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

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ABSTRACT

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

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

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

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

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

Key words: Family Health Nurse; community nursing development; policy and practice; constructivist analysis; remote and rural; Scotland; WHO Europe.
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BOUND-IN PUBLISHED PAPERS


GLOSSARY OF KEY TERMS, ABBREVIATIONS AND ACRONYMS

ASLIB: Electronic data-base of UK theses.

ASSIA: Applied Social Sciences Index and Abstracts.

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

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

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

CINAHL: Cumulative Index to Nursing and Allied Health.

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

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

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

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

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

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

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

Family: a group of individuals with relational connections that may be emotional and/or biological and/or legal in nature. WHO Europe’s HEALTH 21 framework equates families with households, but a broader view can also be taken involving family self-definition (i.e. the family is what individual members say it is).
Family focused care/ family centred care: general terms, denoting a care approach where the whole family is seen as the principal unit of care/the client, and care is organised to reflect this priority. This also applies to the terms family nursing/ family focused nursing/ family centred nursing. Differs from family as context where the individual’s needs are predominant, and the family is seen as the context for this (most commonly as a supportive network).

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

Scottish Executive Health Department (SEHD)

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

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

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

Team Leader: a term used to describe a health professional who has a leadership role. In community nursing in remote and rural Scotland this can involve “leading” one other colleague or a large number of people. As such it has limited value.
**Tertiary prevention work:** health care input whose main purpose is to minimise the effects of the disease for the individual and others, and to promote rehabilitation and adaptation (e.g. education work with a person with newly diagnosed diabetes).

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

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

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

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

**ZETOC:** Electronic Table of Contents from the British Library.
CHAPTER 1
INTRODUCTION TO THE THESIS

Overview of this chapter

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

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

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

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

Policy analysis is another major aspect of the explanation building in the thesis, involving both public policy and health policy analysis approaches. Analysis of the related managerial aspects of family health nursing development in Scotland is also undertaken, but is much more limited in scope. The educational aspect of the development is analysed in some depth via an
evaluative approach, but is considered primarily in terms of its ultimate purpose of preparing FHNs for practice, rather than as an end in itself.

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

Having outlined the aim, ambit and main aspects for analysis in the thesis, it is time to look to its particular subject matter.
1.2 BACKGROUND: AN OUTLINE OF FAMILY HEALTH NURSING DEVELOPMENT IN SCOTLAND

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

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

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

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

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

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

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

Figure 1.1: Regions participating in first year of Scottish FHN pilot
Following a process of competitive tendering the Centre for Nurse Practice Research and Development (CeNPRaD) at the Robert Gordon University, Aberdeen was commissioned by the SEHD to undertake an independent research evaluation. The study’s remit was to evaluate the operation and impact of family health nursing in these remote and rural areas. This included evaluation of the educational programme and the identification of implications for extending family health nursing into other Scottish regions.

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

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

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

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

- aspirations and underlying assumptions can be examined and explained
- key contexts, processes and outcomes, and the dynamics of its development, can be identified and understood in relation to relevant nursing and social science theory
- the consequent implications for future nursing and primary care service development at national level and beyond can be identified and explored.

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

These central research questions are:

1. Why develop family health nursing?
2. How did family health nursing develop in remote and rural Scotland between 2001 and 2004?
3. Why did family health nursing develop in the way that it did in Scotland?
4. What does this mean in terms of the development’s influence and implications?
5. What significance has the resultant analysis for understandings of nursing and health care policy, education, practice, theory and research?

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

As such, the *why* question seemed very pertinent, but was not one of those explicitly included in the commissioned evaluation remit. Rather, the focus was on *how* family health nursing developed in terms of its operation and impact. This relates to the second question being addressed in this thesis. During the evaluation research process I developed increasing fascination with the subject matter, with seemingly constant iterative attempts to make sense of a complex, unfolding reality. The net effect was a sustained desire for more in-depth understanding and explanation of the development in the belief that some valuable learning may be transferable (i.e. questions 3, 4 and 5 above). As this persisted well beyond the professional evaluation contract, there was recognition of an ongoing affliction which only a doctoral study might cure.
Streubert and Carpenter (1995) describe how:

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

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

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\(^1\)“naturalistic” is being used here in the sense of a domain that is concerned primarily with understanding meaning. This should not be confused with the “natural sciences” which are primarily concerned with proof and prediction.
1.5 DESIGN STRUCTURE OF THESIS AND OVERVIEW OF CONTENT

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

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

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

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

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

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

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

This challenge is taken up in Part 3 (2004 – 2005) which is concerned with building a comprehensive explanation of why family health nursing developed in the way that it did in Scotland. This is undertaken by firstly looking outwards (“extrospect”) from family health nursing itself in order to identify relevant theoretical perspectives which might usefully illuminate the understandings derived from documentary evidence in Part 1 and the understandings from empirical research in Part 2. This process is applied in Chapter 7 to construct a retrospective explanation of the enactment of family health nursing in local practice contexts in remote and rural Scotland.
This explanation is further developed in Chapter 8 in relation to the formulation of family health nursing as policy at central Scottish government level and the subsequent mechanisms through which this was taken forward. Here analysis is substantially informed by further empirical research that the author carried out with a few key policy informants. Full details of these interviews and related analytic processes are provided in Annex 3 (CD Rom) for validation and reference purposes. At the end of Part 3 of the thesis the resultant integrated explanation of family health nursing development from policy through to practice is presented in the form of a synoptic story and a new model.

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

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

Part 5 also comprises just one chapter. In concluding the thesis, Chapter 10 provides “conspectus”, or summary, of the knowledge that has been built in the thesis and its significance. Essentially this involves addressing the question: so what? This question is addressed by reviewing what has been learned about the development of family health nursing in Scotland and how this contributes to understandings of community nursing/primary care in general. Finally the value of the thesis’s distinctive approach to exploring the history of an idea is suggested.
Figure 1.3: Overview of Parts 1-5 of the thesis design

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<td>PART 1</td>
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<td>PROSPECTUS</td>
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<tr>
<td>Why develop family health nursing?</td>
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<tr>
<td>CHAPTER 3</td>
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<td>CHAPTER 4</td>
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PART 4
REXSPECTUS, PERSPECTUS, PROSPECTUS
What does this mean in terms of influences and implications?

2006
PROSPECTUS FROM 2006

PART 5
CONSPECTUS
CHAPTER 10
So what?
As can be seen, Figure 1.3 provides overview of all five parts of the thesis design and the way in which they are sequentially related.

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

Overviews at the beginning of chapters and summaries at the end are used to maintain continuity and to focus narrative. Orientation is also aided by the inclusion of visual icons at the start of Chapters 3-8. These are designed to remind the reader of the current position on the “map” that is Figure 1.3. A glossary of key terms is provided at the start of the thesis, along with a list of abbreviations and acronyms. Quotations of more than one sentence that are derived from textual sources such as books, published papers and relevant documents are indented within the thesis text. Quotations from the interviews, questionnaires and field notes that formed part of this enquiry are handled similarly, but are distinguished by the use of italics.
CHAPTER 2

METHODOLOGY AND METHODS

Overview of this chapter

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

2.1.1 A contemporary historical approach

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

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

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

Accordingly it is acknowledged that the explanation offered herein is one situated in time and place, and is the result of viewing the world through a particular personal lens. As Holmes (1997) points out, “the historian exercises a personal judgement as to what will count as
relevant data” and “what counts as relevant data is historically and culturally embedded” (p.31). With this in mind, and in the interests of reflexivity and rigor, it is useful to try to make my personal position more explicit.

2.1.2 Personal position driving this approach

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

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

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

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

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

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

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

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

In contrast, they summarise the beliefs of realism as:

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

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

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

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

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

“somewhat equivocal on this issue. They claim to be drawn to the position that all reality is created by mind, yet are willing to settle for a less radical view of ‘constructed realities’. They hold that constructions are invented or created, yet those constructions are related to ‘tangible entities’ - events, persons, objects. If these tangible entities are not solely creations of mind, then they must be ontologically ‘real’.
The distinction they draw here seems to be one of a difference between experiential reality (constructions) and ontological reality (tangible entities)” (p. 134).

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

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

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

2.1.5 Constructivism, explanation building and the nature of truth

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

Firstly, as noted, the thesis is grounded in what Schwandt (1994) would call “everyday constructivist thinking” i.e. that the mind is active, forming abstractions and concepts so that we “do not find or discover knowledge so much as construct or make it” (p. 125). This lies at the heart of the attempt to construct an explanation of what family health nursing is considered to be, how it developed, and why it developed in the way that it did. I think that it is simplistic to believe that a set of pure, impartial facts exists out there which simply have to be vacuumed out from their sources and re-assembled, jigsaw-like, in order to re-complete the one essential, true picture of family health nursing development as it evolved between 1998-2006.
Rather the task in hand is to engage with and to try to understand individual and/or group constructions relevant to the enquiry (as found in studying the perceptions of nurses, other health professionals, patients, family members, members of the general public and a wide range of textual material). Through a process of interpreting this material, privileging some accounts more than others, and bringing personal accumulated knowledge to bear, a new interpretation and explanation will be created and proffered.

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

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

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

The juxtaposition of the last two quotations highlights an issue on which constructivism has tended to be weak: the issue of differential power. Put bluntly, the lions and their slayers might struggle to agree on truth by consensus. One academic response to this has been to let them get on with the fight and claim to be sculpting it impartially from the sidelines (or academic highground). Another, which is developed by Guba and Lincoln as the logical enactment of
their methodology in evaluation research, is to jump into the arena and persist in trying to broker consensus (what Pawson and Tilley (1997) satirise as the “ethnographer/ringmaster” role, p. 18).

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

2.1.6 Trustworthiness of the enquiry

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

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

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

2.2.1.1 Overview of Part 1 methods

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

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

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

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

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

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\(^2\) Although in the course of the research I undertook contextual review of some videos, DVDs and a radio programme relating to family health nursing, the textual material analysed in this thesis almost exclusively comprised printed words on paper. For this reason the terms “text”, “literature” and “document” are used synonymously in the thesis to refer to relevant English language books, reports, journal articles, published papers (e.g. web based), unpublished theses, and “grey literature” that has had limited circulation but is or has been available to health service professionals and/or the general public. Although research interviews in this study were audio taped then transcribed onto paper for further analysis, these are treated distinctly in the thesis and transcript code numbers are given when citing extracts from particular interviews.
<table>
<thead>
<tr>
<th>Category</th>
<th>Focal relevance</th>
<th>Related relevance</th>
<th>Contextual relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Text presenting detailed evidence of a systematic process of data collection, analysis and synthesis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As Table 2.2 suggests, texts pertaining to many of the important questions about the development of the FHN concept in Europe varied in purpose and nature. However, those of focal relevance tended to be aspirational, promotional papers. There was little research-based evidence, even of related relevance. Accordingly, the enquiry had to work with texts of variable quality. This is not unusual. Historical enquiry, in particular, deals with the art of the possible and the available, when building knowledge (Rafferty 1996).

2.2.1.3 Processes and principles of analyses

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

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

Through this process, a few texts emerged as being of key importance. These were studied in more detail through a narrative analysis technique that can be characterized as “holistic – content” (Lieblich, Tuval-Mashiach and Zilber 1998). Here “the researcher analyses the meaning of the part in the light of content that emerges from the rest of the narrative or in the context of the story in its entirety” (p. 13). This was very useful for analysing the way family health nursing was being represented in key texts as it developed in temporal and conceptual terms. Examples of this type of analysis occur in Chapter 3 (in relation to Asvall 1999) and Chapter 4 (in relation to Proctor 2000), where sections of key texts are quoted. These sections fulfill a narrative function in themselves but are followed by interpretation of the text’s internal validity (credibility) and/or its role within the emergent story of family health nursing.
Finally, the principle of “template analysis” (Miller and Crabtree 1992) was used in this part of the thesis (and extensively in Part 3) as a secondary level analytic approach. In this way Walker and Avant (1995)’s concept analysis framework was applied as an analytic template that helped to summarise and give overview of the FHN concept. Wright and Leahey (1994)’s genogram template was also used to similar effect in Chapter 3.

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

2.2.1.4 Processes and principles of synthesis

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

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

2.2.1.5 Ethical aspects

As indicated in Footnote 2, the textual material analysed was either publicly available or was “grey literature” that had limited circulation to relevant professional groups, but was not of a confidential nature.
2.2.2 Methods used in Part 2: an overview of research methods, principles and processes

2.2.2.1 Overview of Part 2 methods

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

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

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

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

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

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

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

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

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

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

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

1. Application to the education and practice of community-based nurses, Health Visitors and midwives across Scotland.

2. Relevance to remote and rural health care provision in Scotland.
3. Application and relevance to the particular local contexts where the Family Health Nurses had been working
4. Application and relevance to direct face to face experience of education and in practice.

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

**Figure 2.1: Interpretative research processes used in the evaluation study**

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

In evaluating practice the overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot. This approach adapted Pawson and Tilley (1997)’s realistic evaluation framework in order to clarify what FHN practice was in these settings, and then clarify how, and to what extent, the FHN role worked under various circumstances. Again, interviews, questionnaires, observation and documentary analysis were all utilised. The limitations of the evaluation study are discussed in terms of remit and outcomes in Chapter 6 and in terms of design and methods in Annex 2.
2.2.2.3 Overview of methods used to follow up FHN practice 2003-2004

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

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

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

2.2.2.5 Synthesis and trustworthiness

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

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

This is a view that anticipates divergence as well as convergence around aspects of the phenomenon. One of the key practical questions in a multi-data source, multi-method enquiry is: what accounts do you privilege (and why)? Or put in the context of this study, how do you weigh the local Health Visitor’s account of family health nursing against the account of the local Family Health Nurse? Constructivism is helpful in several ways here. Firstly accounts are
simply different, stemming from different contexts and perspectives, and do not necessarily have to be weighed in opposition. All are meaningful in their own terms. However some contrast and comparison is essential in order to ascertain if accounts are incomplete, simplistic, uninformed, internally inconsistent, or derived by an inadequate methodology (see Schwandt’s previous summary of Guba and Lincoln’s ideas).

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

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

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

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

2.2.2.6 Ethical considerations

Annex 2 also gives details of the process of obtaining ethical approval for the evaluation from four NHS Local Research Ethics Committees. One of the main considerations in a study of this type was to avoid identifying individuals in the reporting of the study. Where individuals were potentially identifiable (e.g. in the two in depth case studies of practice in Annex 1), their prior consent was sought. The other two linked studies also received approval from the relevant NHS Local Research Ethics Committees and from the School of Nursing and Midwifery Ethics Review Panel at the Robert Gordon University.
2.2.3 Methods used in Part 3: an overview of research methods, principles and processes

2.2.3.1 Overview of Part 3 methods

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

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

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

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

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

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

2.2.3.3 Methods used in Chapter 8

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

These interviews were part of another example of method triangulation within the study, in that interpretations of relevant texts relating to the WHO Europe concept were put to some of those involved in authoring them. This combination of methods yielded greater depth of insight into the phenomenon, its public and private accounts, and exemplified what Rafferty (1997) describes as “triangulation in the multiple realities of historical retrieval” (p. 7).
This cumulative building of knowledge was then progressed by further application of relevant theoretical perspectives on policy analysis and policy implementation. As Table 2.4 indicates, this firstly involved extensive review within nursing and more generally within public policy literature. Although the primary cognate area and associated questions drove this search, some other criteria were important in determining the theoretical frameworks that were selected. Specifically I was looking for credible research-based frameworks that:

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

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

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

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

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Primary cognate area</th>
<th>Associated questions</th>
<th>Main research methods and data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>WHO Europe and the European context since 2001</td>
<td><em>What is known of the development of family health nursing in other European countries, and how does this compare with Scotland?</em></td>
<td>Analysis of most recent WHO Europe publications; journal articles; conference proceedings (<em>from 2001 onwards</em>). Review of relevant recent European nursing journal publications and books.</td>
</tr>
<tr>
<td></td>
<td>UK health and social care policy and practice (1998 onwards, but mostly since 2001)</td>
<td><em>What is the nature of the contemporary UK policy context and how is this influencing practice? How does family health nursing fit with this picture?</em></td>
<td>Analysis of relevant recent UK health and social care policy literature and research into practice (<em>mostly from 2001 onwards</em>). Particular focus on recent developments in UK community nursing policy and practice.</td>
</tr>
<tr>
<td></td>
<td>Scottish health and social care policy and practice since 2001</td>
<td><em>What is the nature of the contemporary Scottish policy context and how is this influencing practice? What is the place of family health nursing within this picture? What is the future for/legacy from family health nursing in Scotland?</em></td>
<td>Analysis of relevant recent Scottish health and social care policy literature and research into practice (<em>from 2001 onwards</em>). Particular focus on recent developments in Scottish community nursing policy and practice.</td>
</tr>
</tbody>
</table>
As Table 2.5 indicates, the research in Part 4 mainly involved review of contingent developments between 2001 and 2006 in order to further explanation building and to gauge influence and implications. Literature search, selection and analysis procedures were broadly similar to those undertaken in Phase 1. Policy literature was predominant.

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

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

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

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

Reflexive analysis and synthesis were the methods used to achieve conspectus and conclude the thesis.
2.3 SUMMARY OF METHODOLOGY, METHODS, STRENGTHS AND LIMITATIONS

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

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

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

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

Indeed, in concluding this chapter, it is useful to linger longer on the idea of how things actually happen. For this thesis endorses Holmes (1997)’s rejection of a “mechanical model of history” which involves “spelling out step-by-step the precise causal mechanisms which give rise to particular components in historical events” (p.35). Rather it endorses Guba and Lincoln (1989)’s notion of mutual simultaneous shaping where a number of contingent factors typically prefigure and concurrently influence any given action or outcome. Thus the task of the historical researcher is to try to identify the most influential factors and gauge their mode of action and sphere of influence.
No less importantly, a final task for the historical researcher is to try to tell a good story. As Hewitt (1997) points out, “the historian bridges the restrictive standards of scientific research and the artistic standards of narration” (p. 19). The story now begins by turning to WHO Europe in order to examine: the nature of the FHN concept itself; why it emerged; what it was trying to achieve; and what the prospects were for this particular venture. In short, why develop family health nursing?
PART 1

PROSPECTUS

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

“Anticipation forward points the view”

“The Cotter’s Saturday night”, Robert Burns (1786)
CHAPTER 3

THE FAMILY HEALTH NURSE CONCEPT: FROM COPENHAGEN TO CALTON HILL

Overview of this chapter

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

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

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

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

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

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

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3 Please see the glossary of key concepts for an operational definition of this broad term.
literature suggests that there is scope for an international, cross-cultural, comparative study of family nursing models, this is beyond the scope of the present thesis.

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

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

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

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

Table 3.1: HEALTH 21 target subject areas

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

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

The full definition of the Family Health Nurse which is cited in the HEALTH 21 document (see Chapter 1.2) is preceded by the following sentence: “A well trained family health nurse, (as recommended by the 1988 Vienna Conference on Nursing), is another key PHC professional who can make a very substantial contribution to health promotion and disease prevention, besides being a care giver” (WHO Europe 1998a; p. 139). This is ostensibly very significant in that the origins of the concept are being specifically traced to a nursing conference a decade earlier.
On closer scrutiny of the Recommendations from the Vienna Conference (WHO 1989), however, there is no mention at all of a “family health nurse”. This is curious and begs a number of fundamental questions about the concept, the time and nature of its conception, and the context of its gestation. In order to start to investigate these questions it is useful to map out the key European health policy developments which form the context for enquiry. These are presented in Table 3.2.

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

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

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

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

1. What is the nature of European nursing representation at European policy level and what are the key processes linking it to member states and thence to community nursing practice?
2. Why did the “generalist nurse” concept give way to the “Health for All Nurse”, and to what extent did either of these actually exist or develop within European community nursing practice during the 1990s?

3. Why did the change of emphasis to family occur in the naming of the new FHN concept?

4. What are the underlying conceptual differences between the Health for All Nurse and the Family Health Nurse as promulgated?

These questions are now systematically addressed.

### 3.3 ORIGINS OF THE FAMILY HEALTH NURSE CONCEPT

#### 3.3.1 Nursing at European policy level

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

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

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

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

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

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

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

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

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

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

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

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

Given the diverse nature and scope of primary care services across Europe during the 1990s, and their changing political contexts, it is difficult to come to a definitive generalisation about manifestations of the Health for All Nurse. At a very basic level however it seems safe to say
that none of the countries was inspired to actually give a group of their community nurses this title. This is not a flippant point. As this thesis will argue, the act of naming can be important and have significant sequela. One of the cardinal lessons to emerge from any grand tour of European nursing is not to assume that similar names and/or terms denote similar functions. The difference in role between the UK Public Health Nurse (i.e. Health Visitor) and the Irish Public Health Nurse exemplify this.

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

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

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

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

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

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

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

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

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

This impression is sustained in analysis of a promotional article by Dr JE Asvall, Regional Director of the WHO Regional Office for Europe (Asvall 1999). Speaking around a year after
the launch of HEALTH 21, Dr Asvall makes no mention at all of the Family Health Physician.
In contrast he is effusive in shedding more light on the intended role of the FHN:

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

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

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

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

The above passage is significant for two reasons. Firstly it gives voice to, arguably, the key player within the development of the Family Health Nurse concept at European level. Inna Fawcett-Henesy took over the post of Regional Adviser in 1995 and was thus also involved in the formulation of the HEALTH 21 strategy. Secondly, the above passage provides evidence of her concern that, by highlighting the word “Family” in the title, the role will be misconstrued as being narrowly focused. Here we see, somewhat ironically, concern to reaffirm the role’s generalist credentials. Moreover we hear distinct echoes from the name-dropping episode previously cited from “Nursing in Action” (WHO 1993b).
The WHO 2000a document is also useful in that it attempts to explain what is new about the concept. In this regard it states:

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

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

**Figure 3.1: The Family Health Nurse under the “umbrella” of public health and primary health care (from WHO 2000a)**
This is a significant depiction in that, instead of the duo of FHN and FHP supporting primary health care, the FHN is portrayed as the central stanchion of the whole system. The family physician (rather than Family Health Physician) is peripheral. Taken at face value this would suggest the FHN as the fulcrum of entire primary care and public health systems. For countries with very underdeveloped, or non-existent, primary care systems this might seem a very interesting and exciting nursing role development. If well resourced there could be an opportunity for nursing to play the key role in service co-ordination and delivery, and to grow the superstructure which it will end up supporting. For countries with established primary care superstructures (e.g. the UK) however, this represents a vision of radical change. Immediate questions arise about the displacement of GPs from their present central role and about the ability of the FHN to bear the weight of the system.

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

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

3.4.1 Conceptual framework/theoretical underpinnings

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

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

These ideas are brought together into one key conceptual diagram which is reproduced in Figure 3.2.
Interestingly this diagram and much of the associated explanation comes directly from one of the FHN curriculum planning group (Professor June Clark)’s model for health visiting published in 1986. The roots of the model itself can be traced back to Betty Neuman’s systems model for nurse education and practice (1982) which in turn is based on the Von Bertalanffy (1968)’s general systems theory and Antonovsky (1979)’s ideas on stress and coping. As such, it can be seen that the conceptual framework for the proposed role focuses on family and health, but is neither new nor grounded exclusively in nursing.

### 3.4.2 Exemplars of the role for practice

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

On the basis of these examples, the document suggests that the FHN will be in a position to contribute significantly to reaching 20 of the 21 targets in HEALTH 21. The scenarios are
presented to “illustrate what might be part of a typical caseload for a Family Health Nurse”
and, in doing so, to aid understanding of the “breadth, depth and scope of their role” (p. 6).

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

3.4.3 The proposed educational preparation

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

Table 3.3: WHO Europe Curriculum

<table>
<thead>
<tr>
<th>Curricula academic level</th>
<th>Module content</th>
<th>Duration</th>
<th>Assessment techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-graduate level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic award</td>
<td>Concepts, practice and theory</td>
<td>2 weeks</td>
<td>Essay, exam, course work practical assessment</td>
</tr>
<tr>
<td>plus specialist practice award</td>
<td>Provision of care working with families</td>
<td>10 weeks</td>
<td></td>
</tr>
<tr>
<td>No core modules</td>
<td>Decision making</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information management &amp; research</td>
<td>6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provision of care working with communities</td>
<td>10 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managing resources</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leadership and multi-disciplinary working</td>
<td>4 weeks</td>
<td></td>
</tr>
</tbody>
</table>
Not surprisingly, this constitutes a wide-ranging syllabus, and examples of module content are provided. Although half of the Curriculum Planning Group were from the UK (3 UK members; 2 Nordic members; 1 Slovenian), the curriculum does not replicate all features of UK community nursing specialist practice qualification courses. In particular it is interesting to note that it is pitched as a postgraduate award rather than a post-registration award.

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

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

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

These selected stages are usefully summarised in a diagram by Unsworth (2001). This is reproduced in Figure 3.3.
Figure 3.3: Main stages of concept analysis (after Unsworth 2001, and Walker and Avant 1995)

Stage 1

- Dictionary Definitions
- Use of the concept from professional literature
- Practitioner experience

Stage 2

- Identification of attributes

Stage 3

- Case Construction
- Model case
- Related case
- Borderline case
- Contrary case

Stage 4-7

- Identification of related concepts
- Identification of antecedents of the concept
- Identification of tentative list of critical attributes
- Identification of consequences of the concepts
As Figure 3.3 indicates, the first stage involves identifying all uses of the concept from literature and practice. In the case of the WHO Europe FHN concept this is simplified because pre-2001 no practice had occurred, and the literature was restricted to that already reviewed. Nevertheless, in applying this framework, Stage 1 yields a broad range of uses of the concept, as summarized in Figure 3.4.
Figure 3.4: Main features of the FHN concept as illuminated by concept analysis

Stage 1

Dictionary Definitions:
Three complex concepts (family, health and nurse) have been conjoined into one compound concept.

Use of the concept from professional literature:
Promulgated at six or more different levels:
1. Euro nursing policy initiative
2. Pan-Euro nursing role
3. Ideological vehicle to promote family
4. Professional strategy to become fulcrum of primary care
5. Wide and deep role spanning health, illness, individuals, families and communities
6. Role requiring educational preparation for 5 key competencies

Practitioner experience:
None, as yet

Stage 2

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

Stage 3

Case Construction:
14 detailed, but diverse case scenarios were constructed by the Curriculum Planning Group (WHO 2000a).
Each of these can be seen as a Model case

Stage 4-7

Identification of related concepts:
The “generalist” and “Health for All Nurse”

Identification of antecedents of the concept:
The “generalist” and “Health for All Nurse”

Identification of tentative list of critical attributes:
Unclear

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

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

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

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

Figure 3.4 indicates that WHO Europe’s 14 role exemplars, or case scenarios, effectively comprise 14 instances of the model case. As indicated in previous analysis, this makes for impressive scope, but concurrently obscures what the critical attributes of the role should be. Thus Stage 6 of Figure 3.4 cannot be addressed from the evidence reviewed so far, as the WHO Europe literature does not give a clear idea of what related, borderline or contrary cases would/could be. However the overview of European nursing conducted earlier in this chapter does highlight that the generalist nurse and the Health for All Nurse are both related and antecedent concepts (Stages 5 and 6, Fig. 3.4).
This limited use of Walker and Avant’s concept analysis is useful for summarising understandings of the promulgated FHN concept in terms of what it is on paper, and what it aspires to. The next part of this chapter uses a genealogical approach to concept analysis to offer a different perspective. In order to do this it is necessary to leave Copenhagen and make a brief visit to Calgary in Canada.

### 3.4.5 Genealogical concept analysis via North American family nursing

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

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

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

As Gillis (1991) comments, the nature of nursing engagement proposed by Wright and Leahey and other leading family nursing proponents such as Friedemann (1989) indicates a level of specialism in nursing practice. Indeed Wright and Leahey (1994) make a clear distinction between generalists as “nurses at the baccalaureate level who are predominantly using the conceptualisation of the family as context”, and specialists as “nurses who are at the graduate
(master or doctoral) level who are predominantly using the conceptualisation of the family as the unit or client of care” (p.11). Moreover the applications of family systems nursing cited in its associated literature (e.g. Bell 1997) tend to focus on specialist units rather than generalist work in the community.

