is impractical if taken seriously and would require radical

whole systems change involving fundamental commitment from other key professional groups. In effect, the SEHD has a sufficiently large challenge in introducing a radical intra-professional reform in the shape of a pivotal generalist role which aspires to address both health and illness needs within communities. Moreover, the analysis within this thesis highlights the extent to which the SEHD is making a large "leap of faith" in its commitment to introducing the Figure 9.2 model across all of Scotland in the future. For, while the FHN role was enacted and evaluated within typical remote and rural practice, the brief urban pilot involved a very atypical supernumerary nursing role. Thus it remains very unclear whether a generalist community nursing role with an explicit health orientation (i.e. the CHN) will be suited to team working in urban areas and be feasible and affordable.

In this regard, it is unclear whether the Review considered potentially relevant evidence from broadly similar countries where broadly similar generalist roles operate. For example, in the Irish Republic the Public Health Nurse role has operated for many years and has been studied in some detail (see NCNM 2005; Begley et al 2004). However it is unclear whether this informed the Review, and as Table 9.8 indicates, the commissioned literature review does not substantively report on generalist/specialist or urban/rural differences despite its remit.

None of the argument in this section is suggesting that the SEHD is necessarily mistaken in deciding to introduce the CHN and the new service delivery model. Rather it is to seek to highlight: the relationship of the FHN to the new CHN role in terms of key similarities, differences and net influence; the reasons why the conceptual transition from FHN to CHN has progressed in this way; the limitations of arguing for the new CHN role on the basis of the findings from the urban FHN pilot; and the related lack of clarity about the evidence base for the new CHN role and associated service delivery model.

9.3.6. Using the Agency model to understand the Review of Nursing in the Community

Reflecting on Sections 9.3.4 and 9.3.5, it is useful to highlight the importance of what was not being addressed in the Review. In effect, there is very little attempt to engage with and explain community nursing in terms of the recent past. While ostensibly this seems odd, it can be understood as part of a broader strategy to achieve a kind of "tabula rasa" - free from the imprint of the past and ready for the blueprint of *Delivering for Health*. Although the influence of the recent FHN pilot is eventually acknowledged in the Review, there is no sustained analysis of the recent contribution of specific key disciplines such as district nursing, health visiting and practice nursing. Rather the text of the Review document aggregates the disciplines together as "community nursing" and characteristically aggregates its findings in a way that makes it very difficult to gauge: the nature of the data informing consideration of particular issues; the nature of any analytical and weighting processes; and how conclusions were reached. This can be seen as a way of minimising offence to the key community nursing disciplines that will be required to merge and lose their established identities.

The craft of the Review is that it defines itself in relation to the future as depicted in *Delivering for Health*. This creates a sense of an urgent imperative for change which community nursing must rapidly respond to. To this analyst, the nature of the Review (i.e. its remit, timescale, processes and approach to reporting) seems deliberately crafted towards finding an answer that had already been substantially found by the SEHD. To justify this interpretation further, it is useful to return to the Agency model constructed in Chapter 8 of this thesis (see Table 8.8). In this context it can be argued that the FHN's generalist, health-orientated community nursing role (as primed by Anne Jarvie between 1998-2004) had itself become a partially realised aspiration waiting for a new centrally advocated agenda so that it could become more fully realised. In this analysis, Paul Martin and colleagues can be seen as aware that *Delivering for Health* (and, in particular, its workforce capacity concerns) presented an advocated agenda with which this longstanding CNO aspiration could be creatively aligned. By offering a "tested" generalist health nursing approach, the FHN provided the basis of the new CHN solution, once the extra "baggage" associated with family was shed and the new core elements (anticipatory care; self care) were incorporated.

Despite her positional authority, CNO Anne Jarvie had felt unable to explicitly articulate her vision of a future with no District Nurses and Health Visitors due to the sensitivities of these professional groups at the time. In this new situation, CNO Paul Martin and colleagues felt they had sufficient agency to recommend the merging of district nursing, health visiting and family health nursing. In this regard it is important to note that the CHN solution goes further than the solution that had been tentatively proposed in *Nursing for Health* in 2001 (i.e. two core

community nursing roles: FHN and Public Health Nurse). The challenge ahead for the CNO and colleagues is how best to harness collective agency through forging alliances for advancement and adapting the policy initiative advantageously.

The interpretation presented in the preceding three paragraphs necessarily contains some speculative elements, as it has been beyond the scope of the thesis to conduct empirical research into the process of the 2006 Review. As such, a theoretical explanation of these most recent events is being posited, based on what has been learned about the SEHD's development of family health nursing between 1998-2006. This assumes that the SEHD entered the Review with a substantive outline of a preferred option for the future of community nursing in Scotland. In the absence of empirical evidence, it is acknowledged that the latter assumption in particular is open to question and debate. Undoubtedly there is a need for future research into the Review processes, and this might include interviews with the Project Officers, the Steering Group members and those leading the Review at the SEHD.

9.4 PROSPECTUS

9.4.1 Back to the future: using "MAPPED" to anticipate influences and implications

In the preceding section of this chapter, the "Agency" model was used to analyse the SEHD's process of formulating new community nursing policy. As seen in Chapter 8, the Agency model is part of the larger Integrated Model Explaining the Development of Scottish Family Health Nursing (IMEDSFHN; Figure 8.1) which was constructed through retrospective analysis. In this final section of the chapter which looks to prospects ahead, the IMEDSFHN model is used prospectively to anticipate influences on, and implications of, the Executive's new policy initiative. As this represents the first more general application of IMEDSFHN as an analytic template, it is useful to rename it as the "Model for Analysing Policy to Practice Executive Developments" (MAPPED). In this way it is hoped to demonstrate its potential relevance for other developments in health and social care which are: initiated essentially through executive action; advanced in a "top down" way from policy through to practice using piloting as a control mechanism; and involve new role development. Figure 9.3 re-presents the IMEDSFHN model in its generic MAPPED form.

Figure 9.3: The Model for Analysing Policy to Practice Executive Developments

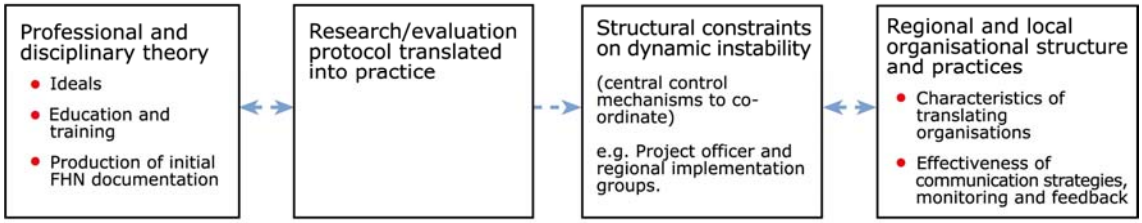
Part 1: Initial policy formulation and advancement

Agency		
Aspiration	Individual Agency	
Awareness and anticipation of opportunities		
Alignment around advocated agendas		
Authority		Collective Agency
Alliances for advancement		
Advantageous adaptation		

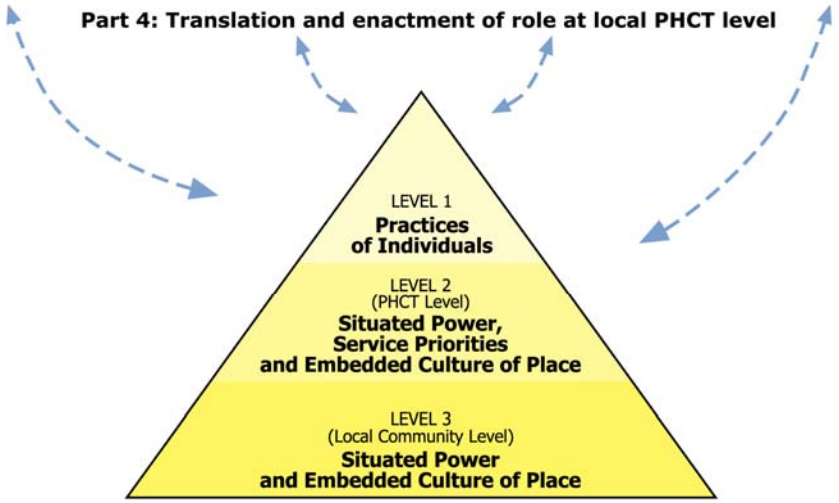
Part 2: Taking the policy initiative forward towards enactment

Level of analysis	Mode of technological development	Mode of knowledge production	Mode of containment	Mode of strategic expansion
Ideation	Idea of new technology.	Notion of research/ evaluation.	Judgements about value.	Key actors.
Mobilisation	Constructs of appropriate design and operation.	Constructs of research/ evaluation methodology.	Selective enrolment into communities of practice.	Emergent practitioner communities.

Part 3: Key elements influencing articulation between policy and practice



Part 4: Translation and enactment of role at local PHCT level



As indicated previously, the recommendations of the 2006 Review will initially be taken forward in a two year Implementation Project whereby the new CHN role and associated service model will be tested and refined at four Development Sites. Concurrent, integral processes also include the revision of education programmes for new practitioners and existing practitioners, workforce modelling, and a commissioned evaluation. This strongly mirrors the actions taken to advance FHN policy, and thus Parts 2 and 3 of MAPPED give a template for mapping and analysis of the major factors and processes that will be involved.

Clearly the process of preparing FHNs has illuminated the nature of some of the educational challenges (left hand side of Figure 9.3, Parts 2 and 3). In this regard two major issues are highlighted for future programme developers. Firstly, how can an optimal mixture of content be achieved when district nursing, health visiting and family health nursing have already developed areas of in-depth, "specialist" knowledge? Commentators such as Kelly and Symons (2003) argue that in this context "shared educational programmes can only lead to inferior standards of care" (p. 142). Clearly the new seven core elements for community nursing roles will serve as foci for the marshalling of appropriate educational content, but this thesis has shown that the gap between a new conceptual model and the prevailing expectations for service delivery in practice can create significant confusions and tensions.

The second, related, issue concerns transition from established cultures of professional identity. As Williams and Sibbald (1999) note, erosion of professional identity can lead to demoralisation and diminished autonomy. The FHN educational programmes in Scotland were notable for the way in which they fostered a "new" professional identity based primarily around the family element which itself incorporated distinctive North American theoretical underpinnings. The challenge for the new CHN programme developers will be to develop educational content that will credibly underpin the core constructs of the proposed role so as to enable a motivating, unifying new professional identity to emerge.

Underlying both of these educational challenges are questions about the nature of the proposed changes to community nursing practice. In particular: *how different is the new role going to be to its predecessors*? (Figure 9.3; Part 4). Again the research in this thesis is relevant, in that it suggests that simply superimposing a new role title and its associated aspirations onto members of unchanged PHCTs is likely to produce minimal change. In the case of family health nursing, this meant that the family and health aspects of the new role had limited development as the primary care system required that they prioritise ill-health related needs of individual patients. One of the strengths of the proposed new CHN role is that it will be developed within the context of a new service model requiring redesigned core nursing teams.

As alluded to earlier in this chapter, Draft 5 of the Review had raised the prospect that these core nursing teams would predominantly address the needs of geographical communities within the 41 recently developed Community Health Partnerships (CHPs) which plan the integration of local health care and social service delivery in Scotland. Arguably this would have enabled the teams to work to a public health influenced template rather than a primary medical services one.

Interestingly, twenty years previously, the Cumberledge Report (DHSS 1986) recommended a broadly similar template for neighbourhood nursing teams in the UK. However this failed to evolve in practice, mostly due to GPs' opposition to written agreements on PHCT objectives that seemed to imply that nurses "would be making an agreement as equal partners with GPs on what services should be delivered, how they would be delivered and by whom" (Walsh and Gough 1999).

As has been noted, the 2006 Review Final Report devolves any such decision on geographical or GP attached working to Health Board level (Figure 9.3; Parts 3; right hand side). As such, it is necessary to ask: *what will change for community nurses in terms of teamwork and relationships with other professionals*? (Figure 9.3; Part 4, Level 2). As the role of the Practice Nurse is not addressed in the Review's new service model, it seems likely that there will be ongoing tension between general medical services and community nursing agendas. Within this context the role of community nursing leadership (Figure 9.3; Parts 2 and 3; right hand side) is highlighted, and the 2006 Review calls for courage and strong leadership, However, it is unclear how this will be fostered, supported and effected.

9.4.2 Back to the future: revisiting Kesby's seven steps

As an intra-nursing initiative, the 2006 Review can be seen as radical in that it merges three disciplines and sets out a new service model. From the analysis of family health nursing undertaken in this thesis, however, it is necessary to question the extent to which the future development of community health nursing will be shaped by the hands, hearts and minds of nursing itself. In order to develop this point, it is useful to refer to the seven steps on the road to UK family health nursing that Kesby ambitiously set out in 2000 (p.122). Table 9.10 presents these.

Table 9.10: Kesby's seven steps on the road to family health nursing

1	Strengthen nursing policy in regard to its proactive contribution to health and social policy and in regard to devising nursing own policy, which will be capable of determining nursing practice and remit for purposes of protecting and preserving patients' interests and the care they receive. This will determine what nursing care shall be and thus will define the nursing destiny.
2	Reconnect the nursing executive with nursing practice and education, and thus unify nursing policy and strategic planning with practice and education.
3	Take up the challenge of the present presented by the RCN and let nurses take charge of their own employment by setting up independent community nursing trusts and/or creating nurse team leaders as independent primary care practitioners who would be partners to GPs. The latter would need to be supported by local nursing committees to match the local medical committees, or there could be one local primary care committee.
4	Ask the very important questions that were not asked in the 1960's: Do the patients, their families and local population need a family health nurse? Is family health nursing the most effective way to continually meet the health needs of individual people, families, and the local population.
5	This implies that the first step on the road is a revisit to needs assessment and population profiles in relation to family health nursing.
6	Clarify the concept of family health nursing accordingly, leading to a shared vision as to what this is with implications for its realization, development and maintenance.
7	Define, or redefine, as appropriate, the nursing roles in the integrated community nursing teams, including the team leader as the family health nurse, and revise their content in relation to one another. The team in its entirety should match the concept, and in its specific structure and function should match the needs and profile of the population that it has been designed to serve.

As Table 9.10 shows, Kesby was calling for UK nurses to rally round family health nursing so as to shape community nursing's own destiny. As this thesis shows, this simply did not happen. Nevertheless, the 2006 Review of Nursing in the Community suggests that several of these steps are now being taken in Scotland, on the road to new community health nursing. If community health nursing replaces family health nursing in Table 9.10, it can be argued that the SEHD Review has positively addressed point 7. In its own distinctive way, the Review has also attempted to address points 2 and 4. Moreover the Implementation Project will necessarily involve attempts to systematically clarify the concept of community health nursing for Scotland (point 6).

From an SEHD perspective it could also be argued that the Review has addressed point 1, in terms of the creation of a new framework for practice and a new service model. While this might seem plausible on initial inspection, this thesis would question whether this really amounts to devising nursing's own policy in a way that determines what nursing care shall be and defines its own destiny. Rather, community nursing is being reshaped once more in the image of the new policy preoccupations, with a premium on flexibility. This is not to say that the 2006 Review's new vision of a generalist model is wrong. What evidence there is on the respective benefits of generalist and specialist community nursing models is essentially equivocal (e.g. McKenna, Keeney and Bradley 2003). It is, however, to be clear that essentially community nursing is responding to, rather than driving, change.

This highlights the importance of point 3 in Table 9.10 which calls for community nurses to take charge of their own employment by setting up independent community nursing trusts and/or creating nurse team leaders as independent primary care practitioners who would be partners to GPs. These more radical steps are not part of the Scottish Review, although Community Nurse Consultants become part of the new service model. It is pertinent to note that nurse "entrepreneurship" is being actively talked up in the more market influenced NHS in England (Pollock 2005), both by the government and by nurse leaders (e.g. Cook 2005). Moreover, the recent Revision of the Prescription of Medicines Act (2006) opens up prescription rights radically, enabling suitably qualified nurses and AHPs to prescribe a very wide range of medicines. As such, there are considerable opportunities for more autonomous community nursing practice. The analysis in this thesis clearly suggests that a less supine posture from community nurses and their leaders could do much to open up new nurse-led approaches to care delivery.

A relevant international perspective is provided by Lauder, Sharkey and Reel (2003) who advance an argument that Australian remote and rural primary care provision should engage in a root and branch restructuring. This would see Family Nurse Practitioners and GPs as the first point of contact for rural and remote communities and Family Health Nurses as the main care providers. Based on evidence of the current system's failure to meet health needs, and evidence of the effectiveness of Nurse Practitioners, the authors argue for redesign of the whole system rather than the "fragmented and over-cautious manner in which nurse practitioners have, and are currently being, implemented in Australia" (p.3). In doing so they make the important point that at times nurses already undertake the GP role due to the demands of context. Accordingly they propose a national plan that explicitly addresses these issues through integrated redesign of services and educational preparation. Predictably this paper produced controversy and

opposition from some GPs, nurses and members of the Australian public who did not wish to see any erosion of medical cover.

Within Scotland a similar reaction could be expected to any proposal which overtly suggested that a group of community nurses should have independent contractor status like GPs and/or should substantively substitute for them in an explicit way. It has already been noted how the FHN development was managed to avoid any such associations. Indeed it also avoided exploration of how the FHN role might articulate with, or contribute to, any more radical Nurse Practitioner role. Nevertheless it was clear in the interview with Anne Jarvie that she saw integrated redesign of all PHCT roles (including the GP role) as the key for holistic community nursing development. In this respect it seems likely that there were again constraints on what could be publicly articulated by a government chief nurse. In this analysis, the FHN policy initiative and the 2006 Review can be seen as maintaining caution in regard to inter-professional boundaries, despite being seen as radical within the nursing profession itself.

The great leap forward would involve community nursing having explicit, substantive and influential policy input into the redesign of public health and primary care services as a whole. In this way community nursing development could move beyond "Type 1" change. The analysis in this thesis suggests that there are significant limits on the agency and advocacy that government nurses can or will exercise in this regard. As such, there is an onus on the nursing profession's academics, managers, practitioners and professional representatives to more effectively advocate the potential contribution of community nursing to these public services.

9.4.3 The European prospectus

The foregoing call for advocacy will have resonance for many of the community nursing leaders involved in the WHO Europe pilot. The multi-national evaluation research report (WHO 2006), which was also published in November, details the efforts that have been ongoing in various European countries to develop family health nursing. As indicated in Table 9.1, the summative picture that emerges is one of very mixed progress within and across countries. While "the results demonstrate that there is a strong commitment by policy makers, stakeholders and providers about the FHN role" (WHO 2006; p. 4), the report also finds widespread problems in relation to: public and professional understandings of the role of the FHN; change management; and funding and sustainability.

As such, the future for family health nursing across Europe is unclear. With the lead country dropping the family focus, there may not be enough critical momentum to collectively advance *family* health nursing. This impression is sustained in the 2006 Review of Nursing in the Community in Scotland which reports that National Chief Nursing Officers agreed at a recent global meeting to review the European FHN model and share experiences of other generic community nursing roles through a "community of practice models approach" (SEHD 2006c, p. 9). In a sense, this brings the thesis story back full circle to its starting point in Chapter 3 where the generalist community nurse first emerged on the policy agenda at the Vienna Conference.

SUMMARY

In order to examine the influence and implications of the development of Scottish family health nursing, this chapter firstly undertook retrospective review of contingent, concurrent developments between 1998 and 2006. At European level, the progress of family health nursing was found to have been much slower than anticipated and very mixed in nature. Differences in structures, systems, finance, healthcare needs and priorities across different countries contributed to a diverse, fragmented picture.

Trends in the development of primary healthcare in the UK, such as the GMS contract, were seen to militate against family being the primary focus for care delivery. Leadership of community nursing continued to be particularly weak. In this regard the Scottish family health nursing pilot can be seen as relatively bold and radical, as it was essentially initiated from within nursing. Other UK countries were much more guarded about the idea of introducing a higher level generalist community nurse. Nevertheless, the SEHD kept options open by initiating the second phase of the FHN pilot in 2003, and by concurrently developing practice nursing. A new round of Scottish health care policy making got underway during 2005 and the resultant policy document, *Delivering for Health*, became the main driver for Scottish nursing policy.

The "perspectus" part of the chapter, viewed and reviewed Scottish family health nursing in the light of four significant documents which were published in a co-ordinated way during November 2006. The SEHD Final Report on the FHN pilot in Scotland affirmed the value of both phases of the pilot and presented a model for family centred healthcare which required whole systems change within primary care. Concurrently the swiftly undertaken SEHD Review of Nursing in the Community in Scotland was published. This presented a new service model with a new higher –level generalist nursing role at its heart, the Community Health Nurse (CHN). The envisioned new CHN role emerged as being very clearly related to the previously envisioned FHN role. The main difference was the dropping of the family focus, and the thesis argues that this was because enacting such a focus in practice was found to be too difficult. Thus the model for family centred healthcare advocated in the "sister" publication was not incorporated in the main Review. Rather the whole systems change was applied in an intra-nursing way, so that the disciplines of district nursing, health visiting and family health nursing were merged into the Community Health Nurse role. Within UK nursing, this can be seen as a radical reform. The process of formulating this policy change was analysed using the "Agency" model constructed in Chapter 8.

The last part of the chapter looked ahead to consider implications and future prospects. The explanatory model posited at the end of Part 3 of the thesis was deployed prospectively in its revised, generic "MAPPED" format in order to analyse the new Scottish development. This highlighted many issues similar to the FHN development. The question of optimal content for an educational programme to prepare CHNs, and the related question of an appropriate theoretical basis, both loomed large. Moreover, application of MAPPED raised questions about the extent to which practice will actually change for CHNs and their nursing teams, and whether community nursing leadership can influence the policy and practice contexts sufficiently.

The chapter concluded by considering possibilities for more radical nursing development, drawing from developments outwith Scotland. In this regard, there was also reflection and projection on the WHO Europe project as a whole.

In summary, this chapter has provided retrospectus, perspectus and prospectus. The former has enabled the findings from Parts 1-3 of the thesis to be examined in the light of other contemporary community nursing and primary care developments in order to understand influence and implications. The perspectus that emerged through analysis of new Scottish policy in 2006 highlights the importance of family health nursing in shaping the new Community Health Nurse (CHN) role.

Moreover, the integrative model that has helped to explain the development of family health nursing has also proven of value when deployed prospectively in its generic MAPPED format to analyse the new policy formulation advancing the CHN role. On this basis, the MAPPED model can be seen as potentially valuable for the analysis of other developments of this type that require purview from policy through to practice.

PART 5

CONSPECTUS

A summary of the knowledge that has been built in the thesis and its significance.

"But this is history. Distance yourselves.

Our perspective on the past alters. Looking back, immediately in front of us is dead ground. We don't see it and because we don't see it this means that there is no period so remote as the recent past and one of the historian's jobs is to anticipate what our perspective of this period will be..."

Excerpt from a speech by Irwin, modern history teacher in Alan Bennett's play, "The History Boys" (2004)

CHAPTER 10

SO WHAT?

Overview

This final chapter of the thesis aims to provide conspectus, or summary, of what has been learned about the development of family health nursing in Scotland and what this means in a wider sense**.** This relates to the final thesis research question which is cumulatively addressed within this chapter i.e. *what significance has the resultant analysis for understandings of nursing and health care policy, education, practice, theory and research?* Or to use the question that Labov (1972) sees as underlying all narrative performances: *so what*?

The conspectus is structured in three sections. The first considers what has been learned about family health nursing. The second considers what this means within the context of community nursing and primary healthcare. The last section considers what other useful learning has been generated. Within each of these sections there is also summary of the contribution of the thesis, its limitations, gaps in knowledge, and related recommendations.

10. 1 WHAT HAS BEEN LEARNED ABOUT FAMILY HEALTH NURSING?

The above question can best be addressed by returning to research questions 1-3.

10.1.1 Why develop family health nursing?

The enquiry in the thesis has found that family health nursing developed in Europe as a continuation of an ongoing initiative to develop generalist community nursing with a strong public health dimension. However two key policy initiators (Dr Jo Asvall and Ainna Fawcet-Henesy) introduced the distinctive family focus in 1998 and aligned it with wider advocated policy. This reflected the beliefs that family is the key unit in society, and that nurses are well placed to engage with families on both health and illness matters. Chief Nursing Officer, Anne Jarvie, exercised similar agency in Scotland that enabled the FHN pilot project to start in 2001, although commitment to the family focus at policy level was less absolute.

The significant original contribution of this thesis is its critical analysis of: this policy formulation; the associated development of the FHN concept; and the initial advancement of family health nursing as a policy initiative in Scotland. In doing so, it has been necessary: to question assumptions that have gone unchallenged in the largely promotional literature on the topic; to further enquiry through interviews with key policy initiators; and to build understanding further by applying relevant theoretical perspectives. This has culminated in

construction of the new "Agency" model. It is contended that this model will be useful for analysis of related policy developments and an example of application has been given within Chapter 9.

The limitations of this cognate area of the thesis relate to the extent to which it is ever possible as an outsider to fully understand the political processes and influences involved in specific policy formulations. Nevertheless, it is contended that the interviews summarised in Annex 3 are notably reflexive in nature and yield considerable insights. Accordingly, two policy analysis recommendations can be made:

1) That further research is undertaken with key policy informants at European and Scottish levels to elicit their understandings of what has been learned overall from the WHO Europe FHN pilot project.

2) That, more generally, nursing researchers exploit the potential learning available by interviewing senior nurses about historically important developments in which they have had a leading role.

The thesis has also undertaken analysis of the "receiving" context for family health nursing in Scotland by examining historical, geographical and cultural influences on community nursing in the Highlands and Islands. This highlighted the lack of systematic study of community nursing practice in and across these regions. It is therefore recommended:

3) That an integrative academic study of the history of community nursing in the Highlands and Islands of Scotland 1912 – present is undertaken.

10.1.2 How did family health nursing develop in remote and rural Scotland between 2001 and 2004?

The answer to this question is best summarised by Table 6.2 which presents the set of primary understandings constructed through empirical research. After initial difficulties, and despite tensions between generic and specialist content, the educational programme for FHNs developed in an innovative way. The enaction of the FHN concept as a practice role also faced difficulties relating to operational definition, but it was possible to identify four typical patterns of practice development. Looking across these, the FHN role typically supplemented rather than supplanted pre-existing services. By 2004, FHN practice was diverse, and the overall picture of progress was a mixed one. Application of Walker and Avant's concept analysis framework enabled comparison of the envisioned FHN concept with the enacted FHN role, and highlighted the different criteria that were being used to assess role development.

This empirical research into education and practice has been important as a basis for understanding the enacted development. In the process an innovative evaluation framework has been designed and applied, and knowledge has been built through typology construction and testing. The research summarised in Chapters 5 and 6, detailed in Annexes 1 and 2, and published in the five bound-in papers comprises a substantive and original body of work that provides the most in-depth textual analysis of this phenomenon to date. This work has already influenced Scottish policy. The main limitations of this work are that it: examines some time periods in more depth than others; addresses professional perspectives more than those of patients and families; and is based on limited study of community nurse managers' perspectives. Moreover, it was originally driven by prescribed SEHD objectives.

10.1.3 Why did family health nursing develop in the way that it did in Scotland?

The thesis has had the more ambitious goal of building understanding of why matters progressed as they did, particularly in relation to policy and practice. Table 8.11 provides a narrative answer to this question by presenting an explanatory synoptic story constructed through the application of relevant theoretical perspectives to the previous set of primary understandings. This story incorporates the significant factors which influenced the behaviour of key actors, and thereby shaped the development.

These key factors and related processes are presented in a different, but complementary, format in Figure 8.1. This integrated explanatory model posits the importance of: the agency involved in FHN policy initiation and formulation; the multiple contingencies present when FHN policy was advanced towards enactment through a piloting mechanism; the key elements that were found to influence articulation between policy and practice (e.g. professional education, research protocol, and organisational structures and practices); and the importance of locally situated power, established service priorities, and the embedded culture of place in influencing the translation of policy into enactment as family health nursing practice. In doing so, the model develops relevant existing theoretical perspectives (e.g. Bergen and While's model and May et al's model) in the light of new empirical knowledge of policy, education and practice.

While the integrated model is useful for focusing on one particular development, it must also be acknowledged that a range of other initiatives/developments will be impacting concurrently at any time in the practice setting. With this in mind, the thesis has also developed the "Living Plaid of Remote and Rural Primary Care Model" (Figs 7.5 and 7.6).

It is contended that both of these models offer useful new ways of visualising and understanding healthcare developments that require purview from policy through to practice. In a new generic formulation called Model for Analysing Policy to Practice Executive Developments (or MAPPED for short), the explanatory model has been applied within the thesis to analyse the planned new 2006 Scottish community nursing development. However, the limitations of the new models constructed in this thesis relate to their specificity and limited application to date. Accordingly two further recommendations can be made which relate to theory development:

4) That the explanatory value of MAPPED is explored and developed in research involving other community nursing/primary care policy initiatives which are "top-down" in nature and involve new role development in practice.

5) That the explanatory value of the Living Plaid model is explored and developed in research involving remote and rural, and other community nursing/primary care developments.

10.2 WHAT DOES THIS MEAN WITHIN THE WIDER CONTEXT OF COMMUNITY NURSING/PRIMARY HEALTHCARE?

This section of the conspectus is concerned with the meaning of the development beyond the particular world of family health nursing. In this regard it relates specifically to research question 4: *what does this mean in terms of the development's influence and implications?* Given that the thesis has sought to build an explanation of a phenomenon in contemporary nursing history, this section also engages with Alan Bennett's challenge to view the development in historical perspective.

10.2.1 The beginning of the end: a family loss

This challenge was addressed within Chapter 9 where the Scottish FHN story was re-framed, interpreted and updated in the light of relevant concurrent and contingent developments. This means that the thesis spans the birth, development and ostensible demise of family health nursing in Scotland. However, as the analysis in Chapter 9 shows, the new CHN role proposed by the 2006 Review of Community Nursing in Scotland can be seen as a direct descendent of the FHN. Thus, at time of writing at the end of 2006, it is either the beginning of the end for Scottish family health nursing, or the end of the beginning.

If the former interpretation is made, it is predicated on losing the FHN title and the distinctive family focus. As has been seen, the educational programme was successful in fostering this focus through the family systems approach which sees the family as the unit, client and focus of care. However one of the key lessons to emerge from this thesis is that the aspiration to engage seriously with whole families across a range of health and illness issues is very ambitious and very difficult to enact within the current primary care system. For the FHNs this was exacerbated by the generalist requirement to concurrently address individuals and communities' needs. The thesis has shown how the breadth of the FHN concept at both WHO Europe and SEHD levels, made it difficult for professional colleagues and patients to understand the proposed role (particularly the family focus) and why it was needed. Moreover during the Scottish pilot there was considerable lack of clarity over: what FHNs were expected to achieve in terms of the breadth and depth of their family care; related prioritisation within the delivery of family care; and the relationship of this work to the servicing of caseloads of individual patients. As the thesis has shown, this was usually resolved at practice level by the latter demand being given priority. All these points have direct relevance for the development of the new CHN role.

This is not to suggest that all families missed out on necessary care from the individual FHNs. Rather the thesis argues that it is very difficult to systematically operationalise meaningful

family focused/centred care if it is not a priority for other colleagues and it is not incentivised through policy. Despite appearing in the Final Report on the FHN pilot to endorse Parfitt et al's model for just such a whole systems change in primary care, the SEHD position in the Review of Community Nursing shows that it does not intend to pursue this.

In a sense the whole 1998-2006 historical episode can therefore be seen as a first, and possibly last, stand for a family focused generalist role within Scottish community nursing. As the thesis has shown, the explicit family focus was out of kilter with trends in primary care provision. A close reading of the GMS contract shows that family care is essentially a contextual, rather than a focal, requirement for GPs, and that the phrase "Family Practice" is largely retained rhetoric. Beyond primary healthcare, it is interesting to note that social work has long recognised the tension between family-as-context and family-as-client in the practice setting (e.g. Horobin 1986).

In effect, the end of the episode leaves a cadre of just under 50 nurses with a distinct NMC recordable qualification that seems set to become one of the relics of the register. As they will presumably be offered the facility to become CHNs, there is further potential to learn from their experiences. Consequently it is recommended:

6) That a follow-up study be undertaken 3-5 years hence to elicit these FHNs reflections on the episode, and the key similarities and differences between the FHN role and CHN role in practice.

10.2.2 The end of the beginning: informing the future development of the generalist community nurse

Thus, the particular title of FHN will soon be defunct. If this is seen as the end of the beginning of a continuous cycle of development of the generalist community nurse, however, it is useful to summarise the transferable knowledge that has accrued.

With family removed from the centre of the picture, the relevance of the family health nursing development to broader discourse within community nursing lies in its contribution to the debate between generalism and specialism. In this regard the thesis is the first systematic study of the first national-level attempt within the UK to introduce a higher-level generalist community nursing role into the specialist-dominated present system. Nevertheless, the findings do not conclusively support either side of this debate. In effect they show that a generalist role in remote and rural regions is very useful for community nurses, their PHCT colleagues, patients and families, and communities at large. However this has not been seen to preclude the value of other specialist nursing posts that have continued to co-exist while family health nursing has been developed. Moreover, family health nursing is by no means the first generalist community nursing role to exist in the Highlands and Islands of Scotland, as triple and double duty nurses will testify.

The flexibility of the generalist nurse emerges strongly from the thesis, and there was little evidence that the new educational preparation and role aspirations were detrimental to the nurses themselves, or others. These were experienced community nurses who were able to adapt creatively to the intra-role conflicts involved. Moreover they were given much flexibility to interpret the role as they saw fit in practice. However it is difficult to know whether the advantages of generalism found in the remote and rural context would extend to the urban contexts in Scotland. The supernumerary status of the urban FHNs is too atypical to make inference in this regard.

Nevertheless, the thesis findings suggest three points of particular relevance to the new CHN role:

- preparing a new generalist higher level community nurse is a significant challenge in terms of programme content and theoretical underpinnings. The programme for Scottish FHNs showed some innovative ways forward as well as some of the pitfalls
- community nursing practice is very much influenced by local needs, context and pre-established roles. Simply re-naming a role will not ensure change. Rather, PHCT priorities and shared understandings have to be addressed

- where there is intra-role conflict because of role overload, family and health focused work tends be accorded less priority than the illness-related problems of individuals

The major differences in the new scenario envisaged in the 2006 Review of Community Nursing in Scotland are that:

- The new CHN role incorporates existing FHN, DN and HV roles, rather than just adding on a new one
- There are seven new core elements for community nursing practice and an associated new service delivery model to structure nursing teamwork

As has been seen, concerns voiced within Scotland have centred on dilution and loss of specialist skills, and related fears that health promotion and public health work will not be prioritised within the new generalist role. The thesis offers some support for such concerns, in that this was the case for many FHNs when workload was busy and triple duty nurses often described a hierarchy of priorities with community development work at the bottom.

There is also some support for such concerns about practice and educational preparation within community nursing literature (e.g. NCNM 2005; Begley et al 2004; Kelly and Symonds 2003), but relevant empirical studies are few and far between. Perhaps McKenna, Keeney and Bradley (2003)'s paper best captures the equivocal nature of the evidence in this debate. On the one side, they outline the problems associated with an over-generic community nursing workforce, using the Republic of Ireland as an example. These problems are similar to those mentioned above. On the other, they outline the problems associated with an over-specialised community nursing workforce, using Northern Ireland as an example. In the latter category, the risk of role duplication, overlap and an associated lack of one identifiable co-ordinating nurse is most prominent. It is interesting to note that the introduction of the FHN in remote and rural regions seemed to change little in this regard, because it essentially supplemented other established specialist roles.

Thus the thesis highlights both useful and more problematic aspects of the generalist role in practice, and adds to this particular debate rather than resolves it. However, there is clearly imminent opportunity to study transition from several key specialist roles into the one new generic role. The SEHD have signalled that this will be part of a commissioned evaluation. To this end, it is pertinent to recommend:

7) That evaluation of transition to the CHN role incorporates sufficient opportunity to study previous practice so that any change can be gauged and understood in context.

10.2.3 The Scottish FHN development as an exemplar

The thesis offers a particular contribution to understandings of how community nursing policy can be initiated and developed. As the thesis has argued, the FHN development in Scotland can be seen as a relatively rare example of a nursing-initiated policy, albeit one whose advancement was couched in the risk management strategy of a pilot. Within the ambit of UK community nursing, both the FHN and CHN policy initiatives can also be seen as relatively radical in comparison to the approaches advanced within the other three UK countries. Moreover, both initiatives have implications at UK national level in terms of their status on the NMC register. In this context, the development of family health nursing in Scotland 1998 – 2006 can be seen as a vanguard community nursing development. Therefore it is important that study of it is widely disseminated. To this end, it is recommended:

8) That a paper giving purview of the FHN development from policy to practice is submitted for publication, based on the work in this thesis.

In effect, one of the underlying questions with which the thesis has grappled is: how do you effect major change in community nursing? In this regard the thesis has shown the need to anticipate important factors, processes and potential problems within an integrated plan. As MAPPED has emerged as very pertinent to the new Scottish community nursing reforms, it is recommended:

9) That MAPPED is used specifically to inform the evaluation of the new Implementation Project arising from the 2006 Review of Nursing in the Community in Scotland.

This thesis has also identified the need for clarity about the nature of any new role and the change envisaged, so that other members of PHCTs may understand and support what is being developed. The Living Plaid model, developed in the thesis, may be useful in this regard as it encourages consideration of the place of any development within a particular context. Study of the Scottish FHN development shows that there is scope for innovation within community nursing at policy, education and practice levels, but that community nursing operates in a wider context dominated by medical and health service management priorities. The strength of the new 2006 Scottish community nursing reform is that it seeks to redesign the whole nursing team, rather than just fit in another role. Its weakness is that it remains essentially an intra-nursing development, with little apparent influence on the fundamental design of primary healthcare delivery systems.

10.3 WHAT OTHER USEFUL LEARNING HAS BEEN GENERATED?: THE THESIS AS AN EXEMPLAR

The thesis has pursued and analysed the development of an idea in Copenhagen, through its reformulation as a policy initiative on Calton Hill, through its enactment in classrooms in Inverness and croft houses in the Outer Hebrides, and back again. Studies of this scope are relatively rare in nursing. As Hennessy (1999) points out, studying policy and implementation processes retrospectively is potentially very valuable, but is time consuming and usually left to academics. Perhaps this study is even more unusual in studying some of these processes concurrently.

In this regard it is contended that the thesis exemplifies an innovative approach to analysing the history of an idea. The thesis design, as summarised in Figure 1.3, provides a useful framework within which the conceptual and chronological development of an idea can be explained. The challenge in this approach is that it involves a slightly different way of conceptualising and presenting a thesis (e.g. eschewing one literature review chapter). While in this instance the design framework has been applied to explain the "top-down" type of transmission and translation of an idea, it may be that it is also suited to other story types or archetypes. Moreover, it seems likely to have more generic application beyond the particular world of nursing and other practice based professions. Thus it is recommended:

10) That the thesis design framework be further disseminated as an exemplar for scholars undertaking studies of the history of ideas.

10.4 CONCLUSION

This thesis has addressed and answered five central research questions. In doing so, it has presented an original explanatory analysis of a significant development in the history of Scottish and UK community nursing, and has examined its influence and implications. The analysis within the thesis has been shown to have:

- significance for nursing policy, practice, research and theory in terms of its generation of specific new knowledge about family health nursing
- significance for healthcare policy, practice, research and theory in terms of its generation of new analytic models
- relevance for scholars in terms of its design approach
- relevance for community nursing's educators and students in terms of its analysis of the role of education within the wider development

On this basis it is contended that the thesis makes a useful academic contribution which can inform further development in the above areas.

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SCOTTISH EXECUTIVE

Evaluating Family Health Nursing Through Education and Practice

Health and Community Care

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GLOSSARY OF TERMS, ABBREVIATIONS AND ACRONYMS

APL: Accreditation of Prior Learning (certificated learning). See credit exemption.

APEL: Accreditation of Prior Experiential Learning. See credit exemption.

ASLIB: Electronic data-base of UK theses.

ASSIA: Applied Social Sciences Index and Abstracts.

Auxiliary nurse: a health worker who is not a registered nurse but who assists in the care of those on the district nursing caseload.

Caseload: a list of people receiving professional intervention for health or illness related matters. The list usually includes summary details of why they are being seen and how frequently. This report is mostly concerned with family health nursing and district nursing caseloads, but has also considered health visiting caseloads. For further information on the difficulties of the concept please see Annex 3.

CINAHL: Cumulative Index to Nursing and Allied Health.

Clinical practice assessment: Assessment of the student's ability to achieve specific learning outcomes related to the practice of nursing. Involves a range of evidence about knowledge, skills, attitudes and understanding.

Community nursing: a broad term denoting varied nursing activities that can take place in settings that range from small community hospitals/doctor's surgeries to work in people's homes. The term can include work done by District Nurses, Health Visitors, Practice Nurses, Midwives and a range of other (often specialist) nurses.

Community specialist practice qualification: a qualification that denotes ability to work at a higher level of practice within the community than a registered nurse. In the UK eight such qualifications are recognised and these include district nursing and health visiting.

Community Staff Nurse (SN): a registered nurse who does not have a specific specialist qualification to work in the community but whose work involves caring for those on the district nursing caseload.

Community Profile: a written appraisal and analysis of the FHN's geographical practice area (including community health issues).

Community Psychiatric Nurse (CPN): a registered nurse who has a specific specialist qualification to carry out mental health nursing work in the community.

Core (e.g. core module): applicable to all areas of community nursing practice.

Core Primary Health Care Team (core PHCT): a group of health care professionals whose everyday work is focused mainly or exclusively on the provision of primary care services for the population of the FHN site. The core PHCT usually comprises all the nurses involved in

the care of the DN caseload(s), all Practice Nurses and GPs from all the practices within the FHN site. It may include the Health Visitor and Midwife(s), but this tends to depend on whether they are based within the FHN site or not.

Credit exemption: as part of APL or APEL, a mechanism whereby a student is given exemption from undertaking particular course components (e.g. module(s)) if he/she shows satisfactory evidence of relevant, current and sufficient prior learning.

Distance learning: flexible mode of learning that requires minimal attendance at an educational institution. Learning materials are usually made available to students in paper or web based formats and assessments are completed at the student's own pace.

District Nurse (DN): a registered nurse who has a specific specialist qualification to carry out home visiting nursing work. Traditionally this work has involved caring for those suffering from illness or disability.

Double duty nurse: a nurse whose job combines 2 distinct professional roles. In remote and rural Scotland traditional combinations are District Nurse and Midwife; Community Staff Nurse and Midwife; or District Nurse and Health Visitor.

Ecomap: a diagram of a family's contact with others outside the immediate family. It is intended to give an overview of the family's social interactions and involvements.

Family: a group of individuals with relational connections that may be emotional and/or biological and/or legal in nature. WHO Europe's HEALTH 21 framework equates families with households, but a broader view can also be taken involving family self-definition (i.e. the family is what individual members say it is).

Family Health Nurse (FHN): a "new type of nurse" proposed by WHO Europe in 1998. Their envisaged role is community based and multifaceted. It includes helping individuals, families and communities to cope with illness and to improve their health. The full WHO Europe role definition is given at the start of Chapter 1 of this report.

Family Health Nurse site (FHN site): a distinct geographic area whose population are served by one (or occasionally two) district nursing team(s) within which an FHN is working. Other health professionals whose work involves the provision of primary care services to the population of this site are known as the Primary Health Care Team. Following the educational course, some of the FHNs were allocated a specific "patch" within the overall site and they practised family health nursing only within their given patch. By contrast some other FHNs were responsible for delivering a family health nursing service to a whole site.

General Practitioner (GP): an independent contractor who personally provides primary care medical services to a local population. Some GPs still describe themselves as family practice doctors but this title has declined in usage over the past two decades.

Generalist: pertaining to knowledge and/or practice that is not distinctive in its boundaries and requires broad understandings across a range of subject areas.

Genogram: a diagram of the family constellation which depicts the relationships among family members for several generations. Their structure resembles conventional genealogical family tree diagrams and they often include the mapping of health status/issues.

Health Visitor (HV): a registered nurse who has a specific specialist qualification and additional registration to carry out health promotion and monitoring work within communities. In the past two decades this work has predominantly involved contact with mothers and children (e.g. developmental screening) but recently the public health aspects of the role have been highlighted for priority.

IBSS: International Bibliography of the Social Sciences.

MEDLINE: International Journal data-base of published medical and health science research.

Midwife: a health professional who has a specific qualification and registration to care for women through pregnancy, childbirth and a short period thereafter.

Module: a self-defined part of a degree programme which has its own assessment processes. Sometimes the term "Unit" is also used in the same sense.

NBS: National Board for Nursing, Midwifery and Health Visiting now incorporated into NES NHS Education Scotland.

NMC: Nursing and Midwifery Council. The new regulatory body for Nursing, Midwifery and Health Visiting which recently replaced the UKCC

Nurse practitioner: a nurse who acts as first point of contact to provide health care advice and treatment to select client groups. This usually involves strong elements of autonomous and advanced practice

Objective Structured Clinical Examination (OSCE): a method of measuring clinical competence that usually involves observation of students' skills when dealing with a variety of standardised clinical problems within a controlled environment.

Placement: a community-based setting to which the student is allocated in order to learn from practical work experience.

Portfolio: a collection of evidence that aims to demonstrate prior learning related to a particular course (or course element).

Practice Nurse: a registered nurse who is employed by a GP practice to provide a range of services within the GP surgery. These vary in nature and scope but usually involve screening programmes and chronic disease management. The Practice Nurse may have a specific specialist qualification, but this requirement is not mandatory.

Primary Health Care Team (PHCT): a group of health care professionals whose work as individuals involves some provision of primary care services for the population of the FHN site. For some (the core PHCT, typically DNs, GPs, Practice Nurses) their everyday work is focused mainly or exclusively on the FHN site. For others (typically HVs, Midwives,

Community Occupational Therapists, Community Physiotherapists, CPNs) their work also involves substantial provision of services to other populations.

Primary prevention work: health care input whose main purpose is to prevent the occurrence of disease (e.g. teaching young children about healthy eating).

SCOTCAT: an acronym for Scottish credit and accumulation transfer and refers to the academic levels of learning that students have undertaken. To obtain a Bachelors degree from a Scottish University the student would normally accumulate credit at different academic levels. The levels generally equate with the year of the course: thus Level 4 would normally be the academic work undertaken in the fourth year of a classified degree programme. In the Scottish education system there are two types of Bachelors degree. The unclassified degree which finishes at Level 3 and the classified degree which finishes at Level 4. The term SCOTCAT can also be referred to as Scottish Degree Level.

Scottish Executive Social Research (SESR)

Scottish Executive Health Department (SEHD)

Secondary prevention work: health care input whose main purpose is to reduce the prevalence of disease and shorten the course of illness (e.g. screening those thought to be at risk of disease; vaccination programmes).

Specialist: pertaining to knowledge and/or practice that is distinctive in its boundaries and requires in-depth study and understanding. Often requires educational input at advanced level.

Stakeholder: a term generally used to denote a person who has an interest, share or investment in something. In this study the "professional stakeholders" at each site comprised all health care staff in the core Primary Health Care Team and all other relevant health, community and social care staff involved closely with the PHCT. "Lay stakeholders" were defined in the much more general sense of any member of the public living within the FHN site and registered on one of the relevant electoral rolls.

Supervisor: in this context a registered nurse with a community specialist practice qualification whose role is to support and educate the student in the placement setting.

Supervisory visit (also sometimes known as "social visit"): a rather ill-defined term used differently by different District Nurses, but usually referring to a general health checking visit. Often these are for the elderly and particularly those living alone. At some sites these are formally scheduled to take place every 3/6 and 12 months, at others they are done as and when required.

Support visit: again a rather ill-defined term used differently by different District Nurses, but usually referring to a more specific, targeted visit where, for example, blood pressure would be monitored.

Team Leader: a term used to describe a health professional who has a leadership role. In community nursing in remote and rural Scotland this can involve "leading" one other colleague or a large number of people. As such it has limited value.

Tertiary prevention work: health care input whose main purpose is to minimise the effects of the disease for the individual and others, and to promote rehabilitation and adaptation (e.g. education work with a person with newly diagnosed diabetes).

Triage: a term used to describe a systematic process of assessing care needs, deciding on their relative priority and planning immediate interventions (usually in the context of competing demands)

Triple duty nurse: a nurse whose job combines 3 distinct professional roles. In remote and rural Scotland the traditional combination is District Nurse, Midwife and Health Visitor.

UKCC: until recently the regulatory body within the UK for nursing, midwifery and health visiting practice. It is now called the Nursing and Midwifery Council (NMC).

Web CT: an internet resource devised by the educational provider to facilitate flexible on-line learning. Students can access a range of educational materials and participate in on-line discussions.

ZETOC: Electronic Table of Contents from the British Library.

EXECUTIVE SUMMARY

BACKGROUND

1 In 1998 the World Health Organisation (WHO) Europe proposed a new type of nurse that could be based in local communities. The envisaged role of this Family Health Nurse (FHN) was multifaceted and included helping individuals, families and communities to cope with illness and to improve their health. The FHN and the Family Health Physician were presented as the key professionals at the hub of a network of primary care services.

2 The Scottish Executive Health Department saw this as a potential solution to some of the problems of providing health care in Scotland's remote and rural regions. In these regions there is increasing difficulty in recruiting, developing and retaining all health professionals, and within nursing and midwifery sustaining the traditional double and triple duty roles has become particularly problematic. Early in 2001 a 2 year "pilot" project began. Three regions in northern Scotland were involved initially, with a fourth joining the project in 2002.

3 A Scottish University was commissioned to provide an educational programme to prepare nurses from these regions. Initially it was envisaged that two educational programmes would be available: a shortened course for nurses with an existing community specialist practitioner qualification (e.g. District Nurses, Health Visitors) and a 40 week course for registered nurses with a minimum of two years post-registration qualifying experience. When education started in February 2001, however, only the arrangements for the 40 week course were in place. Eleven students (Cohort 1) subsequently undertook this course during 2001 and twenty students in 2002 (Cohort 2).

4 The educational course was based at a campus in Highland region but students' clinical practice placements and some theory-based learning took place within their own respective regions. The Scottish Executive paid the students' salaries, course fees, travel and accommodation, and the Health Trusts/Boards in the participating regions resourced temporary replacement staff. After completing the course the new FHNs returned to their home base sites and started to develop the role in practice.

5 In February 2001 the Centre for Nurse Practice Research and Development (CeNPRaD) at Robert Gordon University, Aberdeen was commissioned by Scottish Executive Health Department to undertake an independent research evaluation. The overall aim of the study was to evaluate the operation and impact of family health nursing in specific remote and rural areas within Scotland. This included evaluation of the new educational course.

6 The evaluation design was informed by two key approaches to evaluation research (Pawson and Tilley 1997; Guba and Lincoln 1989) and by case study methods (Yin 1994). As such, the evaluation was primarily grounded in qualitative research methodologies, but it also incorporated quantitative data obtained from questionnaires.

7 The pilot project's goal was thus to simultaneously develop and integrate a new education programme and practice role within a short space of time while under the scrutiny of an independent research evaluation. This ambition was bold, innovative and inherently challenging.

THE EDUCATION OF FAMILY HEALTH NURSES

8 The educational course award was Bachelor of Nursing in Community Studies (Family Health Nursing). The course was designed to be compatible with a curriculum suggested by WHO Europe, and with the UKCC (now NMC) framework for nursing specialist practice qualifications. Validation by the NBS (now NES) was completed in July 2001. Students attended full-time and undertook a fixed sequence of modules.

9 Evaluation of this course involved systematic collection of evidence pertaining to comparative educational processes (e.g. review of other relevant curricula), participant experiences (e.g. interview and questionnaire data from students, supervisors and teachers), and performance (e.g. observation of teaching and assessment; review of course work).

10 Between the commencement of the first and second cohorts of students (Feb 2001 and Feb 2002) a number of major curricular modifications took place. These included clarification and revision of learning outcomes; construction of a scheme for Accreditation of Prior Learning; development of a programme to prepare supervisors; and development of assessment methods and course documentation. Evaluation has focused on this more developed curriculum.

11 Evaluation was also informed through review of educational curricula documentation pertaining to community-based courses for nurses, midwives and health visitors across all Scottish University Higher Education providers. These courses differed from the family health nursing course in that they gave students more flexibility to negotiate learning outcomes and the time taken to complete the programme. They also typically shared core modular content with other community education courses.

12 The family health nursing course differs from these courses (and WHO Europe's suggested curriculum) in that it has no modules dedicated to quality issues, teaching and supervision, management or leadership. Rather it is much more focused on its speciality and is theoretically grounded in an ideology of nursing which combines elements of Family Nursing from North America with the promotional ideas from WHO Europe.

13 However the course also incorporates a range of generic content and the combination has not always been congruent. This is seen particularly in the module on Advanced Family Health Nursing Practice where there is lack of definition, challenge and match of content to assessment procedures.

14 Eleven of the Cohort 2 students obtained some exemption under the scheme for Accreditation of Prior Learning. This meant that they did not have to attend campus during their "AP(E)L" weeks, but most had to return to their jobs, and all still had to complete the modular assessments. This was an unsatisfactory practice from the perspective of students, teachers and by any understanding of APL and APEL processes.

15 As such there is scope for course redesign and the report suggests a restructuring of modular delivery as a starting point. This involves having two modules in the first semester that could be shared with other community based programmes and facilitate credit exemption.

16 The nurses who undertook this course were typically middle-aged females with considerable experience of nursing in general, and of community nursing in their particular remote and rural location. Twenty (65%) were midwives. Twenty (65%) had no specific community specialist nurse qualification and were employed in E or F grade posts. Cohort 1 students in particular felt undervalued and underdeveloped prior to coming on the course.

17 Practice placement supervisors were typically District Nurses or Health Visitors. During the first eight months of the first year of the course, a range of problems with support and supervision was apparent. Students and supervisors concurred on the need to improve selection, preparation and support for supervisors. Many of these difficulties were subsequently addressed and Cohort 2 students were significantly less dissatisfied with their placement experiences. However some problems persisted, with supervisors still not feeling well prepared and lacking dedicated time for the role.

18 Both cohorts of students identified communication skills (e.g. interviewing, listening) and family health assessment/promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) as the most valuable skills they had learned during their clinical placements. The family health skills were seen as central to their emergent new professional identity. The single most valued aspect of campus based learning was the actual process of coming together to learn, share ideas and experiences. In addition family systems theory, communication and IT skills were emphasised, along with research.

19 Teachers also saw the balance between campus attendance and distance learning as being a strength of a course that was very much tailored to a specific market context. There was recognition that to be viable in other contexts the course would require modification. This might involve a greater proportion of distance learning through the innovative web based facility used during the course. On return to practice some of the new FHNs remained active in using the web based facility to maintain learning and support, but five lacked access to reliable internet facilities at work.

20 One of the persistent difficulties for students, supervisors and educators was the simple fact that until 2002 the FHN role was hypothetical. This entailed much uncertainty. Students were concerned about using families for assessment purposes and then moving on while the family's care reverted to established services. The fact that this new way of working was only being used for educational purposes in the first instance raises a number of important issues regarding: the introduction and management of a new role into an established service; the ethics of using students as change agents and the expectations of the public.

21 Considerable effort has gone into the educational preparation of Family Health Nurses. The resultant programme is distinctively different from other specialist community nursing programmes and has growth potential. In this regard a number of suggestions for further curriculum development are made within this report

22 The evaluation has highlighted strengths and weaknesses within an educational course that provides a precedent for other educational providers to reconsider their approach to specialist practice degree level education.

FAMILY HEALTH NURSING PRACTICE

23 In evaluating family health nursing practice the principle unit of analysis was the site where each FHN was working. During 2002 ten FHN sites were studied in depth. This involved extensive profiling of local context; health needs; Primary Health Care Team (PHCT) staff, roles and working practices; and caseload size and mix. Each site was visited several times to interview staff, collate data, take field notes and undertake limited observation of practice. The care of two families at each site was studied in detail.

24 From these 20 families six were selected for in-depth case study. This involved interviewing family members, the FHN, and a maximum of two other health professionals who had involvement with the family.

25 Questionnaires were sent to all the members of the Primary Health Care Team at each site prior to the introduction of the new role and again one year later. In the same way a more limited questionnaire was sent to a random selection of 20 members of the public at 7 of the sites. These questionnaires asked for views on the operation and impact of the new role.

26 Through analysis and synthesis of the above data sets it was possible to construct a typology of family health nursing practice. This identified four distinctive patterns relating to the context of the development, the process of engagement and the outcome of practice. These "CPO" patterns were subsequently given brief labels.

27 Two small island sites shared the following ***High scope-slow build*** pattern:

Context: Small, stable caseload. High pre-existing scope for nursing autonomy and practice development
Process: Gradual introduction of the role by FHN only with little/no change in other professionals' working practices
Outcome: Positively viewed by the limited number of families who received the service, but not seen by colleagues and general public as substantially different from pre-existing service. More satisfying for FHNs but also more demanding

28 Three sites covering large geographic areas shared the following ***Slow build-key ally*** pattern

Context: FHN role super-imposed on "non-heavy" district nursing caseload within established and functional medium sized PHCT
Process: Gradual introduction of the role by FHN with active, focused support from one or more professionals within the core PHCT
Outcome: Positively viewed by the limited number of families who received the service (often specific client groups). "Normal" district nursing services maintained. FHNs generally feel they are making progress

29 Four sites shared a ***Slow/No go*** pattern, with three having the following pattern:

Context: FHN role super-imposed on "heavy" district nursing caseload within established and functional medium sized PHCT.
Process: Sporadic and limited introduction by FHN only, with little/no change in other professionals' activities.

Outcome: No substantive change in practice. "Normal" district nursing services maintained, but remains stressful for FHN and colleagues.

30 One site had a distinctive ***Bold build*** pattern:

Context: "Heavy" district nursing caseload within established medium sized PHCT, but FHN not super-imposed.

Process: New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals' roles. Tensions within core PHCT.

Outcome: Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. "Normal" district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding.

31 Thus evaluation of the first year of family health nursing practice found that the role can be developed in a limited way on top of a district nursing caseload and within pre-existing resources. This typically involved the supplementation, rather than the supplanting, of "normal" community nursing activities.

32 The presence of at least one of the following two factors appeared to be a necessary condition for progress: (i) the perceived scope/space to encourage implementing this approach (ii) the local presence of at least one active supporter who changes their own practice

33 The in-depth family assessments that the FHNs tried to undertake tended to be time consuming and difficult to orchestrate. However this new approach was generally well received by family members. Few professional colleagues were active in referring families to the service and even where the role was legitimised through referrals it could not necessarily be prioritised by the FHNs as there was a "bottom line" expectation that the pre-existing level of community nursing service must be maintained.

34 At one site the role was developed outwith the district nursing caseload and the FHN practised in a more autonomous way. Again family health nursing supplemented pre-existing services by expansion into gaps, but characteristically this involved more sustained, in-depth care programmes. This presents a different type of role that has more potential resource implications if replication is sought.

35 During the first year of practice FHNs usually operated alone and their activities were often not well understood by colleagues. This made integration problematic. There is a need for much stronger local programmes of support and facilitation if the role is to be developed and sustained. This should be part of wider review and development of PHCT working practices and should include review of caseload management and staff skill mix.

THE WIDER SCOTTISH CONTEXT

36 In order to inform our judgements about the applicability of a family health approach to community-based nursing in the wider Scottish context, we carried out 19 telephone interviews. These were held with key informants selected from other Scottish NHS Trusts and Health Boards providing primary care services and their respective Local Health Councils. Perceptions of existing community nursing services, education and the potential of the FHN role were explored.

37 These findings suggest that overall community nursing services are adapting to the policy changes which have been advocated and that current educational provision is generally perceived as good. However there were concerns about duplication of effort, territorialism and recruitment. Perceptions of family health nursing varied widely.

IMPLICATIONS FOR ROLE DEVELOPMENT

38 We found that the educational process for family health nursing has provided experienced nurses with personal and professional development encouraging a graduateness to emerge whereby the individual can reflect and analyse situations. All students have attempted to embrace the ideology behind family health nursing but so far the majority have struggled to substantively incorporate the ideas into practice.

39 We suggest that there are three areas where active facilitation is required in order that the role of those Family Health Nurses currently in post can be developed further:

- Enabling the FHN role to merge with current service provision in a meaningful way
- Developing the core primary health care team in order that they can incorporate a more systematic focus on family and health into existing services and care practices.
- Involving patients and the wider community to expect, accept and value a different approach to nursing care in particular and health care in general.

40 Furthermore we suggest that prior to introducing family health nursing as a new role service providers conduct a comprehensive analysis to plan, facilitate and sustain the development. This should include situational analysis (e.g. why is the role needed?); role analysis (e.g. what work will be done in the new role); cultural analysis (e.g. how will it fit with current practices and understandings); and business analysis (e.g. what resources are available to support and sustain the new role). As such, any development of the FHN role should be considered as part of wider service review and redesign. This would enhance the potential of the FHN role to be a solution to the particular problems of recruitment, development and retention of staff in remote and rural areas.

41 It seems likely that in the short term in Scotland there will be inherent ongoing tension between the distinctive family focus of the role and the demand within the system for generalist activities prioritised around individuals' needs. Whether this tension proves dysfunctional or not will depend on the extent to which the role can be facilitated and the extent to which PHCTs are willing to engage in practice review and service redesign. If the latter activities are successful it is possible to envisage the *Slow build* types, and the *Slow/No*

go types, developing significantly as part of more integrated, family orientated services. In turn this would lead towards a critical mass being achieved that would present a stronger argument to inform debate about changing the present UK system of community specialist practitioner roles.

42 This evaluation has studied the formative stages of the Family Health Nurse role. In attempting to simultaneously develop national policy, education and service delivery the FHN initiative in Scotland has achieved much in a short space of time, but so far the scope of the necessary change process has been underestimated. In order to capitalise on the achievements to date we suggest that:

- Planned development is facilitated with those PHCTs that include a Family Health Nurse in order that the role can be understood and developed further.
- The critical mass of FHNs is helped to grow in the remote and rural areas.
- The educational programme is further developed as suggested in Chapter 2.
- The evaluation is disseminated widely across the UK to foster debate and critical thinking about the nature of community nursing services and suitable educational preparation.

43 The evidence from this evaluation indicates that considerable effort has gone into this initiative. What has been achieved to date should neither be underestimated nor allowed to wither on the vine.

PREFACE

Since devolution in 1997 a number of distinctive policy developments have influenced the practice of health, education and social services within Scotland. Changes in the structure of the health service, a refocusing on public health and the development of policy pertaining to social justice have led to the introduction of a programme of initiatives at grass-roots level that attempt to develop services and annexe previously uncharted health ground. This is exemplified by the various social inclusion programmes which have been developed across Scotland; the redesign of health services especially in remote and rural areas; and the introduction of the role of public health practitioners. The initiative to "pilot" [1] the World Health Organisation (Europe)'s Family Health Nurse concept in remote and rural areas of Scotland can be seen as part of this greater impetus to look at new ways of working within health and social care.

In attempting the co-ordinated introduction of this new, national level, generalist community nursing role the Scottish Executive has taken forward a bold and ambitious initiative. This initiative has sought to simultaneously develop and integrate a new community nurse education programme and a new practice role within a short period of time. Such work is complex and has involved co-ordination over a large geographical area and across disciplines. Those involved in change management in primary care services will recognise the magnitude of this challenge, especially given the established culture of specialist community nurse education and practice within the UK.

Leadership work of this type entails willingness to take some risk in the process of moving forward. At the project's inception, the Scottish Executive commissioned this concurrent, independent research evaluation so that lessons could be learned and shared about the operation and impact of family health nursing. This aspiration has enabled our work as evaluators and in this spirit the report seeks to contribute a perspective that is both critical and constructive.

The report presents a detailed account of the evaluation and is aimed at those with an in-depth interest in the subject matter (e.g. particular health service staff; educationalists; researchers). It is organised in five chapters, each of which is designed to be sufficiently free-standing that it can be viewed in isolation by the reader with a particular interest. Chapter 1 sets the scene by establishing the context of the evaluation. Chapter 2 overviews educational context before presenting a detailed examination of the educational preparation of the Family Health Nurses. Chapter 3 examines the family health nursing practice that took place during 2002. The Scottish primary care policy and practice context is then examined in Chapter 4 as a basis for consideration of the implications for further development of the FHN role in Chapter 5. The

[1]The adoption of the term "pilot" in the Scottish Family Health Nurse Project suggested that it would be tested, controlled and manipulated to determine its efficacy. However, like all good social experiments control over the Family Health Nursing initiative has been impossible to achieve in a dynamically charged context of primary care where change is constantly being introduced. As the evaluation progressed the term "pilot" gave way to "action research" with a few key brokers using this language in an attempt to appreciate what was happening as unforeseen developments took place. From our perspective the Family Health Nursing initiative could not truly be considered as "action research". There was limited systematic incorporation of formative intelligence from the evaluators; practitioners or educators. At the end of the day what we have is the evaluation of a policy initiative not the strict testing of a Pilot nor the evaluation of an action research project.

report includes several annexes, but full details of the research tools and procedures used are available separately on CD Rom from the authors.

The report focuses very much on the Scottish experience of implementing the Family Health Nurse concept. At WHO Europe level it was initially suggested that 17 other continental European countries would also be taking part in the development of the new FHN role through parallel processes of education and implementation. These linked national initiatives were to be termed "pilot" projects and would include evaluation of structures, processes and outcomes. During the past three years, however, it has become increasingly apparent that Scotland is very far ahead of other counties in terms of enactment. This is curious and cannot wholly be explained by the fact that different countries will start from different levels of readiness. Further investigation of the reasons for this would be beneficial to any subsequent action-based simultaneous development of nursing practice and education across different nation states.

However we hope that this report will prove of some interest to other European countries. As it seems likely that a range of different audiences may be interested in various aspects of the Scottish experience, other formats for dissemination have been prepared. In addition to this full report, a very concise summary of the research findings is available to download from the Scottish Executive Social Research website (http://www.scotland.gov.uk/socialresearch). Finally the Scottish Executive has published a concise process and policy orientated report on the project to date and this includes consideration of the evaluation findings detailed in this document.

CHAPTER ONE THE CONTEXT OF THE EVALUATION

1.0 INTRODUCTION

This report presents the findings of a study commissioned by the Scottish Executive Health Department and carried out by the Centre for Nurse Practice Research and Development[2] (CeNPRaD) between February 2001 and December 2002. The overall aim of the study was to evaluate the operation and impact of family health nursing in specific remote and rural areas within Scotland. This included the evaluation of a new educational course devised to prepare Family Health Nurses (FHNs) for practice.

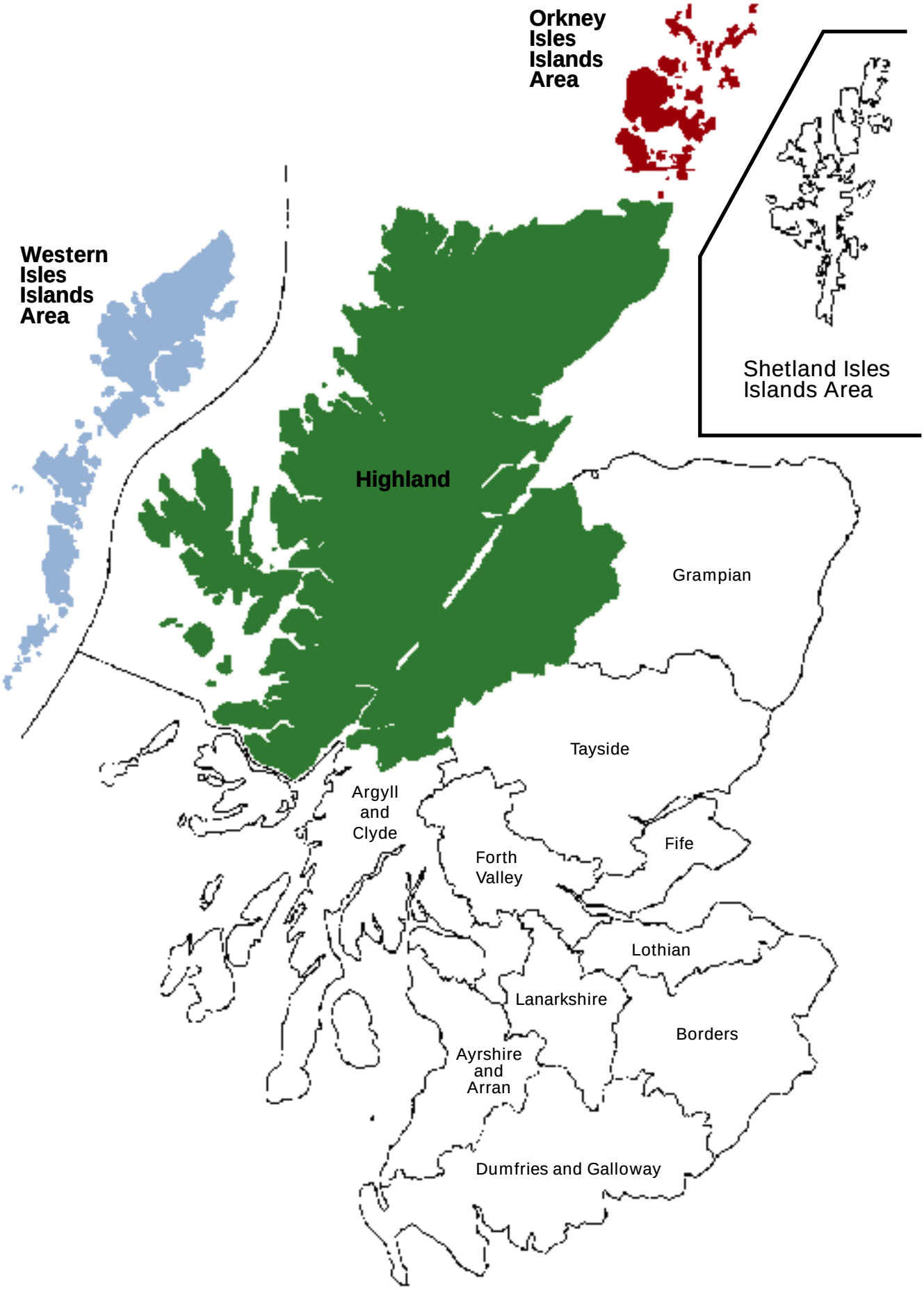
1.1 BACKGROUND

The Family Health Nurse (FHN) concept was introduced by the World Health Organisation (WHO) Europe as a possible means of developing and strengthening family and community oriented health services (WHO 1998a). Within the HEALTH 21 health policy framework it was proposed that this new type of nurse would make *"a key contribution within a multi-disciplinary team of health care professionals to the attainment of the 21 health targets set in the policy."* The full definition of the new role states that "*The Family Health Nurse will: help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family's health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise"*. (WHO Europe 1998a).

The framework posits the FHN and the Family Health Physician as the key professionals at the hub of a network of primary care services. The Scottish Executive Health Department (SEHD) saw this as a potential solution to some of the problems of providing health care in Scotland's remote and rural regions and during 2000 began preparatory work for a Pilot project. Three regions subsequently became involved in this work (Figure 1.1 overleaf). Within these regions populations are characteristically sparse, ageing and declining in numbers. Health profiles are poor, with high incidences of cardiovascular disease and cancer, and socio-economic problems such as unemployment and poverty are relatively widespread. Geographic isolation is associated with transport difficulties, and the regions suffer from migration of the young to urban towns and cities. Recruitment and retention of skilled nursing staff has become increasingly difficult.

[2] For further information about CeNPRaD see our website www.rgu.ac.uk/subj/cenprad.

Regions participating in first year of Scottish Family Health Nurse pilot



The SEHD summarised the principles of the FHN role as:

- A skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required.
- A model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.
- A role founded on the principle of caring for families rather than just the individuals within them.
- A concept of the nurse as first point of contact.

A Scottish University was commissioned to provide the educational programme to prepare nurses from these regions. Initially it was envisaged that two educational programmes would be available: a shortened course for nurses with an existing community specialist practitioner qualification (e.g. District Nurses, Health Visitors) and a 40 week course for registered nurses with a minimum of two years post-registration qualifying experience. When education started in February 2001, however, only the arrangements for the 40 week course were in place[3]. Eleven students (Cohort 1) subsequently undertook this course during 2001 and twenty students in 2002 (Cohort 2).

The project in Scotland was initiated by The Scottish Executive Health Department. A Project Officer was appointed to co-ordinate national and regional activities, and to liase with other European countries. A National Steering Group was convened and met regularly during the course of the project. Local Steering Groups were also set up at regional level. During the evolution of the project a Role Implementation Group was also set up to address emergent issues around FHN documentation, activities and professional boundaries. A further remote and rural region joined the project in 2002.

Following a process of competitive tendering CeNPRaD was commissioned by Scottish Executive Health Department to undertake an independent research evaluation based on the following six objectives:

1 To evaluate the education programme curriculum and consider how well it fits into the Scottish context.

2 To evaluate the learning experience and preparation of FHNs and the support provided to them in placements, focusing in particular on the role of mentors and differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course.

3 To compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN.

4 To explore the operation of the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites.

[3] A formal shortened course was not developed during the two years of the project

5 To identify relevant stakeholders' perceptions of the FHN model.

6 To draw out implications from the study's findings for the future provision of education for FHNs and for the extension of service provision to other areas of Scotland, including urban areas.

This report addresses these objectives within five chapters. The current Chapter 1 develops context for the reader by critically reviewing several key concepts and by outlining the principles of the evaluation's design. Chapter 2 examines the educational preparation of the FHNs and considers implications for course development (objectives 1,2 and 6). Chapter 3 examines FHN practice at 10 sites, presents the typology that emerged, and draws together common themes from practice (objectives 3,4 and 5). Chapter 4 examines the wider Scottish context in terms of policy (objective 6), community nurse education (objective 1) and primary care practice (objective 6). This sets the scene for Chapter 5 which draws together the study's findings in order to consider the implications for further development of the FHN role through education and practice (objectives 1 and 6).

Literature searches and reviews of national policy, research documents and published information sources relevant to community-based education programmes and service development have been ongoing throughout this research. The following subject areas have been pursued through the literature:

- The Family Health Nurse as a concept and as a practised role
- Family nursing
- Community nursing (including district nursing; public health nursing and health visiting)
- Rural/remote nursing and primary health care
- Educational preparation for the above subject areas
- Research in the above subject areas

This has involved searching ASSIA, ASLIB, British Nursing Index, CINAHL, COCHRANE, IBSS, MEDLINE, Nursing Collection, Social Science Citation Index and ZETOC electronic databases for post 1990 journal publications and searching Scottish University Library databases for relevant publications in book format.

These searches have generated a great deal of literature that has informed our thinking during the project. Rather than presenting exhaustive and exhausting reviews of the above subject areas, we have chosen to use relevant literature primarily to inform interpretation of our findings. Thus the report is heavily weighted towards presentation of our own research findings. However to give a frame of reference for the reader, three key concepts are now briefly critically reviewed in relation to the Scottish context.

1.2 REVIEW OF KEY CONCEPTS

1.2.1 Community-based nursing

Within the UK community nursing denotes a very broad range of activities which can take place in a variety of settings (e.g. small community hospitals/doctor's surgeries; peoples' homes; the streets of large cities). Nurses working in these settings in the UK must be

registered with the National Nursing and Midwifery Council (NMC; formerly known as the UKCC) who regulate standards of practice. In addition many nurses will also hold a community specialist practitioner qualification. These include:

- District Nursing (Nursing in the Home)
- Health Visiting (Public Health Nursing)
- General Practice Nursing
- Occupational Health Nursing

Brief explanations of these categories are given in the Glossary to this report. Other specialist nurses working in communities may have expertise in the care of people with specific disease (e.g. Macmillan Nurses for cancer care; Diabetic Specialist Nurses). Midwives are also active in UK communities, caring for women through pregnancy and childbirth.

This diverse array of professionals has evolved in an attempt to meet the health care demands of varied populations. However the community nursing workforce in the UK is frequently criticised as being over-specialised and fragmented (Hyde 1995) to an extent that may be dysfunctional not only for the professions, but also for the public whom they serve.

These types of concerns appear to have informed recent policy documents within Scotland. Nursing for Health (SEHD 2001) states that "*The Scottish Executive will review with all interested parties the outcomes of the new public health and family health nurse programmes with a view to having only two routes to community specialist practice - the Family Health Nurse and the Public Health Nurse*" (p.61).

1.2.2 Family Health Nursing

Unsurprisingly material pertaining specifically to the FHN concept as outlined by WHO Europe is limited, so most of our review on this concept pertains to the WHO publications and associated output. The definition of family health nursing as set out by WHO Europe is broad in its aspirations to meet the needs of individuals, families and communities. Thus it is almost impossible to articulate a unitary operational definition. In the WHO Europe video of family health nursing a range of very different nursing practices and practitioners are presented in order to exemplify practice. Such diversity helps to promote the ideology but causes problems for the analyst in trying to make sense of inconsistency and contradiction.

