family health

NURSING IN SCOTLAND

A report on the WHO Europe pilot
family health
NURSING IN SCOTLAND

A report on the WHO Europe pilot
Contents

Foreword 2
Introduction 4
What did we set out to do and why? 6
How did we develop the pilot? 8
What have we achieved? 12
What have we learnt? 21
What happens next? 24
Appendix 1 Membership of Family Health Nurse Steering Group 28
Appendix 2 Family Health Nurse Research Evaluation Summary Report 30
References 38
Foreword

In the autumn of 1999, when a small group of us first met to discuss whether Family Health Nursing had something to offer as an approach to practice in remote and rural areas, we had only a limited idea of what a Family Health Nurse might look like or do. However, it was clear that the vision of the Family Health Nurse as a generalist community nurse working with families was attractive, particularly in remote and rural areas, where current specialist models are becoming difficult to sustain.

WHO Europe originally established the Family Health Nurse project as a two-year pilot project with formal evaluation to demonstrate the impact. Our two-year pilot commenced in January 2001 when the first Family Health Nurse students commenced their studies at Stirling University and ended in December 2002, when the second cohort of students completed the programme. Our formal evaluation undertaken by Robert Gordon University covered this period.

Throughout the project to date, we have emphasised the pilot nature of the work and been open minded about potential outcomes. This was vital in order not to undermine the valued contribution of existing community nurses and to allow them to explore the Family Health Nurse concept without feeling threatened.

Of course two years is a very short time. The end of the pilot provides an opportunity to reflect back on what we have achieved and what we can learn from it to inform future developments. The fact that we have achieved so much is a very great tribute to all of the people who have been involved. The education team at Stirling University who rose to the challenge of designing a new programme from scratch, without a clear model of what the end product would be. The practice supervisors who had to try to make sense of a new role that they themselves didn’t yet fully appreciate and equip the students with the skills to take it on. The pilot sites who had the vision to see what the Family Health Nurse might offer and the commitment to see through what has been, and continues to be, a very complex change programme. The researchers, who have gathered mountains of rich and complex data, responding constantly to the evolutionary nature of the project and succeeded in making some sense of it all to help inform the future. The professional organisations, regulatory bodies and other professional and lay colleagues who have supported both national and local steering groups, providing both sound advice and the challenging questions necessary to keep the project on track. But most of all, our thanks must go to the Family Health Nurses themselves. 31 nurses who were prepared to put themselves forward as guinea pigs to test out a new way of working. Their enthusiasm and commitment to learning and developing Family Health Nursing has been truly inspiring.
This report summarises what we have learnt from the initial two-year pilot and sets out how we plan to apply that learning in taking forward the development of Family Health Nursing in Scotland.

Anne Jarvie
Chief Nursing Officer
**Introduction**

The Family Health Nurse project has placed Scotland firmly on the International health care map. A core strategy of the WHO Europe’s health policy document (HEALTH21) is to strengthen primary health care by developing family and community-oriented health services. Although differences exist across Europe in the delivery of primary care, there is universal agreement that primary care must be the core of service provision and that provision of medical and nursing services based on specialism is unsustainable in the long term.

Community nursing in the UK has grown and developed, directed by health policy and in response to changing health care needs. The current system comprises eight different specialist nursing pathways within the national regulatory framework of the Nursing and Midwifery Council (NMC). Whilst education programmes have for many years been moving towards a more integrated approach, combining core with specific modules across the eight pathways, practice has, in general, continued with a very specialist approach. In this sense although educationally community nurses are seen to have areas of shared knowledge and skills, once in practice the different community nursing specialisms work within quite clearly defined professional boundaries.

The Family Health Nurse project has challenged this approach by exploring the feasibility of preparing a generalist community nurse who can work across these professional boundaries. Scotland’s reputation of well established community nurse education and practice systems, provided a solid foundation on which to test this different approach to service delivery.

WHO Europe described the role of the Family Health Nurse as one which contains elements which are already part of the role of several different types of nurses working in primary care across the European region. What is new is the particular combination of the various elements, the focus on families and on the home as the setting where family members should jointly take up their own health problems and create a ‘health family’ concept. (WHO Europe 2000:2).

In this sense the focus is very much on the practice approach of working with families in a different way and at a different level from existing models. In line with WHO Europe thinking the use of the term family is operationally defined in its broadest sense to encompass the notion of a unit which may include:

- individuals with geographically distant relatives
- friends who provide a supportive role in a similar way to a family member
- traditional nuclear family with different generations being geographically close.
The Scottish Family Health Nurse project was established initially as a two-year pilot in line with WHO guidance. This report summarises the processes, experiences and learning gained from the two-year Scottish pilot (2001-2003), sharing the journey travelled by those involved in the project to explain Scotland’s involvement in the WHO Europe multi-national study. Exemplars and anecdotal accounts are given where possible to reflect the personal experiences of those involved in the pilot.