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

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

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

![Genogram of the genealogy of the WHO Europe FHN concept]

Figure 3.5 illustrates how selected social science theory is present in the WHO concept’s family tree, has been mediated to some extent by nursing theory, but has been harnessed to one UK health visiting model aimed at family healthcare. This is then brought into conjunction with the evolving concept of a generalist European nurse who will aspire to address health and illness issues for individuals, families and communities. In terms of resultant theoretical offspring, the net outcome is that the new FHN title simply replaces the title “Health Visitor” in
the derived diagrams which constitute the conceptual framework document (WHO 2000a). Within the UK, this raises a question about whether this amounts to a “christening” or a “re-christening” (i.e. to what extent did this HV model influence practice/develop in practice in the UK?). Authors such as Baggeley and Kean (1999) would argue that UK health visiting in the 1990s focused too exclusively on the mother-child dyad.

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

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

Having analysed and summarised the FHN concept through linguistic and genealogical approaches, it is necessary now to turn to consider how WHO Europe went about advancing this concept as a policy initiative.
3.5 WHO EUROPE PLANNING FOR POLICY ADVANCEMENT AND ROLE ENACTMENT

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

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

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

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

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

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

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

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

### Table 3.5: Action steps identified

<table>
<thead>
<tr>
<th>Action steps identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-institutional action; mobilize nursing and midwifery lobbying potential</td>
</tr>
<tr>
<td>Multi-media interest</td>
</tr>
<tr>
<td>Set up multidisciplinary steering groups within countries</td>
</tr>
<tr>
<td>Identification of needs (situation in the country)</td>
</tr>
<tr>
<td>Estimate costs, sources of funding</td>
</tr>
<tr>
<td>Plan and identify the alliances (public, political, professional); make the concept known</td>
</tr>
<tr>
<td>Talk outcomes</td>
</tr>
<tr>
<td>Choose the place for demonstration and the best people for the project; attract sponsors</td>
</tr>
<tr>
<td>Create collaboration between the demonstration site and key stakeholders</td>
</tr>
<tr>
<td>Strategic plan for implementation</td>
</tr>
</tbody>
</table>
At this point it is important to take stock of what the Helsinki meeting appears to have achieved, namely ostensible agreement among the attending CNOs to enact the FHN concept as the leading edge of nursing’s contribution to the HEALTH 21 policy initiative (although UK CNO representation at the meeting was limited to the Assistant Chief Nurse for England). Given the diversity of existing community nursing systems in Europe and the diversity of interests represented, this seems a significant achievement for the Regional Adviser and advocates of the new role. In this regard, the “identification of needs in individual countries” step listed above in Table 3.5 seems to have been superceded by general acceptance of the virtue of the new role.

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

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

Thus the stage was set for each European country to decide on its individual response to Munich and whether to become involved in enacting the FHN concept. The final leg of this chapter’s journey takes the reader to the UK to briefly consider the conditions awaiting the FHN concept therein.
3.6 UK COMMUNITY NURSING IN THE 1990s AS A CONTEXT FOR ENACTING THE FHN CONCEPT

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

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

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

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

As Mason (2001) notes, the UK is possibly at the extreme end of the spectrum in terms of having a wide range of specialist community nurses. Ostensibly this range would seem to cover most, if not all, of the functions expected of the new FHN. Accordingly, it is necessary to question why the latter role should have any appeal at all for UK primary care. To begin to answer this question it is necessary to delve deeper into the state of community nursing in the UK at the end of the 20th century.
For in the late 1990’s each of these three main community specialisms felt under pressure and some might be said to be suffering simmering crises of identity. The latter seems particularly true for District Nurses whose role and remit had been particularly affected by the Community Care reforms of the early 1990’s. These had the effect of dividing health from social care on the basis of types of tasks, leaving many DNs lamenting the loss of holistic care for patients and their families (Kesby 2002; Goodman et al 2003). Simultaneously DNs were expected to adopt a much more overt care management role, devolving much of the hands-on care to registered nurses (community staff nurses), nursing auxiliaries and home carers. Finally the shift away from long stay hospital treatment implemented during this period led to a great increase in the numbers of patients with complex care needs and treatment regimes who required to be nursed at home.

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

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

The above overview is of course a simplification, and analysis of UK community nursing (particularly district nursing) will be undertaken in greater depth within Chapters 7-9 of this thesis. Moreover the above overview stays very much within the realm of professional nursing perspectives. As such it overlooks one of the main arguments that can be advanced for a move away from multiple specialisms, namely that patients, families and communities are receiving a fragmented service that encourages duplication and lacks personal continuity (Hyde 1995).
In the wake of the 1998 announcement of the FHN concept, Sheila Kesby deployed the above argument to try to raise the generalist FHN flag within the UK (Kesby 2000; Kesby 2002). In doing so she offered an interesting historical analysis, pointing out that the idea of a family nurse had been originally been launched in 1967 by Joan Gray, who was Chief Nursing Officer of the UK Queen’s Institute of District Nursing. Kesby (2000) describes how the vast majority of community nurses were against the idea at the time as they felt district nursing, health visiting and community midwifery were distinct roles that did not overlap or interrelate in practice. Accordingly the opportunity passed and community nursing developed an even more specialized superstructure which was later reified by the introduction of the UKCC community specialist practice educational framework introduced in 1994.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A similarly high level of strategic activity prevailed across other key devolved policy areas such as education, housing and the environment during this period. A more limited review of major reports in these areas has been undertaken, primarily in order to understand implications for health and health care provision. However this has also enabled review of relevant family policies in these areas. As Wasoff et al (2002) point out, some areas of family-relevant legislation such as social security are “reserved” by the UK parliament, but many are devolved. This makes analysis of the Scottish policy context for family health nursing important. In this regard research papers accessed from the web pages of the Edinburgh-based Centre for Research on Families and Relationships (http://www.crfr.ac.uk) proved very useful.
Indeed this chapter regularly draws on web-accessed research papers from several Scottish University research centres (e.g. the Arkleton Centre for Rural Development Research at the University of Aberdeen) and government funded initiatives (e.g. the former Remote and Rural Areas Resource Initiative). As the examples suggest, this is particularly the case when the Scottish remote and rural context is being considered. The currency of critical purchase provided by this type of academic literature is very useful, as such papers usually take longer to find their way into journals and books.

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

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

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

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

- Remote/rural health care
- Scotland
- Highlands and Islands
• Primary care
• Medical services
• Community nursing
• District nursing
• Health Visiting
• Midwifery
• Triple-duty nursing
• Double-duty nursing
• Combined duties nursing

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

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

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

A primary aim of the review was to source any evaluative material that could shed light on pre-existing community nursing delivery in regions where family health nursing would be enacted.
Thus the search strategy turned to the “grey literature” of unpublished internal reports carried out by local Health Boards/Divisions. This involved contacting these organisations directly, contacting archivists in regional libraries, and using a network of pre-existing professional and personal contacts in these regions. Again the fruits of these efforts were relatively meager, but recent relevant reports were obtained from each of the two main remote and rural regions involved.

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

4.2 EMERGENCE OF THE FAMILY HEALTH NURSE CONCEPT IN SCOTLAND

4.2.1 Background

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

4.2.2 The “Proctor” position paper

Reflecting on the Scottish Family Health Nurse pilot project in 2003, Chief Nursing Officer Anne Jarvie recalled an initial meeting taking place in autumn 1999 to discuss whether the WHO Europe FHN concept had potential for remote and rural areas (SEHD 2003). The first related position paper (Proctor 2000) emerged in March of the following year. This was presented at a multi-disciplinary conference (organised by the Scottish Council for Postgraduate Medical and Dental Education) that aimed to seek solutions in relation to education and training for remote and rural practice.
A significant part of this paper presents the FHN concept as a potential solution to problems of nursing recruitment, retention and skills maintenance in rural areas where double and triple duties nursing had become increasingly difficult to sustain. Indeed this is taken further in the paper’s rhetorical title: “The future of community nursing?” However, the paper also strongly suggests that the proposal may be a solution to pressure on rural GPs, viz. its opening line: “What is happening to make life as remote or rural GPs a bit better?” (p. 1). This thrust is maintained throughout the paper. It takes an interesting turn, however, in a key passage which attempts to explain the concept’s fit to the current Scottish context:

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

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

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

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

- It is a skilled generalist role – the family health nurse would undertake a broad range of duties, dealing as the first point of contact with any issues that present themselves, referring on to specialists where a greater degree of expertise is required.
• It is a model based on health rather than illness – the family health nurse would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.

• The role is founded on the principle of caring for families rather than just the individuals within them – the family health nurse would expect to look at the needs of the family in a holistic way, rather than looking at individuals or their conditions in isolation. An example might be that a single family could currently have a health visitor visiting a mother with a young baby, whilst a CPN visits the alcoholic father and a district nurse visits to dress the grandmother’s leg ulcer. Not only is this wasteful in resource terms, especially in remote and rural areas, but it results in a fragmented approach to addressing the health needs of the family, whose real problem might not be related to any of the individuals’ health problems.

• The family health nurse would know, and be known by, the community in which she worked – in many respects this mirrors the sort of relationship established by the former triple duty role. It implies a long-term relationship with the community and the sort of detailed knowledge of its needs which is difficult to maintain if nursing roles are divided.

• The family health nurse could operate as a first point of contact with the public, dealing with undifferentiated presenting problems – the proposal from WHO Europe is that the family health nurse would be the first point of call, referring on to the family health doctor those calls that required medical intervention. Although it is unlikely that we would wish to go so far down this line, there is an obvious attraction in remote and rural areas, where a single nurse might work with a single doctor, to have a degree of interchangeability of roles”. (p.2)

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

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

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

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

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

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

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

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

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

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

The paper also details the remote and rural regions that will take part in the pilot: Highland, Western Isles and Orkney. In addition to citing increasing problems with delivering health care services in these regions, the paper lists a range of health related issues that comprise the wider local contexts:
• Sparse, declining, ageing populations
• Small island communities and geographical isolation
• Poor health profiles and indicators of deprivation
• Transport difficulties – infrastructure and availability
• Migration of the young to urban towns and cities
• Increasing percentage of non-indigenous population
• Erosion of extended family infrastructure

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

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

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

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

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

Thus it can safely be asserted that Scottish policy was focusing energy on public health and the redesign of health services, and the FHN concept’s emphasis on health ostensibly fits well within this ambit. However it is now necessary to ask if the same can be said about one of the other key dimensions of the FHN concept, namely its focus on the family.
Detailed review of all the above documents published up to and including 2000 shows family to be very much an implicit theme that is subsumed within an emphasis on the health of communities. Although *Towards a Healthier Scotland* introduces the “Starting Well” health demonstration project focused on young children there is no sustained development of a wider, whole family theme. This is also true of *Our National Health – A Plan for Action, A Plan for Change*, although a range of small, explicitly family focused initiatives are scattered throughout the document.

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

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

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

This sets the scene for a more sustained analysis of remote and rural issues in the Highland and Islands, and the consequences for health care delivery.
4.4 THE REMOTE AND RURAL CONTEXT

4.4.1 Remoteness and rurality: some general issues

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

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

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

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

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

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

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

The finer points of centre-periphery tensions within these regions are subsumed when they are collectively described as the Highlands and Islands. As a phrase, Highlands and Islands, has come to be redolent with connotations. One of the main recurring motifs is that of magnificent elemental landscapes. This has generally positive connotations but is also historically associated with a highly romanticized view of life in these regions. At the other extreme lies the enduring notion of “The Highland Problem” (Munro and Hart 2000) wherein the Highlands and Islands are characterised as a development problem which has been ongoing for central government since at least the nineteenth century. This takes in periods of neglect where the
regions have been thought of as “a cultural museum” (Burnett 2001; p. 35), and periods where new economic initiatives have been tried with varying degrees of success.

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

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

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

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

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

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

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

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

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

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

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

A study of island health care by Bloor et al in 1978 also highlights the crucial role of district nursing/triple duty nursing in island communities. A more recent, primarily quantitative, study of triple duties nursing in Scotland (Fulford 1992) is helpful in giving overview of prevalence of the role, caseloads/workloads and perceptions of advantages and problems. Thus, by 1990 triple duty nurses had declined to 3% of the Scottish community nurse population from a figure of 49% in the 1960s. Most of this remaining cadre of 110 were based in rural areas, with 35 in
Highland region, two in Orkney and none in the Western Isles. The double duty combination of District Nurse and Midwife roles was common in the latter region and also elsewhere across Scotland. Caseloads and related workloads were found to vary very widely, but district nursing activities typically accounted for around half of all triple duty nurses’ work. Triple duty nurses saw the main advantage of their role as delivering holistic care, often with an emphasis on family care. The main disadvantage related to having less time for health visiting if the overall caseload was too large.

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

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

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

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

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

In mapping the Highland review against the four principles of the proposed FHN role outlined in the Proctor paper, it is firstly apparent that there do seem to be problems relating to the number of different specialist nurses (several examples of duplication are cited in the report). In contrast the generalist combined duties nursing model emerges strongly. In fact the report recommends exploration of the idea of developing the triple/quadruple role into that of a Community Nurse Practitioner who would have a care management role and support from a more junior nurse or nursing assistant.
Secondly there seems desire to move towards a more structured, health orientated model of practice, although several constraints are noted (see Table 4.1). The need for more structured health promotion for well adults and their families matches well with FHN principles, but otherwise the family unit as a whole is seldom mentioned within the report and there is little sense of any need for the family to become more focal. The issue of first point of contact is also notable by its absence and community nursing services are presented as accessible.

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

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

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

The report identifies a number of perceived gaps in service provision. The health needs assessment shows a need for much more activity to prevent ill-health and promote behaviour change, but it finds that District Nurses neither report health promotion as a major activity, nor see it as an integral part of their role. Interestingly it concludes, “District Nurses are ideally placed to gauge both the learning needs of patients and family members and the most appropriate way of providing health education, but may not at present have the confidence or skills to address what can be sensitive behavioural issues” (p. 62). The report also found lack of clarity and disagreement amongst District Nurses in regard to their role addressing another local health priority, namely mental health.
Again there was a background of constraints on district nursing time due to perceived lack of staff to provide terminal care and activities that were perceived as inappropriate (e.g. bathing patients whose needs were “social” rather than health-related). The need to support carers more was also raised but the issue of wider family needs usually remained implicit.

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

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

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

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Health Visitors (WTE)</th>
<th>District Nurses (WTE)</th>
<th>Combined duty (typically DN and Midwife, occasionally triple duty) (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>51</td>
<td>49</td>
<td>38</td>
</tr>
<tr>
<td>Orkney</td>
<td>6</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Western Isles</td>
<td>14</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>

These qualified staff were typically supported by teams which included community staff nurses and nursing assistants.
4.6 THE MATCH OF CONCEPT TO CONTEXT

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

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

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

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

Finally, the issue of the nurse as first point of contact was seldom overt in the review. This is because some remote and rural nurses already potentially had this function for any wider health care needs (e.g. those on islands with no GP) or those elsewhere knew that their community nursing service could be accessed openly by the public. The question that arises is whether a more fundamental change was being proposed that would see the FHN potentially being first point of access for any health care need. The Proctor (2000) paper suggests not, but keeps the option open.
Consequently it can be seen that there is some congruence between concept and context but the match is not completely clear. Moreover, from the review of the literature it is hard to gauge the extent of any “felt” need amongst community nursing staff for the sort of new role being proposed. This relates to the fact that what was being proposed at the time was primarily a theoretical concept and the role to be enacted in practice was not entirely clear to its proponents.

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no difference between the double/triple duty nurse and the FHN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>There is not a problem with recruitment and retention of nurses</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>The FHN is not addressing the real problem of a GP shortage</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The FHN title is inappropriate in our society</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitors locally feel comfortable with the FHN concept</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Don’t need an FHN as the different roles within the primary care team complement each other</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Integrated Nursing Teams would be a better solution to the FHN</td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The FHN will be a mini GP</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Educationally you cannot equip such a generalist with education/skills within the designated time scale</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is difficult to see how the FHN will fit into existing systems</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
These ten statements are highlighted because of their particular relevance to analysis of concept and context so far. The responses reveal that the leaders of nursing in these regions perceived a problem with recruitment and retention of nurses, but the majority didn’t see the FHN as a solution to GP shortage. The doubts about the FHN title, the educational programme and the fit of the role into existing systems are all striking. The latter aspect is particularly significant bearing in mind that these leaders would soon be engaged in actively managing the development within their respective regions. As such, this gives insight into the relatively high level of uncertainty around the pilot project early in 2001.

4.9 A TWIST IN THE TALE

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

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

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

The work of Health Visitors with families with young children was to move from surveillance and monitoring for all towards more targeted activity. This was to include Family Health Plans
which would be developed with the family through assessment and discussion, and a clear set of goals and actions would then be set out. The FHN pilot project was also highlighted in the document, and the following recommendation was made:

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

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

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

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

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

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

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

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

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

This was the nature of the prospectus as the new venture began in earnest at the start of 2001.
PART 1: A BRIEF REFLEXIVE RECAP

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

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

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

In transposing the FHN concept to a UK context, further questions about the fit of, and the need for, the development have also been highlighted. Although the match of concept to the contemporary Highland and Islands context has emerged as reasonable in terms of the inherent generalism and related flexibility of the proposed FHN role, the question of need is difficult to answer through the literature alone. Finally, the publication of Nursing for Health raised the prospect of more radical revision of community nursing. While radical reform had previously been a conjectured sub text of the new Scottish venture, in 2001 it became an explicit part of its text and context.
PART 2

PERSPECTUS

The development of family health nursing in Scotland between 2001 and 2004, as seen through the lens of empirical research into education and practice.
CHAPTER 5

THE DEVELOPMENT OF FAMILY HEALTH NURSING IN SCOTLAND 2001-2004

Overview of this chapter

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

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

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

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

The chapter summary draws together the main methods used and the main findings from these three linked studies.
5.1 THE COMMISSIONED EVALUATION STUDY

5.1.1 Overview of remit, governance and timing of the study

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

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

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

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

5.1.2 Evaluation of the educational programme

5.1.2.1 Summary of evaluation methods

Evaluation of educational preparation involved the collation and analysis of evidence from a number of sources. Firstly there was systematic collection of structured information pertaining to comparative educational processes (e.g. review of relevant curricula) and to Stirling University’s own internal course evaluation processes (e.g. summative evaluations of modules). Enactment of the curriculum was investigated primarily through observation of teaching and assessment, and review of course work. Participant experiences were explored through semi-structured group interviews with students and with supervisors during the course, and semi-
structured individual interviews with teachers at the end of the course. A key data collection tool was a questionnaire designed so that students and supervisors could summatively evaluate a number of aspects of the whole educational experience.

5.1.2.2 Profile of the students and the curriculum

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

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

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

Table 5.1: Stirling University Family Health Nursing Curriculum 2002

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

Within the curriculum documentation the rationale for the content and the integration of theory, practice and assessment was addressed in a complex conceptual framework based on ideas from WHO Europe and Family Nursing ideas from North America. Compared to the module
descriptors in the WHO Europe curriculum (see Table 3.3), the modules in the Scottish course placed less overt emphasis on decision making, managing resources, leadership and multidisciplinary working. Rather there was more influence from North American models of family assessment and intervention, such as the Calgary model (Wright & Leahey 1994).

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

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

5.1.2.3 Summary of the educational evaluation findings

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

Table 5.2: Strengths and weaknesses of the Scottish FHN programme

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of students attracted to the course.</td>
<td>Breadth of content</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>APL/APEL procedure</td>
</tr>
<tr>
<td>Family assessment process</td>
<td>Too much assessment</td>
</tr>
<tr>
<td>Balance in modes of delivery</td>
<td>Sequence and content of modules</td>
</tr>
<tr>
<td>Tailoring of course to specific market</td>
<td>Preparation of supervisors</td>
</tr>
</tbody>
</table>

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

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

The latter aspect was also tied to the concurrent development of policy and practice. The focus of evaluation now turns to the first year of family health nursing practice.
5.1.3 Evaluation of the first year of family health nursing practice (2002)

5.1.3.1 Summary of methods for evaluating practice

5.1.3.1.1 Overview of methods

The first cohort of students completed their course at the end of 2001 and commenced work their work as family health nurses at the start of 2002. The evaluation studied this first year of practice up until December 2002. In evaluating practice the overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot (i.e. context of development; process of engagement and outcome of practice). This approach adapted Pawson and Tilley (1997)’s realistic evaluation framework so that process rather than mechanism was studied. The goals were to clarify what FHN practice was in these settings, and then clarify how, and to what extent, the FHN role worked under various circumstances. As such, the ten FHN sites active during 2002 were seen as the main units of analysis in this study4. Explanatory case study methodology (Yin 1994) also informed this approach and knowledge was built at two distinct levels in order to explore the operation of the FHN model and draw comparisons between the pilot sites.

5.1.3.1.2 Data collection

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

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4 Please see the glossary of key concepts for an operational definition of FHN site.
We aimed to frame the selection of families within a detailed understanding of the emergent role of each FHN. FHNs were asked to select 4 families whose circumstances and health needs/problems reflected the range on present caseload (not necessarily families on FHN documentation). Checked against researcher’s data on dn and hv caseloads. These 40 families then mapped onto a large matrix using 7 key parameters: composition of family; distribution of presenting needs/problems within family; frequency of FHN visiting; involvement/s on other health care professional caseload/s; nature of initial referral to FHN; nature of current dominant need in family; and dominant domain for intervention. Distribution pattern studied to identify typical and non-typical cases.

From this matrix 20 families (2 from each site) selected in order to give an optimum permutation that ensured coverage of typical and non-typical cases. All family members written to individually, seeking consent to follow progress via phone contact, casenote scrutiny and possible interview. 42 (79%) accepted; 11 (21%) refused. Other families approached until 20 “tracer” families recruited.

FHNs asked for further details on these families. 20 families mapped re. Primary/secondary/tertiary intervention; perceived extent and success of FHN skills used so far; composition of family; distribution of presenting needs/problems; region; professionals involved. 6 cases emerged consistently as best in terms of potential for learning about range of FHN work.

<table>
<thead>
<tr>
<th>Case Study Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Single parent l/w adult son and daughter, (one disabled)</td>
</tr>
<tr>
<td>2. Pregnant mum l/w 3 daughters and male partner whose own children from previous relationship live elsewhere</td>
</tr>
<tr>
<td>3. Lady (77) l/w adult son &amp; daughter</td>
</tr>
<tr>
<td>4. Lady (58) l/w husband &amp; daughter</td>
</tr>
<tr>
<td>5. Lady (79) living alone</td>
</tr>
<tr>
<td>6. Lady (73) living alone</td>
</tr>
</tbody>
</table>
Study of the operation of family health nursing was further contextualised through the researchers making several visits to each site during the course of the project. This aspect of the study design was influenced by ideas from fourth generation evaluation (Guba and Lincoln 1989), particularly in regard to stakeholder consultation. Profiles of these sites were constructed from the following data sets:

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

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

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

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

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

TYPOLOGY OF 4 CPO PATTERNS PRODUCED

Further analyses for commonalities and distinctions (pattern recognition)

Ten prototype CPO patterns produced

SITE LEVEL ANALYSES X 10

Compare with Data from PHCT. Professional and lay stakeholder questionnaires. Identify emergent CONTEXT-PROCESS OUTCOME (CPO) PATTERNS. Test emergent theory by exploring plausible alternative explanations

CASELOAD LEVEL ANALYSES FOR EACH SITE X 10

Compare with details of whole caseload; workload pie chart analyses; interview notes; telephone checks

TRACER FAMILY LEVEL ANALYSES FOR EACH SITE X 10

Compare with themes from FHN work with other tracer families at each site (using case notes, field notes; phone interviews)

Analysis of family members’ casenotes

Content analysis of each interview then identification of common and distinct themes within each of the 6 cases

CASE STUDY LEVEL ANALYSES

6 FAMILY CASE STUDIES Full transcription of the interviews from each case study. Repeated listening to tapes and reading interview texts

6 FHN’s interviewed

9 family members interviewed (1 male, 8 females, all adults)

7 Health Professionals interviewed (3 GP’s, 1 DN, 1 HV, 1 Community Staff Nurse, 1 Community OT)
5.1.3.2 Findings

5.1.3.2.1 Context of practice

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

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

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

5.1.3.2.2 Typology of practice

As Figure 5.2 shows, the typology of practice was built through analysis and synthesis of a range of data. Table 5.3 presents the resultant typology. This summarises details of the four distinct practice types which emerged, in terms of their constituent context-process-outcome patterns. Further explanation of each type is now given.
<table>
<thead>
<tr>
<th>Type name</th>
<th>Characteristic context/process/outcome pattern (CPO)</th>
<th>Evaluators’ judgement</th>
<th>Site codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High scope-slow build</td>
<td><strong>Context</strong>&lt;br&gt;Small, stable caseload. High pre-existing scope for nursing autonomy and practice development</td>
<td><strong>Partial FHN role development</strong></td>
<td><strong>A, B</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Process</strong>&lt;br&gt;Gradual introduction by FHN only, with little/no change in other professionals working practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcome</strong>&lt;br&gt;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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slow build-key ally</td>
<td><strong>Context</strong>&lt;br&gt;FHN role super-imposed on “non-heavy” district nursing caseload within established and functional medium sized PHCT</td>
<td><strong>Partial FHN role development</strong></td>
<td><strong>C, D, E</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Process</strong>&lt;br&gt;Gradual introduction by FHN with active, focused support from at least one other professional within the core PHCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcome</strong>&lt;br&gt;Positively viewed by the limited number of families who received the service (often specific types of client group). “Normal” district nursing services maintained. FHNs generally feel they are making progress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5.3: Typology of family health nursing practice (continued)

<table>
<thead>
<tr>
<th>Slow/No go</th>
<th>Context</th>
<th>FHN role super-imposed on “heavy” district nursing caseload within established and functional medium sized PHCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Process</td>
<td>Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices</td>
</tr>
<tr>
<td></td>
<td>Outcome</td>
<td>No substantive change in practice. “Normal” district nursing services maintained, but remains stressful for FHN and colleagues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bold build</th>
<th>Context</th>
<th>“Heavy” district nursing caseload within established and functional medium sized PHCT, but FHN role not super-imposed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Process</td>
<td>New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some frictions at boundaries of other professionals’ roles. Tensions within the core PHCT</td>
</tr>
<tr>
<td></td>
<td>Outcome</td>
<td>Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. “Normal” district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for FHN but much more demanding</td>
</tr>
</tbody>
</table>

*Site J presented a slight variation of the Slow/No go pattern in that the role was super-imposed on a local management role (lead nurse) at a time of managing change towards an integrated hospital/community team. The FHN role was never developed in this context as it was felt that other work needed priority.*
The High scope-slow build pattern of practice was found in two small island sites with very small PHCTs. The FHNs “inherited” district nursing caseloads that were small and had relatively few patients needing regular, intensive nursing input. Workload fluctuated but on the whole there was high scope for autonomous practice development. On the other hand there was the responsibility to provide nursing services for the whole island population and this brought with it the particular demands of being almost constantly on-call and being expected to deal with a very wide range of clinical eventualities. Thus context tended to be the predominant aspect in this pattern. Stakeholders perceived little change:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Preventative work usually involved FHN input at secondary and tertiary levels for couples of the same generation, two generational families, and single people living alone (i.e. the typical client groups for district nursing). However most FHNs had ongoing input with at least one family with young children and some of these families had more complex structures. The input here was usually primary prevention relating to common aspects of family living (e.g. diet; exercise). Operationalising the family-as-client philosophy became more difficult where several households
were involved, but this does not mean it was easy within single households. The logistical
difficulties of seeing members of a family group individually and in combination cannot be
overstated.