In effect the WHO Europe idea of family health nursing signifies an aspiration for a pan-European nursing role. Within the main WHO Europe document (2000) family health nursing is portrayed as the central stanchion in the "*umbrella of public health and primary health care*". In a context where there is inadequate or no multi-disciplinary community health care provision then the WHO Europe Family Health Nurse-led service has the potential to be enacted with the nurse being the key co-ordinator of all services and referrals. However an umbrella is seldom the covering of choice in remote and rural Scotland, and as a conceptual framework, and as a metaphor, this portrayal is rather naïve for a context where community health care provision is long established through resource deployment, professional power dynamics and political climate.

Three concepts that have positive connotations but are notoriously difficult to define (viz. family; health; and nursing), have been combined within one role descriptor**.** What emerges

from reviewing this predominantly descriptive literature is the need for caution in assuming these commonly used terms have a unified meaning. Diffuse practice examples pertinent to specific cultural groups are used by WHO Europe and others to exemplify the concept and articulate the ideology of family health nursing (e.g. Chronic disease prevention and management for Type 2 diabetic patients; care of a family where the mother has breast cancer; care of a single person suffering from metastatic breast cancer; care of a family with mental health and alcohol related problems; or care of an elderly couple with poor health). Such examples suggest that a family health nursing approach to the delivery of care by nurses has universal utility. This in turn raises questions for the Scottish context where the educational award is a community specialist practitioner qualification.

There has been a tradition in North America for Family Nursing. Key authors such as Wright and Leahey (1994); and Friedman (1998) have been influential in contributing to the education of nurses, shaping practice and informing curricula development. In particular their frameworks for assessment and intervention with families have been widely deployed or used to inform practice in different countries. The frameworks draw upon ideas from a number of theoretical traditions and practice disciplines, but the dominant paradigms are systems theory and family therapy. Their frameworks are primarily designed for in-depth work where the family is the client and key unit of analysis. The influence of the Wright and Leahey (1994) and the Friedman (1998) texts is absent in the WHO Europe vision. These books, (along with Whyte 1997), have been used as core texts by the Scottish Educational provider of the family health nursing course. Two main paradoxes ensue from this observation. Firstly, is the Scottish approach a functional hybrid of family nursing and family health nursing as advocated by the key authorities or has it's germination been affected further by the Scottish environment?

Secondly, as Gillis (1999) comments the level and nature of nursing engagement proposed by Wright, Leahey and Friedman indicate a level of specialism in nursing practice. The envisaged role of the FHN from the WHO Europe, from the Scottish Executive Department of Health and the educational provider suggest that the role is one of a highly skilled generalist nurse. Is the Scottish approach therefore also an educational hybrid in terms of curriculum construction?

Generally speaking hybrids are difficult to nurture, sustain and develop where fertile species are well established. However within remote and rural Scotland concern has been increasing about the fertility and sustainability of existing species of community based nursing. In using this metaphor it is intended to articulate the potential vigour of such a hybridisation process to the construction of community-based education and the practice of nurses, midwives and health visitors especially in the remote and rural areas of Scotland. Thus we will return to these questions later in the report.

1.2.3 The remote and rural context

Literature on remote or rural health care in Canada, USA and Australia was also reviewed. In these contexts the role of the nurse practitioner or advanced practitioner has been developed as solutions to problems of remoteness. Educational courses up to Masters level have been developed to prepare these practitioners (Ross 1999). A shortage of family physicians or general practitioners coupled with the difficulty of recruiting health care professionals into

these remote or rural areas have often been cited as precursors to the development of the nursing role.

The world organisation of family doctors (WONCA) has recognised since its inception in 1992 that there is a need for special preparation of health professionals to meet the health care needs of rural people and have recently stated that "*The Rural Health Team is a multidisciplinary team of health workers functioning often in a way beyond the normal boundaries of their own discipline ... Providing health care in rural areas requires a well trained and experienced health care team that works closely with a community and is responsive to their needs and preferences"* (WONCA 2001 Policy on rural practice and rural health; cited in RARARI 2002a p62).

The significance of the rural context for other services has also been recognised (for example relevant work has been carried out within social work (e.g. Horobin 1986; Lishman 1984) and by social geographers who have conducted studies in the remote and rural areas of Scotland (e.g. Clark 1997). Furthermore some small-scale medical studies of GP practices in such areas (e.g. Hamilton et al 1997; Cox 1997; Deaville 2001) also illuminate the special demands of context. This body of literature suggests that rural and remote areas have special conditions in terms of living environments, transportation, community cohesion and participation. Each of which it is contended affects the role of the health professional in particular.

Health professionals working in remote and rural contexts have expressed concerns about the community and the availability of telehealth and personally responsive health services (WONCA 2001 Policy on rural practice and rural health; cited in RARARI 2002a). In the literature reviewed there has been a limited concern for the focus of health care to move away from the individual client to that of the family as client**.** Indeed the WHO framework for the development of general practice/family medicine in Europe (WHO 1998b) essentially views families as context, and the generalist paradigm prevails in literature from WONCA Region Europe (The European Society of General Practice/Family Medicine) and EURIPA (European Rural and Isolated Practitioners). The notion of family health nursing as promulgated in the Scottish context urges the nurse to relate to the family as the client. This again presents us with a paradox in that the notion of the client as the family contradicts with commonly held beliefs and practices of individualised health care. We will return to this observation in our examination of the actual practice of the family health nurses.

Undoubtedly remote and rural contexts have been recognised as different from urban contexts of health care. Concentrating the Family Health Nurse initiative within remote and rural areas provides us with the opportunity to evaluate its relevance and application for these contexts but does make sureness of transferability to major urban contexts difficult.

1.3 EVALUATION DESIGN

1.3.1 Overview of design

In conducting this evaluation, and in addressing the six given objectives, it has been essential to sustain research interpretations at four levels of analysis:

1. Application to the education and practice of community-based nurses, Health Visitors and midwives across Scotland.
2. Relevance to remote and rural health care provision in Scotland
3. Application and relevance to the particular local contexts where the Family Health Nurses have been working
4. Application and relevance to direct face to face experience of education and in practice.

This approach to knowledge building has its scientific foundations in frameworks of social science explanation building (Newman & Layton 1984 Fiske and Taylor 1991 Becker 1950 & 1976, Bandura 1986) and relies on the construction of meaning, through interaction, filtration, interpretation and inference. Figure 1.2 (overleaf) presents a model of the interpretative research processes which were followed in order to articulate our explanations.

Such a multiplex evaluation has required the integration and synthesis of the most useful parts of two key approaches to evaluation research (Pawson and Tilley 1997; Guba and Lincoln 1989). Thus in our design[4] we have utilised a longitudinal comparative approach to evaluate changes coupled with in-depth studies of the cultural constructions and the personal experiences of those involved in the education and practice of family health nursing.

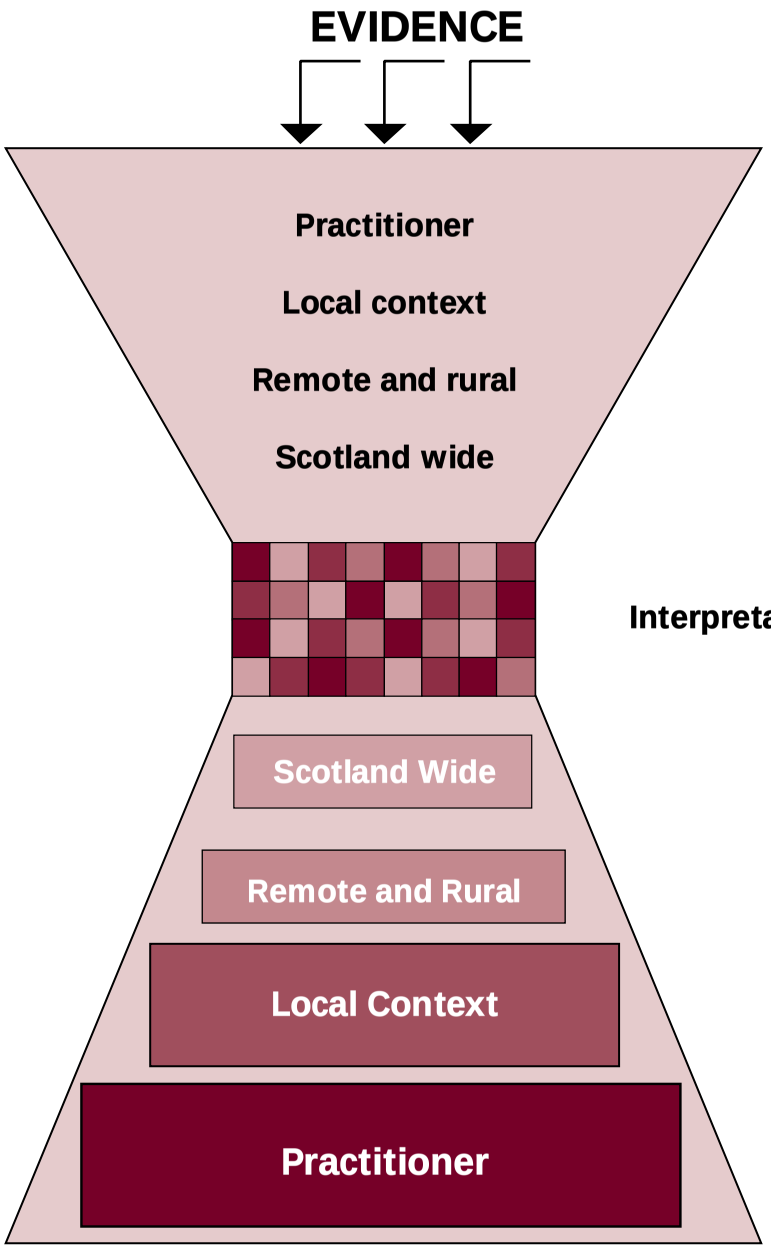
Evaluation of the educational preparation of the Family Health Nurses entailed a systematic collection of evidence pertaining to comparative educational processes, participant experiences and performance. Details of the data collection and analysis procedures involved are presented in Chapter 2.

In evaluating practice our overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot. This approach adapts Pawson and Tilley (1997)'s realistic evaluation framework in order to clarify what FHN practice is in these settings, and then clarify how, and to what extent, the FHN role works under various circumstances. As such, the ten FHN sites active during 2002 were seen as the main units of analysis in this study. Explanatory case study methodology (Yin 1994) also informed this approach. Details of the methods and procedures for data collection and analysis are presented in Chapter 3, Annex 1 and Annex 2.

Examination of the wider Scottish primary care context was undertaken through a combination of policy literature review and telephone interviews with key informants. Details of the data collection and analysis procedures involved are presented in Chapter 4.

[4] Full details of data collection tools are given in a supplementary CD Rom which is available from the authors

Interpretative Research Processes



Sureness of explanation

Strength of Application

1.3.2 The role of the evaluators

The research was designed to respond with some flexibility to an evolving project. This is a very necessary requirement for the evaluation of a policy initiative, as is an awareness of the inherently political nature of the undertaking. During the process of the evaluation there was a need to feed-in some intelligence (e.g. ethical clearance and access, reports to the advisory group, concerns over service issues, and assurances about the evaluation processes). We have also been aware of: the differential power of various voices, and the actual and imputed influence of these on the education and practice of Family Health Nurses (e.g. the Steering Group members; the FHNs themselves, the patients, key allies and professional rivals in primary health care teams). As evaluators there was always tension between getting close enough to engage with the experiences of the participants and maintaining independent, critical perspective.

Contemporary debate within the world of evaluation research is concerned about explicating the role of the evaluator. Leading theorists (Scriven 2003, Eisner 2001) have suggested that evaluators make judgements by bringing to bear a connoisseur's perspective which guides the reader and the sponsor to an appropriate judgement. Other evaluation researchers (House and Howe 1999) have argued that the evaluator should add intelligence into the evaluation context in order that those involved can make better judgements. Finally there are those (Lang 2001) who argue that evaluators have no warrant to make a judgement rather they should act as brokers to provoke and support the judgement of others.

We incline more to the first two positions and will endeavour in the ensuing three chapters to make explicit our evidence for judgements about key aspects of the education programme, family health nursing practice, and the wider Scottish context. However we are also mindful of the creative writing adage "show, don't tell" and have aspired to include sufficient qualitative data within the main text and annexes to allow the reader to draw his/her own conclusions.

CHAPTER TWO EDUCATING FAMILY HEALTH NURSES

2.0 INTRODUCTION

The establishment of degree level education for those nurses who work or seek to work in community and public health settings has resulted in an array of specialist qualifications designed to meet the health care demands of varied populations. In 1994 the former UKCC (now NMC) stated that:

"Specialist practitioners should be able to demonstrate higher levels of clinical decision making and will be able to monitor and improve standards of care through supervision of practice, clinical audit; the provision of skilled professional leadership and the development of practice through research, teaching and the support of professional colleagues" p3

Consequently community-based educational programmes have been constructed around these professional values. This part of the report aims to evaluate the curriculum of the family health nursing educational programme in order to consider how well it fits into the Scottish context of community based education and service requirements.

In addressing this aim a considerable volume of research, policy, educational and service information has been synthesised and simplified for reporting purposes. The knowledge utilisation processes adopted have been explained in Chapter 1.3.1 and Figure 1.2 .

2.1 RESEARCH PROCEDURES

Prior to commencing the research procedures the research protocol was subjected to peer review and ethical review by the appropriate committees[5]

For the duration of the project 2001 – 2002 information has been gathered through processes of negotiation, conference and consultation. Such information has resulted in a record of

[5] As proposed there has been a systematic collection of evidence pertaining to comparative educational processes, participant experiences and performance during the two-year period. Full details of these procedures and the data collection tools used are given in a CD ROM that is available from the authors. The methods used to collect this information included:

1. Review of pertinent research policy and informative literature
2. Retrieval and review of educational curricula pertaining to community-based courses for nurses, midwives and health visitors across all Scottish University Higher Education providers.
3. Telephone interviews with key informants from Primary Care Trusts across Scotland
4. Collation of recorded and supplied verbal information to construct student profiles
5. Distribution of questionnaires pertaining to self–reported rating of competency
6. Distribution of questionnaires pertaining to stress and job satisfaction
7. Distribution of questionnaires pertaining to quality of working life
8. Distribution of questionnaires pertaining to the student experience
9. Distribution of questionnaires pertaining to the supervision process.
10. Review of student assignments; reflective summaries and practice profiles
11. Observation of teaching.
12. Observation of assessment procedures
13. Review of external examiner reports
14. Interviews with academic staff (university and service based) who are responsible for delivering the Family Health Nursing Programme.
15. Group discussions with students on campus
16. Field notes and research journal

complicated field notes and the construction of a research journal. These sources have enabled the educational, managerial and practical aspects of the family health nursing project to be articulated and reviewed. This information has contributed to the building of an explanation of what has been happening and why.

The following table outlines the modes of analysis used with each source of information.

Table 2.1 Sources of information and modes of analysis

Source of information	**Mode of analysis**	**Level of interpretation and application**
Literature	Synthesis of ideas and appraisal. Critique of language	Across all four levels of analysis
Educational curricula	Situational analysis and thematic content	Scotland wide and Local
Student profiles	Description and descriptive statistics	Practitioner
Competency questionnaires	Comparative statistical analyses using SPSS synthesis of qualitative comments	Practitioner
Stress and job satisfaction questionnaire	Comparative statistical analyses using SPSS synthesis of qualitative comments	Practitioner
Quality of working life questionnaire	Comparative statistical analyses using SPSS synthesis of qualitative comments	Practitioner
Student experience questionnaires	Comparative statistical analyses using SPSS synthesis of qualitative comments	Local context: university course
Supervision process questionnaires	Comparative statistical analyses using SPSS synthesis of qualitative comments	Local context: university course and service provision
Student assignments	Thematic analyses of educational level and application of theory to practice	Local context university course
Observation of teaching	Identification of strengths and weaknesses of various approaches to education	Local context university course
Observation of assessment procedures	Thematic analysis of observation notes	Local context: university course and service provision
External examiner reports	Thematic analysis of educational level and application of theory to practice.	Local context university course
Staff interviews	Thematic and content analysis of strengths and weaknesses	Local context: university course and Scotland wide
Group discussions with students	Thematic analyses of notes taken	Practitioner and local context
Field notes pertaining to interviews with students and supervisors in context	Thematic analyses	Face to face and local context(university course and service)

Details of student response rates to the questionnaires are given below in Table 2.2

Table 2.2 Response rates to questionnaires sent to student FHNs (and qualified Cohort 1 FHNs in July 2002)

	Cohort 1 (11 students)				**Cohort 2 (20 students)**		
	June 01*	July 01	Dec 01	July 02	March 02*	July 02	Dec 02
Nursing Competencies	100%			100%	100%		
Stress and job satisfaction	100%	100%		100%	100%	100%	
Quality of working life		100%		100%		100%	
Summative evaluation of campus based learning experiences and clinical placements			100%				100%

*At these time points the students were asked to complete these questionnaires retrospectively (i.e. thinking of the their functioning in the four months prior to starting the educational course). This was because ethical approval for the research was not obtained until May 01 and therefore we could not start to issue questionnaires before this.

Details of response rates to questionnaires sent to supervisors of FHNs are given below in Table 2.3

Table 2.3 Response rates to questionnaires sent to supervisors of FHNs

	Cohort 1 (10 supervisors; 11 students)				Cohort 2 (18 supervisors; 20 students)		
				Dec 01			Dec 02
Summative evaluation of experiences of supervising FHN student				**8** (73%)			**15** (75%)

Data from the above questionnaires were entered on to SPSS V10 databases and data entry checking was undertaken. Frequencies were generated in order to summarise and describe quantitative data. Where inferential testing was appropriate, nonparametric statistics were used (following the principles in Pett, M (1997)). The main tests used were the Mann-Whitney U test to compare separate groups of subjects, the Wilcoxon test to compare consecutive data generated from one group of subjects, and Cohen's kappa statistic which measures agreement taking into account what would be expected through chance. Textual comments were collated and analysed in terms of content frequency and thematic coverage.

The remainder of this part of the report has been structured to enable the analysis to move from the general to the particular and back again: from consideration of all specialist practice educational curricula to a detailed evaluation of the family health nursing programme. Observations and findings are presented and discussed in such a way as to identify the major issues for consideration.

2.2 SPECIALIST PRACTICE EDUCATION: AN OVERVIEW OF STRUCTURE AND CONTENT

Service redesign and organisational change in the delivery of primary care services have resulted in a range of new roles for members of the nursing, midwifery and health visiting professions. Furthermore the establishment of a clinical governance management system across the NHS has required employing organisations to assess risk alongside professional liability in order to ensure that there are: clear lines of accountability and responsibility in clinical care; quality improvement systems in place; and clear policies for the management of risk and professional performance. Overall the combination of service redesign and clinical governance should provide a decision-making framework to determine the optimum mix of generalist, specialist and advanced practitioners needed in the nursing workforce in primary care. In operation the rationality behind developments is often obscured and difficult to articulate. This is the case for family health nursing both in terms of the education and the practice. The challenge for us, as evaluators, was to try and understand this educational and practice initiative which aimed at producing "generalist specialist" nurses who would work in primary care in selected remote and rural areas of Scotland. Clarifying the perceived benefits of any new role and innovative approach to community-based education poses general problems for evaluators. In this particular case, however, the combination of a broad range of educational preparation coupled with a very particular concern for personal practices in remote localities required immersion in fieldwork and a constant comparative approach to our analyses.

2.2.1 Overview of specialist practice curricula

Currently within Scotland there are nine Universities providing education for nurses and midwives who are working or seeking to work in primary care. The courses offered range from short courses with a specialist focus to Master's Level degree programmes. The curricula which have been reviewed pertain to those degree programmes which combine an academic award with a specialist practice qualification.

Thus curricula were obtained from the five Universities in Scotland offering community-based degree programmes with specialist qualifications across the following areas of practice.

- General practice nursing
- Community mental health nursing
- Community learning disabilities nursing
- Community children's nursing
- Public health
- Health visiting
- Occupational health nursing
- District nursing
- Family health nursing

The following Tables 2.4-2.6 provide an overview of the established programmes of study by degree award type rather than by Institution. Thus the Tables provide an overview of

academic award; level[6] and credit transfer allowed using either the Assessment of Prior (Certificated) Learning (APL) or the Assessment of Prior Experiential Learning (APEL)[7]; the nature of core and specialist modules[8]; the mode of delivery and the general means of assessment.

Such an approach has enabled a summary situational analysis of educational curricula to be conducted in order to appreciate and distinguish the family health nursing curricula from the others. A range of judgements internal to the actual curricula has been made based on the following criteria: philosophy of health care and education advocated; concordance with regulatory frameworks; strengths, weaknesses and values inherent in the overall curricula; resources: human physical and financial.

External judgements have also been sought with regard to the nature of educational provision. This external process has involved seeking the views of key informants across Scotland with regard to the strengths and weaknesses of extant community-based services, educational provision for community-based nurses, midwives and health visitors and what health service deficiencies might be provided for by family health nursing. The findings from these interviews are presented in Chapter 4.

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[6] SCOTCAT is an acronym for Scottish credit and accumulation transfer and refers to the academic levels of learning that students have undertaken. To obtain a Bachelors degree from a Scottish University the student would normally accumulate credit at different academic levels. The levels generally equate with the year of the course: thus Level 4 would normally be the academic work undertaken in the fourth year of a classified degree programme. In the Scottish education system there are two types of Bachelors degree. The unclassified degree which finishes at Level 3 and the classified degree which finishes at Level 4. The term SCOTCAT is also referred to as Scottish Degree Level and abbreviated to SD. The European credit equivalent was not given in any of the curricula reviewed.

[7] As nursing has moved into the higher education sector it has been necessary to develop systems to recognise academic levels of learning and the potential for exemption. APL and APEL are two such processes which are used primarily, though not exclusively in vocational degree programmes.

[8] The term module will be used to refer to the components of all degree programmes. This term has been chosen because of its transferable meaning viz: a self defined part of a degree programme which has its own assessment processes, and in order to avoid the confusion of terminology which prevails.

Table 2.4 Overview of community-based educational programmes leading to the academic of award of Bachelor of Science (BSc) and specialist qualification

Academic Award; level and credit exemption	Indicative shared core module content	Indicative specialist module content	Mode of delivery	Indicative assessment techniques
BSc (Hons) SCOTCAT Level 4 APL and APEL up to 60 Level 4 SCOTCAT Programme for supervisors available	Welfare state, care community systems Ethics and professional issues. Management and quality assurance Health needs assessment and evidence base practice.	Relevant to specialist practice. Precise content negotiated with student and practice in the three areas: clinical practice care and programme management and integrated approach	Open learning. Additional short courses available	Essay, case study dissertation and supervised practice
BSc (Ord) SCOTCAT Level 3 Full time and part-time APL and APEL up to 50% of the programme Programme for supervisors available	Clinical practice development Approaches to care delivery Clinical practice leadership Community principles Community practices	Relevant to specialist practice but covering service development, service provision, principles and practices, assessment, role, and therapeutic interventions	Full time and part-time open learning	Portfolios, community profile, essay, examination Supervised practice
BSc (Ord) SCOTCAT Level 3 Access modules APL and APEL up to 60 Level 3 SCOTCAT Programme for supervisors available	Clinical judgement and decision making Managing for quality Research for practice Work-based teaching	Community perspectives Principles Work based modules on systems promoting health and specialist practice as applied to specialist qualification Series of elective choices	Full time or part-time	Essay, portfolio, action plan, service profile supervised practice

Table 2.5 Overview of community based educational programmes leading to the award of Bachelor of Arts (BA) and specialist qualification

Academic Award; level and credit exemption	Indicative shared core module content	Indicative specialist module content	Mode of delivery	Assessment techniques
BA(Ord) SCOTCAT Level 3 APL and APEL up to 60 SCOTCAT Programme for supervisors available	Management and leadership issues. Supervision and teaching Research based practice Quality and audit	Analysis of specialist practice and specialist issues including nurse prescribing for DN and HV	Full or part-time distance learning	Essay, portfolio, action plan, teaching plan examples of good practice Supervised practice
BA (Ord) SCOTCAT Level 3. Level 2 modules available Not normal to award APL, APEL Programme for supervisors available	Evidence based practice and clinical effectiveness Education for health and practice Health policy and health promotion Lifespan development Social perspectives on health	Clinical practice and development care and programme management development of professional leadership and nurse prescribing for public health nursing and nursing in the home.	Part-time	Critical incident literature review teaching package Exam, Observed Structured Clinical Examination (OSCE), case study seminar presentation, portfolio Supervised practice

Table 2.6 Overview of community based educational programmes leading to the award of Bachelor of Nursing (BN) and specialist qualification

Academic Award, level and credit exemption	Indicative shared core module content	Indicative specialist module content	Mode of delivery	Assessment techniques
BN SCOTCAT Level 3 APL, APEL up to 60 Level 3 Programme for supervisors available	Partnerships in learning Nursing accountability From identified problem to research proposal	Learning for action Specialist education and practice	Part-time	Work-based learning folders, clinical essays, research proposal, evidence based guideline Supervised practice

Reading through the curricula there are similarities in content and structure in accordance with the principles and specifications of the regulatory body (UKCC 1994 and 1995). The curricula are constructed around the four specialist domains[9] specified and generally speaking the learning outcomes of the programmes are mapped against these domains. In addition the curricula have identified core education for all nurses, midwives and Health Visitors working in community health services which aims to: monitor and improve standards of care; inform and facilitate the supervision of practice; contribute to research; inform the teaching and support of colleagues. Finally the curricula have been designed within the framework of post-registration education and practice (PREP) which is embedded in the following values: reduction of risk, enhancement of care, provision of support to patients and colleagues and the development of education and practice.

Three academic awards are available: Bachelor of Science (BSc), Bachelor of Arts (BA) and Bachelor of Nursing (BN). In making these academic awards there are strong arguments in the curricula documents supporting the educational theory of andragogy and a taxonomic approach to learning outcomes. The management of services and the importance of research are given prominence and generally all the curricula have been constructed in partnership with health service providers. Nursing and social science theories are deployed in the curricula but there is no curriculum based on a particular theory of nursing or health. Such an approach fits with the notion of "graduateness" in that the education is enabling the practitioner to utilise appropriate knowledge in a given context. Core modules are shared in an attempt to make explicit what is common to all community-based nurses, midwives and health visitors.

The word **family** appears in all the curricula with varying emphasis and sustained attribution. From the educational curricula there is limited insight into the way in which the concept is handled in the various specialist practice programmes. The sociological complexities; cultural biases; legal and fiscal confines or the psychological dynamics of kinship to the meaning or understanding of 'family' are either assumed or ignored. It is impossible to tell from what is written in the curricula documents. There is limited evidence in the curricular documents regarding what is actually taught about the family in any course. Generally the concept of family is treated in a stereotypical way and is elided linguistically as in the following examples from learning outcomes or course objectives: "Assess the health and health related needs of patients, clients, families and other carers" (district nursing, community mental health nursing, learning disabilities nursing, general practice nursing) "Discuss health profiling methods applied to individuals, families, groups or communities"(health visiting course).

All but one BA programme offer student exemption for up to 50% of the programme and all have elaborate processes for recognising prior learning. An array of assessment processes is used generally relying on the submission of written work and the completion of practice based portfolios of evidence. For the majority of the programmes the specific practice-based learning objectives and the content of the assessment portfolio are negotiated between the student, clinical supervisor[10] and academic supervisor.

[9] Clinical nursing practice; Care and programme management; Clinical practice leadership; Practice development

[10] The term supervisor is used as a generic term of reference for those with responsibility for the education of the student within a practice setting

Only one of the programmes offers the academic award at SCOTCAT Level 4. The rest are all at Level 3 (although some Universities also have the provision for specialist awards at Master's Level). As the pre-registration qualifications move to degree level (SCOTCAT Level 3 or 4) so the academic level of post-registration education for specialist practice will have to alter.

Students are generally recruited from the existing nursing workforces and undertake the educational programmes as part-time students. Some receive support from their employer (either in the form of payment of fees or in the form of paid study leave), many are self-funding and utilise time off from work and annual leave entitlement for study purposes.

The new public health nursing programmes in Scotland have been developed concurrently with, but separately from, the FHN project. They have involved a revision of the pre-existing health visiting courses to combine health visiting and school nursing. The Scottish Executive directly funded 128 places, including 48 for existing school nurses. By December 2002 172 public health nurses had successfully completed the programme and were back in practice (Nursing for Health Two Years On*;* SEHD 2003). As such this initiative is on a larger scale than the FHN project yet there is no similar research evaluation of the impact on practice.

Thus what emerges is a flexible approach to education provision in which students can negotiate: learning outcomes; the time taken to complete the programme; and the amount of credit exemption in accordance with regulatory requirements. Furthermore the array of programmes on offer within one University ensures a pool of experienced academics who can contribute to various programmes and utilises resources in an efficient way.

The focus of this evaluation was not to assess the effectiveness and efficiency of all community-based education programmes but rather to use knowledge of these to facilitate the evaluation of the family health nursing programme. We now turn our attention to detailed consideration of this.

2.3 FAMILY HEALTH NURSING CURRICULA MARK 1 AND MARK 2

The original family health nursing curriculum was developed during the latter part of 2000 and in the first year of the course significant modifications took place. The overall structure of the programme and its constituent modules did not change, but many other aspects were substantially reviewed and developed in response to: the process of professional validation by the National Board for Nursing, Midwifery and Health Visiting; influences from the Scottish Executive Health Department and the NHS Boards and Trusts involved in the initiative, and through an ongoing process of review by the educational team and the students. Between the commencement of the first and second cohorts of students (Jan 2001 and Jan 2002) the following major curricular modifications took place:

- The unit outcomes and associated clinical outcomes were clarified and revised
- A scheme for the Accreditation of Prior Learning was constructed.
- A programme for the preparation of supervisors was enhanced and a new short course offered.
- The assessment methods, particularly the Objective Structured Clinical Examination (OSCE) were developed

- Course documentation, particularly the Course Information Booklet and the Clinical Profile documents were substantially revised and developed.
- The course content, particularly the workshops offered in the module "Advanced Family Health Nurse practice", was developed.
- A Project Director was appointed during the year to lead curriculum development

While some modifications would be expected with all new programmes, these constituted substantial changes over a short time period. In approving the programme on 12th July 2001, the NBS acknowledged that its unique nature meant that development and modification would be ongoing throughout the pilot period. With so much development taking place it became difficult to know what we were evaluating at times and whether it would be possible to compare two cohorts of students.

For most purposes the evaluation has used the revised curriculum detailed in the Course Information booklet of October 2001. This is not to ignore the existence of the original curriculum, as we have considered both students and supervisors experiences of it. Rather it is to recognise that a number of perceived deficiencies in the original curriculum were acknowledged and addressed by the educationalists. The object of this evaluation is to be constructive in its frame of reference and analysis in order to fully appreciate what has happened and to give suggestions for future development.

Table 2.7 Extant Curricula for Family Health Nursing

Curricula Academic level	Specialist module content	Duration	Assessment techniques
WHO Europe Curriculum Post-graduate level Academic award plus specialist practice award No core modules	 Concepts, practice and theory Provision of care working with families Decision making Information management &research Provision of care working with communities Managing resources Leadership and multi-disciplinary working	**Total of 40 weeks** 2 weeks 10 weeks 4 weeks 6 weeks 10weeks 4 weeks 4 weeks	Essay, exam, course work practical assessment
Curricula Academic level	**Specialist module content**	**Duration**	**Assessment techniques**
Scottish University Curriculum SCOTCAT Level 3 APL and APEL limited applicability. BN and Specialist practice award No core modules	 Working with families in the community Communication Advanced Family Health Nurse practice Research, decision making and evaluation in clinical practice	**Full time 40 weeks total** 15 weeks *(concurrent with)* 15 weeks 13 weeks 12 weeks	Case study, exam, video presentation and analysis, community portrait, OSCE , case reports

The first curriculum summarised in Table 2.7 is that originally suggested by the WHO Europe (2000). This curriculum aims to develop each FHN to become competent in the following five core functions: **care provider; decision maker; communicator; community leader; manager**. Similarities with other community-based programmes are evident through the title of some modules and although no shared core modules are cited, decision making, information management and research, managing resources and leadership and multidisciplinary working could be core modules to be shared in the broad church of community nursing. The inclusion of this overview enables comparisons to be made with existing community–based programmes and the Family Health Nurse programme used in this initiative.

The validated Scottish curriculum leading to a Bachelor of Nursing (Family Health Nursing) award and specialist practice qualification (Table 2.7) differs from earlier curricula reviewed in that it has no common modules shared with other community nurses. Some content has

been identified as core but this is drawn from three modules: Working with families, Communication and Research, decision-making and evaluation in clinical practice.

As can be seen from Table 2.7 there are no modules dedicated to quality issues, teaching and supervision of others or the management of services, although aspects of these topics are referred to in the modules. This curriculum is different from other specialist programmes in that it has been partially built around an ideology of nursing which combines elements of Family Nursing from North America with the promotional ideas from the World Health Organisation. In addition the curriculum has incorporated specific content to suit the nature of remote and rural nursing in Scotland. In short it is a customised degree programme.

Within the course curriculum document the rationale for the content and the integration of theory, practice and assessment is addressed in a complex conceptual framework which captures the theoretical foundations, operational practices, holistic family-based care and models of assessment, intervention and health strategy. This diagram highlights the range of knowledge and skills required for a role that is expected not only to work in-depth with families but also to do so with individuals and to work with communities. It is theoretically grounded both in its educational approach and in nursing values. **The articulation of these issues indicates that this curriculum is attempting to be different from the WHO Europe curriculum and from other specialist programmes. The construction of the specialist award has been simplified and all effort has been concentrated on the speciality of family health nursing at the level of practice, education and assessment.**

The isolation of family health nursing from other community-based specialist education programmes has neither facilitated the professional understanding of the role nor allowed the debate to take place between practitioners about role boundaries and optimum skill-mix in various contexts of practice. However running the programme in a University with no history of community based post-registration nursing education has advantages as well as disadvantages. On the one hand it can be argued that this isolation may have contributed to the confusions and perceived threats to established nursing, midwifery and health visiting roles and consequently may have impeded the adaptation and development of a family health nursing approach to community-based health care. On the other hand however, the lack of cultural legacy with regard to community nursing educational provision has contributed to curricula innovations as described above and a willingness to think differently about the provision of nursing in remote and rural primary care contexts.

The stated criteria for student selection on to the programme stipulated a minimum requirement that students would have two years post-basic experience. Health service managers in the participating regions were instrumental in the selection and nomination of interested personnel. Our enquiries into local managers' criteria for selection suggest that these varied in nature and weighting. The process was undertaken under considerable time pressure prior to the first course starting. Service development and succession planning issues informed this process but these were hindered to some extent by uncertainties about the nature and scope of the FHN role. Initially interest in participating in this initiative varied across personnel in the different regions, but overall there were less candidates who might realistically be released to undertake the course than had been hoped. Student motivation to do the course and the logistics of facilitating cover for a year seem to have been the two primary factors that determined who joined the cohorts. One region explicitly aimed at good geographic spread when recruiting potential students. Prior to the second year of the course

the regions were encouraged to try to recruit some students with health visiting and other community specialist practitioner qualifications besides district nursing.

The educational course was based at a campus in the Highlands of Scotland and the students' clinical practice placements were within their own region. This course, like other specialist programmes, required students to undertake clinical placements as part of the educational process. Students' course fees, travel and accommodation were paid from a specially designated central budget which also paid the students' salaries whilst they were undertaking the course. As the students were existing employees, their employers in the participating regions could use the money saved on salaries as "backfill" monies, to resource temporary replacement staff to undertake the work previously carried out by the student. After completing the course it was anticipated that the new FHNs would return to their home base sites and start to develop the role in practice.

2.4 EVALUATING THE FAMILY HEALTH NURSING CURRICULUM

The educational curriculum for family health nursing was responsive to developments and changes and the teaching team generally adopted a dynamic student-centred approach to education. Throughout the programme the students were encouraged to reflect on their experiences and to submit these written accounts to the teaching team. Encouraging reflexivity in professionals has long been recognised as being of educational value. By reflecting on an event and responses to it the individual can learn through introspection. In this educational programme the students' reflections were used for additional purposes namely: to inform the teaching team of areas of satisfaction, growth, concern and confusion; and to inform the evaluators of the students' perceptions of events. The issues selected for detailed attention in the evaluation are those issues of concern to the students, teachers, other respondents and the evaluators themselves. Generally evidence has been synthesised from multiple sources prior to presentation.

In constructing the curriculum a range of generic and specialist content has been combined with complicated assessment processes. This combination has not always been congruent and has made for difficulties. This is best exemplified through a critique of the following: **credit exemption processes; selected course content; specific assessment procedures and the sequencing of modules.**

2.4.1 Credit exemption processes

No students from the first cohort obtained exemption based on accreditation of prior learning. In the second cohort however eleven students out of twenty obtained partial exemption under the course APL scheme. This meant that they did not need to attend for campus-based teaching but still were expected to undertake the modular assessment. Students were given between 4 and 8 weeks exemption from attending classes during semesters 1 and 2 when the modules on Communication, Working with families and Advanced Family Health Nurse practice were being offered. If granted time exemption these students were expected to return to their usual place of work and undertake duties as per their former role. This was an unsatisfactory practice from the perspective of students, teachers and by any contemporary understanding of APL and APEL processes.

The students' reflective accounts provide insight into the conflict caused by this approach

"I have APEL for 4 weeks which has caused, is causing me a degree of unhealthy stress. Once I get past the next few weeks I know this will settle, but getting there is no picnic". (Cohort 2 student).

"I have been fortunate enough to be given the names and phone numbers of my families but feel guilty if I contact them whilst on APEL" (Cohort 2 student).

"APEL is unsettling now back to work (Week3) have to keep explaining why I'm back in post". (Cohort 2 student).

" On returning to the community it was strange being an FHN student but also having APEL – caught in the middle of nowhere" (Cohort 2 student).

The APEL and APL processes and procedures need to be developed further in order that full and proper academic credit can be given. To do so may require the reshaping of modular content in order that there are credited components of each module which are assessed in such a way to enable students to obtain full exemption.

2.4.2 Selected course content

In the **Advanced Family Health Nurse practice** module in-depth material on specialist family nursing is covered alongside a number of skills workshops on a range of diverse topics. The aim of this module is to *"provide the opportunity for a period of sustained study and practice of those therapeutic skills considered necessary for effective clinical practice with families and communities"* (Extract from course unit descriptor). The unit is assessed by means of: a community portrait as specified by the Open University (1996); an Objective Structured Clinical Examination (OSCE) and the production of health promotion resource. Over the two years the module has undergone considerable change to incorporate locality-based learning and to develop the OSCE assessment process. The observations forthwith pertain to the experiences of Cohort 2 thereby keeping a constructivist approach to the overall evaluation.

The following Table 2.8 provides an overview of the suggested content of the skills workshops from the curricular documents; and summarised details of the actual workshops which were held within each of the four participating regions. The indicative content given in the curricular documents is elaborate and integrative of a range of competency domains. From the cited content in Table 2.8 it is difficult to know what would not be eligible to be considered as Advanced Family Health Nurse practice. Furthermore it is difficult to discern what makes this content "advanced" since the majority of the actual content delivered is basic community health care. The negotiation of the content was decided by the students and the clinically-based teaching staff. This raises some questions about the quality of the educational experience in terms of parity and equity of experience; variation in content; standards of teaching and application to the practice of family health nursing.

The complexity and generality of this module is of concern when thinking of the academic level of specialist practice and the use of the word "advanced" in the title. The content and learning outcomes of the skills-based workshops at first seem at odds with the notion of

higher level practice. If the skills covered in the workshops are deemed to be specialist and advanced by practitioners and service managers then it is essential that the educational process facilitates deeper levels of understanding with regard to principles, theories and evidence base underpinning the skills.

Table 2.8 Content of skills based workshops for Advanced Family Health Nurse practice

Content as suggested in curricular documents	Screening for health; Stress; Policy changes; Caseload management; Problem solving Risk management; Tissue viability Nursing diagnosis; Facilitation of early discharge and admission to hospital; Family nutrition; Cardiovascular health; Family care giving; Family health in relation to reproduction; Breastfeeding support Child health support and parenting skills
Content delivered in Region 1	Supporting breastfeeding; Parenting skills and child health support; Health promotion Dental health; Diabetes update; Child protection; Alcohol and harm reduction Early discharge and informed admission Palliative care; Principles of rehabilitation; Doppler assessment 4 layer bandaging
Content delivered in Region 2	Palliative care; Chemotherapy; Stoma/breast care update; Diabetes update; Public health agenda; Adolescent care; Aspects of pain Stroke liaison team; Dental health; Tissue viability and leg ulcer care; Doppler assessments; Research based practice; Role of the dermatology nurse; Health promotion
Content delivered in Region 3	Principles of wound healing; Aetiology and management of leg ulcers; Doppler assessment; compression bandaging; Blood borne viruses; Theories of health promotion; Developing health promotion/community development project; Setting up and working with groups; Working with parents and families; Screening and diagnosis of diabetes; dietary perspectives on diabetes; Role of diabetes nurse specialist; Identification and management of diabetes in children; identification of complications and clinical problems related to diabetes; Rehabilitation; role of various professionals in rehabilitation; role of integrated outreach team.
Content delivered in Region 4	Dental health; Hearing health cradle-grave; Tissue Viability; Diabetes update; Planning for health improvement; Drugs and alcohol; Doppler assessment and four layer bandaging; Public health; Child protection; Trauma; Palliative care/pain control.

Students were asked to evaluate these workshops as part of the educational process. The questionnaire used by the teaching team asked whether the content was relevant to their own family health nursing practice; met their own learning needs; and provided adequate resource materials. In general these workshops were seen as relevant to practice, informative and interesting and met the student's needs.

"*Brill workshop. Very useful and relevant to FHN course"* (Student from Region 2 on dental health session). For many of the students the workshops provided a refresher course on a

particular topic. *"Good to get refreshed and reassured that I am not completely rusty"* (Student from Region 1 on diabetes sessions). In addition the students also commented on how useful in general were the resource materials which were provided. *"Networking, leaflets, and web addresses very helpful"* (Student from Region 3 on Rehabilitation session). Finally the majority of students appreciated the "hands on" nature of many sessions as exemplified by *"Very informative session. Enjoyed audio-tapes to help us identify what people with hearing losses hear. Practical tips for caring for hearing aids very helpful."* (Student from Region 4 on hearing– cradle to grave session)

It would appear that much of the educational content of this module did not challenge the students sufficiently. The assessment processes however certainly provided challenges for all students. In constructing and delivering this module it is contended that the academic team have burdened the student with assessment content and processes for which the module did not prepare them well. The assessment process was highly specialised yet the majority of content related to typical community nursing activity.

2.4.3 Specific assessment procedures

The following Table 2.9 presents an overview of the observations made about the assessment procedures and processes. To recap these observations were based on: scrutiny of the students' assignments; external examiners comments; teachers' feedback and assessment comments and direct observation by the evaluators of the OSCE procedures.

Table 2.9 Observations on assessment procedures and processes

Module	Method of assessment per module	Observations on assessment
Working with families in the community	Case study Presentation Exam Clinical assessment	Applicable to content; ethics of family assessment processes lacking; interview skills of students weak; writing skills of students reasonable; exam answers personalised with limited use of literature. All students passed.
Communication	Video with 1000 word account of preparation Case study Clinical assessment	Problems with video equipment in some cases. Applicable to content; writing skills reasonable. Resubmission mechanism used. All students passed.
Advanced Family Health Nurse practice	OSCE Community portrait Health promotion resource Clinical assessment	Mismatch with content; unrelated components in assessment; writing skills of students good; health promotion resources variable; OSCE inappropriate use of term and limited value. All students passed.
Research, decision making and evaluation in clinical practice	3 Annotated case reports Systematic review of clinical cases Clinical assessment	Applicable to content; supported by web CT; writing skills of students good. Deploying literature more effectively. All students passed.

Across the assignments there is some indication of academic progression and development for all students which is primarily observable through the standard of their written work. Although this is a modular course students are expected to follow a designated sequence of modules and cannot choose their own route through.

There is limited information from the external examiners reports to comment upon with the exception of the suggestion that there is a need to separate out the health promotion resource from the OSCE.

This course has an elaborate assessment process per module which aims to integrate theory and practice. Some of the assessment procedures are requiring students to carry out activities before cognitive assimilation has taken place. This is most evident in the first case study assignment of the first module. Students were asked to conduct a family assessment using a genogram and an ecomap. Genogram assessments are based on eugenic principles and aim to identify hereditary disease patterns. Ecomaps are derived from the principles of social interaction, group dynamics, and intervention therapy. Some of these major social science concepts are addressed in the communication module, however, there is limited content in this module on the science of epidemiology or genetics; the ethics of assessment; or the psychology of control. It is questionable if such family assessments should be conducted by naïve students at the beginning of a course. The process however is most appropriate to the assessment of the Advanced Family Health Nurse practice module and would allow for the integration of knowledge from across the modules.

2.4.3.1 Objective Structured Clinical Examination

Two series of these assessment processes were observed by the evaluation team and the following observations were made. This assessment procedure is complex, is conducted on site with individual students and clients and is time limited due to the human resource implications. The usual procedure involves all students being assessed by two members of the teaching team during the same week. Given the geographic remoteness of some students the travel logistics of this process require to be well co-ordinated. The following quote from one of the clinically based teachers illustrates the potential for farce.

"But the OSCE well ... Whistle stop, whizz around it was horrible ..., we had very restricted time limitations and it was like 90 miles an hour" (Teachers view of Cohort 2 OSCE)

The examination relies on a standardised approach to questioning. The schedule used has a range of thematic questions pertaining to Family assessment (19 questions); Individual goal setting (10) Family goal setting (10) Community goal setting (10) Family Health Nurse intervention plan (13); Health promotion resource (17); Therapeutic letter (9); Family Health Nurse documentation (5). Some of these questions are answered by scrutinising the written work submitted at the time of the exam others are asked directly of the student during the OSCE.

"There were many, many questions that repeated themselves and we took out probably half of what was in the original and reworded. A lot of the wording was ambiguous and the students all stumbled over the same questions which would tell you that the question was badly worded" (Member of teaching staff).

The students found the OSCE stressful and commented on the problem of finding a family member to bring along, and talking about this person without fully involving them in the discussion.

" the OSCE is looming large on the horizon with only one practice week to fully establish and develop our relationship, complete the documentation and prepare us all for the visitation" (Cohort 2 student)

A family member accompanied the student for the first part of the examination when the family assessment was discussed. Very few were incorporated into the discussion. Apart from occasionally verifying (through nodding of the head) the comments made by the student only 2 family members out of 12 observed actively participated in the discussion. The role of the family member in the proceedings has not been worked out.

"I hope I did the right thing for Una (the FHN). Was it all right? Has she passed? I don't want to let her down" (Young woman; island location).

This assessment procedure has potential as it does facilitate the integration of theory and practice but requires to be developed so as to:

- Reduce the number of questions.
- Restructure the schedule to separate out general questions about each of themes
- Restructure the schedule to pull together the specialist questions pertaining to the particular family.
- Ensure that genograms, ecomaps and nursing assessment documents are scrutinised prior to the oral exam.
- Clarify the role and involvement of the family member
- Remove the health promotion resource from this assessment

2.4.3.2 Clinical practice assessment

The documentation used for this assessment process was developed over the two years and is called a clinical practice profile. It is highly structured in specifying learning outcomes; and asking for verification of outcome achievement. Students, supervisors, and academic staff have recorded their comments in the profile in a very generalised way which provides limited information about the students learning experiences; capabilities and areas for further growth and development. The following quotes help to illustrate these observations:

" *Video recorded interview of family interaction ... .Submission of communication assignment ... Analysed communication skills and passed assignment ... Positive feedback from families; ... Discussion with family and informal carers – sharing information and design of care plan"* (Extract from student's evidence statement pertaining to working with families in order to support achievement of clinical learning outcomes).

The supervisor's comments with regard to her verification of these statements *"By discussion and demonstration ... Good"*

The maintenance of clinical learning profiles or portfolios is difficult to do well. It requires time and commitment from all parties. In other specialist practice education programmes the student generally negotiates his or her learning needs with the supervisor and devises a portfolio of evidence to support the negotiated learning contract. Such an approach is partially incorporated in this programme through additional documentation entitled "personal learning objectives". It is suggested that the clinical assessment process is developed formally to:

- Reflect the idea of a negotiated learning contract which is student centred
- Focus distinctively on clinical learning outcomes as pertaining to the skills workshops and specialist activity (e.g. family assessments; goal setting and evaluation of interventions).

2.4.4 Sequencing of modules

The route of progression through the course over three semesters followed this sequence of modules:

- Working with families
- Communication
- Advanced Family Health Nurse practice
- Research, decision-making and evaluation in clinical practice.

The rationale for the module sequence is given in terms of academic credit of the modules. Several members of staff and several students have suggested that the research, decision-making and evaluation module should come earlier in the sequence as the skills are required in the other modules. This particular module has two distinct themes and has been constituted as a double credit module: learning how to retrieve and use evidence to inform and guide practice and a casuistic approach to learning which relies on effective supervision, in the practice context, and through the use of Web CT. Casuistry is a branch of philosophy which aims to resolve particular moral dilemmas that arise from general moral rules. Such as: typical intergenerational conflicts which arise in families; or the specious reasoning of the remit of one professional group compared to another. Having such knowledge before embarking on Advanced Family Health Nurse practice would enhance student's learning and facilitate a more sustainable interaction with families and professional colleagues.

"I wish we had this earlier". (Student Cohort 1)

"The research module should come earlier cause we need the skills in all our course work". (Student Cohort 2)

"I think maybe the research should come earlier in the programme. Lots of the students have suggested this. It makes sense really". (Academic staff)

Considering how to restructure the modular delivery is essential for APEL/APL purposes and for educational development. The following sequence is suggested as a discussion point to develop the existing course.

Table 2.10 Suggested modular sequence for course redesign

Semester	Module	Credit exemption	Added value
First	Research and evidence based practice.	Identifiable content from other post-registration courses	Could be shared with other community based programmes
First	Communication and education	Identifiable content from other post registration courses	Could be shared with other community based programmes
Second	Working with families	Specialist content	
	Decision making, quality and evaluation in family and community care	Specialist content	
Third	Advanced Family Health Nurse practice	Specialist content	

This revised structure allows for the development of transferable educational and learning skills; full credit exemption to be awarded; the incorporation of management content as identified in the WHO Europe curriculum and the availability of three specialist modules which could be taken by community nurses or midwives with other specialist qualifications.

2.5 EVALUATING STUDENTS', SUPERVISORS' AND TEACHERS' EXPERIENCES

This section provides insight into the experiences of students, supervisors and teachers whilst engaged in the educational programme.

2.5.1 Profile of the FHN students

The following table provides a profile of the two cohorts of students:

Table 2.11 Profile of FHN students

	Cohort 1 (11 students)	**Cohort 2** (20 students)
Median age	43 (range 29-53)	42 (range 29-57)
Gender	All female	Female =19; male =1
Median number of years experience as a community nurse	8 (range 2-17)	9 (range 3-22)
Number who had worked more than 6 years at their home base site prior to starting course	10 (91%)	14 (70%)
Number employed part time prior to starting course	6 (55%)	7 (35%)
Number employed in G grade post prior to starting course	2 (18%)	4 (20%)
Number with district nursing qualification	4 (36%)	5 (25%)
Number with health visiting qualification	0	3 (15%)
Number with midwifery qualification	7 (64%) Majority still practising at start of course	13 (65%) Majority still practising at start of course

Table 2.11 clearly shows that the two cohorts of FHN students shared a very similar profile. The nurses who undertook this course were typically middle-aged nurses with very considerable experience of nursing in general, and of community nursing in their particular remote and rural location. Most were midwives. Most had no specific community specialist nurse qualification and were employed in E or F grade posts. Cohort 2 had a lesser proportion who were in part-time employment pre-course, and had a small sub-group who had only spent a few years working at their home base site and were typically rather younger. In general these were experienced nurses the majority of whom had established histories of practice in remote and rural contexts. Trying to understand why they should wish to undertake this programme of education has been illuminating. Quotes from the students own reflective summaries and the research field notes provide some insight. *"On commencing the FHN course I felt very excited and motivated about taking part in this pilot study. I also felt very positive about the family health nurse concept"* (Cohort 2 student reflective summary).

"*Now I have to train myself to stop thinking like a nurse, task oriented, lost if I can't physically do something for people"* (Cohort 2 student reflective summary).

"... watched a video on family health nursing. Ideas behind it that nurses should take a more holistic view and get a lot of family knowledge. Good to have a framework for that". (Cohort 1 student field notes).

"The course provided the opportunity for a specialist award ... I was doing another course ... put that on hold when this came up". (Cohort 1 student field notes).

As external evaluators we were also interested in profiling baseline competencies of the nurses who undertook this course. Due to pressures of time and logistics it was decided to use a self-report questionnaire for this purpose. The Nursing Competencies Questionnaire (Bartlett et al 1998) was chosen as it appeared practical, had proved the most valid and reliable (Norman et al 2000) and it had been used with post-registration nurses (Bartlett et al 2000). This questionnaire covers the constructs or domains of: leadership; professional development; assessment; planning; implementation; cognitive ability; social participation; and ego-strength. As such it also seemed broadly comparable to the five core family health nursing competencies indicated in the WHO Europe curriculum and the four specialist domains of practice advocated by the former UKCC.

Thus early in the course students from both cohorts were asked to complete the questionnaire by considering their perceived levels of competency across eight domains immediately prior to coming on the course. Six months after completing the course, Cohort 1 nurses received the questionnaire again. Table 2.12 presents mean percentage competency scores for each construct.

Table 2.12 Mean percentage competency scores for each construct *(range of scores in brackets)*

Construct	FHN Cohort 1 Pre course	FHN Cohort 1 Post course	FHN Cohort2 Pre course
Leadership	87 (83-96)	85 (67-98)	77 (65-92)
Professional development	86 (72-100)	84 69-94)	75 (61-92)
Assessment	87 (75-100)	83 (69-100)	78 (59-100)
Planning	85 (75-96)	85 (75-100)	82 (64-100)
Intervention	87 (77-99)	87 (74-99)	85 (69-96)
Cognitive ability	83 (75-96)	83 (67-96)	79 (58-96)
Social participation	59 (39-81)	65 (47-95)	61 (39-89)
Ego strength	81 (71-96)	83 (58-100)	75 (50-96)

There were no statistically significant differences between the pre and post-course mean construct scores of Cohort 1. When the mean pre-course scores of Cohort 1 and Cohort 2 students were compared, the latter group scored significantly lower in terms of leadership ($p=0.007$), professional development ($p=0.016$) and assessment ($p=0.031$).

Analysis of individual responses, however, suggested a need for caution in the interpretation of aggregate before and after results, in that one respondent from Cohort 1 scored lower for every construct and had clearly revised her interpretation of personal competency across all the domains. This may be an example of "the more you know, the more you know how little you know" which is embedded in the introspective nature of critical reflection advocated in the education programme, or in Allison et al (1997)'s terms "*intra-subject construct dynamism*" where there would be an expectation of dynamic change within the domains in any direction.

Comparison of pre-course results is more informative, and it is noteworthy that the level and pattern of scoring across all constructs, is very similar to the data reported by Bartlett et al (2000) for recently qualified nurses. This raises some questions over the questionnaire's sensitivity when used with very experienced staff. Ceiling effects must be considered as a possibility. The relatively low scoring of respondents in the domain of social participation is consistent. This particular construct is concerned with awareness and activity in relation to social issues, health-related policy issues and research. In comparison to other community specialist courses studied, the family health nurse course certainly devotes less coverage to health and social policy issues and the raising of political awareness. Thus overall we have self-reported high levels of perceived competence.

These students were part of a highly publicised and politicised initiative and, as such, some had feelings of needing to prove themselves and be highly competent whilst in a shifting spotlight. They were concerned to manage the course, improve their practice and develop themselves. Some of their reflective comments help to illustrate these observations.

"The year was a challenge but I have valued greatly being given the opportunity to study for a degree in FH nursing. My previous work as a community nurse has been a good job and has provided me with a great deal of personal and professional satisfaction. My expectation is that putting the FHN degree on top of that will be even more stimulating and a source of even greater satisfaction" (Cohort 1 student).

"Each semester had its own terrors at the beginning and sense of satisfaction at the end" (Cohort 1 student).

" I am now back in charge of my caseload, which has swollen so dramatically since I left it in the capable hands of my replacement. I am quite nervous about having the reins again and wonder if I will be compared unfavourably against her." (Cohort 2 student).

2.5.2 Students' perceptions of stress and job satisfaction

Further exploration of the student experience was undertaken by asking each student to complete a Stress and Job Satisfaction questionnaire at different points during the project. Table 2.13 provides details of these time points for each cohort:

Table 2.13 Time points for stress and job satisfaction questionnaire

FHN Cohort1	FHN Cohort2
June 2001 (asked to complete it by thinking retrospectively of conditions in the four months prior to coming onto course)	**March 2002** (asked to complete it by thinking retrospectively of conditions in the four months prior to coming onto course)
July 2001 (thinking of course experiences in past 4 months)	**July 2002** (thinking of course experiences in past 4 months)
July 2002 (thinking of FHN work experiences in past 4 months)	

A community-nursing specific questionnaire was selected for this purpose (Snelgrove 1998). This questionnaire asks respondents to rate themselves in relation to 46 possible sources of pressure for community nurses and an aggregate score can be derived. Smaller groups of questions similarly elicit feelings of stress and job satisfaction.

The content of the questionnaire emerged as very relevant to the students and their experiences. For Cohort 1 the main sources of pre-course stress were related to:

- change and instability at work (e.g. future of job; uncertainty about role; lack of involvement in decision making; not being notified of changes before they occur; lack of knowledge of role by other professionals; relationships with other professionals).
- work content (e.g. tedious routine work; getting cover; attending meetings). In one region in particular the nurses felt unable to use existing skills to full potential.

The actual demands of working with clients were cited as stressful less often, although there were some feelings of worry and isolation over decision-making. This was offset, however, by most of the nurses feeling free to choose their own method of work and being satisfied with their working hours. In general nurses were dissatisfied with: pay; career development opportunities; support and guidance from their supervisors, and quality of supervision.

Thus a general picture emerges of a Cohort of experienced rural community nurses who were feeling undervalued and under-developed prior to starting the course. A personal quote from one of the students helps to illustrate this observation.

"Looking back on the last 10 months I can trace a development process from an isolated District Nurse to a confident Family Health Nurse mentality with the associated diversification and extension in health care outlook". (Cohort 1 student)

During the first part of the course, stress relating to uncertainty about future job and role continued at a similar level. The students were particularly concerned about perceived lack of knowledge about their role by other professionals. Work content was generally less stressful and more interesting, with much better opportunities to use abilities. There was still relatively little stress reported in relation to direct involvement with clients but only 3 out of the 11 students were satisfied with their placement supervision at this time.

Perceived lack of knowledge about their role by other professionals proved a persistent theme during the first 6 months of working as FHNs. Other prominent concerns related to the organisation and content of work e.g. organisation of caseload; lack of time on visits; work overload; record keeping and quantifying work. However these Cohort 1 students were significantly less dissatisfied with their jobs after the course than they were prior to undertaking the course ($p = 0.044$). This trend was confirmed in the findings from the Quality of Working Life questionnaires which were administered at the same points in time.

Sources of pre-course stress for Cohort 2 were very similar to those emphasised by Cohort 1, but Cohort 2 were significantly less dissatisfied with their pre-course job situation than their predecessors ($p=0.035$). Feelings of isolation and concern over decision-making were of more concern for Cohort2.

During the first half of their course Cohort 2 students continued to feel stress in relation to role uncertainty and lack of knowledge about the role by other professionals. However, in sharp contrast to Cohort 1, none of the students were dissatisfied with the quality of their placement supervision. Indeed Cohort 2 were significantly less dissatisfied with their student experiences up to this point than Cohort 1 ($p=0.031$).

Two quotes from personal reflections help to further illustrate the positive experiences of students from the second cohort.

"The course drew attention to my social and physical isolation, to the fact that my nursing practice was in need of urgent overhaul, that my attitude was negative" (Cohort 2 student)

"I am pleased to have done this course … It is not just in the way of being glad to have stopped banging my head against a wall. But it has been very well worth pushing myself along the flinty road … even though it didn't seem like the right one to be on and surely I should be somewhere else? … I am not a natural student … so to have got me this far at my advanced age is nothing short of miraculous" (Cohort 2 student)

Thus what emerges overall is an indication that stress around role ambiguity and professional understandings are of concern to both cohorts of students. The deficiencies in the educational curriculum which led to stress were resolved for the second cohort.

2.5.3 Placement support and supervision

Providing support and supervision for family health nurse was a difficult undertaking as there were no role models or experienced supervisors who had worked as family health nurses. In addition the role of the family health nurse was evolving during the course of the evaluation.

Evaluation of the support and supervision received by the students during their community placements drew on a number of different information sources including a specifically designed questionnaire which was administered to students and supervisors at the end of the course. This was piloted with a small group of Community Specialist Nursing students at another University and minor revisions were made prior to use with the family health nursing students and their supervisors. The questionnaire was designed so that students and supervisors could rate a number of different aspects of the placement supervision experience (e.g. the initial matching process; the supervisor's understanding of the course and its learning outcomes). In addition it also sought information on the frequency of in-person and remote- mode supervision activities. Aggregate scores for perceived quality of placement supervision were subsequently derived from the students' responses, and comparison of students and their respective supervisors' ratings of a subset of matched questions were analysed using Cohen's kappa statistic (measuring level of agreement).

Table 2.14 Profile of supervisors

	Cohort 1 (10 supervisors; 1 supervised 2 students)	**Cohort 2** (18 supervisors; 2 supervised 2 students)
Number working as District Nurse (often also with active midwifery role)	5 (50%)	10 (56%)
Number working as Health Visitor(often including school nursing)	5 (50%)	4 (22%)
Number working as triple duty nurse (DN +HV+MW)	0	2 (11%)
Number working as lead nurse (triple duty background)	0	1 (6%)
Number working as community psychiatric nurse	0	1 (6%)
Number who were graduates	3 (30%)	4 (22%)
Number who had experience supervising diploma nursing students in past 5 years	9 (90%)	15 (83%)
Number who had experience supervising post-registration community specialist practitioner students in past 5 years	3 (30%)	6 (33%)
Number who undertook specific pre-course preparation to supervise FHN students	0	6 (33%)

As can be seen from Table 2.14 there are many similarities between the first and second cohort of supervisors. The main differences pertain to the spread of professional working practice and the supervisory preparation undertaken.

Cohort 1 students' experiences of practice supervision were mixed, but were predominantly perceived as unsatisfactory**.** This is seen in the students' ratings of overall level of support from supervisors during the course (Table 2.15).

Table 2.15 Students' ratings of overall level of support from placement supervisors

Rating	FHN Cohort1	FHN Cohort2
Excellent	**2** (18%)	**9** (45%)
Good	**2** (18%)	**10** (50%)
Fair	**3** (27%)	**1** (5%)
Poor	**3** (27%)	
Very poor	**1** (9%)	

A range of problems was apparent, especially during the first eight months of the first year of the course. Students and supervisors concurred on the main aspects needing improvement. These were:

- better arrangements for selection of supervisors with supervisors being allowed to refuse to take supervision on if too busy or if their skills are not suitable
- preparation of supervisors so that they have information and a clear understanding of their role and that of the FHN before the course starts
- allocated time for supervisors to provide supervision.

As Table 2.15 shows, Cohort 2 students' experiences were less mixed and more positive. Other questionnaire data confirmed that their perceived quality of clinical placement supervision was significantly better than that reported by Cohort 1 ($p=0.004$), with 90% thinking that the match between their supervisor's knowledge/skills and the knowledge/skills required for the FHN course were good/excellent. This compares to a figure of 46% for Cohort 1.

Nevertheless Cohort 2 supervisors felt that the process of preparing them to supervise was not good. Table 2.16 gives details of their perceptions alongside those of the Cohort 1 supervisors.

Table 2.16 Supervisors' perceptions of their preparation process

Rating	Number of Supervisors Cohort 1	Number of Supervisors Cohort 2
Excellent		
Good	**1** (13%)	
Fair	**3** (38%)	**8** (53%)
Poor	**1** (13%)	**6** (40%)
Very poor	**3** (38%)	**1** (7%)

These perceptions persisted despite the University providing a customised short course to prepare supervisors prior to the start of the course. In addition some of the participating NHS Trusts offered places on a generic supervision skills course. There was still a feeling for many supervisors that they lacked allocated time for supervision and some had concerns about the lack of guidance given by the University.

"After a shaky start I now feel (at the end of the first semester) a bit clearer about the role of supervisors" (Cohort 2 supervisor).

Contact and communication problems arose for those supervisors who did not work in the same geographic area as the allocated student. However the use of telephone and/or e-mail modes of contact for supervision purposes was significantly less of a feature of Cohort 2 supervision than it was for Cohort 1 (p=0.028). Fifty eight percent of Cohort 2 students reported that their supervisor had never been present in person when they were working with families during the course (corresponding figure for Cohort 1 = 64%). Interestingly, supervisors were asked the same question. In 69% of the matched cases for Cohort 2 there was agreement between students and their supervisors that in-person supervision with families had never taken place (corresponding figure for Cohort 1 = 50%). If the more rigorous kappa statistic (which takes into account the amount of agreement that would be expected by chance) were applied these percentages would fall further. Indeed none of the kappa statistics we calculated to measure agreement between students and their supervisors on matching questions came near to the 0.8 (80%) figure generally used to infer good levels of agreement. This highlights how people often retrospectively view the same sequence of events in different ways, even where a matter of objectively verifiable fact (e.g. being there in person) is concerned. Moreover the likelihood of social desirability bias from respondents should be kept in mind with the latter example.

"Although this is my first year as a supervisor, I was one of " the converted" almost from the pilot outset; my understanding of the concept has been further assisted by working alongside qualified FHN. I feel that this positive perception of family health nursing has enabled myself and my student to get onto an even keel fairly quickly after a rather fragmented first month (due to APEL, orienting ourselves family dynamics etc)" (Supervisor Cohort 2 first semester).

We found that when experiences of support and supervision were explored with students and supervisors in private interview, many were much more critical than might be inferred by reading their collated reflective comments. Many supervisors felt that they should be getting some local support so that they could ring-fence time for supervising the students. A few received increased remuneration related to their supervisory activities. Both supervisors and students found the course documentation very hard to understand and work with. This resulted in some supervisors admitting that they were not at all sure what they were signing for. Several others were unclear about the criteria for selection of families for the FHN students on placement. These varied from ideas of incremental progression (i.e. selecting families with more simple needs/problems at first) through to selecting a range of families representative of the major prevalent health problems in the area. The supervisors often relied on the students for guidance in this and other matters such as the documentation.

2.5.4 Practice–based experiences

Both Cohorts of students were in close agreement, when it came to identifying the most valuable skills they had learned during their clinical placements. Overwhelmingly they identified communication skills (e.g. interviewing, listening) and family health assessment/promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) as the most valued.

Working with families was the focus of the practical work experiences. For some of the students this required that they spent the first semester of the course working in a different locality and with different health professionals. From semester 2 onwards, however, the vast majority of Cohort 1 and Cohort 2 students had returned to their usual context of employment for their practice-based education.

Interestingly in the students reflective summaries several commented on the difficulty of finding families to work with. *"I feel I am rushing to extract goals from my family without building a proper relationship first"* (Cohort 2 student).

"Finding new patients for semester two was a difficult task" (Cohort 2 student).

" Gathering families slowly (I have heard that Rome wasn't built in a day). As far as the paperwork goes I'm still not happy with it but at least I understand it now. Last family I admitted and assessed were great. Went through the whole process with them, to discover that they really don't need me, but for them that was good, its reinforced the fact that they are coping well despite their problems". (Cohort 2 student).

Students were also concerned about using families for assessment purposes and then moving on and the family's care reverting to established services. The fact that this new way of working was only being used for educational purposes in the first instance raises a number of important issues regarding: the introduction and management of a new role into an established service; the ethics of using students as change agents and the expectations of the public. Service development requires a process of change management to be planned, articulated and facilitated. The evolving nature of the nursing role and its fit with service delivery posed many challenges for all of those involved.

2.5.5 Campus-based experiences

There was similarly emphatic agreement between the Cohorts when asked to identify the three aspects of campus based learning that they found most valuable. Overwhelmingly they identified coming together on campus to learn together, share ideas and experiences as major benefits. In addition family systems theory, communication and IT skills were emphasised, along with research.

The least valuable aspects of campus-based learning were seen as the content of some of the workshops in Semester 2 (especially for Cohort 1); problems with availability and functioning of IT equipment (especially in the first year of the course); limited time between assignments (especially in Semester 3); and guidelines for assignments being unclear or changed (especially in the second year of the course).

Students were asked to identify any topics that were not covered on the course that should have been. Some respondents from each Cohort identified input on child development and other health visiting skills as being lacking. Topics in the Cohort 2 responses included counselling skills; role-play and joint working with social work. Students were also asked to identify any topics that were not covered well. Both Cohorts identified various workshop sessions which could have been better (e.g. dietetics and coronary heart disease). Topics in the Cohort 1 responses included management skills and mental health, whereas a number of Cohort 2 respondents felt that the input on research should have come much earlier on in the

course. Overall, however, both student Cohorts were very positive about their campus-based learning experiences and very much valued the input by teaching staff. The following quotes help to illustrate these points.

"Reflection for me has been a way forward and has assisted me to look at situations and critically analyse various situations where a scenario could have been avoided or improved upon". (Cohort 1 student).

"I feel I can ask the right questions and discuss sensible solutions, and now I think I may deserve the title – FHN" (Cohort 2 student).

" *The Cohort has been supportive of one another and has been a great asset and strength. We have a unity that is fragile because 20 is a large social group and we are scattered far and wide. However we have a weapon – the bulletin board. We must continue to communicate through it and I take this opportunity to encourage everyone ... to use it"* (Cohort 2 student).

The last quote refers to one of the major innovations of this programme namely the use of information technology through a Web CT system which has encouraged the sharing of ideas between students and with staff. This system has provided the means of maintaining an action learning set at distance with very good effect.

"The Web CT has been a godsend for me. To have contact with the other students was all that kept me going" (Cohort 1 student).

*"It has been brilliant ... I don't know how we would speak ... [*otherwise*]*.
Web CT is very interesting ... now what you will find ... , I don't know if you have read the bulletin board ... but the girls this year seem to like the bulletin board rather than chatting privately so it is like what's meant to be ... Supervisors are an interesting lot as they were all given the same training. They haven't used it once not once, now I thought that this would have been very useful ... but they don' t use it". (Clinically based teacher and supervisor).

The Web CT has the potential to be developed further to provide student and supervisor support. Some formal structuring of academic sessions along with student initiated contact enables facilitation and involvement across the modules. This particular approach has worked well and could provide a model for other distance learning opportunities. Formally there is need to make explicit the educational principles behind the processes, namely action learning; simulated learning and peer review.

2.5.6 The teachers' experiences

Over the two-year period consultations were held with various members of the academic teaching team. All made time for us and were very supportive and helpful in providing information, facilitating access to students whilst on campus and generally looking after us when we arrived at the University.

A formal interview was held with each member of academic staff who had a key role to play in delivering the programme. These interviews aimed to explore the strengths and weaknesses of the course and to identify the lessons learned and the areas for potential

development. Enabling reflexivity was one of the challenges of these interviews as a certain amount of guarding took place. Like the students, the teachers had been in the shifting spotlight and part of a highly politicised process for the last two years.

Questioning began by asking about the strengths and weaknesses of the curriculum; before reflecting on its fit with regulatory learning outcomes; the parity and quality of student experiences and learning; the role of the FHN; and finally focusing on their own personal experiences of being involved in the initiative.

The following Table 2.17 presents a summary of the common strengths and weaknesses as identified by teaching staff.

Table 2.17 Strengths and weaknesses of the curriculum

Strengths	**Weaknesses**
Type of students attracted to the course.	Breadth of content
Theoretical framework	APL/APEL procedure
Family assessment process	Too much assessment
Balance in modes of delivery	Sequence and content of modules
Tailoring of course to specific market	Preparation of supervisors

When asked about the role of the FHN comments were made regarding the project not connecting enough with the students' line managers to enable the role to be enacted more fully. The teachers recognised that there is a need to work in partnership with NHS providers to facilitate service redesign and to provide appropriate education for practitioners.

Several comments were made about the amount of course content which could be taught locally to avoid the students coming on campus. A few words of caution were expressed from the more experienced teachers saying that the students really needed time together on campus and that e-learning suits the educational establishment and the employer but not necessarily the students. Certainly these sentiments were borne out by the students stating how much they valued contact with one another on campus.

Finally comments were made about the way that the initiative was rushed through; the difficult validation processes; the functioning of the Steering Group and the personal strains experienced.

In their own words:

" The course was a very rushed affair with much of the lead in time devoted to contract negotiation and other structural issues. Consequently we pieced together a course in quick time".

" Uni is committed to a range of assessments. OSCE stretched the concept of OSCE beyond or almost beyond recognition. What it is trying to do is examine across a wide range what an FHN is doing as part of the practice of her work".

" There are things that this course is doing because of the pilot nature of it. If you get down to harsh economics things would have to go and I feel that the visits to clinical areas might go beyond what other courses provide"

"It would be great to go out and spend time with students working with families. But that's what we want supervisors to do. The Health Visitor Fieldwork Practice Teacher Role is one that we would aspire to ... but we don't have FHNs to fulfil the role".

"... another potential area for development is that we deliver some of the FHN programme to community staff nurses ... I think we need to think about what community staff nurses need to make them more effective ... this is where our programme originally started"

" Things have worked out better than what I imagined ... Lots of possibilities. I've been a wee bit disappointed when you get someone ... you know ... who's never going to change".

"I think quite a lot of work has to be done around how people understand family. I think there has been some misconceptions about that. I wouldn't like to see the name changed, cos I think we've come quite far in terms of getting the students to think of themselves as family health nurses rather than community nurses"

"The course should continue to be a judicious use of campus and on line learning. I think the most useful learning was the creation of virtual learning networks which could usefully be a model for all rural health care workers"

2.6 SUMMATIVE DISCUSSION

Evaluation of the educational course showed its structure and content to be distinctively different from the other community nurse specialist practitioner courses on offer within Scotland. The FHN course was less flexible in format, did not share core content with other community education courses, and did not dedicate modules to quality issues, teaching and supervision, management or leadership. Rather it emerged as much more focused on its speciality, being theoretically grounded in an ideology of nursing which combined elements of Family Nursing from North America with the promotional ideas from WHO Europe.

This mixture of content differed significantly from WHO Europe's own suggested Family Health Nurse curriculum. The WHO Europe curriculum has more emphasis on management and leadership. Indeed advocates of the FHN role (e.g. Kesby 2002) see the FHN as a nurse leader on equal partnership status with the GP. However the latter interpretation was not a prominent feature of the Scottish initiative. Rather these very experienced community nurses were educationally prepared in such a way that they would be enabled to personally deliver this particular family health nursing approach within their communities.

During the first year of the course a number of major curricular modifications took place, and generally the first cohort of family health nurse students were more dissatisfied with their educational experiences than the second cohort. Most modifications resulted in improvement, but some (such as the introduction of the course APL scheme) were also problematic. Congruence between generic and specialist content within the course curriculum remained difficult to achieve.

Our scrutiny of the educational course has resulted in a number of suggestions for further curriculum development. Table 2.18 summarises these:

Table 2.18 Suggestions for the development of the family health nursing curriculum

Area for development	Suggested actions
APEL and APL processes	• Develop these processes in order to offer full credit exemption
OSCE	• Develop this assessment process in conjunction with the development of the Advanced Family Health Nurse practice module
Clinical Assessment	• Develop tool to reflect the idea of a negotiated learning contract which is student centred and which focuses distinctively on clinical learning outcomes as pertaining to the skills workshops and specialist activity (e.g. family assessments; goal setting and evaluation of interventions).
Module sequence	• Consider re-designing the programme along the lines already suggested to allow for credit exemption and the sharing of content with other community nurses
Preparation of supervisors	• Develop the support mechanisms for supervisors

In many ways the difficulties that arose should not be surprising given the nature of the challenge which the educators faced. In essence they had to accommodate the need for a range of relevant generic content while developing a distinctive new specialist focus that also satisfied the requirements of the UKCC framework. This was a tall order, especially since the role of the FHN was essentially hypothetical during the first year of the course.

The course was very much tailored to a specific market context and the balance between campus attendance and distance learning emerged as being a real strength. Other strengths included the innovative web based facility and the learning of communication skills in the context of family health assessment. Indeed the new family health assessment /promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) were valued very highly and these were seen as central to creating a distinctive new professional identity.

The latter aspect was also tied to the concurrent development of policy and practice. This linkage was innovative and to some extent challenged the existing UKCC specialist practice framework. The simultaneous developmental change process undertaken in the Family Health Nurse initiative did impose particular demands in terms of rapid initiation, creativity and responsiveness, and the effort sustained by individuals (teachers, students and professional colleagues) has been immense and very impressive.