Two years is a very short period of time to undertake a very complex development involving the simultaneous education of nurses and development of a new model of practice. However, the pilot nature of the project has meant that learning would be formally evaluated and that if unsuccessful, the development could be halted. A clear conclusion from the deliberations of the project steering group is that while some questions remain unanswerable from the project to date, there is sufficient value in this new approach to practice to continue to develop and explore its potential. The report therefore concludes by setting out the next steps in the development of Family Health Nursing in Scotland.
What did we set out to do and why?

Within Scotland population sizes, health profiles, and local economies are changing. The current community nursing service provision, however, remains focused on specific roles. Remote and rural communities now have a different landscape, often with declining and increasingly elderly populations spread across large geographical areas. This changing profile means that consideration must be given to the way in which we deliver services in order to ensure that communities continue to receive high quality health care. The Family Health Nursing model described by WHO Europe combines a locally-based skilled generalist with a support network of community nurse specialists who may be geographically distant. Whilst theoretically this model may seem feasible, in order to effectively evidence-base our practice it was important to first test it in a small number of pilot areas.

Two principal reasons underpinned the decision to participate in the WHO multi-national study and to pilot this role in remote and rural areas of Scotland:

1. The policy emphasis on health improvement rather than purely health care. This message is a central tenet of the main strategic documents outlining the future direction of health care services in Scotland.

The focus on family rather than individuals within the Family Health Nurse model creates a role that is focused not just on health care, but on the wider determinants of health. A truly family-focused health improvement role.

2. The difficulties associated with operating a specialist model of practice within small remote communities.

Nursing built on traditional models of education and service has led to a number of difficulties in remote and rural areas. These include recruitment and retention of nurses, professional isolation, and increasing problems of maintaining skills and competencies in sparsely populated areas. Previously this issue was addressed through the appointment of triple duty nurses who had undertaken educational programmes in general nursing, midwifery, health visiting and district nursing. Many of these nurses also provided school nursing services. Whilst double and triple duty nurses remain a mainstay of service delivery in some remote and rural areas of Scotland, NHS Boards are finding it increasingly difficult to recruit, educate and retain people in these posts. There is also anecdotal evidence that equipping nurses with a tool bag of specialist roles does not necessarily prepare them well for a generalist role.
It was against this backdrop of a changing demography, modernisation of health care services and an evolving nurse education system that the piloting of family health nursing was debated and agreed with service and education partners.

The specific objectives of the Scottish pilot were:

- to test the Family Health Nurse model within remote and rural areas
- to develop and test an education programme based on the multi-national curriculum from WHO Europe.

A pilot project running over two years was established to achieve these objectives. The development of the project and the outcomes and learning from it are summarised in subsequent chapters.
How did we develop the pilot?

The initial development process for the pilot involved identifying nurse leaders in remote and rural areas interested in the concept and exploring with them the potential for such a role. Western Isles, Orkney and Highland NHS Boards expressed an interest and discussions were taken forward involving this core group and Stirling University as their main nurse education provider (Argyll & Clyde NHS Board subsequently joined the pilot in year 2). From initial discussions involving this key group a proposal was developed, leading to a formal expression of interest for inclusion in the multi-national study to WHO Europe. This process required a detailed plan incorporating the different elements shown on Figure 1. This plan subsequently provided the blueprint for the Scottish pilot. The Scottish pilot was the first to be approved and has continued to be a front runner amongst the pilot sites.

A formal independent evaluation was commissioned from the Centre for Practice Research and Development at Robert Gordon University, Aberdeen.

Decision-making Processes

A National Steering Group was established to direct the project, chaired by the Chief Nursing Officer. The membership of this group involved a range of different people representing professional and lay perspectives. Membership of this group is detailed in Appendix 1. A project officer was appointed to facilitate and manage what was to prove to be a complex and challenging project.

The Directors of Nursing chaired local Implementation Groups in each of the pilot sites, engaging with stakeholders from health care, social work, health councils and communities. These groups were particularly important for identifying issues specific to the local sites. A further remit of the Directors of Nursing and their senior management colleagues was in working with primary care teams where Family Health Nurses were located. This was challenging for everyone, particularly in the early stages of the pilot, because of the somewhat hypothetical nature of the role, and the anxieties around the integration of this different approach to practice. Teams were encouraged to view the return of their colleague as a Family Health Nurse, as an opportunity for members to reflect on the needs of the practice population, and then to map these against the collective skills they have as a group in order to determine individual responsibilities.