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

5.1.3.2.4 Lay stakeholders’ views

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

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<tbody>
<tr>
<td>I think the FHN will deliver (delivers*) a <strong>different</strong> type of service to what is currently available</td>
<td>Unsure</td>
<td>I think the FHN will deliver (delivers*) a <strong>similar</strong> type of service to what is currently available</td>
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<td>7 (21%)</td>
<td>6 (18%)</td>
<td>14 (41%)</td>
<td>11 (35%)</td>
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<tr>
<td>I think the FHN will <strong>take away</strong> (has taken away*) from existing local services</td>
<td>Unsure</td>
<td>I think the FHN will <strong>add to</strong> (has added on to*) existing local services</td>
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<tr>
<td>3 (9%)</td>
<td>3 (9%)</td>
<td>19 (56%)</td>
<td>15 (44%)</td>
<td>11 (32%)</td>
<td>9 (27%)</td>
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<tr>
<td>I think the FHN development is <strong>well suited</strong> to our local context</td>
<td>Unsure</td>
<td>I think the FHN development is <strong>not well suited</strong> to our local context</td>
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<tr>
<td>Pre</td>
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<tr>
<td>19 (56%)</td>
<td>15 (44%)</td>
<td>10 (29%)</td>
<td>9 (27%)</td>
<td>3 (9%)</td>
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<tbody>
<tr>
<td>I think the FHN development will lead to an <strong>improvement</strong> in local health service</td>
<td>Unsure</td>
<td>I think the FHN development will lead to a <strong>deterioration</strong> in local health service</td>
<td></td>
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<tr>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>12 (35%)</td>
<td>12 (35%)</td>
<td>20 (59%)</td>
<td>15 (44%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

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

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

"If prevention is the aim, how is this to be delivered? Are families to be chosen on perceived socio-economic criteria or some other at-risk category, and once selection is made, how will subject be broached? I would rather see those in need of care get it as priority over some service that could be delivered in an intrusive and ad-hoc manner". (lay stakeholder)
A similar aggregation was made of professional stakeholders’ responses. The useable response rate to the pre-implementation questionnaire was 74% (110/149) and this reduced to 68% post-implementation (88/129). Alpha coefficients of 0.79 and 0.87 respectively suggest that this questionnaire has a satisfactory level of internal consistency. Table 5.5 presents professional stakeholders’ responses to a number of statements in the follow-up questionnaire. The table is based on responses from the FHNs’ 78 professional colleagues.

Table 5.5: Professional stakeholders’ views

<table>
<thead>
<tr>
<th>Statement</th>
<th>Unsure</th>
<th>I think the FHN delivers a different type of service to what is currently available</th>
<th>I think the FHN delivers a similar type of service to what is currently available</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN delivers a different type of service to what is currently available</td>
<td>12 (15%)</td>
<td>35 (45%)</td>
<td>29 (37%)</td>
</tr>
<tr>
<td>I think the FHN has taken away from pre-existing local services</td>
<td>7 (9%)</td>
<td>46 (59%)</td>
<td>22 (28%)</td>
</tr>
<tr>
<td>I think the FHN development has involved substantial change in the way that services are delivered to patients</td>
<td>6 (8%)</td>
<td>34 (44%)</td>
<td>33 (42%)</td>
</tr>
<tr>
<td>I think the FHN development has involved substantial change in the way professions work together</td>
<td>10 (13%)</td>
<td>31 (40%)</td>
<td>33 (42%)</td>
</tr>
<tr>
<td>I think the FHN development is well suited to our local context</td>
<td>23 (29%)</td>
<td>31 (40%)</td>
<td>19 (24%)</td>
</tr>
<tr>
<td>I think the FHN development will lead to an improvement in local health service</td>
<td>26 (33%)</td>
<td>41 (53%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>I think the FHN development is succeeding locally</td>
<td>16 (21%)</td>
<td>37 (47%)</td>
<td>17 (22%)</td>
</tr>
</tbody>
</table>

Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 78 this indicates that the remainder of respondents did not answer that particular question.
These results show that professional colleagues were still unsure about the impact of many aspects of the FHN development, but also that the status quo had not been substantially altered so far. Few saw the FHN as taking away services and engendering deterioration. A comparison was also made using data from the 53 professional stakeholders who responded on both occasions and this showed very little overall shift in these stakeholders’ perceptions.

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

5.1.3.2.6 Summary of findings from evaluation of practice

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

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

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

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

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

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

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

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

- a programme of support and facilitation of the development at site level.
- active team review of case loads and working practices to improve effectiveness and efficiency.
- concurrent review of nursing resources and staff skill mix.
delegation of family health nursing work (possibly by putting FHN in a form of “triage” role, or as an active team leader).

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

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

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

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

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

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

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

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

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

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

Thus it can be seen that the evaluation study’s suggestions on education and practice development were quickly incorporated into plans for imminent action. The next section of this chapter presents findings from a study which followed up the progress of remote and rural Scottish family health nursing during 2004.
5.2. A FOLLOW-UP STUDY OF PROFESSIONALS’ PERSPECTIVES ON THE DEVELOPMENT OF FAMILY HEALTH NURSING

5.2.1 Rationale for a follow-up study

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

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

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

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

The four objectives were:

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

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

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

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

5.2.3 Methods

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

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

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

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

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

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

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

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

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

It was also deemed appropriate to aggregate the survey findings for the FHNs as a group, given their common educational experiences and their common status as pioneers of the new FHN role. Across-site aggregation of survey responses from FHNs’ professional colleagues was also undertaken, but interpretation of resultant findings has been cautious due to a number of factors (e.g. overall responses rate being lower than previously; the tendency of aggregation to hide and/or
distort significant local trends). Accordingly these results are used sparingly, either to highlight a very strong trend that is evident across sites, or to highlight inconclusive results that require site-specific interpretation. Quantitative data is primarily summarised in terms of descriptive statistics such as frequencies and percentages.

5.2.4 Findings

5.2.4.1 Response rates

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

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

A total of 168 questionnaires were distributed in this way, with target populations at local sites ranging from 4 to 22 colleagues. A total of 88 questionnaires (52%) were returned. This is a substantial reduction from response rates achieved in two surveys that were part of the previous evaluation study (79% and 74% respectively). These surveys had used direct mailing and the change in method may account for some of this reduction, along with a perception (widely voiced by the FHNs themselves) that some professional colleagues were fatigued by questionnaires in general and the particular emphasis on family health nursing development. Response rates for individual sites ranged widely from 25% to 100%. However the returned questionnaires were generally well completed, and yielded a range of very useful qualitative and quantitative data. The paired statements part of the questionnaire (see Table 5.5) again proved reliable, with alpha coefficients of 0.84 and 0.81 when used with FHNs and colleagues respectively.
Eight of the FHNs working within these 15 sites were approached to take part in subsequent telephone interviews. All agreed to participate. These interviews typically lasted between 30-80 minutes.

5.2.4.2 Family Health Nurses’ perceptions

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

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

“Individuals/families receive services which previously were not offered”

“Providing care to families under 65 and prior to a medical need”

“More focus on patient/family empowerment/health promotion”

“Even taking a traditional DN caseload and applying FHN theories opens up the potential of work and exposes issues not previously seen as obvious. I always try to involve others in the family – sometimes don’t succeed”

“Where possible, extra nursing time is made available to families with problems”

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

In terms of the professional and personal impact of the development for each FHN, most had predominantly positive experiences. Only three (13%) reported an overall worsening of relationships with colleagues and worsening in general job satisfaction. However nine (39%) did perceive worsening in general job stress. This was usually attributed to the pressures arising from
implementing the new role, but other concurrent organisational changes were also cited in this regard. By contrast a further six FHNs (26%) perceived improvement in their general level of job stress, and the remaining eight (35%) either reported no change or were unsure. When asked for summative evaluation of the impact of the role development on overall quality of working life, a majority of FHNs (13; 57%) perceived improvement, with only four (17%) indicating that their lot was worse.

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

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

A more specific breakdown of working practices was sought by asking the FHNs to estimate the proportion of their work currently occupied by each of the three core primary care nursing functions posited in the “Liberating the Talents” English policy document (DOH 2002). An “other” category was included for estimation of the remainder of their time taken up by other functions. Results from the 22 FHNs who completed this question are presented below in Table 5.8 (figures represent proportion of work in percentage terms).
Table 5.8: FHNs’ estimations of proportion of work (%) occupied by 3 core functions

<table>
<thead>
<tr>
<th>FHN</th>
<th>First contact/ acute assessment, diagnosis, care, treatment and referral</th>
<th>Continuing care, rehabilitation, chronic disease management</th>
<th>Public health/ health protection and health promotion</th>
<th>Other remaining functions aggregated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td>20</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>35</td>
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<td>90*</td>
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<td>8</td>
<td>25</td>
<td>10</td>
<td>60</td>
<td>5</td>
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<td>9</td>
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<td>17</td>
<td>46</td>
<td>50</td>
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<td>18</td>
<td>10</td>
<td>10</td>
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<td>75**</td>
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<td>19</td>
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<td>21</td>
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<td>20</td>
<td>60*</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>10</td>
<td>50</td>
<td>15*</td>
<td>25</td>
</tr>
</tbody>
</table>

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

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

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

Indeed the vast majority of FHNs were still trying to develop the role in the context of continuing service provision to inherited district nursing caseloads. This usually made progress gradual:
“Difficult to implement FHN due to lack of time given for this. I came back into the same post and, although reviewing and reducing the caseload has allowed time for FHN, it is not enough and DN duties still have priority. Lack of line management support” (response from questionnaire).

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

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

“The patients - the families I should say – I’ve been in district nurse mode the day” (extract from telephone interview 04/4)

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

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

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

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

“The genogram and ecomap make the big difference” (response from questionnaire).

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

Nineteen of the 23 FHNs’ (83%) indicated that one of the four previously identified patterns of practice was characteristic of current practice at their own site. Table 5.9 gives details of these responses.
Table 5.9: Characteristic patterns of practice at sites, as perceived by FHNs

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

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

5.2.4.3 FHN’s professional colleagues’ perceptions of practice

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

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

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

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

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

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

Table 5.11: PHCT sites categorised by common contextual features

<table>
<thead>
<tr>
<th>Category</th>
<th>Common contextual features</th>
<th>Number of sites in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small island</td>
<td>Small island with population under 500 people</td>
<td>2</td>
</tr>
<tr>
<td>Small villages, big country</td>
<td>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.</td>
<td>10</td>
</tr>
<tr>
<td>Small town</td>
<td>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.</td>
<td>3</td>
</tr>
</tbody>
</table>

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

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

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

At other Small villages, big country sites there was a greater sense of progress in regard to the consolidation and development of the role. At two of these sites the respective FHNs functioned more independently from the traditional district nursing role, in that they had not inherited a DN caseload and they had more scope to develop autonomous practice. The typical numbers of families
each of these FHNs’ had as a caseload were 20-25. However, just prior to the follow-up study, local circumstances required that one of these FHNs moved to an adjacent site and inherited a small district nursing caseload. Similarly, it was unclear whether funding for the other more independent FHN role would continue beyond May 2005. Thus there was little sense of any momentum behind the development of an FHN role that was independent from local district nursing caseloads.

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

Collation of comments from Site X

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

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

The findings of this follow-up study confirmed the essentially mixed picture that emerged in the original evaluation study. Within this picture the dominant theme was that of gradual positive development that tended to maintain established service provision, yet also supplement this with a limited expansion of family health services and public health activities. One of the most striking findings from follow-up was the flexibility and wide scope of the role in terms of providing generalist community health nurse practice. However, capacity to engage with whole families was found to vary widely in practice.
5.3 A STUDY OF FAMILY HEALTH PRACTICE DEVELOPMENT FACILITATORS’ JUDGEMENTS ON THE PROGRESS OF FAMILY HEALTH NURSING IN REMOTE AND RURAL SCOTLAND

5.3.1 Rationale

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

5.3.2 Summary of method

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

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

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

5.3.3 Findings

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

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

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

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

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

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

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

Indeed the strength of the three linked studies is that they comprise a coherent and unique body of knowledge relating to the development of family health nursing practice in Scotland between 2001 and 2004. In the next chapter of the thesis these findings are interpreted and a set of primary understandings is synthesised in order to harness the benefits of longitudinal overview.
CHAPTER 6
BUILDING PRIMARY UNDERSTANDINGS OF PRACTICE

Overview of this chapter

This chapter is concerned with building primary understandings of family health nursing practice, based on the three linked empirical research studies summarised in Chapter 5. As the strengths of these studies have been alluded to in the preceding chapter, this chapter starts by reflecting on their limitations. This is followed by the presentation of an integrative narrative summary of the primary understandings built from the three linked empirical research studies. Again a concept analysis framework is used to distinguish envisaged enactment of the FHN concept from actual enactment of the FHN as a practice role. These synthesised understandings are summarised in the form of a table at the end of the chapter.
6.1 THE LIMITATIONS OF THE EMPIRICAL RESEARCH INTO FAMILY HEALTH NURSING 2001-2004

6.1.1 The commissioned evaluation study

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

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

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

Van Teijlingen and Huby (1998) graphically exemplify the practical issues involved when evaluation is used as a means of political legitimisation. The role of the evaluation within the development of family health nursing will be returned to in Chapter 8 of the thesis, but for the present it is sufficient to note that the dominant political discourse in the above extract from the Minister’s speech is clearly that of evidence-based policy making. In this regard it is significant that the more fundamental underlying question of why family health nursing at all? was not an explicit part of the evaluation remit. Yet Dougall (2002)’s question of the need for family health nursing in remote and rural Scotland was one that recurred for the evaluators throughout the study. Again Taylor and Balloch (2005) provide useful summation: “Evaluators have some opportunities
for asking *how?*, but are more limited in their options for saying *what* is to be evaluated and *why*” (p.5).

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

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

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

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

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

Thus the technical feasibility of the evaluation was closely related to the nature of the subject being evaluated. In this regard the fundamental question *what is being evaluated?* recurred throughout the study i.e. is it a concept, a model, an aspiration, a role, a policy initiative, or various combinations of all five of these things?
Finally, having outlined inherent limitations relating to the evaluation’s nature and scope, it is also proper to acknowledge that some may stem from the evaluators’ stance and related research design. Reflections on the former can be found on Pages 1 and 12 of the evaluation report (Annex 1), while reflections on the latter can be found in Part 5 of the Supplementary Resource (Annex 2).

6.1.2 The follow-up study

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

6.1.3 The FHPDF study

The limitations of predicking a research study on questionnaire responses from three individuals are manifold. While these individuals were in a unique position to compare and rate sites within their region, it cannot be assumed that their judgements were definitive. However the FHPDF study was essentially an adjunct to the larger follow-up study, and this meant that a substantial body of concurrent evidence provided a counterpoint to the perceptions of the three FHPDFs. This enabled comparison and less cautious interpretation.
The main findings from the three linked empirical research studies are valuable because they can be combined to give both overview of, and insight into, how family health nursing developed through education and practice between 2001 and the end of 2004 in remote and rural regions of Scotland. Accordingly it is useful now to facilitate this contemporary historical overview by presenting an integrated summary of the understandings that have been built from these empirical studies. By making associations and mapping contingencies, the summary starts to build a platform for Part 3’s in-depth analysis of why family health nursing developed in the way that it did.

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

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

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

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

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

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

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

In effect it was found that the role could be developed in a limited way on top of a district nursing caseload and within pre-existing resources. As such the FHN role typically supplemented, rather than supplanted, pre-existing services. Its introduction in these circumstances officially legitimised
and raised awareness of nursing with a strong family and health orientation in general. However many colleagues felt that this orientation already existed and consequently found it difficult to engage with, and understand the need for, this particular new approach. Hence it struggled to become a role in the sociological sense. Even where it was legitimised through recognition of its value (e.g. through referral of families) it could not necessarily be prioritised if traditional primary care provision was to be maintained unaltered.

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

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

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

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

The first is that Typology 1 was essentially a typology of practice development rather than family health nursing practice per se i.e. the dimensions which underlay the discrimination were concerned primarily with the “how” of development rather than the focus/content of practice. This was reflected in the category descriptors which always featured the nature or speed of progress e.g.
Slow build. Typology 2, which emerged from the FHPDF study, was simpler in format but was also essentially a typology of practice development.

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

Indeed the patterns identified in Typology 1 can be integrated into a wider concept analysis framework (Table 6.1) to distinguish aspects of envisaged enactment of the FHN concept from aspects of actual enactment of the FHN as a practice role.
<table>
<thead>
<tr>
<th>Envisionment of enactment</th>
<th>Enactment as a role in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: the concept</strong></td>
<td><strong>Stage 2: attributes</strong></td>
</tr>
<tr>
<td>“The envisaged enactment of the FHN concept in Scotland as a practice role”.</td>
<td>The 4 principles prescribed by the SEHD: Health model. Family focus. Generalist model. First point of contact.</td>
</tr>
<tr>
<td><strong>Stage 3: case construction in practice (as summarized in Typology 1), and analysis of these cases using different criteria</strong></td>
<td></td>
</tr>
<tr>
<td>Stage 3.1</td>
<td>Stage 3.2</td>
</tr>
<tr>
<td>The four constructed cases (Typology 1):</td>
<td>Analysis of extent of enactment of the 4 SEHD principles from 2001</td>
</tr>
<tr>
<td>High scope-slow build</td>
<td>Generalist and first point of contact principles to the fore, but limited progress/change in relation to family and health principles</td>
</tr>
<tr>
<td>Slow build – key ally</td>
<td>First point of contact variable, but inherently generalist. Slightly more sustained enactment of family and health principles</td>
</tr>
<tr>
<td>Slow/No go</td>
<td>Inherently generalist, and sometimes first point of contact. Much difficulty enacting the family and health principles</td>
</tr>
<tr>
<td>Bold build</td>
<td>Vigorous and sustained enactment of family and health principles. However, specialist tendency, rather than generalist. First point of contact variable.</td>
</tr>
</tbody>
</table>
Table 6.1 provides a useful summative overview of the progress of family health nursing by 2003. On the left side of the diagram it can be seen that in 2001 the SEHD identified four principal attributes as the basis for enactment of the FHN concept as a practice role. On the right side of the diagram Stage 3.1 uses Typology 1 to represent the cases constructed in practice. Thus it can be seen that none of the four types consistently contains all of the prescribed SEHD attributes/principles (Stage 3.2). Hence most of the types can be seen as borderline cases of family health nursing, and none of the four types obviously constitutes a model case using the SEHD attributes/principles (Stage 3.3).

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

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

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

As has been seen, the four guiding principles/attributes that were specified were not necessarily mutually compatible in practice. However, during 2003 it became clearer that the SEHD would tend to privilege the generalist attribute over the family focused attribute, in view of its better fit with a primary care system predicated on the care of individuals. Thus, by this time, there was
just a little more clarity emerging in relation to the fundamental question: what are the critical attributes that would indicate success in terms of enacting the FHN role in Scotland?

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

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

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

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

- the inclination of colleagues in the PHCT towards enacting a family orientated approach, in the absence of financial and policy incentives

- the scope for nursing to operate autonomously

- the ability of the individual FHN to influence the approach taken by community nursing colleagues and others at the core of PHCT provision

- the personal motivation and commitment of the individual FHN towards developing care for families

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

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

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

- the nature and scope of family health nursing education and practice

- the processes and modes of operation of family health nursing education and practice

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

The resultant primary understandings are now summarised in Table 6.2.
Table 6.2: Primary understandings derived from empirical research 2001-2004

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

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

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

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

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

These three points highlight the essentially intra-professional nature of the family health nursing development and the strong influence of established work systems, context and culture.
PART 2: A BRIEF REFLEXIVE RECAP

The two chapters that form Part 2 have combined to yield substantial insights into how family health nursing practice developed between 2001 and 2004. In the process of building these primary understandings, some insights have also been generated into why family health nursing practice developed in the way that it did. The next Part of the thesis is concerned with addressing this question and building further explanation by examining these understandings in the light of relevant theoretical perspectives.
PART 3

EXTROSPECTUS, RETROSPECTUS

An explanation of the development of family health nursing in Scotland between 1998 and 2004, constructed through the application of relevant theoretical perspectives to understandings derived from published documentary evidence and new empirical research.
CHAPTER 7

EXPLAINING THE DEVELOPMENT: PRACTICE LEVEL

Overview of this chapter

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

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

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

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

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

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

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

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

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

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

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

Research classifying contemporary nursing role developments provides another lens through which to view the Scottish FHN. Roberts-Davis and Read (2001) used the Delphi technique to attempt to clarify the parameters of Nurse Practitioner roles and the parameters of Clinical
Nurse Specialist roles. Although they found more common competencies than differences, their resultant typology enables some initial mapping of the location of the Scottish FHN. The typology is reproduced in Table 7.2.

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

<table>
<thead>
<tr>
<th>Clinical Nurse Specialist domains of clinical activity</th>
<th>Indicative examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition-specific domain</td>
<td>Breast Care Specialist; Stoma Care Specialist</td>
</tr>
<tr>
<td>Area-specific domain (differentiated)</td>
<td>Coronary Care Unit; Neonatal Unit</td>
</tr>
<tr>
<td>Client group-specific domain (differentiated)</td>
<td>Elderly mentally ill; Gerontological Specialist (where combined with condition-specific focus)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse Practitioner domains of clinical activity</th>
<th>Indicative examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client group-specific domain (undifferentiated)</td>
<td>Homeless Persons; Gerontological Specialist (generic)</td>
</tr>
<tr>
<td>Area-specific domain (undifferentiated)</td>
<td>Accident and Emergency; Minor Injuries Clinic</td>
</tr>
<tr>
<td>Community clinical nursing domain (undifferentiated)</td>
<td>Family or General Practice/Primary Care Nursing</td>
</tr>
<tr>
<td>Public health nursing domain (undifferentiated)</td>
<td>School Health; Public Health (Health Visiting)</td>
</tr>
</tbody>
</table>

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

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

While the above aspirations have much in common with those of the FHN concept as espoused at WHO Europe, however, it can be seen that they go beyond the SEHD vision for enactment of the concept in Scotland (particularly in terms of independence and “advanced skills” such as
diagnostic reasoning). Moreover, even where there is a match of aspiration, this would not necessarily be reflected in the reality of FHN role enactment in Scotland (e.g. first point of contact was only partially realised).

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

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

As can be seen, the use of Roberts-Davis and Read’s typology necessarily entails wrestling with the confusion that has surrounded “specialist” and “advanced/higher-level” nursing role developments in the UK. Nevertheless, it has served to highlight key similarities and differences between the FHN and the Nurse Practitioner as understood in the UK context. This is important as the Nurse Practitioner is arguably the nursing role development with the most potential for autonomous practice within PHCTs in the UK (Chambers 2000) and may offer a way for more primary care nurses to become “nurse entrepreneurs” (Cook 2005) who are equal business partners with GPs. Comparison with the typology has also drawn attention once more to the need to distinguish between the aspirations/envisioning of any role, and what is known about its
actual enactment in practice. Certainly, in terms of its aspirations, the FHN role does not seem to sit comfortably in any of the established domains of recent UK nursing role development.

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

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

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

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

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

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

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

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

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

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

Perhaps the key transferable lesson is identified by Latimer (1995) who understands attempts to enact the nursing process within the UK more as local processes of “enrolment and translation”, rather than reflecting a model of knowledge “diffusion” and subsequent “implementation”. Drawing on the work of Latour (1986) and Walton (1986), Latimer emphasises the active translation of new “technologies” like the nursing process or family health nursing into local context, culture and language: “the translations which occur are the effects of the particular configurations with which the actor(s) is associated: the meanings interpreted for artefacts, the
identities being constituted, the organizing being accomplished and the matters of interest involved” (p. 214).

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

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

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

7.4.1 The context for individual FHNs

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

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

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

7.4.2 Insights from research into the meaning of nursing models

This scenario parallels the experiences that many nurses have had in trying to enact nursing models within the workplace, and Wimpenny (2002)’s research offers some potentially informative comparisons in this regard. Looking at the meaning that nursing models had for practising nurses, he found that these models often remained tangential and external. This contrasts with the apparently strong internalisation of FHN ideas and values that occured during the Scottish educational programme and was voiced by the FHNs in their new role. Nevertheless, Wimpenny’s “model typology” (Figure 7.1) has relevance when trying to understand the professional (and indeed personal) dynamics that the FHNs experienced.
In Wimpenny’s typology the *Theoretical model* is an abstract and general conceptualisation developed by one or more theorists. The *Mental model* is “the personal pattern or schema of the individual nurse, built through personal experience and knowledge and represented in the way that nursing is described by the individual”. The *Surrogate model* is a functional version of the theoretical model used in the clinical area as “a framework or structure around which nurses can collect data, communicate and through which the organisation can standardise and audit practice(s)” (p. 351).

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

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

Argyris and Schon go on to explain that there is usually some disjuncture between espoused theory and the tacit structures that tend to govern actual behaviour, which they term “theory-in-use” i.e. this usually manifests as a gap between what people say they do and what they actually...
appear to do. This theory would certainly be supported by findings from empirical research into FHN practice during 2002, and the gap was often particularly evident when the Surrogate model and its use were scrutinised.

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

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

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

7.4.3 The influence of embedded professional identity and culture

Accordingly, at this point it is useful to move outwards from consideration of meanings and related psychodynamics for the “translating” FHN to consideration of the way that community nurses typically construct their identities in relation to other key actors in the PHCT. Melia (1987) highlights the importance of understanding how nurses construct their role identity,
believing that “it is an occupation’s ambition and self-image that will more than anything else shape the nature of the work it undertakes or the service it provides” (p. 187).

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

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

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

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

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

As can be seen, this model maps a number of key factors that are likely to influence the nature of policy implementation (or translation) at local level. As such, the model provides a basic
template upon which the emergent explanations from this chapter can be mapped. Figure 7.3 presents this process schematically, with modifications highlighted in red.

Figure 7.3: Adaptation of the Bergen and While model to incorporate emergent explanations
Thus, if Box B is seen as representing the professional and disciplinary theory of the FHNs, it can be seen that there is a relatively strong and direct link from the national policy initiative (Box A) by way of the customised, funded educational programme. The onwards link to Box C can be seen as representing the FHNs’ attempts to seek enrolment of key individual allies within the PHCT. This link is presented as relatively weak, due to the struggle the majority of FHNs had in explaining the FHN concept and brokering consensus on the local rationale and direction for the role.

Although general government health policies would usually be seen as a substantial influence on regional and local organisational structures and practices, the specific link from the family health nursing initiative (Box A to Box D) is represented as weak. This is due to the lack of SEHD clarity about the FHN role and its intended outcomes, and an associated lack of linked policy imperatives and/or financial incentives to promote related multidisciplinary development at regional Health Board and LHCC levels. Further analysis of this linkage from the macro to the micro is undertaken in Chapter 8, but the focal activities linking these parts of the model may be seen as the supportive and promotional efforts of regional community nurse managers who were involved in the National Steering Group and/or Local Implementation Groups. The work of the Family Health Practice Development Facilitators was essentially targeted at practices within the PHCT (i.e. Box C).

The need for the FHPDFs suggests that the link between Boxes D and C can be provisionally characterised as relatively weak, albeit bi-directional. Given that the chapter has already identified local culture and context as particularly potent influences, Figure 7.3 provisionally locates these adjacent to the practices of individuals in PHCTs. However, this part of the model would seem to require further explanation and development.

Although all the key factors in Boxes A-D can be seen as influencing the local translation of policy that takes place in the central “arena”, this thesis would argue that in remote and rural regions this is always mitigated through the individual practices of key PHCT members. Thus the “central arena” of policy implementation of Figure 7.2 is moved downwards in Figure 7.3 to reflect this. Within this sphere, the four main patterns of translation have been located adjacent to the factors with which they seem most closely associated. In this way it can be seen that the Slow/No go and High scope-slow build patterns are most closely associated with established structures, culture and practices. The Slow build-key ally pattern is associated slightly more with autonomy of individual practice, and the Bold build pattern is the one that is most closely associated with the ideals as promulgated by the Scottish educational programme (i.e. in terms of its ability to enact in-depth family assessment and intervention as per the Calgary model and to engage in sustained public health activities at community level). In this regard it is important
to note that none of the patterns align directly with the SEHD principles for policy translation (i.e. the four principles below Box A).

