

**A follow-up study of professionals' perspectives on the development of family health
nursing in Scotland**

Colin Macduff
Research Fellow
Centre for Nurse Practice Research and Development (CeNPRaD),
School of Nursing and Midwifery
The Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG

Telephone: 01224 262647
Fax: 01224 262630

c.macduff@rgu.ac.uk

Abstract

Background

In 1998 the World Health Organisation Europe introduced the Family Health Nurse concept. The envisaged role of this community based nurse was seen as multifaceted and included helping individuals, families and communities to cope with illness and improve their health. During 2000-2002 Scotland led enactment of the concept through education and practice, and the first research study evaluating its operation and impact in remote and rural areas was published in 2003.

Objective

This study's purpose was to follow up health care professionals' perspectives on the development of family health nursing in remote and rural areas of Scotland since 2002.

Methods

The main research method used was questionnaire survey of all the established family health nurses in these areas and all other health and social care professionals with whom they had regular work-related contact. Where novel contexts or practice patterns emerged, further investigation was undertaken through telephone interviews.

Findings

Twenty three family health nurses (88%) and 88 of their colleagues (52%) returned questionnaires. Eight family health nurses were interviewed. The dominant theme within the findings was the gradual, positive development of a role which tended to maintain established community nursing service provision, yet also supplement this with a limited expansion of family health services and public health activities. The flexibility and wide scope of the FHN role in terms of providing generalist community health nursing services was clearly evident. However, capacity to engage with whole families was found to vary widely in practice.

Conclusions

Within remote and rural Scotland family health nursing is gradually consolidating and developing, but its particular aspiration to engage with whole families is often difficult to enact and is not a priority within mainstream UK primary care policy, planning or provision.

Keywords: Family Health Nurse; Community nursing practice; Primary care; follow up study

What this paper adds

The World Health Organisation (WHO) Europe Family Health Nurse (FHN) concept was launched in 1998 but, to date, published research evaluating its enactment has been very scarce indeed. This paper addresses this deficit by presenting data from a recent study which followed up professionals' perceptions of the role's development within remote and rural Scotland. The findings show that the role is gradually developing in these settings, but also that a number of challenges remain in relation to its sustainability and further development.

1. Introduction

Scotland has been the first country to enact the World Health Organisation (WHO) Europe Family Health Nurse model. The concept of the Family Health Nurse (FHN) was introduced in 1998 (WHO Europe 1998a) as a new role that would make a key contribution to the achievement of the targets set out in the HEALTH 21 policy framework. The envisaged role of this community based nurse was seen as multifaceted and included helping individuals, families and communities to cope with illness and improve their health. At WHO Europe level it was initially envisaged that 18 European countries would take part in the development of this new role through parallel processes of education and implementation. However, to date, Scotland has been the first to complete a pilot project and initiate further development of the role.

The full definition of the new role (WHO Europe 1998a) outlines its broad scope, stating 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”. As the latter part of the definition indicates, the Family Health Physician is seen as the other key professional at the hub of primary care services.

The Scottish Executive Health Department (SEHD) saw the FHN concept’s particular emphasis on health and family care within a skilled generalist role as suited to the needs of remote and rural communities. Moreover, they saw it as a potential way of addressing some of the recruitment and retention difficulties associated with the need for multi-skilled health and social care professionals in these areas. Accordingly they initiated a pilot project in 2001 which educated nurses in family health nursing and introduced the new role into practice during 2002 (SEHD 2003).

Concurrently an independent research study evaluated the operation and impact of this first enactment of family health nursing (Macduff and West 2003). This comprised evaluation of the educational course undertaken by 31 experienced community nurses (see Macduff and

West 2004), and evaluation of the first year of family health nursing practice as manifest at ten sites within three remote and rural regions (see Macduff and West 2005).

The research found that the new family health assessment/promotion skills learned on the educational course were valued very highly by the FHNs, and were seen as central to creating a distinctive new professional identity. In practice, the FHN role was usually developed in a limited way on top of a district nursing caseload, and this involved the supplementation, rather than the supplanting, of pre-existing community nursing activities. A typology of family health nursing emerged which identified four distinct patterns of practice.

These findings informed further development of the Scottish FHN project during 2003 and led to the opportunity to conduct a follow-up study during 2004. This paper summarises the main body of the resultant research and discusses the implications of its findings.