The resultant programme is distinctively different from other specialist community nursing programmes. It emerges as a distinctive Scottish educational hybrid which has produced a skilled and knowledgeable generalist community nurse who has been specially prepared to work in remote and rural health care. It has growth potential unto itself, but it also provides a precedent for other educational providers to reconsider their approach to specialist practice degree level education.

In this regard it suggests the potential value of:

- developing clear theoretical and philosophical bases for specific programmes which encapsulate a strong value based approach to nursing, midwifery or health visiting in the context of primary care
- working in conjunction with service providers to customise courses for specific markets.
- incorporating e-learning approaches and work-based learning strategies alongside more traditional teaching and learning methods.
- working in conjunction with policy makers and service providers to facilitate an incremental approach to service and educational development

CHAPTER THREE THE PRACTICE OF FAMILY HEALTH NURSING

3.0 INTRODUCTION

This chapter of the report presents the main findings from our investigation of the practice of family health nursing during the first year of this new role. To recap, the Scottish Executive Health Department summarised the principles of the role as:

1 A skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required.
2 A model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.
3 A role founded on the principle of caring for families rather than just the individuals within them.
4 A concept of the nurse as first point of contact.

The chapter is composed of four sections:

Methods: a summary of the methods used to investigate and evaluate FHN practice
Typology of FHN practice: this part presents the typology of family health nursing that emerged through comparing and contrasting practice at different sites. The typology is explained through summary analyses of the ten sites where the family health nursing role was introduced and partially developed.
Overview of FHN practice: this part draws together common themes that emerged across the ten sites and aggregates quantitative data to give an overview of FHN practice
Discussion: the final section summarises and analyses the findings

3.1 METHODS

Concurrent evaluation of an evolving, multi-factorial, and geographically diverse development such as the Family Health Nurse initiative mitigates against the use of quasi-experimental research designs that depend on notions of control. Accordingly our research is grounded more in the traditions of qualitative enquiry, while also incorporating survey methods.

In evaluating practice our overall aim has been to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot (i.e. context of development; process of engagement and outcome of practice). This approach adapts Pawson and Tilley (1997)'s realistic evaluation framework so that process rather than mechanism is studied. The goals have been to clarify what FHN practice is in these settings, and then clarify how, and to what extent, the FHN role works under various circumstances. As such, the ten FHN sites active during 2002 are seen as the main units of analysis in this study. Explanatory case study methodology (Yin 1994) informs this approach and knowledge was built at two distinct levels in order to address objective 4 (i.e. *to explore the operation of*

the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites).

Firstly, at the *micro* level, a set of case studies was conducted which focused on the care received by six families in different locations where Family Health Nurses were employed. This involved in-depth, semi-structured interviews with family members, the Family Health Nurse and a maximum of two other key health care professionals involved in delivering care. These cases were selected from a pool of 20 "tracer families" (2 for each FHN site) whose progress was followed during the latter part of 2002. Details of the selection of tracer families and case study families are given in Annex 1. The family members who took part in the case studies were also asked to complete a consultation satisfaction questionnaire (Poulton 1996).

Study of the operation of the FHN model was further contextualised through the researchers making several visits to each site during the course of the project. Profiles of these sites were constructed based on the following data sets:

- Available documentation on the epidemiology and demography of each site location, including any extant health needs assessments
- The FHN students' community portraits
- Summary profiles of all health care staff comprising the core Primary Health Care Team for each site. Summary profiles of all other relevant health, community and social care staff involved closely with the PHCT at each site (e.g. social workers; voluntary sector workers; teachers). Together these groups comprised the "professional stakeholders"
- Community nursing caseload[11] and mix data available from routine collations (variable in quality) and specifically obtained in-person by the research team
- Field notes from interviews with key site personnel. These gathered details of cultural context; working practices; referrals; local resources etc)
- Field notes from telephone discussions with practising FHNs (made throughout project)
- Field notes from direct observations of FHNs' work with selected families
- Scrutiny of the nursing case notes of the 20 "tracer families"

Much of this work was undertaken during 2001 as a baseline from which to address objective 3 (i.e. to compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN). The identification of professional stakeholders was also a first step in addressing objective 5 (i.e. to identify relevant stakeholders' perceptions of the FHN model). In November 2001 we mailed a questionnaire[12] to professional stakeholders at each site seeking their baseline perceptions of the FHN role. This was repeated a year later using a similar questionnaire to gauge the emergent impact of the development.

Details of overall response rates to the professional stakeholder questionnaire on both occasions are given in Table 3.1

[11] Please see explanatory notes in glossary and in Annex 3 on the nature, definition and problems associated with the term caseload

[12] Full details of all questionnaires and interview schedules used in the evaluation of practice are available on CD Rom from the authors

Table 3.1 Overall response rates to the professional stakeholder questionnaire

December 01				**December 02**			
Number sent*	Number returned	Overall response rate	Useable responses	Number sent**	Number returned	Overall response rate	Useable responses
149	**117**	79%	**110** (74%)	**129**	**95**	74%	**88** (68%)

*Includes the site which wasn't subsequently studied in 2002 as the FHN was on maternity leave. Also includes the FHNs themselves. The replies from the FHNs were handled separately and are not included in any of the site summary analyses or other data aggregations used in this chapter of the report

** Excludes the site which wasn't subsequently studied in 2002 and includes the FHNs themselves. Between Dec 01 and Dec 02 some stakeholders left and consequently were not sent questionnaires in Dec 02. Also a number of new stakeholders were identified during 2002 and were sent questionnaires in Dec 02

Response rates for each site are given in Table 3.2

Table 3.2 Response rates to the professional stakeholder questionnaire at each site

	Overall response including FHNs		**Useable responses excluding FHNs**	
Site	*December 2001*	*December 2002*	*December 2001*	*December 2002*
A	6/9 **(67%)**	**7/8** (88%)	**4/8** (50%)	**6/7** (86%)
B	**10/10** (100%)	**9/9** (100%)	**8/9** (89%)	**8/8** (100%)
C	**8/8** (100%)	**5/8** (63%)	**7/7** (100%)	**3/7** (43%)
D	**10/12** (83%)	**10/12** (83%)	**9/11** (82%)	**9/11** (82%)
E	**16/20** (80%)	**13/22** (59%)	**15/19** (79%)	**12/21** (57%)
F	**12/16** (75%)	**10/14** (71%)	**10/15** (67%)	**8/13** (62%)
G	**13/18** (72%)	**12/19** (63%)	**11/17** (65%)	**10/18** (56%)
H	**5/9** (56%)	**6/9** (67%)	**4/8** (50%)	**3/8** (38%)
I	**10/13** (77%)	**14/15** (93%)	**7/12** (58%)	**13/14** (93%)
J	**10/13** (77%)	**9/13** (69%)	**8/12** (67%)	**6/12** (50%)

A similar, but more restricted repeated consultation exercise was conducted with twenty randomly selected members of the public ("lay stakeholders") at seven of the FHN sites[13]. Details of overall response rates to the lay stakeholder questionnaire on both occasions are given in Table 3.3

Table 3.3 Overall response rates to the lay stakeholder questionnaire

December 01				**December 02**			
Number sent*	Number returned	Overall response rate	Useable responses	Number sent**	Number returned	Overall response rate	Useable responses
140	**69**	49%	**59** (42%)	**130**	**51**	39%	**45** (35%)

*Within each of 7 FHN sites, 20 questionnaires were sent to residents who had been selected at random from the electoral roll. One regional ethics committee refused permission for this one particular aspect of the study, therefore 3 sites were not included

** In Dec 01**,** 10 envelopes had been returned by postal services indicating addressee no longer resident. Therefore we did not send questionnaires to them in Dec 02

[13] One regional ethics committee refused permission for this one particular aspect of the study. Therefore 3 of the 10 sites were not sent "lay stakeholder" questionnaires. Otherwise all the research protocols used in this study were approved by the respective regional ethics committees

Percentage response rates for each site are given below in Table 3.4

Table 3.4 Response to the lay stakeholder questionnaire at each site

	Overall response		Useable responses	
Site	December 2001	December 2002	December 2001	December 2002
A	14/20 **(70%)**	**11/16** (69%)	**10/20** (50%)	**10/16** (63%)
B	**11/20** (55%)	**7/18** (39%)	**9/20** (45%)	**6/18** (33%)
C	Not applicable	Not applicable	Not applicable	Not applicable
D	**9/20** (45%)	**5/20** (25%)	**9/20** (45%)	**4/20** (20%)
E	**10/20** (50%)	**6/17** (35%)	**9/20** (45%)	**6/17** (35%)
F	**7/20** (35%)	**7/20** (35%)	**7/20** (35%)	**7/20** (35%)
G	**8/20** (40%)	**7/20** (35%)	**6/20** (30%)	**6/20** (30%)
H	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*
I	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*
J	**10/20** (50%)	**8/19** (42%)	**9/20** (45%)	**6/19** (32%)

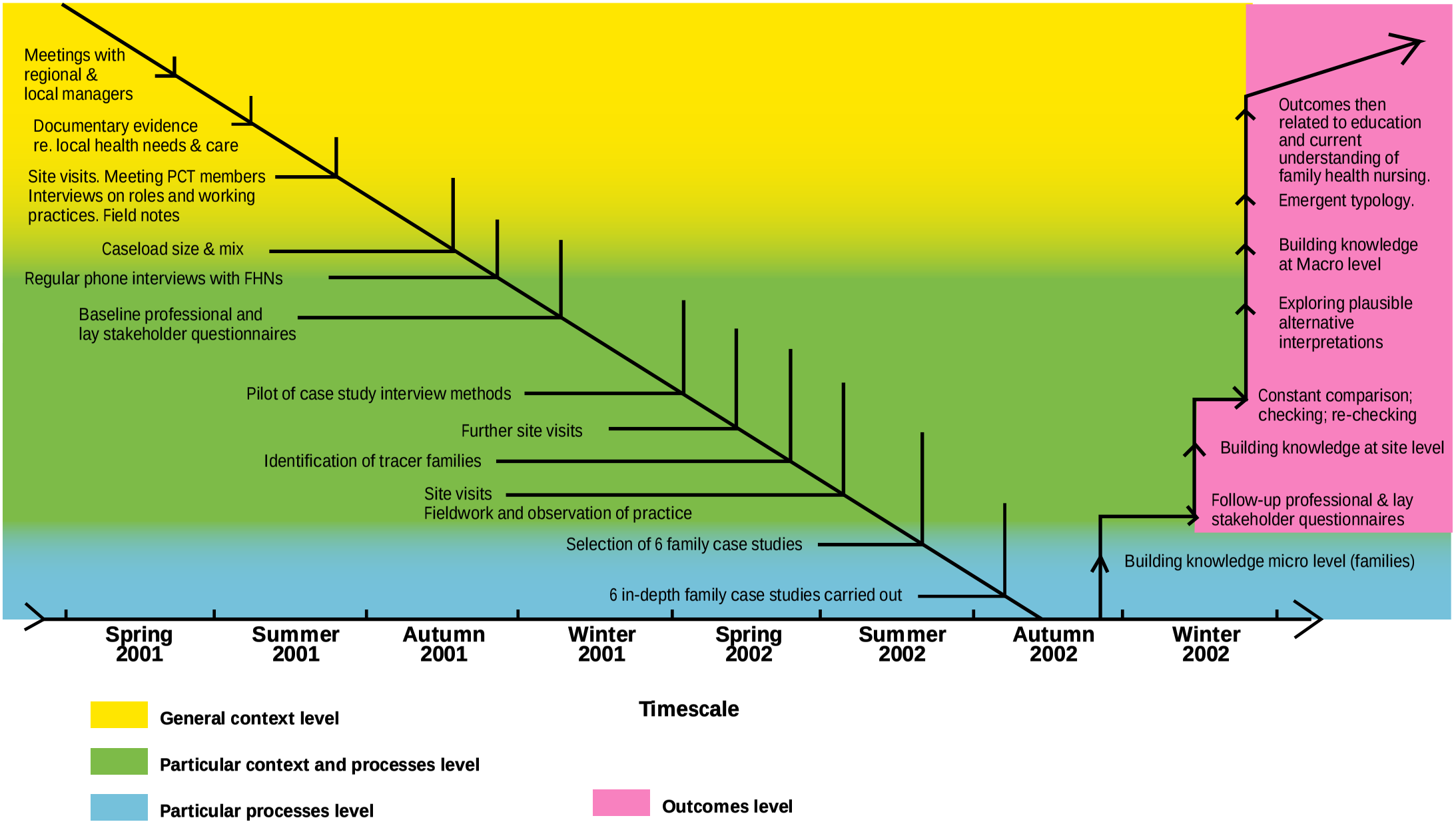
Questionnaire data was entered into an SPSS V10 database and analyses followed the same procedures as described in Chapter 2.

Thus it was possible towards the end of 2002 to draw on all the data sets in order to analyse the emergent patterns of practice in terms of context of development, process of engagement and outcome of practice at each FHN site[14]. This in turn allowed knowledge to be built at the *macro* level whereby the ten, site-specific case studies could be compared and contrasted so as to draw conclusions about what worked under what circumstances and for whom. Although the focus was very much on the first year of work by qualified FHNs, we also visited almost all of the twenty FHN sites scheduled to become active in 2003 and constructed limited profiles.

Figure 3.1 overleaf summarises the evaluation process pictorially.

[14] An overview of this process of analysis and synthesis is provided in Annex 2

The evaluation of family health nursing practice



3.2 TYPOLOGY OF FHN PRACTICE

Before presenting the typology of family health nursing that emerged, it is useful to clarify the context of practice. During 2002 there were ten sites where an FHN sustained activity over the whole year. The eleventh FHN who had completed the education programme during 2001 was on maternity leave for a major part of 2002 and consequently we did not attempt to study practice at her home site.

It must be emphasised that all 10 FHN sites are remote **and** rural as defined by The Scottish Household survey (SEHD 2000). That is, their main settlements all have a population of less than 3000 and are more than a 30 minute drive time from a settlement of 10,000 people or more. All the sites we studied fit easily into this definition.

Secondly it is useful to highlight two operational definitions:

Family Health Nurse site (FHN site): a distinct geographic area whose population are served by one (or occasionally two) district nursing team(s) and wherein an FHN is working. Other health professionals whose work involves the provision of primary care services to the population of this site are known as the Primary Health Care Team

Core Primary Health Care Team (core PHCT): a group of health care professionals whose everyday work is focused mainly or exclusively on the provision of primary care services for the population of the FHN site. The core PHCT usually comprises all the nurses involved in the care of the DN caseload(s), and all Practice Nurses and GPs from GP practices within the FHN site. It may include the Health Visitor and Midwife(s), but this tends to depend on whether they are based within the FHN site or not

At the FHN sites nursing personnel were usually located in buildings where local GP services were based. However the Practice Nurses were the only group employed directly by GPs and the only group whose work was necessarily confined to one GP practice list.

We categorised the sites primarily in terms of common contextual features related to their geography, population density and organisation of primary care services (Table 3.5).

Table 3.5 FHN sites categorised by common contextual features

Category	Common contextual features	Number of sites in this category (and site codes)
1	Site whose predominant feature is a population of less than 500 people living on a small island. The number of health professionals living on site is very low (4 or less). The FHN is responsible for providing nursing services to the whole island population	2 (sites A and B)
2	Site whose predominant feature is a sparsely distributed population of between 500 and 3,600 living within a large, spread-out geographic district where travelling times and distances are high. The number of health professionals within the core PHCT may be between 4 and 19 and there are usually at least two distinct PHCT bases within the overall site. Within the site the FHN usually has been allocated a specific geographic "patch" of her own	6 (sites C,D,E,F,G,H)
3	Site whose predominant feature is a population of between 1000 and 2,500 which is slightly more densely distributed than in Category 2 sites. The number of health professionals within the core PHCT is typically around 10 and there is one predominant PHCT base within the overall site. The FHN is responsible for family health nursing for the whole site, rather than having a specific geographic "patch" of her own	2 (sites I and J)

This categorisation provides context for the typology of family health nursing practice that emerged through comparing and contrasting practice at the 10 different sites (Table 3.6 overleaf). Summary details of the particular sites are given in relation to their respective codes in Annex 3.

Table 3.6 Typology of family health nursing practice

Site category	Site codes	Characteristic context/process/outcome pattern (CPO)	Evaluators judgement	Type name
1	A, B	**Context** Small, stable caseload. High pre-existing scope for nursing autonomy and practice development **Process** Gradual introduction by FHN only, with little/no change in other professionals working practices **Outcome** Positively viewed by the limited number of families who received the service, but not seen by colleagues and general public as substantially different from pre-existing service. More satisfying for FHNs , but also more demanding	**Partial FHN role development**	**High scope-slow build**
2	C, D, E	**Context** FHN role super-imposed on "non-heavy" district nursing caseload within established and functional medium sized PHCT **Process** Gradual introduction by FHN with active, focused support from at least one other professional within the core PHCT **Outcome** Positively viewed by the limited number of families who received the service (often specific types of client group). "Normal" district nursing services maintained. FHNs generally feel they are making progress	**Partial FHN role development**	**Slow build-key ally**
2	F, G, H	**Context** FHN role super-imposed on "heavy" district nursing caseload within established and functional medium sized PHCT **Process** Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices **Outcome** No substantive change in practice. "Normal" district nursing services maintained, but remains stressful for FHN and colleagues	**Very little/ thwarted FHN role development**	**Slow/ No go**

3	**I**	**Context** "Heavy" district nursing caseload within established and functional medium sized PHCT, but FHN role **not** super-imposed **Process** New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some frictions at the boundaries of other professionals' roles. Tensions within the core PHCT **Outcome** Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. "Normal" district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for FHN but much more demanding	**Substantial FHN role development**	**Bold build**
3	**J**	**Context** FHN role super-imposed on local management role at time of change towards an integrated hospital/community team. Background of "heavy" district nursing caseload within established medium sized PHCT. **Process** Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices **Outcome** No substantive change in practice. FHN role not a priority as wider service management changes necessary first "Normal" district nursing services maintained, but stressful for FHN and colleagues	**Very little/ thwarted FHN role development**	**Slow/ No go**

Explanation and illustration of each pattern within the typology is now undertaken using summary analyses of the FHN sites. These site analyses draw on a number of data sources. Where professional and lay stakeholder data is utilised this is based on useable responses (see Tables 3.2 and 3.4 respectively). Firstly *High scope-slow build* is examined through analyses of the two sites characterised by this pattern.

3.2.1 High scope-slow build

As Category 1 denotes (see Table 3.5), these two small island sites shared common contextual features. The district nursing caseloads were small and had relatively few patients needing regular, intensive nursing input. Workload fluctuated but on the whole there was high scope for autonomous practice development within the existing staffing complement. On the other hand there was the responsibility to provide nursing services for the whole island population and this brought with it the particular demands of being almost constantly on-call and being expected to deal with a very wide range of clinical eventualities.

This situation was particularly pronounced at Site A where nursing is the only resident health service for an island with around 70 permanent residents. In this situation the nursing caseload is synonymous with the whole island population and nursing assessment is bound up in everyday social contacts with a substantial proportion of the population. Prior to undertaking the course, the FHN had a long established role as the island's District Nurse and Midwife.

Response to the lay stakeholder questionnaire was particularly good. Prior to the introduction of FHN practice, seven out of ten respondents (70%) had heard about the new role and they generally saw it as congruent with, and virtually indistinguishable from, pre-existing nursing. By the end of 2002 only one out of 10 of respondents (10%) viewed the FHN as a different kind of service:

"There has been no change"

"I think the FHN is ideally suited to our local situation in principle: in practice it has made no difference at all"

"FHN could have been modelled on what was happening here before i.e. District Nurse always providing a high level of care due to the exceptional circumstances of a small isolated community"

Professional stakeholder responses told a broadly similar story and again there was a feeling that the pre-existing service was satisfactory in meeting family needs. Interestingly, however the FHN herself felt that she was seeing practice differently in that the focus on family drew together many different elements of care. She was gradually working to transfer individual's nursing records to Family Health Nurse documentation, but this process was slow (7 of the island's 35 families were on FHN notes by the end of 2002). This was partly attributed to the need for full family assessment to occur but also to difficulties in using the FHN

documentation[15] and doubts about its appropriateness for individuals needing only very specific nursing interventions.

Frustration with documentation was also a theme at Site B. The pre-existing district nursing caseload numbered around 15 clients, many of whom required regular input. Most of these clients and the relatives involved in their care have been assessed using the FHN documentation. Again, however this documentation is not seen as ideal for the nursing needs of some individuals (e.g. those with leg ulcers; wound care), therefore elements of the pre-existing nursing documentation are also incorporated. This has resulted in a number of "hybrid" notes.

New referrals for nursing input who were assessed as having more than very short-term needs were also then given fuller assessment using FHN documentation. This provided a "way in" to include other family members (the "FHN caseload" now totals around 35 individuals) but the depth of development of the assessment and intervention processes is very varied. This variation is not only in response to individual family members' needs but also a result of the FHN finding that such in-depth assessment is time consuming and practically difficult with family members who are out working. There is an aspiration to eventually have all the island's 450 residents as "the caseload", but also a realisation that this would take several years and would entail seeing "caseload" in a very different way.

None of the nine respondents to the lay stakeholder questionnaire at Site B had heard about the new role prior to its introduction. Only one respondent felt it might take away from pre-existing local services. This is relevant because the new FHN had been relief nurse on the island for many years but was now effectively replacing the triple duty nurse who had recently retired. At the end of 2002 there were still few respondents who knew about the role, but none felt that family health nursing was taking away from local services.

Professional stakeholders saw the FHN development as well suited to the site prior to its introduction. They continued to be positive at the end of 2002 with no respondents feeling that the development had been unsuccessful so far:

"Some families benefited considerably"

"They have benefited from the wider remit of the FHN vis a vis the District Nurse"

However opinion was divided about whether there was a specific need for the FHN role.

[15] The Family Health Nursing documentation used by the FHNs in practice during most of 2002 was developed during the educational course in 2001. The documentation incorporated in-depth assessment sections based on the Calgary Family Assessment Model (e.g. use of genogram and ecomap) and included in-depth questions on family power structure, dynamics, strengths and weaknesses. It ran to over 12 pages and during 2002 the FHNs all made extensive individual adaptations in the light of practice. This resulted in a range of hybrid notes that generally incorporated elements of pre-existing standard community nursing notes. During 2002 the Project Steering Group set up a Role Implementation group whose remit included review of family health nursing documentation and towards the end of the year new documentation was produced. This retained the genogram and ecomap but dispensed with recording other parts of the Calgary Model. It incorporated an adaptation of the Omaha Activity Recording System for family health nursing, but at the time of writing the use of this new documentation is just beginning.

At both sites some close professional colleagues still did not fully understand the nature and scope of the FHN role. This seems related to the development of the role being confined to the individual FHN, with relief nurses having minimal involvement in the new style of family assessment that has taken up a lot of FHN time. As such, much of the FHN activity was visible only through the new hybrid documentation. Accordingly these local professional stakeholders comments are not surprising:

"I see no difference from what the nurses were already providing"

"Has always been good interdisciplinary working and this continues with FHN"

"Although well suited to island communities I think the FHN role still needs clarifying to fellow professionals as well as public"

Referrals from professional colleagues have continued to be for usual district nursing type problems (i.e. individual patients). There have only been very isolated occasions when a family has been referred. In effect, the bottom line for the development at both sites has been that the usual district nursing service (which tends to be focused on individuals with health problems) must continue with no detriment and that the new role should be supplementary to normal service. This has been achieved so far because there was already scope for supplementary development but it has meant that progress has felt slow to the FHNs.

Nevertheless they have both managed to develop different, new aspects of practice. At Site A, Healthy Living group-based sessions have been developed with the local community. At Site B, the FHN and local GP jointly initiated a mens' health clinic that has been well received, with substantial uptake of the service.

Role boundaries remain completely unchanged. On local islands where there is no resident Health Visitor or Community Psychiatric Nurse, the District Nurse has always carried out some informal monitoring of general child development and of clients with mental health problems. This has carried on. However, throughout the project there has been a degree of tension locally with the health visiting service due to a perception that FHNs might start to formally carry out child developmental assessments. This possibility was in fact rejected by a regional committee fairly early in 2002 but residual concerns about the definition and scope of the FHN role have persisted.

During the first year of FHN practice there has been no substantive change in the nursing staffing costs at both sites. The characteristic typology for both sites can be summarised as:

Context: Small, stable caseload. High pre-existing scope for nursing autonomy and practice Development.

Process: Gradual introduction by FHN only with little/no change in other professionals' working practices.

Outcome: Positively viewed by the limited number of families who received the service, but not seen by colleagues and the general public as substantially different from pre-existing service. More satisfying for FHNs but also more demanding.

3.2.2 Slow build-key ally

Three of the six Category 2 sites (C, D and E; see Table 3.5) were found to share the characteristic *Slow build-key ally* pattern (see Table 3.6). These sites also shared the following common characteristics as a baseline:

- The FHN was trying to introduce the role on top of a pre-existing district nursing caseload. Two of the FHNs had been allocated a distinct geographic patch within their PHCT site and their work was normally restricted to that patch unless called on to cover sickness or holidays.
- The district nursing caseloads inherited by the FHNs typically comprised 30-48 people, the majority of whom were elderly. The caseloads were not perceived as heavy and had relatively few patients needing very regular, intensive nursing input. Workload fluctuated (e.g. with terminal care cases) but on the whole there was scope for FHN practice development without changing the pre-existing working practices of the district nursing teams at these three sites.

Study of these sights yielded a further key characteristic that emerged during the year:

- The FHNs had one or more key allies within the core PHCT who recognised the need for the role and actively supported it through their routine working practices (e.g. by referring families to them).

At Site C the FHN was still practising as a Midwife and she expanded the FHN role from the basis of her small midwifery caseload. This was done by continuing to care for families after the usual 10 day post-natal period of community midwifery input ceased. She was very actively supported in this by a Health Visitor colleague who shared the same home base site. Joint visits to the families were conducted initially and there was sharing of skills. While an element of duplication was acknowledged (particularly as several different sets of notes were in use), this was seen as a useful joint basis from which to develop more complementary working. Because the HV covered such a wide geographical area, she felt that she tended to have to concentrate on child health, whereas the FHN seemed better placed to have more in-depth input with these local families. This would include doing routine child developmental checks when there was mutual agreement on competency.

With the encouragement and support of the local GP, this FHN also developed a hypertension clinic (there was no Practice Nurse locally). This was successful in terms of a service for individual patients but raised some dilemmas for the FHN in terms of how, when and why a specific family health nursing approach might be applied. She developed FHN notes for a few families through this clinic.

Prior to the introduction of the new role, professional stakeholders at Site C were generally supportive with none feeling that the development was unsuited to local context. The three respondents at the end of 2002, all positively saw the need for a distinct FHN role locally.

Initial opinions about the suitability of the FHN development were more mixed at Site D. Subsequent FHN working at this site involved some joint working with an HV, but it was less sustained than at Site C as the HV was based elsewhere. The FHN developed good working relations with the local Primary School and now has weekly sessions doing health

education/health promotion work. She also developed some health educational materials for the local farming community.

The FHN has been supported in these endeavours by the local Practice Nurse whose routine work with the elderly of the local community involves some home outreach activities (e.g. blood pressure and pulmonary monitoring) and is well integrated with other services. Thus the FHN has had more chance to develop the child health/community aspect of her role. By the end of 2002 five out of nine professional stakeholders at Site D (56%) positively saw a need for a distinct FHN role locally and no-one thought the role unsuited to local context. The response rates for the lay stakeholder questionnaires were low at this site, but respondents were generally supportive of the idea in principle.

At Site E the FHN has developed a particular strand of her role in the area of mental health. This involves spending more time with individuals and families in the local community who are having problems with substance misuse (almost exclusively alcohol). Much of this has involved building trust. She has been supported in this work by the local Community Psychiatric Nurse and Substance Misuse Worker, who in turn have benefited from more regular linking. One local GP has also been particularly active in encouraging the FHN role and has referred several families to the service.

Site E is interesting in that prior to the introduction of the FHN role eight out of fifteen professional stakeholders (56%) saw it as unsuited to the locality and six (40%) thought it likely to fail. By the end of 2002 there was little change in the former figure, a slight reduction in the latter figure, and only three professional stakeholders out of twelve (25%) saw a positive need for a distinct FHN role locally. As such this site demonstrates the gradual development of a specific aspect of the role despite fairly high levels of doubt amongst fellow professionals. It also shows the importance of interpreting the stakeholder data in the light of site visits, in that some professional stakeholders are more active and influential than others in their ability to support role development. The majority of lay stakeholders who responded knew little about the FHN development but were generally supportive of the idea.

These three summaries show different aspects of the FHN role being developed. As yet most of these are small scale expansions into areas where there is an opportunity for service development and/or an acknowledged local gap in services. Sometimes there have been elements of duplication and not all professional stakeholders have seen the need for the role. The development of the role has typically occurred only within the specific FHN geographic patch and this may explain why some other members of the same PHCT have not been aware of any particular process or impact. It was notable that the key allies were always based in the same specific geographic patch as the FHN, rather than at a different base within the whole PHCT site.

The FHNs themselves have tried to apply their new way of nursing so that the whole emergent caseload is conceptualised as family health nursing. This has not always proved easy however and often there has been inherent tension amongst the constituent parts. These constituent parts would typically consist of the district nursing caseload of individual patients; a small number of families who have been fully FHN assessed and are receiving active interventions (some of whose members may be individual patients); and all the general public in the “patch” (i.e. the local community).

However the role development has been more sustained in these sites compared with the other Category 2 sites and the active support of one or more key allies emerged as an important contributory factor. Typically there has been no net increase in nursing staff/budget at these sites.

The characteristic pattern can be summarised as:

Context: FHN role super-imposed on non-heavy district nursing caseload within established and functional medium sized PHCT.

Process: Gradual introduction by FHN with active, focused support from one or more professionals within the core PHCT.

Outcome: Positively viewed by the limited number of families who received the service (often specific client groups). Normal district nursing services maintained. FHNs generally feel they are making progress.

The final two context-process-outcome patterns that emerged were the *Slow/No go* and *Bold build* patterns. Explanation and illustration of these patterns will continue with summary analyses of sites with these characteristics.

However, further illumination can be found in Annex 4 where one in-depth site case study is presented in relation to each pattern. We have chosen to do this as the *Slow/No go* and *Bold build* patterns represent different ends of the spectrum of family health nursing that we studied. Within this contrast lies a great deal of useful knowledge about how the FHN role may or may not work. These in-depth site case studies have been constructed to illustrate particular themes that are characteristic of these patterns. In doing so they also offer the reader further insights through the words of Family Health Nurses, family members, professional colleagues and the researchers. As such, Annex 4 supplements the more basic summaries that now follow.

3.2.3 Slow/No go

The remaining three Category 2 sites (F,G and H; see Table 3.5) were found to share the characteristic *Slow/No go* pattern (see Table 3.6). These sites shared the following common characteristics as a baseline:

- The FHN was trying to introduce the role on top of a pre-existing district nursing caseload. Two of the FHNs had been allocated a distinct geographic patch within their PHCT site and their work was normally restricted to that patch unless called on to cover holidays or sickness.
- The district nursing caseloads inherited by the FHNs typically comprised 33-55 people, the majority of whom were elderly. The caseloads were perceived as heavy. Workload did fluctuate, especially in relation to terminal care cases, but there was a general feeling of little time being available in which to develop the FHN role. One of the sites in particular was short in its staffing complement during the year of practice studied.

At Site F the FHN was allocated a distinct geographic patch within the PHCT site, but lacked access to any office amenities when working there. This resulted in long travel times. The FHN continued to practise as a midwife, providing ante natal and post natal care to a very small number of mothers.

Prior to the introduction of the new role most of the professional and lay stakeholders who responded were unsure whether it would be suited to the local context. During the ensuing year the FHN found it difficult to develop momentum in taking the role forward, despite her feeling that there was much potential in the area. She perceived the "hands-on" work demands of the district nursing caseload to have priority over her own goal of assessing families needs and developing related care packages. During the year she did achieve the latter with two families who had members who were already receiving district nursing interventions. Furthermore she developed her work with three families whom she had seen as a student. Generally, however, work with these five families was sporadic and fitted in around the demands of traditional district nursing caseload work. When the FHN was on holiday these families would not receive input unless there was a need for district nursing contact.

The FHN felt that she was now more aware of family problems in the course of her district nursing caseload work. However she would not necessarily use the full FHN documentation in these situations as she felt that it might open up a range of related issues that she would not have time to fully address. This caused the FHN significant intra-role conflict and she tended to use the traditional nursing notes to record relevant family issues in a more limited way.

Although treatment and intervention work tended to take precedence, the FHN managed to develop a local health support group with a particular focus on weight management and the prevention of related health problems. This was supported by the local dietician. Nevertheless most of the FHN work at this site was solitary in nature and this is reflected by the fact that she received no referrals of families from any colleagues during the first year of practice. By the end of the year only one of eight professional colleagues (13%) saw substantial change in professional working practices or service delivery. Similarly only one saw a positive need for a distinct FHN role locally. Despite this significant degree of professional isolation the FHN remained fairly optimistic that a family health nursing approach could be successful if it was supported through a team approach.

Professional isolation was also a feature at Site G despite colleagues being very personally supportive towards the FHN. The introduction of the FHN role at this site is described in greater detail in Annex 4, but one of the interesting features was the way that the core PHCT set up an open diary for ongoing team reflection on the process of implementing family health nursing. Professional stakeholders initially reported mixed perceptions in regard to the impending introduction of the role, with five out of eleven (46%) believing it to be unsuited to the local area and two (18%) thinking it well suited.

The FHN had previously worked at the site for many years as a District Nurse. Late in 2001 she was allocated a specific FHN geographic patch within the district. During the first three months of practice there were several terminal care cases within this patch and very regular, sustained input was required. This inhibited early development of the FHN role beyond the district nursing caseload. Yet throughout the year it also proved difficult to expand activity within families who already had a member receiving district nursing input. Again the

demands of the district nursing caseload and lack of time were seen as the main reasons for this.

It proved possible to engage in sustained, in-depth family work with less than five families during the year. Customised documentation was used for these families. This involved a fusion of the full FHN notes with traditional nursing notes. The resultant documents provided comprehensive evidence of care but were unwieldy. Although the FHN enjoyed good relationships with patients and other family members within her patch it did not necessarily follow that she was seen as the first point of contact. Local custom was to contact the district nursing service or seek direct medical input as required, and this did not change during the first year of FHN practice.

Some health promotion and screening work was developed in the local primary school by the FHN with some support from the local HV. Again this activity was sporadic and difficult to sustain due to other perceived priorities. For the FHN's colleagues the priority was that normal district nursing service delivery within the whole district should not be adversely affected by the introduction of the new role, and this belief was largely shared by the FHN herself. The open diary entries included colleagues' concerns that the routine data returned monthly on patient contacts did not properly reflect their own input to the FHN patch.

During the year some extra nursing auxiliary hours were allocated to assist the development of the role, but by the end of the year there was general consensus that the role wasn't working. For the FHN and many of her colleagues the problem lay in the role being based on a busy district nursing caseload. Although a specific geographical patch had been hived off for the FHN, the advent of the new role was not seen as an opportunity for any substantive review of nursing caseloads or working practices within the team. During the year there were less than five referrals of families to the FHN.

Many colleagues felt that it would have been better if the FHN role had been supernumerary and not cover a district nursing caseload. When this scenario was explored in greater depth however, it became clear that the problem was more fundamental. In effect the PHCT felt that existing services for local families were already very good and there was no gap to be filled. Generally the team had not felt well consulted about the initial introduction of the role, and by the end of the year only one out of ten professional stakeholders (10%) felt that there was a positive need for a distinct FHN role. Most of the lay stakeholders who responded felt unable to give an opinion on the implementation of family health nursing so far.

Understandably the FHN at Site G felt frustrated that development of the FHN role had been so difficult to achieve. This feeling was shared by her colleague at Site H where there had been a persistent shortage of staff during the first half of 2002. This had resulted in the FHN having to cover the whole district during this time. In turn this had entailed particularly long travel times and she felt that the ongoing demands of the district nursing caseload (and the episodic demands of her small midwifery caseload) took priority.

Accordingly she was only able to develop the FHN role more fully with a few families during this time and her level of input varied. She found the full FHN documentation cumbersome and tended to customise the existing nursing notes. Professional colleagues were generally well disposed to the FHN concept prior to its introduction and they remained so during the first year. However they were small in number, geographically scattered and tended to be pre-occupied with maintaining pre-existing levels of service delivery.

Matters improved in the second part of the year with the recruitment of more staff, but it still proved difficult to gain momentum in developing work with families. At the end of the year one of the three professional stakeholders who responded saw a positive need for a distinct FHN role within the district. Nevertheless the FHN remained hopeful that family health nursing might develop well in the district if it could be supported and integrated within the overall team approach. This prospect was felt to be realistic as she already had close support from an FHN working in an adjacent district, and a further FHN was due to start work within Site H in 2003.

These three summaries of FHN role development at Category 2 sites show progress to have been slow or at a standstill during the first year of practice. While the presenting cause for this has usually been cited as the time demands imposed by heavy district nursing caseloads, there has been a more fundamental underlying lack of active support for the new role at these sites. Other team members have generally not engaged with the role to the extent that it could be seen as at all integrated with team practice. Rather there has been a pre-occupation with the maintenance of existing services and service priorities. Often this has reflected persistent professional perceptions that there is no clear need for this sort of new role in these districts. Typically there has been no net increase in nursing staff/budget at these three sites.

In summary family health nursing at these sites can be characterised as:

- sporadic, and seldom developed or sustained, despite much effort
- not necessarily seen as needed by professional colleagues

The characteristic pattern can be summarised as:

Context: FHN role super-imposed on "heavy" district nursing caseload within established and functional medium sized PHCT.

Process: Sporadic and limited introduction by FHN only, with little/no change in other professionals' activities.

Outcome: No substantive change in practice. "Normal" district nursing services maintained, but remains stressful for FHN and colleagues.

A variant of this characteristic pattern was also seen at one of the Category 3 sites (Site J). This site is interesting as the FHN had been working as G grade leader of a fairly large community nursing team prior to starting the course. As such there was the possibility that the site might offer particular potential to study the FHN as a team leader for a whole district. During the year, however, wider service management changes resulted in the FHN becoming Lead Nurse for the district. This brought with it the responsibility to lead the integration of community nursing services with local community hospital services. Preoccupation with this agenda meant that the development of the FHN role was never a priority. Accordingly assessment and planning of care for families using FHN documentation tended to be infrequent and fitted in around other work demands. As a practising midwife, however, the FHN did feel that the roles integrated well and enhanced her input with mothers and babies.

There was little substantive delegation of family health nursing work (rather than district nursing work) to other members of the team. In effect the FHN role remained marginal to service provision and this is reflected in the feedback from the six professional stakeholders

who responded at the end of 2002. None perceived any substantive change in professional working or service delivery. None felt that the role was succeeding and none saw a positive need for a distinct FHN role locally.

This variant of the *Slow/No go* pattern can be summarised as:

Context: FHN role super-imposed on local management role at time of change towards an integrated hospital/community team. Background of "heavy" district nursing caseload within established medium sized PCT

Process: Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices

Outcome: No substantive change in practice. FHN role not a priority as wider service management changes necessary first "Normal" district nursing services maintained, but stressful for FHN and colleagues

3.2.4 Bold build

The distinctive *Bold build* pattern (see Table 3.6) was found to be unique to Site I. Development of the role at this Category 3 site (see Table 3.5) is examined in greater detail in the site case study presented in Annex 4.

At Site I the FHN was responsible for family health nursing for the whole site, rather than having a specific geographic patch of her own within the site. The real novelty of the FHN role in Site I though, was that it was not superimposed on the existing district nursing caseload. Rather the FHN built up a group of clientele "from scratch", primarily through referrals from other health and social care professionals, but also through direct self-referrals from local people.

Prior to the educational course the FHN had been employed at the site as an E grade community staff nurse for 15 hours per week. During the education course the FHN and colleagues from the project team initiated meetings to try to explain the new role to professional colleagues and the local public. The FHN's colleagues generally felt, however, that they had been poorly consulted prior to the introduction of the role and many were unclear about what the role involved and did not involve. From the start of 2002 the new G grade full time FHN role was developed in such a way that it was distinct from the district nursing service. The process of introducing and establishing the role entailed considerable stress for the FHN and a number of colleagues within the core PHCT.

Nevertheless most colleagues within the team soon became active in making referrals. Some patients from the district nursing caseload were actively referred for family assessment and this resulted in a small number of patients receiving both services concurrently. As the year progressed the FHN developed work with a core group of around 20-25 families at any one time. Site I had a particularly high proportion of elderly patients with chronic conditions and much of the FHN's work focused on secondary and tertiary prevention work with these patients and their families.

Such work often involved regular and sustained input, with visits typically lasting between 60 to 90 minutes. FHN documentation was used comprehensively with evidence not only of assessment but also of very detailed care planning, interventions and evaluation of progress. Within the core PHCT it was generally acknowledged that the FHN service was providing this group of families with in-depth care and some colleagues saw it as a positive response to a real gap in service provision. These professionals felt that they themselves often didn't have time to provide this level of service. This view was not unanimous however and other colleagues felt that the pre-existing level of service was satisfactory and were unconvinced of any extra benefit that might be attributable to the new role.

Within the core PHCT there was also some concern about who should receive this new service and whether a "two-tier" situation might be arising. These concerns were related to perceptions that the FHN caseload was separate and finite, and that the role was not integrated in the sense of being a necessary part of an open, on-call primary care service that would have to respond to the full range of community nursing and/or medical priorities. In this regard colleagues questioned whether an FHN could truly be the first point of contact for local families.

As the year progressed the FHN vigorously developed more broad-based community work that focused on health promotion and empowerment. This came to assume around 30% of the FHN workload. Such activity included a regular, open general health clinic in the GP surgery; work as the health link person for the local community centre which included offering teenage girls the chance to discuss contraception and other health and lifestyle issues; joint facilitation of an exercise, music and health group for over 65s in the village; weekly visits to the local Day Care Centre offering ad-hoc health checks and information/advice; and setting up a community reference group to enable the local community to pass on their views on local health needs.

This work was particularly well received by professional stakeholders within the wider health and social care community at this site. Within the core PHCT however, some concerns remained that these FHN services were being developed in isolation from overall PHCT services. Anxieties over infringement of role boundaries remained a persistent feature during the first year of FHN practice at this site.

Nevertheless by the end of the first year four out of thirteen professional stakeholders (31%) locally did see it as providing a substantively different service, while two (15%) actively took an opposite view. This contrasts markedly with all the other sites and tends to confirm the distinctiveness of this FHN role development. Seven respondents (54%) felt the development to be well suited to the area. Eight (62%) thought it likely to lead to an improvement in local health service and none characterised it as a failure. Five respondents (39%) felt the development had involved substantial change for professionals in the way they work together.

The majority felt that the development had added to, rather than taken away from, pre-existing local services. This perception was not universally shared, however, and amongst the district nursing team there remained a feeling that they had lost 15 hours of service provision from their team. This highlights that family health nursing was being seen within the core PHCT as a different kind of service that should be supplementary to the maintenance of normal service, rather than supplanting it. Indeed district nursing activities continued very

much as normal during the year. There was a small net increase in spending on the total nursing staff budget at the site during the period that FHN practice was introduced.

By the end of the first year six of the thirteen professional stakeholders who replied (46%) felt there was definitely a need for an FHN locally. Four did not know (31%) and two felt that there wasn't (15%). The fact that most of the core PHCT had actively referred families to the FHN in sufficient quantities to form a new caseload tends to confirm the need for an additional service of some kind. There were still doubts, however, about what the format of that service should be.

The characteristic pattern of FHN development at this site can be summarised as:

Context: "Heavy" district nursing caseload within established medium sized PHCT, but FHN not super-imposed.

Process: New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals' roles. Tensions within the core PHCT.

Outcome: Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. "Normal" district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding.

3.3 OVERVIEW OF FAMILY HEALTH NURSING PRACTICE

In drawing together common themes that emerged across the ten sites, we can now make a number of more general points about the nature, coverage and extent of primary care nursing services pre and post introduction of the FHN role.

Firstly it is noteworthy that in our contacts with families and through the consultation with lay stakeholders there was very little evidence that local people were dissatisfied with pre-existing service provision. On the contrary several families compared the level of service very favourably with that received in other parts of the UK and abroad. These families valued the range, depth and personal nature of the health services provided and there was concern that these elements should be maintained and not eroded.

During the first year of practice the majority of families who had involvement with an FHN did so because a family member was on the district nursing caseload. Where the FHN role failed to thrive that involvement remained focused predominantly on the individual and was virtually indistinguishable from "normal" district nursing. However it is important to note that all the FHNs felt that they were seeing these families much more as a whole and that this gave their practice a different quality. The difficulty was that this was not tangible for many of their close professional colleagues. To some extent this relates to the more general problem of the invisibility of nursing work conducted in peoples' homes.

Across the 10 sites there was an embedded "bottom line" that the introduction of the new role should not adversely affect the pre-existing level of district nursing service. This was a belief held not only by professional colleagues but by the FHNs themselves who inherited district nursing caseloads. Although there have been stresses for colleagues in cross-covering FHN "patches", and some instances of FHNs insisting that they could no longer do some of the former routine work, on the whole the pre-existing district nursing services have remained unchanged. Indeed the FHNs have usually felt obliged to prioritise this sort of work over overt family health work.

This means that where the role has been developed it almost always supplements rather than supplants existing service. As the previous explanation of the typology illustrates, this has given rise to some interesting and varied developments of primary care nursing services. At some sites (e.g. *Slow build-key ally*) these developments were planned actively with colleagues and could be seen more as integrated PHCT initiatives for the local community. More often they were developed by the FHN alone as an opportunistic response to perceived need. Such need did not emanate solely from their assessment of services in their communities but also from their own felt need for a visible community role that broke free from the district nursing caseload.

Thus many FHNs started to run "healthy living" groups in the evenings that were open to all. These have allowed development of primary prevention work often focused on weight and diet. Such groups have had mixed success so far (men almost never attend) but have been a way of making the FHN service more accessible to the public. FHNs have also used local shops and media to advertise their role, and recently a generic information leaflet has been produced that can be distributed in communities.

Between this type of open outreach and the confines of the district nursing caseload there has been difficult ground to negotiate. One lay stakeholder's comments capture the dilemma:

"If prevention is the aim, how is this to be delivered? Are families to be chosen on perceived socio-economic criteria or some other at-risk category, and once selection is made, how will subject be broached? I would rather see those in need of care get it as priority over some service that could be delivered in an intrusive and ad-hoc manner"

None of the FHNs have done "cold calls" knocking on doors to offer the service, but some have made introductory phone contact with new families moving into these small communities.

In effect the FHNs have been dependent on professional colleagues for a "way-in" to families who do not already have contact with district nursing services. This was required when the FHNs were students on placement during the educational course, but since then referrals of families have been relatively low (78 professional colleagues replying to the stakeholder questionnaire reported referring a total of 30 families in all). The majority of referrals to FHNs have continued to be for district nursing type service to individual patients. There was evidence from site visits and stakeholder questionnaires that the new FHNs were themselves active in referring individual patients and families to other colleagues and services.

Preventative work usually involved FHN input at secondary and tertiary levels for couples of the same generation, two generational families, and single people living alone (i.e. the typical client groups for district nursing). However most FHNs had ongoing input with at least one

family with young children and some of these families had more complex structures (e.g. two generations with two families coming together through re-marriage; three generational families with several households). The input here was usually primary prevention relating to common aspects of family living (e.g. diet; exercise). In the first year of practice very little FHN work has taken place in common dwellings such as residential homes or nursing homes, but some of the sites had no amenities of this sort anyway.

Operationalising the family-as-client philosophy became more difficult where several households were involved, but this does not mean it was easy within single households. The logistical difficulties of trying to see members of a family group individually and in combination cannot be overstated. Often evenings or weekends would be preferred by families, but regular work at these times was not provided for in FHN contracts and would not necessarily have been welcomed by all FHNs. Working men in particular had little contact with FHNs.

Moreover the nature of the family assessment process itself raised particular challenges. Completing a genogram and ecomap with family members was found to be a very time consuming process that typically involved a number of lengthy home visits. The 1-2 hour long visits referred to in the Site I case study were typical for FHN assessment visits. The following extract from another case study interview with an FHN highlights some common difficulties:

FHN: *... so this took a wee while and she then trusted me and had confidence in what she was saying to me. It took quite a few visits too and then once it was opened, where was the cut off point? You know there was so much that she has unspoken and then well a lot of it you just didn't record.*

Researcher: *I think again it is interesting when you elicit so much information there is only so much that you would be putting into the document.*

FHN: *There is also the confidentiality side when you have other professionals who could have access to your notes.*

Researcher: *It does raise the question for me of how you use the genogram then. Who is it for and what use is it?*

FHN: *Well exactly. It is only really for the FHN. I mean nobody else would understand the genogram, you know the ins and outs unless you are taking them through it. I mean I do outline to the family the reasons for the genogram and the ecomap to highlight strengths and weakness as you know.*

Researcher: *Do they have a copy of it?*

FHN: *No they don't have a copy of any of the notes, I keep the notes back here.*

Researcher: *But in terms of other professionals, they wouldn't ...*

FHN: *I wouldn't show them myself.*

Thus we see the power of the family health nursing assessment to elicit a range of narrative over time that gives insight into family health, background and functioning, but also the associated dilemma of what to do with such information and the resultant tendency for it to become the sole property and province of the FHN. None of the six families that we studied in depth actually had a copy of the genogram or ecomap in the house. This may be related to another practical ethical problem concerning confidentiality between individuals within families.

The original comprehensive FHN documentation developed during the educational course included in-depth questions on family power structure and dynamics. In practice such an overt focus on typically covert issues was found to be unsuited to Scottish Highland and Island culture. FHNs felt that such questioning could often be uncomfortable and inappropriate for family members, especially if several were present. It is interesting to note that the North American influence is much reduced in the most recent FHN documentation produced through the Role Implementation Group.

Some of the discomfort alluded to above undoubtedly belonged to the FHNs themselves. There was no doubt that insights into power and dynamics could be useful to inform care, but these could often be gleaned more subtly than by direct questioning. Some of the FHNs reported encountering families/family members who didn't wish to participate in the sort of in-depth assessment being offered, and this was usually because they found it intrusive and/or didn't see why it was needed. These sort of overt refusals were relatively rare and this is almost certainly attributable to the fact that the FHNs were very experienced community nurses who used their inter-personal skills to tailor the assessment content to the situations encountered.

Much of the explicit FHN activity during 2002 involved the assessment of local families. The depth and development of this work varied but, with the exception of Site I, it generally proved difficult for FHNs to progress sustained, in-depth programmes of interventions and evaluations for more than a few families. Although plans with goals were usually explicit in the FHN documentation that we studied, we found that family members usually struggled to identify any joint family plan or specific individual goals, and never portrayed themselves as active participants in a specific shared contract. Perhaps this is more a reflection of a general culture of patient passivity than a reflection on the efforts of the FHNs. This mother and daughter were typical:

Researcher: *At the moment is there any sort of plan, if you like, for your health that you are working on with Una(FHN)? Any kind of plan?*

Mother: *She hasn't mentioned anything has she?*

Daughter: *No she hasn't.*

Mother: *And I've not thought to be honest. I haven't really thought about anything.*

Nevertheless the family members that we interviewed were knowledgeable about the range of health services in their respective areas and it was interesting to note that they did not necessarily see the FHN as their first point of contact for a health problem. Typically they would say that it depended on the nature of the problem and who would be most suitable and readily available. Even where the problem was specifically within the nursing domain, it was

not axiomatic that the FHN would be the first choice (unless at sites where only an FHN was available). These families valued FHN input, but they also valued choice of a range of responsive services. Talking of the FHN, HV and GP this couple said:

Pregnant mother: *... so you know that if you've got a problem you can just lift the phone and you'd get one of them.*

Male partner: *They have an understanding of what we're about- of the problems that we might encounter or how we deal with things ... I guess it just prepares them more to give us a better level of care than just, you know, Glasgow or Aberdeen and walking in somewhere and you're a number.*

Confirmation that these families were satisfied with FHN care was evident from their responses to the adapted version of the Consultation Satisfaction Questionnaire (Poulton 1996) that they completed towards the end of 2002. These highlighted the inter-personal skills of the FHNs and the value family members placed on the time that had been spent with them.

3.3.1 Professional stakeholders' views

The end of the year also saw the collation of responses from the follow-up professional stakeholder questionnaire. Although this material has been analysed primarily at the level of each site, there is some value in its aggregation to give an overview of colleagues' perceptions of the FHN development so far. Table 3.7 presents professional stakeholders' responses to a number of statements in the follow-up questionnaire (December 2002). The table is based on responses from a total of 78 professional colleagues of the FHNs.

Table 3.7 Professional stakeholders' responses to questions post introduction of FHN

Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 78 this indicates that the remainder of respondents did not answer that particular question.

I think the FHN delivers a **different** type of service to what is currently available	**Unsure**	I think the FHN delivers a **similar** type of service to what is currently available
12 (15%)	**35** (45%)	**29** (37%)

I think the FHN has **taken away** from pre-existing local services	**Unsure**	I think the FHN has **added on** to pre- existing local services
7 (9%)	**46** (59%)	**22** (28%)

I think the FHN development has involved **substantial change** in the way that services are delivered to patients	**Unsure**	I think the FHN development has involved **minimal change** in the way that services are delivered to patients
6 (8%)	**34** (44%)	**33** (42%)

I think the FHN development has involved **substantial change** in way professions work together	**Unsure**	I think the FHN development has involved **minimal change** in way professions work together
10 (13%)	**31** (40%)	**33** (42%)

I think the FHN development is **well suited** to our local context	**Unsure**	I think the FHN development is **not well suited** to our local context
23 (29%)	**31** (40%)	**19** (24%)

I think the FHN development will lead to an **improvement** in local health service	**Unsure**	I think the FHN development will lead to a **deterioration** in local health service
26 (33%)	**41** (53%)	**5** (6%)

I think the FHN development is **succeeding** locally	**Unsure**	I think the FHN development is **not succeeding** locally
16 (21%)	**37** (47%)	**17** (22%)

The above results show that professional colleagues are still unsure about the impact of many aspects of the FHN development, but also that the status quo has not been substantially altered so far. Few see the FHN as taking away services and engendering deterioration. A comparison was also made using data from the 53 professional stakeholders who responded on both occasions (Annex 5). This shows that there has been very little overall shift in these stakeholders' perceptions.

At follow-up we also elicited professional stakeholders' views on whether they saw the need for a distinct FHN role locally. Overall opinion was fairly evenly divided, with 31% seeing a need, 33% not seeing a need and 28% indicating that they didn't know. When this data is broken down into responses from distinct professional groupings the results are interesting. Table 3.8 provides details.

Table 3.8 Professional groups' responses at follow-up to question Is there a need for a distinct FHN role locally? *Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages of each row*

Professional group	Response				
	Yes	No	Don't know	No answer	Total
District nurses	**2** (33)	**4** (67)	**0**	**0**	**6**
Community staff nurses & auxiliaries	**4** (27)	**6** (40)	**3** (20)	**2** (13)	**15**
Health visitors	**2** (22)	**4** (44)	**2** (22)	**1** (11)	**9**
Practice nurses	**1** (10)	**4** (40)	**5** (50)	**0**	**10**
GPs	**7** (37)	**6** (32)	**6** (32)	**0**	**19**
Other health professionals (e.g. physiotherapists; dentists; midwives; occupational therapists; specialist nurses; local nurse managers)	**4** (31)	**2** (15)	**4** (31)	**3** (23)	**13**
Workers in wider community (e.g. voluntary sector; social worker; school teacher; project worker; home care co-ordinator)	**4** (67)	**0**	**2** (33)	**0**	**6**
Totals	**24** (31)	**26** (33)	**22** (28)	**6** (8)	**78**

These results suggest that the other professional nursing groups at the core of PHCTs tended to be less receptive to the new role than the wider spectrum of professional colleagues. This affords opportunity to briefly summarise the perceptions of the different professional groups about the FHN development.

3.3.1.1 District Nurses, community staff nurses and auxiliary nurses

This group was generally the most affected by the FHN role development. Some adjustment of working arrangements was usually necessary to accommodate the new role, but this usually took the form of separation of FHN work into a "patch" rather than substantive, integrated site review of caseload management. Nevertheless at some sites there were strains relating to cross-cover especially when there was staff illness or shortages. Very few of these staff were hostile to the FHN role, but more felt that family nursing happened already and could not understand the new role and the need for it. It is important to note that four of the new FHNs were already qualified District Nurses and most of them found that colleagues and clients still saw them in their former role.

3.3.1.2 Health Visitors

At national level this is the group that voiced most concerns about the new role when it was first mooted. During the first year of FHN practice, however, there was very little substantive impingement on the work of the Health Visitors at the ten FHN sites. With the possible exception of Site I, FHN forays into overt child health work and community health promotion have been on a small scale. Some local HVs have welcomed this as extra help and worked closely with the FHNs to share skills and avoid future duplication. With their geographically widespread caseloads, these HVs have taken the view that another health worker could help address the needs of some family members that they don't often see (e.g. the elderly and men). Others have been more resistant and have either not engaged at all with the

development or sought to re-enforce professional boundaries (often formal child health development checks are seen as "the line in the sand"). Many continue to have concerns about the integration of the FHN role into PHCT service provision.

3.3.1.3 Practice Nurses

There were Practice Nurses at seven of the ten FHN sites. Many had very little working contact with FHNs and felt unsure about what the new role entailed. At one site several Practice Nurses felt that the development had disrupted team working practices in that the FHN was no longer so willing to be involved in elderly assessments and immunisation programmes. Only one Practice Nurse was markedly enthusiastic about service development opportunities for the new role.

3.3.1.4 General Practitioners

GPs are key players in all PHCTs. A striking aspect of the FHN initiative was the extent to which it was kept separate from concurrent debates about recruitment and retention of GPs in remote and rural areas of Scotland (see RARARI 2002b). GPs generally did not feel threatened and felt there was little impact on their own roles. They were divided on the need for the FHN role but few were overtly opposed as long as normal nursing services were seen to be maintained. Some more actively supported the development of the role by referring families and sharing skills in a structured way.

3.3.1.5 Midwives

It is also important to emphasise the extent to which the FHN initiative was kept separate from concurrent review of midwifery services in remote and rural areas of Scotland. In these areas the community Midwife has traditionally been a key health professional and the role has usually been carried out in combination with a nursing role (i.e. "double duty" District Nurse and Midwife; "double duty" community staff nurse and Midwife; or "triple duty" District Nurse, Health Visitor and Midwife). Six of the ten FHNs were qualified midwives and five continued to practice during 2002. Their midwifery caseloads are typically very small, with home births in these areas now very rare indeed. Rather the majority of their care is ante natal and post natal. Where working relationships with Health Visitors have been good, some of the FHNs have taken the opportunity to continue and expand their work with young babies and their families beyond the traditional time when families are handed over to the Health Visitor. Such work is in its infancy just now but has usually involved some joint assessment whereby both professionals meet at the developmental milestones.

At sites where the FHN was not a Midwife, the role was usually carried out by a "single duty" Midwife who was part of a team based in an adjacent area. Generally the FHN development had little effect on this group.

3.3.1.6 Nurse managers

Managers of community nursing services in the regions studied were only included in the stakeholder questionnaires if they were identified exclusively with a particular site. This was rare as nurse managers were few in number and usually geographically remote from the FHN sites. More often we interviewed nurse managers individually. As a group they had mixed feelings about the introduction of the FHN role and different perceptions of why it might be being introduced. Facilitating student participation in the educational course required that replacement staff be found at short notice in 2001. By the end of 2002 most of the managers were cautiously positive about the FHN development but were waiting for the outcome of the evaluation before initiating any related action.

3.3.1.7 Other health professionals

As Table 3.8 shows, other health professionals who had some engagement with an FHN were broadly supportive. This included other community specialist nurses such as CPNs and Macmillan nurses.

3.3.1.8 Workers in the wider community

Again, as Table 3.8 shows, workers in the wider community at these sites who had some engagement with an FHN were enthusiastic about the role. Many welcomed the contact and found it useful to have the extra resource and support from the FHN.

3.3.2 Lay stakeholders' views

Finally by aggregating responses from lay stakeholders across the ten sites it is possible to obtain an overview. Table 3.9 shows data from the 34 individuals who responded on consecutive occasions.

Table 3.9 Comparison of the perceptions of 34 lay stakeholders who responded to the questionnaire pre and post introduction of FHN *(* denotes wording used when questionnaire sent post FHN introduction). Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 34 this indicates that the remainder of the respondents did not answer that particular question.*

I think the FHN will deliver (delivers*) a **different** type of service to what is currently available		**Unsure**		I think the FHN will deliver (delivers*) a **similar** type of service to what is currently available	
Pre	Post	Pre	Post	Pre	Post
7 (21%)	**6** (18%)	**14** (41%)	**11** (35%)	**10** (29%)	**10** (29%)

I think the FHN will **take away** (has taken away*) from existing local services		**Unsure**		I think the FHN will **add to** (has added on to*) existing local services	
Pre	Post	Pre	Post	Pre	Post
3 (9%)	**3** (9%)	**19** (56%)	**15** (44%)	**11** (32%)	**9** (27%)

I think the FHN development is **well suited** to our local context		**Unsure**		I think the FHN development is **not well suited** to our local context	
Pre	Post	Pre	Post	Pre	Post
19 (56%)	**15** (44%)	**10** (29%)	**9** (27%)	**3** (9%)	**3** (9%)

I think the FHN development will lead to an **improvement** in local health service		**Unsure**		I think the FHN development will lead to a **deterioration** in local health service	
Pre	Post	Pre	Post	Pre	Post
12 (35%)	**12** (35%)	**20** (59%)	**15** (44%)	**1** (3%)	**1** (3%)

Table 3.9 shows little change in these respondents' views. They remain unsure about several aspects of the FHN development but they have also maintained a generally supportive attitude towards it. Fear of service withdrawal does not emerge numerically as a big issue but it was prominent amongst initial comments:

"I hope the FHN is in addition to those here already- not taken or seconded from other staff"

"It is important that it is in addition to the service already provided and not in place of"

Pre-introduction of the role, sixteen respondents (27%) had heard at least something about it, usually through a friend/relative or a health care professional. By the end of 2002, ten respondents (22%) had been in contact with an FHN and some of this involved care for themselves or their family. These respondents generally saw the FHN as a similar service but one that they viewed positively.

3.3.3 Perceptions of consultation

During 2001 and 2002 work to explain the new role to local professionals and the public was co-ordinated at national and regional level. When professional stakeholders were asked at the end of 2002 whether they had been adequately consulted on the introduction of the FHN role twenty six (33%) replied positively, forty four (56%) said no and seven (9%) did not know. We also asked professional stakeholders whether they felt that consultations with the local

public about the introduction of the role had been adequate. Ten (13%) responded positively, thirty eight (49%) said no, and twenty nine (37%) did not know.

3.4 SUMMATIVE DISCUSSION

Our evaluation has studied the first year of family health nursing practice in remote and rural Scotland. As a basis for drawing conclusions it is useful to map progress so far against the Scottish Executive's summary of the principles of the FHN role (see **3.0**).

Looking first at points 1 and 4, it can be seen that during the first year the FHNs usually functioned as skilled generalists encompassing a range of duties. For many, however, the range of duties did not differ substantially from the traditional work and concerns of the district nursing role. As such there was usually little change in terms of them being first point of contact (i.e. some FHNs were necessarily the first point of contact as there was no other type of nursing service immediately available; others would potentially be the first point of contact for their "inherited" district nursing caseload patients and a small number of other families). There was evidence that typically the FHNs were active in making referrals where more particular expertise was required.

Points 2 and 3 relate to the essential identity of the new Family Health Nurse role. Our study of practice showed that all the FHNs actively tried to take forward some work encouraging healthy living and preventing ill-health. Sometimes this was at a primary level within communities, but more often it was at secondary and tertiary levels with individual patients and other family members. For most FHNs, however, the main part of their job remained caring for ill members of the community requiring nursing care. This made it difficult for them to really develop a lead role in preventing illness and promoting health at their home sites. The FHN at Site I was a notable exception in this regard.

Irrespective of circumstances at their sites, all FHNs reported approaching their daily work with a changed and enhanced awareness of the importance of the family dimension. As has been seen their capacity to implement the family-as-client concept through in-depth assessment often seemed to be inhibited by the traditional demands for primary care work focusing on individuals. In turn this raises questions about the extent to which caring for families is already integral to the work of local primary care health teams, and whether there is shared perception of a need for change.

Consideration of the above four principles of the FHN role also highlighted some of the differences that emerged through the typology, leading to the question: *what factors make an FHN role work?* From our findings so far it seems that there are two basic factors:

1. **The perceived scope and space to encourage implementing this approach.** This was seen to pre-exist in the context of the *High scope-slow build* pattern and was also seen in the context of the *Bold build* pattern where the FHN role was separate from the district nursing caseload.
2. **The local presence of at least one active supporter who changes their own practice.** This was evident in the process of implementation at sites that shared the *Slow build-key ally* pattern.

The presence of at least one of these factors appeared to be a necessary condition for progress. Where neither of the foregoing conditions existed, family health nursing failed to thrive. During the evaluation we were also aware that the individual creativity and drive of the FHN were influential factors.

Whether these factors together are sufficient to further develop and sustain the role is doubtful. In our judgement the following factors have largely been absent during the first year of family health nursing practice and would be worth considering as a basis for future development of the role

- a programme of support and facilitation of the development at site level.
- active team review of case loads and working practices to improve effectiveness and efficiency.
- concurrent review of nursing resources and staff skill mix.
- delegation of family health nursing work (possibly by putting FHN in a form of "triage" role, or as an active team leader).

In effect we found that the role can be developed in a limited way on top of a district nursing caseload and within pre-existing resources. Its introduction in these circumstances officially legitimises and raises awareness of nursing that has a strong family and health orientation in general. We would argue that this orientation is already apparent in some existing nursing practice within the Highlands and Islands of Scotland.

However the distinctive systematic approach that characterises family health nursing is new and different for the area. So far, many colleagues have found it difficult to engage with, and understand the need for, this particular approach. As such it has struggled to become a role in the sociological sense. Even where it has been **legitimised through recognition** (e.g. through referral of families by key allies within the PHCT) **it cannot necessarily be prioritised** if traditional community nursing service is to be maintained unaltered.

One of the key aspects that potentially gave the new role definition was the distinctive in-depth framework for assessment and intervention. From our study of the educational course it was clear that the FHN students saw this as a core element that was central to their new professional identity. The newly qualified FHNs spent much time trying to operationalise this framework within the context of other demands on their time. Many teething problems with the documentation were resolved creatively but during the first year it became particularly clear that the assessment process for a whole family was often complex, time consuming and difficult to orchestrate in practice. This caused intra-role conflict for the FHNs and sometimes inter-role conflict in terms of team functioning.

Through the use of community profiling the educational course also encouraged the students to conceptualise their whole home base site as the legitimate focus for their new role. This approach to practice would address the needs of individuals, families and communities. On return to practice, however, it has proved difficult for many of the FHNs to operationalise this vision in a balanced and meaningful way. For the community nursing culture from which they came, and into which they returned, tends to be permeated by the concept of caseload.

These listings of people receiving intervention/s serve to define the focus and limits for the organisation and delivery of care. In the context of introducing family health nursing so far the most relevant and dominant caseloads have undoubtedly been those of the district nursing

service. Therefore it is not surprising that the FHNs who have had to develop the role at their sites from a basis of at least maintaining the current level of district nursing service have struggled to re-conceptualise and re-prioritise their working practices. When we studied current caseload lists there was often the traditional district nursing listing followed by a small list of family names. Integration of these listings was difficult as the family health nursing work was typically seen as done by the FHN herself while the rest of the team usually only focused on the main listing. Thus family health nursing activity tended to supplement rather than supplant traditional district nursing activity. Moreover, even in small remote and rural settings, re-conceptualisation of the notion of caseload could not occur without the active engagement of other key team members in the process.

The development of family health nursing at Site I offered possible solutions to some of the above difficulties. Here the role was developed outwith the district nursing caseload and with the FHN defining the role's boundaries in a more autonomous way. In some ways this led to a more specialist role, with referral patterns and caseload dynamics more analogous to those of a Macmillan nurse or diabetic nurse specialist. The specialism aspect was pronounced for the family part of the role, but also for the health part in terms of the primacy it gave to health education and promotion. A key feature was that this health work could cover a very large range of subject matter and client groups. The breadth of this health work brought with it some features of generalism, in the sense of having to have a broad knowledge base about a large number of topics. The key point, however, was that this FHN did not necessarily have to be generalist in the sense of concurrently addressing all the role expectations traditionally associated with the district nursing caseload. Within the existing primary care system, however, this made it more difficult for her to often act as the first point of contact.

Rather this role gave an in-depth service to a smaller number of patients and families. At the particular site we studied, the role only became very partially integrated within core, mainstream primary care team activity. However in a short space of time it made a substantive contribution to the development of health and social care in the wider community. There was some duplication of activity with the district nursing and health visiting services but the majority of the FHN activity was supplementary to the existing service. Compared to other sites, professional colleagues at Site I were more likely to see the FHN as providing a different kind of service.

As such there would appear to be cost implications if the *Bold build* pattern were to be developed and replicated in this way, in the absence of re-appraisal of existing PHCT roles and working practices. In essence a new, supplementary community nursing role would be created. One of the inherent aspirations of the Scottish Executive initiative has been that any viable change would be sustainable from within existing resources. In this regard it is worth noting that our previous suggestions for developing the other patterns of practice towards sustainability would also be likely to require some additional deployment of resource.

Before moving on from our analysis of practice it should be noted again that we have not studied the practice of the second cohort of FHN students. For this larger group are now qualified and currently developing the FHN role at their local sites. This includes three Health Visitors, and even within this sub-group it appears probable that distinctly different interpretations of the role may emerge.

One of the regions participating in the initiative has also been exploring the possibility of the family health nursing course being the basis for a more advanced nurse practitioner role. This

remote and rural region has particularly acute problems with the recruitment and retention of GPs, especially in a number of small islands. The region already has at least one nurse practitioner who is the key health professional delivering services to the population of a small island with no resident GP. This role has a relatively high degree of autonomy that includes limited diagnostic capacity, management of social services and use of nurse prescribing.

Thus there are possibilities for other patterns of practice to emerge and other ways that the role might be developed in practice. For the Scottish primary care sector is currently diverse and dynamic. In order to examine this more fully, and to provide wider perspective to our findings in Chapters 2 and 3, we now consider the wider Scottish context.

CHAPTER FOUR THE WIDER SCOTTISH CONTEXT

4.0 INTRODUCTION

This part of the report considers contemporary policies which have influenced primary health care in general, and then moves on to an analysis of the effectiveness, deficiencies and requirements of community-based nursing, midwifery and health visiting services across the Scottish primary care sector.

4.1 CONTEMPORARY POLICY ISSUES

Over the last five years the popularisation of former academic interests in the determinants of health, differences in rural and urban life patterns and styles, and the functioning of health professionals has led to policy reviews; new legislation; new directives and administrative initiatives which have sought to redress concerns[16]. In doing so central policy has changed, and a programme of initiatives have been introduced at grass-roots levels in an attempt to develop services and annexe previously uncharted health ground. The family health nursing initiative was one such of these. Other comparable initiatives can be seen in the various social inclusion programmes enacted across Scotland and the development of the role of public health practitioners. Funding for such initiatives has multi-various sources (e.g. National Lottery, New Opportunities Fund, NHS providers, Local Authorities and Scottish Executive Health Department) with the majority being time-limited thereby inviting problems of sustainability and proven long-term effectiveness.

4.1.1 Functioning of health professionals

Before considering some of the wider aspects of community-based nursing, midwifery and health visiting services it is worth reflecting on some of the restructuring processes which influence the working of health professionals. Local Health Care Co-operatives (LHCCs) were introduced to provide a different approach to primary care provision in Scotland. Service providers were brought together with the aim of facilitating community involvement in the design and delivery of primary health care services. Across Scotland there is no universal model for constructing LHCCs and the policy argument states that this is intentional to allow services to develop in accordance with local needs, conditions and circumstances. So we have diversity in primary care provision, not only in the remote and rural areas of Scotland, but across the country as a whole. During the time of the evaluation the notion of an LHCC has been revised for many localities. In remote and rural contexts and elsewhere in Scotland there have been shifts in service organisation in accordance with contractual agreements and service redesign[17] within primary care. This has added another

[16] Much of this policy change has relevance to the wider United Kingdom but for present purposes we shall be focusing on Scotland in particular. Since Scottish devolution in 1997 changes in the structure of the health service, a refocusing on public health and the development of policy pertaining to social inclusion and social justice have influenced the practice and development of health, education and social services. The current evaluation of family health nursing has been conducted against this policy backdrop.

[17] These changes are related to GP contracts; restructuring of midwifery services and planned developments for health visiting and public health nursing.

dimension to the analysis of the role of the FHN: namely in what framework of care or at what level in an organisational structure do family health nurses operate?

4.1.2 Influences on health

Many factors are known to affect the health of individuals and groups within society. These range from infra-structural inequalities (such as inadequate provision of housing, transport, educational services and health services) to more socio-cultural issues (such as poverty, highly differentiated employment practices and institutionalised prejudices)[18]. Variations in health care outcomes have been identified within rural communities both in Scotland and elsewhere (Campbell 2000, Jones, Bentham and Horwell 1999). In addition there have been concerns expressed about the recruitment and retention of health care staff into remote and rural areas. These issues along with others have contributed to a range of localised resource development initiatives being set up under the auspices of Scottish Remote and Rural Areas Resource Initiative (2002b).

Changing patterns of working-life; relaxation of the social mores regarding marriage and child rearing; and the sub-contracting of care for children and older people have all contributed to the reconstruction of family. It is no longer an objectified entity but rather it has become a subjective expression of individual agency i.e. it means what the individual says it means.

The evaluated Family Health Nursing educational programme has attempted to be inclusive of all permutations of family, been specific in its remote and rural focus and has relied on the assessment process to identify the complex nature of post-modern living and social networks. The assessment framework used to construct the official health records has caused problems for service managers across the regions. At present there are serious doubts about the utility of these family health nurse documents to other health professionals or to the patients themselves. The recording of quasi-genetic/hereditary data alongside value judgements about the dynamics of power in a family and the health care needs of individuals does raise many unresolved questions. Firstly the ownership of the records: (e.g. do they belong to the family health nurse; the family themselves; or a dominant member; or does it belong to the wider primary health care team?); secondly the utility of the information disclosed and the ability of the FHN to act on it; thirdly the value of the record to other health care professionals; fourthly incorporating the content of this record of health assessment, goals and care interventions with the proposed "Integrated Care Record" (SEHD 2003) will be problematic due to non-compatibility with existing record systems.

4.1.3 Nursing policies and public health

A number of nursing policies have been published during the research period, ranging from *Nursing for Health* and *Caring for Scotland* (SEHD 2001) through to the UKCC's *Consultation on requirements for programmes leading to registration as a Health Visitor*

[18] Indeed the concern to understand these complex issues more fully is evident in the ongoing Economic and Social Science Research Council programme aimed at exploring the connections between social policies and ill-health across Europe.

(UKCC 2001) and subsequent revision of health visiting competencies (NMC 2002). In addition we have seen the production of a strategy for nursing and midwifery research in Scotland (SEHD 2002) and a consultation document pertaining to the revision of the professional Register which has suggested the possibility of a third part of the Register pertaining to public health. Finally and most recently a new White Paper has been produced which advocates partnership working at multiple levels within the health service (SEHD 2003).

The contextualisation of this evaluation in the world of policy has been necessary in order to remind the reader of the complex influences on health care provision in primary care settings and the potential demands made of service providers. For the next section of the report tries to explore the application of policy in practice at the level of community–based health services across Scotland. This stage of the evaluation research was designed to inform our judgements about the applicability of a family health approach to community-based nursing in the wider Scottish context. Reservations about the automatic transferability of our findings, which were derived from studies of distinctive education and practice in remote and rural contexts, into the wider Scottish world of community care, have already been stated. In this section, however, we aim to identify common concerns about community nursing services in Scotland generally and to explicate requirements for the further development of services, education and practice with special reference to family health nursing.

4.2 COMMUNITY NURSING SERVICES: STRENGTHS, WEAKNESSES AND SCOPE FOR DEVELOPMENT ACROSS SCOTLAND

A series of telephone interviews were held with key informants selected from Scottish NHS Trusts and Health Boards providing primary care services and their respective Local Health Councils. Those Trusts and Boards involved in the initiative were excluded. A total of 22 telephone interviews were planned[19]. Informants were asked to consider the strengths and weaknesses of existing community nursing services in their locality; the strengths and weaknesses of educational and continuing professional development activities; how they perceived the role of the Family Health Nurse and where they saw this role fitting or not with their existing service provision.