7.5 PLACE, POWER AND THE LIVING PLAID OF PRIMARY CARE

Thus the modified Bergen and While model provides useful summation of explanation building so far. As noted above, however, the powerful influence of local context and culture requires further exploration, explanation and incorporation within a model that attempts to explain why family health nursing developed as it did at local sites.

In this regard the recent work of Poland et al (2005) focusing on the importance of place is useful. As they observe, “there have been few attempts to systematically ‘unpack’ those aspects of place that matter most to an understanding of the variability of health and social care practice, as well as to experiences of care, in a way that could directly impact policy, practice and research” (p. 171). Poland et al argue that place is more than a physical setting. Rather it is “culture manifest” in that “a distinctive culture of place emerges from the pragmatic and routinised interactions between engaged participants and social processes (various forms and levels of social structure)” (p. 172). For Poland et al, culture of place includes “the many ways in which place both represents and is represented within language, meaning, experience and subjectivity” (p. 172). This view links clearly with the initial analysis of Highland and Island “communities of place” developed in Chapter 4.

However Poland et al’s work goes on to examine the emplacement of power relations within the set of “situated” social dynamics that constitute place. This view sees power as situational and relational: “Power is what allows the economic and social interests of some persons and social groups to (routinely) prevail over those of others. Power is embedded in ways of thinking and doing things, in mundane daily actions and interactions, as well as in institutional practices and broader social and economic policy” (p. 173). As Poland et al continue, “Most health and social care practitioners will be acutely aware of the extent to which settings are rife with power relations (who controls access, who sets the agenda, whose interest are served, how those lower in the social hierarchy are treated in ways that continually ‘remind’ them of – and keep them in – their place etc.)” (p. 173).

Within UK primary care provision, GPs have for many years been at the top of local health and social care hierarchies (Peckham and Exworthy 2003). Their practice and concerns have very actively influenced the nature and scope of community nursing practice (Witz 1994). If there was ever any doubt about this it can be assuaged by study of national statistics. In an overview of primary care provision in Scotland since 1980, Ritchie (2003) notes that District Nurses’
home visits to those aged 75 and over increased by around 75%, and that this trend co-incided with the 1990 GP contractual requirement for the provision of systematic annual health checks in this age group. Even allowing for demographic shift in the age profile of the population, it is difficult to avoid the conclusion that community nursing activity is profoundly influenced by the interests of GPs.

This analysis is supported if Grabb (1977)’s three fundamental dimensions of power are considered. These are: control of material resources (means of production, wealth); control of human resources (labour, power); and control of ideas (ideology, hegemony, and cultural dominance). In the context of community nursing in the Highlands and Islands there has been increasing “attachment” of community nursing to GP practices. Although most community nurses remain employed by NHS Boards, at local level “GP attachment” has involved negotiating space and facilities with these independent contractors who have substantial control over much of the material resource. Moreover the rise in the employment of Practice Nurses directly by GPs has meant that they also have increasing control over the community nursing human resource. Finally the “biomedical model” focus on treatment of disease/health problems, with the GP at the centre as expert (Macdonald 1992), continues to be the dominant idea within primary care provision in the Highlands and Islands.

This is not to ignore significant historical narrative relating to holistic family and community care by GPs and nurses in the Highlands and Islands (Dougall 2002). However it is necessary to recognise how important the provision of accessible and safe medical treatment is to local communities. During the 2000-2004 there were several high profile disputes in the Highland region where communities successfully resisted the perceived withdrawal of their local GP service. Patient safety was usually at the heart of communities’ fears. Thus public expectations in the Highlands and Islands, nourished over nearly 100 years since the Dewar Report, serve to re-inforce the power of the GP within the PHCT. As has been seen already in Chapter 4, through their “community embeddedness” (Lauder et al 2001), GPs also have a central role in the life of remote and rural communities (Hope, Anderson and Sawyer 2000; Clark 1997).

Accordingly, one of the central issues for FHNs seeking to translate this policy initiative into meaningful local practice was its interface with the situated power and interests of the local GP(s). As has been seen FHNs approached this in different ways, depending on individual confidence, established relationships, local priorities, local working practices and a range of other contingent variables. Nevertheless, it is easy to see why the vast majority of FHNs avoided radical interpretations of their new role that might be seen to involve significant disruption or change to pre-established primary care delivered by community nursing in line with GP expectations. Service maintenance with niche supplementation maintained balance,
avoided making large waves, yet could be seen to further individual development of family health nursing. Importantly, one of the consequences of service maintenance with niche supplementation was the striking diversity of FHN practice as evident in relation to the three core primary care functions (see Chapter 5).

Undoubtedly the other large influence shaping this approach was the expectations of the range of community nursing colleagues at local sites. Site visits by the author during 2001 and 2002 revealed that many of these colleagues found it hard to understand what the new role was and why it was needed. In this climate the need to maintain reasonable working relationships with colleagues was important. With the vast majority of the FHN students being drawn from roles that primarily serviced established (often embedded) district nursing caseloads, it was seen as a matter of priority by colleagues that these services should not be adversely affected. Where there was little pre-existing autonomy or “slack” for the incoming FHN, this “bottom line” usually thwarted individual development of the FHN role. This is vividly rendered in the Slow/No go case study at the end of Annex 1. However some of the FHNs returned to sites where they had previously already established substantial personal autonomy and/or “slack” (e.g. small island sites), and this facilitated development and enhancement of pre-existing services under the rubric of family health nursing. For many, first level change to their own practice became the realistic limit of their ambitions. For some, however, it was possible to enrol key allies towards more integrated family health service developments.

The above analyses of prevailing conditions at the micro site level show the general influence of local context over the way that the FHN policy initiative was translated into practice. Within this general picture, the specific notions of situated power, established service priorities and culture of place have emerged as offering useful explanatory potential. Drawing on the work of Poland et al, these elements are now incorporated into the evolving explanatory schema which also integrates elements of the second typology of practice development which emerged from the 2004 follow-up research (Figure 7.4).
Figure 7.4: Explanatory model of translation of family health nursing policy to and at practice level
Figure 7.4 presents a pictorial overview of the major contingent factors, processes and findings that explain how and why family health nursing developed in the way that it did at local sites between 2002 and 2004. This carefully built construction offers an initial (and, at time of writing, a unique) theoretical explanation of the practice-based development of this historically important policy initiative in community nursing. However, it is important to locate this model in relation to wider perspectives. To repeat Dingwall, Rafferty and Webster’s (1988) dictum, “the shape of nursing cannot be entirely understood from within” (p.228). For this reason the final part of this chapter attempts to build further explanation of the relationship between local family health nursing development and primary care provision in the Highlands and Islands.

For a range of other initiatives/developments will be impacting concurrently at any time at any one PHCT site. In this way, between 2000 and 2004, remote and rural PHCT sites in the Highlands and Islands were experiencing many translations and associated transitions, most notably in relation to: the new Local Health Care Cooperative structures; the new General Medical Services (GMS) contract; Single Shared Assessment for patients by health and social care services; review of midwifery provision; and development of the public health aspects of School Nursing and Health Visiting. Thus, if Boxes A-D of Figure 7.4 are seen as the irregular blades of the FHN windmill, it is possible to imagine an overall picture of many different sized windmills independently contributing to the generation of primary care. This metaphor has some topicality in the Highlands and Islands context. Nevertheless, on reflection, it fails to capture the inter-dependency and synergy between concurrent influences on contemporary primary care.

However, a different visualization can be achieved if Levels 1 and 2 within “Box” C of Figure 7.4 are seen as interwoven, constituting the “fabric” of local primary care provision. Drawing again on natural metaphor from the regions studied, this fabric may be seen as a sort of “living plaid”. Figure 7.5 illustrates how GP services can be seen as the major warp threads and district nursing services can be seen as the major interlacing weft threads, together constituting the living heart of the fabric. It is noteworthy that this pattern was laid down by the Dewar Commission Report in 1912 and has remained largely unchanged since then.
Figure 7.5: Explanatory model incorporating the “Living Plaid of Remote and Rural Primary Care”
In this three-dimensional metaphor, the topside of the plaid comprises those aspects of individual professional practice and PHCT functioning that are visible to the wider public and/or are espoused as representative (i.e. PHCT “face”). Implicit within Figure 7.5, and underlying this topside, is the substantive body (i.e. thickness, depth) of the fabric, which is largely invisible to the outsider. This relates to the dynamics of inter-professional teamwork and also, importantly, to the actual practice of individual professionals with patients, carers and families in their own homes (e.g. the “invisible” work of community nursing). The latter aspect in particular can be seen as part of the underside of the plaid, where services articulate intimately with (and within) local communities (Level 3, “Box” C, Figure 7.4).

Indeed, given the nature of remote and rural healthcare, there are likely to be many points where the underside of the Plaid may effectively seem inseparable/indistinguishable from the specific community that it covers. These “points of embedding” or “vertical adhesions” may occur when a GP and/or nurse lives and works in a very small, specific community. This relates clearly to the “community embeddedness” referred to by Farmer et al (2003) and the social capital dimension of rural nursing described by Lauder et al (2006). As has been seen, these communities all have their own embedded cultures of place.

Figure 7.6 now depicts the Living Plaid in more detail, illustrating some important contingent and concurrent processes.
Figure 7.6: Detail of the “Living Plaid of Remote and Rural Primary Care”
Figure 7.6 illustrates how the body of the fabric may absorb, generate and/or regenerate in relation to a range of external, and internal, influences. Thus, if each different but contingent initiative/development is seen as a needle pulling thread, there is the capacity for the plaid to simultaneously “darn in” and/or resist threads of different length, strength and hue, dependent on local need or local power interests. In turn this helps to explain the variety of very different local patterns on the living plaid of primary care that were routinely encountered when visiting PHCT sites.

The latter observation brings to mind another metaphor that is sometimes used to refer to the shape of primary care provision in the Highlands and Islands: the “patchwork quilt”. While this captures some of the irregularity of the overall appearance of service provision, it fails to reflect the essential pattern that binds together the elements of primary care provision in these regions.

Thus “The Living Plaid” is posited as a potentially useful new metaphor for primary care provision in the Highlands and Islands. As with original Highland plaid, the primary care garment has typically been primarily designed for multi-function rather than show. In recent years, regeneration has become difficult when the fabric has worn thin or been laterally stretched in places, but the fabric’s capacity for wear, tear and running repair has been its enduring quality to date. When Highland and Island primary care is considered in this way, it raises the question of whether history will view family health nursing as an enduring, strengthening repair or a foppish piece of foreign embroidery.
SUMMARY

This chapter has built explanation of why family health nursing practice developed as it did at local PHCT level, and has focused particularly on the enactment of the FHN concept as a role. To this end, the primary understandings from Part 2 were considered in the light of a number of relevant theoretical perspectives. The prevalent pattern of FHN role development reflected the “niche” type (Scholes and Vaughan 2002) and can best be characterised as “service maintenance with niche supplementation”. However the FHN role development emerged as atypical in that it had been “top down”, nationally co-ordinated, and had incorporated an educational programme and evaluation.

Insights from previous UK experiences with the nursing process showed the value of understanding local family health nursing development in terms of enrolment and translation processes, rather than implementation. A typology of nursing models was used to help explain the personal and professional psychodynamics of the translation of the FHN concept into a nursing role. Further illumination was afforded by relevant literature on professional identity and inter-professional relations.

These understandings were then integrated into an explanatory framework developed by Bergen and While (2005) to capture the mechanisms by which health and social care policies may be translated into community nursing practice. This framework itself was then further developed to take account of the particularly strong influence of established work systems, context, culture and place in the local development of family health nursing. This resulted in a new summative model of the main contingent factors and processes that together explain the nature of local development of family health nursing in Scotland up until 2004.

Although this new model could be seen as sufficient in terms of the scope of the thesis, it was recognised that it had limitations in terms of its ability to reflect the many other concurrent initiatives and policy translations ongoing at local PHCT level. In order to address this, an alternative adaptation to the model was developed using the metaphor of “the living plaid of remote and rural primary care”.

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Overview of this chapter

The focus in this chapter moves from local practice level back to national level in order to develop further explanation and build comprehensive understandings of why family health nursing developed as it did in Scotland. In doing so, analysis centres primarily on the formulation and advancement of nursing and health care policy.

A prologue to the chapter seeks to aid this transition from practice to policy by reflecting on the commonalities, as well as the distinctions, between the professional – personal worlds of the FHN, the researcher and the Chief Nursing Officer (CNO). By including dialogue from an interview with the CNO, the prologue also exemplifies the approach taken during interviews with four key policy informants who were involved in initiating and promoting family health nursing (see Annex 3 for full details). Undertaken in 2005, these interviews invited reflections on three of the central questions in this study, thereby interrogating cumulative understandings built up through literature review in Part 1 and through empirical research in Part 2. Accordingly this chapter draws extensively on understandings derived from these interviews.

Following description of interview, analysis and synthesis methods, the emergence of the FHN concept in Europe and its enactment into policy is revisited through understandings synthesised from the key informant interviews. Two relevant policy analysis frameworks are then applied in order to gain further insights into why events developed as they did. This process is then repeated in relation to Scotland, enabling a new explanatory model of the emergence of the FHN concept at both European and Scottish levels to be presented.

The next section of the chapter constructs a different model that explains the contingencies involved in taking the FHN policy initiative forward for enactment. This completes the link back to practice, and the chapter concludes by presenting a final integrated model of the main contingent factors and processes that explain the development of family health nursing in Scotland up to 2004.
8.1 PROLOGUE ON PROFESSIONAL - PERSONAL WORLDS OF PRACTICE: THE FAMILY HEALTH NURSE, THE RESEARCHER AND THE CHIEF NURSING OFFICER

In order to synthesise understandings about the development of family health nursing practice, the analysis in Chapter 7 primarily considered the local sites in overview. Before moving away from the realm of practice to the realm of policy, however, it is important to reflect on the professional and personal worlds of meaning that underlie both.

Interviews and observation of practice undertaken as part of site visits during the commissioned evaluation study yielded a large number of insights into the professional and personal worlds of FHNs and their clients. As the FHNs almost always lived within the small communities where they worked, the dividing line between the professional and personal was often very hard to discern. A passage from an interview with a very experienced community nurse who had recently started to work as an FHN gives a glimpse of the underside of “the Living Plaid”:

“.......You can’t be a person who really wants their privacy. You are in a goldfish bowl. You have to be able to cope with people’s interests. You also have to recognise, or to know, to have lived in an area, to be brought up in a country area, to know that this is how country areas live. Remote and rural areas. People do feel they own you. If you’ve lived in an area all your life there are people who see you as a baby. They maybe fed you a bottle, or changed your nappy, and from that they feel an ownership of you. And they feel it isn’t just curiosity or nosiness. They want to know how you’re getting on. They feel they’ve had a hand in bringing you up..........and this is how country people feel if you are part of a community and living there. And it also depends on the experiences you’ve been through with them. If you’ve been through a bereavement with them, either their bereavement or yours, these all make big connections in a remote and rural area, and it’s part of the trust that builds up between Family Health Nurse and the community” (extract from interview 02/03).

Although particularly vivid, this passage is typical of the psychological and social context within which FHNs were working. It is interesting to note how similar this is to the experiences of the retired remote and rural DNs who informed Dougall’s 2002 study. Some of the consequences are explored in a further extract from the same FHN interview:

FHN: “.....you’re living in an area for a long time and you have a lot of information also, a lot of which perhaps you cannot write down, its that sensitive. But you make connections in your head and you know how the whole community intermingles and you have got a picture of that. Its like the community portrait but its in your head. But there are some things you can’t write down.

CM: Yes, you see that interests me.

FHN: See, I know some people who are not who they think they are

CM: Right, even that fundamental?

FHN: I know it but they don’t
CM: You know that? You’ve lived in the area a while, and that’s hearing from other people?

FHN: Yes (extract from interview 02/03).

Given the nature of the family health nursing assessment process promoted by the educational programme, and its associated documentation, this raised potentially difficult issues for FHNs. Indeed several independently reported the experience of being privy to a different version of family history than the one that a family member had related during construction of the genogram. This usually seems to have been dealt with by the exercise of discretion and/or circumspection on the part of the FHN.

I observed another strategy during a field visit. The following account was developed, based on my research field notes taken at the time:

I set off early to meet Una (FHN). A series of tortuous single track roads led through, then over, the spine of the island until moor, bare rock, lochan and sky gave way to machair, sea and a scattering of crofts. I’d brought the address of the GP surgery where she was based, but I didn’t have a detailed map and, anyway, there were rarely street signs in the island’s villages. Only a stranger would need them, and then, not for long.

Una was going to visit the Ross family to try to continue the formal family assessment process. The Ross’s comprised: grandfather; daughter; husband (away at sea); husband’s 14 year old daughter from a previous relationship; and their two small sons. Apart from the five year old son’s intermittent difficulties with wetting his trousers, there were no current “presenting” health problems.

I watched and listened as Una asked the mother questions in order to develop the genogram and ecomap. The process combined a search for new knowledge (e.g. about any illness on the husband’s side of the family) with superficial checking of deep-rooted mutual understandings (Una and the mother both had children at the local primary school). The latter strategy was applied to some of the questions on family power structure and dynamics in the assessment tool, while the remainder were skillfully omitted by Una.

The mother also had some skilful response strategies. On the few occasions that questions overtly probed difficult areas (e.g. relationship with husband’s daughter) she would deflect these by giving vague answers (“getting on well enough”) or veering into copious and largely circumstantial detail about her husband’s side of the family. I later heard this described by a university lecturer based in the Highland’s as a typical local strategy of “polite non-co-operation”. In turn, Una recognised the signals and always moved on to less threatening ground.

As I watched this lengthy and elaborate “dance” I was struck, as often before during the research, by the need to attend as much to what was not being said as to what was being said. I was also conscious of another recurring question: what was the need for this? Finally, I felt a strange mixture of wonder and puzzlement at how and why the family health nurse concept was being acted out in this way, in a remote croft hundreds of miles from Calton Hill and Copenhagen. All of these thoughts I kept to myself.
The above account changes some details in order to avoid family and FHN identification. However, it has been developed to show how my professional engagement with the world of FHN and clients led to a personal puzzlement about the transmission and translation of an idea. This puzzlement became the driving force for PhD study. As has been seen, this study not only tries to answer the seminal questions why here, and why now?, but it also attempts to answer why has it happened as it has here?, and to build an explanatory model of the Scottish development by linking this back to why did it happen at all?

Addressing the latter question requires a return to the policy formulation and enactment worlds of Calton Hill and Copenhagen. In order to try to overcome some of the limitations of doing this exclusively via literature (as evident in Chapters 3 and 4), the present chapter also draws on interviews with a few “key informants” who were involved in the FHN concept’s initiation, policy formulation, and enactment. While the work context for these key informants was typically extremely different from the world of remote and rural FHN practice described above, nevertheless, it is important to recognise that there are similarities as well as differences in the professional-personal dimensions of these respective worlds. Similar tensions prevail in regard to what can be said and what cannot, and what is written down and what is never recorded. This is particularly important to remember when an historical research perspective is being adopted.

The following extract from the key informant interview with Anne Jarvie, Scotland’s Chief Nursing Officer from 1992 to 2004, illustrates this point and sets the scene for the next section of the chapter:

**CM:** “…but it could be said that at the end of the day, if you haven’t shifted the pre-existing roles, then you’ve just added another one.

**AJ:** Absolutely. You see I had hoped, and I couldn’t articulate this because this was what was making everybody feel very protective and sensitive who were not doing the FHN course. I had expected that in some areas in Scotland we would no longer have District Nurses and Health Visitors.

**CM:** Mmh. And did you have an inkling that that might ehm, you might have people that would help you in that, shall I say (laughs)?

**AJ:** Yes

**CM:** Right

**AJ:** If it had worked out. And it may. I mean it is still quite early days. If it had worked out that this cohort of people were generalists, that they could be the gatekeeper, that they could ehm be the people who had the confidence to function to the level of their, the higher level, of their skill and knowledge, and could have been the referrer on to others without a middle man” (extract from key informant interview 05/1).
In addition to yielding insight into the professional – personal dynamics of change management, the above interview passage also exemplifies the approach taken in the key informant interviews. The next section of this chapter gives more information about interview methods and more information about the interpretative processes applied to the understandings derived from the interviews.
8.2 RESEARCH METHODS

An overview of methods used in this chapter is given in Chapter 2.2.3.3. Moreover, a full account of the nature, scope, design, methods and findings of the key informant interview part of the study is given in Annex 3 to the thesis. At this point, however, it is useful to summarise the key informant interview approach and its underlying rationale, in order to make clear its part in the process of building an explanation of family health nursing development.

8.2.1 Interviews with key informants

As has been seen in Parts 1 and 2, the emergence of family health nursing and its subsequent enactment were primarily studied by reviewing extant literature and conducting primary empirical research into education and practice in Scotland. Through a combination of these primary and secondary research strategies, a set of advanced understandings about family health nursing had been constructed by 2005. However, one prime source of knowledge about the development remained untapped, namely, the small group of people who were instrumental to the initiation and promotion of the concept i.e. the “key informants”. Accordingly, during the summer of 2005, I sought to elicit the perceptions of these key informants in relation to the three main research questions at the heart of the study. These were:

- Why develop family health nursing?
- Why did family health nursing develop in the way that it did in Scotland?
- What does this mean in terms of the development’s influence and implications?

In addition to seeking general reflexive overview on these questions, I was also:

- seeking answers to a number of specific questions which had arisen from prior analyses of literature and empirical data (e.g. how, when and why did the “family” part of the FHN concept arise?)
- checking emergent understandings against key informants’ interpretations of events, underlying motivations, and related personal explanations (e.g. the SEHD policy on family health nursing being essentially ambivalent in that more individual-focused community nursing roles such as practice nursing were simultaneously being promoted)
- jointly exploring the possible explanatory value of theoretical frameworks for policy analysis (e.g. discussing application of Rafferty and Traynors’ Context-Convergence-Contingency model to the evolution of family health nursing policy)

Thus, to some extent, the interviews were part of a process of authentication.
In-depth interviews were carried out with two individuals who were central to the initiation and policy development of family health nursing in Europe and Scotland respectively:

- Ainna Fawcet-Henesy (AFH), WHO Europe Regional Advisor for Nursing from 1995 onwards. During 2005, AFH was on extended leave due to illness.
- Anne Jarvie (AJ), Chief Nursing Officer for Scotland from 1992-2004. AJ had recently retired.

Interview with AFH was undertaken by telephone, while interview with AJ was undertaken in-person.

More limited interviews were undertaken via e-mail with two key informants who had particularly important input into the development of the FHN conceptual framework and curriculum. These were:

- Professor Margaret Alexander (MA), who was Director of the WHO Collaborating Centre at Glasgow Caledonian University during the period when the FHN concept was developed
- Majda Slajmer Japelj (MSJ), International Manager in the WHO Collaborating Centre for PHC Nursing in Maribor, Slovenia, during the time when FHN was being developed. MSJ also worked for WHO Europe in Copenhagen as Temporary Adviser/Short term consultant for transition countries.

All four interviews were designed to cover a core set of questions related to those driving the thesis, but each interview schedule was also customised in order to address specific questions of particular relevance to the professional role of the interviewee. Interviewees agreed to resultant dialogue being “on the record”, with their contributions being attributable and identified with them personally. This direct-attribute approach was chosen because these informants’ involvement at the core of policy development was a matter of public record, and attempts to anonymise their contributions seemed both futile and inappropriate. Annex 3 presents more detailed reflections on the ethics, merits and demerits of this approach.

Annex 3 also presents examples of core, relevant narrative from these interviews along with the main themes derived by myself and informed by critical review from my supervisor. These comprised a first stage of data analysis and the reader is referred to these for detailed and particular insights. The second stage of analysis involved comparison of narrative across the four different interviews to examine points of convergence and divergence. In this way it was
possible to synthesise a summative narrative (see Table 8.1 below). A third stage of analysis extracted core ideas from each individual interview and set out the consequent understandings derived (see Table 8.2 for an example). The fourth and final analytic approach involved the identification and application of relevant theoretical perspectives on policy analysis and policy implementation.

8.2.2 Identification and application of relevant policy analysis and policy implementation frameworks

As Table 2.4 indicates, this firstly involved extensive review within nursing and more generally within public policy literature. Although the primary cognate area and associated questions drove this search, some other criteria were important in determining the theoretical frameworks that were selected. Specifically I was looking for credible research-based frameworks that:

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

This led to the selection of two models which focused primarily on analysis of policy formulation and initial advancement. These were applied as analytic templates (Miller and Crabtree 1992; see Table 8.3 for an applied example) to interrogate both the understandings already derived from prior stages in analysis of the interview material, and the understandings already derived from review of relevant literature. This involved processes of extraction, comparison, differentiation, interpretation, integration and illustration. A further model was subsequently selected to help explain the way in which the FHN policy initiative was taken further forward towards enactment in Scotland. Again this was applied as an analytic template (see Table 8.10).

Through these methods the chapter takes forward the process of building further explanation of the formulation, development and enactment of family health nursing policy. The next section considers policy formulation and development at European level.
8.3 THE EMERGENCE OF THE FHN CONCEPT IN EUROPE AND ITS ADVANCEMENT INTO POLICY

8.3.1 A synthesised narrative, plus the core ideas of the key informant

This part of the chapter revisits the FHN concept’s Copenhagen cradling in the light of the findings from the key informant interviews. As Table 8.1 shows, it was possible to construct a summative synthesis of narrative across the four interviews which shows convergence around one central explanation of events, while also highlighting two areas where there was divergence of emphasis.
### Table 8.1: Summative synthesis of narrative across four interviews*

<table>
<thead>
<tr>
<th>Convergence/corroboration around a central narrative</th>
<th>Divergence/distinct difference in emphasis within the narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health for All Nurse concept was the core from which the FHN concept was developed. However there was no FHN as such in the Vienna 1988 Declaration</td>
<td></td>
</tr>
<tr>
<td>Dr Asvall (JA) initiated the new (1998) emphasis on the family, and developed the concept with AFH</td>
<td></td>
</tr>
<tr>
<td>While JA was a major advocate of the FHN concept, AFH was the main driver of its subsequent development</td>
<td>Distinct differences in emphasis emerged in regard to the centrality and importance of family within the FHN concept. AFH saw it as foundational and focal, while the other interviewees saw it as important but placed less emphasis on it. There were some tensions around this issue amongst the senior nurses involved in developing the concept at WHO Europe level, but these didn’t last long due to a recognised need to move quickly to grasp the HEALTH 21 opportunity. For Anne Jarvie (AJ) the emphasis on family was not seen necessarily as permanent and immutable.</td>
</tr>
<tr>
<td>HEALTH 21 was a timely opportunity to advocate, develop and attempt to embed modern public health nursing across Europe</td>
<td></td>
</tr>
<tr>
<td>The drive from the two central figures (JA and AFH) was essential, but in itself could not guarantee desired outcomes</td>
<td></td>
</tr>
<tr>
<td>The matched Family Health Physician (FHP) concept never developed due to the lack of a champion (other than JA)</td>
<td>There seemed distinct differences in emphasis about the extent to which the FHN should be seen/presented as a catalyst for provoking wider systems change. Although all interviewees wished this to happen, AFH stressed the FHN role itself more as an autonomous entity. Perhaps this reflected engagement with developing countries where primary health care systems were less established and embedded. AJ acknowledged that, since retirement, she was rather more explicit about the desire and need for the FHN to help change existing PHCT approaches than had been possible during the earlier stages of the developing FHN initiative.</td>
</tr>
<tr>
<td>Indeed there was active opposition to the FHN concept from GPs at WHO Europe level who saw it as encroaching on their territory</td>
<td></td>
</tr>
<tr>
<td>Slovenia, the UK and Scandinavian countries were the main influence on the development of the conceptual framework and curriculum for the FHN</td>
<td></td>
</tr>
<tr>
<td>The envisaged scope of the FHN role was ambitious but necessary and legitimate</td>
<td></td>
</tr>
<tr>
<td>There was some significant opposition to the FHN development at European level from health visitors and midwives</td>
<td></td>
</tr>
<tr>
<td>Scotland has been exemplary in progressing the FHN from concept into enacted role, but remains far ahead of other interested countries</td>
<td></td>
</tr>
<tr>
<td>Many European countries still lack infrastructure and legislation for development of nurse education and nursing practice</td>
<td></td>
</tr>
</tbody>
</table>

*The interview schedules had some core common questions, but were individually tailored to optimize learning opportunities from key informants with distinctive roles in the initiation, promotion and enactment of the FHN concept. Therefore cross-case analysis and subsequent synthesis of perspectives has only been undertaken where appropriate. This has been almost entirely in relation to the core common questions on the emergence and development of the concept at European level.*
Table 8.1 shows the value of the key informant interviews in answering many of the questions that emerged from review of the WHO Europe literature on family health nursing. In effect it is clear that:

1) The 1998 allusion to there being a Family Health Nurse in the 1988 Vienna Declaration was factually incorrect, but was meant to refer to related ideas implicit in the Health for All Nurse
2) Dr Jo Asvall (JA) initiated the new emphasis on family in 1998
3) The Family Health Physician concept was never developed due to the lack of a champion (other than JA), and there was active opposition from European GPs to the FHN concept

None of these points could be deduced from the WHO Europe literature due to its inherently promotional/aspirational nature.