A separate group was established to oversee the evaluation, managed by the Central Research Unit (subsequently the Social Research Unit) in the Scottish Executive to help ensure the independence of the evaluation. Feedback from local implementation groups and the evaluation steering group was received by the project steering group at its three monthly meetings in order to inform its discussions.
Communication

In the early stages of the pilot information was limited mainly because there was little known about the actual role. As such this caused some unease in both the pilot areas and the wider community nursing workforce. In recognising this problem several strategies were initiated to respond to these anxieties including:

- creation of a Family Health Nurse project website (www.show.scot.nhs.uk/sehd/familyhealthnurseproject)
- project presentations to nurses at team meetings, professional events and conferences
- undertaking road shows in the pilot areas for people from local communities and professional groups
- press releases to local newspapers in pilot communities
- articles in nursing journals and professional organisation newsletters.

While communication within the pilot was essential and continued throughout the duration of the initiative, external communication has been deliberately more limited in order to protect the participants and allow them the space to learn and develop new roles.
### Request to be considered as a Pilot Country
Initial expression of interest to WHO Europe (2000).

### Reasons why pilot is being considered
- Policy move to health improvement.
- Delivering health care to remote and rural communities.

### Who will be involved in planning & implementation?
- National Steering Group chaired by Chief Nursing Officer representing pilot sites, education, research, community health council, professional organisations.
- Local implementation group within each pilot site representing key stakeholders within the community.

### Where will the pilot be located?
NHS Boards of Highland, Western Isles, Orkney, and Argyll & Clyde (joined in 2nd year of pilot).

### How will the nurses be selected?
- Workforce planning process by Directors of Nursing in each of the pilot sites.
- Mix of community nurses with existing specialist practitioner qualification (DN, HV, triple duty), and first level registered nurses who have worked within primary care.
- Minimum of 2 years’ post-basic experience (in line with Community Nursing Specialist Practitioner Qualification recommendation from NMC).
- Interview with panel from practice and education.

### When will the two-year pilot begin?
February 2001 (first intake of students to education programme).
Outline of different stages

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Recruit project officer and establish National Steering &amp; Local Implementation groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Select 1st cohort of students from practice &amp; backfill posts.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Complete curriculum and prepare for validation event with NES (NHS Education for Scotland).</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Commence cohort 1 (n=11) on education programme and start independent evaluation.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Work with local primary health care teams re integration of FHN role.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Graduation of cohort 1 and commencement of cohort 2 (n=20) on education programme.</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Dissemination of findings from evaluation, publication of SEHD project report and Conference.</td>
</tr>
</tbody>
</table>

What are the three main challenges in piloting the Family Health Nurse?
- Changing the approach and range of practice of experienced nurses.
- Integrating and sustaining the role in established primary health care teams (nurses mainly returned to their own teams).
- Addressing expectations of local communities.

How will the pilot be evaluated within your region?
Concurrent independent evaluation by research team from Centre for Practice. Research and Development (CeNPRaD), Robert Gordon University, Aberdeen.
What have we achieved?

The Education programme

The selection of Stirling University to lead the education programme was based on existing development work with service partners exploring a community nurse education model for remote and rural areas and the geographical proximity of its two satellite campuses in Inverness and Stornoway to the pilot areas.

The Family Health Nurse programme was developed from a competency and research based WHO Europe Curriculum for Family Health Nursing (WHO Europe 2000). On completion of the curriculum the Family Health Nurse was expected to be competent as, a:

- care provider
- decision-maker
- communicator
- community leader
- manager.

Stirling University adapted and developed their programme from this original document to meet the requirements of the Nursing and Midwifery Council, and to fit with contemporary primary health care in remote and rural areas. A programme development group was convened comprising both educators and practitioners to produce a curriculum for the Scottish Family Health Nurse pilot. The Bachelor of Nursing in Community Studies (Family Health Nurse) was subsequently validated by the then National Board for Nursing, Midwifery & Health Visiting for Scotland. This curriculum comprised the following units of study:

- Working with Families  1 advanced credit
- Communication  1 advanced credit
- Advanced Family Health Nurse Practice  2 advanced credits
- Research, Decision-making, and Evaluation in Clinical Practice  2 advanced credits

(note each advanced credit is equivalent to 20 SCOTCAT points at level 3)

Originally the intention had been to create a shortened conversion course for those nurses with an existing specialist practitioner qualification. However, it soon became apparent that we would need to have a better understanding of both the Family Health Nurse role in practice and the necessary competencies before this would be possible.
The Family Health Nurse course was studied full time over one academic year. The programme was designed to reflect the remote nature of the practice sites and made extensive use of Information Technology and distance learning as well as more traditional teaching methods.