The initial point of contact was with the Directors of Nursing. They were invited to participate personally and to assist in the identification of a senior nurse at LHCC level who would be willing to participate and another senior person (either manager or chairman of an LHCC) from a non-nursing professional background) who would be willing to participate. In addition the chairman of the Local Health Council was independently invited to participate by the researchers.

[19] Details of the letter of invitation, planning and nomination documents, the advanced organiser which was used to guide the interview, and an information document about Family Health Nursing which was distributed with the other materials are provided on CD Rom. This last document was included as we were confident that some non-nursing informants who would be interviewed would not necessarily know anything about family health nursing. (This assumption was borne out as most of the doctors and key people in Local Health Councils whom we interviewed knew nothing about family health nursing). This in itself is an interesting observation given the imputed potential of family health nursing.

Annex 6 presents details of those who were interviewed. along with the evaluators judgements about the level of knowledge that the interviewee had about community nursing services and the education of community nurses in general; the personal stance of the informant; the quality of the interview and a synopsis of the most interesting parts of the interview. The judgement about level of knowledge has been made to accommodate clichéd or stereotypical responses whereas the quality of the interview has been judged in order to try and identify differences between informants with regard to their analysis of complex and varied situations. Those interviewed are referred to as Key Informants in the sense that to understand what they are saying requires the researcher to move away from the notion of grand knowing (as though there is one definite answer) to an appreciation that the job is to build a science of personal perspectives which are localised, pragmatic and constructed based on personal experiences and actions. In this way it is possible to enter into a process of collaborative and co-operative enquiry (Heron 1996, Reason 2001) where meanings are checked out and compared both within and between informants.

Thus a total of 19 people were interviewed (12 senior nurses, 2 doctors, 2 representatives of the allied health professions and 3 chairman of local health councils). Another three interviews were planned but these were cancelled by the informants and no alternative arrangements were made. As illustrated in Table 4.1 the perspectives ranged from very localised levels of knowledge and understanding or a myopic individuated view of the world; to those with wider vision who attempted to incorporate fundamental values about health care provision; or nursing development; or strategic national directives[20].

The following table provides a summary of recurring themes which emerged from the elicitations and subsequent narrative analysis carried out on the audio-tapes of the telephone interviews[21]. Themes have been selected for inclusion when more than two people made reference to the same issue. The phraseology used to articulate the theme has been taken from the language used by the respondents during the interviews.

[20] Such a range of perspectives has also been evident in the views of Steering Group members who have been overseeing the Family Health Nurse initiative. Minutes of these meetings along with observation of a key meeting to determine the way forward have been used to inform the evaluation.

[21] This particular approach to analysis has been developed by the evaluators and has its roots in Psychology especially the work of Kelly (1954) Personal Construct Theory Vols I and II; Bruner (1991) Acts of Meaning and Sarbin (1986) Narrative Psychology: The Storied Nature of Human Conduct

Table 4.1 Narrative analysis of recorded telephone interviews

Expressed strengths of existing services	Expressed weaknesses of existing services	Common concerns about introducing Family Health Nursing	Perceived benefits of Family Health Nursing
Duration of time in post and experience of workforce **18 respondents**	Duplication of effort between different team members **15 respondents**	Is this a correct role for community nursing services? The public are already confused about the range of people providing care. **7 respondents**	Will work in rural context where team sizes are limited **12 respondents**
Commitment of existing workforce **12 respondents**	Recruitment in general **10 respondents**	Maybe better to develop existing roles with some Family Health Nursing ideas **7 respondents**	Solve recruitment problems into rural areas **12 respondents**
Flexibility of existing workforce to adapt to demands **10 respondents**	Lack of service integration and territoriality of professionals **10 respondents**	The idea of the FHN as first point of contact; patients would not go to her first and who would refer first to an FHN **6 respondents**	It should prevent duplication of effort if one person is co-ordinating in rural areas. **11 respondents**
Strength of team working **8 respondents**	No clear understanding of workloads **9 respondents**	Too much resistance fixed professional boundaries **6 respondents**	Applicability in rural contexts as triple duty nurses become rarer. **8 respondents**
The general level of the education of the existing work- force **6 respondents**	Lack of matching workforce skill mix to population needs **5 respondents**	Lack of consolidation of existing nursing roles without introducing another **6 respondents**	Complement role of Public Health Nurse and other roles **5 respondents**
Integrated record systems **5 respondents**	Limited delegation or devolution of work between groups **4 respondents**	Another tier of nurses is not a good idea. **6 respondents**	FHN would make a good team leader to co-ordinate services **5 respondents**
Innovations with specific client groups especially vulnerable groups **4 respondents**	Community Nurses Midwives and Health visitors do not use existing autonomy **3 respondents**	Would it work alongside traditional district nursing is there a risk of DN being deskilled? **4 respondents**	It's really to do with the education of the nurse. A different way of looking at and carrying out care **3 respondents**
Availability of local training to develop services. **3 respondents**	Human resource model of GP attachment **3 respondents**	Good training for midwives: a multi-skilled role in rural areas **3 respondents**	

Thus what emerged from these interviews was a general perception that the strengths of existing services lay in the experience, the flexibility, the adaptability and the team-working potential of the nursing workforce.

"*Our strengths lie in our diversity of services and the people themselves. We have good relationships with three education providers and we have been working at up-skilling our health visitors, encouraging joint working with D/Ns, CPNs Learning Disability and Health Visitors*" (Director of Nursing)

"We have good enthusiastic practitioners. A skilled workforce linked in with general practice"(Director of Nursing).

"Community management is good and the skill-mix is good. Community nursing teams keep close links with general practice … There is very effective core training for at G grade levels. The LHCC have been up-skilling nurses and there are opportunities for nurses to be involved in projects" (Medical Chairman LHCC).

"Out in the shire services are developed in terms of knowledge of the population, the health professionals know the people and have good local knowledge. The LHCC is a major strength it gives support to team-working. In some areas there is more multi-disciplinary team working and the nurses are all experts. There have been no concerns raised through the patient line. It is more difficult in the big cities for the staff to know people" (Chairman Local Health Council).

Another minor theme, which was discussed in terms of strengths of the services, pertained to the use of record systems. A few respondents spoke of developments with "single shared assessments" or the attempt to plan your workforce and skill-mix in terms of patient need.

"We have nursing care plans linked in to Reid codes for ISD purposes. We can measure our care plan needs and match these to time for care and the allocation of appropriate staff. The whole system is also linked in to GPASS. At the moment it is based in district nursing but health visitors are feeding in to it slowly and we have 8 pilot sites working on a single shared assessment. We are trying to have our nursing data-bases [for management and care] mirror developments in policy." (Senior nurse LHCC).

"We have introduced a corporate case load for Health Visiting which is geographic and links with Schools … That's made for a strong service" (LHCC manager allied health professional)

The **weaknesses** of the services were described in terms of duplication of effort, recruitment problems, and the nature of the workload involved whether in rural or urban contexts.

"Not having a clear handle on workload and not employing staff on a basis of workload – rather we attach staff to GP practices. There is territorialism within community nursing. Pure territorialism … over the way we look after some clients … children and families. For years health visitors have done nothing in nursing and district nurses have not even thought about health". (Director of Nursing)

"Weaknesses in one area impact on others. For us the geography of the area and how we attract nurses. The main public issue is that we are not obtaining staff here" (Local Health Council Chairman).

"*Recruiting staff with the right qualifications might take two rounds*" (Director of Nursing).

"Recruitment and retention are weaknesses we have no HVs in the Bank. Starting Well and other national projects ... you must feel this with NHS 24? ... Siphon off key staff without any consultation with service providers" (Medical Chairman of LHCC)

"Staff recruitment and retention and the diversity of care needs are challenging. The way the teams divvy up work is a weakness" (Senior nurse LHCC).

When asked about education and training the majority of respondents saw strengths in the current provision and reported that weaknesses were to do with placements and funding.

"We have joint appointees and have been commended on our service education collaboration. The supervisors preparations are good the main weakness in finding placements for pre-reg students" (Director of Nursing)

"Our post-reg courses are better now we have more control in terms of course content. The immediate post-reg bit is dodgy. We need a staff nurse development programme built on family" (Senior nurse LHCC).

"Education that produces a community nurse who is generalist might meet service needs but what the public require is a specialist. You see this ... a lot in cancer ... people say we want a specialist nurse" (Chairman Local Health Council).

"Distance learning is a saviour ... made a big difference to us ... District nursing and health visiting have a common language in many issues ... common core of learning ... Everybody understands district nurse and health visitor. I can't see what Family Health Nurse will solve or mean ... Public health is targeted to the health visitor ... District nursing needs a boost". (Senior Nurse Executive Level)

The **concerns** raised about family health nursing as an approach to community nursing focused primarily on the scope for public confusion. Invariably at this point in the interview, the interviewer was asked many questions. The issues that were raised covered the following: *How will the public health nurse role fit with this? (12 respondents) Who is going to look after sick people? (8 respondents) Why has there been such a lack of good quality information about this project (6 respondents).* Answering these questions involved a dialogue of exchange to gauge insight - as there were no answers to give. The information gained during these additional discussions has informed some thinking about the nature and management of the initiative and the main work of community-based nurses, midwives and health visitors.

Other specific concerns about skill-maintenance of a generic community nurse and how Family Health Nurses would fit with existing community nursing services.

"I am concerned about the skills these nurses need and how they can be maintained". (Senior Nurse LHCC).

"I am worried about how it [family health nursing] fits into the existing system. It's not good enough or acceptable just to keep changing course names" (Senior Nurse LHCC)

"Family health nursing was seen as a solution to problems of recruitment. It's a mixture of everything. There may be a need for a role like this in very rural areas. Community nursing

services are like fried eggs *in a pan. When you fry eggs the whites mingle the yolks stay separate. Good teams mingle in places but each keeps their distinctive parts"*. (Senior nurse LHCC).

"You need to watch the erosion of specialisms"(Director of Nursing)

"It would be good to try it [family health nursing] in a big town area and see if it works. Staff here feel it is a jack of all trades approach and causes dilution of specialism. They can see that the role of the family is important" (Manager of LHCC Allied Health Professional)

Finally the informants identified the **perceived benefits** of Family Health Nursing primarily in terms of its applicability to remote and rural health care.

"The Family Health Nurse idea appeals. I am a great believer in holism, family and community, promoting health and treating illness. It would fit with our ideas of a healthy living centre" (Chairman Local Health Council).

" I am looking for ways it could fit. Possibly district nursing education ... bring in family ... also at pre-registration levels. We tend to be a bit over focused on deliverables but I think we could develop services using family health nursing concepts ... in a home grown way rather than inventing another group of staff".
(Director of nursing services)

"The family group as the client has potential when families at younger age ... Reconfiguring the work of community nurses into geographic collectives with the family as focus ... the blurring of roles might be better for city wide management" (Medical Chairman of LHCC).

"I like the idea in the rural area ... you could redesign the staff nurse role ... it fits with our ideas of practice teams" (Senior Nurse LHCC).

"The Family Health Nurse is a positive move for rural areas ... it could be an attractive post for people to move into area. May even help in recruiting staff to stay ... It adds to the public health agenda" (Manager of LHCC Allied Health Professional).

"It's to do with the education of nurses. Not just another level of nurse. There is a danger of confusing nurses ... Our approach to care and caring skills are fundamental" (Senior Nurse LHCC).

"*As I see it there could be two ways of developing services, one where the FHN is a specialist alongside other specialists like Public Health Nurses and Clinical Nurse Specialists. So family health nursing is a development of a new district nursing. The other approach is to consider the Family Health Nurse as the community nurse who then refers on to other specialists. This wouldn't work especially if they are all G grades. One nurse who looks at the whole family and builds up a relationship over a period of time would be good ... .District nursing and practice nursing have lost nurse-led services and confidence and have become medicalised. The role of the midwife needs to move into wider aspects of women's health maybe family health nursing would fit".* (Director of Nursing Services).

4.3 SUMMATIVE DISCUSSION

These findings suggest that overall community nursing services are adapting to the policy changes which have been advocated and that current educational provision is generally perceived as good. Nevertheless a number of problem areas were highlighted, most notably duplication of effort, territorialism and recruitment problems. There was also a recognition that newly qualified staff may require additional education to work in the community and that family health nursing may enhance the role of the District Nurse, Community Staff Nurse or Midwife.

Informants' perceptions of family health nursing varied widely and there were some concerns about quality of information and public confusion. The majority agreed that remote and rural areas have special needs with regard to recruitment of staff and the design of services thereby suggesting that family health nursing has special meaning in these contexts. Such a value stance has been informed in some cases by experience of managing services in remote and rural areas but also by the fact that the initiative took place in remote and rural areas.

A further analysis of the interview data has identified an array of contemporary problems which are affecting community nursing services. These are summarised in Table 4.2

Table 4.2 Contemporary problems affecting community nursing in Scotland

the age of the workforce	professional isolation
referral criteria	role ambiguity
methods of caseload management	stress
equity of service provision	lack of support
equity of out of hours service provision	pressure to prove worth
use of evidence based practice	line accountability
documentation	

Many of these issues also emerged as common problems at the Family Health Nurse sites.

This research was not primarily concerned to evaluate the nature or quality of community nursing services across Scotland, but rather to gain insight into common issues in order to consider how family health nursing may be extended to other remote or rural or urban areas of Scotland.

It is worth noting, however, the dearth of research-based evidence on the nature and quality of community nursing services across Scotland. This makes it difficult to know what baseline, pre-existing services are doing and how they are performing. Some of the difficulty for policy makers, service planners and researchers stems from the fact that community nursing is not a unitary discipline and has such a wide range of professional roles and entrenched interests. Moreover professional roles may be interpreted very differently within regions and even within local teams. Routinely collated data on professional activity is often of very limited value due to problems with its scope and its reliability. Thus reliable comparisons within and between regions at one point in time are difficult, and reliable longitudinal comparisons of service developments are even more problematic.

As such our interviews with key informants represent an attempt to elicit a range of relevant contemporary understandings of community nursing and family health nursing in Scotland.

The final chapter of this report considers this evidence alongside our other research findings and evidence from wider perspectives in order to draw out the implications for development of the FHN role and to make explicit the lessons learned from this evaluation.

CHAPTER FIVE IMPLICATIONS FOR THE DEVELOPMENT OF THE FAMILY HEALTH NURSE ROLE

5.0 INTRODUCTION

From the basis of the findings reported in the previous three chapters, this chapter now considers implications for development of the FHN role. This is done firstly in relation to the role as it currently exists in a number of remote and rural areas of Scotland. This leads to consideration of its possible introduction within other areas of Scotland. The final section of the report reflects on the nature of the Scottish project before exploring its potential to inform debate about practice development and nurse education within the UK and beyond.

5.1 THE FAMILY HEALTH NURSE ROLE AS IT EXISTS

Firstly it is necessary to re-iterate that this research has been conducted over a relatively short period of time which includes only the first year of FHN practice. As such we have studied the formative stages of the role as it exists and our initial understandings should be seen in this light. The emergent typology shows four distinct patterns of FHN practice, but the majority share a significant common feature: the pervasive influence of the traditional work and concerns of the district nurse role.

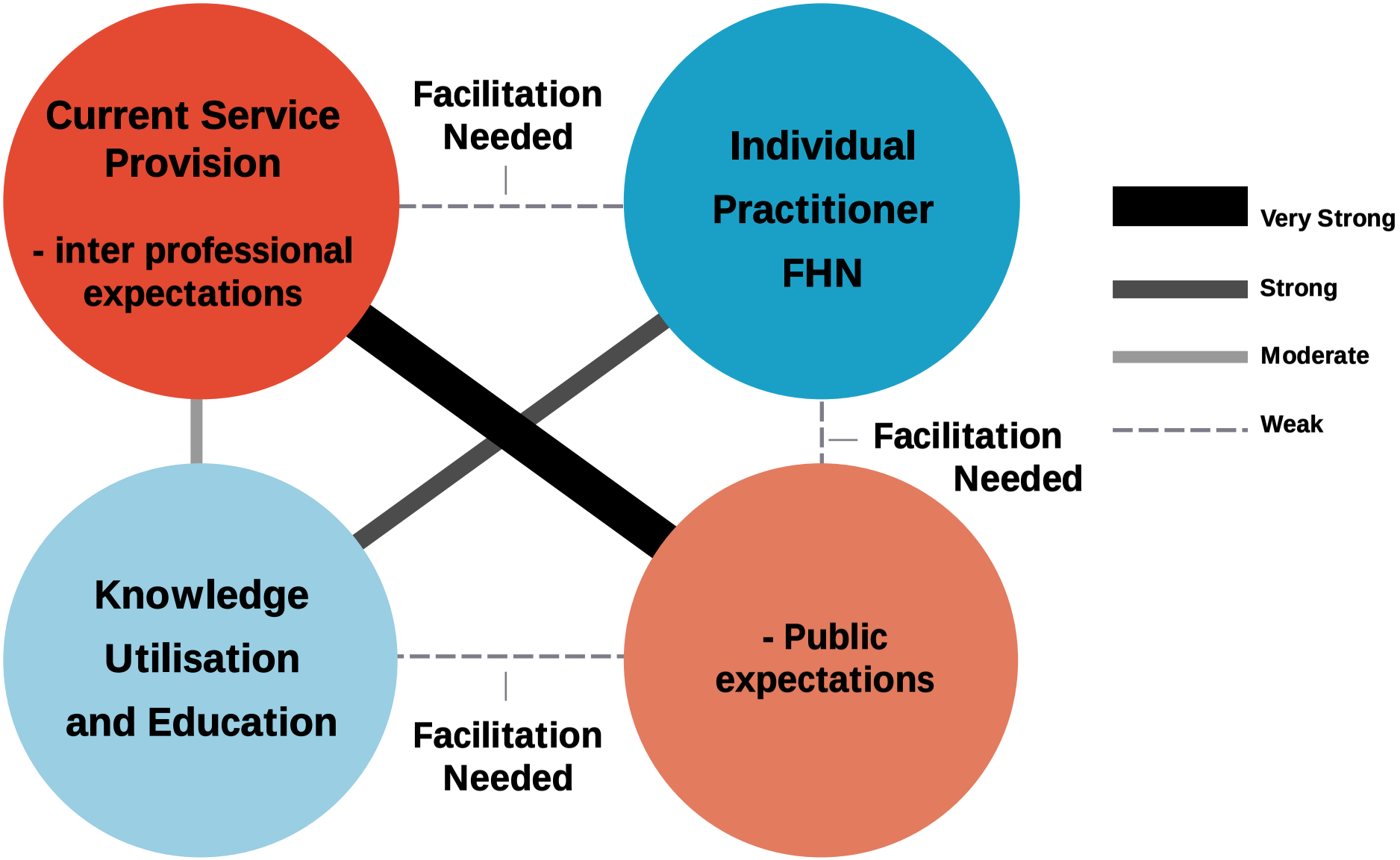
Given the professional backgrounds and employment contexts of the first cohort of family health nurses this should not be surprising. In Chapter 2 it was seen that the educational process for family health nursing provided these experienced nurses with personal and professional development, encouraging a graduateness to emerge whereby they could reflect and analyse situations. All students have attempted to embrace the ideology behind family health nursing, and this is seen particularly in their enthusiasm for trying to operationalise the distinctive assessment process. However, so far, the majority have struggled to substantively incorporate the ideas into practice.

The real world of primary health care is a psychodynamic place full of cultural history, hidden meanings and assumptions. For a role to be recognised and enacted requires joint action in concordance with other people. An overt and positive need for the role was generally not recognised within the core Primary Health Care Teams at most of the sites studied. Moreover there has been limited facilitation of the role to enable enactment to take place. In effect the nature and scope of the necessary change process has been underestimated.

Although a small number of key allies emerged during the year, there was generally a lack of active “champions” for the role at local grass roots level. Others within the core PHCTs didn’t necessarily feel a need to actively engage with the new role and modify their practice. This has made it difficult for the new FHNs to develop and sustain their own new vision. For to meaningfully enact the concept of the whole family as the client would require at least a commitment to systems and role review within PHCTs whose service provision is typically predicated and prioritised on the basis of response to individuals needs. The practical difficulties around making the FHN the first point of contact illustrate the nature of the challenge involved in regard to integration of the role within PHCTs.

Figure 5.1 overleaf illustrates the context for role development. Using the principles of mapping we have identified the relative strength of associations between the major influences on the development of the FHN role.

Context for Role Development



Having conducted this eco-assessment we are able to identify the areas for planned intervention and development by means of a process of facilitation.[22] As Figure 5.1 shows there are very strong associations between current service provision (i.e. pre family health nursing) and the expectations of the public and the professionals involved in care delivery. Theories about family, health and assessment and the attempt to utilise this knowledge in practice were strong whilst the family health nurse was a student undertaking the education programme. Utilisation of comparable knowledge by the core PHCT is weaker as is the FHNs ability to utilise this new approach to nursing in the context of current service provision.

In effect the educational programme has attempted to lead practice. There is a need now for service development to be given more emphasis so that in turn it can inform future educational development. Having already made specific proposals for course re-design in Chapter 2, we suggest that there are now three areas where active facilitation is required in order that the role of those Family Health Nurses currently in post can be developed further.

1. Enabling the FHN role to merge with current service provision in a meaningful way.
2. Developing the core primary health care team in order that they can incorporate a more systematic focus on family and health into existing services and care practices.
3. Involving patients and the wider community to expect, accept and value a different approach to nursing care in particular and health care in general.

5.2 THE POSSIBLE INTRODUCTION OF THE ROLE ELSEWHERE IN SCOTLAND

The application of family health nursing to other remote and rural areas of Scotland or to the wider Scottish context requires careful consideration. A multi-skilled generalist nurse who can provide a range of services should be suited to remote and rural areas of Scotland where small teams exist and recruitment problems prevail. Whether the optimum knowledge and skill-base for this individual is premised on family health nursing requires careful assessment by service providers.

For in effect this initiative has served to open up a spectrum of possibilities. The *Bold build* pattern represents one end of the practice spectrum. This casts the FHN as a further specialist community nurse whose work involves more in-depth programmes of care for families than those typically offered by District Nurses and Health Visitors. Although the way that *Bold build* developed involved some duplication of service, it was mostly supplementary to existing services. Therefore if this role were to be developed in other villages or cities, with no concurrent revision of existing roles, this would be an extra service with cost implications.

At the other end of the spectrum the FHN is virtually synonymous with the District Nurse. In this context our research has shown that sustained development of family health care programmes is difficult if all other existing services are to remain unchanged. This was the case even where teams and caseloads were relatively small and stable. This would suggest

[22] Facilitation has long been recognised as a reliable means of supporting and effecting change in practice settings (e.g. Harvey et al 2002)

more difficulty if the role were simply to be super-imposed on busy urban caseloads where throughput of individual patients may be much higher. Relevant research from other parts of the UK (Audit Commission 1999) and Aberdeen (McAskill 2002) strongly suggests that demand for an illness focused, medically responsive district nursing service remains a very high service priority.

What emerges strongly across the practice spectrum that we studied is the need for any introduction and development of the FHN role to be considered as part of wider service review and redesign. Thus we suggest that prior to introducing such a role service providers conduct a comprehensive analysis to plan, facilitate and sustain the development. This may require the deployment of an incremental approach to change management. We suggest there are four phases of analysis to be considered before deciding to introduce Family Health Nurses into the workforce.

1 Situational analysis: What needs require to be addressed and why? What are the current gaps in service provision? What type of FHN role would best meet these needs/fill these gaps? Could this be done by other means? What do others think of current services? Which aspects of current service provision will need to be modified to accommodate the new role?

2 Role analysis: What work will be done in the new role? Who will they work with? What type of person is best suited to the role? What education and training do they need? At what level in the organisation will they be employed?

3 Cultural analysis: What is the organisation's approach to health care? Is this understood by service providers? How will this new role be perceived? How will it fit with current understandings? Will the new role be accepted and supported by professionals and communities?

4 Business analysis: What resources are available for the development, support and facilitation of the new role? What resources are needed to sustain the development and allow for growth?

In considering each of these questions clarity of purpose for role development begins to emerge in such a way as to facilitate the customised integration of new roles into current service provision. These considerations would have relevance to urban applications and enhance the potential of the FHN role to be a solution to the particular problems of recruitment, development and retention of staff in remote and rural areas.

Given the diverse perspectives within Scottish community nursing and primary care that emerged in Chapter 4, and given the related concerns over public confusion about the FHN role, clarity is at a premium. It is hoped that this report proves useful in this regard, but it should also be noted that the situation is dynamic. As has been noted in Chapter 3, new interpretations of the role may emerge through the practice of the Cohort 2 students. Moreover the new Public Health Nurses, whose preparation combines Health Visiting and School Nursing, have recently started to practice in Scotland. This adds another element into the mix and many of the key informants interviewed in Chapter 4 were seeking more understanding of how this role will integrate with the emerging FHN role.

During the initiative it was sometimes suggested that the FHN role could be particularly well suited to distinct client groups such as travelling people, asylum seekers or the homeless. This

could imbue the role with a particular specialist element. We have also already noted that one of the regions participating in the initiative has been exploring the possibility of the family health nursing course being the basis for a more advanced nurse practitioner role.

In many ways our considerations of the possible introduction of the FHN to other areas of Scotland are permeated by the idea of service design, and redesign, starting from the basis of local need. As indicated in Chapter 4, this is reflected to some extent in existing Scottish Executive policy towards the construction and working practices of LHCCs. Nevertheless it is easy to see how more local interpretations could lead to further expansion of the FHN typology and consequent diversity, rather than necessarily creating one distinct, defined role. This tension between local needs and the need for national/international health services to share common understandings of nursing roles sets the scene for our final reflections on the Scottish experience so far and our projections about its potential to inform practice development and nurse education within the UK and beyond.

5.3 REFLECTIONS AND PROJECTIONS

5.3.1. Changing community nursing: the wider issues

Although the Scottish initiative has so far been restricted in scope to remote and rural regions, it has raised many more general issues about change management, role development, practice development and the nature of health/healthcare services. Through the mechanisms of a national project Steering Group and a Project Officer concerted efforts have been made within a short space of time to introduce and nurture the new role. To date, however, it appears that the scope of the necessary change process has been underestimated, especially in terms of facilitating local engagement. While some of the reasons for this may be project-specific, we feel that further perspective can be gained through a brief consideration of other wider issues.

Over the past twenty years professional role development within UK nursing has been characterised by moves towards more specialist and advanced practice, bringing with it a profusion of new job titles (Tolson and West 1999; Cameron 2000). Community nursing has reflected this trend and often local necessity has driven evolution with professional education lagging somewhat behind (Spencer 2001). The UKCC educational framework published in 1994 was an attempt to address this but it can be argued that it has had the effect of reifying a fragmented and anomalous specialist superstructure for community nursing practice in the UK. For concurrently much of the nursing care delivered in communities has been devolved to registered nurses, nursing assistants and, arguably, home carers.

Therefore it is not surprising that, for some, resolution is seen in the form of a much more generic community nursing role. The WHO Europe FHN role represents one particular form of this through its focus on the family. The Scottish experience is interesting in that, to our knowledge, it represents the first UK attempt to systematically introduce at national level a new higher-level generalist role into a field that is now characterised by differentiated specialist roles. It is important to re-iterate that the introduction of the role was being underpinned by an educational course that had to also satisfy the requirements of the pre-existing specialist practice framework.

The initial process of introducing and managing this change has been driven forward within a relatively short period of time. During the first year of the initiative the efforts of the Steering Group and the Project Officer to engage with relevant members of the professions and the public through consultation were hampered by the fact that the FHN role was:

- hypothetical in nature and lacking in precedent
- very broad in its aspirations therefore difficult to define in operational terms
- consequently difficult to understand and therefore predisposing to disengagement or perceived threat
- not necessarily addressing a priority need as perceived by staff (i.e. in some areas there was a feeling that services for families were already very good)

Thus it is easy to see how the initiative could be viewed as essentially "top down" in nature. In a sense the importation of a concept such as the Family Health Nurse necessarily has something of this character. At this level there are plenty of broad precedents and parallels within recent nursing history such as regional introductions of the nursing process or specific nursing models.

Nevertheless lack of role clarity can also be a feature of new roles that evolve from very localised "bottom-up" developments. Cameron and Doyal (2000) cite findings from the Department of Health's "Exploring new roles in practice" project which suggest that new postholders, their colleagues and managers all experienced confusion in relation to expectations of new roles that had evolved in this way.

It is moot to consider how much the ground can be prepared for the introduction of a new role like the Family Health Nurse. To return to our horticultural metaphor of Chapter 1, the community nursing garden in Scotland has a number of mature, established species including some that poorer countries in Europe might consider exotic blooms rather than the hardy perennials that they are. New seeds have been sown quickly during the course of the Family Health Nurse initiative and so far the remote and rural Scottish soil has indeed produced some hybrids. Only one of the distinctive *Bold build* type has flourished. The other *Slow build* types have raised small shoots, while the *Slow/No go* type has lacked space and light.

This raises an obvious question about the growth and spread of pre-existing species. During our research some professionals raised the possibility of family health nursing replacing district nursing. Moreover this is implicitly suggested within recent Scottish policy (SEHD 2000). Our research suggests that simply replacing district nursing with family health nursing is likely to produce relatively minor change if the new incumbents are expected to maintain existing service priorities and work with families only when they have time.

In effect the FHN initiative raises a much broader question about the nature and scope of primary care provision. Hartrick (1997) highlights the tension between primary care provision of a service that is primarily problem-focused and the aspiration to enhance family capacity through health promotion. The latter wish is almost limitless in scope and poses both profound and practical questions for service managers if the whole family-as-client concept is to be integral to service provision. The *Bold build* type represented the most developed and sustained implementation of the family-as-client concept, and in doing so raised within the PHCT questions about relative equity and priority that were usually either dormant or unrecognised.

As Hanafin et al (2002) note, need is a contested concept. These authors propose a new model for provision of the public health nursing service in the Irish Republic based on revised understandings of the need for service at the point of delivery. The Irish experience is relevant in that the role of their long-established public health nurses is in many ways very similar to the aspirations of the FHN role (e.g. having a nurse who works with a wide range of client groups across the lifespan, and who may focus service on primary, secondary or tertiary nursing care). Hanafin et al (2002) note the increasing pressure on this generalist role and the relentless pull of specialisation. As such it provides a fascinating contrast for any country considering trying to move from specialism to a more generalist community nursing role like the FHN.

Such a large scale aspiration is not yet overt in recent primary care policy within England (DOH 2002). Valuing generalists is emphasised in relation to support workers/health care assistants and registered nurses, rather than FHNs. Although some examples of innovation in family-focused care are cited in this document there is no particular policy emphasis or priority ascribed to the care of whole families. Rather a new framework for nursing in primary care sets out three core functions for nurses, midwives and health visitors:

1) First contact/acute assessment, diagnosis, care, treatment and referral

2) Continuing care, rehabilitation, chronic disease management and delivering National Service Frameworks

3) Public health/health protection and promotion programmes that improve health and reduce inequalities

Mapping the WHO Europe and Scottish Executive vision of the FHN against this framework, it can be seen that the FHN would be expected to cover all three of these functions. Most of the FHNs in Scotland so far have been attempting this, but it is interesting to note how the *Bold build* type tended to concentrate effort on the last two of these functions as it was not super-imposed on a district nursing workload. It is also interesting to note how the ordering of the three functions in the DOH 2002 document reflects the hierarchy of priorities so often cited to us in relation to the other relevant role that would be attempting to cover all functions: the triple duty nurse.

Consideration of current primary care policy in England is relevant as it raises the question: *if you did want a new, higher level generalist community nursing role, would it be useful to put such an overt emphasis on family?* During the first year of the Scottish initiative the FHNs tried very hard to address whole families' needs through a detailed assessment and intervention framework that derived directly from the Calgary model. By the end of the year new abbreviated documentation had been produced which made the influence of this model much less overt, while simultaneously introducing an adaptation of the Omaha Activity Recording System. This reflects a pressure to spend less time on assessment and to adapt the more family specialist aspects of the role to the general demands of primary care practice.

It seems likely that in the short term in Scotland there will be inherent ongoing tension between the distinctive family focus of the role and the demand within the system for generalist activities prioritised around individuals needs. Whether this tension proves dysfunctional or not will depend on the extent to which the role can be facilitated and the extent to which PHCTs are willing to engage in practice review and service redesign. If the

latter activities are successful it is possible to envisage the *Slow build* types, and the *Slow/No go* types, developing significantly as part of more integrated, family orientated services. In turn this would lead towards a critical mass being achieved that would present a stronger argument to inform debate about changing the present UK system of community specialist practitioner roles.

5.3.3 Educational development: the wider issues

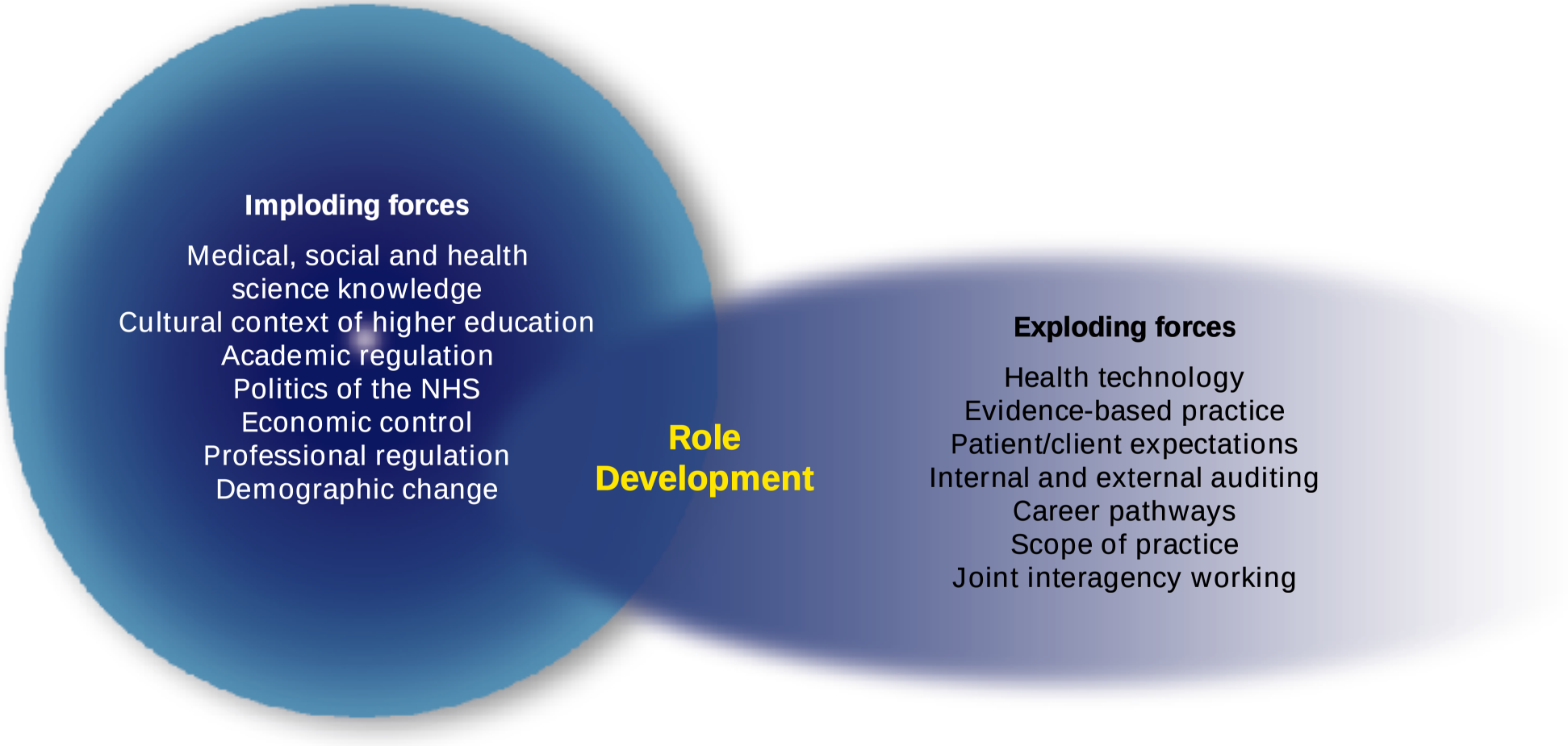
The notion of changing the whole system has been a tangible element of the macro climate in which this initiative has evolved. At times it has cast the Scottish FHN initiative as something of a sparkling light in a new dawn for community nursing. At others it has hung like a dark cloud, imposing a heavy burden of expectation on one small project. Part of the climatic turbulence in the UK relates to proposed changes to the nursing register and their possible consequences for education as well as general concern about the nature and scope of specialist practice amongst educationalists and service providers.

It seems likely that educational providers in the UK may soon have to reconsider their approach to specialist practitioner degree level education. In September 2002 the NMC agreed the new structure and parts of the UK register. The new register will have only three parts: nursing, midwifery and specialist community public health nursing. Entry to the latter part can only follow initial registration as a nurse or midwife. Further consultation on the standards for the specialist community public health nursing part of the register are due to take place in autumn 2003, but the council has already "recognised the distinct difference between nursing and public health nursing and agreed that standards for health visiting clearly demonstrated the level of specialisation required for public health nursing" (NMC 2003).

This raises the question as to whether all the other existing specialist practitioner qualifications will have a similar claim and, in particular where family health nursing will fit in. Will health visitors have a monopoly on this part of the register or will others have legitimate claims that public health is their primary and/or definitive function? A further sub part of the register is likely to be developed for a level beyond initial registration. It may be possible that some of the other existing specialist practitioner qualifications will live within this category.

The following Figure 5.2 overleaf represents a fusion of current influences on professional education for nurses, midwives and health visitors and begins to conceptualise the main differences between the Scottish family health nursing curriculum and other specialist practice degree programmes. Some of the influences, referred to in Figure 5.2 as imploding forces, have resulted in educational curricula being more confined by regulation. Role development provides the opportunity for curricula to expand and explode into new structures. The Scottish family health nursing curriculum has weakened the pull of the imploding forces and allowed itself to explode (not always in a controlled way) into role development, health technology, evidence-based practice, the scope of practice, patient client expectations and career pathways. In doing so it has helped to prepare the ground for re-conceptualising specialist practice in community–based education.

Influences on Nursing, Midwifery and Health Visiting Education



5.4 CONCLUSION

This report has presented an evaluation of family health nursing through education and practice. In doing so it has highlighted strengths and weaknesses that have emerged during the two years of the Scottish initiative. The development of education, national policy and service delivery simultaneously is a very considerable challenge. The extent of the change required has been underestimated. Suggestions for potential development have been made throughout the report. To conclude, we now offer a brief synopsis of these based on the main lessons learned.

In order to capitalise on the achievements to date we suggest that:

- Planned development is facilitated with those PHCTs that include a Family Health Nurse in order that the role can be understood and developed further.
- The critical mass of FHNs is helped to grow in the remote and rural areas.
- The educational programme is further developed as suggested in Chapter 2.
- The evaluation process and resultant evidence is disseminated widely across the UK to foster debate and critical thinking about the nature of community nursing services and suitable educational preparation.

The evidence from this evaluation indicates that considerable effort has gone into this initiative. What has been achieved to date should neither be underestimated nor allowed to wither on the vine.

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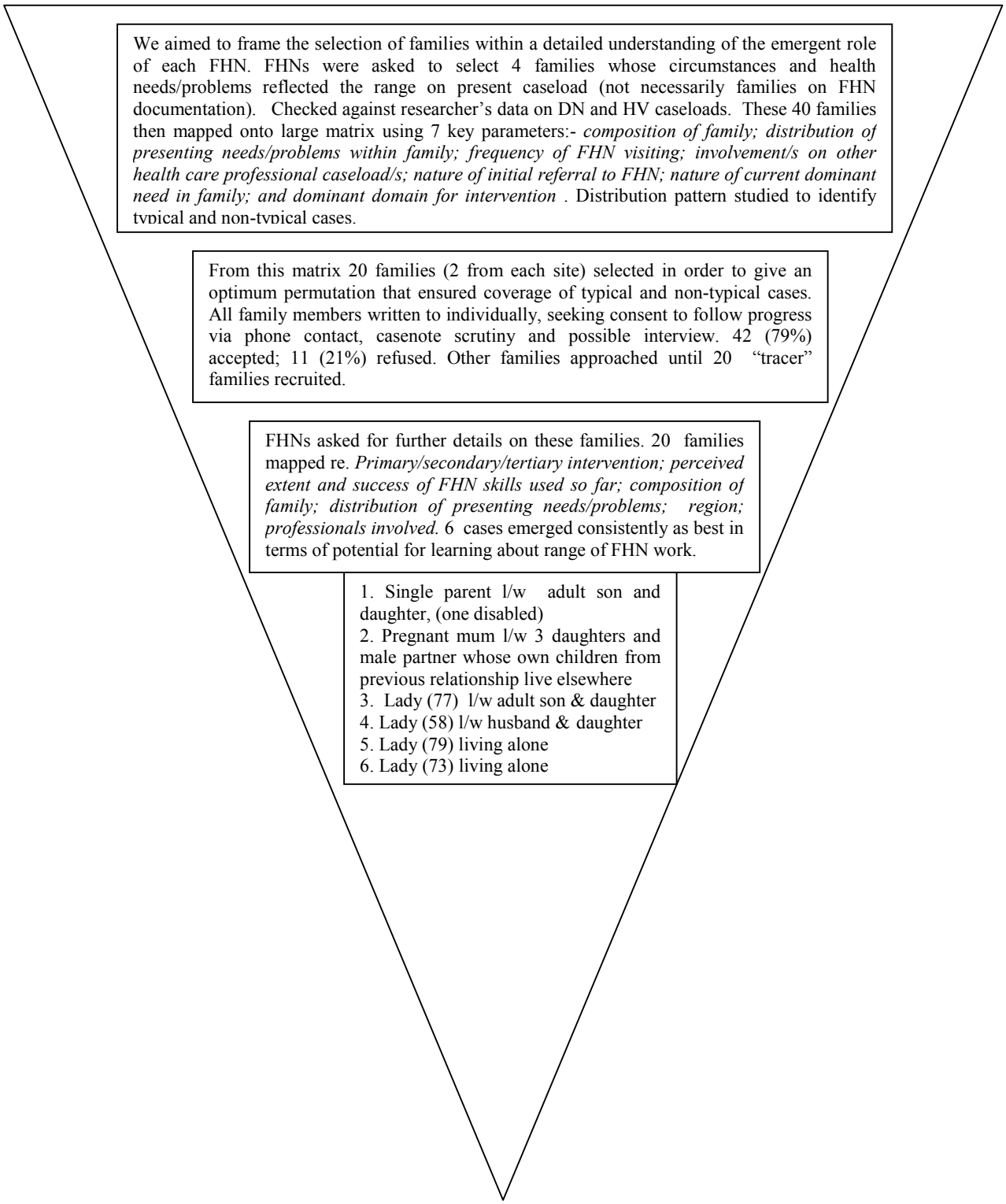
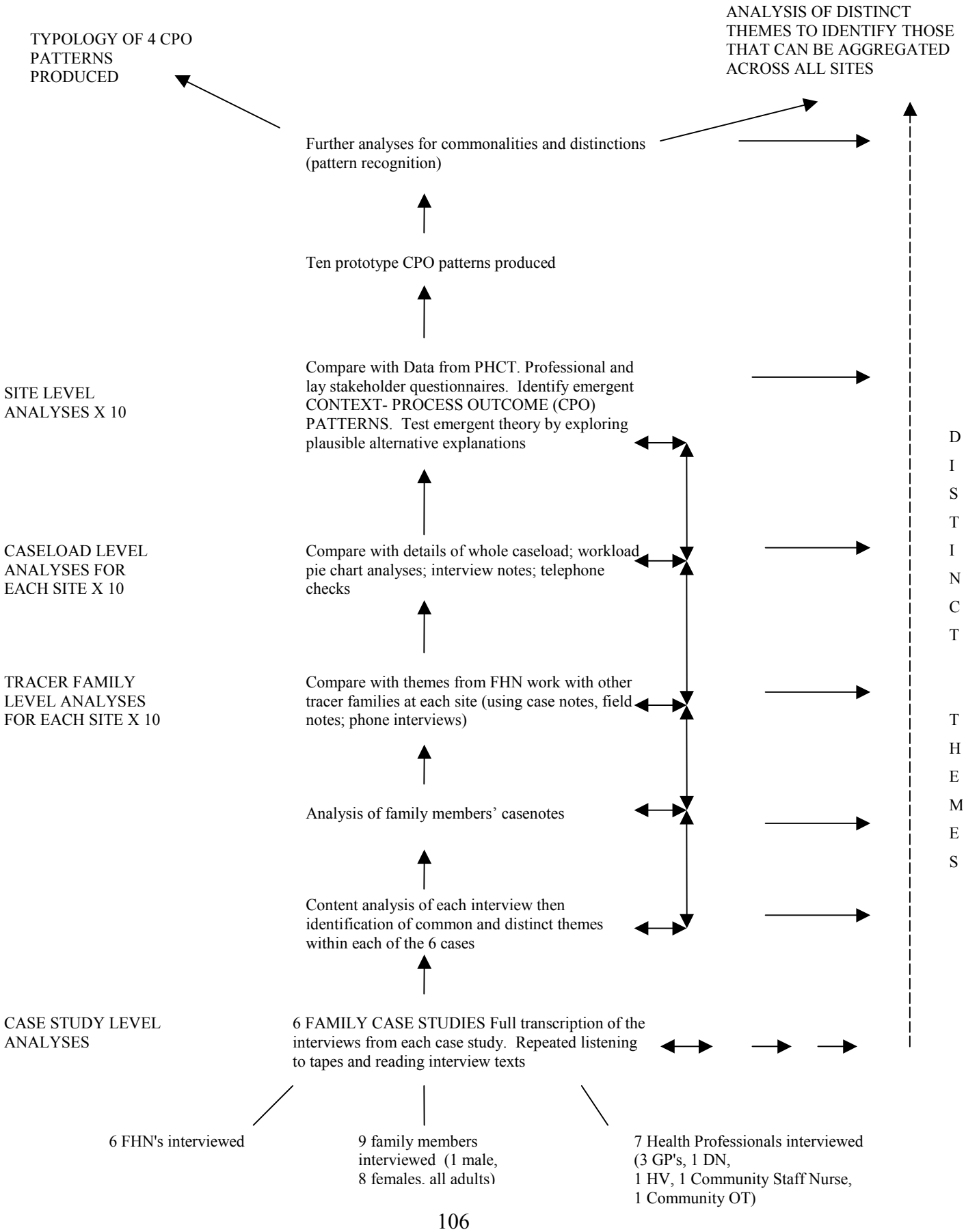
ANNEX ONE PROCESS OF SELECTING "TRACER" AND CASE STUDY FAMILIES



ANNEX TWO PROCESS OF ANALYSIS OF DATA ON FHN PRACTICE



ANNEX THREE SUMMARY DETAILS OF THE 10 FHN SITES

Site code	Approximate population served by site PHCT	District* nursing caseload for whole PHCT site (and % receiving input every week or more often)	Staff complement covering District nursing caseload (mid 2002)	Number in core PCT (eg. GPs, DNs, other nurses, HV)	"Inherited" District* nursing caseload for FHN "patch" (and % receiving input every week or more often)	FHN role, grade and hours pre-course	FHN role, grade and hours post-course	Any substantial change in staffing complement for DN caseload during year of FHN introduction
A	70	70 (4%)**	1 G FHN f/t 1 relief nurse p/t	2 on site 4 associated	70 (4%)**	DN/Midwife G; f/t	FHN; G; f/t	No
B	400	15 (47%)	1 G FHN f/t 1 relief nurse p/t	4 on site 3 associated	15 (47%)	SN; G; f/t	FHN; G; f/t	No
C	520	31 (29%)	1 G FHN f/t 1 Aux nurse 20hrs+ bank	4	31 (29%)	SN/Midwife F; f/t	FHN; G; f/t	No
D	2500	90 (59%)	1 G FHN f/t 1 G DN f/t 1 D SN 30hrs 1 Aux nurse 12hrs	9	34 (44%)	SN; E; f/t	FHN; G; f/t	No
E	3600	202 (30%)	2 G DN f/t 1 G FHN f/t 2 E SN 30 hrs 2 Aux nurse p/t	19	48 (31%)	DN; F; 30 hrs	FHN; G; f/t	No
F	1900	79 (50%)	1 G DN f/t 1 G FHN f/t 1 E SN 30 hrs 1 Aux nurse f/t	9	33 (50%)	SN/Midwife F; 30 hrs	FHN; G; f/t	No
G	1700	202 (21%)**	1 G DN f/t 1 G FHN 30hrs 2 SN f/t (one F & one E) 1 Aux nurse f/t	12	46 (30%)	DN; F; 30 hrs	FHN; G; 30hrs	No
H	1250	100 (29%)	1 G FHN f/t 1 G DN f/t 1 D SN f/t 1 Aux nurse 20hrs	8	55 (23%)	SN/Midwife F; 15-30 hrs	FHN; G; f/t	No, but short staffed for 6 months until G grade DN recruited
I	2200	120 (58%)	2 G DN f/t 2 F SN 15 hrs each 2 Aux nurses 10 & 13.5 hrs	10	N/A	SN; E; 15hrs	FHN; G; f/t	Yes, small net increase (see case study)
J	1150	36 (61%)	1 G FHN f/t 1 F SN 22.5 hrs 2 relief nurses (DN & SN) 1 Aux nurse (bank hours)	10	36 (61%)	DN/Midwife G; f/t	FHN; G; f/t & lead nurse	Yes, service integrating with hospital staff

*CASELOAD FIGURES: These figures should be treated with much caution. Firstly they are based on snapshots when visiting sites during 2002. Secondly practice varied so much as to what constituted a caseload (eg. what people were visited for; frequency of visiting; entry and exit from caseload lists) that meaningful comparison was very difficult. Routinely collected data on nursing activity was virtually worthless in this regard as recording practices varied so widely. Accordingly the "percentage receiving input every week or more often" figure is our very crude attempt at meaningful comparison. However this does not allow for the type or amount of input (eg. several concurrent terminal care cases at Site G when FHN took on "patch"). At the end of the day, perceived burden of caseload (ie. non-heavy or heavy) proved as useful a proxy indicator as any, especially since this was cross-checked with other members of the PHCT. Thus we have used this indicator in our typology of practice.

** Extreme low percentages often merely reflect the limitations of using the percentage receiving frequent input measure. At Site A the whole population is the caseload. Formal frequent district nursing input is very low, but weekly contact with most of the population is unavoidable and will usually involve informal assessment. At Site G the community nursing register includes a very large proportion of infrequent supervisory or support visits (eg. for over 75 assessment). This large denominator makes the resultant percentage low (despite 42 patients needing frequent input).

ANNEX FOUR TWO CASE STUDIES OF FAMILY HEALTH NURSE PRACTICE

INTRODUCTION

These in-depth case studies have been constructed in order to offer the reader greater insights into the world of family health nursing through the words of the Family Health Nurses themselves, family members, professional colleagues and researchers. Sites exemplifying the *Slow/No go* and *Bold build* patterns have been selected as they represent different ends of the spectrum of family health nursing practice that we studied. Within this contrast lies a great deal of useful knowledge about how the FHN role may or may not work. The case studies have been constructed to illustrate particular themes that are characteristic of these patterns. They also aim to offer some insights into the interview methods used by the researchers. It is important to note that these case studies are based on data from the first year of FHN practice and only reflect the evolution of the role up until autumn/winter 2002.

Each site case study starts by "going in through the eye" of a family case study done at the site. The working of the FHN model with this particular family is then considered in relation to FHN practice with other local families, district nursing practice at the site, and the practice and perceptions of the wider Primary Health Care Team and local community.

Extracts of dialogue from interviews have been selected for analytical purposes but at times also fulfil a narrative function. These extracts are used verbatim except for the very occasional editing out of any excessively personal material. Different names have been used to help protect the identities of those **family members** who kindly took part in interviews. **FHNs are referred to as "FHN" except for in the body of dialogue where they are referred to as Una** (as Cohort 1 were pioneering this role). Other health professionals who had knowledge and close involvement in the case are all referred to as "**Colleague**". Finally, somewhat predictably, the researcher is referred to as "**Researcher**".

SLOW/NO GO

The context for this case study is a large geographic district (Site G) with a sparsely distributed population of around 1700 people. The district has one predominant settlement where almost all the Primary Health Care team members are based. The FHN has been allocated a distinct geographic "patch" within the district. Cardiovascular disease, cancers and diabetes are all prominent health problems within the community.

The focal case involves the following family who are native to the area:

Grace, a 77 year old lady who for many years has required district nursing input for recurrent problems with varicose leg ulcers. She lives with her daughter Heather (42) and son Calum (44).

Researcher: *.... generally, what have you been trying to achieve with this particular family?*

FHN: *What I set out to achieve I haven't because of other pressures within the caseload. With terminal care I've had quite a few ill people. I haven't been able to cause I had to prioritise. When I originally spoke to them the mother had got varicose ulcers, Calum had been diagnosed diabetic and Heather has been under investigation just now, but she's been having this skin problem.....*

This extract exemplifies the theme of thwarted case development that frequently emerged for those trying to implement family health nursing on top of busy district nursing caseloads. The FHN was typically going in once or twice a week to attend to Grace's ulcer, and other members of the community nursing team provided back up:

Colleague: *... our input now with Grace is purely on a relief basis for Una (FHN). You know if Grace is pencilled in for a visit on Una's days off or she is on holiday, then we go in and do that visit and record it on Una's notes.*

Researcher: *Can I ask you about Una's notes, do they stay in the house or do they stay in here (site base)?*

Colleague: *Here.*

Researcher: *Is that them you've got there?*

Colleague: *Yes, it's the same notes, the same but different. They are the same as our own notes, except Una's got extra bits for the genogram and ecomap.*

This customisation also incorporated completed assessment sheets pertaining to family dynamics (such as power structure, roles, strengths, stresses and coping) and culminated in a family plan: *To discuss dietary habits with family in view of Calum's hypertension and diabetes, and Heather's anaemia.* A family "progress sheet" recording sheet had two entries by the FHN, one of which was *Unable to have family discussion due to visitors being present.* This family assessment material supplemented sections with individual traditional nursing notes for all three

family members, with comprehensive information relating to the range of medical problems that were existing and emergent. As such the notes provided comprehensive evidence of care and represented a sustained, if rather unwieldy, attempt to reconcile family health nursing and district nursing documentation.

The FHN had made a start to the plan by giving the family a number of leaflets on healthy eating, but had not had a chance to follow this through. The other community nursing staff did not have any specific input with the family in this regard.

Researcher: *So has there been any need to change your diet, to use these booklets?*

Grace: *No.*

Heather: *We were going to look them up to do with losing weight.*

Researcher: *Is that something you've made any progress with?*

Heather: *Haven't started. You haven't tried to lose weight yet, have you?*

Grace: *I don't take sweet things or anything. Maybe I could do more walking and that. That would help.*

However the family members interviewed were very appreciative of all nursing input received, and made special mention of the FHN's listening skills. Indeed the FHN herself felt that some progress had been made

Researcher: *Is the contact you've been having with the family similar to your previous way of working before you came on the course? Are you doing anything different?*

FHN: *Probably not. I've arranged more with them. Probably as a DN you'd go in twice a week on the same days. It's a bit more flexible and has their agreement that the days get changed. The times are more flexible.*

Researcher: *Is that more flexible to suit you or to suit them?*

FHN: *Well, if it suits us both. I discuss it with them. What suits them.*

Researcher: *And previously would it have mattered if you'd seen Heather? I mean you were going in anyway to do the dressing. But do you think in the past if Grace had said to you 2 or 3 years ago when you were doing the dressing that she had some worries about Heather or Calum, what would you have done?*

FHN: *Spoken to them and spoken to the GP. And would have been involved then if there was anything nursing wise. I feel Grace is more communicative with me, talking more, certainly, and she's coming across with more of her feelings.*

Researcher: *Do you think that's been influenced by your attempt to sort of formally assess them by spending time with them?*

FHN: *I think maybe it is. Just getting to know her better and building up trust.*

Researcher: *Would that have been legitimate activity before in terms of your DN work? If you had said to your colleagues or decided that it seems as if Heather has got some needs here, I'm going to spend some time trying to get to the bottom of this, would that have been a reasonable thing to do in terms of your normal work?*

FHN: *Yes.*

At the time of interview Heather was receiving input from the local GP and Calum saw the diabetic specialist nurse periodically.

Researcher: *I suppose I'm hunting for what extra dimension, if any, you feel that the FHN brings to a family like this?*

FHN: *I think had I more time it could have been more. More meetings with them. More discussion. More in-depth. Which is what I planned to do, but then there were other priorities on the caseload and really in the past two months they've had to come further down my list. I haven't been able to spend time with them or do what I initially set out to do.*

Confirmation was provided by the family that a new approach to care hadn't yet been established:

Researcher: *Who would you contact first if you had a problem with your health; that is yourself? Would it be the doctor, the family health nurse or the District Nurse?*

Heather: *Probably the District Nurse.*

Researcher: *For yourself?*

Heather: *Probably. I only go to the doctor when I have to. Eventually.*

Researcher: *And for your mum, would it be……..?*

Heather: *Probably get in touch with the nurse, like going to the District Nurse in Maintown. Either phone the doc, or to the hospital.*

Researcher: *So the district nursing service you'd contact rather than Una (FHN) herself?*

Heather: *Yes. Yes.*

Researcher: *Do you think what Una is doing is, as far as you can tell, any different from what happened before with the family?*

Heather: *Well there wasn't really a before so I can't tell you.*

Researcher: *Yes, there was just the District Nurse coming in. As far as you are aware, is there any sort of plan for the family's health, or anything like that?*

Heather: *No.*

The above extract also confirms the FHN's assessment that there is a need and opportunity for some integrated secondary prevention work with this family as a whole. However the challenge of delivering sustained work of this sort (eg. working on attitude change) within the present local working arrangements had so far proved insuperable. Moreover there was still the question of how much individual members, and the family as a whole, might want to engage in any more pro-active, health focused model of service delivery. There was no suggestion of any dissatisfaction with pre-existing health care services.

This affords good opportunity to broaden discussion towards analysis of working practices at the site as a whole.

Overall the core PHCT comprises the FHN (G grade 30 hours per week); one full-time District Nurse who is team leader; two full time community nurses (one F grade, one E grade); one community nurse who does "bank, relief" work; a full time auxiliary nurse; two Practice Nurses, and 3 GPs. The nursing caseload for the whole geographic district numbers around 200 patients and is dominated by chronic health problems of over 75s. Many supervisory visits take place. Bathing is mostly done by the auxiliary nurse, but nurses do some. The FHN's distinct "patch" within this site typically has 40-50 community nursing patients. A team midwifery system operates locally from a different base. Although many of the core primary care team listed above are midwives, none now are practising.

The Health Visitor covers an even wider geographic area . Within the part of her patch that is coterminus with this primary care team, she carries out a range of work. Much of this work is with children and mothers (around 30 children who receive developmental screening and related interventions if necessary). She also does health checks and health teaching in the local primary school; sees a limited number of adults individually to help them with smoking cessation and/or cardiac rehabilitation; and runs a variety of evening groups in the area (eg. womens' "look after yourself" group).

Within this team context the FHN has been trying to make the role work:

FHN: *I feel that I'm not really working on my own, yet I'm not really part of the team as I was either.*

Researcher: *So, in between?*

FHN: *I feel I'm missing out. I haven't been able to do anything sort of community based.*

In fact there was evidence that the FHN had been active in some health promotion and screening work with the local primary school. Some of this was in collaboration with the Health Visitor, but there had not been sustained development of this activity. Work with specific families was slow and it had been possible to engage in sustained, in-depth family health work with less than five families since starting the post.

Researcher: *I'm interested in what makes someone a family health nurse case, or what makes a family a family health nurse case, and the example you are giving here is where there's quite a lot going on in terms of health needs.*

FHN: *Probably for education.*

Researcher: *Yes and you are also saying that it's possibly easier for you to take on people or families who haven't had previous DN involvement. But from what I understand the vast majority of your work so far has actually been with the traditional DN caseload in your area. In a few cases like this family, you've tried to branch out from that caseload to other family members. Would…*

FHN: *What I'm finding is hard. There's another family as well that I've done an assessment on and it's the daughter in that family that's diabetic and the mothers diabetic, but when I go in primarily as a DN I've been going in to visit the mother. And because they're all so polite they get out the room to let me speak to mother, and I find it very difficult to get them to come back in to the room as a family committee. Because of what traditionally happened. But I find it easier if there's been no involvement, then from the beginning I can get the family together and have discussion.*

From the beginning of the project the rest of the primary care team were very supportive of the FHN's personal professional development and of her aspiration to make the role work. There was already a good pre-existing culture of regular, open team meetings and the team set up an open diary for ongoing team reflection on the process of introducing family health nursing. Negative comments tended to predominate. One particular issue for the rest of the team was that the routine data returned monthly on patient contacts and activities did not properly reflect their input in covering the FHN's patch. By the end of the year there was general consensus that the role wasn't working:

Researcher: *So there's a question about where it fits in. Is it providing a similar or a different service?*

Colleague: *At the moment Una (FHN) is doing DN under a different title. But then that's not Una's fault. Cause Una was brought back into the community as a member of the team. And she was given a caseload, so she had to carry that caseload and she had to continue doing the work that was done before. And we all felt that it would have been better if Una had been brought back supernumerary, and if they had come out as new nurses and developed their caseload, rather than taking on what was already there and having to continue doing what was already being done.*

The above extract exemplifies a strong theme that emerged at this site and indeed the vast majority of other sites. That is the embedded need for the community nursing service to continue as normal. At this site a specific geographical sub-patch had been hived off for the FHN but it was not seen as an opportunity for any substantive review of nursing caseloads and working practices. Given that the family health nurse initiative was presented as a time-limited experiment this is not surprising, but it does suggest that the team at the site saw it more as an experiment on them, rather than by them. The professional stakeholders' comments about consultation on the introduction of the role support this interpretation:

"I don't think the concept and where the FHN fits in vis a vis community nursing and health visiting was explained to us at all"

"Consultations have been mainly with evaluators. Nothing prior to project start"

At a more fundamental level team members struggled to see the need for a new role

Researcher: *How do you feel that the role of the FHN fits in with local services in general?*

Colleague: *Well it was felt, we all felt, that it's a difficult one because there's already a framework in place for the delivery of service. You know there's already the DN service, the HVs, there's health promotion.....*

At the end of the year only one of the ten professional stakeholders who replied (10%) said there was a positive need for a distinct FHN role. Three (30%) felt there wasn't, and the remainder didn't know. Explanatory comments revealed a range of perceptions:

"I think it should be decided whether we have DN or FHN. There is so much duplication of remit that it is otherwise confusing to the public"

"I feel the role is that of the present Health Visitor. Duplication not needed"

"Good community nursing care is already given and it would be better to extend the district nursing role. Health visiting service is very good also"

"Existing team networks well and has staff who are motivated and continuously professionally develop. We should concentrate on development of existing team"

Amongst the team there was little recognition of any substantive gap in current service provision

Researcher: *I don't know if you would have a chance to discuss this as a team but in that event, which is now hypothetical, but if she'd been brought back as a supernumerary person, do you think you could see the need for that?*

Colleague: *No, I don't really know. I think we would be doubtful about that. Again because, and you can correct me if you've got information that I don't have, but you know things are pretty well covered.*

Researcher: *Yes and you mentioned that health promotion are covering a number of areas, District Nurses ... But I suppose if we take the elements of this new title, family health nurse, emphasising health, do you think there is anything missing in terms of the care of families?*

Colleague: *In respect of the DN service?*

Researcher: *In respect of the whole team: the net effect?*

Colleague: *Maybe because we are rural and nearly everyone knows everyone else, I think it's pretty much covered because the HV, the DNs, the Practice Nurses, we do pick up things with families. We do pick them up and you find out, you know word of mouth, you pick up what's happening.*

Researcher: *Maybe not in the way that's in these notes (FHN) where, if you like, there's a systematic…*

Colleague: *Yes. I don't know, Una (FHN), whether she's had any problems, but especially the Highland and Island personality is quite reluctant to change. And I don't know how well people will take to these forms which are quite probing. And I think there might be some…*

Researcher: *Do you think that some of that's a bit too intrusive?*

Colleague: *Well I think that people might find that.*

Most of the lay stakeholders who responded felt unable to give an opinion on the implementation of family health nursing so far, but one respondent saw possibilities:

"I believe that this would be a valuable service and prevent illness if individuals and family unit were assessed as a whole, not mainly when medical assistance is required for specific illness"

While a few of the professional stakeholders indicated that the development had caused disruption to the team (especially when the FHN was away on the course), many also commented positively on the FHN's professional development and saw her recent training and experience as a useful resource for the team. However referral activity continued to be almost exclusively for traditional district nursing input with individual patients. During the year there were less than five referrals of families to the FHN. When asked to comment on any change for professionals in the way they worked together, one stakeholder commented:

"It should have but hasn't – needed more facilitation and support"

The FHN provides summation

Researcher: *If you could change one thing about your current role, what would that be?*

FHN: *What I'm doing just now? I would change it totally.*

Researcher: *Totally? Right, let's hear about it!*

FHN: *I don't think the FHN is working and will work in this area based on a DN caseload as there is too many other things going on. The area I'm working in has a lot of elderly and initially when I started there was a lot of general nursing care which I had never minded doing. But when there's auxiliaries and carers that can do the role, I think I should have been doing things that I'd been trained to do.*

During the year some extra auxiliary nursing hours were allocated to assist the development of the role, but these came from within existing resources and there was no net increase in nursing resource at the site during the first year of implementation.

In summary, the FHN development in this Category 2 site (see Table 3.5) can be characterised as:

- sporadic, and seldom developed or sustained, despite much effort
- not really seen as needed by professional colleagues, but the team tried to support the FHN

The characteristic pattern can be summarised as:

Context: FHN role super-imposed on "heavy" district nursing caseload within established and functional medium sized PHCT

Process: Sporadic and limited introduction by FHN only, with little/no change in other professionals' activities

Outcome: No substantive change in practice. "Normal" district nursing services maintained, but remains stressful for FHN and colleagues.

Two other sites (F and H) shared this characteristic pattern (see Table 3.6). Like Site G, each of these sites had some difficulties with staff shortages and sickness during 2002.

BOLD BUILD

The context for this case study is a large geographic district (Site I) with a population of around 2200 people. This population is sparsely distributed apart from one relatively isolated large village with a distinctive post-industrial heritage. The majority of the core Primary Health Care team members are based in this village. The FHN does not have a distinct geographic "patch" within the district, but much of her work is focused on the needs of people in the village. The village has a particularly high proportion of vulnerable groups (the elderly, unemployed, single parent families, cultural minorities and socially deprived families). Cardiovascular disease, cancers and mental health problems are all prominent health issues within the community.

The focal case involves the following person who had raised her family in the area:

Jean, a 74 year old widowed lady who lives alone and has a large number of chronic health problems. Jean has four grown up children who live outwith the immediate district but keep in regular contact.

Researcher: *What was your first contact with Jean?*

FHN**:** *Well she approached me. I met her in the surgery waiting room when she was waiting to go in to the doctor, and she said "Oh I hear you've been away on a course" and she asked me if I could come in and speak to her. She'd recently been diagnosed with diabetes and was unsure about her diet and different things, and she was wondering if I could help her with that. So I said "Yes, that would be fine, I'll come and see you". And then I cleared it with my colleague and saw her, and from then on I've been seeing her on a weekly basis most of the time. I think probably now we'll be tailoring it down a bit, but it has been weekly so far.*

Researcher: *What is the main thing you've been trying to achieve?*

FHN**:** *Really trying to improve her basic knowledge of diabetes. How it affects her, how it affects her life, and also the other medical problems she's got, cause she's got a whole host of medical problems on her list. But diabetes was the first thing and through that we've just been discussing her and realised that she was wanting more information on angina, her chronic obstructive airways disease and things like that. She wasn't sure about what they were, or how they affected her, and what she could do to help, so its really been a lot of health education we've been doing together, and also looking at building up her independence and trying to reduce stress as she finds coping on her own quite hard.*

This input from the FHN had been sustained over the past 8 months.

FHN: *... so I think, as far as the diabetes management, I know from asking her myself how she feels she's getting on, as its her targets that we stick to, and she feels that she has quite good knowledge of the diabetes, how it affects her and what her diet should be and what the complications are and how to reduce the chances of developing any more. So I think the progress from that part has been good.*

... Cause if I was a community nurse I would come in, give the info, do what I have to do and then that would be it finished, whereas with this I've been going over it over a month and building up slowly. Going back over things cause quite often you can tell someone something and they say "Oh yea I understand that" and then a few months down the line they think "I didn't really quite understand that, can we go back over that again" So its been quite a back and forth programme.

Researcher: *And while we're on that pre-FHN, why would you not have spent so much time on health education? Was it because you lacked the knowledge yourself or did you have other things to do?*

FHN: *Usually because I had other things to do. Cause that was always what frustrated me about being a community nurse, being stuck in that situation where you didn't have the time to give properly to your patients, and you would give ad hoc kind of info that you knew that the patient couldn't actually use very well. But you felt you were doing your job right if you did it anyway.*

This perception of a more in-depth service was confirmed by colleagues within the core PHCT, but the view of community nurse information giving expressed above was by no means universally held within the core PHCT. There were also differing perceptions as to how much this service was needed and whether any extra quality/benefit was actually being delivered.

Colleague 2: *... also you have problems trying to cope with people who are needing a lot of support and input, and Una (FHN) filled the gap.*

Colleague 1: *I'm not entirely sure the benefit an FHN can give to Jean that would not already be addressed by the GP, the Practice Nurse and the District Nurse.*

In the context of diabetes care a number of services were already available within the site. These included the practice nurse, a dietician who visited the site weekly and a Nurse Specialist in Diabetes Care based outwith the site. Jean had some contact with these services prior to the FHN becoming involved and occasional contact with the practice nurse and Nurse Specialist thereafter.

Jean also continued to have fairly regular contact with other members of the core PHCT, particularly the district nursing service which continued to visit weekly in order to co-ordinate Jean's complex oral medication arrangements. These visits were typically brief (around 10-15 minutes) and occurred at the other end of the week from the FHN visits. This arrangement was initially seen as beneficial by all parties in that it gave more regular support to Jean, but in recent months the district nurse and the FHN had recognised that the arrangement involved some unnecessary duplication. Despite mutual recognition that the FHN alone could cover all home input for Jean, however, both services continued to visit and record brief details on continuation sheets within a summary nursing care plan kept in Jean's home.

FHN notes were kept at the nursing base. These were comprehensive and incorporated two main sections. Firstly there was a full FHN documentation including a genogram, an ecomap, and assessment of family roles, functions, values, activities and strengths. Secondly there was a

section comprising individual health history sheet, medication record sheet, a variety of diabetic monitoring sheets, and finally need-goal-intervention plans for six different health needs. The latter plans were very detailed, had been evaluated on each FHN visit and included Jean's own perceptions of progress.

The genogram highlighted a family history of cardiovascular problems.

Researcher: *Even though ostensibly you're dealing with one individual, do you feel its been worthwhile doing the genogram?*

FHN: *Definitely because Jean herself found it very interesting. Just looking at the family members and looking at the links, because not many people realise, until its down in black and white, you can be talking about past family history and they know that things travel in families, but until they see something like this they cant actually get that into their head and see how important it is to encourage a healthy lifestyle throughout the generations.*

Although the FHN did not have professional contact with Jean's children, she indicated that Jean herself had raised the topic of lifestyle issues with her sons and daughters. Jean derived a great deal of psychosocial support from the FHN's visits.

Jean**:** *She's got a good listening ear.*

Researcher**:** *Is that one of the important things?*

Jean: *Yes very much so.*

Researcher: *What sort of things do you tell her?*

Jean: *Sometimes the way I feel and things like that. It's hard to say really. I'd be lost without her, she makes my day.*

Researcher: *So it gives you a support?*

Jean**:** *Definitely, If I need any help or aid she'll try and get it for me.*

Researcher**:** *Financial?*

Jean**:** *Yes. She's supposed to try the internet for it, but she hasn't got access yet.*

Researcher**:** *So that's a bit different from the district nursing?*

Jean: *Oh aye, different entirely.*

The FHN highlighted one of the major differences.

Researcher: *I found it very useful that latterly in your notes you'd actually write down how long some of your visits had been taking. It's very helpful and gave me an idea that you were often there for an hour or so, and that's quite intensive work?*

FHN**:** *That's right it's a long time. And I do find on average most of my visits are about an hour to everyone that I see really, and I was clocking up so I thought I would write it down in the notes as it does reflect that it is very different from community nursing where you average visit is 15-20 minutes in and out, whereas mine last year has been on average one hour to one and a half hours.*

The FHN was working towards reducing her input with Jean and recognised that dependency was a potential problem. Colleagues shared this concern.

Colleague 2**:** *Its difficult for Una (FHN) as well, if she's going to restrict herself down to X number of families and they've all got problems that are not going to go away today. She's going to have them on her books for months & months, that's a problem. I mean I don't know how many families she's supposed to have in all, but I think she's pretty near full, if not full. What can you do in that situation?*

Indeed the FHN's colleagues had a number of broader concerns about the development of the role and how it fitted in with core PHCT activities. As such this is a good point at which to broaden discussion towards analysis of working practices at the site as a whole.

The core primary health care team based in the main village comprises one full time G grade District Nurse; one F grade community staff nurse (15 hours per week); one auxiliary nurse (10 hours per week); one Practice Nurse (10.5 hours per week) and two GPs. Prior to undertaking the course, the FHN had been working locally as an E grade community nurse for 7.5 hours per week in this village and 7.5 hours per week in a smaller village. Since completing the course the FHN was now working full time at G grade (Monday to Friday). Although based in the main village the FHN provided family health nursing services across the district.

The rest of the core PHCT for the district are based in a smaller village and comprise one full time G grade District Nurse; one F grade community staff nurse (15 hours per week); one auxiliary nurse (13.5 hours per week); one full time Health Visitor. The Health Visitor's work within the district was predominantly with children and mothers, and involved work in a number of local schools. Her remit also involved working in schools outwith the district.

The district nursing caseload for the district as a whole numbers around 120 and is dominated by elderly people with chronic health problems. Many supervisory visits take place and these are seen within the district nursing team as part of the family dimension of their care. Bathing is mostly done by the auxiliary nurse, but nurses do some. A team midwifery system operates locally from a base just outwith the district.

The mode of FHN role development at this site was found to be unique in our study of practice:

Researcher: *If there's a whole lot of people with needs, how do you choose who you prioritise?*

FHN**:** *Very difficult.*

Researcher**:** *Is that,.... it sounds like its been an issue, or has it?*

FHN: *Not for me personally, because I haven't been choosing my patients. I've had all my patients have been referred to me directly, either by self or by DN, GP other community professionals, (midwives, practice nurses), so I haven't in a sense been choosing them because of their need; they haven't been getting priority over other people. I take anyone or anything it doesn't matter.*

Researcher**:** *Right, cause that's an interesting way. You've developed the caseload pretty much from scratch, haven't you?*

FHN**:** *Yes.*

Researcher**:** *And you're telling me that you've developed it from referrals from other professionals. So the need has been recognised by them?*

FHN: *Yes.*

Researcher: *And would you ever say "no" to some of the people?*

FHN**:** *Yes. And I have done. If I feel that the caseload is too heavy, or I'm too busy and I feel that I cannot give that fairly equal time and proper input, then I would say could you either defer this, or I have a waiting list of a month, and I'll get round to seeing them in a months time. And that's worked OK so far.....*

Assessment of referrals often proved interesting

FHN: *... if there is somebody that they send me that I think will probably, may not be suitable, I'll see them and try and work out things. But often actually sometimes from what the referring person perceives as that persons problem, when that person comes to me and I assess them, sometimes its quite different. What the patient sees their problem is and why they think they've been sent to me. And then it can actually turn out that they are an ideal candidate for an FHN, but I wouldn't have known that sometimes from the assessment. So every patient that I'm referred I do see, if only once to ascertain that they are not falling within my jurisdiction...*

The client led aspect of the service was highlighted by the FHN:

Researcher: *... from what you're saying its different?*

FHN: *It is different, definitely. I think it meets the clients needs more because I ask the client what they need. Often as a DN you go in, because the doctors told you that you've got a diabetic patient that's on heaps of medication, can you sort it out? You're not going in under any other terms, that's your task go and do it. But with this its much more open, it's often at patient's request, or at other reasons to go in. So it's much more client-led and so it's quite different.*

Researcher: *Sticking on that client-led nature, and Jean, how many more cases like her could you have on your caseload where you are going in quite frequently (eg. weekly)?*

FHN**:** *I am not sure. I've got about 24 caseload at the moment. I've lost a few in the past few weeks. I manage that just, but I do a lot of other stuff.*

However the client-led aspect did not necessarily fit easily into the overall system of service provision locally:

Colleague 1**:** *So I'm not sure how productive it is for Una (FHN) to be spending time with a patient selected out of all the other ones, with no particular reason why its this patient as opposed to other patients with chronic heart, lung, diabetes.*

... There are lots of people, so how do you select, I mean which ones get the sort of intensive care (as in one is worthy of more attention than the other) and my criticism is that we are not making best use of the PHCT.