While review of the literature had shown Ainna Fawcet-Henesy as the main driver of the FHN concept’s policy development, the key informant interviews also highlight her initial role in fostering the concept with Dr Asvall. Indeed her own account of the evolution and subsequent development of the FHN concept provides considerable insights into her beliefs, motivations and political strategies. A summary of these “core ideas” is presented in Table 8.2.
Table 8.2: Core ideas which emerged from interview with AFH

<table>
<thead>
<tr>
<th>CORE IDEA</th>
<th>DERIVED UNDERSTANDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) The opportunity and imperative for a public health focus</td>
<td>This idea was central to the “macro” approach AFH took forward through WHO Europe and HEALTH 21, and was also central to the FHN concept and envisaged role. It was seen as imperative that nurses had a good educational preparation for meeting the considerable public health challenges across Europe. There was doubt that many of the existing primary care systems, dominated by disease-focused medicine, could meet these challenges.</td>
</tr>
<tr>
<td>2) The family as the single most important unit in society</td>
<td>This phrase was stressed several times during the interview, and was a key belief that AFH saw as underpinning all nursing activity. As such, the “family” focus in the FHN title was seen as reflecting a primary purpose in itself (i.e. being alongside the family) rather than simply a means to the end of getting public health embedded into community development.</td>
</tr>
<tr>
<td>3) The FHN as a development from the Health for All Nurse</td>
<td>These two ideas were seen as sharing a similar core, with the main difference being that the FHN was more developed as a concept, with a specific conceptual framework and educational curriculum. The decision to foreground family as a key element had been initiated by Dr Asvall and developed jointly with AFH.</td>
</tr>
<tr>
<td>4) Need for legislation and education to address poor infrastructure for nursing in many European countries</td>
<td>This was seen as the main big issue for nursing to address. AFH felt that the only way to effectively do this was for nurse leaders to engage politically and try to influence Ministers. Poor funding was linked to nursing’s low status. These problems were the main cause of the slow progress of many countries involved in the FHN pilot.</td>
</tr>
<tr>
<td>5) Importance of good project preparation and adequate funding</td>
<td>Multinational pilot projects like the FHN need some substantial core funding and good preparatory work to ensure a critical mass of success. Nevertheless, in the absence of more funding, positive action is still needed as nothing will happen if we wait for money. In this regard, leadership, inspiration and good core teamwork are essential.</td>
</tr>
<tr>
<td>6) Tensions and frictions are inevitable if anything is to change</td>
<td>Although regrettable, tensions and frictions are inevitable when change is being introduced. Opposition from professional self-interest groups has always been a factor in any major reform. There is a need to focus on the over-riding aim as the key outcome that will ensure better care. Healthcare practice can be most fundamentally improved through policy influence.</td>
</tr>
</tbody>
</table>

In addition to highlighting AFH’s strong and long-standing belief in the need for a form of public health nursing that works with families, Table 8.2 also conveys some of her deep conviction that strong political leadership from nursing is the cardinal means by which nursing practice in Europe will be improved. In this regard all the key informants emphasised that her role in leading the WHO Europe FHN project was central and crucial.
8.3.2 Application of Kingdon’s model

In order to gain further critical purchase and to stand back somewhat from the personal perspectives which were elicited, two theoretical frameworks from policy analysis were applied to the interview findings. The first, Kingdon (1995)’s agenda setting model, is drawn from analysis of public policy in general, while Rafferty and Traynor (2004)’s Context-Convergence-Contingency (C-C-C) model has been developed primarily through analysis of policy relating to nursing education and research.

Kingdon’s model is well summarised by Peckham and Exworthy (2003), and it is worth quoting their description of it:

“Kingdon’s model examines how issues get on to the policy agenda in the first place and how they become translated into policy (Kendall 2002). The various streams must be connected before the “policy window” opens. The model is useful in explaining how opportunities for policy formulation and implementation are created and destroyed. The problem stream comprises evidence of the nature of an issue which becomes defined as a problem amenable to policy interventions. This evidence might be crisis incidents, research results, patient feedback or performance indicators. The policy stream consists of proposals, strategies and initiatives to address the problem. These often pre-date the problem being recognised and circulate in a “primeval soup” awaiting their identification. This requires a critical mass of stakeholders to appreciate the merits of the policy. The merits must include an accordance with (political or organisational) values, a technical feasibility and a recognition of future constraints. The politics stream comprises party politics, organisational power struggles and interest groups. These three streams may be connected by natural cycles (such as elections), crises or the actions of a policy entrepreneur, an individual or individuals who invest their reputation, status and time in joining the streams in order to open and keep open the policy window. Natural cycles, complacency or the entrepreneur’s departure might force the window to close” (p.38).

As Hill (2005) notes, Kingdon’s model is derived specifically from analysis of public policy in the USA. The combination of the soup, stream and window metaphors is a rather uneasy one, but its application may usefully highlight possible explanations of how and why the FHN concept was moved onto central agendas and promoted. The emergence of the FHN concept is viewed through this lens in Table 8.3.
Table 8.3: Application of Kingdon’s agenda setting model to the European emergence of the FHN concept

<table>
<thead>
<tr>
<th>Dimension of Model</th>
<th>Understanding derived through analysis</th>
</tr>
</thead>
</table>
| Problems           | Presenting problem for WHO Europe: Despite Vienna Declaration, the Health for All Nurse was never really enacted in European countries. Most remained hospital-dominated and both primary care and public health nursing were slow to develop. However, unclear to what extent individual countries really saw these matters as problematic.  
Underlying problem: In many countries there was a lack of infrastructure and legislation that would enable nursing education and practice development. |
| Policies           | In WHO terms the key policy had been Health for All 2000. However, national governments determined nursing policy in individual nations, and cost containment policies were common in the 1990’s. At WHO Europe level HEALTH 21 offered a new chance to push for better public health care across Europe. Within HEALTH 21 the FHN can be seen as a nursing policy development of the Health for All Nurse, with specific new foregrounding of a family element. |
| Politics           | In WHO Europe AFH focusing nursing efforts on public health and primary care. Key ally in JA. Therefore strong personal medical-nursing alliance, and FHN idea developed together. However, context of opposition from European GPs to nursing expansion. Also intra-professional tensions within nursing and midwifery when FHN concept announced. |
| Policy entrepreneurs | AFH and JA were the two policy entrepreneurs working vigorously to align the perceived problem with the impending policy, and to lobby for political support within governments and professions. AFH’s strategy twin-pronged in this regard: involving CNOs in the FHN development to promote ownership and trying to “sign up” individual Health Ministers from across Europe to attend the Munich Conference (a “Ministerial” Conference). |
| Windows of opportunity | The HEALTH 21 launch in 1998 marked the initial opening of this window of opportunity, and the Munich Conference of 2000 was designed to thrust then wedge it open. |

The problems, policies and politics dimensions of Kingdon’s model, as applied in Table 8.3, provide useful foci for considering insights derived from literature review and the key informant interviews. In this way, the analyst is directed to such fundamental agenda setting questions as:

- what problems was the European FHN project actually addressing?
- was the Health for All Nurse a dormant nursing policy initiative waiting for the window of opportunity presented by the renewed “problematisation” of public health service delivery within HEALTH 21?
- in this context, was the FHN an opportunistic (and arguably peculiar) “re-badging” of the Health for All Nurse?
- what were the attendant political dynamics and strategies?
The answers, as manifest in the understandings in Table 8.3, suggest that the European FHN project was addressing problems that were very general in nature (i.e. under-capacity in primary care and public health nursing) and there was a lack of a more precisely defined focal problem necessitating this particular new solution. Moreover, there appeared to be a lack of accord in the extent to which different countries actually saw existing primary care and public health nursing as problematic. Accordingly the limitations of viewing the FHN project primarily as a response to one problem tend to be exposed through the lens of the Kingdon model. Rather this lens suggests that HEALTH 21 provided a re-focusing of attention on public health generally, and within this ambit the FHN nursing policy initiative sought to enrol Ministerial support so as to give it the momentum and sustenance that the Health for All Nurse never achieved. This emphasises the aspirations of JA and AFH and their seminal roles as policy initiators, policy entrepreneurs and strategists. Accordingly the application of the Kingdon model to this particular example of policy agenda setting would give more weighting to the policy entrepreneurs dimension than the problems dimension, and view these entrepreneurs more as an antecedent force than opportunistic respondents who reactively brought the problems, policies and politics streams into confluence.

8.3.3 Application of Rafferty and Traynor’s C-C-C model

Rafferty and Traynor’s Context-Convergence-Contingency model provides a different lens for policy analysis. The model was outlined in a study of international trends in nurse education (Traynor and Rafferty 1999):

“Attempting to identify the key ingredients of successful nursing educational reform in different countries has suggested that three sets of conditions need to be satisfied for change to follow. These relate to context, convergence and contingency. Context refers to the creation of a positive climate of opinion or a case and pressure for change. Convergence refers to the fortuitous fusion of professional and government agendas. Contingency provides the unforeseen consequence, the spark that ignites a political change. Well articulated, rational arguments within the profession appeared necessary but not sufficient to move largely indifferent governments until the moment that some contingency arose. The latter might be an unforeseen policy imperative, largely unconnected to the original content of nurses’ lobbying.” (p.91)

The model was developed further when analysing UK research policy (Rafferty and Traynor 2004). Here the consequences for nursing’s political leadership were highlighted:

“....successful policy change in nursing requires the sometimes serendipitous synchronisation of professional and government agendas. This has been evident in case studies in the past (Rafferty 1996). Three sets of conditions need to be satisfied. First, the context needs to be “primed” for the proposed change to happen; secondly, the priorities of government and the profession need to converge and thirdly, the role of
contingency or some fortuitous factor such as timing needs to be right. The role of political leadership in this process relies upon several interrelated activities; first the ability to “read” the policy environment; second to identify targets for influence and third to mobilise the resources and champion the case for change” (p.258).

As can be seen, the C-C-C model shares some of the Kingdon model’s key elements, such as the notions of deliberate alignment of key elements and related action. However Kingdon’s model focuses more on agenda setting and policy formulation, whereas Rafferty and Traynor’s model takes analysis slightly further towards consideration of policy enactment. The C-C-C model also has a much more overt focus on the role of fortuitous timing in determining successful policy change. Perhaps this reflects nursing’s relative unimportance within the power hierarchies of UK healthcare planning and provision (Robinson 1997; Davies 2004).

Application of the C-C-C model to the European emergence of the FHN concept is presented in Table 8.4.

**Table 8.4: Application of Rafferty and Traynor’s C-C-C model to the European emergence of the FHN concept**

<table>
<thead>
<tr>
<th>Dimension of Model</th>
<th>Understanding derived through analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>The context/case for changing primary care nursing to make it more public health focused seems to have been accepted by a core set of people at WHO Europe, and various Chief Nursing Officers from different countries. However the “priming” for the proposed change was inadequate. Insufficient preparation time was cited as a factor in this, but it remains unclear whether there was ever going to be enough positive multi-professional support for this sort of initiative. No obvious “sea-change” in incentives since the relative failure of the Health for All Nurse.</td>
</tr>
<tr>
<td>Convergence</td>
<td>Thinking of the “push” from the profession in Europe and the “pull” from individual national governments, it is clear that sufficient momentum was generated to produce convergence on paper. In this way Ministers signed-up for a (watered-down) declaration and a pilot project was launched. However a great deal of the push towards alignment was coming from AFH and JA. Few individual nations have subsequently been able to sustain significant convergence between their professional and governmental agendas in such a way as to develop family health nursing substantially.</td>
</tr>
<tr>
<td>Contingency</td>
<td>Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at European level, it may be argued that JA and AFH’s concept was unforeseen by many and they attempted to spark the concept and kindle it towards ignition. However, to date, it has not caught fire. As such, looking at the bigger picture, it must be argued that no significant contingency has arisen to fan its flames. Health policy across Europe has not changed decisively towards nations investing primarily in public health and primary care. GPs across Europe have not decided to make family care their priority. Nursing interest in family care remains more of a speciality area than a primary focus.</td>
</tr>
</tbody>
</table>
Reflecting on the application of the C-C-C model in Table 8.4, it can be seen that the **Context** dimension provides a very general means through which to identify relevant influences. In effect this would seem to subsume the **Problems, Policies** and **Politics** dimensions of the Kingdon model. Both the **Convergence** and **Contingency** dimensions encourage more particular analytical thinking. The former tends to highlight the extent to which JA and AFH worked to actively engineer policy convergence that might enable the “christening” of family health nursing. What is absent, however, is any sense of this convergence being fortuitous. The same can be said for the **Contingency** dimension in that no unforeseen spark has kindled the project and no political wind-of-change has fanned its flames.

In effect the WHO Europe FHN project emerged as a policy **initiative** but the three conditions that Rafferty and Traynor see as necessary for successful policy **change** have not as yet been sufficiently satisfied. In this way the C-C-C model raises questions about:

- subsequent maintenance and sustenance of initial policy convergence
- possible over-dependence on a tiny group of policy entrepreneurs
- the prospect of dependence on fortuitous contingency for success

Perhaps the key question to emerge here is: *did this initiative really matter, and continue to matter, to many other people, particularly those in positions of influence?*

Thus the C-C-C model provides some interesting ways of thinking about the relative success and/or failure of the FHN initiative both in terms of its initial formulation as a key policy for European nursing, and in terms of its subsequent enactment. Nevertheless, as with the Kingdon model, it is useful as much for highlighting what has not happened in the course of policy evolution as what has happened. As such there seems scope for some adaptation of the model to more closely reflect the main dimensions apparent in the evolution of the FHN concept into a policy initiative.

This assertion is now explored further during the course of using both theoretical frameworks to analyse the emergence of the FHN concept in Scotland.
8.4 THE EMERGENCE OF THE FHN CONCEPT IN SCOTLAND AND ITS ADVANCEMENT INTO POLICY

8.4.1 The core ideas of the key informant

This part of the chapter revisits the FHN concept’s Calton Hill cradling in the light of the findings from the key informant interviews. In doing so it draws very extensively on the key informant interview with Anne Jarvie. While the other key informants were asked for their reflections on the emergence and advancement of the FHN concept within Scotland, their knowledge of these aspects was necessarily limited as their personal involvements had primarily been at WHO Europe level.

Anne Jarvie was purposively targeted as the key informant for the concept’s Scottish emergence for two reasons. Firstly, other SEHD staff (e.g. Lead Nursing Officer and Project Officer) and NHS staff (e.g. Regional Directors of Nursing) with key involvement in the project had been interviewed during the previous evaluation study. Secondly, by 2005 the set of understandings constructed by the author all conclusively identified Anne Jarvie as a crucial and unique source of knowledge about the subject due to the nature of her involvement.

Annex 3 presents examples of core, relevant narrative from the interview with Anne Jarvie, along with the main themes derived by the author. The core ideas underpinning her thinking are now summarised in Table 8.5, as understood by the present author.
<table>
<thead>
<tr>
<th>CORE IDEA</th>
<th>DERIVED UNDERSTANDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Advocacy</td>
<td>This idea related to influential policy initiatives/directions being developed by key professional peers. An important part of a leader’s ability was seen as anticipating these, or at least recognising these, and planning ahead accordingly. Used in relation to policy at WHO Europe and Scottish government level.</td>
</tr>
<tr>
<td>2) Tackling the big, core issues first</td>
<td>This idea was central to AJ’s approach. If the fundamental foundations were put in place, it was felt that more specialised or ambitious projects could build from these. The Public Health review and the FHN initiative were seen as examples of the latter. In policy evaluation terms this approach incorporates elements of both rationalism and incrementalism.</td>
</tr>
<tr>
<td>3) Modernising</td>
<td>A recurrent idea used in a general way to meet perceived imperatives e.g. to make educational programmes or health services more responsive to current needs. Often involved a related perceived need for “new thinking”.</td>
</tr>
<tr>
<td>4) Anticipation and the importance of timing</td>
<td>This was seen as the cardinal lesson from 12 years as CNO. It was vital to know or sense in advance when something might be possible, and then seize the opportunity if/when it came. This involved prior development of ideas (e.g. potential value of a more generalist community nurse incorporating public health nursing) and sometimes nurturing these until the time was right. Converging policy agendas (e.g. public health and remote and rural agendas) could provide such opportunities. By implication from the interview, these abilities developed during the job. However there was no explicit exploration of whether such abilities could be taught.</td>
</tr>
<tr>
<td>5) Core political support; consultation with key professional peers; and team building</td>
<td>These related ideas were strong motifs. It was important to build networks, ensure core political support, and gauge the thinking of key professional peers prior to fully developing policy initiatives. Thereafter it was important to build a core development team with key known individuals. There was recognition that the FHN project had particular personal significance for the core team members.</td>
</tr>
<tr>
<td>6) Weighing risks and benefits</td>
<td>It was recognised that some degree of risk was inevitable when developing policy initiatives, and the important thing was to try to identify what these were likely to be and to weigh them against likely benefits. This process was seen in relation to anticipating opposition to the FHN concept, and also commissioning the educational programme and external evaluation.</td>
</tr>
<tr>
<td>7) The value of generalism in nursing</td>
<td>This idea was recurrent, but was applied mostly to the context of the FHN being a generalist role that might sustain public health and community nursing in remote and rural regions. The word “hybrid” was sometimes used in this context as well. The key nursing values were seen as versatility and responsiveness to public needs. There was a measure of concern that nursing had become over-specialised and, at times, task-orientated.</td>
</tr>
</tbody>
</table>
Table 8.5: Core ideas which emerged from interview with AJ (continued)

<table>
<thead>
<tr>
<th>No.</th>
<th>Idea</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8)</td>
<td>Remote and rural regions as a suitable test-bed for FHN</td>
<td>Scotland’s remote and rural regions (in particular the Highlands and Islands) were clearly seen as suited to the FHN pilot and offering the best chance of identifying both specific and potentially transferable learning. The suitability of the Highlands and Islands for experimentation related to their geography, demography and the diverse nature of their health service provision.</td>
</tr>
<tr>
<td>9)</td>
<td>The need for drive from the centre and regional leadership</td>
<td>These were seen as necessary and mutually dependent. The need for central control over a funded policy initiative was recognised, but, perhaps more importantly, there was a need to drive progress from the centre initially.</td>
</tr>
<tr>
<td>10)</td>
<td>The need for new educational thinking and the need for evidence from an external evaluation</td>
<td>These two related ideas became evident through the commissioning activities early in the evolution of this policy initiative. AJ felt that the potential benefits offered by Stirling University (local knowledge and a novel educational approach) outweighed risks. The notion of an externally scrutinised pilot that would produce evidence also mitigated this risk and the risk of introducing a new role.</td>
</tr>
<tr>
<td>11)</td>
<td>The FHN as a catalyst for change</td>
<td>The word “catalyst” was used several times to suggest that the FHN initiative should potentially provoke change in others’ practice. This was seen as almost overt within the profession (e.g. to help change health visiting and district nursing approaches) although it had been necessary to modulate the intensity and frequency of such a message depending on the prevailing national and local political sensitivities. The aim of catalytic change within the PHCT (e.g. to change doctors’ behaviours) was less overtly stressed but present nonetheless. In both contexts, the implied meaning seemed to be that the FHNs themselves have undergone change through an educational course, so that when they are re-introduced to the crucible of the PHCT, a reaction between other elements may be provoked. The extent to which this can be said to have happened is a key element for discussion in the present thesis. Moreover there is the question of the extent to which the FHN could (like a catalyst) remain unchanged if such a reaction ensued. In the latter regard, AJ clearly felt further contingent development of the FHN role would be useful, and the role had to keep evolving. Thus, the catalyst analogy was being used more to refer to the process of provoking initial reactive change within the PHCT.</td>
</tr>
<tr>
<td>12)</td>
<td>The FHN as an evolving and adapting role</td>
<td>The value of the new way of preparing these community nurses was seen as substantial, and many transferable lessons had emerged. Nevertheless the future of the FHN as a particular individual discipline was still seen as rather uncertain. AJ was clear about the need and scope for a new generalist community nursing role in Scotland. She was less certain that this needed to hinge on the family as the central defining concept.</td>
</tr>
<tr>
<td>13)</td>
<td>Redesign</td>
<td>A recurrent and pervasive idea used in relation to structuring health care services in a way that will meet newly recognised needs. In this sense, often used alongside “modernisation”. Redesign was usually seen as necessary and far-reaching in scope (e.g. to realise the benefits of the FHN role, or to truly integrate a public health approach, fundamental redesign was needed so that the practice and skills of all professions were reconsidered as part of the process). There was now scope for more regional initiatives in this regard.</td>
</tr>
</tbody>
</table>
As Table 8.5 suggests, the interview with Anne Jarvie was particularly wide-ranging and yielded considerable insights into the beliefs, motivations and strategies of the person at the heart of this policy development in Scotland.

8.4.2 Application of the Kingdon model

Table 8.6 now presents analysis of derived understandings by applying Kingdon’s agenda setting model.

**Table 8.6: Application of Kingdon’s agenda setting model to the Scottish emergence of the FHN concept**

<table>
<thead>
<tr>
<th>Dimension of Model</th>
<th>Understanding derived through analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems</strong></td>
<td>At CNO level there was a perceived need to modernise community nursing services to meet changing health needs of the Scottish population. Desire to integrate a public health approach within generalist nursing roles. General problems arising in sustaining health service provision to remote and rural areas.</td>
</tr>
<tr>
<td></td>
<td>Within nursing profession broad assent for an increased focus on health if feasible. Beginnings of perception of problems in sustaining nursing services in remote and rural areas.</td>
</tr>
<tr>
<td></td>
<td>Little evidence that community nursing care for families was seen as inadequate and/or a priority problem.</td>
</tr>
<tr>
<td><strong>Policies</strong></td>
<td>Huge raft of health and social care policies since Scottish devolution. Particular emphasis on promoting health and preventing disease. Family care an implicit theme, but rarely focal. Recent reviews of public health function of medical and nursing professions. Remote and rural issues becoming more central in health and social care policy papers. Scotland enthusiastic signatory to European HEALTH 21 but providing context rather than a focal policy driver.</td>
</tr>
<tr>
<td><strong>Politics</strong></td>
<td>Advocacy for initiatives to address health promotion and disease prevention. A time of change and optimism. Governmental support for nursing development. Advocacy for initiatives to address remote and rural concerns. Proactive Health Minister. However GPs very influential on remote and rural issues and public anxiety to retain GP services. Also anticipation of intra-professional tensions within nursing and midwifery if/when FHN concept announced.</td>
</tr>
<tr>
<td><strong>Policy entrepreneurs</strong></td>
<td>One policy entrepreneur only: AJ. Recognised that health and remote and rural agendas could be aligned. Had nursed the idea of a more generalist community public health nurse for a number of years. After emergence of FHN concept at European level, worked to align this and achieve confluence of this “third stream”.</td>
</tr>
<tr>
<td><strong>Windows of opportunity</strong></td>
<td>Having tackled a number of more general, fundamental issues during the 1990’s (e.g. nurse education into HEIs), in 1999 the timing was right for AJ to push on the FHN. It seemed that problems, policies and politics were sufficiently aligned to make a pilot project possible. This would involve some risk but a number of measures could be taken to balance these with likely benefits.</td>
</tr>
</tbody>
</table>
Again the *problems, policies* and *politics* dimensions of Kingdon’s model emerge as useful foci for analysis. While it seems clear that the nursing profession in Scotland broadly supported the increased focus on health in general policy, it is less clear that they shared AJ’s view that there was a major problem in community nursing’s ability to deliver a modern public health approach. Similarly, although some concerns were evident about over-specialisation in Scottish community nursing towards the end of the 20th century, there was no consensus on a need for a new generalist community nursing role. Thirdly there was little evidence that community nursing care for families was seen as inadequate and/or a priority problem in any region in Scotland.

Thus, as with the emergence of the FHN concept in Europe, there appeared to be a lack of one precisely defined and widely acknowledged problem necessitating this particular new solution. Once more, the limitations of viewing the FHN project primarily as a response to a problem tend to be exposed through the lens of the Kingdon model. However it can be argued that a generic policy solution (i.e. the generalist community nurse of the Health for All Nurse) had been circulating amongst a network of interested European Chief Nursing Officers for many years, and that AJ was particularly astute in recognising remote and rural nursing recruitment and retention as an ostensibly suitable problem necessitating the “new” solution (i.e. the FHN as updated HFA nurse). In AJ’s view (see Annex 3) this gave her a “lever” that the other UK CNOs did not have. It is notable that there was always vagueness about how the FHN would actually ameliorate remote and rural recruitment and retention problems.

Certainly, AJ’s role as the sole Scottish policy entrepreneur is emphasised in that her previous experiences and interests (and the agency inherent in her professional role) put her in a unique position to creatively align aspirations for the FHN concept with current Scottish advocacy around health and remote and rural agendas. In the light of prevailing political concerns and the need to manage risk, however, the resultant policy initiative was placed on to the Scottish agenda as a regional pilot project subject to external evaluation.

The application of the Kingdon model to this Scottish example of FHN policy agenda setting would again give more weighting to the *policy entrepreneur* dimension than the *problems* dimension, and view AJ more as an antecedent force than an opportunistic respondent who reactively brought the problems, policies and politics streams into confluence.
8.4.3 Application of Rafferty and Traynor’s C-C-C model

Application of Rafferty and Traynor’s C-C-C model to the Scottish emergence of the FHN concept is presented in Table 8.7.