One difficulty associated with developing a new role in this way is providing appropriate practice-based education and supervision. Supervisors on the programme were experienced health visitors and district nurses from within the pilot sites, many of whom were heavily involved in developing the education programme. The preparation of practice supervisors was further developed in year 2 of the programme in response to a need identified by educators and practitioners. The reflection of one supervisor shows how their understanding of the Family Health Nurse role has continued to grow.

**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 now working alongside qualified Family Health Nurses.**

A total of 31 students undertook the Family Health Nursing programme, 11 in the first year and 20 in the second year. This was a diverse group from a mixture of different Scottish cultural backgrounds and with a broad range of professional experiences. The student cohort included staff nurses from primary care settings, district nurses, a health visitor and a triple duty nurse. Many were also midwives. The enthusiasm of this group was inspiring and the opportunity to share learning with nurses from other areas provided a real catalyst for their personal development. For these nurses working in remote and rural areas the opportunity to network with others and undertake learning via web-based systems was highly valued. As part of their education programme they were asked to record their feelings and experiences in a reflective diary. These reflections provided unique insights into their commitment to family health nursing and highlighted their very personal achievement in successfully completing the education programme.
Reflections on the education experience

1. On new beginnings
   “I’m at the beginning of a journey, I’m pleased to be here although the end is not yet in sight, but as yet that doesn’t worry me. I’m not even sure of the route that I’m going to take but I’m happy just to take it one step at a time.”

2. On the student experience
   “Like the mobile analogy we have all effected movement and change in response to the whirlwind of campus life and psuedo-student status.”

3. On group learning
   “I find networking with others so inspirational, how many years experience are in that room, and almost everyone of us is there because we really want to be here at the cutting edge of nursing provision.”

4. On working in a different way with families
   “My previous ideas of family dynamics and communication needs questioning. Met two of the families, my previous perception of both families was wrong.”

5. On the value of practice supervisors
   “My contact with my supervisor has given me bursts of sunshine.”

6. On life long learning
   “Life long learning is a must and I have found this course has made me eager to learn more not only for my benefit but also the benefit of the community in which I work.”

7. On the concept of family health nursing
   “I am more convinced than ever that this is the model to pursue as the way forward for community nursing.”

Throughout the pilot the education team worked closely with the other stakeholder groups and provided an invaluable input to the Steering Group discussions.
Family Health Nursing in Practice

All of the students were identified to participate in the programme by a combination of their enthusiasm and interest in the pilot and consideration of current and potential workforce needs. For many of the Family Health Nurses, this meant that at the end of the programme they would return to their former practice areas to take up their new role as a Family Health Nurse. This transition back into practice was inevitably a challenging time as the new Family Health Nurses attempted to establish their new identity and consolidate learning from the education programme. The evaluation report captures some of the experiences of the first cohort of 11 students as they pioneered a new model of Family Health Nursing practice. For some, this proved to be easier than for others, due to a combination of workload and the expectations of both the Family Health Nurses and fellow team members. However, all of the Family Health Nurses have changed the way that they approach practice, which is demonstrated in the range of work they are involved in either individually or as part of the wider primary health care team.

The original vision of Family Health Nursing in Scotland was to create a role that had three underpinning principles:

- It is a skilled generalist role encompassing 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 evaluation report details the extent to which this vision was achieved in the early months of practice of the Family Health Nurses.

The skilled generalist role is the underpinning core of the Family Health Nurse role. For a number of reasons this has been the most difficult aspect to realise for the nurses. Creating a generalist role, within a context of existing specialist roles has been challenging. Those nurses working as a single practitioner within an isolated community have inevitably had the greatest success in this respect and have been able to apply the learning acquired to expanding their existing generalist role to better meet the needs of communities.
For other nurses, the lack on any preconceived boundary on their role has proven valuable to enabling them to expand into areas not well addressed by other members of the team. This is most notably the case with certain dimensions of public health practice.

The Generalist/Specialist Nurse Interface
Collaborative working between the Family Health Nurse and Health Visitor in a Island community has enabled a Parenting Skills Group to be started. The Health Visitor will work with the Family Health Nurse to enable her to further develop skills and knowledge in this area of practice. The mentorship-type arrangement of the generalist being supported by a specialist community specialist is an example of a different way of developing services in response to local need.