The way that family health nursing was developed at this particular site raised issues about the equity of the new service amongst several members of the core PHCT, and in turn engendered reflections about the equity of pre-existing services at this site. These included the service coverage for particular client groups.

Colleague 2**:** *I think we're very well provided for here really. But if Una (FHN) wasn't here, excluding her, the PHCT team would work but there would be various things like the clinics she's doing down there wouldn't be getting done and again these problem families wouldn't be getting covered because you'd be running in and running out. Whereas Una can sit and say "right just exactly what is it you want?". Right, I'll refer you to OT whatever and go through the assessment. We do the assessment but it's not in as much depth.*

Researcher**:** *Last time we spoke you raised the question of a possible 2 tier service.*

Colleague 2**:** *It is actually still a worry. I feel that it's a service that probably everyone should have, but that's an ideal situation. But everyone should have that sort of assessment to start with...*

During the first year of FHN practice though, this single FHN had necessarily only been able to provide the service to a limited number of individuals and families. Moreover from the FHN perspective this new service was based entirely on expressed need (ie. referrals from other health professionals and by local people self-referring) and everyone who was referred was assessed.

The possibility of widening FHN service coverage through delegation was explored:

Researcher**:** *Thinking of your own work with Jean, as an FHN, are there any aspects of your own work that you would think about delegating, or that could be done by someone else feasibly?*

FHN**:** *Yes, I suppose a lot of it…well not a lot of it, but part of it could be delegated. Maybe the weekly, day-to-day visiting of families could be done once a case plan is put in motion and the assessment done. Some of the support could be done by somebody else. And the health education part of it as well, there is no reason why a community nurse who has a special interest or knowledge in that area couldn't do that too. And a lot of the documentation and planning and organising of groups could also be done by somebody else. And lots of kind of letters you write, that could be delegated, I don't know, its difficult to answer that in this context at the moment because it's just me and there's no-one I can kind of delegate to.*

This highlights that integration with mainstream community nursing had not been achieved during the first year of FHN practice. The reasons underlying this were contested within the site. During the educational course the FHN and colleagues from the project team initiated meetings to try to explain the new role to professional colleagues and the local public. The FHN's colleagues generally felt, however, that they had been poorly consulted prior to the introduction of the role and many were unclear about what the role involved and did not involve:

"We were told that this was going ahead. We had no choice"

"Initial information patchy. Caused upset and confusion with health care professionals"

The process of introducing and establishing the role entailed considerable stress for the FHN and a number of colleagues within the core PHCT. From the FHN perspective there was the very difficult challenge of trying to grow this distinctive new role while simultaneously trying to fit into the established core team approach. From the perspective of some, but not all, colleagues within the core PHCT there was an ongoing feeling that:

- the role was being imposed from outwith the site
- there was no clear need for the role
- its introduction reflected badly on pre-existing services

Unsurprisingly this gave rise to some sustained working difficulties. During the first nine months in particular there had been some conflict between roles:

Colleague 1: *... she's got some resentment from people she works with as to taking over their patients.*

In a more general sense some colleagues within the core team did not see the FHN role as being part of an open, on-call primary care service that would necessarily have to respond to the full range of community nursing and/or medical priorities.

Colleague 1: *... the FHN has a far smaller number of cases. The other thing with the DN is that she's got an open model - she can't turn down any work. If someone gets discharged from hospital tomorrow she's got to take on the case. The distinction is that you have an open workload for the DN which is whatever work that happens to be needed for the day , and a closed workload which is controllable - I can see that it's far better - I mean I would like it if you could start the day and you knew exactly what you were going to do and nothing else - it takes all the stress out of it, no worries.*

This point is important as, unlike the other FHN practice that we studied, this FHN did not necessarily have to be generalist in the sense of concurrently addressing all the role expectations traditionally associated with the district nursing caseload. This enabled the FHN to have more autonomy to determine and act on FHN priority:

Researcher**:** *Well that's a useful explanation of priority within an FHN caseload, because I'm thinking of, when I talk to triple duty nurses for instance, they will often give you the hierarchy of work which usually goes along the lines of, midwifery or acute DN care first, going through to less acute DN work, to health promotion, to notionally community development work if that's even on the agenda, that's what I hear.*

FHN**:** *Cause health promotion and education to me is my top priority.*

Researcher**:** *Is it?*

FHN**:** *Yes, Cause what we are trying to do. We're trying for the long run, for the future. We're trying to educate these families to live with their chronic conditions and to empower them, and for them to be able to be independent, and not need so much from health service in the future. So its vitally important, and yes if they have an acute problem I would deal with that (obviously I'd have to) but if it was just a well individual that I was going to see my first priority would be the health promotion/education, lifestyle issues that they had, that I was going to see them with. That's really what we are doing ,or what I'm doing anyway.*

What this model of family health nursing implementation also did not necessarily do, within the present system, was make the FHN the first point of contact:

Colleague 1: *You see it mentions in this Scottish Executive thing about the nurse as the first point of contact for patients. I think that's daft, as I don't see how she can be - she hasn't got a role that makes her the first point.*

... So the first contact concept seems a bit hopeful to me, totally impractical in fact. If you've only got one. If you're thinking of this person as a nurse practitioner, that nurse is the first contact with patients so it makes sense to have her as a prescriber and as someone who is going to

consult, make a diagnosis and management plan. That I could see as person who is going to have first contact, but not your FHN.

By the end of the first year of practice the FHN had actually become an extended nurse prescriber, but she remained the only provider of family health nursing services and this limited her capacity to necessarily be the first point of contact for nursing and/or other primary care services.

In some ways the FHN's model of consultation at this site had more in common with the ideals of health visiting than district nursing (eg. overt prioritisation of health work). In addition to addressing the needs of individuals and families, the FHN had considered need at the general community level in her community portrait (completed during the educational course) and was using this to underpin the development of more broad based community work. By the end of the year the following activities had been developed which together comprise roughly 30% of the FHN workload:

- a fortnightly general health clinic in the main village which is open to anyone who wants to discuss a health issue or concern. This has been advertised in local media. Appointments are encouraged but people can drop-in and still be seen. Typical consultations have involved short-term input for smoking cessation; weight checks and healthy eating advice; immunisations; and mental health problems
- working as the health link person for the local community centre. This has involved a key role within a local Social Inclusion Project which has been offering teenage girls the chance to discuss contraception and other health and lifestyle issues. It has also involved joint facilitation of an exercise and music group for over 65s in the village, with health checks are incorporated into the programme
- weekly visits to the local Day Care Centre offering ad-hoc health checks and information/advice
- setting up a community reference group to enable the local community to pass on their views on local health needs. So far this has proved more difficult to establish and sustain
- consulting with others regarding setting up a Carers Group, having found that there are many young carers in the village with unmet needs
- consulting with others (eg. community OT for mental health) regarding setting up a Stress and Anxiety management group

Within the activities outlined above there are many that appear to be addressing gaps in wider health and social care provision locally. Professional stakeholders from the wider health and social care community (eg. community workers) viewed the FHN role as a very positive development indeed:

"In area my local FHN works there are many medical/social interlinked problems which don't fit neatly into any "box". She has been aware of "bigger picture" and improved care/support"

"Huge impact on my ability to address health issues in an informal setting but with professional knowledge and back up"

"Our FHN has been very supportive of our project, she is always available if we need to talk. She gives talks on health issues and does checks whenever she can"

"Highlights the appropriateness and positive impact of bringing health issues into the "community" sphere of work"

Some of these community based activities (e.g. immunisation; sex education for teenagers; assessment of the elderly) clearly overlap with the role boundaries of other core service providers within the PHCT (eg. GP; Health Visitor; Practice Nurse). Again there were concerns among some of the core team that these FHN services were being developed in isolation from overall PHCT services and that, from their perspective, further fragmentation rather than integration would ensue. Anxieties over infringement of role boundaries were a persistent feature during the first year of FHN practice at this site. Given the very broad range of activities being undertaken by the FHN, and their relatively vigorous development, this is not surprising.

Colleague 1**:** *... it (FHN) seems to be such a big job, it seems to be everything. I mean this specialist/generalist thing is anything you can think of.*

Indeed a key feature of this FHN's health work was that it could cover a very large range of subject matter and client groups. There was a particular focus on secondary and tertiary prevention work for elderly patients with chronic conditions. This is a client group that some people locally saw as "falling through gaps in the net". Some work with families with young children was undertaken but there was very little joint working with the Health Visitor.

The breadth of the health work undertaken brought with it some features of "generalism", in the sense of having to have a broad knowledge base about a large number of topics. However the FHN also emphasised the distinct, specialist nature of the role:

Researcher**:** *Thinking of future development, how would you like to see the FHN go, would you like to see it fit in alongside other existing specialist community nursing roles such as HV, DN FHN in one team like this, or do you think it could replace these roles?*

FHN: *In this situation I don' think it could replace any of these roles because of the population and the kind of area. But maybe a smaller area and where you have a set population or a very tight geographical area where influx was not going to be a huge amount, you could, have just an FHN I suppose. But I think the real strength of the FHN role lies in it being a speciality. In it being separate from DN & HV. Because I do think it's a completely different role. It complements DN & HV, because it takes it that step further.*

Four out of thirteen professional stakeholders locally (31%) did see it as providing a substantively different service by the end of the first year, while two (15%) actively took an opposite view. This contrasts markedly with all the other sites and tends to confirm the distinctiveness of this FHN role development. A key feature within this site was that the FHN was seen as providing a much more in-depth, intensive and sustained service to a small/medium caseload of families. Professional stakeholders generally felt poorly consulted in the early stages of the development, but by the end of the year seven respondents (54%) felt the development to

be well suited to the area. Eight (62%) thought it likely to lead to an improvement in local health service and none characterised it as a failure. Five respondents (39%) felt the development had involved substantial change for professionals in the way they work together.

The majority (54%) felt that the development had added to, rather than taken away from, pre-existing local services. This perception was not universally shared, however, and amongst the district nursing team there was still a feeling that they had lost 15 hours of service provision from their team (prior to undertaking the course, the FHN had been working locally as an E grade community nurse for a total of 15 hours per week). This highlights that family health nursing is being seen within the core PHCT as a different kind of service that should be supplementary to the maintenance of normal service, rather than supplanting it. Indeed district nursing activities continued very much as normal during the year. While the introduction of the FHN was not seen as a catalyst for substantive review of community nursing caseloads, a number of families were referred to the FHN. Sometimes the FHN subsequently delivered all their care, but often there was concurrent input from both services.

Looking at the net change in site staffing over the first year of implementation, there has been:

- loss of 15 hours of E grade community staff nurse
- gain of 37 hours of G grade FHN
- one F grade community staff nurse (15 hours) has been replaced by an E grade community staff nurse (15 hours)

Accordingly there has been a small increase in the nursing budget during the period that FHN practice was introduced.

By the end of the first year six of the thirteen professional stakeholders who replied (46%) felt there was definitely a need for an FHN locally. Four did not know (31%) and two felt that there wasn't (15%). The fact that most of the core PHCT had actively referred families to the FHN in sufficient quantities to form a new caseload tends to confirm the need for an additional service of some kind. There were still doubts, however, about what the format of that service should be:

"I am not sure if its about creating a further role to DN and HV or about ensuring that the FHN role is accepted as being the way DNs should work, and their role changed accordingly"

"The FHN is really a "licensing" or permission for time and space to work in the way many of our health professionals already do on their own initiative"

Colleague 1: *I think it's a bad idea to have yet another category of nurse full stop. It doesn't matter what she is doing or the quality. There is too many categories of nurses already....*

The characteristic pattern of FHN development at this site can be summarised as:

Context: "Heavy" district nursing caseload within established medium sized PHCT, but FHN not super-imposed

Process: New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals' roles. Tensions within the core PHCT

Outcome: Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. "Normal" district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding

ANNEX FIVE COMPARISON OF THE PERCEPTIONS OF THE 53 PROFESSIONAL STAKEHOLDERS WHO RESPONDED TO THE QUESTIONNAIRE PRE AND POST INTRODUCTION OF FHN

** denotes wording used when questionnaire sent post-FHN introduction. Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 53 this indicates that the remainder of the respondents did not answer that particular question.*

I think the FHN will deliver (delivers*) a **different** type of service to what is currently available		Unsure		I think the FHN will deliver (delivers*) a **similar** type of service to what is currently available	
Pre	Post	Pre	Post	Pre	Post
4 (8)	**6** (11)	**24** (45)	**22** (42)	**25** (47)	**24** (45)

I think the FHN development will **take away** (has taken away*) from existing local services		Unsure		I think the FHN development will **add to** (has added on to*) existing local services	
Pre	Post	Pre	Post	Pre	Post
3 (6)	**3** (6)	**32** (60)	**36** (68)	**18** (34)	**13** (25)

I think the FHN development will involve (has involved*) **substantial change** in the way that services are delivered to patients		Unsure		I think the FHN development will involve (has involved*) **minimal change** in the way that services are delivered to patients	
Pre	Post	Pre	Post	Pre	Post
5 (9)	**0**	**26** (49)	**24** (45)	**22** (42)	**27** (51)

I think the FHN development will involve (has involved*) **substantial change** in the way professions work together		Unsure		I think the FHN development will involve (has involved*) **minimal change** in the way professions work together	
Pre	Post	Pre	Post	Pre	Post
9 (17)	**5** (9)	**22** (42)	**21** (40)	**21** (40)	**26** (49)

I think the FHN development is **well suited** to our local context		Unsure		I think the FHN development is **not well suited** to our local context	
Pre	Post	Pre	Post	Pre	Post
16 (30)	**16** (30)	**18** (34)	**21** (40)	**18** (34)	**13** (25)

I think the FHN development will lead to an **improvement** in local health service		Unsure		I think the FHN development will lead to a **deterioration** in local health service	
Pre	Post	Pre	Post	Pre	Post
12 (23)	**14** (26)	**36** (68)	**33** (62)	**3** (6)	**1** (2)

I think the FHN development is **likely to succeed** (is succeeding*) locally		Unsure		I think the FHN development is **unlikely to succeed** (is not succeeding*) locally	
Pre	Post	Pre	Post	Pre	Post
12 (23)	**8** (15)	**26** (49)	**28** (53)	**13** (25)	**13** (25)

ANNEX SIX KEY INFORMANTS

Signifier and duration of interview	Perspective (discipline and level)	Level of Knowledge and personal stance	Quality of interview	Most important part of interview
A 40 mins	Strategic national regional and operational Urban and rural **Nursing**	High Pro FHN Suggested urban pilot	Very good information. Frameworks suggested	Section on Integrated approach and framework towards end of interview.
B 30mins	**Health Council** Local	Moderate Sees nursing as looking after sick	Good in places. Concerned about plethora of nurses and titles and specialisms	Section on non-medical model and notion of family.
C 45mins	Strategic to regional and operational **Nursing**	Moderate Pro HV Anti Dr	Good Tuned into the morale of D/Ns feeling devalued.	Section at the beginning on the strengths and use of models and records.
D 30mins	LHCC Urban **Nursing**	Moderate Aware of deprivation and poverty issues. Post code health	Good Sees need for more integration to avoid duplications	Section on education of community staff and section on the difficulties of the DN
E 25mins	Local **Nursing**	Low Lack of knowledge	Average Emphasised potential for confusion amongst public.	Section on beefing up general skills of community nurses.
F 60 mins	Strategic operational and national Rural and urban **Allied health professional**	High Good intellectual approach to the issues. Analytical problem solver Learning from other contexts	Very good Gave several leads for us to follow up. Keen on nursing development.	Section on Strengths and description of cohesive services. Section on Education and Multi-disciplinary approach and final section on FHN.
G 20 mins	Health council Local	Low Lack of knowledge acute and primary care differences	Average Enthusiastic for nurse-led services	Section on patient assessment towards end.
H 25mins	LHCC urban Medical	Moderate Concerned about national projects which siphon off good staff	Average Concerned about pace of change. Curative and treatment elements of care	Section on weaknesses re conflict and final statement about pace of change.

ANNEX 6 KEY INFORMANTS CONTINUED

Signifier and duration	Perspective	Knowledge base and personal stance	Quality of interview	Most important part of interview
I 50mins	Strategic operational and national **Nursing**	High Concerned about professional boundaries and need to free people's minds	Good Gave insight into matching workforce with population needs	Section on weaknesses and also one on up-skilling
J 35mins	LHCC Remote and urban **Allied health professions**	Moderate Optimum use of workforce a concern	Good Gave insight into notion of corporate caseload	Section on strengths and section on the FHN role as an aid to recruitment
K 30mins	LHCC Urban & rural **Nursing**	Moderate Pro HV perspective	Average Gave some insight into needs assessment and staffing levels	Section on skills of FHN at end and section on staffing levels.
L 25mins	Local rural **Nursing**	High Keen on developing existing services and thinks DN service should be given a boost.	Good Appreciates value of distance learning Strength of existing service	Section on distance learning and section on FHN
M 50 mins	LHCC Urban **Nursing**	High Concerned about short-termism in the NHS. Very pro nurse	Good Raised issue of supervision and concern about just keeping changing nursing courses	Section on education and FHN at the end and section on need to roll out short term projects which work well.
N 45mins	Strategic and operational urban Nursing	High Need to integrate education practice and research	Very good Raised awareness of care recording systems. Concerned about how FHN would add to service. Need to conduct service reviews to match workforce to patient needs	Section on reviews of service and section criticising literature available
O 25mins	Health council Local	Moderate Still coming to terms with problems faced as a carer herself.	Good Brought to awareness the patient line.	Section on holism as it brings in personal experiences and ideological beliefs.

ANNEX 6 KEY INFORMANTS CONTINUED

Signifier and duration	Perspective	Knowledge base and personal stance	Quality of interview	Most important part of the interview
P 20mins	LHCC semi rural **Nursing**	Low Pro HV Anti FHN without any real argument	Average Raised issue that FHN was set up to solve recruitment problem only	Section at the beginning of the FHN conversation.
Q 20 mins	LHCC and national primary care **Medical**	Moderate Concerned with out of hours services and reshaping services	Good Raised issue to workforce organisation	Section on practice attachment and geographic working
R 55mins	LHCC Operational educational and developmental **Nursing**	High Concerned about patient expectations	Good Provided insight into a framework for staff development	Section on demands under weaknesses and section on frameworks.
S 45mins	Strategic operational and national **Nursing**	High Concerned to match workforce skill mix to patient need Pro FHN	Very good Provided insight into use of Arbuthnott Problems of remote nursing Links with mental health nursing & gaps in education	Section On Arbuthnott and bench marking also contact economist cited. Section on FHN

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ANNEX 2

A SUPPLEMENTARY RESOURCE FOR

"EVALUATING FAMILY HEALTH NURSING THROUGH EDUCATION AND PRACTICE"

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This resource was published in March 2004 by The Robert Gordon University on CD Rom format (ISBN 1 901 085 775) in order to provide supplementary information about the research methods used during the SEHD-commissioned study "Evaluating Family Health Nursing through Education and Practice".

INTRODUCTION

This CD Rom has been prepared by CeNPRaD as a supplementary resource to be used in conjunction with the document "Evaluating Family Health Nursing through Education and Practice" (Macduff and West 2003). The contents give further details of the research methods used.

Any large scale evaluation study generates a welter of paperwork such as introductory letters, draft schedules and contract arrangements. Rather than replicate this, the CD Rom seeks to include only material that will substantively inform understandings of the research that took place. In this regard there is a particular emphasis on presenting more detail of questionnaires and interview schedules used.

The format for presenting the selected material largely mirrors that used in the main report. Thus information on specific questionnaires used in the evaluation of the FHNs' educational experiences will be found in one of the Part 2 folders of the CD Rom. An index to the major content of each folder is presented on the following pages.

For each substantive data collection method used we have adopted the following presentational format:

Textual commentary explaining reasons for adopting this particular method and the process involved in applying it
Accompanying information for the data collection context (eg. explanatory letter/s where appropriate)
The data collection tool used
Other analyses carried out (beyond those detailed in the main report)
The research team's reflections on the strengths and weaknesses of using this method

We hope this CD Rom proves a useful adjunct to the main report. It is important to stress that copyright for several of the data collection tools presented within this CD Rom remains with the original authors whom we cite. As such they should be approached if permission is being sought to use their data collection tool. Copyright relating to all other material within this CD Rom rests with ourselves, unless where otherwise indicated.

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December 2003

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PART 1 ESTABLISHING CONTEXT, ENABLING ENGAGEMENT

1.0 ESTABLISHING CONTEXT, ENABLING ENGAGEMENT

1.01 Administrative context of the evaluation

The research evaluation of the operation and impact of Family Health Nursing in specific remote and rural areas within Scotland was commissioned by The Scottish Executive Health Department following a process of competitive tendering. The evaluation was based on the following six proscribed objectives:

1 To evaluate the education programme curriculum and consider how well it fits into the Scottish context.

2 To evaluate the learning experience and preparation of FHNs and the support provided to them in placements, focusing in particular on the role of mentors and differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course.

3 To compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN.

4 To explore the operation of the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites.

5 To identify relevant stakeholders' perceptions of the FHN model.

6 To draw out implications from the study's findings for the future provision of education for FHNs and for the extension of service provision to other areas of Scotland, including urban areas.

Contractual arrangements for the conduct of the study were issued through The Scottish Executive Central Research Unit[1] which managed the contract and acted in an internal brokerage capacity during the research. The Principal Research Officer from the Health and Community Care branch of this Unit convened a small Research Advisory Group which comprised the client (Scottish Executive Nursing Primary Care Division) and ourselves as the external contractor. This group met regularly during the study and acted as a forum for exchange of information relating to the conduct and progress of the research.

Thus, while the research was necessarily dependent on the existence of the Family Health Nurse pilot project and had to adapt to its unanticipated developments, it is important to emphasise that its conduct and administration was independent from the project's National Steering Group, local Steering Groups, sites and ongoing implementation mechanisms.

[1] The Health and Community Care branch of this Unit were initially responsible for liaison with CeNPRaD. Following re-organisation within the Scottish Executive our contacts were with Scottish Executive Social Research.

1.0.2 Initial consultations and considerations

Indeed to enable initial engagement with these groups and processes, it was first necessary for the research team to embark on a round of sustained consultations in the Spring and Summer of 2001. This activity combined preliminary stakeholder consultation and reading of the overall situation with efforts to establish good inter-personal working relationships. Such activity is vital to the success of this type of study and tends to be underemphasised in nursing literature on evaluation research.

Although it was often necessary at this stage to communicate some information using paper-based methods and e-mail, we consciously maximised other methods involving personal contact. Thus we made several productive visits to each of the regions during this early stage of the research, made occasional use of videoconferencing and frequent use of the telephone.

It is also important to emphasise that the research team had previous personal knowledge of the geography of the remote and rural regions involved. Indeed between us we had previously visited at least two thirds of the site locations involved in the first year of FHN practice. While these previous visits were mostly built up over the years in a tourist capacity, nevertheless it meant that we came in to the research having had some sort of engagement with local culture and having had extensive experience of the logistics of travelling in these regions.

The latter aspect is a very important consideration that necessarily affects the design of a research study such as this. The 31 FHN sites involved in the pilot project included many that were at the outer limits of Scottish remoteness and rurality. If our base in Aberdeen is visualised as the handle of an opened lady's fan, these sites would trace the arc of the outer edge. To use a more tangential analogy, they could be visualised as the tips of the displaying peacock's feathers. Admittedly the peacock in question would have to be listing somewhat and, by extension, our base in Aberdeen would be proximal to its nether regions!

These challenges in visualisation are made in order to preface the more serious point that travelling in a relatively direct line to the outer arc was usually either time consuming or very expensive. Occasionally it was downright impossible. Moreover, travel between the sites on the outer arc was often characterised by similar difficulties. Given the confines of a finite research budget, this imposed some constraints on the overall design of the study so that site fieldwork was necessarily limited in frequency.

Nevertheless with guile, prior planning, and with the help of local knowledge and assistance, it often proved possible to combine many site visits so as to maximise contact time. This was a very explicit goal in that we always found that our understandings moved forward following site visits, even when wrestling with a range of data that could initially seem contradictory or paradoxical. In the process it also afforded more insights into the everyday problems faced by health and social care staff at each particular site, one of which was always the logistics of travel.

During the design phase of the study, and during its conduct, we reviewed literature on definitions of remoteness and rurality. This was driven to some extent by our felt need to sub-classify the sites. We also sought advice from recognised scholars in the field who informed us on a range of classification systems, each of which had limitations. In the end we found the Scottish Household Survey six-fold area definition was generally useful in that it clearly defined all the 31 FHN sites as remote and rural. Further sub-classification of these sites on the basis of remoteness and rurality alone proved to be fraught with difficulty and inconsistency. In any case we increasingly came to see this as inappropriate in that many other factors were relevant to the formation of sub-groupings in the context of our study. Thus, after much deliberation, we opted for our own pragmatic customised classification of the sites involved in the first year of practice (Table 3.5 in main report). This entailed categorising the sites primarily in terms of common

contextual features related to their geography, population density and organisation of primary care services.

What some of the above reflections on initial research design and subsequent experience illustrate is that at the start of evaluations of this nature (i.e. complex, evolving policy initiatives/practice developments) the potential researcher's knowledge (and often those of the policy initiators and practice enactors) is necessarily limited. For example, on invitation to tender, it was not clear how many sites would be taking part and where they would be.

Moreover, on invitation to tender, one of the study's six proscribed objectives referred to "differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course". However, during the initial consultation phase of the research in Spring and Summer 2001, it became increasingly apparent that a formal short course would not run. This underlines the importance of building some scope for flexibility into initial research designs.

While we were at the centre of our own research design considerations, the hub of the project for the FHNs as students was the educational centre in Inverness. Despite this city being the transport hub of the Highlands and Islands, most of the FHNs faced substantial travelling distances and times.

1.0.3 Ethical considerations and approval processes

Subsequent to the research contract being awarded in February 2001, the process of seeking ethical approval for the proposed study began. At the same time the educational programme to prepare the first cohort of FHNs also began. Naturally this meant that it was not possible for us to collect study data during this time. However, in effect, this allowed the staff and students of this new course some time to establish practices before taking part in the evaluation.

Applications were made to the three relevant Regional Research Ethics Committees. Two of the Committees approved the application without need for further clarification/amendments, while the other requested clarification on a number of points and some minor amendments. These were achieved to the Committee's satisfaction by the end of May 2001 at which time the research study formally commenced.

During the Summer of 2001, however, the research team became aware of the need to seek amendment to one particular part of the study design. Initially it was envisaged that stakeholder consultation with lay members of the general community at each site would be achieved by asking relevant professionals to identify community leaders, those active in the voluntary sector and those on local Health Councils. Thus as professional stakeholder identification progressed we also interviewed a number of interested lay people who had been suggested by local health and social care staff. While these interviews yielded valuable perspectives, both members of the research team felt that the views elicited were necessarily partial and often rather closely aligned with the views of those who had suggested them.

Accordingly we sought a method of more randomly sampling perceptions within local communities about to be served by an FHN. The resultant proposal to use the appropriate electoral roll as a basis for randomly identifying 20 members of each local community seemed a reasonable and feasible way of doing this. These local people would be mailed a brief stakeholder questionnaire (see Folder 3.1). While it was acknowledged that, in terms of representativeness, this would potentially provide proportionately greater coverage of lay opinion in FHN sites with small populations, it seemed to offer a useful snapshot of the extent to which local communities at each site had become informed through the public consultation processes that were taking place as part of the FHN project.

Approval for this amendment was sought from the Ethics Committees in August 2001. Again two of the Committees approved the application without need for further clarification/amendments, while the other requested clarification on a number of points and some amendments. Despite much consultation and work over the next six months, however, mutual understanding on the stipulated amendments could not be achieved. Consequently our application for amendment to the lay stakeholder aspect of the study was withdrawn from this Committee. This meant that in the three active FHN sites under the jurisdiction of this regional committee during 2001, stakeholder consultations were limited to the professionals involved in each site.

1.0.4 Literature review and expert consultations

Our literature searching and reviewing strategies are presented in the main report. It is important to note that literature review was ongoing throughout the evaluation research process. In this regard we found the ZETOC electronic update system useful in alerting us to new journal articles of potential interest. In some instances we approached authors in order to further explore their thinking.

Our various networking activities helped alert us to relevant new policy documents. In addition we made and took opportunities to consult with a range of recognised subject experts in order to inform our understandings during the research.

PART 2 EDUCATING FAMILY HEALTH NURSES

2.0 ACCESS AND EDUCATIONAL CURRICULA

2.0.1 Seeking the participation of the FHN students

In order to address Objective 2 it was firstly necessary to seek consent from the FHNs to participate in the research. The information letter given to the first cohort of students at the end of May 2001 is presented overleaf, followed by the consent form used. At the end of 2001 a very similar information letter was given to the four Trusts so that prospective FHN students for the 2002 cohort could have prior briefing in relation to the study.

All the students from both cohorts consented to participate in the study. Following receipt of their completed consent forms we forwarded these to Stirling University in order that they could provide us with their routinely collated data in relation to each student's personal circumstances, professional experience, academic/professional qualifications and progress on the course. This arrangement had been previously agreed between the two Universities, with due consideration of data protection and ethical issues.

Evaluation of the operation and impact of the Family Health Nurse Pilot in Scotland

Information for FHN students ***May 2001***

Following Dr West's presentation of information about the proposed evaluation, and the subsequent discussion on 30th March, we are writing to seek your participation in the evaluation. To recap, your involvement would comprise five main elements:

- giving the research team access to the information held about yourself by The University of Stirling. In particular we are interested in profiling each student's personal circumstances, professional experience, academic/professional qualifications and progress on the course. All of this information will be treated in strict confidence by the research team and will be used only in anonymised format in any publications
- completing a number of questionnaires during the evaluation, including your: self-assessment of competency (x3); experiences of placement (x1); stress and quality of working life (x3)
- assisting the research team to access the best sources of data on the nature and scope of local health needs and primary health care provision
- facilitating the research team's on-site visits (eg accompanying on limited observation of practice; assisting the research team to access health care records)
- facilitating the selection of families whose progress can be followed

As researchers we are aware of the sensitivities of working on a new project in rural communites. We re-iterate that information shared with us will be treated in strict confidence and we will report the study in such a way as to avoid identifying individual FHN students. The proposed evaluation will be thoroughly scrutinised by the Local Research Ethics Committees in Highland, Western Isles and Orkney before proceeding. You are free to withdraw from participation in the evaluation at any time without giving a reason, although we would welcome dialogue in any such eventuality.

If you have any further questions please do not hesitate to ask us for clarification.

Dr Bernice West, Director, Centre for Nurse Practice Research and Development
Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

CONSENT FORM FOR FHN STUDENTS

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

please tick box

1. I confirm that I have read and understand the information letter for the above study, and have had the opportunity to ask questions ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason ☐

3. I give permission for the research team to access information about myself held by the University of Stirling. I understand that this information will be stored and treated in strict confidence and I will not be individually identified in any report ☐

4. I agree to take part in the above study ☐

Name (in capitals) .....

Signed.....

Date.....

Address.....

2.0.2 Review of other community nursing educational curricula in Scotland

In order to address Objectives 1 and 6, it was necessary to review curricula from the five Universities in Scotland offering community-based degree programmes with specialist practice qualifications.

The letter overleaf was sent to the appropriate person/s within each of these institutions. All the institutions kindly forwarded the desired documents. This support from academic colleagues throughout Scotland was very helpful and much appreciated.

BW/FR

22nd August 2001

Name and address

Dear

Recent policy developments from the Scottish executive with regard to nursing have recognised the importance of public health and family centred nursing. As educationalists we have for many years attempted to incorporate some of these ideas into post-registration nursing programmes for health visitors and district nurses.

Earlier this year Colin Macduff and myself tendered for the evaluation of the Family Health Nurse Pilot (Scotland) and were successful. Six objectives were set by the Scottish Executive, one of which asks us to consider the educational programme for family health nursing in light of current existing educational provision across Scotland.

To meet this objective we would like to review current course documentation pertaining to the preparation of qualified nurses to work in the community or in Primary Care.

I believe that ********** University offers the following programmes:

****
****
****

If possible I would like a copy of course documentation (Definitive Course Documents; curricula: student handbooks) pertaining to each of these programmes of study.

These documents will be reviewed by myself and reported upon anonymously in the final report to the Scottish Executive.

In the course of carrying out this part of the Evaluation I plan to devise a review document and process which may be of interest to you in reviewing your own courses.
On completion of the entire evaluation I will ensure that a copy of the report is sent to you.

I plan to start this phase of the evaluation in October 2001 and would welcome copies of course documentation by the 30th September 2001. I enclose a batch of FREEPOST address labels for your convenience and look forward to receiving your course documents.

If you require any further information about this evaluation please contact me on 01224 262647 (work); e-mail b.west@rgu.ac.uk. Alternatively my colleague and co-researcher Colin Macduff can also be contacted on 01224 262647 or e-mail c.macduff@rgu.ac.uk.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD

2.1 STUDENT COMPETENCE, STRESS/SATISFACTION, QUALITY OF WORKING LIFE

2.1.1 Nursing Competencies Questionnaire (NCQ)

As external evaluators we were interested in profiling baseline competencies of the nurses who undertook this course. This would inform Objectives 1, 2 and 6 of the evaluation. Firstly it was important to ascertain whether the educational programme providers would be doing this themselves, as there was concern throughout the evaluation to avoid duplication of effort for all concerned.

As this was not being attempted by the educational programme providers, and as it seemed to potentially offer information that would be relevant to this and any subsequent family health nursing developments, we set about trying to find a suitable method. However, given the difficulties associated with clinical competence assessment in nursing (see Watson et al 2002), this was a tall order.

Essentially we were looking in a short space of time for a brief, "off-the-peg", competency measurement tool that would be relatively "light on its feet" in providing a valid external gauge that would complement rather than interfere with subsequent internal educational course mechanisms. As such the aim was to gather relevant pre (and post) course contextual information rather than to use the tool as a basis for assessing individual students during the educational experience. The latter aspect was already being addressed by the educational programme providers.

Perhaps unsurprisingly a literature search found very few measurement instruments with many of the above properties. However the Nursing Competencies Questionnaire (NCQ; Bartlett et al 1998) seemed promising in this regard. This self-report questionnaire appeared practical and had proved the most valid and reliable in a detailed comparison of methods conducted by Norman et al (2000) with Scottish pre-registration nursing students. Moreover it had been used with post-registration nurses (Bartlett et al 2000), albeit with recently qualified ones. The questionnaire covers the constructs or domains of: leadership; professional development; assessment; planning; implementation; cognitive ability; social participation; and ego-strength. As such it also seemed broadly comparable to the five core family health nursing competencies indicated in the WHO Europe curriculum and the four specialist domains of practice advocated by the former UKCC.

Thus it was decided to try this approach with these very experienced community nurses. Permission to use the questionnaire was obtained from one of the authors. Early in the course[2] students from both cohorts were asked to complete the questionnaire (see following pages) by considering their perceived levels of competency across eight domains immediately prior to coming on the course. Six months after completing the course, Cohort 1 nurses were sent the questionnaire again.

[2] It was not possible to do this with the first cohort until the end of May 2001 when ethical approval had been obtained for the study.

FHN EVALUATION COMPETENCIES QUESTIONNAIRE TIME 1

This questionnaire presents you with a list of ideal attributes and skills, and asks you to rate how often you carry each of these out. The list is comprehensive and it is not expected that you will achieve the maximum level on all items. As such, it is important that you rate yourself as honestly as possible in each case. The information that you give will be used only for the evaluation study. It is not part of your assessment on the FHN course.

In answering the questionnaire we would like you to rate yourself in relation to your clinical practice during the four months prior to coming on the FHN course (ie. October 2001 - January 2002). Try to think of your typical working practices during that time.

In this way, answering:

ALWAYS indicates that you always achieved the level of competence during that period, with almost no exceptions (tick box under column 4)

USUALLY indicates that you usually achieved the level of competence during that period (tick box under column 3)

OCCASIONALLY indicates that you occasionally achieved the level of competence during that period (tick box under column 2)

NEVER indicates that you never achieved the level of competence during that period, with almost no exceptions (tick box under column 1)

Please tick an appropriate box for each item listed. Thank you.

****

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
1 give praise and recognition to colleagues for achievement	☐	☐	☐	☐
2 delegate duties to colleagues appropriately after assessing skill levels	☐	☐	☐	☐
3 guide and supervise less experienced colleagues in the provision of care to assigned clients	☐	☐	☐	☐
4 provide feedback to colleagues concerning appropriate or inappropriate clinical interventions	☐	☐	☐	☐
5 initiate changes to the organisation of care delivery when necessary	☐	☐	☐	☐
6 demonstrate responsiveness to colleagues by listening, providing support, or referring to appropriate source of help if indicated	☐	☐	☐	☐
7 resolve conflict between colleagues when appropriate	☐	☐	☐	☐

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
8 encourage educational and professional development of colleagues	☐	☐	☐	☐
9 initiate changes in clinical practice	☐	☐	☐	☐
10 contribute to an atmosphere of mutual trust, acceptance and respect amongst colleagues	☐	☐	☐	☐
11 manage unexpected changes in work situations	☐	☐	☐	☐
12 maintain accountability for own actions and those delegated to others	☐	☐	☐	☐
13 participate actively in clinical meetings, committees and working groups	☐	☐	☐	☐
14 participate in a professional organisation	☐	☐	☐	☐
15 accept and use constructive criticism	☐	☐	☐	☐
16 accept responsibility for own actions	☐	☐	☐	☐
17 demonstrate self confidence	☐	☐	☐	☐
18 adapt clinical practice in line with current trends	☐	☐	☐	☐
19 assume new responsibilities appropriate to capabilities	☐	☐	☐	☐
20 demonstrate a sense of independence and autonomy in work	☐	☐	☐	☐
21 express opinions on clinical issues	☐	☐	☐	☐
22 collect accurate client health data from available sources	☐	☐	☐	☐
23 conduct accurate clinical assessment	☐	☐	☐	☐
24 perform accurate and comprehensive psychosocial assessment skills	☐	☐	☐	☐

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
25 demonstrate knowledge about the condition of clients assigned to you	☐	☐	☐	☐
26 anticipate teaching needs of clients	☐	☐	☐	☐
27 consider psychosocial aspects of any illness or disability when planning care	☐	☐	☐	☐
28 make accurate clinical judgement based on assessment data	☐	☐	☐	☐
29 revise care as necessary, based on accurate evaluation of client's condition and response to care	☐	☐	☐	☐
30 arrange therapeutic activities appropriate to interest and needs of various clients	☐	☐	☐	☐
31 address the clients preference when planning care	☐	☐	☐	☐
32 establish clinical priorities in relation to total patient needs	☐	☐	☐	☐
33 identify and use community resources in the delivery of care	☐	☐	☐	☐
34 identify and use resources within the hospital in the delivery of care where appropriate	☐	☐	☐	☐
35 adopt individualised approach in planning client care	☐	☐	☐	☐
36 seek advice from health care personnel within the organisational structure to manage client care when appropriate	☐	☐	☐	☐
37 practice safely at all times	☐	☐	☐	☐
38 carry out clinical activities consistent with local policies and procedures	☐	☐	☐	☐
39 use clinical procedures as an opportunity for interactions with clients	☐	☐	☐	☐
40 demonstrate a working knowledge of equipment	☐	☐	☐	☐
41 perform manual skills with dexterity	☐	☐	☐	☐

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
42 function competently in emergency situations	☐	☐	☐	☐
43 use time and resources effectively and efficiently	☐	☐	☐	☐
44 encourage family to participate in the care of clients	☐	☐	☐	☐
45 strive for optimum standards of clinical care	☐	☐	☐	☐
46 give emotional support to clients in need	☐	☐	☐	☐
47 give emotional support to family of clients in need	☐	☐	☐	☐
48 plan and implement health teaching for clients when necessary	☐	☐	☐	☐
49 plan and implement health teaching for families when necessary	☐	☐	☐	☐
50 use appropriate teaching methods and materials for different audiences	☐	☐	☐	☐
51 respond to family or client requests, explaining if wishes can not be achieved	☐	☐	☐	☐
52 communicate concise and appropriate client information as necessary to members of the health care team	☐	☐	☐	☐
53 document clients care and progress acccurately	☐	☐	☐	☐
54 encourage client to take responsibility for his/her care according to capabilities	☐	☐	☐	☐
55 take an advocacy role for the client	☐	☐	☐	☐
56 uphold ethical principles in clinical practice	☐	☐	☐	☐
57 recognise legal responsibilities in clinical practices	☐	☐	☐	☐
58 identify rational for making clinical decision	☐	☐	☐	☐

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
59 provide rational for thoughts and behaviour when questioned	☐	☐	☐	☐
60 apply resources in a creative manner to solve clinical problems	☐	☐	☐	☐
61 utilise a problem solving process in planning care	☐	☐	☐	☐
62 identify and reflect upon own behaviour, feelings or beliefs	☐	☐	☐	☐
63 apply findings from research to clinical practice as appropriate	☐	☐	☐	☐
64 seek information to help resolve a clinical or health care issue	☐	☐	☐	☐
65 show insight into situations involving human relationships	☐	☐	☐	☐
66 discuss options expressed in the press or general media	☐	☐	☐	☐
67 engage in debate about a social or political issue	☐	☐	☐	☐
68 respond to social or health related policy issues through various channels	☐	☐	☐	☐
69 attempt to influence the stand of a professional organisation on a professional issue	☐	☐	☐	☐
70 display knowledge about current political and social issues	☐	☐	☐	☐
71 consult researchers appropriately to assist the investigation of clinical problems	☐	☐	☐	☐
72 initiate research studies and surveys on health related topics	☐	☐	☐	☐
73 perform responsibilities competently despite strong emotional reaction to a situation	☐	☐	☐	☐
74 act assertively to defend a point of view	☐	☐	☐	☐

4 ALWAYS **3** USUALLY **2** OCCASIONALLY **1** NEVER	**4**	**3**	**2**	**1**
75 fulfil responsibility at the risk of disapproval of manager, client or peer	☐	☐	☐	☐
76 admit a weakness, mistake or lack of knowledge while recognising the importance of remedying it	☐	☐	☐	☐
77 recognise own limitations and seek help from appropriate sources when needed	☐	☐	☐	☐
78 take initiative at work when there is no external pressure to do so	☐	☐	☐	☐

Detailed analyses of the responses to this questionnaire are presented within the main report where the need for cautious inference in relation to before-and-after competence comparisons is also highlighted.

Norman et al (2000) suggest that the NCQ may comprise coverage of six domains/constructs (intervention; assessment; leadership; awareness; teaching; research/staff development) rather than the eight suggested by Bartlett et al (2000). After consultation with the former authors[3] we also took the opportunity to analyse our data in terms of the six domains suggested. This analysis confirmed no statistically significant differences between the pre and post-course mean domain scores.

When the mean pre-course scores of Cohort 1 and Cohort 2 students were compared in this way, the latter group scored significantly lower in terms of leadership only ($p=0.003$). Our previous comparison using Bartlett et al's eight domains had also found significant differences in professional development and assessment (see main report).

It is probably prudent not to read too much into our findings based on these factor analyses as both Bartlett et al and Norman et al's published "solutions" were essentially exploratory. Given our relatively small sample of nurses, it was deemed inappropriate to attempt our own factor analysis (Watson 1998 cites Kline as recommending a required variable to subject ratio of between 1:5 and 1:10 to make factor analysis valid).

Moreover we would also counsel caution in regard to interpretation of our comparisons of mean scores, even in terms of baseline scores. The typically high mean scores across most domains tended at times to mask relatively large variations between the minimum and maximum scores of individual students (i.e. ranges and standard deviations were often large). Thus while one Cohort 2 student scored 12 out of a possible 24 points in relation to self-reported ego-strength (50%) another scored 23 points (96%). Normative statistics such as measures of central tendency tend to iron out such variations, but as evaluators working with a relatively small number of students such variations were noticeable and often noteworthy (e.g. our perceptions of the ego strength of known individuals at times were at odds with their own self-perceptions as reported via the questionnaire).

This highlights one of the limitations of our application in that the main data comprised only the student's self-reported competency. Due to the constraints of the evaluation timescale it was not possible to identify colleagues who could have reported their perceptions of the students' competency from a pre and/or post course perspective. Moreover such an undertaking would require considerable attention to matters of consistency and ethical understandings, especially in remote and rural community nursing where the chance to observe colleagues' actual work may be limited. In this regard it could be easier when there is a defined, agreed supervisor-supervisee relationship such as during an educational course. Bartlett et al (2000) used this approach, asking the mentors/supervisors of graduates and diplomates to complete the NCQ. From the presentation of their results it is not entirely clear whether there were statistically significant differences between the perceptions of these nurses and their own mentors/supervisors. However it can be seen that the mentors/supervisors mean ratings were lower than the nurses in 81% of cases (i.e. they typically assessed the individual nurse's competence as being at a lower level than the nurses' self-reports).

The NCQ itself also has its limitations as a questionnaire. Some of these were apparent on initial scrutiny and were highlighted during its first administration in a classroom setting (e.g. Statement 75 actually contains three elements that are by no means resolvable through one answer). A small number of other similar anomalies were also apparent. Interestingly Watson et al (2002) have

[3] We are grateful to these authors for sharing details of the six factor solution they obtained by using Principal Components Analysis.

recently proposed a revised short NCQ comprising 18 of the statements from the original NCQ. However several of the more problematic statements from the original questionnaire are retained, notably "*I use time and resources effectively and efficiently"*. The latter statement is something of a tour-de-force in that it combines two aspects and a further two criteria in the space of eight words! When the multiple possibilities this raises are then considered in the light of the four different possibilities for responding, there is obvious scope for conceptual confusion and related doubt about the validity of what is being gauged.

As we indicated in the main report, our consistent findings of high mean scores across domains raised the possibility of the questionnaire showing a ceiling effect when used with very experienced staff. To our knowledge this was the first application of the NCQ with such an experienced group of nurses and, while our reflections have a number of caveats, we feel it yielded interesting data and experience. Many of the difficulties encountered are merely symptomatic of more general problems in the whole field of competency assessment that go beyond the profession of nursing. We hope to publish further reflections on this topic based on these experiences.

2.1.2 Stress and job satisfaction

In order to address Objective 2 we were interested in gaining insights into perceived stress and job satisfaction for this group of community nurses before they undertook the course, during the course and afterwards. Again it was important to ascertain whether the educational programme providers would be doing this themselves. Although a number of feedback mechanisms were built into the course, it turned out that the educational programme providers had no plans to formally assess the above aspects.

In considering the selection of a suitable method, an extensive range of literature was reviewed. Many tools exist to measure stress and job satisfaction but, on closer scrutiny, it was possible to eliminate several for being too general in nature (e.g. the General Health Questionnaire in its different formats; see Goldberg et al 1997) or too institution-orientated (e.g. the Nurse Stress Index which asks about "my department"; see Cooper and Mitchell 1990). A number of reports on community-orientated questionnaires were therefore reviewed including Fletcher et al (1991), Parry-Jones et al (1998), Snelgrove (1998) and Rout (2000). The latter two questionnaires seemed most promising in terms of content that would pertain to remote and rural contexts. It proved possible to contact Sherrill Snelgrove who kindly shared the full questionnaire with us and agreed that we could use it. On scrutiny the full questionnaire appeared very well matched to the context of our study. Although the questionnaire appeared to have been subject to limited psychometric testing based on its application to one mixed group of community nursing staff, it seemed sufficiently promising to merit using on this study.

The questionnaire was administered at different time points (see Table 2.13; main report) during the study in order to gain insight longitudinally. The version displayed on the following pages was amended very slightly for administrations where the students were being asked to answer in relation to the last 4 months as a student on the course (i.e. Time 2). The amendments consisted of adding two statements to the table in Section C. These read "Your fellow students" and "Overall quality of campus supervision". The existing statement "Overall quality of supervision" was also modified to read "Overall quality of placement supervision". In this way distinction between campus and placement aspects of job satisfaction was sought.

The latter amendments were agreed with students when they completed it between classes on campus. On later occasions the questionnaire was administered postally.

OCCUPATIONAL STRESS INDICATOR FOR COMMUNITY NURSES

Section A: Sources of stress

The statements below are concerned with **the pressures arising in your work life during the 4 months prior to coming on the FHN course (ie. between October 2001 and January 2002)**

Pressure *is defined as a problem, something you find difficulty coping with, about which you've been feeling worried or anxious*

Thinking back about your normal working life then, please indicate the degree to which each statement was a source of pressure to you. There are no right or wrong answers, but you are asked to tick an appropriate box for each statement.

	Amount of pressure this caused me in 4 months pre course				
	none	slight	moderate	considerable	extreme
Lack of time on a visit					
Work overload					
Organisation of caseload					
Getting cover					
Unpredictable occurences					
Tedious routine work					
Inadequate office facilities					
Work underload					
Referring problems to other agencies					
Responsibilities for students					
Vicious dogs					
Driving/other drivers /car parking					
Breaking down in isolated spots					
Conflict with home/work problems					
Winding down					
Taking paperwork home					
Lack of emotional support at home					
Worry about childcare					
Superiors non appreciative of home pressures					
Lack of contact with supervisors					
Future of job					
Relationships with other professionals					
Record keeping					

	Amount of pressure this caused me in 4 months pre course				
	none	slight	moderate	considerable	extreme
Attending meetings					
Not liking a colleague					
Lack of involvement in decision making					
Not being notified of changes before they occur					
Uncertainty about role					
Lack of knowledge of role by other professionals					
Emotional involvement with clients					
Dealing with death and dying					
Clients with on-going social problems					
Fear of physical attack					
Coping with sexual harassment					
Unreasonable demands from clients					
Unreasonable demands from relatives					
Poor social conditions of clients					
Emotional problems of clients					
Difficult cases: child cases					
Difficult cases: elderly focus					
Chronic cases					
Failed visits					
Worry over decision making					
Feelings of isolation over decision making					
Lack of resources for clients (physical aids, physical, social and emotional help)					
Quantifying work					

Section B: Feelings of stress

In the 4 months prior to coming on the course, did you have prolonged periods of the following?

	not at all	slightly	moderately	most of the time	all of the time
Physical exhaustion					
Isolation					
Boredom					
Emotional exhaustion					

Section C: Job satisfaction

This section asks how satisfied/dissatisfied you felt with a number of aspects of your work life during the 4 months prior to coming on the course.

	very satisfied	**satisfied**	**undecided**	**dissatisfied**	**very dissatisfied**
Freedom to choose own method of work					
Your fellow workers					
Opportunity to use your abilities					
Rate of pay					
Career development opportunities					
In-services training received					
Hours of work					
Adequate training for job					
Support and guidance from superiors					
Overall quality of supervision					

Section D: Satisfaction with role before starting course

	very satisfied	satisfied	undecided	dissatisfied	very dissatisfied
To what extent were you satisfied with your work role during the 4 months prior to starting the course					

Section E: Social support

Thinking of your normal work life prior to coming on the course, if you had a work centred problem which of the following people would you talk to about it? (please circle as many as appropriate)

MOTHER FATHER SON DAUGHTER

PARTNER/SPOUSE FRIEND WORK COLLEAGUE

SUPERVISOR MANAGER OTHER

Section F: Any other comments

Finally if there are any other comments that you would like to make about pre course work stress/satisfaction, please do so below:

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete the questionnaire

Our analyses of responses to this questionnaire started from basic review of frequencies and other descriptive statistics in order to identify the items that seemed to be most involved in determining stress and job satisfaction. We also calculated total scores for: sources of stress; feelings of stress and job satisfaction. Again the range of scores across individual students within each cohort was typically large, and this was found each time the questionnaires were administered. This indicates that amongst respondents there was often wide variation in perceived levels of stress and job satisfaction. This pertained during the course as well as prior to coming on the course.

The total scores derived were then used in order to compare scores within each cohort at different time points (see Table 2.13; main report) using the Wilcoxon test and between the two cohorts at the same relative time points using the Mann Whitney test. These are the comparisons reported in Section 2.5.2 of the main study.

Snelgrove (1998) reported a factor analysis that identified four dimensions linked to the largest areas of variance in the stress items. These were:

a) emotional pressures/difficult cases

b) unpredictable events at work

c) change and instability at work

d) work content

We had hoped to analyse our data in terms of these four dimensions but the original mapping of items to dimensions was not available to us. Again it was deemed inappropriate to attempt our own factor analysis in view of our relatively small sample of nurses.

Nevertheless the questionnaire was seen by the FHN students as being very relevant to their experiences and relatively quick and easy to answer. The quality of responses was generally good and overall the questionnaire yielded useful information on all occasions. It also included a number of items that were very comparable in content to items within the questionnaire that we devised for students' summative evaluations of their learning experiences (i.e. that completed at the end of the course). This enabled cross checking of individual's answers in order to study whether experiences were consistent across a number of time points. In this respect findings were generally very confirmatory.

2.1.3 Quality of Working Life (QOWL)

In addition to measuring stress and job satisfaction, we devised a further instrument to gauge the related, but broader, concept of quality of working life. While the questionnaire on stress and job satisfaction was based on the *standard needs* principles that characterise the majority of questionnaires (i.e. items of equal weighting are presented to the potential respondent on the basis that they have been found through previous research/review to embody the characteristic elements of the concept being investigated, such as quality of life; see Browne et al 1997) the new questionnaire was devised as a purely respondent generated tool (see Macduff 2000).

The respondent generated approach does not assume such consensus over item selection and weighting. Rather it attempts to give the respondents the scope to choose items that they see as constituting the concept in question, and the means by which to indicate the current relative importance of these items.

Our decision to complement our study of stress and job satisfaction with an exploration of quality of working life, stemmed from a perception that there may be some very particular and individual factors that impinge on the life and work of nurses in distinctive remote and rural communities. This emerges to some extent in the literature on remote and rural health care (e.g. see Farmer et al 2003), but we also felt this to be the case from our previous nursing and research work.

Thus we reasoned that a respondent generated approach would give participants the scope to raise their own issues. Review of existing respondent generated tools found several that addressed the broader concept of quality of life, but none that focused on the particular concept of quality of working life. Consequently we designed a new tool for exploratory use in this study. The design was substantially informed by the pioneering work of Ruta et al (1994) who developed the Patient Generated Index (PGI) and O'Boyle et al (1992) who developed the SEIQoL questionnaire. It was also informed by personal experience of using the PGI (Macduff and Russell 1998) and by review of Annells et al (1999)'s experiences of adapting the PGI for use by Australian district nurses with their patients.

The resultant tool is presented as a separate document within this folder of the CD Rom as it proved technically difficult to incorporate it within the main body of this word document. As will be seen the three parts of the questionnaire provide respondents with the opportunity to:

- identify areas of their current working life that they perceive as most important
- rate how good or bad they are at present
- indicate the relative importance of the areas chosen

The questionnaire was explained and given to the first cohort of FHN students in person in June 2001. They were asked to complete it in their own time based on their current perceptions of quality of working life as a student (rather than attempting to complete it retrospectively based on their perceptions of their working life prior to starting the course). All questionnaires were returned by July 2001 (see Table 2.2 in the main report). A similar procedure was followed for the Cohort 2 students at a similar point during their course. Finally the questionnaire was sent to Cohort 1 students approximately six months into their experience of working as a qualified FHN.

We found that the questionnaire was generally well completed in that the respondents clearly understood what was being asked of them. This is important as some respondent generated tools have had problems in this regard (see Macduff and Russell 1998). The one exception to this was the student who replicated the aspects given in the explanatory example at the foot of the questionnaire. Whether this was through misunderstanding or mischievousness was not clear, but we suspect the latter given that the ratings and weightings differed from the explanatory example. In view of the potentially sensitive nature of one of the replicated aspects we refrained from follow-up enquiry!

The questionnaire proved useful in eliciting issues about balancing their experience of being a full time student (e.g. study skills; isolation while on placement; travel to campus) with their own role as a family member (e.g. childcare; finance). This group of typically very experienced female community nurses were very often mothers and, by a long way, the major earner within their own families. The latter factor may be more prevalent amongst nurses within remote and rural communities than amongst their peers within large cities. These findings raise some questions about how feasible and/or desirable it is to attempt to separate quality of working life from more general quality of life issues.

Such a separation was rather more evident in the responses from the qualified FHNs from Cohort 1 in July 2002. These were characterised by a mixture of positive experiences when actually working with families, and difficulties related to the introduction of their new role (e.g. organisation of caseload; colleagues' limited understanding of role; time pressures). These findings tended to confirm findings from the Stress and Job Satisfaction questionnaire completed at the same time.

In designing the questionnaire for the purpose of this study, our focus was primarily on the information that might be elicited through its three stages. It was, however, also possible to derive an overall score for perceived quality of working life on a scale of 0-10 (0 being the worst possible; 10 being the best possible). This was done for the purposes of some further, exploratory analysis.

For Cohort 1 at time 1 (i.e. while they were students) the average QOWL score was 4.27 (range 4.8). For Cohort 1 at time 2 (i.e. while working as FHNs) the average QOWL score was very slightly higher at 4.78 (range 6). Thus again we see relatively wide variation amongst the perceptions of individual members of each cohort. When total QOWL scores at time 1 and time 2 were compared using the Wilcoxon test no statistically significant difference was apparent[4].

The latter comparison was essentially exploratory. As Macduff (2000) notes, respondent generated questionnaires tend to highlight some essential difficulties involved in comparing scores over time. In this case we were comparing QOWL where the respondent was occupied in two essentially different roles (i.e. that of student and qualified FHN). Thus one might expect some difference in perceptions of what is important in constituting quality of working life. Our questionnaire made this manifest in that respondents typically chose a number of different aspects to rate and weight at Time 2. By contrast a questionnaire based on the *standard needs* approach would present the respondent with the same pre-determined aspects as it did before, in the assumption that these would still have equal currency and weighting.

[4] In writing this our attention is drawn to an error in the main report (Page 35; last sentence of paragraph 5). This sentence implies that our statistical findings from analysis of the QOWL questionnaires confirm the finding from analysis of the job satisfaction questionnaires that Cohort 1 were significantly less dissatisfied with their jobs after the course than they were prior to undertaking the course. In fact our statistical findings from analysis of the QOWL questionnaires were comparing **student experience** with later work experience. We apologise for this error.

These reflections pertain to the notion of *intra-subject construct dynamism* (Allison et al 1997) referred to in the main report. In turn they highlight some of the assumptions we have made in interpreting findings from some of our more conventional questionnaires that were administered over a number of points in time. In mitigation we would merely say that we are definitely not alone in working on the basis of such assumptions! In fact it remains relatively unusual in published studies to explicitly recognise that some fundamental assumptions of this nature are being made (e.g. that sequential respondents are using consistent construct criteria as the basis of their replies).

Finally our exploratory analyses with this questionnaire compared the two cohorts' perceived quality of working life as students on the course (i.e. comparison of the total scores of both cohorts at T1 using the Mann Whitney test). No significant statistical difference was evident, although for Cohort 2 at time 1 the mean QOWL score was slightly higher 4.76 (range 6.4). Again the large range of scores demonstrates the variation in perceived experience amongst members of the cohort.

Overall the new quality of working life questionnaire proved a useful adjunct to the more conventional questionnaires. As such there seems scope for its further development and application.

2.2 EXPERIENCES OF STUDENTS AND SUPERVISORS

2.2.1 The summative questionnaires for students and supervisors

In order primarily to address Objective 2, we reasoned that it would be useful to study students' campus-based learning experiences and clinical placement experiences as perceived summatively at the end of the course. Such information would complement data that we were collecting during the course and data that the educational providers were collecting and making available to us. Firstly we ascertained the nature and extent of the latter "in-house" processes. In addition to asking regularly for students' reflections on the course, the educational providers also collated student evaluations of each module and administered a brief end-of-course questionnaire. Accordingly our starting point was to minimise duplication with the latter, although a small amount proved inevitable.

We reviewed relevant literature in order to find out whether a suitable "off the peg" questionnaire might be available for this summative application. The broad concept of clinical supervision was firstly explored, including the work of Butterworth et al (1997) and Winstanley (2000). However we were more concerned with supervision in the context of the supervisor/mentor-student relationship. Within Scotland, the National Board for Nursing, Midwifery and Health Visiting (NBS; now NHS Education Scotland) has commissioned a number of research projects that have explored aspects of this topic in recent years. The work of Cameron-Jones et al (2000) in the field of pre-registration nursing was informative in this regard. Moreover Watson and Harris (1999) looked at supporting students in practice placements within Scotland, and included post registration students on specialist community practitioner courses within their study sample.

Neither of the questionnaires used in these studies appeared to offer a ready-made tool that would be ideally suited to the particular context of our study. However their approach of matching student and supervisor/mentor responses, and their coverage of content areas, informed the development of the questionnaire that we subsequently designed for the FHN study. Thus we acknowledge the usefulness of this previous scholarship.

The resultant questionnaire for students is presented on the following pages. As can be seen the first part seeks to gather mostly written data summarising campus based learning experiences. The second, more extensive part of the questionnaire makes more use of 5-point response scales to gauge experiences of clinical placement. This approach was also then used in a similarly designed, matched questionnaire for the supervisors of these students. The supervisor questionnaire is presented on the pages directly after the student one in order to facilitate comparison.

The questionnaire was firstly distributed to selected colleagues within our School of Nursing for review and revision. The revised questionnaire was then sent to four nurses who had recently completed a Community Specialist Practitioner nursing course at the Robert Gordon University. The explanatory letter asked them to complete the questionnaire and provide feedback on its clarity, length, topic coverage and any other comments. Two completed questionnaires and feedback forms were subsequently returned. Following this a small number of minor revisions were made. Due to time constraints it was not possible to pilot test the questionnaire designed for supervisors.

The final questionnaire was explained to the FHN students during the final week of their course when they were on campus. They then completed the questionnaire in their own time so as to facilitate reflection. The same process was followed with those supervisors who attended campus during this final week. The questionnaire was mailed, with an explanatory letter, to those supervisors who had been unable to attend.

QUESTIONNAIRE FOR FHN STUDENTS

ON

CAMPUS BASED LEARNING EXPERIENCES

AND

EXPERIENCES OF CLINICAL PLACEMENTS

This questionnaire asks you to reflect on your learning experiences during the past year. In the first section, you are asked about your learning experiences when you have been based on campus in Inverness. In the second, longer section, you are asked about your learning experiences when you have been on clinical placements. Please take some time to reflect on the questions before completion. We would be grateful if you could return the questionnaire in the FREEPOST envelope by *7th January 2002*.

Thank you

Colin and Bernice

Code number:

Date:

PART 1: YOUR CAMPUS BASED LEARNING EXPERIENCES

1) Looking back over your learning experiences at Inverness campus this year, please write down the three aspects of the course that you found **most valuable**

(i)_____

(ii)_____

(iii)_____

2) Looking back over your learning experiences at Inverness campus this year, please write down the three aspects of the course that you found **least valuable**

(i)_____

(ii)_____

(iii)_____

3) Were there any **topics that were not covered at all** in the FHN course that you feel **should have been covered**?

Yes ☐ **No** ☐

If you answered "yes", please name the topics and say why they should have been covered

_____

_____

_____

4) Were there any **topics that were covered** in the FHN course but **were not covered well**?

Yes ☐ **No** ☐

If you answered "yes", please name the topics and indicate how the coverage was poor

_____

_____

_____

5) If you have any other comments about your campus based learning, please write them below

_____

_____

_____

_____

PART 2: YOUR EXPERIENCES OF CLINICAL PLACEMENTS

1) Looking back over your experiences of placement supervision on the FHN course, please give an overall rating to each of the following aspects (please tick appropriate box). Any explanatory comments would also be appreciated

	excellent	good	fair	poor	very poor
The process of matching you with an appropriate supervisor					
Comments					
Your supervisor's understanding of your pre-course level of knowledge & skills					
Comments					
Your supervisor's understanding of the FHN course and its learning outcomes					
Comments					
Your supervisor's understanding of the FHN course assessment process					
Comments					
Your supervisor's understanding of the FHN course documentation					
Comments					
The match between your supervisor's knowledge & skills and the knowledge & skills appropriate for the FHN course					
Comments					
The attitude of your supervisor towards sharing appropriate knowledge & skills with you					
Comments					
The level of rapport that you and your supervisor developed during the course					
Comments					
The overall attitude of your supervisor towards the FHN course					
Comments					
The overall level of support that you received from your supervisor during placement					
Comments					
The overall level of support that you received from University lecturers/teaching fellows during placement					
Comments					
Understanding of your placement circumstances shown by University lecturers/teaching fellows					
Comments					

2) **Thinking of contact between yourself and your placement supervisor** BY REMOTE MEANS **such as** TELEPHONE OR E MAIL**, please indicate the typical frequency with which the following kinds of dialogue occurred**

	at least once a week	at least once a month	at least once every 3 months	at least once during the course	never
General catching up on progress					
Comments					
Discussion of your clinical casework (eg. work with specific families)					
Comments					
Reflective discussion relating theory to practice					
Comments					
Discussion of specific skills relevant to your FHN role					
Comments					
Identification and review of specific goals to be achieved in your work with families					
Comments					
Discussion of interpersonal issues related to your placement (eg. teamwork)					
Comments					
Discussion of personal issues related to your placement (eg. home/work conflict)					
Comments					

3) **Thinking of contact between yourself and your placement supervisor** IN PERSON, **please indicate the typical frequency with which the following kinds of interaction occurred**

	at least once a week	at least once a month	at least once every 3 months	at least once during the course	never
General catching up on progress					
Comments					
Discussion of your clinical casework (eg. work with specific families)					
Comments					
Reflective discussion relating theory to practice					
Comments					
Your supervisor being present when you were working with families					
Comments					
Your supervisor teaching specific skills relevant to your FHN role					
Comments					
Identification and review of specific goals to be achieved in your work with families					
Comments					
Discussion of interpersonal issues related to your placement (eg. teamwork)					
Comments					
Discussion of personal issues related to your placement (eg. confidence)					
Comments					

4) Other than your placement supervisor, was there anyone else who supervised your practice or taught you skills?

Yes ☐ **No** ☐

If you answered "yes", please indicate the job title(s) of this person/these people and briefly indicate how they helped you

_____

_____

5) **How many families have you worked with so far during your placements as an FHN student?**

_____**families**

6) **Please write down the three most valuable skills that you have developed during your placement work with families**

(i)_____

(ii)_____

(iii)_____

7) **Please give a brief description of any ways in which you feel these families have** benefited **from your input so far**

_____

_____

_____

_____

7) **Please give a brief description of any ways in which you feel your input has been** problematic **for these families**

_____

_____

_____

_____

8) What difference do you feel that placement supervision has made to the quality of your work with these families?

a great deal	**quite alot**	**very little**	**none**
☐	☐	☐	☐

*Comments*_____

_____

9) Please write down any three aspects of placement supervision for FHNs that you think could be improved

(i)_____

(ii)_____

(iii)_____

10) Finally, if you have any other comments about your placement supervision experiences, please write them below

_____

_____

_____

_____

QUESTIONNAIRE
FOR PLACEMENT SUPERVISORS
OF STUDENTS
ON THE
FAMILY HEALTH NURSE
COURSE

This questionnaire asks you to reflect on your experiences of acting as a supervisor on the Family Health Nurse course during the past year. Your feedback will inform the evaluation of the pilot project. Please take some time to reflect on the questions before completion. We would be grateful if you could return the questionnaire in the FREEPOST envelope by *30th January 2002*.

Thank you

ColinMacduff and Dr Bernice West

Code number:

1) Looking back over your experiences of supervising placements on the FHN course, please give an overall rating to each of the following aspects (please tick appropriate box). Any explanatory comments would also be appreciated

	excellent	good	fair	poor	very poor
The process of matching you with an FHN student					
Comments					
The process of preparing you to undertake supervision on this course					
Comments					
Your understanding of the student's pre-course level of knowledge & skills					
Comments					
The attitude of the student towards receiving supervision from you					
Comments					
The level of rapport that you and the student developed during the course					
Comments					
The overall level of support that you gave to the student during placement					
Comments					
The overall level of support that you received from University staff during your supervision of placements					
Comments					
Understanding of your placement circumstances shown by University staff					
Comments					
Your present understanding of the FHN course and its learning outcomes					
Comments					
Your present understanding of the FHN course assessment process					
Comments					
Your present understanding of the FHN course documentation					
Comments					
The match between your knowledge and skills and the knowledge and skills appropriate for the FHN course					
Comments					

2) **Thinking of contact between yourself and the student** BY REMOTE MEANS **such as** TELEPHONE OR E MAIL**, please indicate the typical frequency with which the following kinds of dialogue occured**

	at least once a week	at least once a month	at least once every 3 months	at least once during the course	never
General catching up on progress					
Comments					
Discussion of clinical casework (eg. work with specific families)					
Comments					
Reflective discussion relating theory to practice					
Comments					
Discussion of specific skills relevant to the FHN role					
Comments					
Identification and review of specific goals to be achieved in the student's work with families					
Comments					
Discussion of interpersonal issues related to the student's placement (eg. teamwork)					
Comments					
Discussion of personal issues related to the student's placement (eg. home/work conflict)					
Comments					

3) **Thinking of contact between yourself and the student** IN PERSON, **please indicate the typical frequency with which the following kinds of interaction occured**

	at least once a week	at least once a month	at least once every 3 months	at least once during the course	never
General catching up on progress					
Comments					
Discussion of clinical casework (eg. work with specific families)					
Comments					
Reflective discussion relating theory to practice					
Comments					
Being present in person when the student was working with families					
Comments					
Teaching the student specific skills relevant to the FHN role					
Comments					
Identification and review of specific goals to be achieved in the student's work with families					
Comments					
Discussion of interpersonal issues related to the student's placement (eg. teamwork)					
Comments					
Discussion of personal issues related to the student's placement (eg. confidence)					
Comments					

4) Thinking of a normal week, how much time on average did you spend on supervision of the FHN student?

_____hours

5) During the time that you supervised the FHN student, were you involved in supervising any other students?

Yes ☐ No ☐

If you answered yes, please give brief details of the number of students and their courses

_____

_____

6) **During the total time that you supervised the FHN student, how many families did they work with?**

_____families

7) **Please give a brief description of any ways in which you feel these families have** benefited **from having input from the FHN student**

_____

_____

_____

_____

8) Please give a brief description of any ways in which you feel the FHN student's input has been **problematic** for these families

_____

_____

_____

_____

9) What difference do you feel that placement supervision has made to the quality of the FHN student's work with these families?

a great deal	**quite alot**	**very little**	**none**
☐	☐	☐	☐

*Comments*_____

_____

10) Please write down any three aspects relating to placement supervision that you think could be improved

(i)_____

(ii)_____

(iii)_____

11) If you have any other comments about experiences relating to placement supervision, please write them below

_____

_____

_____

_____

Finally, we would be grateful if you could provide some details about your professional background and your preparation for supervisory roles

12) Please give details of any professional qualifications that you hold and the year obtained

Qualification	*Year obtained*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13) Apart from supervising the FHN student, have you been involved in supervising any other pre or post registration nursing students during the past five years?

Yes ☐ No ☐

If you answered yes, please indicate the course(s) involved and describe any specific preparation that you received in order that you could undertake the supervisory role

Course *(eg. Diploma in Nursing; BA Community Nursing HV Specialism etc)*	***Preparation given*** *(eg. formal 2 day preparatory course; informal briefing) from colleague etc)*
_____	_____
_____	_____
_____	_____

14) Please give details of any preparation that you received **specifically to prepare you to undertake the role of supervisor to the FHN student**

_____

_____

_____

_____

15) Finally, what aspects of your own professional experience have been most useful for supervising the FHN student?

(i)_____

(ii)_____

(iii)_____

Thank you very much for taking the time to complete this questionnaire. Please return it now in the FREEPOST envelope provided

The student and supervisor questionnaires were generally well completed across the different sub-sections. Qualitative comments were collated using SPSS and analysed in terms of content frequency and broader thematic coverage.

Aggregate scores for perceived quality of placement supervision, frequency of supervisor contact by remote means, and frequency of in-person supervisor contact were subsequently derived from the students' responses (the same procedure was followed with the responses from their supervisors). This facilitated subsequent comparison of scores between the two cohorts of students using the Mann Whitney test. As reported in the main study, Cohort 2's perceived quality of clinical placement supervision was significantly better than that reported by Cohort 1 ($p=0.004$). This finding confirmed similar findings from a range of other quantitative and qualitative data.

Use of Cohen's kappa statistic (measuring level of agreement) for comparison of students and their respective supervisors' ratings of a subset of matched individual questions is described within the main report. The report also reflects on the findings of relatively poor agreement on many of the questions using this rigorous statistical index.

As alluded to in previous sections of this CD Rom, the student (and supervisor) sample was too small for the use of factor analysis based on their responses to the new questionnaire. However we were able to explore the reliability of sub-scales of both questionnaires using the alpha coefficient statistic. This reflects the internal consistency of the items which comprise these sub-scales. It is generally accepted that alpha scores of over 0.70 are satisfactory, especially if a relatively small number of items comprise the sub-scale (Streiner and Norman 1995). Scores of over 0.90 may indicate that a number of items are asking the same question in a slightly different way (i.e. there is some item redundancy; see Streiner and Norman 1995).

The table below presents alpha coefficients based on students' and supervisors' responses to the main sub-scales.

Sub scale	**Respondents**			
	Cohort 1 students	Cohort 2 students	Cohort 1 supervisors	Cohort 2 supervisors
quality of placement supervision	0.86	0.73	0.88	0.74
frequency of supervisor contact by remote means	0.97	0.93	0.59	0.96
frequency of in-person supervisor contact	0.88	0.84	0.53	0.89

It can be seen that the student questionnaire's sub-scales typically appear to be internally consistent and reliable, although there may be some scope for reducing the number of items within the "remote contact" sub-scale. The results for the supervisor questionnaire are more mixed. The "remote contact" and "in-person contact" sub-scales perform very differently when responded to by the Cohort 1 and Cohort 2 supervisors. Some further exploration of possible reasons for this is required in order to inform future applications of this questionnaire.

2.2.2 Methods of review of student course work and evaluations

In order to study the student experience it was necessary to scrutinise a range of documents that were used in the educational programme. The academic teaching team were very helpful in providing information and facilitating access to the required information.

Where assessment procedures for individual modules involved written assignments (e.g. initial case study; exam; community portraits; annotated case reports) we typically asked to see a cross-section of the work. This would span those receiving the highest marks, average marks and the lowest marks. This proved a useful way of gauging the level of the course and student performance on it. Both researchers were involved in scrutiny of these documents and there was regular discussion of our interpretations. In the case of the community portraits we asked for and received all the students' work as these were particularly useful to our understandings of the sites involved.

The educational team encouraged the students to regularly produce written reflections on their experiences and progress. These were collated, anonymised through some editing, and circulated to the Project Steering Group and a number of other parties such as service managers and ourselves. These were another useful set of data that informed ongoing understandings.

Our scrutiny of student practice profile forms was most often conducted in context when we visited the students at their respective home base sites. Discussion of the profile documents would sometimes include input from supervisors. We generally took field notes recording specific details and summarising themes arising.

Finally the academic staff supplied us with the collated results from students' final evaluations of each module.

2.2.3 Methods of review of teaching, assessment and external examination

In person observation of campus based teaching sessions was occasional rather than frequent, averaging around one session per semester. Our critical reflections on the curriculum and our knowledge of emerging issues gathered through site visits tended to influence our requests to sit in on certain sessions (e.g. when the students were involved in in-depth interviews with families towards the very start of the course we asked to sit in on the next ethics session). Detailed notes were taken during these sessions, recording strengths and weaknesses. These were then summarised by thematic analysis and sometimes augmented by means of a written reflective commentary.

The main report gives insight into our observations of the Objective Structured Clinical Examination (OSCE) assessment procedure. As indicated, we observed twelve of the twenty OSCEs for Cohort 2 students, and this involved detailed note taking and subsequent discussion of emergent themes within the research team. One of these OSCEs was observed by means of video-link.

The external examiner reports that informed course review were also shared with the research team. These tended to be limited in scope.

2.2.4 Group discussions with students on campus

Informal contacts and interviews with students were ongoing throughout the project, but periods on campus provided the opportunity for the research team to engage in group discussions with each cohort. These took place once every three months or so and usually lasted around one hour. Academic teaching staff would help arrange a time for this, but they were not present at the discussions. Dialogue was usually structured around some topical issues that the research team wished to explore and issues spontaneously raised by the students. Often a good deal of "ventilation" took place whereby students voiced current concerns. These discussions were useful in sustaining and developing the relationship between the research team and the student body, but the group interaction necessarily inhibited more reserved students and less popular views. The member(s) of the research team present took notes around the main themes discussed.

2.3 EXPERIENCES OF RESEARCHERS AND TEACHERS

2.3.1 Field notes and research journals

As indicated already field notes were an important way of recording descriptive data, emerging questions and ongoing reflections. This technique was used extensively during visits to campus and on visits to sites where FHN students or qualified FHNs were working. Usually these notes would be prefaced by a number of themes or questions which we took with us on our visits. Moreover, whenever possible, we subsequently discussed our experiences within the research team in order to help to make sense of what was often a complex and paradoxical unfolding of events. The challenge of attempting to describe and explain such fieldwork, and the challenge of jointly exploring different interpretations, was a vital part of explanation building. This process was iterative and highlights the need for good teamwork and mutual support in work of this nature, especially where there are pronounced political dimensions to the development under scrutiny.