**Table 8.7: Application of the C-C-C model to the Scottish emergence of the FHN concept**

<table>
<thead>
<tr>
<th>Dimension of Model</th>
<th>Understanding derived through analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>The context/case for changing primary care nursing to make it more public health focused had been “primed” to some extent by the publication of policy documents and the review of the public health role of the nurse. However there was widespread unease amongst Health Visitors who felt threatened by the nature and pace of change. Therefore there was some professional momentum for more proactive community nursing development in Scotland, but any pressure for change was certainly not focusing on the care of families. Some leaders of nursing in remote and rural regions were looking for possible solutions to perceived problems of nurse recruitment, retention and sustaining service provision. GPs in remote and rural areas were becoming more vocal re. need to maintain cover and improve their quality of life: widespread public support. Experienced CNO looking to foster more specific nursing developments.</td>
</tr>
<tr>
<td><strong>Convergence</strong></td>
<td>As the above context suggests, good possibilities of governmental “pull” for a policy initiative in remote and rural community nursing. Health and remote and rural policy agendas were converging, but family care was again an implicit theme. Professional “push” was somewhat mixed across the above areas. There was scope for an initiative, but also scope for significant intra and inter-professional friction. AJ successfully secured political support and funding first then worked to build a team that would help to bring about convergence of the new FHN concept with the other main policy agendas. General reaction was surprise/puzzlement in Scotland on announcement of pilot project, particularly in relation to the “family” emphasis. However sufficient convergence had been engineered for a substantive pilot of the concept and associated role. The extent to which the FHN can align with current policy agendas and sustain itself beyond the pilot and remote and rural regions is a central concern of Chapter 9 of this thesis.</td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
<td>Contingency may be thought of as providing the unforeseen consequence or spark that ignites a political change. In the case of the emergence of the FHN at Scottish level, it is clear that AJ’s importation of the concept was unforeseen by most observers. It is clear that such a development would not and could not have happened without her agency. By securing key political support and a core development team AJ attempted to spark the concept and kindle it towards ignition. By her own admission there was always some doubt about whether the development would catch fire and in what direction it would travel. The key premise however was that the process would shed some light for the future. Undoubtedly Scotland has been a beacon for the other interested countries in Europe. However it is necessary to ask not only what has been learned but also what, if any, significant contingency will fan and fuel its flames in the future. As indicated above, this is a central concern of Chapter 9 of this thesis.</td>
</tr>
</tbody>
</table>
Reflecting on the application of the C-C-C model in Table 8.7, it can be seen that the *Convergence* and *Contingency* dimensions again provide the most productive foci. What these tend to highlight is the unexpected way in which AJ aligned the FHN concept with the health and remote and rural policy agendas. Initially this was her sole doing and, as is made clear in the interview excerpts in Annex 3, she was under no pressure to act in this way. In effect she was the one person who saw the possibility for this triple convergence as a possible way of realising a long-held aspiration. Crucially, through her own agency, political support and funding were successfully secured before work started to build wider collective agency that would help to bring about more tangible convergence of the new FHN concept with the other main policy agendas. As the records of the FHN Madrid meeting (WHO 2003) show, this ability to secure substantive political support and funding for the initiative made Scotland unique amongst the participating European countries. Thus, although clearly couched as a pilot project, the FHN concept was placed onto the Scottish national nursing agenda as a “fait accompli” formulated policy initiative. Moreover, due to the prevailing regulatory structures for Community Specialist Practitioner Qualifications, this necessarily placed the concept on to the UK national nursing agenda.

AJ’s very active work in securing this initial convergence emerges clearly as deliberate rather than fortuitous. To many external onlookers this appeared as an unforeseen “sparking”, but it can be argued that only one initial candle (i.e. the pilot project) was lit. Rather the *Contingency* dimension of the C-C-C model is primarily concerned with the extent to which any unforeseen (and fortuitous) political wind-of-change fans the policy flames from initial ignition so that they successfully spread and sustain. It is this feature of the model that draws the analyst further towards consideration of policy enactment and evaluation than does the Kingdon agenda setting model.

As with the FHN concept’s evolution in Europe, it can be said that in Scotland it emerged as a policy *initiative* but the three conditions that Rafferty and Traynor see as necessary for successful policy change have not as yet been sufficiently satisfied. Again the C-C-C model raises pertinent questions about:

- subsequent maintenance and sustenance of initial policy convergence
- possible over-dependence on one policy entrepreneur
- the prospect of dependence on fortuitous contingency for success

Again, in policy analysis terms, the following question seems as apposite for Scotland as for Europe: *did this initiative really matter, and continue to matter, to many other people, particularly those in positions of influence?*
Once more the C-C-C model yields valuable perspectives on the relative success and/or failure of the FHN initiative both in terms of its initial formulation as a key policy for European nursing, and in terms of its subsequent enactment. Nevertheless, as with the Kingdon model, it is useful as much for highlighting what has not happened in the course of policy evolution as what has happened.
8.5 AN EXPLANATORY MODEL OF THE EMERGENCE OF THE FHN CONCEPT INTO POLICY IN EUROPE AND SCOTLAND

The preceding analyses show that both the Kingdon and Rafferty/Traynor models have much to contribute to understanding of the policy dimensions of the emergence of family health nursing. Yet neither of these models captures all of the essential characteristics of the evolution of the FHN policy initiative. While the Kingdon model has been widely seen as ground-breaking (Hill 2005), it gives limited consideration to the processes of collective agency through which policy initiatives are initially taken forward for enactment. In contrast, the Rafferty and Traynor model tends to underplay the role of individual agency and over-emphasise the role of fortune when applied to the FHN policy initiative.

Following reflection on the application of these models, a new explanatory model of FHN policy formulation and advancement entitled the “Agency model” is now posited. This draws on: understandings synthesised from literature review; the discourse and core concepts of the key informants; central ideas from both the Kingdon and Rafferty/Traynor models; and the tradition of alliterative presentation seen in such policy analysis models. The seven elements of the new model are presented in Table 8.8, along with explanatory notes.
Table 8.8: The Agency model of FHN policy formulation and advancement

<table>
<thead>
<tr>
<th>Agency</th>
<th>Defined as “the power/force through which a result is achieved”, the idea of agency is posited as the central dynamic within this model. In this thesis the individual agency of AFH is seen to drive the evolution of the FHN concept at European level. The same is true in relation to AJ’s role within Scotland. However the collective agency of key strategic allies also emerges as necessary for policy formulation and advancement. The following six elements are associated with this agency and can be seen as the key characteristics of FHN policy formulation and advancement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration</td>
<td>Both AFH and AJ had longstanding aspirations which they sought to realise through the FHN initiative. For the former it was definitive development of public health nursing across Europe. For the latter it was the integration of public health within a new generalist community nursing role. Both these aspirations had roots in the Health for All Nurse, which was more a paper policy initiative than an enacted one. As such, the HFA Nurse can be seen as a dormant “proto-policy” waiting to be re-kindled by those with agency who could (re)align it into the up-draught of other advocated agendas.</td>
</tr>
<tr>
<td>Awareness and anticipation of opportunities</td>
<td>Both AFH and AJ highlighted the need to be alert in order to recognise potential opportunities through which to realise aspirations. AJ talked of well developed “political antennae”.</td>
</tr>
<tr>
<td>Alignment around advocated agendas</td>
<td>Related to the above, was the ability to align any new policy initiative with other relevant influential political agendas that were currently being advocated. This was seen as one of the arts of leadership. For AFH this meant alignment with the HEALTH 21 policy framework. For AJ this meant alignment with wider health and remote and rural agendas in Scotland.</td>
</tr>
<tr>
<td>Authority</td>
<td>Importantly AFH and AJ each had some authority through which to advance their aspirations into policy. For the former, this was mostly personal/professional authority exercised at the interpersonal level through lobbying and networking. It is important to note that AFH did not have the organisational authority associated with directing a large staff or budget. While AJ’s team and budget were rather larger, her main advantage was that her professional position carried much more executive power in relation to nursing affairs.</td>
</tr>
<tr>
<td>Alliances for advancement</td>
<td>In order to advance their policy interests, both AFH and AJ ensured support from key strategic allies. For AFH this was with JA, interested CNOs around Europe, and latterly European Health Ministers. For AJ this was with the Scottish Health Minister, Directors of Nursing, and latterly a specially formulated multidisciplinary Steering Group.</td>
</tr>
<tr>
<td>Advantageous adaptation</td>
<td>This was a necessary tactic for advancement of the FHN concept as a policy initiative. At European level the established format for WHO Europe Nursing Conferences was adapted to make the 2000 Munich event a Ministerial one. At Scottish level the FHN concept was adapted by ensuring that its advocacy of equal partnership with GPs, and associated ideas of GP substitution, did not form part of the principles of the pilot project. This minimised the risk of active GP opposition.</td>
</tr>
</tbody>
</table>
The six key characteristics in Table 8.8 are presented in a sequence reflecting “best-fit” with understandings of ordering derived from the key informant interviews. In particular, AJ tended to stress that certain basic elements had to be in place before others could happen. However it is recognised that some of the ordering in Table 8.8 is probably a product of the broadly chronological framework underpinning the interview schedules. Moreover post-hoc analyses have also contributed to an impression of logical progression through a series of linear steps. While this has superficial explanatory appeal, it is important to stress that the Agency model should be interpreted in the same way as the Kingdon model i.e. it is assumed that in reality key characteristics manifest and interact in different temporal sequences. For example, many of AFH and AJ’s key personal/professional alliances pre-dated the attempted advancement of the particular FHN policy initiative.

Nevertheless the creation of the Agency model is significant because it represents a culmination of the explanation building started in Chapters 3 and 4 of the thesis. In effect it distills answers to the first of the three central questions at the heart of the thesis i.e. why family health nursing? Through a process of systematic enquiry it has become clear why the concept emerged in Copenhagen in 1998. Essentially it was the aspiration of Dr Jo Asvall and Ainna Fawcett-Henesy to develop public health nursing across Europe and to this end the Health for All Nurse concept was re-developed with a new emphasis on family. Through their agency these actors advanced the new FHN concept into a policy initiative that would be piloted in a number of European countries. Table 8.8 shows how this was primarily achieved i.e. through: aspiration; awareness and anticipation of opportunities; alignment around advocated agendas; authority; alliances for advancement; and advantageous adaptation.

Similarly it is clear why the FHN concept came to be adopted on Calton Hill and subsequently enacted in Scotland. Essentially it was Anne Jarvie’s aspiration that a relevant public health approach could be integrated within a generalist community nursing role, and in remote and rural regions she saw an opportunity to try this in the form of the new FHN role. Primarily through her individual agency, the new FHN concept was then advanced into a policy initiative that would be piloted in three Scottish regions. Again Table 8.8 shows how this initial policy formulation and advancement was primarily achieved i.e. through: aspiration; awareness and anticipation of opportunities; alignment around advocated agendas; authority; alliances for advancement; and advantageous adaptation.

These explanations are important because their construction has arisen through a process of systematic, critical enquiry that is at present unique in this particular field i.e. to date the vast majority of literature on the WHO Europe FHN concept and project is promotional and aspirational. What is striking about the above explanations is the crucial role of just two
individual actors in initiating the FHN concept and formulating it into WHO Europe policy, and the crucial role of just one actor in re-formulating it into the Scottish policy arena.

However, no policy initiative can be advanced, developed and enacted without support from others, and the Agency model shows how initial processes of collective agency were fostered. The next part of the chapter attempts to explain how these processes were further developed in Scotland.
8.6 TAKING THE POLICY INITIATIVE FORWARDS FOR ENACTMENT IN SCOTLAND: AN EXPLANATORY MODEL

Having analysed local enactment at PHCT level in Chapter 7, and having synthesised understandings of policy evolution and formulation at SEHD level in the first part of this chapter, it is now necessary to gain critical purchase on the “linkage” between these elements i.e. the Scottish national and regional processes of collective agency that were involved in taking the new policy initiative forward. A model that is potentially helpful in this regard has been developed by May et al (2003) through studies of telehealthcare implementation and evaluation in the UK. Although their focus on this particular form of health technology assessment may initially seem an unlikely source for analogy, May et al’s model, reproduced in Table 8.9 offers a useful analytical framework based on mapping contingencies.
Table 8.9: May et al (2003)’s contingency model

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Mode of technological development</th>
<th>Mode of knowledge production</th>
<th>Mode of containment</th>
<th>Mode of strategic expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>Idea of new technology: expectation of applications of new technology to clinical settings, concepts of utility and effectiveness.</td>
<td>Notion of research/evaluation: Normative expectations about the production and circulation of generalisable and reliable knowledge</td>
<td>Judgements about value: Expectations of intellectual and other kinds of capital, and constructs of the social worth of a technology (what’s better, what works?)</td>
<td>Key actors: work to champion technology and construct a persuasive field of possibilities; link in to polocies and programmes of R&amp;D in design and manufacturing sector</td>
</tr>
<tr>
<td>Mobilisation</td>
<td>Constructs of appropriate design and operation: translation of expectancies into plans, technical decision making systems thinking</td>
<td>Constructs of research/evaluation methodology: normative models of transferable knowledge circulating within communities of practice, subject to the elision of contingency</td>
<td>Selective enrolment into communities of practice: recruitment and integration of actors into networks; entry criteria and control over activities; contextualisation of fields of agreement and disagreement</td>
<td>Emergent practitioner communities: organise expectancies into programmes of work; contest patterns of infrastructure organisation and resource allocation; organise the market place to receive technology</td>
</tr>
<tr>
<td>Clinical Specification</td>
<td>Technical implementation: system intended to structure contingent practice within a framework of reliable clinical knowledge</td>
<td>Research/ Evaluation protocol: specific instrument intended to structure otherwise contingent processes of knowledge production within a framework of reliable practice</td>
<td>Structural constraints on dynamic instability: fixes technologies and techniques in place, forces the elision of contingency of interpretation</td>
<td>Practitioner groups reify possibilities of technology: construct ideal forms of specific application organise resources and infrastructure situate dynamic activities in specific settings</td>
</tr>
<tr>
<td>Specific application</td>
<td>Clinical intervention: activities leading to the organisation of clinical procedures about which claims of reliability can be made, and which are intended to meet the normative expectations of external adjudicators</td>
<td>Research/ Evaluation application: activities leading to the production of knowledge about which claims of reliability can be made and which are intended to meet normative expectations of external adjudicators</td>
<td>Attempts to prevent interpretive flexibility: act to place restrictions on creative modification of systems in play, intended to frame standardised and generalisable products of clinical evaluation and practice</td>
<td>Possibility of Normalisation: Conventional processes of reporting and publication; informal diffusion through networks of practitioners; social construction of localised possibilities</td>
</tr>
</tbody>
</table>
As May et al explain, their model provides:

"a conceptual framework that elucidates a set of contingent points on a map of social practices. The model locates actors and activities against these contingent points – and in doing so, sets out the points of resistance and constraint that appear as new technologies are brought into the play of service development and evaluation practice, as well as the points at which strategic and local expansion of opportunities are situated” (p. 701).

In this regard it is important to emphasise that the authors are using “contingent” in the sense of conditional, dependent and related, rather than in Rafferty and Traynor’s use of “contingency” as unforeseen consequence.

May et al’s framework is apposite for a number of reasons. Firstly, it highlights that evaluation is increasingly a “normative political expectation, as discourses of ‘evidence-based’ practice run through health policy in the UK and elsewhere” (p. 697). As such, evaluation research is framed as the dominant mode of knowledge production within the social enactment of healthcare technology and new policy initiatives. This has clearly been seen in relation to the FHN initiative in Scotland, as reflected in the words of the Scottish Health Minister quoted in the preceding chapter. Moreover the FHN initiative was couched as a “pilot”, suggesting scientific notions of testing, control and manipulation. Again, May et al’s model offers a framework for more detailed analysis of the dynamics of control of containment and expansion that were possible under the rubric of “pilot project”. Finally, their framework is useful in separating out different levels of analysis, from ideation through mobilisation to more specific application. As has been noted often within the thesis, the nature of the family health nursing development in Scotland frequently made it difficult to be precise about what was being evaluated i.e. was it a concept, model, aspiration, role, policy initiative, or all five?

Table 8.10 presents the summary mapping that arises from the application of May et al’s contingency model to the FHN pilot (viewed as a healthcare technology).
### Table 8.10: May et al (2003)’s contingency model applied to the FHN pilot in Scotland

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Mode of technological development</th>
<th>Mode of knowledge production</th>
<th>Mode of containment</th>
<th>Mode of strategic expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation 1.1 Idea of new technology:</td>
<td>The idea that the WHO Europe FHN concept would be useful in remote and rural regions, and possibly elsewhere in Scotland.</td>
<td>1.2 Notion of research/evaluation: Normative expectations that a pilot project with inbuilt external evaluation would produce generalisable and reliable knowledge to inform further action i.e. evidence-based policy making.</td>
<td>1.3 Judgements about value: Pilot confined to remote and rural. Related notions of value in addressing recruitment and retention problems. “Pilot” suggests control, safe testing, and management. Pilot managed nationally to minimise potential conflicts with other professional groups.</td>
<td>1.4 Key actors: Small band of champions at national and regional levels (CNO and DoNs). Steering Group mixes enthusiasts with interested insiders. National publicity for initiative is frequent but tempered to some extent by recognition of professional sensitivities.</td>
</tr>
<tr>
<td>Mobilisation 2.2 Constructs of</td>
<td>2.2 Constructs of methodology: prescribed evaluation brief concerned with the operation and impact of FHN, and the educational experience. Acknowledgement that a mixture of qualitative and quantitative approaches might be necessary.</td>
<td>2.3 Selective enrolment into communities of practice: recruitment of 3 Directors of Nursing providing regional management. Variable subsequent involvement of local managers. Variable criteria for FHN student selection. Deliberate and inclusive selection of members for national Steering Group.</td>
<td>2.4 Emergent practitioner communities: 3 DoNs primed local nurse managers and staff about the pilot. However, the concept was sketchy and time was short. Selection of FHN students was often influenced more by personal interest and local expediency, than by planning for long term service development.</td>
<td></td>
</tr>
<tr>
<td>Clinical Specification 3.1 Technical implementation: development of initial FHN clinical documentation during educational programme (e.g. genograms, ecomaps). Seen very much as formative, however.</td>
<td>3.2 Research/ Evaluation protocol: RGU team articulated an evaluation framework to structure data collection. A variety of standardised instruments were used or devised to study education and practice.</td>
<td>3.3 Structural constraints on dynamic instability: appointment of national Project Officer and creation of regional implementation groups to integrate development approaches.</td>
<td>3.4 Practitioner groups reify possibilities of technology: There were a number of promotional publications during the pilot. FHNs enthusiastic but still found it difficult to clearly articulate the concept and to agree on one preferred example of enactment of the role in practice.</td>
<td></td>
</tr>
<tr>
<td>Specific application 4.1 Clinical intervention: nature of application and related interventions left almost completely to the new FHNs. Issues of reliability and fit to normative expectations seen as primarily the concern of the local PHCTs and the evaluation team.</td>
<td>4.2 Research/ Evaluation application: Context-Process-Outcome framework particularly useful: gave overall structure enabling researchers to compare FHN practice at PHCT sites. Production of final evaluation report in 2003.</td>
<td>4.3 Attempts to prevent interpretive flexibility: later attempts (through implementation groups) to get agreement on one set of FHN documents and to incorporate the OMAHA outcome measurement system. Attempts mostly unsuccessful.</td>
<td>4.4 Possibility of Normalisation: At the end of the evaluation, SEHD held conference. Pilot deemed encouraging; potential for normalisation but still provisional (Phase 2 of pilot announced, with city testsite). Options kept open.</td>
<td></td>
</tr>
</tbody>
</table>
The application in Table 8.10 is useful as it maps important underpinning ideas, processes for their advancement and some related outcomes. In doing so, it tends to highlight considerable central (national level) activities that were designed to shape and control the evolution of the pilot as an enacted policy initiative. The setting of its boundaries and the avoidance of major conflicts with other professions were clearly of much initial importance. This makes for considerable contrast with the relative latitude that existed in relation to any national clinical specification for family health nursing and for specific application in terms of local interpretation and enactment. This was recognised by the Steering Group later in the evolution of the pilot project, but the resultant regional implementation groups usually struggled to achieve significant standardisation of FHN practices in the face of diverse local PHCT contexts and needs.

Indeed as Table 8.10 hints, the role of regional/local community nursing management in the advancement of the FHN initiative tended to be one of linkage and general facilitation rather than vociferous promotion and/or proactive shaping of FHN development at local PHCT sites. There were a number of reasons for this, and these emerged during interviews with individual nurse managers during the commissioned evaluation study. Firstly, these nurse managers were few in number and usually geographically remote from the sites where FHNs were practising. Typically they had to manage a number of different professional groupings, some of whom felt very threatened by the FHN pilot due to its nature and implications being unclear. Moreover some of these managers admitted that they shared these concerns, had reservations about the need for the FHN, and felt that the project had been rushed and/or thrust on them.

The latter aspects had made it difficult for them to select suitable FHN students for the first educational cohort and difficult for them to articulate the place of the FHN in any longer term service development plan. Although the SEHD made “backfill” monies available to cover the students’ posts during their absences, there was usually no extra funding attached to the initiative. Under these circumstances it is not surprising that the public line taken by most regional/local nurse managers was one of cautious optimism while their private feelings were more ambivalent. Moreover, some “hedging of bets” seemed reasonable given that the FHN project was a pilot. While their Directors of Nursing also had to be seen to view the pilot as dependent on evaluation, they typically were much more prominent in their promotion of the FHN concept. In effect the pilot placed these DoNs on the national stage in a way that had not happened before, and accordingly they had much to gain through their direct alignment with the CNO.

Thus, while the regional DoNs emerge as key actors in advancing the FHN initiative, their community nursing managers are much more marginal figures in the story. To some extent this
may be due to the limitations of the research approach taken herein. While the managers were also included in the evaluation study’s stakeholder questionnaire surveys, it must be acknowledged that their views were not sought in either of the follow-up studies conducted subsequently. Within the present study’s large ambit of examining the development of family health nursing from policy through to practice, this would certainly be a point of weakness.

Nevertheless during five years of formal and less formal engagement with FHN developments in Scotland, I have neither heard nor seen evidence to suggest that nurse managers played a particularly influential role. Indeed, it was not uncommon for the regional DoNs and the FHNs themselves to have direct communication and they often appeared together at regional and national events. To some extent, the ostensibly limited influence of regional/local community nursing managers may relate to their small number and wide geographical remit. However the limited influence of community nurse managers is also a wider UK national characteristic identified by a number of authors (e.g. McMurray and Cheater 2004; McKenna, Keeney and Bradley 2004).
Reflecting on Table 8.10, it is evident that the four analytic levels all yield productive insights. The *ideation* and *mobilisation* levels give critical purchase on ways in which the pilot was actively constructed and controlled at national and regional Health Board/Divisional levels. Conversely, the *clinical specification* and the *specific application* levels tend to highlight interpretive flexibility at local PHCT level. Indeed in the context of diverse local practice development, there is a sense in which the evaluation research framework and data collection tools provided consistency and continuity for an ongoing initiative of this type. The model’s depiction of research as an integrated, concurrent and contingent social practice is therefore very relevant to the FHN pilot. Indeed, the research evaluation can be seen as a key element that influenced articulation between policy and practice levels.

The latter relationship is depicted visually in Figure 8.1 which presents an overall model of the main characteristics of the development of family health nursing in Scotland 2000-2004. This links the explanation of policy formulation provided by the Agency model with the explanation of policy enactment processes provided by the adaptation of May et al’s model. In turn these parts are linked onwards to the explanation of translation and enactment of the FHN role at local PHCT level (as developed in Chapter 7). In achieving this final linkage, some adjustments have been made to avoid duplication. To this end, the *specific application* level in the May et al model has been truncated, and parts of the *clinical specification* level have been merged with the Chapter 7 model to represent the key elements of the FHN initiative which influenced articulation between policy and practice levels (i.e. Part 3 of Figure 8.1).
Figure 8.1: An integrated model explaining the development of Scottish family health nursing

Part 1: Initial policy formulation and advancement

<table>
<thead>
<tr>
<th>Agency</th>
<th>Individual</th>
<th>Collective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness and anticipation of opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alignment around advocated agendas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliances for advancement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advantageous adaptation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part 2: Taking the policy initiative forward towards enactment

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Mode of technological development</th>
<th>Mode of knowledge production</th>
<th>Mode of containment</th>
<th>Mode of strategic expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>The idea that the WHO Europe FHN concept would be useful in remote and rural regions, and possibly elsewhere in Scotland.</td>
<td>Normative expectations that a pilot project with an integrated external evaluation could produce generalisable and reliable knowledge to inform further action, i.e. evidence-based policy making.</td>
<td>Pilot confined to remote and rural, related to national and local issues of value in addressing recruitment and retention problems. &quot;Pilot&quot; suggests control, safe testing, and management. Pilot managed nationally to minimise potential conflicts with other professional groups.</td>
<td>Small band of champions at national and regional levels (CNO and Deans). Steering Group mixes enthusiasts with interested insiders. National publicity for initiative is frequent, but tempered by some pressure by recognition of professional sensitivities.</td>
</tr>
<tr>
<td>Mobilisation</td>
<td>SEHD translation of the FHN concept into 4 principles that would characterise the FHN role. Commissioning of the educational programme informed by WHO FHN curriculum. Struggling with the idea, support from North American family nursing model which gave FHNs distinctive professional identity.</td>
<td>Prescribed evaluation brief concerned with the operation and impact of FHN, and the educational experience. Acknowledgement that a mixture of qualitative and quantitative approaches might be necessary.</td>
<td>Recruitment of 3 Directors of Nursing providing regional management. Variable subsequent involvement of local managers. Variable criteria for FHN student selection. Deliberate and indicative selection of members for national Steering Group.</td>
<td>3 Deans invited local nurse managers and staff about the pilot. However, the concept was sketchy and time was short. Selection of FHN students was often influenced by personal interest and local expediency, rather than by planning for long-term service development.</td>
</tr>
</tbody>
</table>

Part 3: Key elements influencing articulation between policy and practice

- Professional and disciplinary theory
  - Ideas
  - Education and training
  - Production of initial FHN documentation
- Research/evaluation protocol translated into practice
- Structural constraints on dynamic instability (central control mechanisms to co-ordinate)
  - e.g. Project officer and regional implementation groups
- Regional and local organisational structure and practices
  - Characteristics of translating organisations
  - Effectiveness of communication strategies, monitoring and feedback

Part 4: Translation and enactment of FHN role at local PHCT level
8.8 THE INTEGRATIVE MODEL AS A BASIS FOR EXPLANATION

The integrated model of Figure 8.1 gives a basis for definitively answering two of the central questions of the study: why was the FHN concept enacted in Scotland; and why did it develop in the way that it did? Table 8.11 now provides the other key part of this explanation by presenting a synoptic story which identifies and links together twelve factors that have emerged through this study as being particularly important. Taken together, Figure 8.1 and Table 8.11 provide summative explanation of the development of family health nursing in Scotland up until the end of 2004.
Table 8.11: Synoptic story of the development of family health nursing

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The WHO Europe FHN concept was enacted in Scotland primarily because of its potential to meet with the CNO’s aspirations in regard to integrating a modern public health approach into community nursing. The CNO’s agency was seminal and crucial, and this is reflected in the “Agency” model of policy formulation and advancement posited in this thesis.</td>
</tr>
<tr>
<td>2</td>
<td>The SEHD’s translation of the FHN concept into four principles for enactment made manifest a role description with significant potential for both internal (intra-role) tensions and external tensions (e.g. with existing primary care system and other professionals). The centrally managed pilot was designed to minimise the latter.</td>
</tr>
<tr>
<td>3</td>
<td>The commissioned educational programme for FHNs emerged as innovative. Its difficulties stemmed primarily from the requirement to promote the generalist WHO Europe curriculum within the ambit of a regulatory framework designed for specialist education.</td>
</tr>
<tr>
<td>4</td>
<td>The educational programme incorporated North American family nursing care models as they had more developed theoretical and practical bases. This gave the new FHNs distinctive assessment and intervention tools, which in turn became central to the construction of their new professional identity. The drawback was that these tools were labour-intensive and more suited to specialist practice.</td>
</tr>
<tr>
<td>5</td>
<td>The new FHNs returned to practice at their local sites and usually in the context of their pre-existing community nursing jobs. They attempted to enrol colleagues from many different disciplines to support their role and to develop more family-orientated PHCT approaches.</td>
</tr>
<tr>
<td>6</td>
<td>However, the FHN concept and the need for the pilot initiative were generally hard to understand for some staff at regional/local management level and for many staff at PHCT level. The need for family health nursing was by no means self-evident, and at all levels there was difficulty in clearly articulating the FHN concept and role.</td>
</tr>
<tr>
<td>7</td>
<td>Local interpretation/translation of the FHN role was mostly left to individual FHNs. Under these circumstances the influence of local context tended to dominate and the role usually developed by maintaining pre-existing community nursing services and supplementing them with limited, niche expansions. This minimised inter-professional conflicts while allowing some points of growth. FHN documentation was adapted accordingly.</td>
</tr>
<tr>
<td>8</td>
<td>The commissioned evaluation research played an important role in the construction of knowledge about the pilot project. Four initial patterns of FHN practice emerged in 2002. These tended to reflect internal and external tensions associated with the role as prescribed by SEHD. Most of the research report’s suggestions for improvement were speedily enacted by the SEHD who announced a second phase of the pilot in 2003.</td>
</tr>
<tr>
<td>9</td>
<td>Further facilitation of the FHN role and related family orientated PHCT approaches took place in 2004, along with follow-up research. An updated typology of family health nursing practice development was subsequently constructed. The influence of local context, in terms of situated power and embedded culture of place, remained dominant.</td>
</tr>
<tr>
<td>10</td>
<td>In order to understand the influence of local context on the translation of the FHN policy initiative, it is necessary to acknowledge that many other policies were, and are, concurrently impacting at local level. This may be visualised by using the “living plaid of primary care” metaphor developed in this thesis.</td>
</tr>
<tr>
<td>11</td>
<td>Due to the influence of diverse local contexts, family health nursing in remote and rural Scotland has quickly become diverse itself. FHNs’ capacity to engage with whole families on both health and illness matters is very variable, and is often at odds with the demands of a primary care system predicated on treatment of individual’s problems.</td>
</tr>
<tr>
<td>12</td>
<td>The idea that family health nursing would be a solution to recruitment and retention problems in remote and rural regions emerges as something of a “red herring” in terms of the story so far. In contrast the idea of “family” as the central motif in the new role is crucial. This is because it was foundational to the Scottish educational programme but, arguably, marginal in terms of local PHCT service provision. Moreover, this study suggests that the family emphasis was less of a priority for the SEHD than other principles such as generalism and the health focus.</td>
</tr>
</tbody>
</table>
As such, the thesis argues that this model and story facilitate understanding of an important formative episode in contemporary nursing history. However the Figure 8.1 model may have useful application beyond the particular world of Scottish family health nursing. Specifically it may offer a theoretical basis for prospective consideration of other community nursing developments which are essentially “top-down” in nature, are substantially driven at policy level by individual agency, and are predicated on the idea of pilot testing. This contention will be further explored through application of the model in the next Part of the thesis. Moreover, the essential pattern of contingent developmental factors and processes outlined in Figure 8.1 may have more wide-ranging transferable application. Family health nursing is by no means the only health service development which would benefit from an analysis that ranges from policy through to practice.
SUMMARY

This chapter has examined why family health nursing developed in the way that it did in Scotland, with particular focus on processes of policy formulation and enactment. Initial reflections on the professional – personal worlds of key actors highlighted the need to attend to what may not be able to be spoken or written down. Thereafter, understandings from key informant interviews were scrutinised in the light of two relevant policy analysis frameworks.