2. Rationale for the follow-up study

The first cohort of FHNs graduated at the end of 2001 and numbered eleven in total. During 2002, ten were active in developing the role at their local Primary Health Care Team (PHCT) sites. 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 a suggestion in the evaluation report (Macduff and West 2003) 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, the author 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.

3. 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

This paper focuses on the research and findings related to the first, second and fourth objectives. The research and findings relating to the practice typology are explored in a separate paper.

4. 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 2005). 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 et al 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. Findings

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 3) 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.

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 1 (figures represent proportion of work in percentage terms).

Table 1: FHNs' estimations of proportion of work (%) occupied by 3 core functions

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 1 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)

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).

FHN's professional colleagues' perceptions of practice

Across-site aggregation of 88 professional colleagues' responses showed a broad range of opinions 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.

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 has been produced in relation to the 15 PHCT sites where survey of colleagues was facilitated. This is presented below in Table 2, 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 2000).

Table 2: PHCT sites categorised by common contextual features

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 2 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 is unclear whether funding for the other more independent FHN role will continue beyond May 2005. Thus there is little sense of any momentum behind the development of an FHN role that is 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. However, a more detailed breakdown of findings at one of the sites where progress appeared most positive is presented in Table 3.

Table 3: Results* of responses to “paired” statements at Site X (local response rate 10/20 ; 50%)**

All respondents felt that the local PHCT as a whole needed to have a more family health orientated approach, and eight (80%) saw a need for a distinct FHN role locally. There was a similarly high level of concurrence amongst respondents that the pattern of FHN practice at the site was “High scope-slow build”. This pattern is characterised by: a pre-existing context of a small, stable district nursing caseload with high scope for nursing autonomy; a process of gradual introduction by the FHN only, with little/no change in other professionals’ working practices; and the outcome that the service is positively viewed by the limited number of families who receive it, but that it is not seen by the general public and colleagues as substantially different from pre-existing service. The results in Table 3 suggest that the latter aspect was beginning to change.

The sections of the questionnaire that invited written comments were particularly useful in illuminating the range of perspectives and understandings at individual sites. Figure 1 presents a collation of comments from Site X.

Figure 1: Collation of comments from Site X

Table 3 and Figure 1 exemplify the aggregations of findings that were fed back to each respective site in order to inform local practice development. Figure 1 deliberately presents a “field of comments” format to try to convey something of the mix of perceptions that surrounded the FHN as she tried to develop and consolidate the role at Site X. Although the response rate for this site was 50%, the core PHCT professions were generally well represented and non-respondents tended to have more peripheral involvement with the site. Thus a positive context for development of the FHN role and more family orientated PHCT approaches was evident at Site X, but was tempered by some continuing uncertainty about the nature and purpose of the role, and the demands on the individual FHN. Telephone interview with the FHN yielded further insights, emphasising that the FHN development was taking place at a time of major change for the organisation of PHCT services locally. As such, it was just one small part within a wider picture that was evolving, and could be sketched rather than seen in its entirety.

6. Discussion

The findings of this follow-up study are confirmatory of the essentially mixed picture that emerged in the original evaluation study. Within this picture the dominant theme is that of gradual positive development that tends 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 is the flexibility and wide scope of the role in terms of providing generalist community health nurse practice. Such provision is generally valued by colleagues and there is little evidence that the development of family health nursing has been detrimental to service delivery. Rather the effect has more often been service enhancement or expansion. Despite the pressures such a wide remit might be expected to bring, the majority of FHNs have found that their own job satisfaction and overall quality of working life have improved.

As predicted (Macduff and West 2005), the diversity of what can be considered family health nursing practice has grown in relation to the pre-existing roles of the second cohort of FHNs and associated local contextual influences. While this is understandable and may ensure good fit to previously established local team culture, it does make unitary operational definition of the FHN role difficult. The comparatively unbounded nature of the role can make for problems when explaining it to professional colleagues and the general public. A more serious corollary relates to the potential for such diversity to engender idiosyncratic and inequitable practice.

The latter possibility is worth recognising because it has been highlighted frequently in relation to district nursing work in recent years (e.g. Audit Commission 1999). Griffiths (1996) found district nursing work to be “relatively ill-defined” and often carried out in isolation, so that “caseload management had become highly idiosyncratic, with the important consequence that there was inequity in service provision”. Speed and Luker (2004) speak of a “culture of individuality in which care provision could vary from patch to patch, practice to practice and even patient to patient”. To some extent variation at the patch and practice level is an inevitable, and often useful, aspect of remote and rural health care, where limited resource has to adapt to meet distinctive local needs. However the supplementation of idiosyncratic pre-existing district nursing services with a limited expansion of family and public health services raises further scope for variation at the level of provision for patients and families.