Research journals were used in a less detailed way to log and explore themes at a "meta" level (i.e. to step back from the detailed experience and data, and pull out important elements and issues). Sometimes we also used these journals to summarise the content of the regular, informal, phone discussions that we had with a range of people involved in the project.

2.3.2 Interviews with teachers

As the main report indicates, a formal interview was held with each member of academic staff who had a key role to play in delivering the programme. These interviews took place towards the end of the pilot project (i.e. December 2002) in order to explore summative reflections on the experience. A key member of the academic staff informed colleagues about the nature of the intended interviews and the main thematic areas that we wished to cover. All the relevant staff kindly agreed to take part.

Specifically the interviews aimed to explore the strengths and weaknesses of the course and to identify the lessons learned and the areas for potential development. Enabling reflexivity was one of the challenges of these interviews as a certain amount of guarding took place. Like the students, the teachers had been in the shifting spotlight and part of a highly politicised process for the last two years.

Questioning began by asking about the strengths and weaknesses of the curriculum; before reflecting on its fit with regulatory learning outcomes; the parity and quality of student experiences and learning; the role of the FHN; and finally focusing on their own personal experiences of being involved in the initiative.

Apart from one interview that was conducted by e-mail due to time and geographic restrictions, the interviews were conducted in person and tape recorded. Typically the interviews lasted between 25 and 75 minutes. The tapes were listened to several times, initial indicative thematic areas were mapped to tape-counter locations, and selected sections of the interview were fully transcribed. For some interviews this entailed transcription of almost all the content. For others the transcription was more limited in scope. Through a process of qualitative content analysis, the main themes were then derived from the transcribed material. Full details of application of this method are given in Folder 3.2 of this CD Rom (section on case studies).

PART 3 THE PRACTICE OF FAMILY HEALTH NURSING

3.0 CONTEXTS OF SITES, CASELOADS AND FIELD NOTES

3.0.1 Contextual data for the FHN sites

During the evaluation we gathered a wide range of literature relating to the epidemiology and demography of each site location. Most often such information pertained to rather wider areas than the FHN sites themselves, but a few were completely co-terminus. These documents had typically been produced by the various regional Primary Health Care Trusts involved in the project, but these were supplemented by information available through national sources (e.g. Public Health Institute for Scotland).

One of the regions gave us access to some particularly useful health needs assessments which they had commissioned. These gave some insights into the way that health services in general, and nursing services in particular, were viewed by local communities. One Community Health Profile (Hope et al 1997) also surveyed health care staffs' perceptions of current service and included analyses of district nursing caseloads in the area. This proved a very helpful and informative document which, unusually, gave at least a systematic research/audit basis on which to base further role development. For example one major finding was that, whilst health promotion and mental health issues were recognised as Health Board priorities and germane to the local population and health professionals, there was little evidence that these were currently being addressed as priorities in the work of district nurses.

As such this information gave a useful "frame" for closer investigation of conditions at the FHN sites. In addition to gathering any relevant epidemiological and demographic data that was available to us when we visited specific FHN sites, we also drew on the community portrait documents that the first cohort of FHN students constructed during 2001 as part of their coursework. Again the quality and quantity of data available within these documents were variable, but most of the community portraits also gave more information and insight about the coverage and extent of local health and social care provision.

Sometimes this included a listing of the numbers of staff and the roles in which they functioned. This proved useful, but it was only by visiting each individual FHN site that we could obtain and cross-check such information in detail. Sites were typically visited at least twice during 2001 so that such information could be compiled, along with more detailed information on working and referral practices. In this way a list of professional stakeholders was compiled for each FHN site. This comprised all health care staff in the core Primary Health Care Team, along with all other relevant health, community and social care staff involved closely with the PHCT. Identification of the latter, non-core, group of individuals involved checking and cross checking names with several members of staff at each site.

3.0.2 Caseload details

An important aspect of the site visits involved establishing the coverage and extent of district nursing, health visiting, midwifery, practice nursing and GP service provision. For the latter three groups it was usually sufficient to obtain fairly general data (e.g. typical number of live births per year; practice population numbers and demographics etc.) and supplement this through triangulated interview data on working practices. As the main predicted interface of the FHN role was with district nursing and health visiting care, however, it seemed important to achieve a detailed understanding of the work carried out by these groups at each site.

To this end we sought scrutiny of caseloads relevant to each site. This firstly involved studying the means through which relevant data was recorded. This varied across the regions, and sometimes within the regions, but usually a register (large book) was kept with each patient's name, age, address, presenting problem, frequency of visiting and various other entries. Moreover daily diaries were used to log visits. Finally a monthly collation of statistics for contacts was usually returned to regional headquarters based on the information from the register.

The required content for these monthly collations varied across the regions. Some used a "kalamazoo" format whereby the number of contacts with patients in different age categories was recorded for each day of a particular month. Others had more sophisticated layouts involving an array of computer-friendly codes which represented discrete aspects of each individual patient contact. Accompanying documentation explained the codes which the nurse would then enter. Interestingly one of the regions had recently reverted to more simplified details of contact information before our study commenced. Apparently there had been difficulty in getting nursing staff to return and complete the new forms, and there was some debate about what the ensuing statistics were actually used for.

In order to try to extract meaningful primary data we decided to seek full details of district nursing caseloads for a typical month during autumn 2001. Typically we had already met each district nursing caseload holder during earlier visits when we had explained the nature of our study. This was also supplemented by more information given to them by the FHNs at each site. Usually we then phoned each district nursing caseload holder to give them more information about the details that we wanted, and arranged to meet them in order to extract the information from the register together. We found that by talking through individual cases and entering them on to our data extraction form, we gained great insight into the nature and scope of the work being carried out. Furthermore the process invariably elicited the district nurse's more general worldview in relation to her work, her community and perceptions of the FHN role.

Due to logistics it was possible to do this in person with all but two of the district nursing caseload holders. Where an in-person meeting was not possible we sent them the letter presented on the following page along with the data extraction grid presented on the page thereafter. Through both of these approaches it was possible to extract data for nine of the ten FHN sites involved in the first year of practice. At the remaining site the district nursing caseload holder repeatedly said that she would collate the data but this never happened. Subsequent visits to the site revealed that basic data was often very difficult to find, even for the staff working there. In this case we drew on information from the FHN and other community nursing colleagues in order to construct a typical picture of caseload activity.

The letter and the second data extraction grid presented were sent to the Health Visitors who covered the FHN sites. Again we attempted to meet first with the HVs in person to explain the nature of our study. This was possible in six out of ten cases. One of the problems in this regard was that some of the HVs were based outwith the FHN site (i.e. the FHN site was only a part of their "patch") and it was difficult to arrange our schedules to coincide. Where this was the case the phone was used for initial introductions and explanations. Six of the Health Visitors returned

completed data extraction sheets. One gave a summary of information by phone and the remaining three refused our request citing pressure of workload. Again in these cases we tried to compile a typical picture of caseload activity based on information from colleagues. However in these cases it was instructive to note how little detail each colleague within the core team could actually provide about the HV's typical activities.

29th October 2001

Dear

As part of the evaluation of The Family Health Nurse (FHN) project, we are seeking to gather data about the usual work of the community nurses and health visitors who cover the pilot sites. This is important as it will provide a baseline picture which will inform our understanding of the future local development of the FHN role.

To this end we would be very grateful if you could complete the attached A3 grid form which is designed to capture a one-off picture of the part of your present caseload that covers the .....area. While we would welcome any details that you think relevant, we are mindful of the pressures on clinical staff and are really just looking for a summary of client need and your current input in each case. We would wish to avoid individual clients names being listed under the patient identifier column so if it is possible to use a CHISS number or other unique identifier, this would be ideal. If not, perhaps you could number them in such a way that you would be able to identify their case again to us next year. Alternatively, initials could be used.

If you feel that there are other aspects of your work that are relevant to the site and that cannot be entered on to the large grid form (eg. work with groups etc.), please give details on the enclosed yellow sheet.

The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive. Approval for the research has been obtained from the Local Ethics Committees in the pilot regions and from the respective Directors of Nursing. Data will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. We will take all steps to ensure that no individual is identified in written reports on the project.

We hope that you will support this research. It is very important that developments such as this are evaluated so that future decision making can procede from an informed basis. Your support and participation will help to ensure this. If you have any questions please do not hesitate to contact us.

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development (CeNPRaD)

Dr Bernice West, Director, CeNPRaD

Date:.....Site:.....

Person(s) responsible for this caseload at present (*plus their role)*.....

Patient identifier	Age	Sex m/f	How often seen at present	Main health need/problem	Related nursing activity	Other health need/problem	Related nursing activity	Other professionals involved

Date:.....Site:.....

Person(s) responsible for this caseload at present (*plus their role)*.....

Patient identifier	**Age**	**Sex m/f**	**How often seen at present**	**Main health need/problem**	**Related h.v. activity**	**Other health need/problem**	**Related h.v. activity**	**Other professionals involved** *(eg. OT; CPN)*

Overall the information elicited through these processes proved very useful in providing baseline understandings of the nature, coverage and extent of service activities. However the processes also drew attention to wide variations in: what people would be visited for; frequency of visiting; and in criteria for entry to, and exit from, caseload listings. Such variation was evident across the three regions but was also found amongst individual sites within the same region.

In turn this highlighted similar variation in the matched monthly collations of community nursing contacts that we were able to obtain. It was clear that different nurses completed these forms using very different criteria for what constituted a contact. This resulted in some contrasting data for sites with ostensibly similar patient populations and levels of professional staffing.

Accordingly we have noted these caveats in the main report and detailed the proxy measures that we have used towards engaging in any sort of meaningful comparison. The issues about recording of activities that were raised during this study are similar to those we have encountered in previous experiences of evaluating community nursing. In effect they reflect more fundamental difficulties relating to how the qualitative and contextual aspects of intimate interpersonal work can be rendered through quantification.

The above issues are made manifest vividly in the following excerpt from an interview with an FHN:

FHN: *".....there is a man that I see occasionally on the road, or if he is in someone else's house. Now if I see him on the road, I know he's alive. If I go to his house I can't find him-he'll be on the wander. That's one. There's another one who's very hard to find. He's back to his own house which is uninhabitable. But he's there. But I see him on the road or walking in heavy weather. I'll stop and have a chat with them and find out how they are going if I can. Or if I see them somewhere, or if I see them in the clinic we go to the side and go to the side and have a wee chat to see how they are getting on.*

That's a visit. I don't always write down the "co-op" ones. For some reason I don't feel its valid, but it should actually be. It is a contact. Of course it can be on a Saturday and nothing to do with work, but it just happens.

Researcher: *Yes, there's just a difficulty with the nature of recording...*

FHN: *but they are very good in a way, because they know it isn't just a kind of private interest in them. They know that I'm genuinely interested in how they are and how they are getting on. Therefore if I am talking with somebody there might be a line waiting! The DNs have that problem. They'll hover at the tinned peas until you're free!....."My chest is better....."*

3.0.3 Field notes

The procedures for taking field notes on site visits were similar to those already outlined in relation to the evaluation of educational experiences (Folder 2.3 of this CD Rom). However it is worth stressing how valuable this technique was in terms of keeping track of large amounts of information and in terms of answering and generating questions. We had initially envisaged using a laptop computer for the majority of this work. Indeed we used one during a number of early site visits. However the difficulties of using it on sustained trips to remote and rural contexts soon became apparent, and we resorted to tried and tested traditional methods (i.e. pen and paper).

In this way we almost always took summary notes during "informal" discussions at sites. These had usually been prefaced by a number of questions or themes that we wanted to explore with staff or patients. These notes were then expanded, from memory, in the evenings in guest houses and, just occasionally, hotel bars! It was usual to conclude with a reflective summary on the themes covered and the emergent questions. Then it was time to prepare for the next day's visits and to log the themes that were to be specifically explored in those contexts. In this way it usually proved possible to keep on top of the enquiry and avoid becoming too confused.

During field trips some improvisation in methodology was also useful when responding to a need for more insight into a situation. One example of this was that during our on-site work with FHNs in 2002 it was sometimes difficult to get a clear picture of their emergent new role in terms of both their activities and their understandings. Thus during a round of site visits we started to ask each FHN to list the typical types of work they were doing and to draw these freehand as a pie chart so as to indicate relative proportions for each. Explanatory examples were then elicited in order to give further insight. Although this data never attained enough consistency to be analysed in terms of measurement, it showed how the FHNs were thinking. Many spontaneously divided the pie into "district nursing type work", "health visiting type work" etc. while a few insisted it was all FHN work before subdividing the pie along other lines. For almost all, however, there was some intra-role conflict and difficulty in representing their work to others.

Telephone calls to the staff at the sites (and to "tracer" families) were also summarised through note taking. Such calls were relatively frequent, particularly to the FHNs themselves. As such this provided a mechanism through which we could keep up with perceptions of progress.

3.1 STAKEHOLDERS

3.1.1 The professional stakeholder questionnaire(s)

In order to address Objective 5 we sought to obtain professional stakeholders' perceptions in relation to the local implementation of family health nursing at two points in time. Firstly we wished to systematically seek these perceptions at the end of 2001 when the concept had been "in circulation" for around a year and the FHN students were on the verge of trying to put the concept into practice locally. As such we would be seeking perceptions of what was still a hypothetical concept for professional colleagues. Secondly we wished to follow up in order to assess perceptions later when local FHN practice had been in place for one year.

Our procedures for identifying professional stakeholders have already been described. Our preferred method for seeking their perceptions was through the use of a standardised questionnaire. Unsurprisingly we found no such tools that had looked specifically at the concept of family health nursing as promulgated by the Scottish Executive and WHO Europe. In designing our own tool we decided to incorporate use of semantic differential technique (Osgood et al 1957). This involves the use of rating scales (usually seven point) that are bipolar with each extreme usually defined adjectivally (Oppenheim 1992). One of the major advantages of this technique is that it can be used not only to explore perceptions of relatively "matter-of-fact" aspects, but also perceptions of abstract ideas (Anastasi and Urbina 1997). This seemed well matched to our aspiration to study what was essentially an abstract idea at Time 1 and a "matter-of-fact" reality at Time 2.

Within the wider context of our evaluation the questionnaire was designed primarily to inform our understandings of emergent context-process-outcome patterns at each individual FHN site. However the questionnaire also offered opportunity to aggregate data in order to study the perceptions of all professional stakeholders and distinct sub-groupings amongst them.

Design of the tool took place early on in the evolution of the pilot project. Our own selection of aspects for semantic differential rating took place in the context of what was known (essentially little) and projected (essentially a lot) about the future implementation of family health nursing practice. It was however clear that there was a need to gauge perceptions of what was happening and its impact. We were aware of a number of potentially important and influential factors through our initial fieldwork, but at the end of the day we decided on seven items to be rated. A premium was put on keeping the questionnaire brief to avoid burdening potential respondents and aid return rates. Moreover our previous experiences of using semantic differential technique (West, Wilcock and Phillmore 1997) suggested the value of including an explanatory example of rating.

There was no opportunity to pilot our first prototype questionnaire without intrusion on the only sample for whom the concept under study would be an imminent reality. Accordingly we circulated the prototype to selected colleagues within the School of Nursing and asked for comments/suggestions. These were mostly affirmative and supported the inclusion of a line below each rated item in order to give scope for explanatory comments. The latter were seen as being useful on a number of levels. In particular it was felt that these would help us better understand responses to a few of the items where positive polarity could not necessarily be assumed (e.g. for the item contrasting different and similar service it was not axiomatic that difference would/should necessarily be associated with improvement). Within the larger group of items whose polarity could more safely be assumed we followed Oppenheim's advice to vary the location of the positive end in order to try to counteract any halo effect. This was done with two items. Feedback from colleagues also confirmed that the pairs of poles for each rated item could truly be considered as opposites (see Oppenheim 1992) and that the mixture of adjectival and verbal anchoring was satisfactory.

The resultant finalised questionnaire also invited free text responses relating to anticipated impact on different sub groups. This was sent to professional stakeholders in the latter part of 2001 along with an explanatory letter and information sheet (see following pages).

29th October 2001

Dear.....

As you may be aware, a new type of nursing role called The Family Health Nurse is currently being developed in the Highlands and Islands of Scotland. The main aim of these nurses is to work with local families to identify and meet their health needs. As the development is currently getting underway in your area, we are writing to ask if you would be prepared to help with our research into its operation and impact. The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive.

Your involvement would comprise the following:

- completing the attached questionnaire which aims to elicit your initial thoughts on the development (an information sheet summarising the Family Health Nurse concept is attached)
- completing a similar follow-up questionnaire later next year. This would elicit your thoughts on how the development has impacted so far
- possibly taking part in a short telephone interview later next year. This would explore your perceptions in greater detail

Any information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. The questionnaire has a coding number so that there is no need to add your name to it. Telephone interviews will be tape recorded then destroyed after analysis. Similarly, we will take all steps to ensure that no individual is identified in written reports on the project.

We hope you will support this research. It is very important that our evaluation is based on the thoughts and feelings of those who are involved and/or affected by this development. In this way we can have a sound basis for studying the value of the emergent Family Health Nurse role. Please complete the attached questionnaire and return it by ***23rd November*** using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

INFORMATION SHEET ON THE FAMILY HEALTH NURSE CONCEPT

Within recent years, the Family Health Nurse (FHN) model has been developed by the World Health Organisation (WHO). It is based on the following principles:

- a skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required
- a model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care
- a role founded on the principle of caring for families rather than just the individuals within them
- a concept of the nurse as first point of contact

Within Scotland piloting of this model is currently getting underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region are undertaking a degree level education programme based on the WHO FHN model. This course (of approximately one year's duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses are undertaking it.

These nurses are on placement locally during the course. They will be working with a number of local families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. On qualification as Family Health Nurses at the end of this year, they will then seek to further develop and establish the role at their local sites.

FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION A

The pairs of statements listed below present opposing views of the Family Health Nurse (FHN) development. For each pair, please circle a star on the seven point scale between them which most closely corresponds with your view. An example of how to complete this section is now given.

For example if you believed that fuel prices were very unfair, you might complete as below:

Fuel pricing is generally fair	*	*	*	*	*	*	⊗	Fuel pricing is generally unfair

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

Fuel pricing is generally fair	*	*	⊗	*	*	*	*	Fuel pricing is generally unfair

Now, thinking about your local context and the potential contribution of Family Health Nursing, please complete for the statements below. (*Family Health Nurse has been abbreviated to* FHN*).* Please add comments if you wish.

I think the FHN will deliver a different type of service to what is currently available	*	*	*	*	*	*	*	I think the FHN will deliver a similar service to what is currently available

*Comments*_____

I think the FHN will take away existing local services	*	*	*	*	*	*	*	I think the FHN will add to existing local services

*Comments*_____

I think the FHN development will involve substantial change to the way that services are delivered to patients	*	*	*	*	*	*	*	I think the FHN development will involve minimal change to the way that services are delivered to patients

*Comments*_____

I think the FHN development will involve substantial change for professionals in the way they work together	*	*	*	*	*	*	*	I think the FHN development will involve minimal change for professionals in the way they work together

*Comments*_____

I think the FHN development is not well suited to our local context	*	*	*	*	*	*	*	I think the FHN development is well suited to our local context

*Comments*_____

I think the FHN development will lead to an improvement in local health service	*	*	*	*	*	*	*	I think the FHN development will lead to a deterioration in local health service

*Comments*_____

I think the FHN development is likely to succeed locally	*	*	*	*	*	*	*	I think the FHN development is unlikely to succeed locally

*Comments*_____

SECTION B

In this section we would like you to write down any initial thoughts you have about the likely impact of the Family Health Nurse development on each of the following groups:

Patients and families

_____

_____

Other health or social care professionals *(please specify)*

_____

_____

The Family Health Nurses themselves

_____

_____

Finally, if you have any other comments please add them below

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided

Reminder letters were sent to those who did not respond within three weeks. Response to the first administration of the professional stakeholder questionnaire is detailed in the main report. We judged the overall response rate as satisfactory in terms of minimisation of response bias. There was no evidence that any particular sub-group of professionals was less likely to respond. The useable response rate was only marginally less and there was no evidence that any particular sub-group of professionals was more likely to fail to complete the questionnaire in an intelligible way. On the contrary, from responses to the semantic differential ratings, explanatory free text comments and the other free text responses it was clear that respondents had appreciated what was being asked of them. Free text responses were very useful in illuminating baseline attitudes and the breadth of range in these responses suggested that the questionnaire was performing well.

However a relatively large number of respondents added explanatory comments below individual scale items to the effect that, as they knew little/nothing about the FHN development at present, it was difficult to answer. Typically these respondents either opted for an "undifferentiated" point on the scale (i.e. the mid-range points 3, 4, or 5) or they left the item unmarked. While this reflected some of the fundamental difficulty relating to perceptions of an abstract concept, it was also very useful at this point in the evaluation to learn from these professional colleagues that they felt they knew so little. Some indicated that they had been given no information beyond what we had included with the questionnaire.

The response behaviour of this sub-group was also helpful in informing our general procedures for interpretation of responses. Several approaches to this are possible with semantic differential technique, including classifying true mid-point (point 4) responses as the only undifferentiated ones (i.e. constituting the "unsure" category). In the context of our study, however, it seemed that more definitive focus would be achieved by categorising responses on the mid-range points 3, 4, or 5 as undifferentiated. In this way responses on points 1 or 2, and responses on points 6 or 7, were categorised as the respective opposite poles. This system was duly followed in our basic analyses throughout the study and is illustrated in the layout of results within Annex 5 of the main report. In order to check the implications of this interpretation on our analyses we later re-analysed Annex 5 using true mid-point (4) responses as the only ones in the "unsure" category. While this naturally decreased the proportion of responses within this category, it made little difference to the proportionate balance of positive and negative responses.

In addition to producing frequencies and other descriptive statistics based on the semantic differential part of the questionnaire, we also took the opportunity to gauge the reliability of this section in terms of internal consistency. The resultant alpha coefficient for our Time 1 administration of the professional stakeholder questionnaire was 0.79. As indicated previously, this suggests a satisfactory level of internal consistency.

We also took the opportunity to further explore the structure of the semantic differential part of the questionnaire through the use of exploratory factor analysis. This technique has previously been used extensively in this context (Oppenheim 1992). Our aim was to find out more about the underlying factors that our questionnaire was "tapping into", and to find out which factors the seven items "mapped" or "loaded" on to.

In this case our variable to subject ratio seemed suited to the use of factor analysis (Watson 1998). Our sample comprised the useable responses from the ten sites subsequently studied (excluding responses from the FHNs themselves). This totalled 83 responses (see Table 3.2 in the main report; fourth column entitled "December 2001"). Thus we used Principal Components Analysis with subsequent Varimax rotation in order to explore factorial solutions where Eigenvalues were greater than 1 (unity).

We plan to publish full details of the factor analysis in due course, based on Watson (1998)'s guidelines. In summary we found two factors that explained a total of 70% of the variance in responses. The first factor, which explained 46% of variance, we entitled "(anticipated) nature of impact". The second factor, which explained 24% of variance, we entitled "(anticipated) magnitude of practice change". Four of the seven semantic differential items loaded on the first factor, and the resultant alpha coefficient for this factor was 0.84. The remaining three items loaded on to the second factor (although one of these items tended to "bridge" both factors), and the resultant alpha coefficient for this factor was 0.76.

These results were encouraging in that they suggested that the questionnaire was measuring two underlying factors that were fundamental to our study's aim. Moreover they suggested little, if any, item redundancy within the questionnaire. Interestingly the two factors very clearly relate to the main factors that Osgood (1957) found to be typically elicited through the semantic differential technique i.e. in order of importance: evaluation, potency and activity. In this regard our "nature of impact" factor reflects evaluation and our "magnitude of practice change" factor reflects potency.

Thus the professional stakeholder questionnaire seemed to provide a very useful, valid, reliable and brief means through which to obtain perceptions about local family health nurse implementation. On this basis it was decided to leave all existing items in the questionnaire that would be sent as a follow up at the end of the first year of practice (November/December 2002). This offered the added advantage of facilitating matched comparisons in perceptions between Time 1 and Time 2. Minor changes in the wording of the semantic differential items were made so as to reflect the fact that respondents would now be basing their answers on experience of the enacted concept.

During our field trips and other data collection procedures in 2002 it became apparent that it would be useful to ask some other questions systematically through the professional stakeholder questionnaire. Thus we added in a section that asked for perceptions of consultation; referral behaviour; frequency of contact with FHN; and need for a distinct FHN role locally. The latter question reflected a theme that had emerged throughout the pilot project in that there seemed to be a wide range of opinion about this fundamental, underlying aspect.

As indicated in the main report a number of the stakeholders who had responded in 2001 subsequently changed employment and location. Moreover a number of new stakeholders were identified, often in relation to new activities started by the FHNs. Using our updated listings we sent out the revised questionnaire and explanatory letter in November 2002. These documents are presented on the following pages.

26th November 2002

Dear

It is now almost a year since Family Health Nurses began working at various pilot sites in the Highlands and Islands of Scotland. As our evaluation of the pilot project nears its conclusion, we are writing to ask if you would be willing to complete the enclosed questionnaire which seeks your thoughts on the operation and impact of family health nursing so far in your local area.

Any information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. The questionnaire has a coding number so that there is no need to add your name to it. The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive.

We hope that you will support this research. It is very important that our evaluation is privy to the thoughts and feelings of those who have been involved and/or affected by this development. Please complete the attached questionnaire and return it by ***9th December*** using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you very much

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION A

The pairs of statements listed below present opposing views of the Family Health Nurse (FHN) development. For each pair, please circle a star on the seven point scale between them which most closely corresponds with your view. An example of how to complete this section is now given.

For example if you believed that fuel prices were very unfair, you might complete as below:

Fuel pricing is generally fair	*	*	*	*	*	*	⊗	Fuel pricing is generally unfair

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

Fuel pricing is generally fair	*	*	⊗	*	*	*	*	Fuel pricing is generally unfair

Now, thinking about your local context and the development of Family Health Nursing so far, please complete for the statements below. Please add comments if you wish.

I think the FHN delivers a different type of service to what was previously available	*	*	*	*	*	*	*	I think the FHN delivers a similar type of service to what was previously available

*Comments*_____

I think the FHN development has taken away from pre-existing local services	*	*	*	*	*	*	*	I think the FHN development has added on to pre-existing local services

*Comments*_____

I think the FHN development has involved substantial change to the way that services are delivered to patients	*	*	*	*	*	*	*	I think the FHN development has involved minimal change to the way that services are delivered to patients

*Comments*_____

I think the FHN development has involved substantial change for professionals in the way they work together	*	*	*	*	*	*	*	I think the FHN development has involved minimal change for professionals in the way they work together

*Comments*_____

I think the FHN development is not well suited to our local context	*	*	*	*	*	*	*	I think the FHN development is well suited to our local context

*Comments*_____

I think the FHN development will lead to an improvement in local health service	*	*	*	*	*	*	*	I think the FHN development will lead to a deterioration in local health service

*Comments*_____

I think the FHN development is succeeding locally	*	*	*	*	*	*	*	I think the FHN development is not succeeding locally

*Comments*_____

SECTION B

In this section we ask some questions about the evolution of the FHN role locally from your perspective.

(i) Do you feel that **you** have been adequately consulted in regard to the local introduction of family health nursing? *(please tick most appropriate box)*

Yes ☐ **No** ☐ **Don't Know** ☐

*Comments*_____

_____

(ii) Do you feel that consultations with the **local public** about the introduction of family health nursing have been adequate?

Yes ☐ **No** ☐ **Don't Know** ☐

*Comments*_____

_____

(iii) Over the past year, approximately how many referrals have **you made** to the FHN? *(please write down a number in each box)*

Individual patients ☐ **Whole families** ☐

Please indicate the main reason for making these referrals

_____

_____

(iv) Over the past year, approximately how many referrals have **you received** from the FHN? *(please write down a number)* _____

Please comment on the nature and appropriateness of these referrals

_____

_____

(v) Please tick the box which best describes how often you usually have work-related contact with your local FHN

Daily	Every other day	Weekly	Fortnightly	Monthly or less often
☐	☐	☐	☐	☐

(vi) In your view is there a need for a distinct FHN role locally?

Yes	No	Don't Know
☐	☐	☐

Please give further comments to explain your answer

_____

_____

_____

SECTION C

In this last section we would like you to write down any thoughts you have about the **impact** of the Family Health Nurse development so far on each of the following:

Your own work

_____

_____

Patients and families

_____

_____

Other health or social care professionals *(please specify)*

_____

_____

The Family Health Nurses themselves

_____

_____

Finally, if you have any other comments please add them below

_____

_____

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided

Again, reminder letters were sent to those who did not respond within three weeks. Response to this second administration of the professional stakeholder questionnaire is detailed in the main report. Although the overall and useable response rates were slightly lower than for Time 1, these were still generally satisfactory. Again there was no evidence that any particular sub-group of professionals was less likely to respond or be less likely to complete the questionnaire in an intelligible way.

The additional questions that had been incorporated for this follow-up administration were answered well, and the free text responses now illuminated perceptions of the FHN role in action. In general the findings were very confirmatory, in that they were consistent with interview material and other data that we had gathered on successive site visits.

Excluding replies from the FHNs themselves, there were 78 useable responses. These gave a basis for further checking of the questionnaire's reliability in terms of internal consistency. In this regard the alpha coefficient at Time 2 was 0.87.

Exploratory factor analysis was repeated at Time 2. This time only one factor was identified and this explained 58% of variance in replies. However a further factor that explained a further 13% of the variance almost had an eigenvalue of 1. Some authors (e.g. Tripp Reimer et al 1996) explore solutions with factors that explain over 10% of variance, so we took the opportunity to also impose a two factor solution on our data from the 78 responses. In terms of item to factor mapping, this produced a similar two factor solution to that obtained at Time 1 (when respondents were anticipating the development rather than interpreting its actual enactment).

For the latter reason, and because the respective populations of stakeholders surveyed at Times 1 and 2 differed somewhat, it is perhaps not surprising that our initial exploratory analyses of the Time 2 data produced a slightly different factorial solution. We further explored this finding by conducting a factor analysis on the replies from the 53 Time 2 respondents who had also answered the Time 1 questionnaire. This confirmed that the same two factor solution was consistent on both occasions for this core group of respondents.

In order to further explore the difference between the perceptions of the group of 53 and the remainder of the T2 respondents (i.e. the 25 new respondents), we used the Mann Whitney test. This showed that the group of 25 new respondents were more likely to feel that the FHN was providing a different service and that substantial change in service delivery had occurred.

The influence of this new group of respondents was also seen to some extent when we adopted a less conservative approach to comparison of the consecutive semantic differential data than that taken in Annex 5 of the main report. This involved using the Wilcoxon test to compare before and after mean ranks for each of the seven items (i.e. using the Time 1 sample of 83 useable responses and the time 2 sample of 78 useable responses). This showed one statistically significant difference: that respondents at Time 2 were significantly more likely to see the development as resulting in improvement to local service ($p= 0.22$). However when the same test was done to compare responses from the core group of 53 consecutive responders there were no statistically significant differences. This confirms the main reports finding that the status quo had not been substantially altered after a year of FHN practice.

Indeed the above explorations are generally very helpful in confirming the reliability and validity of the methods used, and in turn confirming the validity of the interpretations that we have made. On this basis the professional stakeholder questionnaire would seem very suitable for further use and development through application in other studies.

3.1.2 The lay stakeholder questionnaires

An abbreviated and adapted version of the professional stakeholder questionnaire was designed for sending to the 20 lay people randomly selected at each of seven sites. Details of the rationale, procedures and ethical considerations related to our consultations with people living within the local FHN sites have already been given in Folder 1.0 of this CD Rom.

The questionnaire sent in November 2001 is presented on the following pages, prefaced by the accompanying letter and information sheet. One of the main purposes of this approach was to gauge what, if anything, local people had heard about this impending development of local service (and how they had heard of it). Accordingly this is addressed in Section 1 of the questionnaire. We were also interested in obtaining initial thoughts on the application of the concept locally, irrespective of whether those mailed had previously heard of the development or not. To this end we included the information sheet.

For Section 2, the number of semantic differential items was reduced to four, in view of our feeling that brevity and cogency were important and might encourage responses from those who had no prior knowledge of the development. The items that were retained were those judged most likely to be answerable by the general population. At this stage no space was offered below these items for explanatory comments. However a further section (3) offered opportunity for general reactions. Finally Section 4 asked for some basic personal data and sought to establish whether the respondent had recent experiential knowledge of community nursing services. This would allow for further contextualisation of responses.

Indeed contextualisation was the main goal for analysing and interpreting data from this questionnaire. As such the data was used primarily to inform our understandings of the context for development at each site.

26th November 2001

Dear Mr/Mrs/Ms.....

A new type of nursing role called The Family Health Nurse is currently being developed in the Highlands and Islands of Scotland. The main aim of these nurses is to work with local families to identify and meet their health needs. As a qualified Family Health Nurse will soon be working in your area, we are writing to ask if you would be prepared to help with our research into this development. The research is being carried out independently for The Scottish Executive by The Centre for Nurse Practice Research and Development (CeNPRaD), The Robert Gordon University, Aberdeen.

Your participation would involve:

- completing the attached questionnaire which asks for your initial thoughts on the development (a sheet giving more information on Family Health Nursing is attached)
- completing a similar questionnaire late in 2002.

If you decide to take part, only our small team of researchers will be aware of this and any information that you share with us will be treated in strict confidence. The questionnaire has a coding number so that there is no need to add your name to it. We obtained your name and address by making a random selection from the electoral roll and you are under no obligation to take part in this research.

We hope, however, that you will choose to do so, as it is very important that our evaluation is based on the thoughts and feelings of those who may be affected by this development. Please complete the attached questionnaire and return it by **14th December** using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

INFORMATION SHEET ON THE FAMILY HEALTH NURSE

Within recent years, a new type of nursing role called the Family Health Nurse (FHN) has been developed by the World Health Organisation (WHO). The main aspects of the role are:

- the FHN is expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care. This is a model based on health rather than illness
- the FHN is expected to care for families rather than just the individuals within them
- the FHN will be a skilled generalist nurse doing a broad range of duties
- the FHN will act as a first point of contact and refer on to specialists where a greater degree of expertise is required

Within Scotland piloting of this model is currently getting underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region will undertake a degree level education programme based on the WHO FHN model. This course (of approximately one year's duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses are undertaking it.

These nurses are currently on placement locally. They are working with a small number of families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. On qualification as Family Health Nurses at the end of this year, they will seek to further develop and establish the role at their local sites.

FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION 1

Prior to receiving this letter, how much had you heard about the Family Health Nurse development? *(please tick one box)*

nothing ☐ a little ☐ a lot ☐

*If you answered "a little" or "a lot", please indicate how you **first** heard about it*

through a friend/relative ☐ through a health care professional (eg. nurse/doctor) ☐

through local publicity ☐ through attending a local meeting ☐

through another source ☐ *(please describe.....)*

SECTION 2

In this section we present opposing pairs of statements. For each pair, please circle a star on the scale which most closely corresponds with your view. An example of how to complete this type of question is now given, using the subject of fuel pricing.

For example if you believed that fuel prices were very unfair, you might complete as below:

Fuel pricing is generally fair	*	*	*	*	*	*	⊗	Fuel pricing is generally unfair

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

Fuel pricing is generally fair	*	*	⊗	*	*	*	*	Fuel pricing is generally unfair

The next four pairs of statements present opposing views of the Family Health Nurse (FHN) development. Thinking about your local situation and the potential contribution of family health nursing, please circle the most appropriate star between each of the statements. (*Family Health Nurse has been abbreviated to* FHN*)*

I think the FHN will deliver a different type of service to what is currently available	*	*	*	*	*	*	*	I think the FHN will deliver a similar service to what is currently available
I think the FHN will add to existing local services	*	*	*	*	*	*	*	I think the FHN will take away existing local services

I think the FHN development is not well suited to our local situation	*	*	*	*	*	*	*	I think the FHN development is well suited to our local situation
I think the FHN development will lead to an improvement in local health service	*	*	*	*	*	*	*	I think the FHN development will lead to a deterioration in local health service

SECTION 3

If you have any initial thoughts about the FHN development that you would like to share, please write these in the space below.

_____

_____

_____

_____

_____

SECTION 4

Finally we would be grateful if you could provide some personal information:

Your **age** _____

Whether you are **male** or **female** *(please circle as appropriate)*

Have you received any community nursing services in the past two years? **Yes** ☐ **No** ☐

Have any other members of your family received any community nursing services in the past two years?

Yes ☐ **No** ☐

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided.

Reminder letters were sent to those who did not respond within three weeks. Response to the initial lay stakeholder questionnaire is detailed in the main report. The overall and useable response rates (49% and 42% respectively) were reasonable for this type of "cold call" mailing of the general public. As the more detailed table in the main report (Table 3.4) shows, response rates varied quite widely amongst individual sites. Perhaps unsurprisingly, response tended to be better from FHN sites with numerically small populations who lived within a relatively small geographic area.

Due to constraints of space within the main report, the aggregated results from this questionnaire were relatively under-reported. Accordingly some further details are reported here. Almost 75% of respondents had heard nothing about the FHN development prior to receiving our letter. Most of the remainder had heard a little from a health professional and a few had heard a lot. Again those that had heard about the development tended to live within FHN sites with numerically small populations. Only a few of the respondents had personal experience of receiving community nursing within the past 2 years, and a few others had relatives in this position.

Aggregated perceptions were fairly balanced as to whether the new service would be different or similar. Most respondents well relatively well disposed to the development and felt that it was well suited to local context, would add to services and result in improvement.

The "any comments" section of the questionnaire was particularly useful as a means of gaining insight into respondents' initial reactions to the FHN concept. Only a relatively small number of respondents (4) indicated that they couldn't really comment as they hadn't heard about it/found the questions meaningless. Rather a further 15 raised a range of interesting points. Again most were well disposed towards it but, for some, there was a strong feeling that this family care happened already and that the role would duplicate current service. As indicated in the main report there was general concern that the FHN role should be additional and not entail any withdrawal of existing service provision. Finally two respondents raised interesting points relating to access to patients and to the GP role:

The district nurse is currently in attendance following a planned course of treatment directed by a personal GP. That is why she is there. How does the FHN gain entry by referrals? Spontaneous visit possibly seen as intrusive. Trust?

On initial reading has little to commend it. The bullet points describe a meddling health care. How are the families contacted, or only the sick ones? It describes a doctor replacement. It should be a doctor who decides what expertise.

Thus the initial lay questionnaire was not only useful in informing our understandings of the context for the development at each site but was also useful in a more general way. While the data that we obtained on local perceptions was obviously limited in terms of depth and coverage, this overall method proved feasible and seemed sustainable for follow-up purposes.

On a technical note, the reliability of the semantic differential part of the questionnaire was tested in terms of internal consistency. The resultant alpha coefficient of 0.83 suggested a satisfactory level. Unsurprisingly an exploratory factor analysis on this part of the questionnaire yielded a one factor solution explaining 72% of variance.

The follow up questionnaire that was mailed approximately one year later is presented on the following pages (prefaced by the accompanying letter). The first section was adapted in order to explore the nature of any contacts that respondents might have had with the new FHN service. The other two sections were unchanged apart from the addition of space for explanatory comments below each semantic differential item.

29th November 2002

Dear

You may remember that last year we asked for your views on a new type of nursing role called The Family Health Nurse. During the past year a qualified Family Health Nurse has been working in your area. We are writing to ask if you would be prepared to help again. This would involve completing the attached questionnaire which asks for your thoughts on the development of the role locally. A sheet giving general background information on Family Health Nursing is also attached.

The research is being carried out independently for The Scottish Executive by The Centre for Nurse Practice Research and Development (CeNPRaD), The Robert Gordon University, Aberdeen. If you decide to take part, only our small team of researchers will be aware of this and any information that you share with us will be treated in strict confidence. The questionnaire has a coding number so that there is no need to add your name to it. We obtained your name and address by making a random selection from the electoral roll and you are under no obligation to take part in this research.

We hope, however, that you will choose to do so, as it is important that our evaluation is based on the thoughts and feelings of those who may be affected by this development. Please complete the attached questionnaire and return it by **19th December** using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION 1

During the past year have you had any contact with your local Family Health Nurse (FHN)? *(please tick one box)*

yes ☐ no ☐ don't know ☐

If you answered "yes", please indicate the nature of this contact. Tick any boxes that apply.

I have received health care/support/advice from the FHN ☐

Members of my family have received health care/support/advice from the FHN ☐

I have met the FHN through her involvement with local health activities/community matters ☐

I know the FHN as a friend/colleague/acquaintance ☐

Other contact ☐ *(please describe.....)*

SECTION 2

In this section we present opposing pairs of statements. For each pair, please circle a star on the scale which most closely corresponds with your view. An example of how to complete this type of question is now given, using the subject of fuel pricing.

For example if you believed that fuel prices were very unfair, you might complete as below:

Fuel pricing is generally fair	*	*	*	*	*	*	⊗	Fuel pricing is generally unfair

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

Fuel pricing is generally fair	*	*	⊗	*	*	*	*	Fuel pricing is generally unfair

The next four pairs of statements present opposing views of the Family Health Nurse (FHN) development. *Based on what you know about the development of family health nursing locally*, please circle the most appropriate star between each of the statements. Please also add comments if you wish.

I think the FHN delivers a different type of service to what was previously available	*	*	*	*	*	*	*	I think the FHN delivers a similar type of service to what was previously available

*Comments*_____

I think the FHN development has added on to pre-existing local services	*	*	*	*	*	*	*	I think the FHN development has taken away from pre-existing local services

*Comments*_____

I think the FHN development is not well suited to our local situation	*	*	*	*	*	*	*	I think the FHN development is well suited to our local situation

*Comments*_____

I think the FHN development will lead to an improvement in local health service	*	*	*	*	*	*	*	I think the FHN development will lead to a deterioration in local health service

*Comments*_____

SECTION 3

Finally, if you have any thoughts about the FHN development that you would like to share, please write these in the space below.

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided.

Once again, reminder letters were sent to those who did not respond within three weeks. Response to this second administration of the lay stakeholder questionnaire is detailed in the main report. The overall and useable response rates (39% and 35% respectively) were more disappointing. Again response rates varied quite widely amongst individual sites and tended to be better from FHN sites with numerically small populations.

Data from lay stakeholder follow up was mainly used to inform our site analyses within the main report. On aggregation of the 45 useable responses, the data showed that almost 75% had not had any contact with the FHN during the first year of practice. For the remainder, the nature of contacts with the local FHN were various and often bound up in social activities.

Relatively few respondents felt that the FHN development had actually taken away from service provision (9%) or resulted in deterioration (4%). Only 11% felt that the development was unsuited to local context, but only 16% felt that it was providing a different kind of service. The predominant response, however, was one of uncertainty about what actually had been going on in the past year. Many respondents felt that they just did not know enough about the role, and this was reflected in their explanatory comments. The general comments section again produced some interesting remarks and observations.

The reliability of the semantic differential part of the questionnaire was tested in terms of internal consistency. The resultant alpha coefficient of 0.76 again suggested a satisfactory level. Exploratory factor analysis on this part of the questionnaire again yielded a one factor solution which on this occasion explained 60% of variance.

Overall the administration of the lay questionnaire on consecutive occasions resulted in some useful data. This tended to confirm findings from the professional stakeholder questionnaires, interviews and site visits. Nevertheless our attempts to consult the local public on this development raised a number of broader questions about how this is best done. Without the constraints of time and geography we might have opted for a more in-depth approach where more time was spent with local communities. However this was not a realistic option in this evaluation study.

3.2 FAMILIES

3.2.1 The "Tracer" families

The process of identifying "tracer"[5] families and following their progress occupied a major part of the research team's time during 2002. The process involved the numerous letters and documents included on the following pages, but also many phone calls and site visits. The process was undertaken in parallel with our ongoing data gathering on the size and nature of FHN, District Nursing and Health Visiting caseloads. It also resulted in the selection of the 6 case study families who were subsequently approached for interview. An overview of the selection of tracer and case study families is presented in Annex 1 of the main report.

The numerous letters and documents included on the following pages are presented as they should provide detailed insight into the nature and scope of this work, if read sequentially. The method of extraction of data from case notes, and the criteria for family selection, are also made manifest within these documents. As such, further explanation seems unnecessary.

[5] The term *tracer* was used simply to mean that the care of particular families would be traced during the evolution of family health nursing practice. For the most part this involved following their care, but at times the FHN and researchers were involved in some joint projective discussions around whether these families would be likely to require sustained input.

28th March 2002

Dear ******* (FHN)

Thanks for updating me on your progress when I phoned recently. We now want to move further forward with the process of identifying two tracer families whose progress we can follow over the next six to nine months.

In order to do this we would like you now to complete the attached forms for 4 families with whom you think you will have some sustained contact over the next six months or so. From our telephone conversations with the FHN pioneer group we know that it is proving difficult for some of you to identify such families, so please be assured of the following:

- we are not looking for "perfect" families or "perfect" family health nursing
- rather, we are interested in the typical nursing that you are doing and that you anticipate doing ie. the reality of the role for yourself and the families that you have on your caseload
- this is likely to include both strengths and weaknesses from the nursing point of view
- we understand that circumstances for families may change during the next six months and that anticipated involvement may not be sustained for a number of reasons

As such, we would like you to select four families whose circumstances and health needs/problems reflect the range on your existing/developing caseload. This can include families of any description or dynamic (eg. ranging from large families with more complex dynamics to individuals living alone). Across the four families it would be good to include a mix of anticipated health needs or existing health problems. It is not necessary that you should have done a Family Health Nursing assessment on these families:- only that you have, or anticipate having, some involvement with them. Finally, we would ask that you include no more than one family that you worked with as an FHN student.

The idea of having a pool of four potential tracer families is that it will give us a basis for further discussion and selection. With your help we will then invite the individuals within the two selected families to take part. This would involve you letting the family know that we will be sending a letter to all individuals aged 12 years or over seeking their consent (children under 12 will only be included with consent from parents/guardians). Their participation will involve granting us access to their health care records as appropriate and occasional phone calls from ourselves to follow their progress. For a few families participation will involve personal interviews (as part of the more in-depth case studies we will conduct with a total of six families across the whole project).

We will only be able to follow the progress of consenting individuals within any family. This is another good reason to have an initial pool of four potential tracer families at each site (ie. selected families may refuse to participate).

Your own ongoing role in assisting us to follow the progress of the tracer families will mostly involve phone calls from ourselves, but also facilitating access to health care records (and occasionally to the families themselves) when we visit each site.

We hope that this letter is helpful in explaining what we are looking for, but please contact either of us if you have any questions or require further discussion. Please complete the attached forms as soon as you can. After we receive them we will be in touch to refine the selection process further.

Looking forward to getting out on the road again! Many thanks.

kind regards

Colin and Bernice

SITE_____ FAMILY NUMBER _____

Family member *(initials)*	**Age**	**Sex m/f**	**Role relationship within family** *(eg. son)*	**How often seen at present**	**Main health need/problem** ***(if any)***	**Related nursing activity**	**Other professionals involved**

Please put a "1" beside the initials of the family member whom you anticipate will require most input from yourself
Please put a "2" beside the initials of the family member who would be the key contact person for this family

Please briefly describe any involvement that you have had with this family so far

_____

_____

Please indicate what caseload (if any) this family was on before you became involved *(tick appropriate box)*

District nursing ☐ Health Visiting ☐ Other ☐ *(please specify)*_____

*Comments*_____

Please indicate why you think following this family's progress could be valuable

_____

Please indicate any difficulties that might be anticipated in following this family's progress

_____

5th June 2002

Dear ******** (FHN)

Finally (!) we have compiled a list of the families that we would like to follow as "tracer families". By the time you read this I will hopefully have spoken with you to get the full contact details for all the members of the 2 families selected from your area.

However before we send out letters to these individuals, we would ask for your help in 2 ways:

(i) by reading the enclosed material. This is what will be sent out to them, so it is important that you know what is in it. This should help you answer some questions that family members might have

(ii) by contacting the 2 families (by phone or in person) to tell them that we shall be sending these letters to all those aged 12 or over. Hopefully this should help prepare the way and you might be able to alleviate natural anxieties that arise at the prospect of contact from researchers!

However if you can't answer particular questions please get in touch and we will try to do so: either by discussion with yourself or by us contacting them directly. In this regard it is worth noting that in most cases we will only be accessing community nursing notes. However we need to keep open the option of gaining access to medical notes, should this be appropriate. In a few cases a more specialist consent form will be required (eg. where the patient cannot sign due to physical infirmity or intellectual difficulties of understanding). However I will hopefully have discussed this already with you if there is an individual amongst your families who might need this sort of form).

Please get in touch if you have any questions. Thanks again for your help with this.

kind regards

Colin and Bernice

PS. Did anyone try eating their porage (porridge??) from the glass bowl?!!

6th June 2002

Mr Name
Address

Dear Mr

As you may be aware, ********** has recently started working as a Family Health Nurse in ********. Family Health Nursing is a new role and we are keen to find out if it is of value in meeting the needs of people living in********. For this reason we are writing to ask if you would be prepared to help with our research.

We would be grateful if you could read the attached information sheet which gives details of what would be involved. If you have any questions, please don't hesitate to get in touch with us. **Will you please return either the blue or the green reply slip as appropriate by 21st June 2002**. A FREEPOST envelope is enclosed so there is no need to use a stamp. Many thanks.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Information sheet about research into the new Family Health Nurse role

Family Health Nursing is currently being developed in the Highlands and Islands of Scotland. The main aim of Family Health nurses is to work with local families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals.

In order to find out how well this new role works in practice, our small team of nursing researchers from The Robert Gordon University, Aberdeen would like to follow the progress of individuals who have involvement with these nurses. For this reason we may also be writing to other members of your family to ask if they would be willing to take part in this research. This sheet is designed to give you information about what would be involved should you be willing to take part.

Our main aim is to find out how your health needs are being met by local services. In order to do this we would like to speak to you on the telephone at least once during the next six months. In addition, with your permission, we would like to be able to look at your health care records and those of any children you may have who are aged under 12 years. This will allow us to follow your progress through these documents. Finally, during Autumn 2002 we may ask to interview you about your recent experiences of health and health services. This would involve one of our researchers visiting you at home. The interview would be tape recorded and we would also ask you to complete a short questionnaire about your opinion of the Family Health Nursing service.

All information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. Although your local GP and Family Health Nurse will be informed if you are taking part in our research, they will not have access to information that you share with us. The tape recordings of interviews will be destroyed after analysis and we will take all steps to ensure that no individual patient or family member is identified in written reports on the project. You are under no obligation to take part in the research. Should you decide to take part you may withdraw at any time without jeopardy to your treatment.

If you decide to participate we estimate that your involvement would not exceed 3 hours in total over the next six months. In most cases this is likely to be substantially less. Should you have any questions, or wish to discuss any particular points, please do not hesitate to contact us.

The research is being carried out in co-operation with local health service staff and is funded by The Scottish Executive. We hope that you will be willing to help in this research as it will help to inform the future development of health services. As such, we would be very grateful if you could return either the blue or the green reply slip as appropriate by 21st June 2002 using the FREEPOST envelope (no stamp required). Thank you for taking the time to read this.

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

CONSENT FORM

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researchers: Dr Bernice West, The Robert Gordon University
Colin Macduff, The Robert Gordon University

please tick box

1. I confirm that I have read and understand the information sheet for the above study, and have had the opportunity to ask questions ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected ☐

3. I understand that sections of any of my health care notes may be looked at by responsible individuals from The Centre for Nurse Practice Research and Development, The Robert Gordon University, Aberdeen, where it is relevant to my taking part in research. I give permission for these individuals to have access to my records ☐

4. I agree to take part in the above study ☐

Name (in capitals) .....
Signed.....
Date.....
Address.....

(If applicable)
As the legal parent/guardian of .....
.....
.....
(please insert names of children under 12),

I give the researchers permission to access the health records of the above named.

Signed.....

Date.....

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researchers: Dr Bernice West, The Robert Gordon University
Colin Macduff, The Robert Gordon University

I do not wish to take part in the above study

Name (in capitals) .....
Signed.....
Date.....
Address.....

CONSENT FORM (to be used where consent is being given on behalf of another due to the other's physical infirmity, or intellectual/cultural difficulties in understanding)

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researcher: Dr Bernice West, The Robert Gordon University

Please read the following two statements and complete the one which applies.

1. As the next of kin/legal guardian/advocate* (*please delete as necessary)* of

.....*(insert name)*

I confirm that I have explained to him/her what would be involved in taking part in this research study. He/she understands that the researchers will access his/her health records and may ask to talk to him/her about health and health services. I am satisfied that he/she is willing to take part.

Name (in capitals) .....

Signed.....

Date.....

Address.....

Name of witness (in capitals) .....

Signature of witness.....

Date.....

Address.....

2. As the next of kin/legal guardian/advocate* (*please delete as necessary)* of

.....*(insert name)*

I confirm that he/she is unable to give informed consent to take part in this research study. On his/her behalf, I agree that the research team can have access to his/her health records.

Name (in capitals) .....

Signed.....

Date.....

Address.....

Dr Name
Address

Date

Dear Dr. ******(GP)

I am writing to inform you that the patients on the attached list have agreed to take part in our research evaluating the role of the Family Health Nurse. The attached information sheet describes the nature of patient participation in the study.

As you will see this involves granting our study team access to relevant health care records. We anticipate that this will mainly involve community nursing and health visiting records. However it is possible that in the next six months we will contact you again in regard to the possibility of accessing medical records. As such, please find enclosed a copy of the appropriate consent forms.

Approval for the study has been granted by the respective Research Ethics Committees within Highland, Western Isles and Orkney. However, if you have any questions about the research, please do not hesitate to contact us.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

FHN TRACER FAMILY DATA:

Form for researcher's abstraction and analysis of nursing case note documentation

FHN site:

Name of family:

Key contact family member:

Family member receiving most input:

Composition of family *(eg. single person; 2 generations and 2 families etc)*

Distribution of presenting needs/problems within family *(eg. single person problem; multiple problems for several family members etc)*

Frequency of FHN visiting

Involvements on other professionals' caseloads *(eg. on existing caseload of d/n; h/v; m/w; new to area etc.)*

Nature of initial referral to FHN ie. Origin *(eg. inhereted from previous caseload; active referral by h/v etc)*

Nature of current dominant need in family *(eg. Chronic; acute)*

Dominant domain for intervention *(eg. environmental and community; physiological etc)*

PRIMARY ABSRACTION FROM DOCUMENTATION

1) Describe format of notes for each family member

IF "TRADITONAL NOTES",

(i) Summarise the story told for index family member

(ii) Summarise the story told for other family members

(iii) Summarise the story told re involvement of other professionals

(iv) Summarise the story told re relationship to wider community

IF FHN NOTES

(v) Summarise the story told for index family member

(vi) Summarise the story told for other family members

(vii) Summarise the story told re involvement of other professionals

(viii) Summarise the story told re relationship to wider community

ANALYSIS OF DOCUMENTATION

Prompts:consider both the forms themselves and the way they have been filled in; Also, before and after comparisons; ethics; legal; research base etc.

(i) Nature and scope of assessment *(eg.model; emphasis; breadth and depth)*

(ii) How is assessment acted on? *(eg. action plan; goals; interventions; outcomes; evaluations etc)*

(iii) Quality and quantity of evidence in relation to other family members and to any health focus

(iv)Quality and quantity of evidence in relation to involvement with other health professionals

(v) Overall strengths of documentation *(eg. comissions)*

(vi) Overall weaknesses of documentation *(eg. serious omissions)*

FINAL CONSIDERATIONS

(i) Who uses the notes and where kept normally?

(ii) Who appears to be the other key professional (if any) involved with this family?

(iii) Are there any sensitivities that might be anticipated in following up this family in greater depth?

(iv) Phone number for key contact family member

12th September 2002

Dear ****** (FHN)

Thanks for your recent help in regard to a) completing the questionnaire on competencies, and b) getting tracer family notes to us so that we could abstract data. The latter process is now almost complete and by the end of the month we hope to have selected six families for more in-depth study.

To make this possible we need you to complete the final part of the tracer jigsaw: ie. the attached questionnaire! Not only that, but we would ask you to **complete and return it as soon as possible** and by Monday 23rd Sept at the latest. You may find some of the questions quite challenging, but it is important that we get your own thoughts and judgements about how work has progressed with these particular families. Your responses will be an important factor influencing the selection of six families for more in-depth study (alongside other data that we have collected and our own perceptions of potential to learn from particular cases).

We will be in touch again soon if one of your families is selected for more in-depth study. Obviously this will involve a visit from one of us, and we would be aiming to interview family members and another key professional (as well as yourself!). If one of your families is not selected, please be assured that it is not a reflection on the perceived quality of your work. We are hoping to learn from a range of cases with different characteristics, rather than to pick the six "best" family health nursed cases. Moreover the focus on these particular families is balanced by the bigger picture of casework at each site which has been built up during this year.

Kind regards

Colin and Bernice

FHN EVALUATION OF WORK WITH TRACER FAMILIES

Family:

1) To what extent have you used family health nursing knowledge and skills in working with this family? *(please tick appropriate box)*

very extensively	extensively	a fair amount	a little	not at all
☐	☐	☐	☐	☐

Please indicate the main fhn knowledge/skills that you used

_____

_____

_____

2) In what ways, if any, has your involvement with this family differed from other possible community nursing service approaches? (*eg. from district nursing and/or health visiting)*

_____

_____

_____

_____

3) Other than yourself, who do you consider to be the health/social care professional who has had most involvement recently with this family? (*eg. other nurse, GP, social worker, midwife etc).* Please give name and contact details below

_____

_____

4) What factors have enabled your own involvement with this family?

_____

_____

_____

_____

5) What factors have hindered your own involvement with this family?

_____

_____

_____

_____

6) Thinking critically of the impact of the family health nursing approach so far within the family, please briefly describe the nature of any benefits and disadvantages for individual family members

Family member's name	**Benefits**	**Disadvantages**

7) How would you rate the overall success of the family health nursing approach so far in addressing the needs of this family?

very successful	**mostly successful**	**uncertain**	**mostly unsuccessful**	**very unsuccessful**
☐	☐	☐	☐	☐

Any other comments

_____

_____

_____

8) Finally, do you think in-depth study of this family's experience of the family health nursing approach could be valuable? *(and if so, why?)*

_____

_____

_____

Thank you very much for completing this questionnaire. Please return it in FREEPOST envelope.

Overall, these processes for identifying and following the progress of tracer families worked well. However our processes had to adapt somewhat to the rate of progress of the development of practice itself. During the first six months of 2002 most of the new FHNs felt that their progress with family work was slow and accordingly several felt that it was difficult to suggest suitable tracer families. In this regard reassurance was needed that we were interested primarily in their typical daily work rather than only their "best" family cases.

The details of the 4 families obtained from each of the 10 sites were mapped on to a giant matrix sheet. This presented a summary of their details in relation to the seven key parameters listed in Annex 1 of the main report. In this way the distribution pattern of typical and non-typical cases could be readily visualised. Our goal was to select 20 tracer families from this (2 per site) so that an optimum permutation of typical and non-typical cases could be achieved. This would ensure coverage of the sort of families and health/illness needs that the FHNs were dealing with most frequently. However it would ensure that we could also follow the progress of families with more unusual circumstances and/or needs (e.g. large, compound families where some of the children have come into the family through one, or both, parents previous relationship/s).

As mentioned in Annex 1 of the main report, following our invitations to take part, 42 individuals accepted (79%). This figure includes five persons aged between 12 and 18 who gave their own consent. The figure does not include a further ten children aged under 12 for whom consent had been given by their parent/guardian. One adult also gave consent on behalf of another adult due to the other's physical infirmity and intellectual difficulty in understanding.

Eleven people (21%) refused to take part. This figure included an eleven year old and a thirteen year old. Where a person refused to take part we did not seek a reason. However it was interesting that 7 of the 11 refusals were from individuals who had contact with one particular FHN[6].

Where one family member refused to take part and the remainder consented, we made a judgement about the wisdom of continuing to follow that family's progress. This was influenced by such factors as whether the member who had refused was a key contact of the FHNs and/or was in receipt of direct care. If the latter factors were the case we would not proceed. However if the member who refused was essentially on the periphery of FHN contact and input with the family, we sometimes decided to continue to follow the progress of the other members on the explicit understanding that no data would be sought in relation to the member who had refused. Where more than one member of the family refused to participate we would not follow the family's progress.

Where we could not follow the progress of one, or even both, of the selected families at a particular site due to refusal, we looked amongst the four initially suggested for another family whose characteristics would fit into the desired overall matrix of 20. If the family seemed to fit, we then approached the individual members with a view to their participation. If none of the remaining families seemed to fit with the desired overall matrix we then asked the site's FHN for details of one or two other families whom we might consider. The latter process was also sometimes necessary when the circumstances of participating tracer families changed (e.g. when they moved from the area).

The detailed considerations described above are all very much part of the nature of research where the family is the main "unit of analysis", but the rights of the individuals within it are paramount. This tension for the researchers mirrors a similar tension faced by the clinicians.

[6] This did not necessarily reflect on the approach of the particular FHN, who in fact became quite embarrassed after a series of patients from different families refused. Interestingly she felt that one of the reasons that they refused was that there was a general feeling in the area that the pre-existing services were satisfactory and they didn't want to take part in anything (i.e. the research) that might be seen to threaten this in any way.

3.2.2 The Case Studies

Annex 1 in the main report also summarises the process involved in gathering data on the twenty tracer families in order to facilitate the subsequent selection of six families for more in-depth case study. The selection process involved detailed consideration and discussion of a number of factors. The overall goal was to select the six cases that seemed to offer most potential insight and learning in relation to the nature and range of FHN work.

The latter phrase requires further explanation. The initial mapping of 40 families onto a giant matrix sheet, and the subsequent selection of 20 tracer families, had given ostensibly equal weighting to seven key parameters (i.e. *composition of family; distribution of presenting needs/problems within family; frequency of FHN visiting; involvement/s on other health care professional caseload/s; nature of initial referral to FHN; nature of current dominant need in family; dominant domain for intervention).* This ensured range of coverage. In following the progress of the 20 tracer families it became clear that some of these parameters would, and should, be more important than others in influencing our consideration of which six family cases to study in more depth. For example the frequency of FHN visiting varied fairly widely over the 20 tracer families and seemed, in itself, relatively less important. In contrast, the distribution of presenting needs/problems within each family seemed more important as a basis for in-depth study of how the FHNs were tackling their new role.

In effect our considerations were guided by re-focusing on what the FHN role was trying to achieve (i.e. in the Scottish Executive's interpretation: to be a skilled generalist; to use a model based on health rather than illness; to care for families rather than just the individuals within them; and to act as first point of contact). This led us to further mapping of all twenty cases in relation to the following parameters: *Primary/secondary/tertiary intervention; perceived extent and success of FHN skills used so far; composition of family; distribution of presenting needs/problems within family; region; involvement/s on other health care professional caseload/s.*

Moreover, during our fieldwork, we had also generated a number of related questions that it seemed might be fruitfully addressed through more in-depth study. Many of these were in a simple *what happens?* format (e.g. *what happens when an FHN consciously expands from the care of an individual who was already on the D/N caseload to addressing the needs of all family members?; what happens when an FHN offers care to a family who have had minimal/no previous contact with local primary care services?; what difference, if any, does the FHN approach bring to the care of patients with chronic illness who are visited daily?*). However they also seemed to predispose to the investigation of a number of underlying *why?* questions if further explored through case selection and interviews.

During the process of this further mapping, we were informed that one of the twenty families was no longer able to take part in the research. Thus we were left to select using mapped data on 19 families. We set about the selection process by systematically interrogating our data using each of the parameters in turn. Thus we asked which six cases would give best insight into FHN work with: families of different compositional types; families with differing distributions of presenting needs/problems; families who had involvement with other health and social care professionals and those who didn't. This process was also informed by the type of fieldwork questions mentioned above.

We also interrogated our data by using the other three more recently generated parameters. In this way we asked which six cases would give best insight into: the range of primary/secondary and tertiary interventions; the varying extent of FHN skills used; the range of success achieved, as perceived by the FHNs themselves[7].

The outcome of this process of interrogation can be likened to overlaying the original matrix with successive sheets of tracing paper on which the six "best" cases for each parameter have been sequentially marked. In this way it was soon evident and clear that a particular set of six families offered the best potential for more in-depth case study using in-person interview methods.

Summary details of the six families selected are given in Annex 1 of the main report. Our approach to arranging interviews with these families, their FHNs, and one or more key professionals also involved in their care, was influenced by our previous experiences of piloting the case study methods.

The piloting took place in Spring 2002 in one of the regions involved in the study. In 2001 two FHN students from this region had carried out their practice placements in areas to which they would not subsequently be returning. As such this meant that there were several families who had been involved relatively briefly with FHN students, but who would not be receiving continuing care from a qualified FHN. Through the former FHN students we approached two of these families (one elderly couple with chronic illness problems; one more "complex" family with five young children[8], one of whom had previous health problems).

This offered potential opportunity to test our approach to families; consent procedures; access arrangements; interview formats, schedules and recording; the consultation questionnaire; and our methods of analysis.

In this way we piloted the consent forms that were subsequently used with the tracer families. On this occasion both individuals in the elderly family declined the offer to participate. We did not seek a reason, but the FHN who had been involved thought that they were both very much preoccupied with coping with their respective health problems and that interviews might be seen as too onerous.

Within the other family, both of the parents consented to take part and gave consent on behalf of their three children who were under 12. However, the two children who were over 12 both declined to take part.

While the relatively high rate of declining to participate raised some concerns for us in relation to future conduct of the main case studies, it did affirm that individuals within families could, and would, exercise choice. This was useful experience as it proved that the consent forms worked and it made us think more about how we would address this eventuality through our methods and future working processes.

---

[7] In mapping the 19 cases using WHO-derived understandings of primary, secondary and tertiary intervention it was usually difficult to assign a case to one discrete category, as interventions were mixed. Thus 5 family cases were deemed "primary/secondary", 3 "secondary" and 11 "secondary/tertiary". Four FHNs reported using their new skills extensively with particular families, 12 reported using them "a fair amount" and 3 "a little". Two FHNs judged their approach with particular families as "very successful" in meeting needs, 13 judged their approach as "mostly successful" and 4 were "uncertain". None judged their input "unsuccessful".

[8] The children of the household comprised those from the parents' current relationship, those from the father's previous relationship, and those from the mother's previous relationship.

In view of restraints of time and access it was decided to pilot our interview methods with the consenting individuals from this one family, and with the other health care professional who had most involvement. The latter individual had been identified by the FHN in response to our questionnaire, which had asked her to evaluate her work as a student with this family (we used the opportunity to test this questionnaire and subsequently made some minor revisions and additions to it). The FHN herself was not at the time able to meet with us for in-person interview due to family commitments so we decided to confine piloting of the FHN interview schedule to a subsequent, informal telephone interview.

We reasoned that our sequence of interviewing should start with the other professional with whom the family had most current involvement. This might forewarn us of any potentially difficult or sensitive issues in regard to the family's health and health care. This arrangement proved possible and we then arranged, by telephone, to visit the family in their home the following day.

We interviewed the other health professional in her own home too as this was most convenient for her. The semi–structured interview schedule that we piloted aimed to explore: *the nature of the health care needs of the individuals who had consented to take part; their contact with health services in general in the past two years, and in particular with community nursing services; the rationale for FHN involvement and its subsequent nature and scope; the impact and outcome of this for these family members; the relationship between FHN involvement and ongoing service provision by other community health and social care professionals.* It also aimed to elicit more general reflections on: *pre-existing service provision in general*; *the fit of the FHN role to this framework; future development of the FHN role.*

The other health professional involved had accessed the community nursing records of those who had consented. This informed her responses during the initial part of an interview that was conducted jointly by both members of the research team. The process was hindered somewhat by the fact that the interviewee only had sporadic contact with the family (her colleague who had recently left the area had been most involved during the past two years). Moreover the interviewee had little direct knowledge of the FHN student's involvement with the family and had to rely on the minimal information that was available in the community nursing notes.

Consequently a major part of the interview involved trying to establish what had actually been taking place in terms of health care needs and service involvement. Even with the community nursing notes available, this was not easily accomplished. The latter part of the interview was more productive in that the interviewee was much more able to furnish us with general reflections on local service provision and perceptions of the FHN role.

The interview lasted around 70 minutes and was tape recorded. It was subsequently transcribed in full. The data was analysed firstly by qualitative content analysis involving grouping content in relation to the factors italicised above (i.e. *the nature of the health care needs of the individuals who had consented to take part, etc*). This framing provided a basis for subsequent thematic analysis. Amongst the themes to emerge were:

- Possible lack of clarity about what the FHN students were doing
- Related lack of clarity about the future role of qualified FHNs
- Health Visitors' ambivalence about whether their own role should be generalist or specialist
- Good pre-existing relations between DNs and HVs in terms of liason and role flexibility, especially where very geographically isolated areas involved
- A danger of FHNs over-reaching their limitations
- GPs' general lack of engagement with the project

Our interview schedule for the family members was designed so as to cover a core of similar factors to those covered in the interview with professionals (and the FHNs themselves). However we were also particularly interested in eliciting perceptions of what the FHN was doing and why she was doing it. In turn we were interested in eliciting comparison between this and the role of any other health and social care staff who had input with family members.

There was also the important and very practical issue of whether to conduct separate interviews with the different family members who had consented (i.e. the male and female partners and the three children under 12), or to interview them all together (or in sub-groups). Astedt-Kurki et al (2001) review some of the methodological issues involved in interviewing families and conclude that the choice of methods is completely dependent on the nature of the particular study.

In the context of our study it was possible to advance arguments for individual or group interviewing. The primary purpose of our interviews would be to explore experiential understandings of the new Family Health Nurse role and this could be valuable from both the individual point of view and from the point of view of the whole family-as-client. The latter perspective was seen as the ultimate goal for the FHN service, but at the time that piloting took place it was not entirely clear to what extent this might be achieved in the reality of practice.

Moreover the pilot interview was somewhat different as we were asking the family members to consider the FHN student's input to the family. We had also decided that both members of the research team should take part in the interview. Although both members of the research team had extensive experience of conducting individual and group interviews, it seemed a valuable opportunity for each to take the lead with different parts of the schedule so that we could share feedback and reflections afterwards.

After much consideration we decided that it might be useful to try to interview the two adults individually (i.e. sequentially) if this was possible. The male partner had said that he would be available if work commitments permitted, and it seemed an opportunity to explore his own perspective on health services and FHN input. Astedt-Kurki et al (2001) cite Backett who states that "too often the views of men and husbands have been ignored, inferred, or developed from women's accounts", and this is a deficiency that has also been noted in relation to health visiting practice with families (Baggeley and Kean 1999).

Moreover we wanted to explore whether it would be feasible to involve the three youngest children in some discussion of health and recent contacts with health care workers. We decided to be flexible in our approach and to explore when and how this might be best achieved *in situ*. Neither of the research team had any substantive experience of conducting research interviews with young children, but there was a shared awareness of many potential difficulties (e.g. being seen as strangers; winning their confidence even at a basic level; the logistics of orchestrating a non-threatening interaction).

On arrival in this busy household we were received warmly. After some general social conversation we took the opportunity to recap on the aims of our visit and to check whether they were happy with this. Although the main living room was obviously the hub of the household the adults thought it would be feasible for us to interview them sequentially in this room, and possibly to involve two of the children later on.

Our interview with the male adult was very interesting and gave us food for thought. He had no particular health concerns of his own, but was able to say a little about the health visiting services that the family had been in receipt of in the past few years. Again he'd had no personal involvement in terms of consulting the HV about his own health needs, but he felt it was useful that the HV would actually come out to the house to see the children. When asked why the HV might be doing this he supposed that it was to do with checking up to see that the children were

being looked after. When this theme was further explored he said that he felt this was ok and that they had nothing to hide, but he did know some people who wouldn't like someone coming in and asking questions.

He hadn't seen much of the FHN student, but couldn't distinguish her role from that of the Health Visitor. He did feel, however, that the idea of a nurse who would look after the whole family was a good one, so that they could keep an eye on things and save bothering a doctor.

Throughout the interview there was a sense of the interviewee's good-natured bemusement as to why we might be trying to tease out so much about this new nursing role. He felt that it was basically a good idea but there wasn't much more he could say about it. As interviewers we were both conscious of the disparity between our in-depth probing and his benevolent humouring of us. After 10-15 minutes we mutually agreed, with some amusement, that there was no more to say and he went to bring through his female partner.

This interview was conducted with the mother cuddling the youngest child who was generally placid and quiet throughout. This interviewee was much more voluble and it became clear that she had been at the centre of all recent contacts from primary care professionals. She had received a great deal of help from the health visiting service in supporting her to care for the child who had experienced serious health problems in the past. Interestingly she felt that she could not always burden her own family with her worries, and the HV had been a great source of support in listening to her and suggesting practical ways of coping. The HV had always given her time and had formed a close and fruitful relationship with the children.

This detailed narrative was accompanied by a quiet conviction that gave it a heartfelt quality. Perhaps unsurprisingly, she was able to clearly distinguish this HV input from the more recent input of the student FHN. She had been happy to help the student FHN to learn through involvement with her family, and was able to recall some of the detailed assessment processes involved (e.g. "*she does sheets of family members with different things and lifestyle of each of the family members and personalities and different things"*). The genogram was also alluded to and she was able to recall some specific advice from the FHN that she had tried to act on. She understood the FHN student to have more time with the whole family as a unit, but that the student would go to the HV supervisor if there was a problem that she needed help with.

She felt the FHN was a good idea and that this type of nurse might be flexible and have more time. She felt that the HV might usually focus more on one subject and on routine assessment checks on the children. However she also felt that the HV had always given her time and been available when she needed her.

Following some more general reflections on local health services, and her relatives' predominantly positive experiences of these, we concluded the interview. The duration was around 40 minutes and the interviewee had needed little prompting to answer questions fully.

By this time the two older children had joined us and the mother suggested that they talk with us alone for a short time. However they were rather shy and reluctant to talk without their Mum there and it became clear that it would be better not to push on this. As so often happens once the tape recorder is switched off and once the "formal" interview is over, there was some interesting discussion which covered a mix of topics. The mother outlined a little about the contact that the children had with the FHN and this encouraged a little disclosure from them. She also volunteered that she had helped the FHN student with her OSCE exam and had been very concerned to "*do the right thing for her*".

Prior to leaving we explained the nature of the Consultation Satisfaction questionnaire (Poulton 1996) that we wanted each of the two adults to separately complete. We felt that it might be useful for them to be able to reflect and complete this in their own time before sending it to us.

This detailed recounting of one pilot situation has been undertaken in order to give the reader insight into some of the issues encountered in trying to conduct interviews in a family household. Moreover our learning was not confined to that immediate situation, as it later became clear that sections of the tape recording were unable to be completely transcribed due to a combination of factors (high ambient background noise; softly spoken interviewees; dialect; poor positioning of recording equipment). Accordingly a more restricted analysis was undertaken and was this informed by notes we had taken in a debriefing session following the interview. The process of sharing impressions and reflections was vital in helping us develop mutual understandings that in turn would inform our future approach to the case study interviews.

In effect the pilot interviews with this family had demonstrated that it would be important to try to achieve as much mutual understanding by phone prior to meeting in person (e.g. in regard to the practicalities of what might be possible). However it especially underlined the need to respond flexibly to the situation encountered. In this regard we reasoned that it might be best in future to give family members the choice as to whether they would prefer to be interviewed sequentially or together. The former option seemed to demand more of the family in terms of time commitment and orchestration.

We later received the two completed Consultation Satisfaction questionnaires. The "tick box" replies to the eighteen statements were consistent in nature with the perceptions expressed at interview, and were also internally consistent (this particular questionnaire often asks the same question in a number of different ways; please see the following section). Neither of the respondents had used the space below each item to expand on their answers through comments, but perhaps they felt that they had already done so at interview.

Prior to selecting this questionnaire for use we had looked at a number of other patient satisfaction instruments. While the conceptualisation and measurement of patient satisfaction is associated with a number of well documented difficulties (Fitzpatrick 1983), we thought it might be useful to supplement our much more wide-ranging interviews with a questionnaire focusing specifically on satisfaction with interactions with the FHN.

The Consultation Satisfaction Questionnaire was originally developed and used with General Practitioners, but Poulton (1996) adapted it for concurrent use with community nurses. As such it seemed generally well suited to our purpose, although several statements required the respondent to delete text so as to distinguish between individual and family consultations (i.e. they required careful reading by the respondent). The only adaptations that we made to Poulton's version were to replace the "doctor/nurse/health visitor" options with "Family Health Nurse", and to add space for comments below each statement. Permission to use the questionnaire was obtained.