The emergence of the FHN concept at European level was re-visited and outstanding questions from Chapter 3 were answered. The policy entrepreneur roles adopted by Ainna Fawcet-Henesy and Dr Jo Asvall emerged as crucial, in terms of re-developing the Health for All Nurse concept, re-badging it as the FHN, and promoting it as a pan European policy initiative. These activities were driven by long-standing professional-personal aspirations to put family and public health at the heart of policy and practice. However the policy analysis frameworks highlighted lack of a focal perceived problem, lack of concurrent associated developments (e.g. Family Health Physician), and lack of any fortuitous political contingency to enable the initiative to gather momentum. As such, there was the risk that it didn’t matter enough to enough people.

However Anne Jarvie’s engagement with European nursing developments during the 1990’s had fostered the aspiration to explore enactment of a generalist community nursing role with an integral public health approach. At the end of the decade she recognised her opportunity and was the crucial entrepreneur who engineered its alignment with prevailing policy agendas. Remote and rural health issues, and associated staff recruitment and retention problems, were the ostensible problem or “lever”. Moreover she had the authority and alliances to ensure that the FHN concept could be advanced as a funded policy initiative, albeit in pilot format. Again, however, there was the risk that it wouldn’t matter enough to enough people.

This synopsis of policy formulation and initial advancement incorporates substantial explanation of why and how family health nursing emerged, and why it developed in the way that it did at international and national levels. The “Agency model” has been developed within this chapter to synthesise these new understandings.

An adaptation of May et al’s “Contingency Model” has also enabled overview of how the FHN policy initiative was subsequently taken forward towards enactment through collective agency. Mapping of knowledge production, containment and expansion at different levels from ideation through to application helped to explain the dynamics of the initiative. In this context the idea of “piloting” emerged as central, with its connotations of controlled, evidence-based development informed by a commissioned evaluation study. Moreover the model served to highlight: central
control mechanisms (which set boundaries and minimised intra and inter-professional conflicts); the relatively marginal role of community nursing managers; the breadth of the FHN role definition; and the related flexibility of local FHN interpretation and enactment of the role.

The chapter ended by linking all the elements of explanation building together into an integrated model and an accompanying synoptic story summarising the main contingent factors and processes involved in the development of family health nursing in Scotland up to 2004. The potential relevance of this new model to other related prospective developments was also suggested.
PART 3: A BRIEF REFLEXIVE RECAP

The two chapters that form Part 3 have combined to build explanation of why family health nursing developed in the way that it did in Scotland between 2001 and 2004. Analyses of family health nursing at practice level and policy level have been informed and enriched by the application of relevant theoretical perspectives. In turn this has facilitated the synthesis of an original, integrative explanatory model and story. In addition to offering a basis for explaining the development of family health nursing retrospectively, the new model offers a potentially valuable framework for prospective consideration of the contingent factors and processes that will influence similar types of development within and beyond nursing.

The explanation in Part 3 is the conclusion of the triptych formed by Parts 1-3 of the thesis. The next Part of the thesis is concerned to update and interpret the FHN story from a 2006 perspectus, in order to understand its influence and implications.
PART 4

RETROSPECTUS, PERSPECTUS, PROSPECTUS

A “re-framing” of the explanation in the light of contingent contemporary developments primarily between 2001 and 2006, enabling analysis of the influence of family health nursing and related implications for the future.
CHAPTER 9

INFLUENCE AND IMPLICATIONS

Overview of this chapter

This chapter examines the influence and implications of the development of Scottish family health nursing (i.e. research question 4). In order to make this possible, the chapter firstly undertakes a retrospective review. This looks back from 2006 on significant contingent, concurrent developments within health and social care since 1998, as understood through policy and research literature. This “re-framing” of the explanation constructed in Parts 1-3 of the thesis is required because, to re-iterate a key idea, “the shape of nursing cannot be entirely understood from within” (Dingwall, Rafferty and Webster 1988; p. 228). As Part 1 of the thesis focused on relevant policy up to 2001, this chapter places particular emphasis on subsequent developments. Selected European, UK and Scottish developments are thus considered in terms of their relationship to, and relevance for, family health nursing in Scotland. In turn this begins a process of building contextualized understandings of the relative significance and influence of Scottish family health nursing itself, and considering the related implications. Retrospective review also facilitates some updating of the FHN story within the context of Scottish developments between 2005 and early 2006.

This brings the reader to the “perspectus” part of the chapter, which views and reviews Scottish family health nursing in the light of four significant documents that were published in November 2006. Two of these documents provide summative perspectives on the development of family health nursing, while the remaining two set out a relatively radical new policy agenda for Scottish nursing. Accordingly, the perspectus part of the chapter seeks to analyse and explain the relationship between family health nursing (1998 – 2006) and the emergent new model for Scottish community nursing.

The last part of the chapter looks ahead to consider implications and future prospects. The explanatory model posited at the end of Part 3 of the thesis is deployed prospectively to map the contingent factors and processes that will be central to the future development of the new model for Scottish community nursing. Finally, other relevant models and wider visions of the future are considered.
9.1 RESEARCH METHODS

Overview of the research methods, principles and processes used in this chapter has already been given in Chapter 2.2.4 and has been summarized pictorially within Figure 1.3. Before proceeding, however, it is useful to recap particularly on literature selection and analysis procedures, and to explain the format used to present and discuss selected material.

The search for and selection of relevant textual material that would enable better understanding of influence and implications, was driven primarily by the associated questions listed in Table 2.5. In effect these interrogated contemporary health and social care policy and research into practice in order to identify ideas or developments of most relevance to family health nursing. While review of European literature was confined to WHO Europe publications, there was more extensive review of recent policy and research/review texts emanating from within the UK, and specifically from within Scotland. Following general screening, key documents were selected in terms of their:

- contextual relevance i.e. where a document presented policy ideas or research/review findings that were of key importance for understanding the context within which family health nursing was developing
- related relevance i.e. where a document presented policy ideas or research/review findings about a substantive development that was directly related to family health nursing and had an important contingent relationship with it
- focal relevance i.e. where a substantive document presented policy ideas or research/review findings specifically about family health nursing

Documents of contextual or related relevance were examined using thematic and qualitative content analysis techniques respectively (see Chapter 2.2.1.3). Key documents of focal relevance, such as the SEHD Final Report on the FHN pilot (SEHD 2006), were studied in more detail using the holistic-content narrative analysis technique described earlier in Chapter 2.2.1.3.

These processes facilitated summative interpretation of each key policy and research/review document (within-case analysis) and further comparative analysis of these documents (across-case analysis). This is reflected in the presentation of the material selected for inclusion in the next two sections of the chapter. Summary tables are used to present the name of each key document, its main purpose, and an interpretative synopsis of its relevance. Within each table there is typically progression from documents of contextual relevance to those of focal relevance, and ordering also seeks where possible to incorporate chronological progression. These tables serve as a basis for further integrative discussion of influences on, and from, family health nursing.
9.2 RETROSPECTUS

9.2.1 The WHO Europe context: what is known about progress up until 2006?

Since the launch of HEALTH 21 and the Family Health Nurse in 1998, WHO Europe has published a small number of documents that review progress. The most significant of these are presented in Table 9.1.

Table 9.1: Selected WHO Europe documents of relevance

<table>
<thead>
<tr>
<th>Document</th>
<th>Purpose</th>
<th>Relevance and interpretative synopsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health for All policy framework for the WHO European region: 2005 update (WHO 2005a)</td>
<td>Review and update of overall progress towards Health for All, as manifest in evidence of meeting the HEALTH 21 targets to date. Wide purview.</td>
<td>Contextual relevance. A very mixed picture of progress in relation to individual targets, and in relation to different countries. Emphasis on importance of governmental action, rather than the actions of specific groups of health service professionals. FHN not mentioned.</td>
</tr>
<tr>
<td>Analysis of implementation of the Munich Declaration 2004 (WHO 2005b)</td>
<td>Review and update of progress towards meeting the objectives in the Munich Declaration of 2000. Nursing and midwifery focus.</td>
<td>Related relevance. Again, a very mixed picture of progress in relation to individual objectives, and in relation to different countries. Despite the engagement of Ministers at Munich, governments have typically not been active in supporting the objectives in practice. In most countries, nurses and midwives lack political influence and are still not involved in planning health care priorities. The UK is seen as the major exception in this regard.</td>
</tr>
<tr>
<td>Fourth WHO meeting on FHN implementation in Europe (WHO 2005c), Held in Glasgow.</td>
<td>Formative evaluation of the progress made on family health nursing within, and across, the participating European countries. Designed to ensure that the multinational evaluation study could finally take place.</td>
<td>Focal relevance. The 12 remaining participating countries found to all be at very different stages of development of family health nursing. Scotland significantly ahead of all other countries in terms of enactment and evaluation processes. Out of the 12 countries, seven agreed to take part in the multinational evaluation study.</td>
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Perhaps inevitably, the cardinal theme to emerge from review of these documents is the variation across the different countries within WHO Europe, in terms of structures, systems, finance, and perceived healthcare needs and priorities. A major related theme is the relative lack of influence of senior nurses and midwives at policy formulation and enactment level. With the UK being seen as the major exception in this regard, there is a clear basis for explaining some of the stark contrast between progress in enacting family health nursing in Scotland and progress in almost all of the other participating countries. However it is also clear that the other UK countries chose not to engage closely with family health nursing. Accordingly the importance of individual CNO agency and political will, as examined in Chapter 8, should again be borne in mind.
9.2.2 The UK context: what forms the contemporary UK policy context, how does this influence practice, and where does family health nursing fit within this?

From a UK perspective, there is inherent irony in the idea that senior nurses and midwives should be seen as exemplars influencing healthcare policy. For scrutiny of UK healthcare policy analysis literature would tend to contradict this. Thus, Robinson (1997)’s incisive examination concludes that: “it appears that policy in relation to nursing almost invariably develops second-hand as a consequence of other actors’ responses to health and welfare initiatives which, in turn, are developed elsewhere” (p. 277). Moreover, “without the analysis of the broad picture it would not have been possible to illuminate how relatively unimportant nursing is to government and to managers in comparison to medicine” (p.251).

While Robinson’s analysis pertains to nursing in general and to the situation almost ten years ago, there is much to suggest its continued relevance to community nursing in the UK. This impression is sustained in Peckam and Exworthy (2003)’s examination of policy, organization and management of primary care in the UK. Like Walsh and Gough (1999), these authors persuasively argue that the domination of primary health care by primary medical care has been inherently damaging for community nursing. Even significant nursing role developments such as practice nursing and nurse practitioners are seen to have “co-incided with nursing’s professionalisation rather than having been initiated by nursing” (Peckham and Exworthy 2003; p.171).

Indeed there is a strong argument that community nursing has been particularly subservient and impotent. In a wide ranging review, Kelly and Symonds (2003) conclude that: “the current constructions of the roles of community nurses have been seriously impaired by the actions of others, and that the focus on caring has been subjugated to the need for a flexible workforce whose purpose is to support medical and managerial goals rather than care for people’s health and social needs” (p. 143).

Tracing the historical development of this situation, Walsh and Gough (1999) describe modern community nursing as a “commodity” brokered and traded by others. Unsurprisingly, an associated lack of nursing leadership within primary care is often identified. Importantly, empirical studies show that this is not only the perception of influential actors such as government policy makers and GPs, but that it is also shared by front-line community nurses and members of the public (McKenna, Keeney and Bradley 2004; McMurray and Cheater 2004).
Viewed against this rather gloomy context, Anne Jarvie’s agency in championing a nursing-specific policy initiative with European associations, national UK implications (i.e. for the UKCC/NMC) and holistic aspirations seems somewhat exceptional. As has been seen, the particular focus on family was unusual in the UK context and the particular aspiration to integrate a modern public health approach into an inherently generalist community nursing role governed by a specialist regulatory framework (Mason 2001) was both bold and ambitious.

Between 2001-2006, many other contemporary UK healthcare policy reviews/initiatives had significance in terms of their actual or potential influence on the development of family health nursing in Scotland. Four of particular note are listed in Table 9.2, along with a summary of their purpose and relevance to this thesis.
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<th>Document</th>
<th>Purpose</th>
<th>Relevance and interpretative synopsis</th>
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<tr>
<td>NHS (Primary Care) Act 1997 introducing Personal Medical Services, and subsequent evaluation of pilot schemes (Lewis 2001)</td>
<td>Enabled new types of organizations (both public and private) to contract to provide primary care. Offered GPs more flexible employment (e.g. salaried options) aimed to improve GP recruitment and retention. Also to enable alternative sources of primary care such as Walk-in Centres and NHS Direct (Lewis and Dixon 2005). “The beginning of the end of GP’s monopoly of primary care” (Pollock 2005).</td>
<td>Contextual relevance. Ostensibly opened up significant opportunities for other health professionals. However explicit government agenda of transferring some of GP workload to nurses and AHPs (Pollock 2005). Led to a few nurses employing doctors, but most community nurses still focused on clinical care provision and lacked capacity and/or interest in becoming “nurse entrepreneurs” (Cook 2005).</td>
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<tr>
<td>Liberating the Talents: (DOH 2002)</td>
<td>Presented a new framework for nursing in primary care in England that would help Primary Care Trusts and Nurses to deliver the NHS Plan. Posited 3 core nursing functions: first contact assessment and care; continuing care and disease management; and public health/health protection and promotion.</td>
<td>Contextual relevance. Very little mention of family. Community nursing defined and aligned in relation to government policy. Criticised for being tied to medical agenda and revised GMS contract (Howkins and Thornton 2003). However, a marked influence on definition of, and strategic direction for, community nursing in both Northern Ireland (NMAG 2003) and Wales (Williams et al 2004).</td>
</tr>
<tr>
<td>New UK GP contract, rolled out in 2004 in Scotland (SEHD 2004a). This is known as the General Medical Services (GMS) contract.</td>
<td>Transferred the ultimate accountability for primary care services from GPs to Primary Care Trusts. Differentiated between essential (core) services, and additional and enhanced services. This enabled GP’s to opt out of the provision of “out-of-hours” care. Also created a Quality and Outcomes Framework with financial incentives.</td>
<td>Related relevance. “Family” almost entirely absent from the contract. Plethora of outcome indicators based primarily on the recording of tasks carried out in relation to the management of individual patients. Thus, within the contract at the heart of primary care provision, no overt incentive for provision of the holistic family health orientated approach to which FHNs aspire.</td>
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<tr>
<td>NMC revision of the UK nursing register (2004)</td>
<td>Opened a new three part register. Third part exclusively for “Registered Specialist Community Public Health Nurses”. Family Health Nurses were “migrated” onto this part of the register immediately after Health Visitors.</td>
<td>Related relevance. FHN recognised at national level as a public health nursing qualification, but the way that it was “recorded” changed. Family Health Nurses by far the smallest sub-group on this part of the register.</td>
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The main theme to emerge from review of the documents in Table 9.2 is that the initial years of the new millennium have brought some radical changes to the nature of primary care in the UK and, by extension, to the context and content of community nursing practice. The nature and scope of GP work has always had potent influence on community nursing practice (Peckham and Exworthy 2003), and the recent developments highlighted above have specific significance for the future of family health nursing within the UK. For the role’s particular emphasis on the family is being developed at the same time as the concept and practice of the “Family Doctor” (or “Family Physician” as posited by WHO Europe) is manifestly not. In Pollock (2005)’s view, “the potential to subcontract primary care services to numerous providers, however, clearly puts an end to the much-admired traditional model of UK family medicine, removing its holistic nature and giving up continuity of care” (p. 149).

Thus the FHN’s family focus again emerges as being somewhat out of kilter with contemporary UK healthcare policy and practice development. This is reflected in the community nursing policy review documents (England, Wales and Northern Ireland) mentioned in Table 9.2. These contain little about engaging with families. While both the Welsh and Northern Irish documents give cautious acknowledgement of the FHN initiative in Scotland, Liberating the Talents makes no mention of it at all.

Indeed the English, Welsh and Northern Irish documents are all more guarded about any possible move away from current specialist community nursing roles towards greater generalism. Arguably, this relative caution is also evident in relation to public health nursing roles and functions. As Poulton (2003) points out, Scotland’s Nursing for Health (2001) was far more radical in its recommendations. Interestingly the later Welsh review (Williams et al 2004) was not endorsed as policy by the Welsh Assembly Government. Williams et al conclude that “primary care and community nursing in Wales appears to be struggling to define its identity and contribution in the face of the current changes” (p. 8). This sense of community nursing being reactive and rudderless is apparent in many of the academic and popular UK nursing journal articles reviewed between 2001-2006 (e.g. Bennett and Robinson 2005a and 2005b.).

The latter trend co-exists with a significant aspirational literature which tends to focus on meeting challenges and exploiting related opportunities (e.g. Cook 2005). As Table 9.2 indicates, recent policy changes have the potential to enable more entrepreneurial and autonomous nursing practice. As Kelly and Symonds (2003) and Williams and Sibbald (1999) note however, there is a long history of nursing being “talked up” at such times, only for optimism to subsequently founder in the face of unchanged power relationships with medicine and managers. In this regard it is again important to note how the Scottish FHN development
was managed from the start to minimise challenge to existing medical and managerial hierarchies.

Indeed, review of UK community nursing policy documents tends to highlight how nursing’s leaders conform to, and characteristically confine nursing within, prevailing policy parameters. As these documents are almost always managed and produced by government civil servants, perhaps this should not be surprising. Nevertheless, the sense of nursing doing what it is told is often so ingrained and pervasive that it appears unremarkable. While similar documents emanating from government-employed medical leaders will often present strategies which overtly require change to nursing roles, it remains almost unheard of for nursing policy to propose change for other senior professional groups. In effect the UK’s Chief Nurses characteristically work within the confines of intra-nursing “how” questions. As such, and strictly within this ambit, the development of the FHN in Scotland is an example of an unusually bold and radical CNO-initiated policy. More often, in the words of Kelly and Symonds (2003), “optimism about nursing autonomy to create constructs that fit with their own philosophical paradigms of a caring profession is almost strangled at birth” (p. 136).

9.2.3 The Scottish context 1: what was the nature of the Scottish policy context up until 2005, how did this influence practice, and where did family health nursing fit within this?

While governance of health matters has been devolved to the Scottish Parliament since 1997, much of the major UK legislation on health applies to Scotland, either by direct adoption or adaptation. Nevertheless, as Pollock (2005) points out, some significant differences of approach are evident within the UK:

“While England is fast becoming the laboratory and test bed for market-driven experiments, Scotland and Wales are currently trying to minimize the effects of the market forces that were unleashed throughout the 1990’s – and with some success. Although the Treasury and Westminster have thrust upon Scotland and Wales the pernicious policy of public-private partnerships and private finance, both countries have begun to take small steps to undo the internal market, trying to strengthen public health functions and restore some basic planning functions.” (p. viii)

The plethora of health and social policy making in Scotland post 1997 (analysed in Chapter 4) is evidence of the latter trend, and the FHN initiative occurred within this context. Interestingly, in 2004 and 2005, the vast majority of Scottish GPs (89%; ISD Scotland 2007b) remained part of the General Medical Services scheme. Personal Medical Services contracts remain rare in the Highlands and Islands of Scotland, and it is evident that the introduction of the new GMS contract in 2004 has been one of the major contingent influences on the development of the FHN role in these regions. At the most obvious level, the reduction in most GPs’ out-of-hours commitments has had implications for the nature and format of community nursing in remote and rural areas in terms of cross-cover and teamworking practice. However, as suggested
previously, the contract’s lack of any overt incentive to provide an holistic family health oriented approach poses a more pervasive and profound problem for the future advancement of family health nursing within PHCT service delivery.

In this context the SEHD anticipated further rise in the direct employment of Practice Nurses by GPs and engaged in concurrent efforts to develop a framework and competences for practice nursing (SEHD 2004b). However, one would look long and hard for any sustained emphasis on family care within practice nursing literature (e.g. Carey 2003), and in many ways practice nursing can be seen to have fundamentally more limited goals than the holistic family care espoused by family health nursing educators and practitioners. Accordingly there is some evidence that, since its inception, family health nursing has occupied an ambivalent position within the Scottish Executive’s community nursing policy agenda. The impression of options being kept open is a theme that recurs within several Scottish FHN-related documents that were published between 2003-2004. Five of these are summarised in Table 9.3.
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<th>Document</th>
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<tr>
<td><em>Nursing for Health: two years on</em> (SEHD 2003b)</td>
<td>To review progress in relation to implementation of the recommendations of <em>Nursing for Health.</em> Used a “report card” format in relation to each recommendation. Progress very mixed. New structures had been set up, but working processes and culture slow to change.</td>
<td>Related relevance. Small specific section on FHN, but more emphasis on Health Visiting and School Nursing as merged within the new Public Health Nurse role. Two important points emerge to compare and contrast with FHN. Firstly, 172 of the new Public Health Nurses had been trained by 2003, but there was no evaluation of impact on practice. Secondly, much evidence of continuing tension between public health and the individual patient focus of PHCTs.</td>
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<tr>
<td><em>Voices from the frontline: community nurses and the joint future agenda</em> (RCN 2003)</td>
<td>RCN Scotland “snapshot” research study looking at community nurses initial experiences of joint working with social services as part of the Joint Future Agenda. Enabled by the Community Care and Health (Scotland) Act, Joint Futures aimed to achieve seamless service for patients so that duplicate professional assessments would be eliminated and one practitioner would co-ordinate service delivery.</td>
<td>Related relevance. This policy initiative was impacting throughout the development of FHN in Scotland. The Single Shared Assessment documentation was often the visible manifestation of this. This RCN research revealed some of the profound initial difficulties between nurses and social service staff relating to different working practices, professional identities and boundaries, status, and organizational culture.</td>
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<tr>
<td><em>Exploration of Attitudes towards Family Health Plans</em> (NES 2003)</td>
<td>Health Education Board for Scotland commissioned research study looking at current and possible uses of Family Health Plans in Scotland, and public attitudes towards them.</td>
<td>Related relevance. Showed that there is no standard method of record keeping on child and family health in Scotland, and practice complex, multi-professional and diverse. FHN documentation reviewed: seen as practitioner-led and problem-orientated.</td>
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<td><em>The Family Health Nursing in Scotland report</em> (SEHD 2003a)</td>
<td>To draw together conclusions about the FHN pilot in Scotland, as informed by the Macduff and West evaluation. To set out the way forward in Scotland (Phase 2, as described in Table 5.7).</td>
<td>Focal relevance. SEHD felt it was not possible to draw a definitive conclusion about the future of FHN in Scotland. However, wished to continue development and set up Phase 2. This implemented many of the evaluation report’s recommendations.</td>
</tr>
<tr>
<td><em>Partnerships in Education: guidelines for the design and delivery of Family health Nurse Education Programmes in Scotland</em> (NES 2004)</td>
<td>Production of a revised curriculum to prepare any future cohorts of FHNs in Scotland, co-incident with Phase 2. Informed by recommendations from the Macduff and West (2003) evaluation report, but also extensively by the ICN Framework and Competencies for the Family Nurse.</td>
<td>Focal relevance. Revised curriculum built on what had gone before, but introduced new element in the form of the ICN framework. Accordingly new programme mapped onto 3 frameworks: WHO; ICN; NMC. The strong and particular emphasis on family was, however, clearly retained. Only one Scottish University (Stirling) offered this new programme however.</td>
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The main theme to emerge from scrutiny of Table 9.3 is that of continuing limited development of family health nursing in Scotland, in the midst of other contingent health and social care developments. The SEHD position at the time is summarised in their *Family Health Nursing in Scotland* report (SEHD 2003):

“With the evidence available to date, it is not possible to draw a definite conclusion about the future contribution of the Family Health Nurse as a generalist community nurse working with families. However, there is sufficient evidence of the value and potential of the role to continue to support its development and evaluate its impact. The overriding message from the pilot areas is that it would be undesirable, if not impossible, to dismantle this new approach to practice. Even though progress has been variable, the commitment to the model remains” (p. 23)

The above passage is notable for its assertion that once family health nursing has been constructed in practice, it becomes difficult to dismantle. This highlights the extent to which the FHN initiative was an evolving social experiment at practice level, rather than a controlled catalyst which remained unchanged when tested within local PHCT “crucibles”.

This point is, if anything, developed by other reflections within the *Family Health Nursing in Scotland* report (SEHD 2003): “The project steering group took the view at the outset that as a pilot project any outcome would be regarded as a success, so long as we were able to learn from it and apply the learning to the further development of community nursing practice” (p. 21)

This sentence is important as it demonstrates how the criteria for success were not only set very low (e.g. a common government response to disasters is to say that lessons will be learned), but also lacked focus and clarity in terms of specific desired care outcomes. Rather the pilot was predicated on the implementation of four broad principles. Accordingly, it is not surprising that some of the questions that recurred throughout the evaluation were: “why is this being done here?”; “what is the need?”; and “what is family health nursing trying to achieve?”.

Nevertheless, substantial evaluation took place. As Table 9.3 shows, the same cannot be said in relation to a much larger simultaneous Scottish development: the education of the new Public Health Nurses and the subsequent impact of this on practice. *Nursing for Health: two years on* (SEHD 2003b) did, however, recognise that developing public health nursing roles often involved tension with the individual patient focus of primary care and medical priorities. During 2003 it was also becoming increasingly clear that community nurses were facing significant challenges in enacting the form of joint working with social services that the Government were advocating (RCN 2003). As Poulton (2003) notes, numerous studies have found evidence of interdisciplinary conflicts within PHCTs, but the RCN study illuminated the nature and extent
of the gulfs in culture between health and social care organizations at the start of the millennium in Scotland.