To date, family health service expansion has mostly been confined to client-specific services delivered by the FHNs themselves. While some sites have made sustained progress in this regard, others have 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 seems to vary widely in practice, and is 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, irrespective 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

The longer term problems likely to arise if these factors are not managed actively and positively are those of patchy and inequitable family service delivery, erosion of the continued provision of the enhanced nursing service to families that has been developed to date, and some related erosion of the distinctive ethos and professional identity of the FHNs themselves. Such scenarios would not necessarily prevent remote and rural FHNs from functioning in their present posts, as their actual practice roles have emerged as inherently flexible and valued in terms of providing generalist community health nursing services. However they would inhibit further development of their roles as key players within any expanded form of family-orientated primary health care service provision.

The latter point is raised because it is important to try to understand the ongoing development of family health nursing within the context of national primary care provision and the international context of WHO Europe. Even within remote and rural Scotland, family health nursing has so far proved to be a relatively small scale development, in that practice remains confined to the small cadre of FHNs produced by the 2001-2002 pilot. That initiative was specifically managed in order to minimise potential conflict with other professional groups and established practices. For example, the FHN project was kept separate from concurrent reviews of midwifery provision (SEHD 2002) and solutions to continuing difficulties in recruiting and retaining General Practitioners (RARARI 2002). As such, it is not surprising that FHN role development has continued to be gradual in tempo and non-radical in nature.

This contrasts markedly with a recent UK national development currently impacting within remote and rural primary care, namely the introduction of the General Medical Services

(GMS) contract. This contract specifies new terms and conditions between the government and suppliers of general medical services, and aims to “reward practices offering higher quality care, improve GPs’ working lives and ensure patients benefit from a wider range of services in the community”. For many years GPs have led the supply of such services in the UK, and their practice has always been a very potent influence on community nursing practice. The GMS contract facilitates reduction in GPs’ out-of-hours commitments and this has implications for the nature and format of community nursing in remote and rural areas in terms of cross-cover and teamworking. However the specific implications for family health nursing lie more within the fine print of the GMS contract (SEHD 2004a) and its associated Quality and Outcomes Framework and financial entitlements scheme.

These documents, in combination, run to over 650 pages but the word “family” occurs a total of six times, and never in relation to the explicit enhancement of *family* services. The extent of service pledged is that immediate family members may apply for inclusion on GP patient lists that are otherwise closed. “Family” is absent from the plethora of indicators cited. Rather the indicators are based primarily on the recording of tasks carried out in relation to the management of individual patients. Accordingly, within the contract that will be central to most PHCT service provision, there is simply no overt incentive for provision of the holistic family health orientated approach to which FHNs aspire. The latter approach is typically time-consuming at the family assessment stage, and this would seem to contrast with the need to achieve essentially short-term targets for individuals within discrete disease categories.

Beyond the provision of *essential* services (e.g. management of illness and chronic disease), the GMS contract also covers the provision of *additional* services (e.g. child health surveillance; cervical screening) and *enhanced* services (e.g. more specialised services undertaken by nurses or GPs, such as immunization schemes). Again, however, scrutiny of the contract’s details and remuneration scheme make it difficult to envisage that an holistic, family focused approach would be considered either as a nationally, or a locally negotiated, *enhanced* service.

In this context it seems likely that the rise in the direct employment of practice nurses by GPs that has been such a UK trend in the past two decades (DOH 1999) will be accelerated. The Scottish Executive has anticipated this and has been 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.

Thus family health nursing seems to occupy an ambivalent position within the Scottish policy agenda. It is also difficult to see clearly how it sits within the broader thrust of UK primary care policy. The “Liberating the Talents” blueprint for English primary care nursing (DOH 2002) has been criticised for being tied to the GMS medical agenda and trying to compensate for medically focused shortfalls (Howkins and Thornton 2003). Moreover, at WHO Europe level there is limited concern amongst GPs for the focus of health care to move away from the individual client towards the family as client (WHO 1998b).