After the pilot interviewing in Spring 2002, we selected the tracer families and followed their progress for approximately six months. Through this process we became aware of more issues and questions, some of which were "general" and would be of relevance to the interview questioning across all six family case studies (e.g. *do the family member/s have a copy of the genogram and/or ecomap in the house?)* while others were related to very specific circumstances within one particular family case (e.g. *what happens when there are very many health and social care services involved simultaneously with a family receiving family health nursing?)*. Accordingly our interview schedules for the family, FHN, and other professional(s) evolved so that there was a core set of questions that were common across all the cases and also some very specific questions that had been generated through prior reflection on a particular case. This is evident in the schedules presented on the following pages. The interview schedules are prefaced by an example of the letter of invitation that was sent to the other relevant professional(s). Invitations to family members and the FHNs themselves were usually made by telephone. The Consultation Satisfaction Questionnaire was left with participating family members at the end of the interview, unless they preferred our help in completing it.

Name

Address

5th November 2002

Dear ********** (other health care professional with substantial direct involvement)

As you are aware, Family Health Nursing is currently being developed as part of a pilot project in the Highlands and Islands of Scotland. In order to find out how well this new role works in practice, our small team of nursing researchers would like to get the views of other health and social care professionals who have involvement with specific families.

As such, we are writing to ask if you might be prepared to take part in a short interview focusing mostly on the care of Mrs **********

The interview would take place at a place and time convenient for you, and would typically last around 20-30 minutes. Where it is not possible to meet in person we can arrange an interview by telephone. We would hope to cover the following areas:

1) The nature of your own work with this family
2) The Family Health Nurse's input with this family
3) Any impact on your own role and/or that of other colleagues
4) Reflections on the Family Health Nurse role in general

All information that you share with us will be treated in strict confidence. The interview would be tape recorded and the tape will be destroyed after analysis. We will take all steps to ensure that no individual patient, family member, or health care professional is identified in any subsequent written reports. The research study has been approved by the Research Ethics Committee within your region and we enclose copies of relevant consent forms completed by the family members taking part in the study. Please also find enclosed a sheet giving more information on the Family Health Nurse pilot and its evaluation.

Please complete the attached form indicating whether you would be willing to participate and, if so, what dates might be suitable to you. A FREEPOST envelope is included for your reply.
Many thanks.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Please tick as appropriate

I am willing to take part in a short interview as part of the above study ☐

I do not wish to take part in an interview as part of the above study ☐

Name .....

If willing to participate, please circle any dates that would be suitable for you, giving an indication of suitable times of the day in the space below

	Mon	Tue	Weds	Thurs	Fri	Sat	Sun
October	**21**	**22**	**23**	**24**	**25**	**26**	**27**
	28	**29**	**30**	**31**			
November					**1**	**2**	**3**
	4	**5**	**6**	**7**	**8**	**9**	**10**
	11	**12**	**13**	**14**	**15**	**16**	**17**

Times

_____

_____

INTERVIEW SCHEDULE FOR OTHER CARE PROFESSIONALS INVOLVED IN THE FAMILY'S CARE

CORE QUESTIONS

Thinking of the specific family,

Can you tell me more about the contact/s you have had with the ..... family during the past year? *(elicit which members of family involved; nature and frequency; when last seen)*

How have these contacts come about? (*initiated by self/family or other health care professional? If the latter, who?*)

Can you tell me a bit more about what went on/what happened then and the outcome/s?

Thinking of what you know about the FHN's contacts with this family,

What do you think the FHN was/is doing? What are they trying to achieve? *(communication with other team members; use of nursing notes; shared goals?)*

Is this similar to their previous ways of working or is it different? (*in what way?*)

Do you feel that the FHN's work has been successful so far? *(strengths and weaknesses)*

Thinking about your own role and the work of your colleagues

Has the FHN's involvement with this patient/family had any impact on your own role/working practices or those of colleagues? (*if so, what, how, why?*)

How do feel this role fits in with current local service provision *(similar or different*?)

Who do you think this family/this particular family member would contact first if they had a health problem?

Thinking about this new role in general,

What do you understand by the term Family Health Nurse?

Is it useful? Acceptable to patients?

What do you think about the emphasis on family?

What do you think about the emphasis on health?

CASE SPECIFIC QUESTIONS

A few examples:

1) If she'd been brought back in a supernumerary capacity would you have seen the need?
2) Is there still concern about a possible two-tier service at this site?
3) When you made the referral, what FHN input did you think was needed? How did you make the referral (*formal or verbal)* ?

INTERVIEW SCHEDULE FOR PATIENTS/OTHER FAMILY MEMBERS

CORE QUESTIONS

Yourself and your family

Can you tell me about your own health during the past year?

Can you tell me about any contact/s with health care/social care services in this period (*who initiated contact; what happened? how did you feel about the help you received? outcome for yourself and/or other family members?)*

Can you tell me about the health of other (consenting) family members during the past year?

Can you tell me about their contact/s with health care/social care services in this period (*who initiated contact; what happened? how did you feel about the help you received? outcome for yourself and/or other family members?)*

Contacts with the FHN specifically

Can you tell me more specifically about contacts with the Family Health Nurse *(what did they do with you and/or others in the family? why were they doing this? what did you think of it? what did you think of genogram/ecomap? what did it mean to you? copy of any records in the house? do you use them?)*

Was there any plan, or any goals, that you or the FHN spoke about?

What progress has been made?

How do you feel about the help you received? *(useful? acceptable or delving too deep?)*

Relationship to other services

Is the FHN service similar to previous contact you have had with any health care staff locally, or is it different? (*in what way?*)

Have you noticed any particular change in local health services? (*if so, what?*)

If you have a health problem in the future, who would you contact first?

Thinking about this new role

What do you understand by the term Family Health Nurse/ What does it mean to you?

Is it a useful title?

CASE SPECIFIC QUESTIONS

A few examples:

1) Do you have any contact with the FHN that doesn't involve her visiting you here at home?

2) You have a number of different people providing services to you: do you feel that there is any duplication?

INTERVIEW SCHEDULE FOR THE FHN INVOLVED IN THE FAMILY'S CARE

CORE QUESTIONS

Your contacts with this family

Can you tell me a bit more about the nature of the contacts you have had with family members? *(initial contact/s; establishing relationships)*

What have you been trying to achieve with this family? *(plan; goals?)*

Why? What work has this involved?

Is this similar to your previous ways of working or is it different? (*in what way?*)

Are there any features of the Family Health Nursing model that have proved particularly helpful or unhelpful in this case? *(in what way; why?)*

To what extent do you feel the nursing case notes reflect the input you have had with this family?

What do you think the impact has been for the family members with whom you have had contact?

In the context of your overall caseload, what makes this particular family a "family health" case?

Relationship to other services

Does your input differ from pre-existing community nursing services at this site? *(in what way?)*

Has your involvement with this patient/family affected the role/working practices of other colleagues? (*if so, who, what, how, why?*)

How does this new role fit within the framework of primary care service provision at this site?

Do you think you are the first point of contact for the members of this family?

General reflections

If you could change one thing about your current role, what would it be?

Which is more important in your FHN work- the focus on family or the focus on health? *(ie. if you had to choose one what would it be?)*

CASE SPECIFIC QUESTIONS

A few examples:

1) How does your role as midwife for this family fit with your role as FHN ?

2) How many "family health cases" like this could feasibly be dealt with by one FHN?

3) Would you see yourself doing these child development checks alone and unsupervised in the future?

4) Is your input with Mrs..... primary, secondary or tertiary in nature?

The following statements explore your satisfaction in regard to contacts with the Family Health Nurse. Please delete any of the words *in italics* that may not apply in your case, then put a tick in one box for each statement. There is space beneath each statement should you wish to add any comments.

	strongly agree	**agree**	**neither agree nor disagree**	**disagree**	**strongly disagree**
1. I am totally satisfied with my visits *to/from* the Family Health Nurse	☐	☐	☐	☐	☐

Comments

_____

_____

2. The Family Health Nurse was very careful to check everything when *examining me/carrying out my care/ discussing my family's health*	☐	☐	☐	☐	☐

Comments

_____

_____

3. I will follow the Family Health Nurse's advice because I think *he/she* is absolutely right	☐	☐	☐	☐	☐

Comments

_____

_____

4. I felt able to tell the Family Health Nurse about very personal things	☐	☐	☐	☐	☐

Comments

_____

_____

5. The time I was able to spend with the the Family Health Nurse was a bit too short	☐	☐	☐	☐	☐

Comments

_____

_____

	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
6. The Family Health Nurse *told me everything about my treatment/care/ explained the reasons for advice given*	☐	☐	☐	☐	☐

Comments

_____

_____

7. Some things about the consultations with the Family Health Nurse could have been better	☐	☐	☐	☐	☐

Comments

_____

_____

8. There are some things the Family Health Nurse does not know about me	☐	☐	☐	☐	☐

Comments

_____

_____

9. The Family Health Nurse listened very carefully to what I had to say	☐	☐	☐	☐	☐

Comments

_____

_____

10. I thought the Family Health Nurse took notice of me as a person	☐	☐	☐	☐	☐

Comments

_____

_____

	strongly agree	**agree**	**neither agree nor disagree**	**disagree**	**strongly disagree**
11. The time I was able to spend with the Family Health Nurse was not long enough to deal with everything I wanted	☐	☐	☐	☐	☐

Comments

_____

_____

12. I understand *my illness/about my family's health* much better after seeing the Family Health Nurse	☐	☐	☐	☐	☐

Comments

_____

_____

13. The Family Health Nurse was *interested in me as a person not just my illness/interested in the health of my whole family*	☐	☐	☐	☐	☐

Comments

_____

_____

14. The Family Health Nurse knows all about me	☐	☐	☐	☐	☐

Comments

_____

_____

15. I felt the Family Health Nurse really knew what I was thinking	☐	☐	☐	☐	☐

Comments

_____

_____

	strongly agree	**agree**	**neither agree nor disagree**	**disagree**	**strongly disagree**
16. I wish it had been possible to spend a little longer with the Family Health Nurse	☐	☐	☐	☐	☐

Comments

_____

_____

17. I am not completely satisfied with my visits *to/from* the Family Health Nurse	☐	☐	☐	☐	☐

Comments

_____

_____

18. I would find it difficult to tell the Family Health Nurse about some private things	☐	☐	☐	☐	☐

Comments

_____

_____

Thank you very much for taking the time to complete this questionnaire. Please return it now using the FREEPOST envelope.

The practical arrangements for the case study interviews generally worked out well, but the need to fit around family commitments and professional schedules was always a prominent consideration. One member of the research team carried out all the interviews. The sequencing of the interviews at each of the six FHN sites tended to be determined by transport logistics and availability rather than our original idea of interviewing the family last. The latter idea had arisen from the piloting situation where we knew relatively little about the family's needs and dynamics. In the main study, however, we had been following each family's care and progress for approximately six months and consequently there was less concern about unanticipated problems.

Three of the family interviews were conducted with one person alone. In two of these cases this was because that person lived alone and effectively was the family case in terms of FHN input. In the third case the husband had previously declined to take part in the study, and the daughter of the household had recently moved away and was unavailable for interview. Thus the 58 year old lady was the only person interviewed within that family.

The remaining three family interviews were each conducted concurrently with two participants. In all cases this was the mode that they preferred. In two cases this involved mothers and adult daughters. In the last case this involved an adult male and female who saw the concurrent format as expedient given that their young infant daughter was having a brief midday nap. Unfortunately the plan to interview the two girls within this household (aged 12 and 9 respectively) had to be abandoned as they had gone to see friends.

The interviews with family members ranged from 20 minutes to 50 minutes in length. These were all conducted within the family home, apart from one instance where the mother and daughter found it more convenient to combine the interview with their scheduled trip to the local town (a quiet room in the local health centre was used).

The interview recordings were of reasonable quality and there were very few instances where the transcription of particular passages of speech was not subsequently possible. Where the interview involved two concurrent interviewees there were occasional instances where the interviewer failed to direct questions specifically to individuals, but on the whole the understandings and inter-personal dynamics were good. The pairs of interviewees tended to contribute fairly equally, apart from one instance where an elderly lady preferred that her daughter take the lead role.

The interviews with other health care professionals ranged from 20 to 50 minutes in length. These usually took place in a Health Centre or GP surgery, but one took place in the professional's home and one had to be conducted by telephone. As Annex 2 in the main report indicates, a total of seven other health professionals were interviewed. In one of the family cases it was not possible to interview any other professional who had significant involvement. This was because the family member had little contact with the GP and in any case that GP was unavailable for interview. In two of the other family cases we interviewed two professionals from each site. This was because the family member/s had significant concurrent involvement with several professionals. Some of these professionals had been interviewed more informally on a number of previous site visits.

The interviews with the Family Health Nurses ranged from 30 to 90 minutes in length. These usually took place in a Health Centre or GP surgery, but one had to be conducted by telephone. The greater length of these interviews reflects a number of factors. Firstly, given that FHN practice was the main focus of our study, there was a great deal of material to explore. Secondly each individual FHN was well known to the researcher, and the FHNs were used to being interviewed. Finally the FHNs were usually interested in exploring and explaining their role through discussion, and would make time to do this.

Within the main report, Annex 2 indicates how the outcomes of the analysis of the family case studies (at *micro* level) subsequently informed the construction of knowledge at the *macro* level (i.e. so that CPO patterns could be produced for each site, and so that distinct themes could be aggregated, where appropriate, across all sites). However the process of analysis of the case study interviews requires further explanation.

All the interviews relating to family case studies were subsequently fully transcribed. One researcher listened to each tape several times and read the transcripts in full. A memo was written for each interview summarising its characteristics and quality. The first stage of detailed textual analysis comprised qualitative content analysis (Bryman 2001; Priest et al 2002). This differs from more traditional understandings of content analysis that are predicated on consistency of detailed coding and subsequent quantification (Silverman 1993). Rather we used the common conceptual structure across our interviews as a framework for mapping the emergent themes within each case.

This common conceptual structure can be summarised as:

- Family context, health needs and health care contacts
- FHN input *(what; why; how; impact on family)*
- Comparison with: the FHN's previous role; the coverage and extent of previous community nursing services; concurrent health and social care inputs
- The nature of impact on the FHN, other professionals; local services; the community
- General reflections on the role and what it means for the future

It should be noted, in the passing, that the three core elements within this structure reflect the factors that were examined (in less detail) through the professional stakeholder questionnaire (i.e. *magnitude of practice change* and *nature of impact*). This demonstrates how the study design was consciously layered so that the Family Health Nurse development could be studied in terms of both depth and breadth (again, see Annex 2 of the main study for visual representation).

Thus this common conceptual structure was used as a template (Crabtree and Miller 1992) for subsequent mapping of emergent themes. A data matrix similar to that suggested by Miles and Huberman (1994; page 183) was drawn up for each family case and the themes that emerged from analysis of the family, FHN and other professional interviews were mapped on to each of these six matrices. In order to illustrate this process an example of some of the themes from one family case is presented on the following page. This particular case study was used to illustrate the *Slow/No go* pattern in Annex 4 of the main report. Common themes are presented in coloured print while distinct themes are presented in standard black print.

Interviewee	*Core framework*					
	Family's health and contacts with services	**FHN work & impact on this family**	**Comparison with pre-existing & current roles/services**	**Nature of impact on colleagues/ services/ wider community**	**General reflections on the FHN role and development**	**Other**
Family member(s) **(Mother =** *M* **Daughter =** *D*)	Nurses visit regularly for varicose ulcer *(M)* Nurses helped treat cyst but little FHN input now *(D)*	FHN has good relationship with *M* FHN gave leaflets: not used yet No health plan yet	FHN "takes more time" and "you could talk better to her" *(M)* The other nurses still come & do what they did before: no change	FHN not necessarily seen as first point of contact Generally happy with services as they are	FHN title doesn't mean anything in particular to the family	*M* doesn't really see a problem with her diet Usually all 3 eat together, same food
Family Health Nurse	Longstanding health problems *(M)* Daughter and son both have needs but sporadic contact with services Need to tie all family care together Family are passive users Dominant domain for input is physiological Rest of team's care giving is unchanged	Development of family care thwarted due to lack of time Successful referral of *M* to vascular clinic Did genogram with *M* only Hasn't had a chance to do dietary goals yet	FHN service not substantially different yet Still has a lot of heavy DN cases; few family cases developed so far As an FHN visits more flexibly DN service does address families' needs if apparent i.e. it's legitimate activity Existing notes could be kept and added to by FHN	The usual DN work must be covered and has been FHN not necessarily first point of contact for this family: others still involved Very few referrals from colleagues: PHCT working practices unchanged Able to develop some FHN work in local school but sporadic	Existing PHCT care good but FHN needed FHN still part-time: needs more hours Role not working, as its super-imposed: needs to be supernumerary, over a wider geographic area, should target young, less general nursing care Not viable for FHN to be team leader here yet Community dev role under-developed: ?level of public understanding of role	Could be easier to take on new families where no previous DN contact Often does split shifts: PHCT still 1 short Has kept some families that she saw as a student Enjoys terminal care and teaching others Interested in history of local community and why health-related behaviours have arisen e.g. dietary habits
Other professional	Rest of team cover FHN for input with *M* Input from rest of team is unchanged: any other care input from team would be opportunistic Son goes to diabetic clinic at GPs	Doesn't know a lot re. FHN input beyond what is in the notes Don't know if *M* has had anything extra from FHN beyond what is written in the notes Not sure about FHN's dietary advice and its impact	FHN service not substantially different DN service does pick up family issues but more informally Inherited heavy DN caseload: "DN by different title"	Has had to cover the DN caseload in patch FHN development has made for uncertainty within the team	Role not working, as its super-imposed: needs to be supernumerary However can't really see a gap in the service: no real need for FHN? Could you just enhance DN training instead of training FHNs? Public don't know what FHN is	FHN has developed as an individual and professional "We all want it to work for her" Would it have been better if an unqualified community SN had been given the opportunity? Can NHS afford more health promotion?

Some of the themes that emerged from this qualitative content analysis are expressed in respondents' actual words ("manifest content") but more often they are derived from the interpretation and judgement of participants' responses ("latent content"; Wood, cited in Priest et al 2002).

As can be seen, this analysis method gives a clear overview of differences in thematic coverage arising from the family, FHN and other professional interviews respectively. In turn this facilitated the research team's own reflexive analysis of the strengths and weaknesses of the interview schedule and the way each interview was conducted. In this regard the interviewer was aware of missing some opportunities to ask probing questions or seek clarification in some of the earlier interviews. By the time the final (19th) interview was undertaken this was not the case. In short, technique improved through intensive practice.

The main advantage of this method, however, was that it made it easier to identify which themes were common within a family case, and which were distinct to one interviewee. Thus it can be seen from the matrix on the previous page that there was a common perception that the rest of the team's process of care delivery was essentially unchanged. This perception was shared by all three interviewees.

Common themes that emerged like this were often driven by the core questions in the interview structure that sought to find out:

- what FHN practice was
- how, and to what extent, it worked
- and under what circumstances

In this way they became central to informing the development of the Context-Process-Outcome patterns that would come to constitute the practice typology. The convergence of perceptions in the above example strongly suggested that the introduction of FHN practice had not so far resulted in any substantive change to context or process at the site. Thus, in terms of analytical processing, this theme fed in to the central column of rising arrows depicted in Annex 2 of the main report. It was then checked for fit against other site data such as: the family members' case notes; data from the other tracer family; caseload data; stakeholder perceptions; and data from the wider study of practice within the PHCT. As it was affirmed, it gained substance and momentum and flowed upwards to directly inform the CPO pattern. If it had not been supported by other data we would have explored plausible alternative explanations.

Sometimes during the study we succeeded in eliciting respondents' own theories as to why the development was working or not working. The matrix on the previous page summarises a good example (see also main report, Annex 4 pp 113-116) where both the FHN and the other professional agree that the FHN role is not working locally because it has been super-imposed on district nursing. They both advance an argument for supernumerary status but, when challenged, the other professional doubts the need for the FHN role itself.

These sort of "micro-theories" are seen by Pawson and Tilley (1997) as the essential generative mechanisms that explain why and how a program worked (or did not work). In turn this builds theory that can be tested in further realistic evaluation research studies. The theory of the *key ally* is another example that manifested at the *macro* level of our practice typology.

The purpose of triangulating interview data at the family case study level was not solely to look for corroboration or convergence (Silverman 1993), but also to recognise and explore divergence. In the above case there was a common theme in that the FHN and the other professional both saw the role as not working (and they also agreed why). The interviewed family were supportive of

the FHN in terms of their personal experiences but also generally found pre-existing services satisfactory, and the interview did not elicit a substantive theme in regard to the success or failure of the FHN role within the wider context of primary health care services and community health. Accordingly the theme of "role not working" fed to the right and upwards into the stream in Annex 2 with the double headed arrows. Again the theme was checked for fit against all the other relevant site data and it went on to inform the eventual CPO pattern.

At a more fundamental level, however, the FHN and the other professional had differing perceptions as to whether there was really a need for an FHN role locally. In this case the distinct themes of "need for FHN" and "no need for FHN" were both fed to the right and upwards into the stream in Annex 2 with the double headed arrows. This time these *different* interpretations were checked for fit against all the other relevant site data. The one interpretation that strongly prevailed locally (i.e. no real need seen for the FHN role) went on to inform CPO pattern development as a persistent factor underlying context and outcome. This quality of inherence also meant that it retained potential for aggregation as a distinct theme across most, or all, sites (i.e. it could flow upwards to the diagonal rightwards arrow at the top of Annex 2).

In the case of the perception that diverged from other local site data (i.e. there is a distinct need for FHN role) we explored plausible alternative explanations (downwards arrow direction in Annex 2). In this example we concluded that belief in the value of a distinct FHN role was bound up in this postholder's new professional identity. As such this was handled as a distinct theme which filtered into the upwards stream on the right hand side of the page in Annex 2. This belief was found to be characteristic for the practising FHNs, and consequently the theme gathered upwards momentum to become a uni-professional aggregated theme.

A further example where there was both commonality and divergence emerged through elicited comparisons of the FHN service with the District Nursing service. The FHN and the other professional (who tended to speak on behalf of a core group of colleagues who had discussed their perceptions as a group prior to interview) again shared a common perception that the enacted FHN role was not so far substantially different from the District Nursing service. While both of the interviewed family members felt that all the nurses were good, the mother said that the FHN "*takes more time*" and "*you could talk better to her*". This example is interesting as the mother had received community nursing over many years and was currently receiving regular input from both the DN team and the FHN.

Thus it seemed important to check both interpretations against other relevant site data (via the double headed arrow pathway in Annex 2). While the professionals' interpretation prevailed in terms of informing the CPO pattern, it was apparent that we had little other comparative data from families at this site who had experienced both services. In a sense this highlights a more general limitation of our study i.e. that due to the wide scope and difficult logistics of the study we were only able to obtain in-depth data from a relatively small number of families. It is important to note, however, that the objectives of the study did not include comparison of respective community nursing services in terms of quality of service or the achievement of patient outcomes. Such a research goal would have been very difficult to address adequately and systematically in the context of this policy initiative. Rather the goal was to evaluate family health nursing operation and impact, comparing its coverage and extent with pre-existing services.

Consequently the mother's perceptions were handled as two distinct themes which filtered into the upwards stream on the right hand side of the page in Annex 2. This recognised their validity. Although the themes were supported by interview material from one other site (Site I), they were not clearly supported in the other family interview where there was scope for concurrent comparison of community nursing services (Site C). As such there was insufficient momentum for aggregation of the "FHN takes more time" or the "FHN listens better" themes from family interviews across sites. However these themes do suggest a challenge (!) for further research,

given that FHN input in practice did seem to involve substantial time input and that the educational course was found to be strong in its teaching of communication skills.

These rather detailed examples are presented in order to show how data analysis of the interviews worked and how it fitted into the bigger picture. The presentation of qualitative data from in-depth interviews always presents challenges. Our approach to this in the Annex 4 case studies seeks to give the reader some insights into the wider context by presenting sufficient dialogue from interactions. This approach recognises Silverman (1993)'s criticism of qualitative research that selectively reports only very anecdotal snippets. Rather we have sought to use dialogue that illustrates particular themes that are characteristic of certain patterns (i.e. we are considering the issue of representativeness by using indicative material). Nevertheless there is a sense in which the inclusion of particular chunks of text, rather than others, is necessarily selective and we stand by this.

Indeed the confines and the evaluative focus of the main report meant that it was not possible to include some very rich data that was representative of themes that commonly emerged under the "other" category in the core interview framework.. A major theme in this category related to the experience of living and working as a nurse/health professional in a remote and rural area. The following excerpt from an interview with an FHN gets to the heart of this matter:

FHN: *".....You can't be a person who really wants their privacy. You are in a goldfish bowl. You have to be able to cope with people's interests. You also have to recognise, or to know, to have lived in an area, to be brought up in a country area, to know that this is how country areas live. Remote and rural areas. People do feel they own you. If you've lived in an area all your life there are people who see you as a baby. They maybe fed you a bottle, or changed your nappy, and from that they feel an ownership of you. And they feel it isn't just curiosity or nosiness. They want to know how you're getting on. They feel they've had a hand in bringing you up.....and this is how country people feel if you are part of a community and living there. And it also depends on the experiences you've been through with them. If you've been through a bereavement with them, either their bereavement or yours, these all make big connections in a remote and rural area, and its part of the trust that builds up between Family Health Nurse and the community".*

The outcomes from the Consultation Satisfaction Questionnaire (Poulton 1996) were only briefly summarised within the main report. An individual questionnaire was given to each of the nine family members who were interviewed. This was done at the end of the interview, and only one person preferred that the researcher assist in its completion. The remaining eight family members subsequently returned completed questionnaires by post.

We also left a total of three questionnaires for completion by family members who hadn't been able to be present at the interviews (e.g. the two children who had gone off to friends). These were all subsequently returned, but one of the children and one adult male had not completed the questionnaire. The child (9 years old) did not know how to answer the questions and the adult male felt that he had not consulted the FHN on his own behalf.

Thus there were a total of ten completed Consultation Satisfaction Questionnaires. As indicated in the main report, these were very affirmative of the contacts with the FHNs. Typically respondents were well satisfied with the inter-personal skills of the FHNs and with the thoroughness of their assessments. There was almost no dissatisfaction with the consultations (one respondent felt that a little more time could have been spent). However, only a few respondents added written comments and overall these questionnaires added little to our understanding of the experience of family health nursing. This was probably a case of the researchers going for a "belt and braces" approach where in fact only the interviews were necessary.

The Consultation Satisfaction Questionnaires itself is more suited for large surveys. In passing it is also worth mentioning that we have doubts about the inherent meaning and value of some of the statements in the questionnaire. While we understand that internal consistency checking can be useful, it is difficult to see the inherent informational value in Statement 8 ("There are some things the FHN does not know about me") and Statement 14 ("The FHN knows all about me"). These statements would seem to relate to the "depth of relationship" factor identified by Poulton (1996) and previous developers of the questionnaire. However it would seem odd to suggest that "knowing everything" about a client (if such a thing were possible) directly correlates with depth of relationship. Interestingly several of the FHNs told us that they knew of core data related to family history that clients had either decided not to share during the genogram assessments or had themselves not been aware of. The following example from an interview with an FHN illustrates this vividly:

FHN: *".....you're living in an area for a long time and you have a lot of information also, a lot of which perhaps you cannot write down its that sensitive. But you make connections in your head and you know how the whole community intermingles and you have got a picture of that. Its like the community portrait but its in your head. But there are some things you can't write down.*

Researcher: *Yes, you see that interests me*

FHN: *See, I know some people who are not who they think they are*

Researcher: *Right, even that fundamental?*

FHN: *I know it but they don't*

Researcher: *You know that? You've lived in the area a while, and that's hearing from other people?*

FHN: *Yes*

Thus for small remote and rural communities it seems unsafe to assume that any perceived professional omniscience is necessarily synonymous with a deep personal relationship.

PART 4 THE WIDER CONTEXT

4.0 THE WIDER SCOTTISH CONTEXT

4.0.1 Contemporary understandings of community nursing and the FHN

In Chapter 4 of the main report analysis of contemporary policy issues is followed by analysis of the effectiveness, deficiencies and requirements of community-based nursing, midwifery and health visiting services across the Scottish primary care sector. The methods relating to the telephone interviews and the subsequent approach to analysis are described in the main report. The following pages present the documents relating to these interviews, namely: the letter of invitation; planning and nomination documents; an information document about Family Health Nursing; and the advanced organiser which was used to guide the interview.

Evaluation of Family Health Nurse Pilot Project

As you know I have been working on the evaluation of the Family Health Nurse Pilot Project currently underway in Orkney, Highland and the Western Isles, with my co-researcher Colin Macduff. Over the last year we have been examining the education and practice of family health nurses in their usual working localities.

As part of the evaluation we have been asked to consider how family health nursing may be relevant to other areas of Scotland including urban contexts. To this end we intend to interview (by telephone) key people from various NHS Trusts that provide primary care. Hence this letter asking if you would be prepared to be interviewed on the telephone by myself. I am also seeking your help in identifying two other people to participate likewise: a lead nurse from an LHCC and the chairman of an LHCC (preferably two different LHCC's). If you will provide names and contact addresses I will write to them asking if they are willing to participate.

I appreciate that I am asking a lot given your busy and demanding schedule but I want to be sure that I understand key issues surrounding nursing, health visiting and midwifery care in the community.

The interviews will be recorded (with your permission) and should last between 20-30 minutes. I will telephone at your convenience.

If you are agreeable I will check out my analysis of key issues with you and the other two colleagues. In the final report no mention will be made to you or your organisation by name. I will however recognise your help in the acknowledgements and send you copies of the final report.

I hope that my requests are not too onerous and that you are able to participate. I have attached two brief forms for completion. If you have any queries about the project, please contact me on 01224 262647 (W) or 01224 632840 (H) or e-mail b.west@rgu.ac.uk. Please return the forms to me by 16th July 2002.

With kindest regards.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD

Colin Macduff
Research Fellow
CeNPRaD

Family Health Nurse Pilot Project Evaluation
Telephone Interviews with Directors of Nursing

Name _____

Contact Address _____

_____

_____

Are you willing to be interviewed on the telephone?

Yes ☐ **No** ☐

Optimum date/s for interview (please circle)

July 2002

S	M	T	W	T	F	S
			17	18	19	20
21	22	23	24	25	26	27
			31			

August

				1	2	3
4	5	6	7	8	9	10

Optimum Time _____

Telephone Number _____

Please return this form to me in the Freepost envelope provided. If you have any queries please contact me directly on 01224 262647(W) or 01224 682840 (H) or e-mail b.west@rgu.ac.uk.

Dr Bernice J.M.West
June 2002

Family Health Nurse Pilot Project - Evaluation

Suggestions for participants

Please complete this form giving details of a lead nurse of an LHCC and the chairman of an LHCC who could be approached to participate in this part of the evaluation.

LEAD NURSE Name: _____
LHCC

Contact Address: _____

_____

_____

Chairman LHCC Name: _____

Contact Address: _____

_____

_____

On receipt I will write to each of them individually.

Please return this completed form in the FREEPOST envelope provided.

Dr Bernice J.M. West
June 2002

INFORMATION SHEET ON THE FAMILY HEALTH NURSE

Within recent years, a new type of nursing role called the Family Health Nurse (FHN) has been developed by the World Health Organisation (WHO). The main aspects of the role are:

- the FHN is expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care. This is a model based on health rather than illness
- the FHN is expected to care for families rather than just the individuals within them
- the FHN will be a skilled generalist nurse doing a broad range of duties
- the FHN will act as a first point of contact and refer on to specialists where a greater degree of expertise is required

Within Scotland piloting of this model is currently underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region are involved in undertaking a degree level education programme based on the WHO FHN model. This course (of approximately one year's duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses undertook the course.

Having recently qualified, these nurses are now seeking to further develop and establish the FHN role at their local sites. This role involves identifying aspects of health that individual family members see as important, and then working with them towards improvements. This can include help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. A further twenty nurses commenced the FHN course in early 2002 and are due to finish at the end of the year.

Further information on the pilot project is available at: http://www.show.scot.nhs.uk/familyhealthnurseproject/HomePage.htm

EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with Directors of Nursing: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of.....(your Trust)*, what are the main strengths and weaknesses?

Thinking about current *provision of education for community nurses* within Scotland, what do you see as the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of community nursing services within your Trust, do you see the Family Health Nurse role as being potentially useful and/or viable? (*if so, how?.....)*

Name
Address

5th July 2002

Evaluation of Family Health Nurse Pilot Project

Dear

I am writing on the recommendation of **********, to ask if you would be willing to help with our research.

To explain further, the Family Health Nurse Pilot Project is currently underway in Orkney, Highland and the Western Isles. The project involves the development of a new type of nursing role, as described in the accompanying information sheet. Along with my co-researcher Colin Macduff, I am currently working on an independent evaluation of this new role. As part of the evaluation we have been asked to **consider how family health nursing may be relevant to other areas of Scotland including urban contexts**. To this end we intend to interview (by telephone) key people from various NHS Trusts that provide primary care. Hence this letter asking if you would be prepared to be interviewed on the telephone by myself.

I appreciate that I am asking a lot given your busy and demanding schedule but **I want to be sure that I understand key issues surrounding nursing, health visiting and midwifery care in the community**.

The interviews will be recorded (with your permission) and should last between 20-30 minutes. I will telephone at your convenience.

If you are agreeable I will check out my analysis of key issues with you. In the final report no mention will be made to you or your organisation by name. I will however recognise your help in the acknowledgements and send you copies of the final report.

I hope that my requests are not too onerous and that you are able to participate. I have attached a brief form for completion. If you have any queries about the project, please contact me on 01224 262647 (W) or e-mail b.west@rgu.ac.uk. Please return the form to me by 12th July 2002.

With kindest regards.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD

Colin Macduff
Research Fellow
CeNPRaD

Family Health Nurse Pilot Project Evaluation
Telephone Interviews with Key Representatives
from Local Health Care Co-operatives

Name _____

Contact Address _____

_____

_____

Are you willing to be interviewed on the telephone?

Yes ☐ **No** ☐

Optimum date/s for interview (please circle)

July 2002						
S	**M**	**T**	**W**	**T**	**F**	**S**
14	**15**		**17**	**18**	**19**	**20**
21	**22**	**23**	**24**	**25**	**26**	**27**
			31			
August						
				1	**2**	**3**
4	**5**	**6**	**7**	**8**	**9**	**10**

Optimum Time _____

Telephone Number _____

Please return this form to me in the Freepost envelope provided. If you have any queries please contact me directly on 01224 262647(W) or e-mail b.west@rgu.ac.uk.

Dr Bernice J.M.West
June 2002

EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with LHCC Lead Nurses: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of.....(your LHCC)*, what are the main strengths and weaknesses?

Thinking about current *provision of education for community nurses* within Scotland, what do you see as the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of community nursing services within your LHCC, do you see the Family Health Nurse role as being potentially useful and/or viable? *(if so, how?)*

EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with LHCC Chairpersons: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of.....(your LHCC)*, what are the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of primary care services within your LHCC, do you see the Family Health Nurse role as being potentially useful and/or viable? *(if so, how?)*

EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with Local Health Council Chairpersons: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of.....(your LHC)*, what are the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of primary care services within your LHC, do you see the Family Health Nurse role as being potentially useful and/or viable? *(if so, how?)*

One member of the research team carried out all of the telephone interviews. These interviews with key informants were an attempt to elicit a range of relevant contemporary understandings of community nursing and family health nursing in Scotland. As Table 4.1 and Annex 6 in the main report illustrate, these telephone interviews were successful in this regard. While we were able to identify themes where there was relatively widespread agreement (e.g. experience of the workforce; duplication of effort), the sheer diversity of perspectives was often striking. Perhaps unsurprisingly this was particularly marked in relation to family health nursing.

A few interviewees had obviously considered the FHN role in some depth, but more often there was very little prior knowledge of the concept. In the latter circumstance the interviewees often looked to the interviewer for more information and interpretation of the role. This was quite understandable in as much as the researcher was often the interviewee's sole point of engagement in regard to this concept. In these circumstances the researcher would provide some further contextual detail in regard to the pilot project, but the core representation of the project remained consistent with the information sheet that had already been sent to the interviewee. These sort of interactions gave the researcher more insight into the various ways that this information sheet was perceived, and also highlighted the practical difficulties that the project steering group and others had in explaining the FHN initiative.

A number of contextual factors will influence reciprocal interaction within any one telephone interview (Chapple 1999). In approximately one third of these telephone interviews the interviewer and the interviewee were already known to one another through previous work-related contacts. This immediately brings a different social dimension to the interaction and must also be acknowledged as a possible influence on the process and content of the interview (e.g. prior mutual knowledge of values and beliefs may influence the interviewee to respond in a way that they think the interviewer might expect/want). Annex 6 attempts to accommodate such concerns by making manifest subsequent judgements made about perspective, knowledge and personal stance, and quality of interview.

4.0.2 Steering Group meeting data collection

During the course of the study we had ongoing contact with members of the Advisory Group and occasional contacts with members of the Steering Group. Towards the end of the study we undertook more formal data collection from both of these sources.

Firstly we were invited to a Steering Group meeting in September 2002 which was considering "exit strategy" for the pilot project. While we had been sent the minutes of previous Steering Group meetings, we were not part of the Group and had only previously been present at two meetings for the short time that it took to present an outline of our work. On this occasion it was agreed that there would be mutual benefit in the research team being privy to the particular part of the meeting that involved discussion of future options.

These discussions were structured by the Steering Group so that three sub-groups would each address the same four possible outcome scenarios. These were:

1) That the FHN role is not an appropriate model to meet the health needs of remote and rural communities

2) That the FHN role will be further developed within the four NHS Boards already involved in the pilot

3) That there will be exploration of the FHN role within other remote and rural NHS Boards

4) That further investigation of the role will be carried out in other areas such as urban settings and/or with specific client groups

These concurrent sessions were scheduled to last for 75 minutes and were followed by feedback from each of the groups in turn and a general discussion. It was agreed in advance that the researchers' role would be non-participatory and that the discussions would be recorded on audio tape for research analysis purposes only.

Accordingly the study team were joined by a research colleague, Dr Mike Lyon, so that each of the three group discussions could be observed in person and audio taped. All three researchers were then present at the subsequent feedback and discussion session.

After the event the three researchers had a meeting to discuss initial perceptions of the data. Each researcher then listened several times to the recording from their group and produced a detailed written summary of the themes that emerged, the group dynamics and underlying issues. These were then shared and discussed in depth at a subsequent meeting which also involved similar consideration of the feedback and discussion session.

This data informed our thinking at a number of levels. At a primary level it afforded much insight into the thoughts of individual Steering Group members. A total of 19 Steering Group members attended and they represented a fairly wide range of interests (e.g. service management; professional organisations; professional groups such as doctors and district nurses; a lay representative; education; the European project). Interestingly there was less diversity of perspective on the future than might have been anticipated with this sort of mixed group (e.g. all quickly rejected Scenario 1). There were differences on future emphasis but these seemed to relate mainly to the shared feeling that a project of this sort necessarily generated as many questions as answers.

At a secondary, analytical level there was insight into the differential power of various voices, professed values, tacit/embedded understandings and shared aspirations. In this regard it was clear that the Steering Group functioned through an affirmative, action-orientated, policy making

ethos. Three tentative explanatory models (derived primarily from a sociological perspective) were generated by Dr Lyon in order to inform the researchers' analysis of the meeting. These related to: embeddedness; consensualisation and centre-periphery relations. By building this sort of interpretative reflection into our analytical processes we were able to step back from the immediate personal contexts of the evaluation and be refreshed by wider perspectives. This seems a very necessary part of research teamwork.

4.0.3 Advisory Group interviews

The second element in our collection of formal data from those involved in driving the project involved interviews with two members of the Advisory Group. These took place at the end of 2002 with a view to eliciting overall reflections on the project. The basic thematic framework used to interview the 19 key informants from Primary Care was supplemented with a number of further questions (please see the next page).

EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with Advisory Group members 26/11/02: main themes for exploration

(i) Thinking about community nursing in Scotland at present, what do you see as the main strengths and weaknesses?

(ii) Thinking about current provision of education for community nurses within Scotland, what do you see as the main strengths and weaknesses?

(iii) How might Family Health Nursing make a difference?

(iv) How do you see Family Health Nursing fitting with existing primary care structures?

(v) Thinking of the development of the FHN pilot project in Scotland, what do you see as the main strengths and weaknesses?

(vi) What, if anything, would you do differently if managing a similar project in the future?

Again these interviews were useful in informing our thinking about the origins, evolution and future of the initiative as perceived by those near to the centre of policy making. The timing of the interviews facilitated reflection on a number of the wider issues that emerged during the project. These included the rationale for the FHN pilot project, indicators of success, and the actual experience of acting as a driving force within the project.

PART 5 FINAL REFLECTIONS

5.0 FINAL REFLECTIONS

5.0.1 Design and conduct of the study

In concluding this supplement to the main report, it is timely to reflect briefly on the overall design of the study and our approach to evaluation research.

It is useful to start by reflecting on what we knew when we designed the evaluation in response to the invitation to tender for this work. Some contextual information was provided along with the aim of the evaluation and the six proscribed objectives. Design was made difficult, however, due to the following factors:

- Little was known about the nature of the educational course
- Very little was known about the students who might undertake it (e.g. how many would undertake the course and what would their backgrounds and motivations be?)
- The FHN role was hypothetical but the hypotheses were general and sketchy
- Consequently there was very little known about the actual role that they would undertake in practice
- The participating regions were known but the geographic locations where FHNs would practice were not known

In effect it was clear that many of these questions would be addressed and clarified as the project progressed. Accordingly it seemed important to build a fair amount of flexibility into the study design. Initially we had considered whether it might be possible to design the study of practice so that there was a major comparative element (e.g. by studying "control" sites with similar characteristics where family health nursing was not being implemented). This notion was not seriously entertained for long. Firstly it was clear that the "intervention" (i.e. family health nursing itself) was evolutionary, diffuse and therefore difficult to operationally define. In turn this meant that it would be very difficult to hypothesise which outcomes might be sensitive to this intervention so that rigorous comparison might be made. Thirdly the distinctive characteristics of many of the remote and rural locations meant that in-depth knowledge of context would be necessary before one could confidently "pair-off" intervention and control sites.

In short we believe that an attempt to design and conduct the evaluation within this sort of quasi-experimental framework would have been a methodological and logistical nightmare. This conviction grew as the reality of applying our own design to practice unfolded. It seems likely that a control group design would have involved so much attention to the validity of possible comparisons (and matters of research method) that the researchers' eyes would be diverted from the job in hand (i.e. studying the operation and impact of the FHN role as it was actually enacted). The analogy that a quasi-experimental design repeatedly evoked was that of trying to fit the FHN octopus into a pair of starched, dress trousers: an uncomfortable experience all round, with the ever-present danger of getting snagged in the tentacles!

All this is not to suggest, however, that our own design was perfect. From the main report and the CD Rom it should be clear that we believe that the particular needs of an evaluation study such as this are seldom met sufficiently by one exclusive methodological approach. That is to say we do not believe in a recipe book approach to evaluation research. Rather there is a need to creatively customise designs in order to address complex problems. Most of the progress in evaluation research over the past 50 years has occurred through such need (for instance, see the journey of discovery undertaken by Guba and Lincoln 1989).

Nevertheless a study design informed by Pawson and Tilley (1997), Guba and Lincoln (1989) and Yin (1994) is necessarily a complex mix. In this regard we recognise that Pawson and Tilley's approach usually involves the prior generation of theory for testing. While it would perhaps have been possible at the start of the project to set up a very generalised change theory similar to that

posited by Redfern et al (2000) for their multi-site evaluation, it is debatable whether this would have been of value or a distraction. So many factors were unknown at the start of this project.

One of our main baseline aspirations was simply to produce clear description of the FHN phenomenon as it evolved. However we also aspired to explanation and the production of a typology has gone some way to generating "micro-theory" that can be further interrogated. Similarly our use of multiple case study methodology has been influenced by Yin's explanatory methods, but we were not in a position to overtly test theory at the start of the study. Our incorporation of design elements from Guba and Lincoln recognises the value of incorporating stakeholder perspectives but decidedly makes no attempt to broker concensus amongst them. Moreover, while we broadly endorse Guba and Lincoln's views on the importance of context, we share Pawson and Tilley's basic premise that some generalisation across contexts is possible and indeed desirable.

This demonstrates some of the underlying complexities of drawing on a number of methodological perspectives that are not necessary compatible if adopted in their entirety. However it also demonstrates that it is most unlikely within the paradigm wars, that one methodological perspective has a monopoly on the truth. We hope to publish further on these issues in due course.

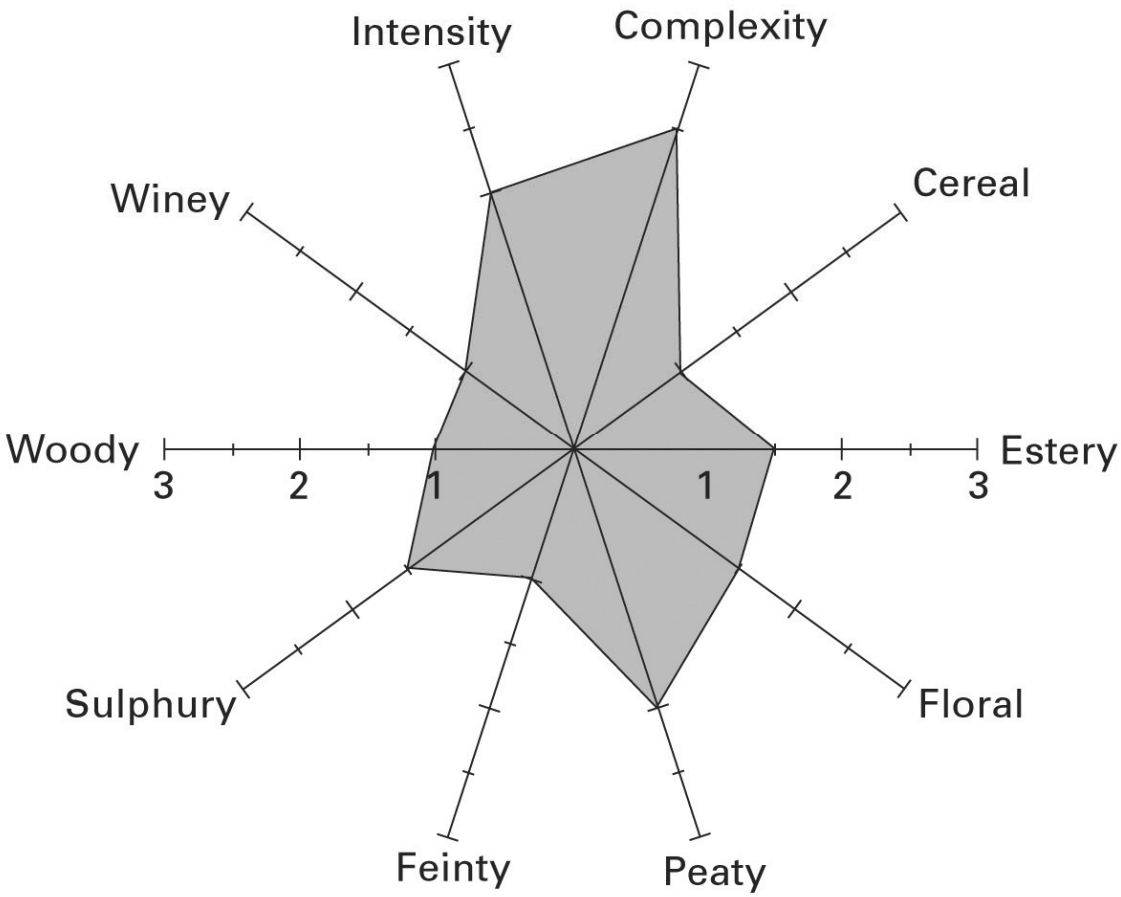
5.0.2 Seen through a whisky glass

Within the main report and this CD Rom we have sought to make our methods as explicit as possible. We believe that this work comprises a sound body of evidence that lays a foundation for further family health nursing research. However this is something that only the individual reader can decide. At the end of the day, the proof of the pudding is in the eating. If you have managed to stay with us through the considerable methodological menu that we have presented, we hope that you feel replete and satisfied. It remains only to suggest that you now partake of one of the excellent range of malt whiskies that are produced in the regions that participated in the Family Health Nurse project (unfortunately not downloadable yet through the CD Rom format!).

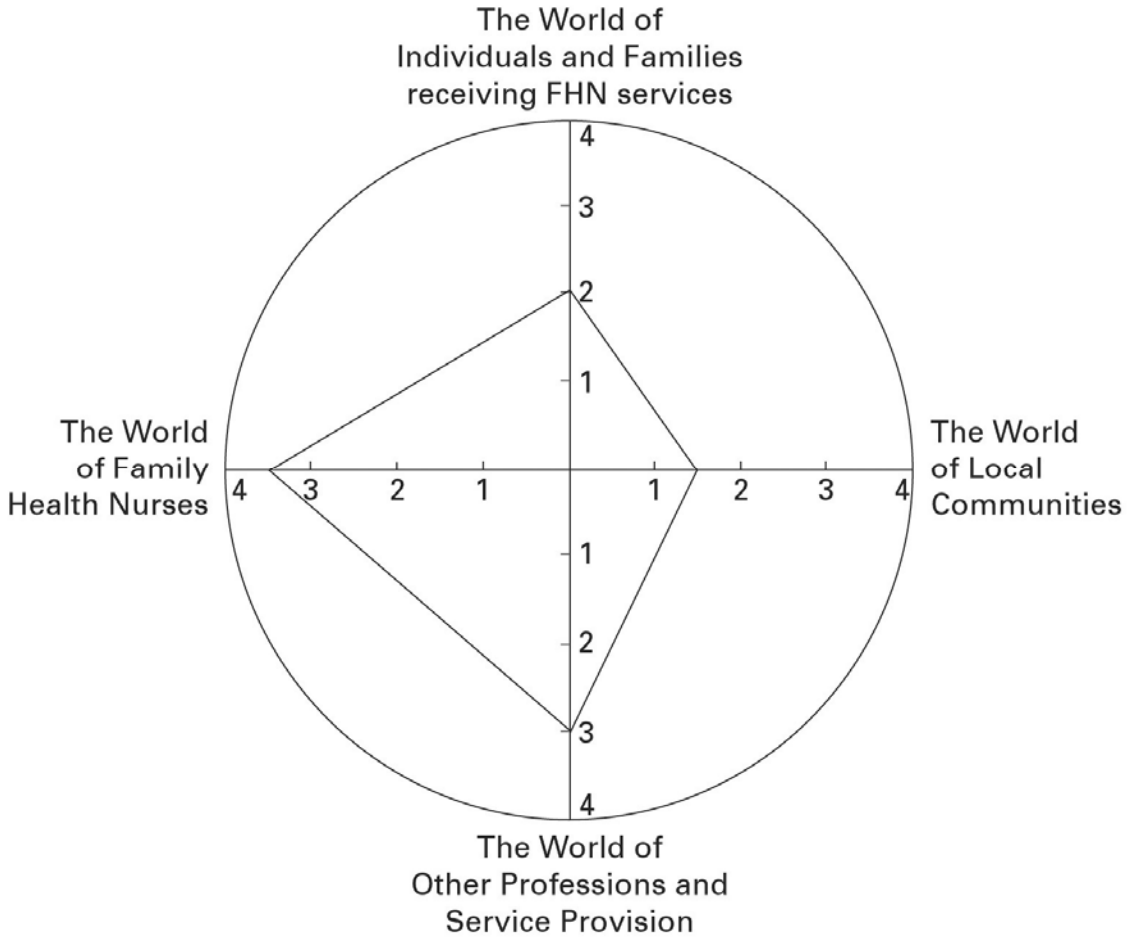
In concluding on this theme, we wish to use the principle of the whisky tasting wheel/star to illustrate and summarise the character of our evaluation study. Firstly, on the next page we present a tasting star that visually represents the key characteristics of one of the finest whiskies to be found in the regions involved in the FHN project[9]. As researchers we do not make this assertion lightly. Rather we have come to this conclusion on the basis of systematic study, based again on *mixed* methods employed when on field trips. Thus the first phase of this research involved an ethnographic element where we *immersed* ourselves in local culture. Thereafter we adopted a purposive *sampling* strategy where a *case* study was made of each malt. Initially the principle unit of analysis was standardised at ¼ gill, but we often found that *single* case study methods were inadequate and that *multiple* units of analysis were necessary. After extensive research we can confidently corroborate Yin (1994)'s assertion that multiple units of analysis are synonymous with *embedding*!

[9] This tasting star is © Copyright 1997 Distillers.com Ltd. Permission has been kindly granted to use it in this context.

TASTE CHARACTERISTICS OF A FINE MALT WHISKY EVALUATED DURING FAMILY HEALTH NURSE RESEARCH



Having illustrated the tasting star, and having explained our painstaking endeavours in the name of research, it remains only to apply the principle to give a final, reflexive overview of the characteristics and coverage of our own evaluation study.



Slainte!

Colin N Macduff

Dr Bernice JM West

Aberdeen

December 2003

PART 6 REFERENCES AND COPYRIGHT

6.0 REFERENCES AND COPYRIGHT

6.0.1 References

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ANNEX 3: KEY INFORMANT INTERVIEWS

The interviews with key informants conducted during summer 2005 were a distinct part of the empirical research carried out for the overall PhD study. This Annex presents details of the methods used and the resultant findings. As the analytical processes were substantial and sequential, the Annex is organised into a number of distinct parts, as indicated below.

PART 1: The nature and scope of the key informant study

1.1 Background and rationale

1.2 Aim

1.3 Design and methods

1.3.1. Sample

1.3.2 Ethical considerations (with letter of invitation; information sheet & consent form)

1.3.3 Interview methods (including example of an interview schedule)

1.3.4 Data analyses

PART 2: Findings – first stage analysis

2.1 Interview with Anne Jarvie

2.2 Interview with Ainna Fawcet-Henesy

2.3 Interview with Majda Slajmer Japelj

2.4 Interview with Professor Margaret Alexander

PART 3: Findings – second stage analysis

3.1 Core ideas within the themes which emerged from interview with Anne Jarvie

3.2 Core ideas within the themes which emerged from interview with Ainna Fawcet-Henesy

PART 4: Findings – a synthesised narrative on the emergence of FHN at European level

PART 5: Findings –application of theoretical frameworks from policy analysis

5.1 Application of Kingdon's model to the European emergence of the FHN concept

5.2 Application of C-C-C model to the European emergence of the FHN concept

5.3 Application of Kingdon's model to the Scottish emergence of the FHN concept

5.4 Application of C-C-C model to the Scottish emergence of the FHN concept

References

PART 1: THE NATURE AND SCOPE OF THE KEY INFORMANT STUDY

1.1 Background and rationale

The need to seek perspectives on the development of family health nursing from key informants became ever clearer as the overall PhD study progressed. By 2005 a substantial amount of primary empirical research had been carried out to inform the construction of a comprehensive, in-depth, explanation of the development of family health nursing in Scotland. To recap, this comprised:

- Phase 1: A national evaluation of family health nursing through study of education and practice between 2001-2002 (Macduff and West 2003). This involved collection and interpretation of a large range of data including interviews with Family Health Nurses (FHNs), professional colleagues, patients and their families.
- Phase 2: A follow-up study of professionals' perspectives on the development of family health nursing (Macduff 2005)
- Phase 3: A study of Family Health Practice Development Facilitators' perspectives on the development of family health nursing (Macduff 2005)

The PhD work also involved review of extant literature relating to the family health nursing concept as proposed by the World Health Organisation (WHO) Europe in 1998. As such this involved accessing and interpreting a range of international texts and also material related specifically to the Scottish context.

Through a combination of these primary and secondary research strategies, a set of advanced understandings about family health nursing were constructed by 2005. However, one key source of knowledge about the development remained untapped, namely, the small group of people who were instrumental to the initiation and promotion of the concept. Thus I designed a study which sought to carry out in-depth interviews with this target population.

1.2 Aim

The aim of the research was to elicit the perceptions of key figures in the development of family health nursing in relation to the central concerns of the study i.e.:

1 How and why did the family health nursing concept emerge through WHO Europe in 1998, and why was it subsequently enacted in Scotland? (i.e. why develop family health nursing?)
2 Why has it developed in the way that it has so far in Scotland?
3 What are the implications of this in terms of policy, practice and theoretical understandings of nursing?

In addition to seeking reflexive overview on these themes, I was also seeking answers to a number of specific questions which had arisen from prior data analyses. Accordingly, in-depth interview was seen as the method of choice for this study.

1.3 Design and methods

1.3.1 *Sample*

The target sample was seen as comprising three individuals who were thought to be at the heart of relevant developments. These were:

- Ainna Fawcet-Henesy (AFH), WHO Europe Regional Advisor for Nursing from 1995 onwards. AFH was known to be on extended leave due to illness.
- Anne Jarvie (AJ), Chief Nursing Officer for Scotland from 1992- 2004. AJ had retired fairly recently.
- Professor Margaret Alexander (MA), who was Director of the WHO Collaborating Centre at Glasgow Caledonian University during the period when the FHN concept was developed. MA was known to have been involved in the development of the FHN conceptual framework and curriculum.

However, the design also incorporated scope for expansion of this initial purposive sampling strategy through the "snowballing" method i.e. if these three key informants agreed to participate and identified others whose perspectives they saw as crucial to understanding the origins and development of family health nursing, consideration would be given to interviewing these individuals. In this way it was thought possible that the interviews might involve between four to six people. As events transpired only one further key informant was identified in this way and interviewed. This was:

- Majda Slajmer Japelj (MSJ), International Manager in the WHO Collaborating Centre for PHC Nursing in Maribor, Slovenia, during the time when FHN was being developed. MSJ also worked for WHO Europe in Copenhagen as Temporary Adviser/Short term consultant for transition countries.

1.3.2 *Ethical considerations*

The focus on very recent historical events which had been driven and shaped by key individuals presented both opportunities and challenges. The former related to the events being within recent times, thus increasing the likelihood that potential interviewees might be traceable and able to recall involvement relatively easy. The latter pertained to the possibility that participants' involvement might be mediated substantially by concerns related to their present employment (particularly if still involved with the FHN development), their ongoing relationships with other key actors, and/or their management of any consequent impressions recorded within this historical account.

The latter concerns raised ethical questions about the nature of participation, identification of participants and subsequent attribution of information. One possible approach to addressing these would have been to offer all potential participants anonymity by referring only to "a key informant at European level" or "a key informant at Scottish level". Ostensibly, this strategy seemed to have possible advantages in regard to promoting participation and disclosure. However, the main argument against this approach was a desire to be more explicit about the accounts of individuals whose leading involvement was already a matter of public record. Moreover it was thought likely that participants would engage in impression management to some degree irrespective of the interview approach taken. As Silverman (1993) points out, interviewees' accounts are both situated and contingent. After much deliberation, it was decided to invite key informants to participate on the basis that all interview data would be "on the record" and potentially attributable personally to them. To support this approach, appropriate documentation was prepared and ethical approval was subsequently granted by the School of Nursing and Midwifery Ethics Review Panel. The letter of invitation to participate, study information sheet, and consent form are presented on the following four pages.

LETTER OF INVITATION TO PARTICIPATE

RGU headed notepaper

Addressee
Address

Date

An analysis of the development of family health nursing in Scotland (2000-2004) and its implications for policy and practice: interviews with key informants

Dear

I am writing to invite you to participate in the above research which I am currently undertaking as a PhD student. The study aims to build a comprehensive, in-depth, explanation of the development of family health nursing in Scotland between 2000-2004. As your own involvement in the development during this period has been particularly significant, I would like to learn about your own personal perspectives on the subject through an interview.

The attached information sheet gives full details of what would be involved. I would be very grateful if you could read this, complete the appropriate part of the attached consent form as desired, and return it to me in the FREEPOST envelope by _____.

I do hope you will be willing to take part as it seems important that understandings of family health nursing are informed by the perspectives of the key people involved in its initiation, promotion and enactment.

Many thanks.

Yours sincerely

Colin Macduff
Research Fellow

INFORMATION SHEET

An analysis of the development of family health nursing in Scotland (2000-2004) and its implications for policy and practice: interviews with key informants

This briefing sheet is designed to give you more information about my PhD study and the aspect of it that I am inviting you to take part in. The study aims to build a comprehensive, in-depth, explanation of the development of family health nursing in Scotland between 2000-2004. This is important because Scotland has been at the forefront of enactment of the WHO Europe Family Health Nurse concept since it was announced in 1998. During this period the approach within Scotland has been to encourage the building of a strong evidence base about family health nursing so that implications for policy and practice can be derived and lessons learned. In turn this knowledge has informed concurrent developments at wider WHO Europe level.

To date, my own involvement in this activity has included three related research studies that will inform my PhD work:

- A national evaluation of family health nursing through study of education and practice between 2001-2002 (Macduff and West 2003). This involved collection and interpretation of a large range of data including interviews with Family Health Nurses (FHNs), professional colleagues, patients and their families.

- A follow-up study of professionals' perspectives on the development of family health nursing (Macduff 2005)

- A study of Family Health Practice Development Facilitators' perspectives on the development of family health nursing (Macduff 2005)

The PhD work also involves review of a range of published literature relating to the family health nursing concept. To date, however, one key source of knowledge about the development has remained untapped, namely, the small group of people who were instrumental to the initiation and promotion of the concept at European and Scottish level. As one of these "key" individuals, I am now inviting you to take part in an interview in order to learn from your own perspectives on the development.

Specifically, the interview would seek your views in relation to three questions that are central to my study:

1 Why did the family health nursing concept emerge through WHO Europe in 1998, and why was it subsequently enacted in Scotland?
2 Why has it developed in the way that it has so far in Scotland?
3 What are the implications of this in terms of policy, practice and theoretical understandings of nursing?

Within these general themes, I would also like to explore a number of more specific questions which have arisen from data analyses to date. Some examples would be:

1 Thinking of the concept's origins, to what extent do you see it as driven from within nursing and to what extent do you see it as driven from outwith nursing?
2 On reflection, what do you see as the advantages and disadvantages of the model of project management (i.e. National Steering Group; Project Officer; Local Steering Groups; commissioned educational provision and independent research) developed within Scotland?
3 How do you feel family health nursing "fits" within other concurrent UK primary care developments such as the GMS contract?

I very much hope that you would find these interesting and worthwhile topics for discussion, and I'd be most grateful for your personal perspective on these. I would anticipate that the interview would take between 60-120 minutes. Ideally I would like to carry out the interview in-person at a suitable location that is convenient for you. If this were not possible, the interview could be undertaken by telephone. In either eventuality, I would like to record the interview on audio tape.

I have given much thought to the issues of anonymity and confidentiality. On balance, I feel that it is better that I ask for your participation on the basis that the interview is "on the record" and that resultant transcribed material may be attributed directly to you in future publications. My thinking is based on the fact that your key involvement in the FHN development is a matter of public record and attempts to confer anonymity may engender confusion in relation to presentation and interpretation of data. Rather, I propose to offer you a copy of the audio taped interview and the subsequent transcription of it. In this way there would be a clear basis from which any subsequent interpretations could be made, discussed and/or challenged.

The master copy of the audio tape and transcription would be stored in a locked filing cabinet drawer within the School of Nursing and Midwifery at The Robert Gordon University. This material would be held for five years then destroyed. During the storage period access to the tapes and transcripts would be limited to the researcher, his supervisory team and any appointed external examiner. However, requests for access to the tapes and transcripts would be considered in accordance with the principles of both the Freedom of Information Scotland Act 2005 and the Data Protection Act. The study has been approved by the School's Ethics Review Panel.

I very much hope that you will be willing to take part. I hope to carry out the interview at a mutually convenient time between June and October. Should you require any further information about the study, or if you have any questions, please do not hesitate to contact me or my Director of Studies, Dr Bernice JM West (b.west@rgu.ac.uk).

Colin Macduff, Research Fellow, tel: 01224 262647 or c.macduff@rgu.ac.uk
School of Nursing and Midwifery, Robert Gordon University, Aberdeen

INTERVIEW CONSENT FORM

Title of Research study: An analysis of the development of family health nursing in Scotland (2000-2004) and its implications for policy and practice

Name of Researcher: Colin Macduff, The Robert Gordon University, Aberdeen

*Please complete **either** PART A or PART B of this form and return it in the FREEPOST envelope.*

PART A

I confirm that I have read and understand the information sheet and letter of invitation to take part in an interview for the above study. I understand that the interview will be recorded on audio tape and that resultant transcribed material may be attributed to me directly. I also understand that I will be offered a copy of the audio tape and the resultant typed transcription for my personal use. I confirm that my participation is voluntary and that I am free to withdraw from the study any time.

I agree to take part in the above study ☐

Name (in capitals) .....
Signed.....
Date.....
Address.....

PART B

I have read the information sheet and letter of invitation to take part in an interview for the above study. **I do not wish to take part.** ☐

Name (in capitals) .....
Signed.....
Date.....
Address.....

1.3.3 *Interview methods*

Before giving more detail on the approach that was taken to conducting these interviews it is useful to briefly recap on the conceptual foundations that underpin them. This thesis is a study of contemporary nursing history grounded within the constructivist-interpretive paradigm (Denzin and Lincoln 1994). It is concerned to build, through interpretation, an explanation of a phenomenon so as to achieve Rafferty's (1997) goals of "writing, researching and reflexivity in nursing history". As such, the task in hand is to engage with and to try to understand individual and/or group constructions relevant to the enquiry (e.g. through in-depth interviews). Through a process of interpreting this material, privileging some accounts more than others, and bringing personal accumulated knowledge to bear, a new explanation can be constructed.

Within this context, the key informant interviews were the final phase of data collection. As such, the content of questions was informed by accumulated understandings of the phenomenon to date, and accumulated unresolved issues. As indicated above, the three primary research questions underpinning the entire thesis were used to structure these interviews. This seemed appropriate as the key informants were in a position both to contribute reflexive overview on one or more of these overarching research questions, and to address very specific questions which had arisen from ongoing data analyses. Some of the latter explicitly reflected theory/explanation building and the informants were invited to affirm or reject these constructions, and/or present their own interpretations. Thus the interviews shared a common core structure but were individuated in terms of the emphasis on particular areas of enquiry and the specific questions asked. The structured schedule that was prepared for interviewing Anne Jarvie is presented on the next four pages in order to give an example of what was involved.

Although the schedule is structured and lengthy, it should be noted that it was never anticipated that it would be possible (or necessarily desirable) to ask all the questions in the sequence indicated. Rather the overall plan was to try to ensure coverage of key thematic areas and key topics within these (indicated by highlighting and colour coding respectively). In this sense the interview was seen as semi-structured i.e. there was a working expectation that there should be flexibility to explore themes both as they were presented and as they arose. This recognises the need for some compromise between interviewer agenda and interviewee agenda. The latter consideration is particularly important when interviewing senior figures in key leadership positions. Puwar (1997) highlights how the micro-politics of the relationship between the researcher and the researched can be influenced by gender and perceived status. Similarly, in reflecting on interviews with elite groups, Chapple (1997) emphasises the need to prepare thoroughly and be self-aware when interviewing.

These were important considerations when planning the interviews. However there were also other factors that might potentially have influence. Firstly it was known that two of three key individuals who comprised the "target" sample were no longer actively involved in the FHN development, having retired from their senior positions. Secondly, I had already met all these people occasionally through working on the FHN evaluation. Perhaps the most important part of the preparation was trying to set the correct tone for the interviews. From the documentation included above it can be seen that the interviews were presented as an opportunity with potentially mutual benefits. While parts of the interviews were explicitly involved in checking researcher understandings relating to key people, texts and sequences of events (almost in the way of a journalistic interview), there were also parts that invited deeper reflections and exchange of emergent understandings. In this sense the interviews deliberately attempted to evoke a slightly distanced historical perspective that was concerned with trying to understand the immediate past so as to move thinking forward and learn from it. These aspirations are incorporated in the example of the interview schedule that now follows.

INTERVIEW GUIDE FOR KEY INFORMANT: ANNE JARVIE

1) WHY AND HOW HAS THE FAMILY HEALTH NURSING CONCEPT EMERGED IN EUROPE AND IN SCOTLAND?

When and how did you personally first become aware of/involved with the FHN concept?

(i) Thinking of the development of the concept in Europe:

Why did the concept emerge and how?

What was the need for it?

Who were the key people who made it emerge? Was it driven from within nursing or without? What sort of involvement did you have personally in this?

The specific question of its name: why family, and who named it?

The concept itself: what was the relationship to the Health for All Nurse? what was different/new? what was useful?

What were the key processes at European level? Support? Resistance?

Who linked it to Scotland and how?

(ii) Thinking of the need for the concept in Scotland:

Was there a lack of nursing that addressed the needs of individuals, families and communities?

The particular emphasis on family: from my analysis of policy documents at the time (Towards a Healthier Scotland; NHS A plan for action, a plan for change), family occurs occasionally but more an implicit theme. So to put the emphasis on "family" explicitly was a bit different. How did you feel about this, in terms of the match to policy?

Do you personally believe that the family is the most important unit in society?

The official dimensions of the Scottish FHN role: a health orientated approach; recruitment and retention; first point of contact (one person); family focus; generalist. Which did you see as most important?

Who were the key people who made it emerge in Scotland? Who did it really matter to? Why bother?

Was it driven from within nursing or without? Relationship to other developments in Scotland? (e.g. GPs; midwifery).

(iii) Thinking of the planning for enactment of the concept in Scotland:

In Madrid in 2003 there was a WHO Europe meeting to review progress on FHN. The main barriers to progress for many countries seem to have been securing support from key stakeholders and getting financial backing. You gave a summary of how you did both and got £1.3 million funding from Susan Deacon? How did you go about this? How difficult was this? Was it "extra" money on top of current budget? How did it compare to other funding in your dept and the total budget?

What sort of reaction did you expect to the idea from the Scottish nursing/midwifery/HV community? From other professions? Chief Medical Officer? Was opposition greater or less than expected?

Some people said that the development was a stalking horse or trojan horse (for the reform of community nursing). To what extent was that true?

How would you characterise the risks and benefits personally? What were your expectations of what would actually happen?

Why remote and rural? What as the fit with other government policy?

Historically Highlands and Islands have often been used by the government as a test area for new policies/schemes. What do you say to the criticism that this was an easy option that has ensured that it is marginal and doesn't threaten any pre-existing healthcare hierarchies?

Thoughts on pre-existing community nursing in Highlands and Islands. Was there a problem with the actual care not being family orientated enough?

The specific question of its name: usefulness of "family" in a Scottish nursing context?

Why go for a pilot with education, project management (Steering Group and Project Officer etc) and evaluation? Was this a model that you had used before or knew to be useful/successful? How would you characterise the risks and benefits in this? Was central control crucial?

The "independent evaluation" was often cited as an important part of this in that it would generate evidence to inform policy. To what extent was it a risk management strategy?

It was deliberately presented as an experiment, and kept from interfering with concurrent reviews of medical staffing (GPs) and even midwifery provision. Was this useful in the short term? Long term? i.e. could it be counter-productive: not upsetting anyone and not changing existing roles?

2) WHY HAS IT DEVELOPED IN THE WAY THAT IT HAS IN SCOTLAND SO FAR?

(i) Thinking of the enactment of the educational programme and role development in practice:

How did you envisage the education initially? Can you say anything else about the educational programme and its progression?

Who were the key shapers of the development as it progressed in Scotland?

Thinking of the evaluation team's report on the first year of practice, to what extent did it accord with your own perceptions of development?

If you accept that it gave a reasonable picture of first year of practice, why do you think FHN practice developed this way? Is it what you would have expected/hoped for?

How do you see progress in remote and rural since 2003?

How is it fitting with other important concurrent developments (e.g. practice nursing?)

The Glasgow pilot?

3) WHAT ARE THE IMPLICATIONS OF THIS IN TERMS OF POLICY, PRACTICE AND THEORETICAL UNDERSTANDINGS OF NURSING?

(i) Relating Scottish progress to Europe:

Were you disappointed that other more developed countries (e.g. other UK countries) did not take up the challenge at all, or did not drive forward more quickly?

What difference might this have made for you and the project?

Was Ainna's move to a different WHO Europe post in 2001 a problem?

What do you think the final multi-national evaluation will show?

(ii) Reflecting on lessons learned and implications for the future

Where now? Is FHN sustainable or inherently marginal?

Would you agree that SEHD policy on the FHN is ambivalent?

We now have another CSPQ yet no-one said they wanted this at the start: can FHN prosper if DN and HV/PH nurse remain unchanged?

Is there a place for a generalist? Is "family" a problem name?

How do you feel the FHN sits with other primary care developments like the GMS contract?

When you spoke recently in Aberdeen, you expressed some concern that nursing was returning to a more task-orientated agenda: where do you see the FHN within this all?

How does it compare with other challenges that you faced during your time as CNO?

Did it ever feel out of control?

I'm interested in theories that would help explain the FHN development: one is Anne Marie Rafferty's idea of context-convergence-contingency. If you accept that the H&I and WHO contexts converged in 1999/2000, what was the contingency or "spark" that made you drive it forward?

How important was getting FHN as a recordable qualification on the register (UKCC)?

In her analysis of policy in nursing, Professor Jane Robinson suggests that typically with any health policy development some groups of nurses gain at the expense of others. Who have been the winners and losers so far in the FHN development?

If there are no losers, is that actually the problem? i.e. there hasn't really been a development, just a fitting in and around exercise? (path of least resistance)

In my analysis, one of the main tensions is between the desire for a generalist nurse and the family specialism that the North American (and WHO model) brings. How do you see this? Was there too much emphasis of North American family assessment tools in the Scottish curriculum?

Was it not radical enough? What about Nurse Practitioner possibilities?

Why no parallel development of Family Health Physicians in Scotland?

Can FHN in Scotland prosper if WHO Europe project doesn't?

What would you do differently if you were to do this sort of thing again?

Is there anything that you'd like to say about FHN project now that you couldn't when you were CNO?

(iii) Further research:

Is there anyone else I should speak to in order to understand the development of family health nursing in Scotland?

As inclusion of the above interview schedule suggests, Anne Jarvie (AJ) agreed to take part in the study. Interview subsequently took place in Glasgow on 28/06/05 (face to face, audio-taped format). The interview lasted for approximately 140 minutes. Ainna Fawcet-Henesy (AFH) also agreed to take part in the study despite contending with fatigue due to recent illness. Interview was undertaken by telephone (audio-taped) on 24/06/05, and this lasted approximately 100 minutes. Thus the two key nursing figures in the development of family health nursing up to 2005 kindly agreed to share their perceptions.

These two interviews covered a great deal of ground and, while there were differences of emphasis in answers to some of the common core questions, there was clear corroboration of a core narrative in terms of key people and key events. Moreover definitive answers to a number of very specific questions that had emerged during earlier research were obtained. This meant that the main aim of this part of the PhD study was substantially achieved through the two interviews.

Professor Margaret Alexander (MA) had already agreed to take part in the study, but had indicated that she felt her involvement was much more peripheral than AJ's or AFH's. Following further discussion it was mutually agreed that it would be most productive to conduct interview by e-mail i.e. by sending a list of questions that MA could address and respond to. This was duly achieved during July 2005.

In earlier discussions MA had strongly recommended interview with Majda Slajmer Japelj (MSJ) who had been International Manager in the WHO Collaborating Centre for PHC Nursing in Maribor, Slovenia, during the time when FHN was being developed. MSJ had also worked for WHO Europe in Copenhagen as Temporary Adviser/Short term consultant for transition countries. As such, she was seen as having comprehensive knowledge and valuable insights into the evolution of the FHN development at European level. After MA kindly facilitated contact, MSJ agreed to take part in a similar e-mail interview. This was undertaken during July 2005.

1.3.4 *Data analyses*

Analyses of the resultant data were undertaken via a specially designed four stage process which is now described prior its application being demonstrated in Parts 2-5 of this Annex.

The first stage of the analytic process initially involved familiarising myself with the data. This was done by listening to the audiotapes of the two main interviews several times, and carrying out a full transcription of this substantial body of material on to paper. A copy of the relevant audiotape and its transcription was then sent to each of these interviewees. My Director of Studies, Dr Bernice West, also listened several times to both tapes, as a basis for discussion of findings and analytic approaches. I also re-read the e-mail correspondence from the other two interviews.

The next phase within this first stage can be characterised as a qualitative content analysis (Bryman 2001; Priest et al 2002) which produced emergent themes. This shares some similarities with the approach taken to interview analysis during the 2001-2003 FHN evaluation study (see Annex 2, Section 3.2.2 for full details) in that the conceptual framework for each interview (i.e. the main areas of questioning/interviewer-presented themes) is used to form one dimension of a data mapping matrix. This draws on techniques suggested by Miles and Huberman (1994) and on the more recent "Framework" approach described by Ritchie, Spencer and O'Connor (2003). These themes (which reflect major points from the interview schedule) can be seen as "exogenous" in the sense that they have already been generated from outside the interaction and are introduced by the interviewer. The matrices presented in Part 2 of this Annex show these themes in the far left column.