Healthy Lifestyles
Family Health Nurses are increasingly involved in developing new initiatives within communities. Some of these are in partnership with other professionals in primary care. Working collaboratively with the local health promotion department has also helped inform the public of the services provided by the Family Health Nurse. New projects include:
The very popular Senior Swimmers Group celebrates the young at heart message with its oldest member of 80 years confirming that active lifestyles can be maintained regardless of age.
Health checks at the local agricultural show have proved such a success that requests are now coming in from other workplaces.
A Healthy Eating Initiative facilitated jointly by the Family Health Nurse and District Nurse will encourage people to make lifestyle changes which could make a real difference to their future health regardless of age.

The focus on family is perhaps the most distinctive dimension of the role, which is markedly different to the approaches used by other nurses. Family Health Nurses have demonstrated skills in working with families with complex underlying health problems and in engaging the wider family in work to improve health and wellbeing.
At its most extreme presentation, the effect of this has been to create a role which is essentially evolving as a separate specialism, with other community nurses referring on families with the most complex health problems. Clearly this is not what was envisaged, but indicates a need to equip a wider group of nurses with the skills and tools of Family Health Nurses.

Working with Families
Family Health Nurses have identified the ways in which they are now working differently with individuals and families since returning to practice. One Family Health Nurse feels they are now recognising much more the resource of the extended family. Working with a family and a young child with special needs the inclusion of grandparents in the family health plan is something which they would not have considered previously. Another Family Health Nurse spoke of the value of including the whole family unit in a health discussion. Previously they would have targeted the individual but now by including other members, the family group is able to support that person. In this way responsibility is given back to the family to create their own healthy lifestyle. For one family the creation of a genogram (health history) enabled them to see with clarity the pattern of smoking-related disease and mortality in their background, and proved the incentive for them to work collectively with the Family Health Nurse on a smoking cessation programme.

At its most extreme presentation, the effect of this has been to create a role which is essentially evolving as a separate specialism, with other community nurses referring on families with the most complex health problems. Clearly this is not what was envisaged, but indicates a need to equip a wider group of nurses with the skills and tools of Family Health Nurses.

Working in a Different Way
Working with an individual with a chronic disease condition the Family Health Nurse discussed different treatment options and provided details which enabled an informed decision to be made by the person. This approach encouraged a previously reluctant person to accept the changes to their regime. In summing up their feelings about the approach used by the nurse the person stated: You didn’t tell me what I must do, you challenged my thinking, presented a rational argument and then backed it with evidence.

For other Family Health Nurses their role as the lynchpin for families receiving input from many different specialists is really developing. Examples have been given on how they are working in this way with families who have complex mental or physical health needs providing the vital resource of a locally based key worker.

The return to practice in January 2003 of the second cohort of 20 Family Health Nurses has helped to further consolidate and develop the role, with a number of primary health care teams now having two or more Family Health Nurses.
There remain however a number of challenges to be addressed in making the most of Family Health Nursing. These include developing effective and meaningful family health records, re-thinking the concept of caseloads in a role where a significant part of the community could become part of the Family Health Nurse’s caseload and reviewing the balance of generalist and specialist functions within primary health care teams.

Evaluation
The research team from the Centre for Nursing Practice, Research and Development, Robert Gordon University were commissioned to conduct the evaluation study following a competitive tendering process. Their work encompassed a broad range of qualitative analysis of both the education programme and the practice of the first cohort of Family Health Nurses and paints a rich picture of how the role has developed.

The objectives of the evaluation were:

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 Family Health Nurses 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 Family Health Nurse.

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

5. To identify relevant stakeholders perceptions of the Family Health Nurse model.

6. To draw out implications from the study’s findings for the future provision of education for Family Health Nurses and for the extension of service provision to other areas of Scotland, including urban areas.
These provided the basis for the research study. The findings are reported under three main themes:

- **The Education of Family Health Nurses**
  Includes a review of education curricula from existing community nursing programmes across Scotland as well as an analysis of the Family Health Nurse programme.

- **Family Health Nursing Practice**
  Provides an overview of practice from the perspectives of different stakeholder groups including Family Health Nurses.

- **The Wider Scottish Context**
  Addresses the issue of applicability of the model to the wider community through seeking views from other NHS Boards.

- **Implications for Role Development**
  Identifies the difficulties associated with the integration and development of the role and recommends areas for facilitation activity.

A full copy of the report can be downloaded from the Scottish Executive Social research website (http://www.scotland.gov.uk/socialresearch). A summary of the evaluation findings covering these main themes in more depth is located in Appendix 2.

**WHO Europe Multi-national Study**

Scotland remains the lead pilot country in the multi-national study. Due to the different stages of readiness of interested countries it was necessary to have a degree of flexibility regarding start dates. Each member state was offered the chance to participate based on their ability to meet certain requirements. These included ministerial and local authority support, and the existence of a robust infrastructure to support and sustain the two-year pilot. Participation in the multi-national study was subject to approval of the country plan. Progress within other pilot countries has been variable. This is due to a range of circumstances. However enthusiasm and commitment remains high and there is evidence of preparatory work being undertaken to develop the practice and nurse education systems to meet the criteria for inclusion in the multi-national study.