In effect, family health nursing 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. As such, the major threat to the momentum of its development must be that family care is not systematically prioritised within PHCTs, and that consequently family health nursing is viewed as nice, but essentially a uni-professional optional extra that enhances essential district nursing, practice nursing and health visiting activity. In turn this could prejudice the education of further cadres of FHNs and lead to a dwindling stock rather than an emergent critical mass.

The above scenario may seem inherently negative, given the generally positive nature of the findings of the follow-up study. However it is outlined in order to emphasise that the good works of individual FHNs will not be enough in themselves to ensure that the role prospers. Indeed, several of the FHNs who were interviewed alluded to worries in this regard. One FHN’s comments provide summation:

“As I said before, I do see the potential in it (family health nursing), but I see there’s always that many external factors pushing it off to the side. And its probably because there’s so few of us and because its seen as a kind of extra thing, I don’t know when it will ever become that important to the powers that be” (extract from telephone interview).

Thus, from a UK perspective, it seems clear that greater central government incentives for the prioritisation of the development of family health care services within primary health care will be necessary for the sustenance and meaningful development of *family* health nursing. Nevertheless, within the UK, Scotland has been able to initiate enactment of the WHO Europe FHN concept. This contrasts with the majority of other Western European countries that expressed initial interest in participating in the linked pilot studies. By 2003, government funding to initiate pilot studies in Denmark and Germany had still not been secured and this seemed to reflect more fundamental difficulties in gaining governmental approval for the whole FHN concept (WHO 2003). In Spain an educational programme was set up, but government funding remained insufficient to support enactment (WHO 2003).

Questions around funding and appropriate educational preparation for family health nursing have also been prominent within developments in the participating countries of Central and Eastern Europe, and in participating countries which were formerly part of the USSR. Progress reports for individual countries (WHO 2003) highlight a number of different challenges relating to attempts to introduce family nursing as posited by the WHO Europe (2000) FHN conceptual framework and curriculum. Within Slovenia, the pre-existing Patronage Nursing model was seen as broadly similar to the WHO Europe FHN concept and this seems to have engendered some difficulties and delay in initiating an appropriate educational programme for a pilot study (WHO 2003). In contrast, Tajikistan revised its undergraduate nursing preparation in 2002 with a view to incorporating WHO Europe FHN principles and recommendations.

To date, published information about the progress of the WHO Europe Family Health Nurse project is very limited. The WHO (2003) report presents a very mixed picture which to some extent reflects the different pre-existing traditions of primary care service provision and nurse education within the various countries involved. The report indicates that in 2003 twelve countries remained involved and that progress for most had been slow. Illumination of more recent progress should be forthcoming early in 2006 when a multi-national evaluation report is due to be published.

An interesting, and more radical, international perspective is provided by Lauder et al (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 FHNs as the main care provider. Predictably this 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 and there has never been any explicit SEHD linkage of the FHN development to substantive substitution for GPs. Indeed there has been little developed exploration of how the FHN role might articulate with, or contribute to, any more radical Family Nurse Practitioner role.

7. Conclusion

This study has followed up professional perspectives on the development of family health nursing during 2003 and 2004. It has yielded a mixed picture, but one that overall shows gradual consolidation and development of the role within remote and rural areas of Scotland.

The particular aspiration of Scottish family health nursing to engage seriously with whole families across a range of health and illness issues has set a challenge not only unto itself, but also for primary care policy and practice. For at present this aspiration would seem to go somewhat beyond the ambition of mainstream UK service planning and provision. Accordingly, greater central government incentives for the prioritisation of the development of family health care services within primary health care will be necessary for more systematic, integrated and meaningful development of family health nursing in the UK.

Acknowledgements

The author is grateful to all those who contributed to making the study possible, particularly the Family Health Nurses and their professional colleagues. Thanks are also due to Dr Bernice West for support and guidance, and to the Scottish Executive Health Department who supported the idea that an independent follow up study be conducted. However the study was funded solely by the Robert Gordon University and the views expressed within this article are those of the researcher alone.