The middle column of these matrices consists of what I came to term a "core relevant narrative formed from the interview". The purpose of this approach was to create a distillation of the parts

of the interview with most relevance to the enquiry, and to present these in a logically sequenced narrative. To this end key content was summarised by using a combination of relevant verbatim quotations from the interview transcipts and "formulated meaning statements" which provided linkage and context. The use of formulated meaning statements was adapted from the phenomenological data analysis techniques of Colaizzi (cited in Tuck 1995) who derived "formulated meaning statements" from primary textual material. In phenomenological studies these are used to convey the core meaning or essence of an interviewee's experiences, and I had found these useful in a previous study (Macduff 1998). In the context of these key informant interviews, however, the technique was being applied in a looser, less intense way to summarise core content that could help structure and link an interview narrative.

The main body of this narrative, however, comprises relevant verbatim quotations from the interview transcipts. This approach attempts to convey relevant, characteristic and important dialogue from the interview to the reader. By including substantial sections of verbatim dialogue, the approach seeks to address Silverman (1993)'s criticism of qualitative research that selectively reports only very anecdotal snippets. Rather, many of the passages that have been selected show the flow of dialogue between interviewer and interviewee. Many also reflect what qualitative researchers regard as "thick description", in that the text captures reflexive analysis or evaluation of developments and offers consequent interpretation that makes personal sense of this.

The far right hand column of the Tables in Part 2 of this Annex (2.1 – 2.4) lists the themes which I saw as emerging from within each interview. These themes relate to the primary subject matter of the enquiry and can be termed "endogenous" in the sense that their genesis is from within the interview dialogue. Although I necessarily abstracted them to some extent through subsequent interpretation, the aim has been to reflect the interviewee's own ideas and use of words whenever possible. This process was checked and validated by my Director of Studies. Again, Part 2 of this Annex has been designed to demonstrate the application of this process as a part of the first stage of analysis.

The second stage of analysis, demonstrated in Part 3 of this Annex, involved further scrutiny of the emergent themes from the interviews. This attempted to look beyond the primary subject matter of the enquiry in order to identify and explore the inherent, "core" ideas which underlay the thinking of the two main interviewees. By reflecting at length on the emergent themes then identifying recurrent ideas and characteristic ways of thinking and expression, I constructed a small set of core ideas from each interview. Again this process was informed by dialogue with my Director of Studies. These themes are listed in the left hand column of Tables 3.1 and 3.2 of this Annex. The right hand column then summarises the understandings that I derived about these ideas. Much of this relates to policy and its enactment in nursing, and the matrices from second stage analysis are used to inform the development of ideas in Chapter 8 of the thesis itself.

The third stage of analysis, demonstrated in Part 4 of this Annex, was designed to identify where there was a common narrative in relation to the development of family health nursing, and where there was divergence across the four interviews. As mentioned previously, the interview schedules had some core common questions, but were individually tailored to optimise learning opportunities from key informants with distinctive roles in the initiation, promotion and enactment of the FHN concept. Therefore cross-case analysis (comparing and contrasting individual responses) and subsequent synthesis of perspectives was only undertaken where appropriate. As Table 4.1 in this Annex shows, this was almost entirely in relation to the core common questions on the emergence and development of the concept at European level. This table also shows that contradiction and/or substantial divergence in regard to narrative of events and their causation was not found across the four interviews. Thus it was possible to synthesise a central narrative. However there were two important areas (FHN concept and role) within which individual interviewees placed distinctly different emphases. This table is used in Chapter 8 of the thesis to summarise understandings of events derived from key informants who were involved in shaping them. This provides a useful counterpoint to the understandings derived exclusively from review of relevant literature in Chapter 3 of the thesis.

The fourth and final stage of analysis, demonstrated in Part 5 of this Annex, involved the use of two theoretical frameworks from policy analysis literature. As Ritchie, Spencer and O'Connor (2003) point out, such an approach can be useful for relating particular findings to a broader context in order to build explanation. Prior to the key informant interviews a number of theoretical frameworks for policy analysis were explored, and two from within nursing seemed to have potentially good explanatory value (based on accumulated understandings of the development of family health nursing). These were:

- The "Context – Convergence – Contingency" framework (Rafferty and Traynor 2004)
- The "Winners and Losers" framework (Robinson 1997)

Subsequently the core elements of these frameworks were outlined to both AFH and AJ in the course of interview in order to gauge the degree of perceived "fit". Following the key informant interviews it became clear that Robinson's framework was likely to have limited explanatory value in this particular context, and that a less profession-specific theoretical framework from the world of general public policy analysis (Kingdon 1995) might give a more useful counterpoint to Rafferty and Traynor's model. Thus two theoretical frameworks were applied as analytic templates (Miller and Crabtree 1992) to interrogate both the understandings already derived from stages 1-3 of analysis of the interview material, and the understandings already derived from review of relevant literature. This facilitated exploration and comparison of "macro" explanations of the emergence of the FHN concept at European level (see Tables 5.1 and 5.3 of this Annex) and Scottish level (see Tables 5.2 and 5.4).

In order to aid interpretation of Part 5 it is necessary to summarise the main elements of both of the theoretical frameworks. Kingdon's agenda setting model is well summarised by Peckham and Exworthy (2003), and it is worth quoting their description of it:

"Kingdon's model examines how issues get on to the policy agenda in the first place and how they become translated into policy *(Kendall 2002)*. The various streams must be connected before the "policy window" opens. The model is useful in explaining how opportunities for policy formulation and implementation are created and destroyed. The *problem stream* comprises evidence of the nature of an issue which becomes defined as a problem amenable to policy interventions. This evidence might be crisis incidents, research results, patient feedback or performance indicators. The *policy stream* consists of proposals, strategies and initiatives to address the problem. These often pre-date the problem being recognised and circulate in a "primeval soup" awaiting their identification. This requires a critical mass of stakeholders to appreciate the merits of the policy. The merits must include an accordance with (political or organisational) values, a technical feasibility and a recognition of future constraints. The *politics stream* comprises party politics, organisational power struggles and interest groups. These three streams may be connected by natural cycles (such as elections), crises or the actions of a policy entrepreneur, an individual or individuals who invest their reputation, status and time in joining the streams in order to open and keep open the policy window. Natural cycles, complacency or the entrepreneur's departure might force the window to close".

As Hill (2005) notes, Kingdon's model is derived specifically from analysis of public policy in the USA and, to my taste, the combination of the soup, stream and window metaphors is a rather uneasy one. Nevertheless its application to both the European and Scottish dimensions of the FHN development in Part 5 usefully highlights possible explanations of how and why the concept was moved onto central agendas and promoted. Moreover it highlights a number of explanatory factors that could be influential in the future development and enactment of the FHN concept. Accordingly this material is used extensively in Chapter 8 of the thesis to try to build explanation of the "macro" policy level development of family health nursing, and to subsequently relate this to the "micro" level of local enactment in Scotland as analysed in Chapter 7.

The "Context – Convergence – Contingency" (C-C-C) model was first outlined in a study of international trends in nurse education (Traynor and Rafferty 1999):

"Attempting to identify the key ingredients of successful nursing educational reform in different countries has suggested that three sets of conditions need to be satisfied for change to follow. These relate to context, convergence and contingency. Context refers to the creation of a positive climate of opinion or a case and pressure for change. Convergence refers to the fortuitous fusion of professional and government agendas. Contingency provides the unforeseen consequence, the spark that ignites a political change. Well articulated, rational arguments within the profession appeared necessary but not sufficient to move largely indifferent governments until the moment that some contingency arose. The latter might be an unforeseen policy imperative, largely unconnected to the original content of nurses' lobbying."

The model is developed further when analysing recent UK research policy (Rafferty and Traynor 2004). Here the consequences for nursing's political leadership are highlighted:

"....successful policy change in nursing requires the sometimes serendipitous synchronisation of professional and government agendas. This has been evident in case studies in the past *(Rafferty 1996).* Three sets of conditions need to be satisfied. First, the context needs to be "primed" for the proposed change to happen; secondly, the priorities of government and the profession need to converge and thirdly, the role of contingency or some fortuitous factor such as timing needs to be right. The role of political leadership in this process relies upon several interrelated activities; first the ability to "read" the policy environment; second to identify targets for influence and third to mobilise the resources and champion the case for change".

As can be seen, the C-C-C model shares some of the Kingdon model's key elements, such as the notions of deliberate alignment of key elements and related action. However Kingdon's model focuses more on agenda setting and policy formulation, whereas Rafferty and Traynor's model takes analysis further towards policy implementation/translation. The C-C-C model also has a much more overt focus on the role of fortuitous timing in determining successful policy change. Perhaps this reflects nursing's relative unimportance within the power hierarchies of UK healthcare planning and provision (Robinson 1997; Davies 2004). When applied to both the European and Scottish dimensions of the FHN development in Part 5, the C-C-C framework thus provides a slightly different lens through which to focus on events and explanations. Accordingly this material is also used extensively in Chapter 8 of the thesis to try to build explanation of the "macro" policy level development of family health nursing, and to subsequently relate this to the "micro" level of local enactment in Scotland as analysed in Chapter 7.

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Having described the four stages of data analysis used for the interviews, the application of each stage is now demonstrated in Parts 2-5 of this Annex. These present the main findings from the study of key informants.

PART 2: Findings – first stage analysis

2.1 Interview with Anne Jarvie

TABLE 2.1 INTERVIEW 1: ANNE JARVIE (AJ)

PRIMARY QUESTION 1) HOW AND WHY DID THE FHN CONCEPT EMERGE IN EUROPE AND SCOTLAND?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EUROPEAN EMERGENCE		
1) Own involvement and with whom? **2) Who were the key people who initiated the FHN concept?**	From early 1990s quite close involvement with WHO Europe nursing department. Worked periodically with Ainna Fawcet-Henesy (AFH) and Dr Jo Asvall (JA). AFH particularly interested in community nursing. JA felt nursing skills under-exploited and potential to expand into some aspects of GP role. HEALTH 21 policies being formulated (around 1997). *AJ: I didn't know what it was going to say, I didn't know what it was going to look like, but I knew that there was going to be some advocacy around exploring the role of the nurse in the community setting* JA and AFH were key initiators of FHN concept, but AJ had also built up network of European CNOs through WHO Europe conference involvement. *AJ: I was usually on the planning group for those meetings …….I was hearing where they were all coming from and their kind of thinking around community nursing*	Established relationships with key initiators of FHN. Established European CNO network. New European health policy framework opportunity. Euro advocacy for community nursing.
3) The FHN concept and its evolution?	***AJ*** *…the Health for All Nurse is actually another name for the FHN. It was the same concept that was being generated if you like.* ***CM:*** *Yes, yea. I've sort of looked at the, in fact I've looked at the outcomes of that Glasgow meeting* (1994) *and the statement about Health for All and I can certainly see that the elements of individual and family and community are all there: it just seems as if in the following years the sort of family part became a bit more upfront* ***AJ:*** *Absolutely, and I think that again was Dr Asvall. He liked to consider the family as the unit that they should be interested in if you like. Because I think he saw if you did that there was a better chance of getting into preventive and promoting health, rather than responding when things had gone wrong. Now you really need to do both, but he saw the family unit as the opportunity for you to anticipate, lets put it that way.* ***CM:*** *Right, right. So yes, so you sort of supported the Health for All Nurse in that way, in a general way. But at that time presumably there wasn't any sort of explicit agenda to bring the Health for All Nurse to bear on community nursing in Scotland?* ***AJ:*** *No, and I suppose I thought that we had more than enough community nurses if I was being honest, you know, but what I was more interested in was the role of the HV and the role of the School Nurse*	Concepts of HFA nurse and FHN virtually the same. Family emphasis driven by Dr Asvall as a means to the end of ill-health prevention/ health promotion: a way in. Community nurses need to anticipate but also respond In 1990's AJ's interest in addressing HV and School nursing grew. However did not attempt to enact Euro HFA nurse role then.
4) Feelings about the word family in the title?	*CM: …but the actual word "family" arriving in 1998 for this role of Family Health Nurse, ehm how did you feel about that? Ehm were you totally on board with that?* ***AJ:*** *I was on board for the concept. I was a bit worried because what is the family unit now?* ***CM:*** *Yes* ***AJ:*** *So I always saw a definitional problem, potentially.*	Some reservations about emphasising family, but overall concept of FHN seen as potentially valuable.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
SCOTTISH EMERGENCE		
1) Context: what was the Scottish background to your involvement? **2) What was the policy context and how did the FHN concept emerge as relevant?**	Between 1992 and 1996, managing the move of nursing education into HEI's was predominant. This laid a foundation for nursing development. In late 1990's, post devolution, a flurry of new general Scottish policy especially on health and social care: *AJ: And it was just because we had all the general policy, health policy, that we needed, that then we could say, I could say, I need to do this to demonstrate what nursing and midwifery's response will be to all of that.* However AJ had already developed some ideas on modernising community nursing: *AJ: It felt to me as if we weren't sufficiently focused on promoting health and the health agenda. And ehm so thats when I began to be really interested in how we could modernise the thinking around health visiting.* ***CM:** Right, right. So that was kind of brewing in the mid 90's?* ***AJ:** That was brewing in my thinking and I was at that stage looking for some kind of opportunity, because you've always got to wait until your opportunity comes for doing something about it. So ehm when the White Paper came out I was able to say in it that we would do a review of the contribution made by nurses and midwives to the public's health, and at the same time, able to say that "Now look we are going to look fundamentally". And by then remember, after the..ehm particularly after the Acute Services Review that Sir David Carter did, there was much more emphasis on remote and rural than there had been before. Now I'm not saying it hadn't been there, but it was centre stage. So, that while I had kind of thought that the FHN probably didn't have a place in Scotland, other than maybe to think through some of the concepts that were to underpin the notion of the FHN that maybe could help us to modernise the preparation programme for health visiting and school nursing, I didn't actually think we would come up with something called a Family Health Nurse, until the remote and rural .. ehm agenda developed.* ***CM:** Right* ***AJ:** And at the same time we were beginning to see gaps in availability of General Practitioners.* This was recognised as an opportunity: ***AJ:** It all came together towards the end, around 1999/2000, in a way that made it possible for me to push this.* This was supported by the Minister, as part of a wider range of activities. The explicit emphasis on family was not seen as problematic in terms of its fit with policy.	Laying foundations for nursing development Tackling the big core issues first Responding to key new health policies and building from them in an ordered way. Modernising health visiting under rubric of public health Articulating nursing's public health contribution Importance of timing. Modernising educational programmes for HVs and school nurses within one Public Health Nurse programme. Remote and rural health care provision issues becoming much less marginal to central policy. Initial doubt that FHN could be applicable in Scotland, until remote and rural agenda started to move. GP recruitment and retention problems growing in remote and rural areas. Health and remote/rural policy agendas felt to be converging and, in this context, it was possible to try FHN pilot. Timing crucial. Health and nursing already highlighted as important. Family seen as generally positive.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
SCOTTISH EMERGENCE		
3) What was the need for the FHN concept?	*AJ: ....we needed to modernise what was happening in the community setting. And Public Health Nurses was one aspect of it. Family Health Nurse was "Well let's see if there's a hybrid role here that is more akin to the gatekeeping role of the General Practitioner that allows public health practice to be there alongside clinical practice, if that's what's needed within the family setting.*	Modernisation Trying out hybrid role Integrating public health and clinical practice
4) Who initiated the introduction of the FHN concept to Scotland?	***CM:** Can I, just to sort of finish off the idea of taking the idea of family health nursing from Europe, is it fair then to say that you pretty much ehm brought it in yourself ehm you know from WHO Europe – it wasn't a case that there was a lot of other people sort of lobbying you to do this?* ***AJ:** No, no. Eh it seemed to me to fit our bill at that moment in time. I mean I liked the kind of concept. I liked the kind of prepar, the sound of the preparation that the nurses were going to have. It felt much more holistic, much more inclusive, much more analytical maybe in assessing the need than some of the other things that were around. So it was that that excited me. So, no, nobody lobbied me.*	FHN concept attractive Educational preparation attractive AJ clearly the one key person whose idea it was to try the FHN concept.
5) What were the views of other UK CNOs at the time?	*AJ: And of course the 4 Chief Nursing Officers of the UK would meet every 3 months. So I was beginning to tease out with them where they were coming from around the role of the health visitor. And beginning to say, "I want to get rid of that title. It's the only way that's going to do it because they are Public Health Nurses"* ***CM:** Yes* ***AJ:** So I was beginning to think – Public Health Nurses – for both School Nurses and Health Visitors, rather than Family Health Nurses. But I think the ideas were all consolidating in my head at the time.* ***CM:** And at the time were your eh colleagues in the CNO positions in the rest of the UK going as far you or?* ***AJ:** No, no. They, eh I did invite them to come to the first meeting we had about the FHN, ehm and they just felt it was either not appropriate or a stage too far for them at that stage. And to be fair I had the remoteness as a lever that they didn't have to the same extent, lets put it that way. And I suppose their thinking was, "You put your head above the parapet if you like Anne, and we'll learn" (laughs)* ***CM:** (laughs) Yes.* ***AJ:** (laughs) Which is fair enough, because in many ways this was a very expensive exercise so for everybody to do it, when I on every platform had to say "This is a pilot – I cannot say that we will have FHNs in Scotland in the future. We may have something different but it may not be FHNs". You know, because I just didn't know and I wanted people to realise that there was a bit of experimentation in having gone down this route.* ***CM:** (laughs) So you were prepared to take the risk in that sense?* ***AJ:** Yea, I thought it was I suppose in many ways a measured risk because whatever the outcome we were going to learn something from it. And I was quite clear that the chances were that we would want to at least take some of the components of it into our preparation for community nurses.*	Informing key UK professional peers. Gauging their thinking and level of support. Scotland pushing further on Public Health Nursing and trying to change away from HV title. FHN not seen as appropriate by some other CNOs FHN seen as going too far by some other CNOs or time not right. But implication of tacit CNOs support. Remoteness as a key lever and legitimiser. Scotland as a test-bed for UK Outcome uncertain. Experimentation Measured risk, but guarantee of some useful learning

PRIMARY QUESTION 2) HOW AND WHY DID FAMILY HEALTH NURSING DEVELOP IN THE WAY THAT IT DID IN SCOTLAND?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
PLANNING ENACTMENT		
1) Central support and funding	Minister for Health supportive. Budget eventually amounted to around £1.3 million. This would have been unimaginable in 1992 when the only CNO budget was direct running costs. Chief Medical Officer also supportive. *AJ: This was more likely to be a problem for the profession than the politicians.*	Core political support ensured.
2) Any relevant precedents for managing this type of development?	***CM:*** *……I suppose that leads on to a question I have about you know, were there any precedents for this sort of pilot in your experience as CNO, or thinking of other colleagues that you would know, to do something in this particular way as a pilot?* ***AJ:*** *No, no. I mean I don't know, and cause there were so many components to this. We had to commission the development of the programme based on the work that WHO had done, so not too much of that has been done for a pilot.* However some relevant learning was drawn from the project management of the very recent Review of the Nursing, Midwifery and Health Visiting contribution to Public Health. This related to managing a central Steering Group with a number of working groups. Helping people to feel involved had been important and successful. *AJ:* (talking about GPs) *So again it was obviously mattering to them that they found out more about this and that they were in the inside, rather than on the outside looking in* It was important to build a core team, know the key people who would be involved, and weigh risks and benefits. Yet it was recognized that the project was very distinctive: ***AJ:*** *I think this is such a unique thing that you were bound to get more personal investment.*	Few, if any, relevant precedents for this type of multi-component pilot. Public Health Review had given valuable recent lessons. Projects of this type benefit from wide representation, helping people feel informed and included. Build the team and know the key people. Weigh risks and benefits. FHN project very distinctive. High personal significance for most key participants. Consequently, high personal investment.
3) Commissioning the educational programme and the external evaluation	An element of risk was acknowledged in relation to commissioning the educational programme from a university with no previous experience of delivering community nursing courses. ***AJ:*** *Yea, I was criticised for not going out and inviting all universities to tender. And a legitimate criticism, but my thinking was ehm: this is a pilot; we're going to be doing it in small communities. This is change and that's difficult for anyone, its going to be particularly difficult in small communities and would be a particular challenge for those not used to remote and rural.* Evaluation was seen as necessary and integral from the start. ***AJ:*** *I think the fact that we right at the beginning said "This has got to be evaluated" has got to be one of the biggest benefits, because remember earlier I said one of the key aims was: the very least we are going to get out of this is we are going to learn something about the component parts of this that influence practice.* ***CM:*** *So in a way the evaluation, was that a bit of a risk management strategy, in the sense that you were going to have evidence anyway* ***AJ:*** *Yes, anyway, come what may, we needed the evidence.*	Calculated risk taken with commission of educational programme. Potential benefits of relevant local knowledge and understandings, plus a novel approach. New thinking needed. Evaluation integral from the start Need for an external perspective recognised early on. The risk of introducing new role was mitigated by notion of a scrutinised pilot that would produce evidence to inform a further policy decision.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
PLANNING ENACTMENT		
4) Thinking of the actual FHN role, which of the following aspects was most important: need for a more health orientated approach; addressing recruitment and retention; nurse as first point of contact; family focus; or the idea of a generalist nurse?	All of these were seen as important, but AJ particularly attracted to the idea of the generalist nurse who incorporated a more health orientated approach: *AJ:.....for me the important thing was that we looked at how to sustain both public health and community nursing in remote and rural areas. So my expectation, my hope, my wish was that that programme that prepared them would help me to understand better how we could prepare people in the future. And how we, what did a generalist role look like that had to take those two components in?* ***CM:** Yes* ***AJ:** I had a feeling for what the generalist role looked like if you were a district nurse, but it could be quite task-orientated. And for me the true generalist role ought not to be task orientated, its got to be much more holistic than that.*	Main aim was a generalist role sustaining public health and community nursing in remote and rural Learning from first educational programme Discovering what the role might look like in practice. Desire for an holistic role that develops or goes beyond district nursing.
5) Planning to use remote and rural as a test-bed	*CM: ... what about the criticism that this is an easy option that ensured that family health nursing would be marginal and didn't really threaten any pre-existing power bases in the central belt?* ***AJ:** No, ehm I didn't ever let that bother me, or really enter into my thinking when I was going through the pros and cons. I was quite clear that the best chance we had of exploring whether or not this was something worth having was in remote and rural, I thought. And particularly as we were learning as we went along, all of us.* There was less certainty, however, in regard to the question of whether Highlands and Islands nurses were already nursing families before family health nursing: ***AJ:** ... they may do it, they may be in a better position in the remote areas to practice in this way, but I don't actually think they integrated their practice in the same way as they do with this preparation. I may be wrong.* ***CM:** Well its one of these things that's quite difficult to know because there's not an awful lot of evidence base out there about Highlands and Islands nursing* ***AJ:** There isn't, there isn't. And it would be almost crazy for us to have a part of the country like Highlands and Islands and not exploit that opportunity when we're trying something new. Because it is the thing that makes us that bit unique. Its the thing that makes us quite like a lot of the other European, particularly Eastern European countries. Its the, if you think of the land mass and the population and where it is, you've got a bit of every kind of service. You know you've got Raigmore, you've got community hospital, you've got. So you've got everything you need for experimentation in a sense.*	Clear suitability of remote and rural for a pilot of family health nursing. Everyone learning as they went along. Difficulty in knowing about the pre-existing engagement of remote and rural community nurses with families. Opportunity for better integration of a family approach Characteristics of the Highlands and Islands more similar to some Eastern European countries. Ideal location for experimentation.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
REFLECTIONS & EVALUATION OF PROGRESS SO FAR		
1) Initial opposition to the new role	***CM: …*** *in summary would you say the opposition to it was greater or less than you expected?* ***AJ:*** *That's interesting. It was less angry than I might have expected, particularly with health visiting but I mean you're absolutely right, I think again, timing. Nursing for Health being the re-inforcer around the public health and the role of the Health Visitor may have been what took a bit of the sting out of it.*	Opposition was less angry than expected. Nursing for Health underlined value of health visiting if public health focused.
2) Pilot project processes and risk management	***CM:*** *The idea of control, central control. Did it ever feel like it was out of control?* ***AJ:*** *I think it felt as if it was straddling the rails some of the time, but didn't ever quite de-rail. And I mean some of that was just around different perspectives. I mean we were dealing with so many different organisations. I don't think it could (ah now wait a minute, that's easy to say). I was going to say I think it had to be done centrally. I think it probably had to be done centrally, because it was a policy initiative* Looking back, risks were often balanced by benefits: ***AJ: …****Ehm, well the risk was that it could all go pear shaped and that each of the three bits of the pilot if you like, Highland and the two islands, could just have gone off doing their own thing. Where in fact the benefit that countered that was how closely those three DNSs and the people that the DNSs had designated to be the responsible person if you like, how closely they kept together and how determined they were. Ehm, I kept saying "This is one pilot. We may have several sites". And I think ehm they made that fact. So I think there was a severe risk and a benefit.* The leadership of the regional Directors of Nursing Services was seen as vital in complementing leadership from central government: ***AJ:*** *I think the drive from the centre and the ownership, and the time that initially anyway (and as it began to roll out) that those DNSs invested paid off* There was also concern about possible risks for the new FHN students: ***AJ: … …*** *And that to me was the risk – those three things – you know: individual failure; ehm how we would have the NMC accept them; and the impact on the individual from other professions around them.* Getting the new qualification accepted by the NMC was seen as particularly important: *AJ: It was a challenge around regulation* ***CM:*** *Yes, yea. I mean would you have been sunk if you couldn't have managed to broker that?* ***AJ:*** *Yes, well for the individuals? What what credibility would they have seen themselves as having? What would be the benefit for them? So it was things at that level that were the real challenge.*	Difficulty of co-ordinating a project with so many components. Central control necessary for this funded policy initiative. Concerns about regional differences of approach didn't materialise. Commitment and leadership of DNSs vital. Drive from the centre vital Concerns about individual students being very exposed in a small pilot, in terms of course progression and reaction of colleagues. Getting NMC recognition of the new FHN title was vital for the students and the project as a whole. Credibility was at stake for students, as well as other key people in the pilot project.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
REFLECTIONS & EVALUATION OF PROGRESS SO FAR		
3) Evaluation of outcome	***CM: …*** *Well that's quite a nice point at which to move to the evaluation. Obviously we reported and ehm, to what extent did that square with your own perceptions of it?* ***AJ:*** *Pretty accurately, actually* The evolving nature of the FHN initiative was highlighted in reflections on outcome: ***AJ: ….*** *its now 9 months since I've been anywhere near family health nursing. Even at that time though, I still couldn't have said to you "Family health nursing as we've got it is what should continue in Scotland". What I could say to you is "I'm absolutely crystal clear that the way they are prepared makes them take a different approach to practice that I would think should be beneficial to all community nurses". And I would include practice nurses in that.* ***CM:*** *Yea, so the pilot, if you like, and the associated development has taken us to this point that you could say that. What would you say to the criticism that no-one wanted another Community Specialist Practitioner and now we've got another one?* ***AJ:*** *Yea, I would agree with that. I didn't actually want another community nurse practitioner. I wanted to see whether this role developed in a way that meant that we changed something else, or developed in a way that helped us to know better how to prepare and get more out of the disciplines that we've got. I was never absolutely sure whether this would end up being another discipline. I'm absolutely not, I'm not sure that it is another discipline. I think its just a different way of approaching how you assess and care for people* Indeed a more radical outcome for community nursing was envisaged: ***CM: …****but it could be said that at the end of the day, if you haven't shifted the pre-existing roles, then you've just added another one.* ***AJ:*** *Absolutely. You see I had hoped, and I couldn't articulate this because this was what was making everybody feel very protective and sensitive who were not doing the FHN course. I had expected that in some areas in Scotland we would no longer have District Nurses and Health Visitors.* ***CM:*** *Mhmh. And did you have an inkling that that might ehm, you might have people that would help you in that, shall I say (laughs)?* ***AJ:*** *Yes* ***CM:*** *Right* ***AJ:*** *If it had worked out. And it may. I mean it is still quite early days. If it had worked out that this cohort of people were generalists, that they could be the gatekeeper, that they could ehm be the people who had the confidence to function to the level of their, the higher level, of their skill and knowledge, and could have been the referrer on to others without a middle man*	External evaluation was generally seen as accurate. Key outcome is that new educational programme fosters a different and inherently valuable approach that should have wide application. FHN evolving and future of the role not certain as yet. Present outcome is that a further CSP has been added, and this is not optimal. Secondary change is needed now, involving both FHN and other professionals. CNO wanting to see some regions with an entirely new community nursing role profile. Great sensitivity around explicit statement of such an aim during the pilot process. Desire for more radical change shared by some key allies. The potential still exists for this more radical change that would put FHNs in higher-level, central gatekeeper role.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
REFLECTIONS & EVALUATION OF PROGRESS SO FAR		
3) Evaluation of outcome (continued)	Possible impacts for other PHCT members were also considered:	
	AJ: ……this pilot hopefully will be a catalyst for change because it was plonk in the middle of the primary care team. So it was going to surely make people think about their own practice and its relevance. But that was not an ehm overt aim if you like, but it was just a fact of life that there's something wrong with ehm changing something that impacts on others if it doesn't make them take a look at what they're doing.	FHN as a catalyst for changing roles/practice in primary care. This was an underlying aim.
	Impact of the FHN development on recruitment and retention was evaluated in retrospect as inconclusive. ***CM:*** *Yes. I mean I know to some extent some people would have questioned the recruitment and retention thing.* ***AJ:*** *Yea, I don't think we've proved anything about that.*	Impact of FHN on recruitment and retention not proven.
	Reflections on more recent progress since the 2003 evaluation included consideration of the impact of evolving policy: *CM: … …in the past I suppose almost 18 months its moved on again: how do you see things evolving in remote and rural over that period? Do you feel its more of the same or?* ***AJ:*** *I suppose there hasn't been as much movement as I would maybe have expected given all the emphasis that went into remote and rural. And I'm interested in the Kerr Report, in so far as I've read it, that there is still an emphasis on remote and rural areas* ***CM:*** *Yes, yea* ***AJ:*** *You know, and ehm* ***CM:*** *Community hospitals, I think* ***AJ:*** *Yes, yes, so I think maybe that will give the impetus for re-focusing and for people taking things to the next stage. And exploiting what you can do close to the home as opposed to. I mean bits have happened, but not maybe as much as you would have expected. I mean some people now get their chemotherapy at home, where they would have gone to Inverness or Aberdeen or wherever before. But I think maybe there would be more re-designing around how care can be delivered nearer home.*	Progress in remote and rural with FHN slower/less radical than hoped for since 2003. The Kerr report can give re-focusing impetus for FHN. Redesign of healthcare services necessary. Focus on primary care and the home.
	In summary: *AJ: there's advocacy around further development of the regional scenario if you like, so I think the climate is right for the regions to take ownership*	Advocacy for more autonomous regional action and initiative.

PRIMARY QUESTION 3) WHAT ARE THE IMPLICATIONS OF THIS IN TERMS OF POLICY, PRACTICE AND THEORETICAL UNDERSTANDINGS OF NURSING?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
IMPLICATIONS		
1) The family title	*CM: … ..I got the impression around the time of Nairn that you know, would something happen that possibly Scotland might even decide to drop the family bit of it, which is very much, I suppose, associated with the European thing* ***AJ:** Yes, absolutely* ***CM:** and you could develop things perhaps more just the basic generic, I say "basic", that's not right* ***AJ:** I think we would, and this is why I would be interested in seeing how it all pans out in Glasgow, but I do, I see, I don't see anything wrong with dropping the word "family" cause its about behaviour, isn't it? Its about how you go about your business.* ***CM:** Right, ok* ***AJ:** Rather than what you're called. And its about focusing on the unit, whatever that unit is, and it may not be family.* ***CM:** Right, yea. In that regard, did the, you know how in the Stirling University curriculum it did bring in quite a bit of the North American family nursing, was that something that was, you ever saw as problematic, the genograms, the ecomaps and all that?* ***AJ:** No, cause actually in a way that, while I thought it would be the switch-off, you know I really did worry about that, particularly for highly qualified people, it was the thing that empowered. Because those kind of tools and things were the things that demonstrated it was different.* ***CM:** We started to get a strong sense of that - that some of that knowledge if you like – was what gave them a sense of "Well we're a bit different, this is our niche" which probably they needed* ***AJ:** Yes, absolutely. I think it was essential. And it made them get the information in a more structured and more different way. And they did seem to relate the information they got to their ehm plan for action*	CNO not unduely attached to "family" as the central concept/focus of the new role. Scope exists to change and evolve a new generalist role. Its an approach, and its focus must be appropriate to context. Some initial worries about inclusion of North American family nursing ideas and tools. Worries not realised. Rather acknowledgement that these comprised much of the distinctiveness of the new role. The tools seemed to be useful in clinical work.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
IMPLICATIONS		
2) Practice nursing	***CM: …*** *how is it fitting with other important concurrent developments? I'm thinking of GMS contract and I suppose the associated possibilities for practice nursing coming through. I mean to be devil's advocate I would say that ehm to some extent the Executive's policy is ambivalent because you've got practice nursing being developed, but I see that as quite different tradition and aspiring to a less perhaps holistic and family orientated value than the family health generalist nurse. Can you say anything about that?* ***AJ:*** *I think you are probably right. I think the genesis of practice nursing is significantly different from any other community nursing discipline. What is practice nursing, other than somebody who is employed and works within the practice? And I say that because its not a generic role. In that by and large General Practitioners knew what gaps they wanted to be filled when they employed practice nurses.*	Practice nursing has distinctively different origins and focus that make it less immediately compatible with the holistic, generalist role seen as necessary.
3) GMS contract	*CM: So looking in depth at the GMS contract I couldn't really see an incentive that was going to help family health nursing, I must say.* ***AJ:*** *No, no. Because bottom line is all the contracts: consultants contracts, GMS contract, they are about delivery. They are about meeting targets. And in some ways one can argue that forces a task approach to work…….*	The way doctors are incentivised does not help encourage the sort of approach aspired to by FHNs.
4) The Nurse Practitioner	*AJ: … Because if you say the nurse practitioner, the genesis of nurse practitioner was the Cumberledge report. And actually she was talking more about what the family – she wasn't calling it the family health nurse – but she was actually talking about the gatekeeper. And she was seeing the nurse practitioner about working in the community setting being the replacement for the GP, as we knew the GP. Cause she had a different vision for the GP. So its very interesting, and that was what, 1988 or something, the Cumberledge report?* ***CM:*** *Yes, yes. Yes, and a parallel with, I suppose around that time there was the Vienna conference and the sort of rise of the generalist nurse* ***AJ:*** *Absolutely*	Some similarities noted between the aims of the current FHN development and the aims of the Cumberledge report. However, the latter wanted to develop the Nurse Practitioner role.
5) What would you do differently if doing it again?	***CM:*** *Ehm, this might seem like a clichéd question but at the end you have to ask is there anything you would do differently if you were going to do family health nursing again? You may, I think in the course of some answers you've suggested some things but is there anything outstanding?* ***AJ:*** *I suppose if you do things at different times you would always do it differently. When we started this the whole issue of re-design was beginning to surface but that was about it. If I was doing it now I would want to do it in the context of re-designing how health care is delivered in remote, if that's where you were going to do it, in remote and rural areas* ***CM****: Right, in a more wide way or?* ***AJ:*** *Yes, yes, yes. You would want to, and so the research element would be a bit different, because you would want to explore: what is it that would be the catalyst for changing the way service is delivered in these localities that could include something that looked a bit like the FHN?*	FHN should be advanced as part of more fundamental and wide-ranging redesign of how remote and rural healthcare is delivered. How can the FHN be a catalyst for change?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
IMPLICATIONS		
6) Service redesign	***CM:*** *Do you think that sort of scale of re-design can happen ehm without other professions?*	
	AJ: *No,oh no. So I think if they were being wise and if they were re-designing in the areas where they had got FHNs then they should redesign having first articulated all the knowledge base and skills base of the people who are in that team, and say "Right, how could we use all of this in a fundamentally different way".*	Redesign means re-examination of knowledge base and skills of all PHCT.
	CM: *Right, ok, yep*	
	AJ: *And that's when I think we would have cracked it. And that's not putting one discipline out any more than any other discipline. So, supposing that you ended up that District Nurses and the Health Visitors did different things in different parts of that community rather than what we're doing at the moment, but equally the GP was eh practice had to change and that paramedics were. You know I think if you were doing it across the disciplines, you would do it in a fundamental way that would initially threaten everybody, and then enrich everybody because they would actually be doing the things that they are best at.*	Short term threat and discomfort may be necessary for all, if long term benefits are to be gained.
	CM: *Right, right. I mean that would be a very interesting thing to see happening.*	
	AJ*: It would be fascinating. I would love to be around that.*	
	CM: *Presumably it would need, ehm as well as that whole regional co-ordination within the region, it would need a lot of support from central government level to facilitate?*	
	AJ: Not necessarily. If we're in to regional planning, as they are, and I understand that's developed in a much more robust way now, and with that has got to go regional workforce development, estimation etc, and if you want ownership, then I think it could be done with regional support	Scope for regional initiative and lead in service redesign
	CM: *Right, right. You know with family health nursing you needed to pull all these people together at high level*	Timing now right for a regionally led approach.
	AJ: Yes, but that was at a different stage	
	The converse scenario was also explored:	
	CM: *Can you see family health nursing surviving in the absence of such re-design around it?*	Only more fundamental redesign can ensure future of FHN in its present form.
	AJ: *As a discipline, if that's what you're talking about, probably not. Because to begin with there's not enough of them.*	

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	**CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)**	**EMERGENT THEMES (initial themes arising within interview; "endogenous")**
EXPLANATIONS		
1) Jane Robinson's policy analysis theory	***CM:*** *Well that takes me on to another theory – ehm Jane Robinson has got one. She suggests that typically with any health policy developments some groups of nurses gain at the expense of others* ***AJ:*** *Hmm, interesting* ***CM:*** *And I was going to ask you if you thought with the family health nurse development, if you'd seen any kind of winners or losers, or if looking ahead you see groups of nurses that will gain at the expense of others* ***AJ:*** *Currently I don't see any losers. But again, back to your context, we had Nursing for Health, we had Caring for Scotland, and both of those supported nurses in their development phase in their education phase, all of that. Ehm I think more significant than the FHN will be serious, well thought through re-design. And I think that's more likely to be the trigger for people either feeling more or less valued, more or less important, and indeed may raise questions about whether we've got all the right people in the right jobs in the right place. And I mean all health care professionals* ***CM:*** *Do you think there's got to be some losers actually if we're going to make the change that's needed?* ***AJ:*** *I think there has. The answer has to be yes, because some people will not be able to come to terms. I mean I can't believe for one minute that the people that we've currently got are not going to be needed. They may not be needed in exactly the way that they currently are, but one could argue that that's progress*	No real losers so far from FHN development. Attempts to be inclusive and supportive to all in the profession. More fundamental redesign of services will threaten and if some professional groups can't adapt they may be losers.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EXPLANATIONS		
2) Anne Marie Rafferty: context, convergence and contingency	*CM: … Anne Marie Rafferty – she's got an idea of something called context, convergence and contingency. Which again is words, but I think what she's trying to suggest is sometimes you get a couple of contexts which converge together and then you get a sort of contingency or a spark that makes it happen. And she's explained this in relation to historically in terms of nurse education, but I was trying to think – does that fit with family health nursing? And where I'd got to was that you've got the WHO Europe context, converging with a sort of remote and rural Highlands and Islands eh context. These things come together and there's some sort of spark that actually make's it happen. And to date, as I understand it, you're the spark that made it happen. Do you think that's a reasonable interpretation?* ***AJ:** Yes, its very interesting. I would think, I mean I'd be really interested – has Anne Marie written this up?* ***CM**: She's written about it a bit, but* ***AJ:** But only as far as education's concerned?* ***CM:** Yes, and its not very well developed in terms of* ***AJ:** I think if, if researchers were going to get into working alongside those who are re-designing service, if significant re-design is going on, I'd be very surprised if you don't get evidence for that theory.* ***CM:** Uh huh, alright, yes* ***AJ:** And it I think would also help you to understand why one profession influences another profession. Cause I think it is about convergence you see. As well as context* ***CM:** That's interesting as the other thing that came through from what you were speaking earlier was the timing of it and she does pick up on that. There's certain things - I can't actually to be honest remember the exact example that she gives in education – but it is to do with eh there are certain things which come up at certain times which enables leaders to run with something or not* ***AJ:** Absolutely, yes. I mean that has certainly been ehm the most outstanding observation that I've made in the time that I was in the department. Just the importance of timing*	C-C-C theory is interesting and fits broadly with CNO experience. In terms of contingency, the primacy of timing is most evident. Timing is everything. C-C-C may also help to understand processes of influence between professionals. This would be important in any redesign project.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EXPLANATIONS		
3) Relationship to progress in the rest of Europe	The leadership of AFH was seen as crucial and inspirational, but there was some disappointment about the relative lack of progress in the rest of Europe. ***AJ:*** *Its just a pity that more of Europe didn't run with it cause I mean this is the real disappointment. But again I suppose in many ways while it would have helped WHO to have a clearer view of the world if it had worked in different ways, the chances are we would all do it in such different ways just because of our local needs that maybe you wouldn't learn too much from each other, other than be able to encourage a determined effort to keep going if you like, once you had started.* The need to take forward a coherent national development had become emphasised as the European development struggled: ***CM: …*** *I've been getting a sense that you feel that the FHN development in Scotland can sort of survive and develop almost independently from the European one. Is that right, am I?* ***AJ:*** *Yea, I had to form that view because of the lack of momentum in the rest of Europe.* This was seen to make evaluation problematic: ***CM: …****I mean it's a stiff job for – certainly for the evaluators – but also obviously for the countries involved.* ***AJ:*** *Absolutely. And I think just, unless there's a whole load of countries that are now doing it that weren't doing it, I think for WHO to be able to draw very many conclusions is going to be very difficult*	AFH key leader and driver. Disappointment at relative lack of progress elsewhere in Europe. Some uncertainty about nature and degree of inter-national learning that would have been possible. The need to focus on what is best for Scotland has become even clearer. Uncertain about the ability of the multinational study to draw firm conclusions.

2.2 Interview with Ainna Fawcet-Henesy

TABLE 2.2 INTERVIEW 2: AINNA FAWCET-HENESY (AFH)

PRIMARY QUESTION 1) HOW AND WHY DID THE FHN CONCEPT EMERGE IN EUROPE?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EUROPEAN EMERGENCE		
1) Own involvement	From early 1990s quite close involvement with WHO Europe nursing department as a consultant to Eastern European countries on nursing development. Took up Regional Adviser post in 1995. Changed the focus of WHO Europe nursing department back to a broader pan-European one after the necessary emphasis on Eastern Europe and the new Independent States during Jane Salvage's tenure. Also, because of background as a health visitor and primary care adviser for RCN, came into job with a particular interest in developing the public health dimension of nursing across Europe. On starting the job, the general context of European nursing was one of under-development.	Public health and primary care background. Initiated some change of emphasis after starting as RA.
2) Who were the key people who initiated the FHN concept?	*AFH: ... when I moved into post then I looked at, I had a big agenda of the sort of things that I actually wanted to do. And at the same time the new HEALTH 21 was being developed, you know there was HEALTH FOR ALL 2000, then there was the update, HEALTH 21. And of course it was in that context that the FHN entered the scene because the then Regional Director, Jo Asvall, had very, very good experiences of nursing in public health in his country of birth which was Norway. And it was really his baby. I mean I would hate to say this was me that suddenly developed this concept. I mean I developed it, but the initial ehm thought came from him. And he was looking for this nurse, this all-embracing nurse who focused on health in the family as opposed to illness and disease* AFH worked with JA on the definition of the HEALTH 21 FHN. ***CM:** Yea, and there's another thing I wanted to check that I couldn't quite understand: it's in the introduction to the FHN in the 1998 document* ***AFH:** Yea* ***CM:** before you go into the full definition it says "a well trained Family Health Nurse as recommended by the 1988 Vienna Conference"* ***AFH:** That's right, that's what I'm just saying to you* ***CM:** Yea, and in the Recommendations I can't see anything that says "Family Health Nurse" but* ***AFH:** Where, in the Vienna?* ***CM:** Yea* ***AFH:** No, but it's the concept* ***CM:** the concept* ***AFH:** and you see its, the concept was there but it actually hadn't been realised and ehm so we sort of developed it further.*	Own agenda coinciding with the re-vamping of the European public health agenda through HEALTH 21. Dr Asvall had the initial idea of a family health nurse, based on experiences of public health nursing in Norway. AFH developed the idea with him and they worked to define it. The original recommendations from the Vienna conference did not actually make reference to a Family Health Nurse. When this phrase was attributed in the 1998 document that introduced the FHN, it was used in a loose sense to signify that the same concept had been there at Vienna in 1988, and this was it now being taken further.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EUROPEAN EMERGENCE		
3) The FHN concept	*AFH: … I worked with him* (JA) *on the definition of the HEALTH 21 FHN because you know all this is in the context of the family being the single most important unit in society* ***CM:*** *Right, right* ***AFH:*** *and this nurse would be the sort of the, that person that would be alongside this family. Ehm, you know the sort of, using the Virginia Henderson ehm sort of definition of being alongside. But actually not being alongside in an illness, but in a health promoting at all times. So this nurse would have a huge public health ehm knowledge and a whole sociological base to her work. And really would understand the social determinants of health. So we were looking at a much bigger role, and putting you know the community nurse some notches up.* The public health basis was seen as a key in distinguishing the FHN from, for instance, the North American family nurse. *AFH: everybody tends to build on their own experiences. But mine was very much the public health domain* ***CM:*** *Well that's helpful, cause maybe it anticipates my next question which* ***AFH:*** *That puts you, I mean that will give you then a clue about the FHN as opposed to the family nurse. And those are two different, there's a big distinction for me between the family nurse and the FHN. And the WHO project is the FHN*	The family is the single most important unit in society. FHN will be alongside the family facilitating their health promotion. Public health input a key element. The health focus is what distinguishes it from the North American family nurse.
4) The nature and scope of the envisaged FHN role	***CM:*** *I'm interested in the ambitious nature of the role because it, to some extent – and this comes through in Dr Asvall's article in Nursing Management – it sort of suggests that there might be universal coverage of nursing to all families really, ehm you know in terms of helping them with health and illness.* ***AFH:*** *Yea* ***CM:*** *You know to me that does go, certainly in UK terms, go quite a bit beyond what has traditionally maybe been thought of as ehm the coverage. It does put quite, eh it's a big aspiration isn't it?* ***AFH:*** *Yes it is. It's a big aspiration, yea absolutely. Yea, I agree with that, but that doesn't mean that I shouldn't have that big aspiration. That is, that is it. Ehm that's my belief* ***CM:*** *But in my analysis of the Scottish experience what it has set up is quite a tension between the sort of the pre-existing primary care service* ***AFH:*** *Yea, sure, but that was inevitable wasn't it?* ***CM:*** *Was it? (laughs)* ***AFH****: Of course it was because you know people don't like change and you know if you go back to the Briggs Report, I remember the absolutely outcry from the profession that you know, that anybody might be marginalised anywhere. You know we've had it all through the ages*	When the new FHN concept is enacted in a role it legitimately aspires to provide a service to all families in terms of health and illness issues. This is acknowledged as ambitious but seen as necessary and the proper scope of such a nursing service. Resultant tensions with pre-existing primary care services are inevitable if anything is ever to change.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
PLANNING ENACTMENT		
1) Gaining support and momentum	AFH not aware of any particularly relevant precedents for this type of project. The support of the European CNOs group was gained and preparations to advance the FHN concept and role were made. ***CM:*** *Yea**,** was there any tension around you know the family name as such?* ***AFH:*** *No. Eh yes, I mean there were, there were - not about the family, but the worry that we would exclude single people and homeless people and that we may marginalise important people in society. But, but that's why we had, I was at pains to point out that ehm that everybody in society was included.* There wasn't a parallel programme to develop the Family Health Physician concept because of lack of enthusiasm. Indeed a substantial group of GPs at WHO level were opposed to the idea as they felt that it encroached on their territory. Dr Asvall was very helpful in assuaging these concerns. For similar reasons there was substantial opposition from midwives and health visitors. Also some countries thought the FHN implied criticism of their existing service. These sources of resistance led to the watering down of the Declaration at the Munich conference by insertion of the clause "including where appropriate the FHN". The total budget for WHO Europe nursing department is small and while meetings for the FHN project were funded, there was no budget for substantive development work with individual countries etc. *CM: I was going to ask about your expectations when you sort of set out on setting up these projects. Did you think it would happen for all the countries or some of them or just a few?* ***AFH:*** *I thought, I thought some would do better than others. And ehm I think I was over-optimistic. In retrospect, I was over-optimistic* Nevertheless, the endorsement by Ministers at the Munich Conference was widely recognized as an important milestone and substantial achievement.	FHN European project not able to draw on any particularly relevant precedents. Support of key group obtained (CNOs) Some clarification required around the family title, but broadly supported by CNOs. Significant opposition to the FHN concept within Europe from GPs, midwives and health visitors. Some countries perceived implied criticism of their present systems/services. Munich Declaration watered down, but still a success in enrolling so many Ministers and nurses from different countries. Budget for Euro FHN development very small. Country-specific variations in progress anticipated, but generally AFH was over-optimistic.
2) Curriculum development	AFH looked for educationalists with experience in curriculum development from across Europe. Maribor in Slovenia was prominent as they are a leading country in public health and had a model similar to FHN. *AFH: ... what we had to do was take this concept of the FHN and look at the competencies that would underpin it. And for example June Clark had actually done her own PhD on ehm the Family Health Visitor. So that's why she was involved in it* ***CM:*** *Right. Cause that comes through quite strongly, June's model. And there wasn't ehm any sort of overt references to North American family kind of model* ***AFH:*** *Yea, but you see the North American is family nursing, without the health focus. And June's model was very much the health, had the health. I mean that's the difference really. That its its much more to do with the community model as opposed to the broader model of all hospitals*	Team of experienced nurse educationalists recruited by AFH. Slovenia an influential contributor. Description of competencies was important June Clark's model stressed both family and health, and was therefore more apt than some other possible models.

PRIMARY QUESTION 2) PERCEIVED STRENGTHS AND WEAKNESSES OF THE DEVELOPMENT OF FAMILY HEALTH NURSING IN SCOTLAND?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	**CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)**	**EMERGENT THEMES (initial themes arising within interview; "endogenous")**
Strengths	*AFH: I think the strength has been that you've had very good leadership, you have ehm invested in it, you've had commitment from education, commitment from from Ministers*	Scotland had strong leadership, funding and commitment from key people.
Weaknesses	The weaknesses were seen as more minor but related to the perceived restriction of the growth of the new role by other professions. ***CM: …*** *could you criticise Scotland that it wasn't bold enough? For instance you could have the FHN ehm developing more towards ehm, you know, a Nurse Practitioner sort of role* ***AFH:*** *Model. Yea I mean that would be ultimately. But I mean you might be able to do that in Scotland, but you wouldn't be able to do that in the other countries because its too early for them*	Some professions in Scotland resisted the FHN concept. Further development towards Nurse Practitioner status may be feasible and desirable.

PRIMARY QUESTION 3) WHAT ARE THE IMPLICATIONS OF THE EUROPEAN DEVELOPMENT IN TERMS OF POLICY, PRACTICE AND THEORETICAL UNDERSTANDINGS OF NURSING?

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
Evaluation of progress	Progress was seen as mixed so far, with some countries ahead of others. CNO leadership was seen as vital, as were the pre-existing structures and support for nursing within each country. *AFH: … But I'm not, I'm not at all surprised at the pace that countries have have moved at. You know I think our timescale was unrealistic. And ehm there's no doubt about that. Because ehm if you compared where nursing is at in Scotland and where nursing is at in these other countries then ehm I mean it's a huge polarisation.* The need for some of the most under-developed participating countries to have legislation and education to properly support nursing was emphasised. *AFH: You know I mean we're talking about nurses who didn't have a proper nursing education and we were trying to bridge, to bridge that gap between ehm the sort of how nurses were educated and how they should be educated. And then on top of that develop them into FHNs.* There was disappointment that some countries had attained Ministerial support, yet not been able to progress far: ***AFH: …** I mean the Ministers gave their approval, and they were excited about giving their approval. Ehm when it came to the nurses running with it, they didn't run with it. And some of that was the fault of the nurses. But the other part of it was actually the ehm influence, the position of influence that they did or didn't have.* In contrast, UK nursing was seen as having much more influence: ***CM:** Were you disappointed that more UK nations didn't sort of take it up?. I know Scotland did but there was* ***AFH:** I was, of course I was because I felt that they are so, I mean they are highly respected in the way that nursing has moved on in these countries. And it would have been a very powerful message ehm and , you know but there wasn't the interest. I mean Anne Jarvie was motivated and interested and thought that it would be useful in a model to test out in Scotland. And she was very involved in WHO as well. I mean she was a very active participant in all my work at WHO. And you know understood the public health domain, and was very willing to go with it*	Progress on Euro FHN project mixed. Initial timescale unrealistic. Many of the participating countries starting from a context of poor nursing infrastructure. Proper legislation and education essential pre-requisites. Therefore slow progress unsurprising. Some nurse leaders in some countries might have moved things on better, but their ability to influence key people was low due to status of nursing. UK nursing widely respected within Europe and seen as influential. Some disappointment at lack of engagement by other 3 UK countries. Scotland exemplary in many ways.

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through relevant *quotations from transcription* and linked by formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
Implications for policy: general	The main implications for policy were seen as relating to the need for nurses and key allies to try to influence their respective governments (and key international organisations) to support nursing through appropriate legislation and funding of education programmes. *AFH: …in many of the countries, nursing is not recognised in the way that we would like it to be. It is undervalued. And its no different to what Jane Salvage was saying, you know, 15 years ago. Nursing is undervalued, eh under-supported, and even with the changes to ehm the real problem with recruitment and retention, it hasn't shaken them, it hasn't given them the wake-up call that they need. And you know the ehm influence that nurses have at policy level is tragic* Engagement with Ministers and bold nursing leadership were necessary if this was going to happen. Such policy engagement was seen as the essential way to facilitate substantive positive change that would feed through to nursing practice.	There still remains a need for many countries to establish (through legislation, funding and education) a good infrastructure for nursing that will enable the sort of development aspired to in FHN project. Many European countries have not grasped the problems that underdeveloped nursing services bring, and their potential for improving public health Increased political activity by nurses is essential to ensure development of nursing practice.
Implications for policy: more specific to the FHN project	***CM: …*** *what are the lessons for nursing policy that you take out of a project like this?* ***AFH:*** *Are you talking about the process now or the concept?* ***CM:*** *No the process more* ***AFH:*** *The process. Ehm I mean one lesson is that your preparatory work in the countries has to be much more intense before you even get to the stage of starting the project* ***CM:*** *Uh huh* ***AFH:*** *I mean that is, that is absolutely crucial. That all the ground work is done. And, I mean there's no doubt in my mind that ehm one of the failings of WHO was actually not to have ehm somebody dedicated to doing, to working on this as a project. And then being able to visit the countries and work with them to set all of this up. You know, I mean that's, I don't know if I'm reading your question* ***CM:*** *Yes, that's exactly it* ***AFH:*** *the preparatory work. And to make sure that you've got the people in place that can actually run with it. I mean that is for me crucial* ***CM:*** *Would that almost be like a macro model of what happened in Scotland, with the Steering Group and Lesley Whyte?* ***AFH:*** *Yes it would have been.* Reflecting on the educational preparation, AFH felt that the year's curriculum was not long enough to cover the complexity of the FHN role, so there was a need for further development in this sphere. Finally, it was hoped that the multinational evaluation study would provide useful findings. The findings would be particularly important for those countries with a health insurance model where payments relate directly to episodes of care.	For a multinational project like FHN, better preparatory work is essential. This might have been achieved if funding had been available for a project worker. Identifying key people in advance is vital. Ironically, the Scottish model of FHN project development and management provides an example of what may have been necessary at WHO Europe level. Difference in funding and support highlighted. FHN educational programme needs lengthened. Multinational evaluation study is keenly awaited and could influence state attitudes to the FHN.

2.3 Interview with Majda Slajmer Japelj

TABLE 2.3 INTERVIEW 3: MAJDA SLAJMER JAPELJ (MSJ)

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EUROPEAN EMERGENCE		
1) Own involvement	Worked as International Manager in the WHO Collaborating Centre for PHC Nursing in Maribor, Slovenia, during the time when FHN was being developed. Also worked for WHO Europe in Copenhagen as Temporary Adviser/Short term consultant for transition countries.	Key member of core group who further developed FHN during late 1990's.
2) Antecedents of the FHN concept	Rich parts of Europe did not accept the Alma-Ata Declaration as their own at first. It was seen as for developing countries. However rising health care costs associated with medical, hospital based models have forced some change. One of the risks is that they may be looking for cheaper nursing personnel. However some politicians and doctors have realised there is a need for a new PHC nurse.	
3) Who were the key people who initiated the FHN concept?	Dr Asvall was the central figure who understood the redefinition of the PHC nursing role and made it possible to start the FHN project and realise it with AFH.	Dr Asvall key initiator. AFH main driver.
4) The Family Health Nurse name	Dr Asvall also stressed Family Medicine and wanted a development that would make both FHN and FHP equal partners in the Family Health Team. Nursing colleagues in different FHN development working groups were not unified about the name. Some suggested "Health Practitioners", others wanted "community" in the title. However Dr Asvall had wanted "family" and AFH made it clear that the project could not succeed without his agreement and support. So quite quickly the FHN name was agreed, without very explicit support or resistance: there was simply a need to be pragmatic and act quickly to realise the opportunity.	Tensions around the forefronting of "family" were subsumed within the need to act swiftly.
5) The HFA Nurse and the FHN	The Vienna Conference in 1988 did not mention FHN. The general idea of the Health for All Nurse was the basis for FHN development, but the HFA Nurse was a very dispersed description that was not useful for concrete planning and reforms. FHN has educational curriculum and competencies.	FHN is a much more substantially developed concept than the HFA Nurse although they share some core content.
6) The FHN concept and curriculum development	Finland, Slovenia and Scotland were seen as the countries with most influence on the development of the conceptual framework and the educational curriculum. In particular the Slovenian "Patronage" model was seen as an example of a community nursing system based on family and community needs, rather than a hospital/medically dominated model. The "umbrella" diagram in the FHN conceptual framework document could lead to confusion and opposition. Rather, the role of the FHN is to be a catalyst linking with others.	Influence of a few key countries on the FHN concept and curriculum. FHN as catalyst rather than fulcrum.
7) Thoughts on progress to date	AFH has been very active and influential in driving the project forward, but the push from WHO Europe has subsided since AFH's illness. If left to themselves, nurses in most European countries will be slow to progress the concept. WHO could do more to support the project. Scotland has set a good example. Some other countries like Moldova have a real FHN team working on the ground, but they work in the poorest conditions with minimal resource. There are hopeful signs in a number of countries. There is strength in sharing experiences and acting together.	Mixed progress of FHN pilot project. Some loss of momentum. Need to share, learn and lobby for change.

2.4 Interview with Professor Margaret Alexander

TABLE 2.4 INTERVIEW 4: PROFESSOR MARGARET ALEXANDER (MA)

AREA OF QUESTIONING (interviewer-presented, "exogenous" themes)	CORE RELEVANT NARRATIVE FORMED FROM INTERVIEW (key content summarised through formulated meaning statements)	EMERGENT THEMES (initial themes arising within interview; "endogenous")
EUROPEAN EMERGENCE		
1) Own involvement	Director of the WHO Collaborating Centre at Glasgow Caledonian University during the 1990s (covering all the key periods of initial FHN concept development). Member of the curriculum development team at WHO Europe.	Key member of core group who further developed FHN during late 1990's.
2) Antecedents/evolution of the FHN concept.	HEALTH 21 and the life course approach are the main elements. Important to understand that many European countries have very under-developed nurse education systems and nurses work very much as medical assistants with minimal professional status or autonomy. However health care reforms under way, recognising the importance of life circumstances for health. Opportunity for change and development of the community nursing role.	Political and economic drivers for health care reform. Policy opportunity for nursing.
3) Who were the key people who initiated the FHN concept?	Clearly Dr Asvall and AFH were the pivotal figures and their synergy was productive. AFH was the indefatigable driving force for FHN development.	JA and AFH the key initiators.
4) The FHN concept and curriculum development	The pre-existing national systems for delivering community nursing that were most influential in the development of the FHN concept and curriculum were those of Slovenia, the UK and Scandinavia (particularly Finland). The pre-existing national system for educating community nurses that was most influential in the development of the FHN concept and curriculum was that of the UK (e.g. modularisation; adult learning approach). Slovenia also had significant influence, particularly on the FHN role scenarios in the curriculum document. These took a problem-based learning approach. North American models of family nursing were considered by the curriculum working group, but it was felt that they had limited relevance to the WHO Europe HEALTH 21 targets. Rather there were examples from within Europe (e.g. Slovenia, Scandinavia, UK) of health and family centred approaches with more to offer.	Main influences on the concept and curriculum were from Slovenia, Scandinavia and the UK, rather than North America.

PART 3: Findings – second stage analysis

3.1 Core ideas within the themes which emerged from interview with Anne Jarvie

TABLE 3.1 ANNE JARVIE INTERVIEW: CORE IDEAS WITHIN THE EMERGENT THEMES

CORE IDEA	DERIVED UNDERSTANDING
1) Advocacy	This idea related to influential policy initiatives/directions being developed by key professional peers. An important part of a leader's ability was seen as anticipating these, or at least recognising these, and planning ahead accordingly. Used in relation to policy at WHO Europe and Scottish government level.
2) Tackling the big, core issues first	This idea was central to AJ's approach. If the fundamental foundations were put in place, it was felt that more specialised or ambitious projects could build from these. The Public Health review and the FHN initiative were seen as examples of the latter. In policy evaluation terms this approach is redolent of *incrementalism*.
3) Modernising	A recurrent idea used in a general way to meet perceived imperatives e.g. to make educational programmes or health services more responsive to current needs. Often involved a related perceived need for "new thinking".
4) Anticipation and the importance of timing	This was seen as the cardinal lesson from 12 years as CNO. It was vital to know or sense in advance when something might be possible, and then seize the opportunity if/when it came. This involved prior development of ideas (e.g. potential value of a more generalist community nurse incorporating public health nursing) and sometimes nurturing these until the time was right. Converging policy agendas (e.g. public health and remote and rural agendas) could provide such opportunities. By implication from the interview, these abilities developed during the job. However there was no explicit exploration of whether such abilities could be taught.
5) Core political support; consultation with key professional peers; and team building	These related ideas were strong motifs. It was important to build networks, ensure core political support, and gauge the thinking of key professional peers prior to fully developing policy initiatives. Thereafter it was important to build a core development team with key known individuals. There was recognition that the FHN project had particular personal significance for the core team members.
6) Weighing risks and benefits	It was recognised that some degree of risk was inevitable when developing policy initiatives, and the important thing was to try to identify what these were likely to be and to weigh them against likely benefits. This process was seen in relation to anticipating opposition to the FHN concept, and also commissioning the educational programme and external evaluation.
7) The value of generalism in nursing	This idea was recurrent, but was applied mostly to the context of the FHN being a generalist role that might sustain public health and community nursing in remote and rural regions. The word "hybrid" was sometimes used in this context as well. The key nursing values were seen as versatility and responsiveness to public needs. There was a measure of concern that nursing had become over-specialised and, at times, task-orientated.
8) Remote and rural regions as a suitable test-bed for FHN	Scotland's remote and rural regions (in particular the Highlands and Islands) were clearly seen as suited to the FHN pilot and offering the best chance of identifying both specific and potentially transferable learning. The suitability of the Highlands and Islands for experimentation related to their geography, demography and the diverse nature of their health service provision.
9) The need for drive from the centre and regional leadership	These were seen as necessary and mutually dependent. The need for central control over a funded policy initiative was recognised, but, perhaps more importantly, there was a need to drive progress from the centre initially.
10) The need for new educational thinking and the need for evidence from an external evaluation	These two related ideas became evident through the commissioning activities early in the evolution of this policy initiative. AJ felt that the potential benefits offered by Stirling University (local knowledge and a novel educational approach) outweighed risks. The notion of an externally scrutinised pilot that would produce evidence also mitigated this risk and the risk of introducing a new role.
11) The FHN as a catalyst for change	The word "catalyst" was used several times to suggest that the FHN initiative should potentially provoke change in others' practice. This was seen as almost overt within the profession (e.g. to help change health visiting and district nursing approaches) although it had been necessary to modulate the intensity and frequency of such a message depending on the prevailing national and local political sensitivities. The aim of catalytic change within the PHCT (e.g. to change doctors' behaviours) was less overtly stressed but present nonetheless. In both contexts, the implied meaning seemed to be that the FHNs themselves have undergone change through an educational course, so that when they are re-introduced to the crucible of the PHCT, a reaction between other elements may be provoked. The extent to which this can be said to have happened is a key element for discussion in the present thesis. Moreover there is the question of the extent to which the FHN could (like a catalyst) remain unchanged if such a reaction ensued. In the latter regard, AJ clearly felt further contingent development of the FHN role would be useful, and the role had to keep evolving. Thus, the catalyst analogy was being used more to refer to the process of provoking initial reactive change within the PHCT.
12) The FHN as an evolving and adapting role	The value of the new way of preparing these community nurses was seen as substantial, and many transferable lessons had emerged. Nevertheless the future of the FHN as a particular individual discipline was still seen as rather uncertain. AJ was clear about the need and scope for a new generalist community nursing role in Scotland. She was less certain that this needed to hinge on the family as the central defining concept.
13) Redesign	A recurrent and pervasive idea used in relation to structuring health care services in a way that will meet newly recognised needs. In this sense, often used alongside "modernisation". Redesign was usually seen as necessary and far-reaching in scope (e.g. to realise the benefits of the FHN role, or to truly integrate a public health approach, fundamental redesign was needed so that the practice and skills of all professions were reconsidered as part of the process). There was now scope for more regional initiatives in this regard.

3.2 Core ideas within the themes which emerged from interview with Annia Fawcet-Henesy

TABLE 3.2 ANNIA FAWCET-HENESY INTERVIEW: CORE IDEAS WITHIN THE EMERGENT THEMES

CORE IDEA	DERIVED UNDERSTANDING
1) The opportunity and imperative for a public health focus	This idea was central to the "macro" approach AFH took forward through WHO Europe and HEALTH 21, and was also central to the FHN concept and envisaged role. It was seen as imperative that nurses had a good educational preparation for meeting the considerable public health challenges across Europe. There was doubt that many of the existing primary care systems, dominated by disease-focused medicine, could meet these challenges.
2) The family as the single most important unit in society	This phrase was stressed several times during the interview, and was a key belief that AFH saw as underpinning all nursing activity. As such, the "family" focus in the FHN title was seen as reflecting a primary purpose in itself (i.e. being alongside the family) rather than simply a means to the end of getting public health embedded into community development.
3) The FHN as a development from the Health for All Nurse	These two ideas were seen as sharing a similar core, with the main difference being that the FHN was more developed as a concept, with a specific conceptual framework and educational curriculum. The decision to foreground family as a key element had been initiated by Dr Asvall and developed jointly with AFH.
4) Need for legislation and education to address poor infrastructure for nursing in many European countries	This was seen as the main big issue for nursing to address. AFH felt that the only way to effectively do this was for nurse leaders to engage politically and try to influence Ministers. Poor funding was linked to nursing's low status. These problems were the main cause of the slow progress of many countries involved in the FHN pilot.
5) Importance of good project preparation and adequate funding	Multinational pilot projects like the FHN need some substantial core funding and good preparatory work to ensure a critical mass of success. Nevertheless, in the absence of more funding, positive action is still needed as nothing will happen if we wait for money. In this regard, leadership, inspiration and good core teamwork are essential.
6) Tensions and frictions are inevitable if anything is to change	Although regrettable, tensions and frictions are inevitable when change is being introduced. Opposition from professional self-interest groups has always been a factor in any major reform. There is a need to focus on the over-riding aim as the key outcome that will ensure better care. Healthcare practice can be most fundamentally improved through policy influence.

PART 4: Findings – a synthesised narrative on the emergence of FHN at European level

TABLE 4.1 SUMMATIVE SYNTHESIS OF NARRATIVE ACROSS FOUR INTERVIEWS*

Convergence/corroboration around a central narrative	Divergence/distinct difference in emphasis within the narrative
The Health for All Nurse concept was the core from which the FHN concept was developed. However there was no FHN as such in the Vienna 1988 Declaration	
Dr Asvall (JA) initiated the new (1998) emphasis on the family, and developed the concept with AFH	
While JA was a major advocate of the FHN concept, AFH was the main driver of its subsequent development	
HEALTH 21 was a timely opportunity to advocate, develop and attempt to embed modern public health nursing across Europe	Distinct differences in emphasis emerged in regard to the centrality and importance of family within the FHN concept. AFH saw it as foundational and focal, while the other interviewees saw it as important but placed less emphasis on it. There were some tensions around this issue amongst the senior nurses involved in developing the concept at WHO Europe level, but these didn't last long due to a recognised need to move quickly to grasp the HEALTH 21 opportunity. For Anne Jarvie (AJ) the emphasis on family was not seen necessarily as permanent and immutable.
The drive from the two central figures (JA and AFH) was essential, but in itself could not guarantee desired outcomes	
The matched Family Health Physician (FHP) concept never developed due to the lack of a champion (other than JA)	
Indeed there was active opposition to the FHN concept from GPs at WHO Europe level who saw it as encroaching on their territory	There seemed distinct differences in emphasis about the extent to which the FHN should be seen/presented as a catalyst for provoking wider systems change. Although all interviewees wished this to happen, AFH stressed the FHN role itself more as an autonomous entity. Perhaps this reflected engagement with developing countries where primary health care systems were less established and embedded. AJ acknowledged that, since retirement, she was rather more explicit about the desire and need for the FHN to help change existing PHCT approaches than had been possible during the earlier stages of the developing FHN initiative.
Slovenia, the UK and Scandinavian countries were the main influence on the development of the conceptual framework and curriculum for the FHN	
The envisaged scope of the FHN role was ambitious but necessary and legitimate	
There was some significant opposition to the FHN development at European level from health visitors and midwives	
Scotland has been exemplary in progressing the FHN from concept into enacted role, but remains far ahead of other interested countries	
Many European countries still lack infrastructure and legislation for development of nurse education and nursing practice	

- The interview schedules had some core common questions, but were individually tailored to optimize learning opportunities from key informants with distinctive roles in the initiation, promotion and enactment of the FHN concept. Therefore cross-case analysis and subsequent synthesis of perspectives has only been undertaken where appropriate. This has been almost entirely in relation to the core common questions on the emergence and development of the concept at European level.

PART 5: Findings –application of theoretical frameworks from policy analysis

Table 5.1 Application of Kingdon's agenda setting model to the European emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Problems	Presenting problem for WHO Europe: Despite Vienna Declaration, the Health for All Nurse was never really enacted in European countries. Most remained hospital-dominated and both primary care and public health nursing were slow to develop. However, unclear to what extent individual countries really saw these matters as problematic. Underlying problem: In many countries there was a lack of infrastructure and legislation that would enable nursing education and practice development.
Policies	In WHO terms the key policy had been Health for All 2000. However, national governments determined nursing policy in individual nations, and cost containment policies were common in the 1990's. At WHO Europe level HEALTH 21 offered a new chance to push for better public health care across Europe.
Politics	In WHO Europe AFH focusing nursing efforts on public health and primary care. Key ally in JA. Therefore strong medical-nursing alliance, and FHN idea developed together. However, context of opposition from European GPs to nursing expansion. Also intra-professional tensions within nursing and midwifery when FHN concept announced.
Policy entrepreneurs	AFH and JA the two policy entrepreneurs working vigorously to align the perceived problem with the impending policy, and to lobby for political support within governments and professions. AFH's strategy twin-pronged in this regard: involving CNOs in the FHN development to promote ownership and trying to "sign up" individual Health Ministers from across Europe to attend the Munich Conference (a "Ministerial" Conference).
Windows of opportunity	The HEALTH 21 launch in 1998 marked the initial opening of this window of opportunity, and the Munich Conference of 2000 was designed to thrust then wedge it open.

Table 5.2 Application of C-C-C model to the European emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Context	The context/case for changing primary care nursing to make it more public health focused seems to have been accepted by a core set of people at WHO Europe, and various Chief Nursing Officers from different countries. However the "priming" for the proposed change was inadequate. Insufficient preparation time was cited as a factor in this, but it remains unclear whether there was ever going to be enough positive multi-professional support for this sort of initiative. No obvious "sea-change" in incentives since the relative failure of the Health for All Nurse.
Convergence	Thinking of the "push" from the profession in Europe and the "pull" from individual national governments, it is clear that sufficient momentum was generated to produce convergence on paper. In this way Ministers signed-up for a (watered-down) declaration and a pilot project was launched. However a great deal of the push towards alignment was coming from AFH and JA. Few individual nations have subsequently been able to sustain significant convergence between their professional and governmental agendas in such a way as to develop family health nursing substantially.
Contingency	Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at European level, it may be argued that JA and AFH's concept was unforeseen by many and they attempted to spark the concept and kindle it towards ignition. However, to date, it has not caught fire. As such, looking at the bigger picture, it must be argued that no significant contingency has arisen to fan its flames. Health policy across Europe has not changed decisively towards nations investing primarily in public health and primary care. GPs across Europe have not decided to make family care their priority. Nursing interest in family care remains more of a speciality area than a primary focus.

Table 5.3 Application of Kingdon's agenda setting model to the Scottish emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Problems	At CNO level there was a perceived need to modernise community nursing services to meet changing health needs of the Scottish population. Desire to integrate a public health approach within generalist nursing roles. General problems arising in sustaining health service provision to remote and rural areas. Within nursing profession broad assent for an increased focus on health if feasible. Beginnings of perception of problems in sustaining nursing services in remote and rural areas. Little evidence that community nursing care for families was seen as inadequate and/or a priority problem.
Policies	Huge raft of health and social care policies since Scottish devolution. Particular emphasis on promoting health and preventing disease. Family care an implicit theme, but rarely focal. Recent reviews of public health function of medical and nursing professions. Remote and rural issues becoming more central in health and social care policy papers. Scotland enthusiastic signatory to European HEALTH 21 but providing context rather than a focal policy driver.
Politics	Advocacy for initiatives to address health promotion and disease prevention. A time of change and optimism. Governmental support for nursing development. Advocacy for initiatives to address remote and rural concerns. Proactive Health Minister. However GPs very influential on remote and rural issues as public anxiety to retain GP services. Also anticipation of intra-professional tensions within nursing and midwifery if/when FHN concept announced.
Policy entrepreneurs	One policy entrepreneur only, AJ. Recognised that health and remote and rural agendas could be aligned. Had nursed the idea of a more generalist community public health nurse for a number of years. After emergence of FHN concept at European level, worked to align this and achieve confluence of this "third stream".
Windows of opportunity	Having tackled a number of more general, fundamental issues during the 1990's (e.g. nurse education into HEIs), in 1999 the timing was right for AJ to push on the FHN. It seemed that problems, policies and politics were sufficiently aligned to make a pilot project possible. This would involve some risk but a number of measures could be taken to balance these with likely benefits.

Table 5.4 Application of C-C-C model to the Scottish emergence of the FHN concept

Dimension of Model	Understanding derived through analysis
Context	The context/case for changing primary care nursing to make it more public health focused had been "primed" to some extent by the publication of policy documents and the review of the public health role of the nurse. However there was widespread unease amongst Health Visitors who felt threatened by the nature and pace of change. Therefore some professional momentum for more proactive community nursing development in Scotland, but any pressure for change was certainly not focusing on the care of families. Some leaders of nursing in remote and rural regions looking for possible solutions to perceived problems of nurse recruitment, retention and sustaining service provision. GPs in remote and rural areas becoming more vocal re. need to maintain cover and improve their quality of life: widespread public support. Experienced CNO looking to foster more specific nursing developments.
Convergence	As above context suggests, good possibilities of governmental "pull" for a policy initiative in remote and rural community nursing. Health and remote and rural policy agendas converging, but family care again an implicit theme. Professional "push" somewhat mixed across the above areas. Scope for an initiative, but also scope for significant intra and inter-professional friction. AJ successfully secured political support and funding first then worked to build a team that would help to bring about convergence of the new FHN concept with the other main policy agendas. General reaction of surprise/puzzlement in Scotland on announcement of pilot project, particularly in relation to the "family" emphasis. However sufficient convergence had been engineered for a substantive pilot of the concept and associated role. The extent to which the FHN can align with current policy agendas and sustain itself beyond the pilot and remote and rural regions is a central concern of the final two chapters of this thesis
Contingency	Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at Scottish level, it is clear that AJ's importation of the concept was unforeseen by most observers. It is clear that such a development would not and could not have happened without her agency. By securing key political support and a core development team AJ attempted to spark the concept and kindle it towards ignition. By her own admission there was always some doubt about whether the development would catch fire and in what direction it would travel. The key premise however was that the process would shed some light for the future. Undoubtedly Scotland has been a beacon for the other interested countries in Europe. However it is necessary to ask not only what has been learned but also what, if any, significant contingency will fan and fuel its flames in the future. As indicated above, this is a central concern of the final two chapters of this thesis.

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