Countries participating in the multi-national study include Armenia, Estonia, Finland, Kyrgyzstan, Lithuania, Republic of Moldova, Slovenia, Scotland and Tajikistan. Denmark, Germany and Spain remain interested but are still involved in discussions at a country level. The confirmed countries provide a good representation of member states from Western, Central and Eastern Europe. As part of the multi-national study a comparative analysis across the region is being undertaken by Dr Deborah Hennessy. Scotland was selected as the country to pilot the evaluation tools for this analysis.
The multi-national study group chaired by Ainna Fawcett-Henesy (Regional Advisor Nursing and Midwifery, Health Policies, Systems & Services) meets to review progress on Family Health Nurse implementation and to discuss the assistance required to support individual countries. As part of this support programme Scotland has worked closely with other countries. To date the project officer has delivered workshops to community nurse educators from Armenia and Uzbekistan, and guidance has been provided on curriculum development and Family Health Nursing practice.
What have we learnt?

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. So what have we learnt from the pilot?

At its last two meetings, the project steering group considered a number of different scenarios as potential outcomes of the project and discussed what would need to happen were any of these to be the final outcome.

- **Scenario 1** – The Family Health Nurse is not an appropriate model to meet the health needs of remote and rural communities. The pilot should end and alternative roles should be found for the existing Family Health Nurses.
- **Scenario 2** – There is sufficient evidence to suggest that the Family Health Nurse role is valuable and it should be further developed within the four pilot NHS Boards.
- **Scenario 3** – The Family Health Nurse role provides a worthwhile model for practice in remote and rural areas and it should be further developed in other remote and rural NHS Boards.
- **Scenario 4** – The Family Health Nurse provides a future model for community nursing practice and should be developed further in other settings, i.e. urban or with specific client groups.

It quickly became apparent from discussion that all participants believed that option one was not feasible. Having developed the approach to Family Health Nursing within the pilot sites none of the sites believed that it would be either possible or desirable to halt the development and expansion of the role at this point. Discussion therefore centred on the three remaining scenarios and was further developed at a two-day workshop informed by the first draft of the evaluation report and involving representatives from all four UK health departments.

The outcomes of those discussions summarise the learning from the pilot programme and form the basis for future development of the Family Health Nursing role in Scotland.

The pilot as a whole

The remarkable thing about the pilot has been the way in which the collective expertise of policy-makers, educationalists, practitioners and researchers has been brought to bear in a collaborative and developmental way. Practitioners have informed and supported the development of the education programme, which in turn has helped to shape a new model of practice. The researchers, whilst maintaining their independence, have been able to feed back emerging themes to the project steering group to help inform the direction of the project. This collaborative approach provides some important lessons about what can be achieved through working in partnership.
The education of Family Health Nurses and community nurses as a whole

The Family Health Nurse education programme sought to educate nurses for a role which, at that time, was still hypothetical. Clearly this was very challenging and the achievement is a tribute to both the education team and the students who pioneered the approach.

The greater emphasis within the programme on the practice of Family Health Nursing, including dimensions such as communication and assessment skills set it aside from existing community nursing programmes and provides a precedent to re-think existing approaches to community nursing education.

Our understanding has developed around the different ways in which education can be delivered to practitioners working in remote and rural areas where access to mainstream education programmes can be problematic. The experiences of the Family Health Nurses demonstrate the need to balance distance learning approaches with collective learning. In this sense there is a value in mixed methods where locally based learning is combined with bringing people together to create a group learning environment. In this way students can share experiences from different clinical backgrounds and organisations.

Whilst acknowledging the range of work undertaken by the education team, the evaluation findings also make recommendations for Family Health Nurse curriculum development, which need to be taken forward in any future educational programme (see Appendix 2).

The Practice of Family Health Nurses

Inevitably, the evaluation concluded at a relatively early point in the development of Family Health Nursing practice. Family Health Nurses were allowed considerable leeway in developing their practice, although the ability to continue to network with their peers and the support of local implementation groups were an invaluable support. The four typologies of family health nursing practice referred to in the evaluation report highlight the influence of context and the nature of the impediments which have weakened or slowed the development of the role.