References

- Audit Commission 1999. First Assessment: a review of District Nursing services in England and Wales. Audit Commission: London.
- Bryman, A., 2001. Social Research Methods. Oxford University Press: Oxford.
- Carey, L., 2003. Practice nursing. In: Watkins, D., Edwards, J and Gastrell, P. (Eds.), Community Health Nursing: frameworks for practice 2nd edition. Bailliere Tindall: Edinburgh, pp. 211-223
- Department of Health 1999. Making it happen: strengthening the nursing, midwifery and health visiting contribution to health care. Department of Health: London.
- Department of Health 2002. Liberating the talents: helping Primary Care Trusts and nurses to deliver the NHS plan. Department of Health: London.
- Griffiths, J., 1996. An ethnographic study of district nursing work. Unpublished PhD thesis, University of Liverpool.
- Howkins, E., Thornton, C., 2003. Liberating the talents: whose talents and for what purpose? Journal of Nursing Management 11, 219-220.
- Lauder, W., Sharkey, S., Reel, S., 2003. The development of family health nurses and family health practitioners in remote and rural Australia. Australian Family Physician 32 (9), 1-3.
- Macduff, C., West, BJM., 2003. Evaluating Family Health Nursing through education and practice. Scottish Executive Health Department: The Stationery Office, Edinburgh.
- Macduff, C., West, BJM., 2004. An evaluation of an educational programme to prepare family health nurses. Nurse Education Today 24, 575-583.
- Macduff, C., West, BJM., 2005. An evaluation of the first year of family health nursing in Scotland. International Journal of Nursing Studies 42, 47-59.
- Priest, H., Roberts, P., Woods, L., 2002. An overview of three different approaches to the interpretation of qualitative data Part 1: theoretical issues. Nurse Researcher 10 (1), 30-42.
- RARARI 2002. Solutions for the provision of healthcare in the remote and rural areas of Scotland in the 21st Century. Remote and Rural Areas Resource Initiative (see <http://www.rarari.org.uk>): Fort William, Scotland.
- SEHD 2002. Implementing a framework for maternity services in Scotland- Report of the Expert Group on Acute Maternity Services (EGAMS). Scottish Executive Health Department: The Stationery Office, Edinburgh.
- SEHD 2003. Family Health Nursing in Scotland: A report on the WHO Europe pilot. Scottish Executive Health Department: The Stationery Office, Edinburgh.
- SEHD 2004a. Standard General Medical Services Contract. NHS Circular: PCA (M) (2004) 7 Scottish Executive Health Department: The Stationery Office, Edinburgh. ([http://www.show.scot.nhs.uk/sehd/pca/PCA2004\(M\)07.pdf](http://www.show.scot.nhs.uk/sehd/pca/PCA2004(M)07.pdf))
- SEHD 2004b. Framework for nursing in general practice. Scottish Executive Health Department: Edinburgh (<http://www.show.scot.nhs.uk/sehd/practicenursing>)
- Speed, S., and Luker, K., 2004. Changes in patterns of knowing the patient: the case of British district nurses. International Journal of Nursing Studies 41 (8), 921-931.

World Health Organisation 1998a. HEALTH 21: the health for all policy framework for the WHO European Region. WHO Regional Office for Europe (European Health for All Series No. 5): Copenhagen.

World Health Organisation 1998b. EUR/ICP/DLVR040101 The WHO framework for development of general practice/family medicine in Europe. WHO Regional Office for Europe: Copenhagen.

World Health Organisation, 2000. The Family Health Nurse: context, conceptual framework and curriculum (EUR/OO/5019309/1300074). WHO Regional Office for Europe, Copenhagen.

World Health Organisation, 2003. WHO Family Health Nurse Multinational Study: Report on a WHO Meeting in Madrid, Spain, 15th March 2003. (EUR/O3/5043903). WHO Regional Office for Europe, Copenhagen.

Table 1: 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

Table 2: PHCT sites categorised by common contextual features

Category	Common contextual features	Number of sites in this category
<i>Small island</i>	Small island with population under 500 people	2
<i>Small villages, big country</i>	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
<i>Small town</i>	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

Table 3: Results* of responses to “paired” statements at Site X (local response rate 10/20 ; 50%)**

I think the FHN delivers a different type of service to what was previously available	Unsure	I think the FHN delivers a similar type of service to what was previously available
4 (40 %)	5 (50%)	1 (10%)
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
1 (10%)	5 (50%)	4 (40%)
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
3 (30%)	3 (30%)	3 (30%)
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
1 (10%)	5 (50%)	4 (40%)
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
6 (60%)	3 (30%)	1 (10%)
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
4 (40%)	5 (50%)	0
I think the FHN development is succeeding locally	Unsure	I think the FHN development is not succeeding locally
5 (50%)	3 (30%)	2 (20%)

**Aggregation does not include FHN's own reply ** Where row totals do not add up to 100% this indicates rounding up procedures or missing response(s).*

Figure 1: 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.