A clear message from the evaluation is the need to facilitate and support change within teams if the full potential of the Family Health Nursing approach is to be realised. In particular the experience of the pilot suggests that change needs to be directed at different levels within an organisation in order to sustain this new role. The evaluation report urges the need to invest time in supporting and sustaining changes in practice and offers two necessary factors for progress:

- the perceived scope/space to encourage implementing this approach.
- the local presence of at least one active supporter who changes their own practice.
Anecdotal evidence from the pilot sites suggests that the cohort two nurses, whose practice was not included in the evaluation, are having an effect in shifting the critical mass of practice within the pilot sites, as is the growing experience and confidence of all the Family Health Nurses.

The way forward

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. The evaluation has provided recommendations that reflect discussions from the steering group members.

These are:

- Planned development should be facilitated with those primary health care teams that include a Family Health Nurse in order that the role can be better understood and developed to respond to the needs of local communities.
- The educational programme should be further developed as suggested in Chapter 2 of the evaluation report (summarised in Appendix 2 of this report).
- The evaluation process and resultant evidence should be disseminated widely across the UK to foster debate and critical thinking about the nature of community nursing services and suitable educational preparation.
- The Family Health Nurse model should be further explored in an urban context.
What happens next?

Taking the outcome of the evaluation and the resultant steering group discussions, it was apparent that none of the four scenarios outlined to the steering group fully described the position that we find ourselves in at the end of the pilot. That position might be summarised as follows:

All participants in the project remain committed to the Family Health Nurse as a model of generalist community nursing practice, however, the findings of the evaluation point to more work that needs to be done in order to understand and apply the full potential of the role.

A second phase of the project is therefore proposed that will help address some of the outstanding uncertainty. Phase 2 of the Family Health Nursing project has the following objectives:

1. To consolidate the practice of Family Health Nursing within the primary health care team in each of the existing four pilot sites.

2. To test the suitability of the role in an urban setting.

3. To review and develop the educational programme based on competencies for Family Health Nursing practice.

4. To apply learning from the Family Health Nurse programme to help shape the future of community nurse education.

5. To promote debate on the future development of Family Health Nurse practice in Scotland and the UK.

To consolidate the practice of family health nursing within the primary health care team in each of the existing four pilot sites

In order to facilitate this, an active change management programme will be developed in each of the local pilot areas as part of an overall action research project. In practice, what this will mean is the recruitment of a local facilitator in each of the four NHS board areas who will work with whole primary health care teams in order to support change and develop the full potential of Family Health Nursing within the team. By linking each of these local pieces of work into a nationally focused action research project it will be possible to assess the impact and potential of the role. The action research will be taken forward over an 18-month period commencing October 2003.
To test the suitability of the role in an urban setting
The existing pilot has given us many answers about the potential of the Family Health Nurse role and the action research will move us further towards a conclusion on the value of the role. However, the uniqueness of the existing pilot sites will always raise some questions of replicability of the findings more widely. It is therefore proposed to further test the role within an urban setting. The 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 Family Health Nurses working alongside Family Doctors as originally envisaged by WHO Europe in Health 21.

To review and develop the educational programme based on competencies for family health nursing practice
A vital part of any further developments within Family Health Nursing will be a review of the education programme, picking up on the recommendations of the evaluation report. It is proposed that based on the learning from the pilot, clear competencies for Family Health Nursing 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, focused around the competencies and their comparability to those of existing community specialist practitioners, would be the development of a short conversion course that would allow existing community specialist practitioners to become Family Health Nurses.

To apply learning from the Family Health Nurse programme to help shape the future of community nurse education
This is an important time in the history of community nursing practice, with the NMC consulting on the future regulation of community specialist public health nursing and further reviews of specialist practice to follow. There is much that the work to date on Family Health Nurse education can offer to help inform those debates. There is also learning on approaches to family assessment and practice that could be applied to other fields of practice. The publication of the evaluation report and this project report will provide a basis to support wider discussion on the future of education for community practice.

To promote debate on the future development of Family Health Nurse Practice in Scotland and the UK
A decision was taken early in the development of the pilot project, to maintain a low profile for the project. Partly as the potential outcome was not clear and partly in recognition of the need to protect the pioneers charged with developing the new role from external scrutiny at a formative stage of the development of the role. The time is now right to promote a much wider debate, both within Scotland and the UK and to contribute to the wider WHO Europe project. The conference marking the publication of this report marks a start of that wider engagement.
Figure 3 summarises the objectives and the components of Phase 2.

**Figure 3 Family Health Nurse Project – Phase 2**

**United Kingdom Context**
Engage with national organisations re wider debate on future of specialist community nursing practice.

**WHO Europe**
Contribute to development of Family Health Nurse role across Europe.

**Scottish Project**
1. To consolidate the development of family health nursing in each of the existing four pilot sites.
2. To test the suitability of the role in an urban setting.
3. To review and develop the educational programme based on competencies for family health nursing practice.
4. To apply learning from the Family Health Nurse programme to help shape the future of community nurse education.
5. To promote debate on the future development of Family Health Nurse Practice in Scotland and the UK.

**Existing Pilot Sites**
**Sites**
- NHS Highland
- NHS Orkney
- NHS Western Isles
- NHS Argyll & Clyde

**Aims**
1. Enable FHN role to develop and integrate with current service provision.
2. Develop the core PHCT in order to incorporate a more systematic family focus into existing care practices.
3. Involve individuals and families in recognising a different approach to nursing care.

**Processes**
Action research type project.

**Urban Project**
**Site**
NHS Greater Glasgow

**Aims**
1. Educate a new cohort of Family Health Nurses using revised curriculum.
2. Explore appropriate settings for urban sites.
3. Test suitability of role in urban context.

**Processes**
Small-scale pilot project.

**Education Project**
NHS Education for Scotland with Education partners.

**Aims**
1. Develop a clear set of competencies for family health nursing based on pilot study curriculum, experiences of Family Health Nurses, and evaluation report findings.
2. Design and operate a revised programme based on above.
3. Create a shortened route (conversion programme) for existing community specialist practitioners.

**Processes**
Competency development group.
Within this framework it is essential to have a clearly defined communication pathway to ensure the main strands of Phase 2 are working in tandem and not just in parallel. It is therefore proposed that the strands will be linked at different levels both vertically and horizontally through identified people within each of the main stakeholder organisations. This flowchart is illustrated in Figure 4.

**Figure 4 Communication and Decision-Making Flow Chart for Phase 2**
## Appendix 1 Membership of Family Health Nurse Steering Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Adams</td>
<td>Director of Nursing</td>
<td>NHS Western Isles</td>
</tr>
<tr>
<td>Malcolm Alexander</td>
<td>Strategic Director</td>
<td>RARARI</td>
</tr>
<tr>
<td>Margaret Alexander</td>
<td>Education Consultant</td>
<td>WHO Europe</td>
</tr>
<tr>
<td>Kathleen Bree</td>
<td>Director of AHPs &amp; Nursing</td>
<td>NHS Orkney</td>
</tr>
<tr>
<td>Yvonne Christley</td>
<td>Assistant Policy Advisor</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Graham Cooper</td>
<td>Representative</td>
<td>Highland Health Council</td>
</tr>
<tr>
<td>Anna Daley</td>
<td>Professional Officer</td>
<td>Community Practitioners &amp; Health Visitors Association</td>
</tr>
<tr>
<td>Charlotte Dickson</td>
<td>FHN Programme Leader</td>
<td>Stirling University</td>
</tr>
<tr>
<td>Kay Eastwood</td>
<td>Director of Nursing</td>
<td>NHS Argyll &amp; Clyde</td>
</tr>
<tr>
<td>Ann Gow</td>
<td>Public Health Nurse Consultant</td>
<td>NHS Greater Glasgow</td>
</tr>
<tr>
<td>Sue Hickie</td>
<td>Professional Officer</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>Anne Jarvie</td>
<td>Chief Nursing Officer</td>
<td>Scottish Executive</td>
</tr>
<tr>
<td>Callum Macaulay</td>
<td>General Practitioner</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Julie McNutt</td>
<td>Representative</td>
<td>Community &amp; District Nurses Association</td>
</tr>
<tr>
<td>Alison McVie</td>
<td>Representative</td>
<td>UNISON</td>
</tr>
<tr>
<td>Brian Michie</td>
<td>General Practitioner</td>
<td>NHS Western Isles</td>
</tr>
<tr>
<td>Iain Murray</td>
<td>FHN Programme Director</td>
<td>Stirling University</td>
</tr>
<tr>
<td>Michael Proctor</td>
<td>Primary Care Development Manager</td>
<td>Scottish Executive</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Organisation</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Patricia Purton</td>
<td>Director</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>Linda Sinclair</td>
<td>Acting Assistant Director of Nursing</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Helen Spratt</td>
<td>Director of Nursing</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>Lesley Whyte</td>
<td>Project Officer</td>
<td>Scottish Executive</td>
</tr>
<tr>
<td>Maureen Williams</td>
<td>Professional Officer</td>
<td>Nursing &amp; Midwifery Council</td>
</tr>
</tbody>
</table>
APPENDIX 2 FAMILY HEALTH NURSE RESEARCH EVALUATION 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 two-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 20 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 the Scottish Executive Social Research Group 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.
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.

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

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.

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).

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.

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.
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.

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.

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.

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.

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.

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 lacked dedicated time for the role.

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 seven 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.
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.

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

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.

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

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.

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.
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.

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.

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 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.
References