In this light, it is not surprising that University of Aberdeen researchers found the contemporary use of Family Health Plans (NES 2003) in Scotland to be fragmented, diverse and prone to duplication by different professional groups. Notwithstanding the difficulties that this kind of engagement with families had been found to entail, the revised curriculum guidance document for FHN programmes in Scotland (NES 2004) developed the family focus further by incorporating the International Council of Nurses Framework and Competencies for the Family Nurse. This introduced another element into the structure of the hybrid Scottish programme, which itself remained a very distinctive and different feature of the Scottish university nursing education scene during the first five years of the new century.

The latter point is worth emphasising because there is little evidence of any concurrent groundswell in interest in family nursing within Scotland during this period. Although a Family Nursing Network had been established in 1997 by a group of Scottish nurse educationalists (Claveirole, Mitchell and Whyte 2001; O’Sullivan Burchard, Whyte and Jackson 2002; Burchard et al 2004), this struggled to develop beyond a specialist interest group, and in 2004 could not attract sufficient numbers to sustain an annual conference event. In contrast, the Family Health Nurse initiative was promoted much more forcefully nationally due to high level support, and a number of promotional articles were published in the UK nursing press (e.g. Wright 2002). Nevertheless, as has been noted before, there have been very few articles about family health nursing in the UK nursing press. By the end of 2004 these totaled less than 20, and very few of this number could be said to contain substantive critical engagement and/or analysis. Accordingly, there is little evidence of Scottish, or European, family health nursing being a significant influence on mainstream UK community nursing discourse during this period.
9.2.4 The Scottish context 2: what was the nature of the Scottish policy context between 2005 and early 2006, and where did family health nursing fit within this?

The end of 2004 also marked the beginning of a new cycle of change within Scottish nursing and the wider health services. At this time a new Chief Nursing Officer, Paul Martin, took over from Anne Jarvie who retired after 12 years in the post. Moreover another major review of health service provision in Scotland was underway, led by Professor David Kerr. The subsequent report, *Building a Health Service Fit for the Future* (SEHD 2005b) led to a new raft of policy making and policy responding within Scottish health and social care. Table 9.4 summarises the two key documents at the heart of developments.

**Table 9.4: Key Scottish policy documents published in 2005**

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<tr>
<td><em>Building a Health Service Fit for the Future</em> (SEHD 2005b). Known as “The Kerr Report”.</td>
<td>To address changing health needs by devising a 20 year plan for the NHS in Scotland. Particularly driven by more people living longer, with less people being available to care for them. NHS viewed as service to be delivered predominantly in local communities.</td>
<td><strong>Contextual relevance.</strong> Substantial shift in rhetorical emphasis towards development of primary care. Focus on facilitating health maintenance in terms of preventive, anticipatory and patient/carer self care approaches, particularly in relation to long term conditions. Continued concern that remote and rural communities can sustain suitable services.</td>
</tr>
<tr>
<td><em>Delivering for Health</em> (SEHD 2005c)</td>
<td>To set out a strategic framework and action plan to take forward the Kerr Report. Reproduces emphases on: local services; help for people with long term conditions; reducing inequalities; managing hospital admissions. Details service redesign priorities. Regional and local solutions encouraged.</td>
<td><strong>Contextual relevance.</strong> Rather less emphasis on health improvement than many of its recent predecessors. Very little mention of families. Action plans show continued preoccupation with medical services. Nursing seen as developing “key clinical roles that will support the delivery of actions on unscheduled care, long term conditions, out-of-hours and emergency services, orthopaedic services and diagnostic waiting times”. A review of community nursing will “develop a framework to ensure that community nurses are equipped to provide significant input to the care and treatment of vulnerable people”</td>
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Reviewing the two documents in Table 9.4, four general themes emerge as important:

- The much more vigorous policy rhetoric promoting local primary health care, with particular emphasis on health maintenance for vulnerable groups such as the elderly and those with long term conditions
- Related, significant concerns about the capacity of the Scottish healthcare workforce to meet imminent needs of communities
- Continued absence of “family” as a focal concern, but family usually referred to in their (valued) capacity as carers
- Nursing’s supporting role in this reformulation of service provision

More specifically, Delivering for Health’s requirement for a review of community nursing set a new context for the Scottish FHN pilot whose second phase was due to finish in 2006. During 2005 no substantive reports were made available on the progress of the urban piloting of the FHN role. However the final reports of the FHPDFs employed in the remote and rural regions emerged during the year (e.g. Dickson 2005; Caruana 2005). These advocated the relevance of the FHN role to the new policy context, but typically focused on description of the practice development work that had taken place in each region during Phase 2. There was particular emphasis on the introduction of “Plan-Do-Study-Act” cycles for implementing change, and description of new National Indicators that had been developed so as to benchmark FHN practice. It was anticipated that these practice indicators would inform the final evaluation of the pilot which was being conducted by the National Co-ordinator of the FHN Project (Lesley Whyte) and her colleagues from Glasgow Caledonian University.

Thus the stage was set for the publication in 2006 of a summative evaluation of family health nursing in Scotland, and a major review of Scottish community nursing.
9.3 PERSPECTUS

In fact during 2006 work was being undertaken in Scotland to prepare four publications of key importance to the subject matter, and to the conclusion, of this thesis. It is important to note that this work was co-ordinated at SEHD level to such an extent that all four documents were published within days of each other during November 2006. Accordingly, this section of the chapter views and reviews Scottish family health nursing from the overall current “perspectus” provided by these documents. Each of these documents is examined in turn, but interpretation and discussion is cumulative and integrated. This approach is well suited to the integration evident across the documents themselves.

9.3.1 The new overall framework for Scottish nursing 2006

Key aspects of the new 2006 framework for Scottish nursing (and midwifery and the allied health professions) are summarized below in Table 9.5.

Table 9.5 Key aspects of Delivering Care, Enabling Health

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<tr>
<td>Delivering Care, Enabling Health (SEHD 2006a)</td>
<td>“Harnessing the nursing, midwifery and allied health professions’ contribution to implementing Delivering for Health in Scotland”. Making sure that “our direction of travel matches exactly that set out in Delivering for Health”, and making the most of resultant opportunities. Building related culture, capability and capacity.</td>
<td>Contextual relevance. Explicit re-profiling of Scottish nursing in response to the new policy agenda. Emphasis on “core nursing values” such as caring for the elderly, and team work. Faithful reflection of other emphases in Delivering for Health. Main actions include workforce development plans, new models/frameworks (e.g. for anticipatory care, self care, and competencies). Related action points impacting on pre-registration educational courses in Scotland.</td>
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As indicated in Table 9.5, the new framework is defined by the NHS Scotland plan set out in Delivering for Health. Nursing capability is considered in relation to a new NHS which “will be a service primarily focused on helping older people to stay well and remain engaged with their communities and, if they fall ill, providing them with appropriate access to services locally or in specialist centres” (p.26). There is associated preoccupation with capacity issues and reference to ongoing national workforce planning initiatives. In this regard it is significant to note that, shortly after taking office, CNO Paul Martin had also been appointed as Interim Director of Human Resources for NHS Scotland. Within the new framework, the need for a flexible workforce is repeatedly emphasized, and it is made clear that health service career progression
will increasingly be predicated on the needs of patient care groups rather than the traditional expectations of distinct groups of health professionals. One of the most striking overall themes within the document is the extent to which nursing is being reformulated to conform to policy in such a way that it may ultimately be defined by it and measured against it.

9.3.2 The SEHD Final Report on the FHN pilot

Key aspects of the SEHD’s final report on the FHN pilot are summarized below in Table 9.6.

Table 9.6 Key aspects of The WHO Europe Family Health Nursing Pilot in Scotland Final Report

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<tr>
<td>The WHO Europe Family Health Nursing Pilot in Scotland Final Report (SEHD 2006b)</td>
<td>The Final Report does not explicitly express its aim, but it can be inferred that it purports to summarise what happened in Phases 1 and 2 of the pilot, and what has been learned overall. Within a glossy format, there is brief description of policy context, the WHO Europe initiative, the principle of the Scottish role, conceptual models, the education and research undertaken in Phases 1 and 2, and the new National Indicators. A further section of the report considers impact and outcomes in terms of criteria from Delivering Care, Enabling Health. A final section considers the learning and key messages that have emerged from the SEHD point of view.</td>
<td>Focal relevance. In summarising and re-presenting the five year pilot, the SEHD “re-frame” it in terms of its relevance to the central policy concerns set out in Delivering for Health and Delivering Care, Enabling Health. While some of the difficulties that emerged during both phases are cited (e.g. creating a generalist role within the context of existing specialist nursing roles), these tend to be glossed over through the presentation of individual FHN practice exemplars that promote the role and the value of the pilot. Considerable emphasis is placed on a new conceptual model of family-centred health care (Parfitt et al 2006) that emerged from the research conducted during Phase 2 by the team from Glasgow Caledonian University. The Foreword by the Chief Nursing Officer declares the FHN pilot project’s “enormous influence” on Delivering Care, Enabling Health, and on the development of future community nursing models for Scotland. Thus the pilot project is strongly validated throughout the Final Report.</td>
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A key message from Table 9.6 is that the Final Report re-frames the Scottish FHN pilot project in terms of the new NHS Scotland and new Scottish nursing policy agendas. Thus the value of the role in meeting the needs of older people, providing anticipatory care, supporting self-care, and the other new policy preoccupations is promoted through the exclusive citing of examples
of FHN practice that have had positive impact. The document draws substantially on findings from the evaluation of the urban pilot (Parfitt et al 2006) showing that service users typically valued having the FHN as an identifiable single point of contact, and that this relationship often identified and addressed unmet needs.

However, the Final Report tends to gloss over the context of this relationship, mentioning once in the passing that “Family Health Nurses in the urban setting became additional members of nursing teams and established new client caseloads” (p. 13). In fact this supernumerary status is a key difference to the remote and rural FHN experience, and is one that requires further explanation in terms of its potential contribution to client satisfaction.

A more balanced and less superficial approach is evident in the document’s discussion of learning and key messages, where there is consideration of what would have to change at PHCT level for family health nursing to thrive. In this context, considerable emphasis is placed on a new conceptual model of family-centred health care (Parfitt et al 2006) that emerged from the research conducted during Phase 2 by the team from Glasgow Caledonian University. This is reproduced below in Figure 9.1.

Figure 9.1: Conceptual model for the development of Family-Centred Health Care (Parfitt et al 2006)
Within the Final Report it is made clear that all of the three “interlocking” inputs depicted in Figure 9.1 would have to be present for family health nursing to evolve within PHCTs delivering “family centred” care. This is consistent with the suggestions made in the Phase 1 evaluation research report (Macduff and West 2003). Nevertheless, as this thesis has shown, this sort of productive conjunction of FHN and PHCT aspirations was relatively rare in remote and rural regions even where active external facilitation was taking place. With the GMS contract’s focus on outcomes for individuals, the systematic embedding of such a family-centred care model would seem like a tall order indeed.

Notwithstanding this, the SEHD Final Report concludes that “The Family Health Nurse model underpins the development of family-centred care in a way that reflects the Scottish health policy focus on delivering care that is based on health improvement and disease management” (p. 30). Moreover, in his Foreword, the Chief Nursing Officer declares the FHN pilot project’s “enormous influence” on Delivering Care, Enabling Health, and on the development of future community nursing models for Scotland. Ostensibly then, the Final Report appears to suggest a future existence for FHNs within family-centred Scottish community health care. Before examining the blueprint for the future that was concurrently being developed (i.e. the 2006 Review of Nursing in the Community in Scotland), it is useful to look in more depth at the research evaluation of Phase 2 of the FHN pilot.
9.3.3 An evaluation of the Family Health Nurse Role Phase 2

Key aspects of this document are summarized below in Table 9.7.

Table 9.7 Key aspects of An evaluation of the Family Health Nurse Role Phase 2

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<td>An evaluation of the Family Health Nurse Role Phase 2 (Parfitt et al 2006)</td>
<td>The Phase 2 evaluation had three objectives: (i) To understand the impact of the FHN role in an urban area during the first six months of practice from the perspectives of service users, FHNs and FHNs’ professional colleagues. (ii) To follow up FHNs’ experiences of the role after 3-4 years in remote and rural areas. (iii) To understand the factors that have helped or hindered the implementation of the FHN role.</td>
<td>Focal relevance. The remote and rural part of this study was broadly similar in nature, scope, methods and indeed findings to my own follow-up study (Macduff 2006b) of these regions. The key differences in the urban part of the study are (i) the supernumerary status of the FHNs, and (ii) the 20 interviews carried out with service users and carers. The resultant findings are very positive in terms of user satisfaction with urban FHNs. However, the report often fails to distinguish the urban experience in terms of its particular contexts and processes, so that insights for the reader about transferable understandings are limited. The report strongly advocates whole systems change towards the new model of family centred health care posited.</td>
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</table>

As Table 9.7 indicates, the remote and rural part of Parfitt et al’s study was broadly similar in terms of its nature, scope, methods and findings to my own follow-up study. Indeed it used a questionnaire developed for the Macduff and West (2003) evaluation study.

Consequently the novel aspect of the Parfitt et al research lies in its study of the urban pilot. By giving more detail of the development and related research that took place during Phase 2, their report enables more critical purchase to be applied to the SEHD Final Report. Thus they clarify that:

“In 2005, 15 FHNs qualified and worked for 6 months in an urban area. The key difference in the implementation was that in urban settings FHNs did not return to their previous caseloads (as happened in the rural areas), but were in supernumerary positions, working only in the FHN role. As such, their work depended on colleagues referring clients on to them” (p.2).

This casts the urban pilot as a very short term trial of a role that added distinct extra capacity on to local service delivery. Seen in this context it is not surprising that the 20 service users/carers typically valued having the FHN as an identifiable single point of contact (after initial referral
by another professional), and that this relationship often identified and addressed unmet needs. This is very different from the typical remote and rural FHN experience where servicing of pre-existing caseloads continued and the new role had to develop as an integral part of the PHCT service.

The main limitation of the Parfitt et al study is that it characteristically aggregates urban and rural findings, making it difficult to get a detailed understanding of the urban context(s) and the processes involved for the FHNs and other PHCT members. For example, the report gives details of the age distribution of clients on the caseloads of 23 FHNs who responded, but fails to distinguish which relate to the 10 urban FHN respondents. As there is huge variation across the 23 FHNs’ replies, the reader must guess at the presence or absence of any urban trend. Similarly, although the report argues strongly for a new conceptual model of the development of family-centred health care, it gives no indication of how many of the urban FHNs actually were part of PHCTs where three inputs aligned as in Figure 9.1. Moreover, it is unclear exactly how this worked for urban PHCT members in terms of their contexts, integrated processes, and the nature of any related outcomes. This makes it hard to know: whether the model being advocated is derived directly from empirical evidence from the Scottish urban FHN sites; whether it is derived primarily from evidence from Scottish remote and rural sites; or whether it is primarily a new aspirational, theoretical construct.

The latter interpretation is possible, given that the new construct is presented as a conceptual model and that at least two of the report’s authors have substantial experience of, and alignment with, developing family health nursing in other countries (notably Tajikistan). Certainly, the report is unequivocal on the need for major whole systems organisational change if the FHN role is to prosper in Scotland: “The process depicted in this model is the transformation of the current mode of service delivery in the community into a family-focused system of health care, in which FHNs play a full role” (p.31).

Specifically the report recommends that: strategic leadership at Community Health Partnership (CHP) level is required to instigate the required systems change; manpower modelling research is required to explore the practical feasibility of the FHN model; and that community nursing education programmes should be reviewed to ensure that all practitioners are familiarised with FHN concepts.

Thus the Phase 2 evaluation research report argues for radical change to systems within Scottish primary care, but yields limited understanding of the workings of the FHN role in an urban setting, making it difficult to gauge the extent to which findings may be transferable to other Scottish urban contexts. With these considerations in mind, it is time to examine the major national review of community nursing that was ongoing throughout 2006.
9.3.4: The 2006 Review of Nursing in the Community in Scotland

Key aspects of this document and its associated literature review are summarized below in Table 9.8.

Table 9.8  Key aspects of the 2006 Review of Nursing in the Community in Scotland

<table>
<thead>
<tr>
<th>Document</th>
<th>Purpose</th>
<th>Relevance and interpretative synopsis</th>
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<tbody>
<tr>
<td>Visible, Accessible and Integrated Care: Report of the Review of Nursing</td>
<td>The review’s aim was to:</td>
<td>Related relevance. The review was explicitly driven by Delivering for Health, but its scope was extended</td>
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<td>of the Community in Scotland (SEHD 2006c)</td>
<td>“identify the core components of a modern community nursing service</td>
<td>beyond the care and treatment of vulnerable people. By May 2006, high speed review produced a</td>
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<td>which is flexible and responsive to meet the needs of patients and</td>
<td>controversial new draft framework for structuring delivery of community nursing in Scotland.</td>
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<td>communities in Scotland within a multi-disciplinary setting and make</td>
<td>District nursing, public health nursing and family health nursing were to be merged into a new,</td>
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<td>recommendations for the future delivery of care”.</td>
<td>generalist Community Health Nurse role. Despite a large number of “serious concerns” being voiced</td>
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<td>during the consultation, and related adverse publicity in the Scottish press, the new framework was</td>
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<td>published with minimal changes in November 2006. The implementation plan for the new model involves</td>
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<td>a 2 year project with selected “Development Sites” that reflect the diverse nature of Scotland’s</td>
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<td>geography and demography. This will “test and refine” the new model to ensure fitness for purpose.</td>
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<td></td>
<td>In this way, the concerns raised during consultation will be taken into account.</td>
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<td>(i) To identify current arrangements/models for the provision of</td>
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<td>nursing in the community</td>
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<td>(ii) To determine future nursing requirements to provide modern</td>
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<td>nursing in the community and determine the impact this will have on</td>
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<td>other community disciplines.</td>
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<td>(iii) To identify effective practice</td>
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<td>(iv) To identify models of best practice</td>
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<tr>
<td>Nursing in the Community: a literature review (SEHD 2006d)</td>
<td>The literature review aimed to explore the evidence base for nursing</td>
<td>Related relevance. The review team was set an extremely challenging remit which precluded a formal</td>
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<td>in the community in relation to the key messages/themes within</td>
<td>systematic review protocol. A very mixed literature from Europe, North America and Australasia was</td>
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<td>Delivering for Health. Specifically, for each of the main themes</td>
<td>screened and assessed (164 papers) using a range of quality criteria. The evidence base for</td>
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<td>such as anticipatory care and managing long term conditions,</td>
<td>community nursing was found to be limited for most of the key themes at the heart of Scottish</td>
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<td>there was also the requirement to identify any significant differences</td>
<td>policy. A more general overview of nursing in the community was produced which highlighted some of</td>
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<td>for nurses in urban or rural areas, and to “explore where on the</td>
<td>the recurring themes within nursing research (e.g. difficulty of identifying the specific community</td>
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<td>continuum of generalist to specialist nurse any impact is most</td>
<td>nursing contribution to outcomes). The review does not substantively report on urban/rural or</td>
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<td>significant”. Search, synthesis of findings and report production was</td>
<td>generalist/specialist differences despite its remit.</td>
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<td>to occur within three months.</td>
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9.3.4.1 Review aim, processes and politics

Before looking at the Review’s findings and outcomes in more detail, it is necessary to say more about the processes involved and the political context. The Review formally started work in January 2006, with the very ambitious target of reporting by the end of May 2006. As noted in Table 9.8, it is significant that the CNO set the Review’s scope beyond the focus on vulnerable people that had been specified in *Nursing for Health*. Rather, the opportunity for a “full”, but very rapid review, was recognised.

In this regard the Review’s aim (see Table 9.8) contains a phrase of particular significance: “to identify the core components of a modern community nursing service which is flexible and responsive” (p. 36). “Core components” is noteworthy because it raises the prospect of common ground, with *Delivering for Health* as the rallying point. “Flexible and responsive” reflects not only the changing nature of patient needs, but also the workforce capacity concerns driving policy and presumably being highlighted for the CNO in his capacity as Interim Director of Human Resources for NHS Scotland. As Kelly and Symonds (2003) historical analysis shows, however, flexibility and responsiveness carry significant professional risk for community nursing in terms of likely concurrent supplication to medical and managerial agendas.

The Review’s objectives were addressed through the literature review and a rapid series of regional workshops with: community nurses; NHS managers and other staff; and patient and carer representative groups. Moreover a National Conference was held in March and a Consensus Conference took place in May. While the former event (and the minutes of the Review’s National Steering Group) gave little, if any, indication that radical change to a Community Health Nurse (CHN) generalist model was imminent, the May event was convened to consider a draft of just such a model (see CHN model in Figure 9.2 for reference). Professional reactions, as manifest in consultation responses to the first public draft of the report (Draft 5), were very mixed but typically included substantive concerns. A selection of these from the Review’s website is given in Table 9.9.
Table 9.9: Serious concerns expressed by respondents during the consultation process

<table>
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<tr>
<th>Concern</th>
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<td>The move towards generic skills vs. specialisation among community nurses (jack of all trades with the associated dilution of skills and loss of specialist skills, master of none)</td>
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<td>The “clinical” nature of a model which endeavours to give equal weight to health promotion and prevention and clinical care of unwell patients, with concerns that inevitably the needs of the sick individual would override the health promotion work.</td>
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<td>The uni-disciplinary focus on nursing vs. a focus on multi-disciplinary integrated services</td>
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<td>The impact of such radical proposals on the morale of an already demoralised, change fatigued workforce, with concerns that some would leave the nursing profession.</td>
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<td>The place of children and young people within the proposal, with particular concerns around child protection issues.</td>
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<tr>
<td>The place of Practice Nurses within the model and lack of acknowledgement of their central role in managing long term conditions etc.</td>
</tr>
<tr>
<td>A lack of evidence for the recommendations and the proposed model.</td>
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<tr>
<td>Concerns about the transferability of qualifications between Scotland and the other UK countries and vice versa.</td>
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<tr>
<td>The inadequate consultation time around the recommendations and proposed model for such far-reaching changes.</td>
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<tr>
<td>A lack of awareness or acknowledgement in the report of the wider policy context and other national initiatives.</td>
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<tr>
<td>Geographical based teams vs. attachment to a primary care practice.</td>
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<tr>
<td>Training and competencies of nurses both initially and maintaining skills for the new role, with consequent concerns around patient safety.</td>
</tr>
<tr>
<td>Management issues – particularly how the consultant nurse role fits within the CHP structure and the CHP Lead Nurse, along with the affordability of the new structure.</td>
</tr>
</tbody>
</table>

In a subsequent draft of the report (Draft 6), and in the final published version, the SEHD addressed a few of these concerns. Firstly they added a new core element, “Adopting public health approaches to protecting the public” on to the six that they had already identified as being at the core of nursing roles in the community i.e. working directly with individuals and their carers; co-ordinating services; supporting self care; multi-disciplinary and multi-agency teamworking; meeting health needs of communities; and supporting anticipatory care. This addition was designed to assuage vocal concerns about child protection in particular.

More significantly, from the perspective of this thesis, the final published version explicitly cites the FHN model on several occasions as an example of what works in community nursing and as a major influence on the new service model that is promulgated in the Review. This foregrounding contrasts markedly with the way that the FHN pilot project was kept very much in the background during the early stages of the Review. This thesis would argue that, in the face of charges of a lack of evidence for the recommendations and the proposed model, the SEHD was forced to become more explicit about the model’s origins. This contention will be explored in more depth later in this chapter.

Despite pressure from the Scottish press for reconsideration, the final published version made few other changes in response to professional and public concerns. Indeed the final published
version is pared down from Draft 5 to such an extent that: basic definitions are omitted (e.g. what is meant by community nursing); the sources of evidence for the report’s many generalisations are usually not made explicit within the text; and the finished document is slimmer than many executive summaries. While such conciseness has virtues, it makes it difficult for the reader to understand how and why the Review arrived at the findings and conclusions that it did.

9.3.4.2 Review findings and recommendations

The findings of the Review firstly focus on the perceived strengths of Scottish community nursing in general. These are perceived to include knowledge and skill levels, problem solving and relationship building activities. On the distaff side, the Review argues that the profusion of community nursing roles and job titles is confusing for both the public and professionals alike. Moreover the latter groups were seen as wanting a single point of access to community nursing services, which at present could lack co-ordination.

The Review also argues that the “sporadic and inconsistent” (p. 12) implementation of the Nursing for Health (2001) recommendations that were intended to focus nursing’s public health activities, means that: “Nursing needs to reclaim public health as a core function, with public health awareness and approaches being adopted as a kind of ‘default position’ by each nurse working in the community” (p. 12).

On this basis the Review sets out a new framework aimed at clarifying the nursing role in the community, “to create greatest benefits to individuals, carers, families and communities” (p. 16). This new service model is reproduced in its final form in Figure 9.2.
As Figure 9.2 illustrates, at the heart of this model is the proposed new Community Health Nurse (CHN) role. The seven core practice elements listed above in Section 9.3.4.1 are not only seen as the foci for this role, but also for the activities of all nurses in the community. Thus the new CHN role is posited as the central structural component of the new service model. To start to make this possible:

“The Review recommends that the disciplines of District Nursing, Public Health Nursing (Health Visiting and School Nursing) and Family Health Nursing be absorbed into a new, single Community Health Nursing discipline. The elements common to each of these disciplines will be assumed by the new Community Health Nursing discipline.” (p. 15)

Apart from the obvious historical significance of ending distinct disciplines such as district nursing and health visiting in Scotland, with their long-established cultural identities, the above recommendation raises immediate practical questions about the mechanics of merging these disciplines. As Table 9.9 shows, the merger also raises many major questions about its possible impact, such as: can public health really be enacted as a core function/default position within the CHN role? As Table 9.8 indicates, the Review typically suggests that such questions will be addressed during the two year implementation project whereby selected Development Sites will
test and refine the new model to ensure fitness for purpose. This distinctly echoes the policy advancement and enactment strategies developed for the FHN pilot project.

There is, however, clarity about one group of nursing staff, in that the Review reports that it “has not been possible to identify Practice Nurses in the model due to the particular nature of their employment circumstances” (p. 15). This highlights a significant limit on the Review’s scope and raises questions about the level and nature of GP support for the new model.

Related concerns are exacerbated in the final published version’s description of how and where the new nursing teams will work. While Draft 5 had placed considerable emphasis on this responding creatively to local community needs and being contiguous with Community Health Partnerships, the final published document is much more guarded, stating that “It will be a matter for individual NHS Boards to determine whether group attached/aligned or geographically based services are selected for their areas” (p. 25). This puts a premium on local community nursing leadership to advocate the nursing case appropriately and forcefully. As this thesis has argued, this has not been a prominent feature of multi-disciplinary working at this level.

In summary, the Review sets out a radical new model for community nursing in Scotland, but only partially explains the origins of, rationale for, and means of enactment of this new model. While many of the associated arising questions must remain to be answered in the future, for the purposes of this thesis, it is now important to analyse in more depth the relationship between the envisioned CHN and the FHN as envisioned and enacted.
9.3.5 The relationship between the Community Health Nurse and the Family Health Nurse

In order to analyse this relationship, it is firstly useful to compare the newly envisaged CHN role with the FHN role as it was envisaged on Calton Hill five years previously. This can be done by once more referring to the four principles that the SEHD posited as core for the FHN role.

Firstly, it will be recalled that the FHN role was seen as “a skilled generalist role encompassing a broad range of duties”. In essence the CHN appears to be a skilled generalist role formulated around seven core elements which represent a mixture of: long-established community nursing role expectations (e.g. working directly with individuals and their carers); more recently formulated community nursing role expectations (e.g. multi-disciplinary and multi-agency team working, meeting health needs of communities, co-ordinating services); and newly conceptualised community nursing role expectations (e.g. supporting anticipatory care, supporting self care). Clearly this would entail a broad range of duties of generally similar nature and scope to the FHN role as it was envisaged. The major differences are the particular new emphases on supporting anticipatory and self care, and the absence of specific reference to families.

It also seems clear that both roles share health as an envisaged core element, although the CHN role adds carers on to the FHN’s remit to cover individual, family and community health matters. However the tenor of the 2006 Review suggests that the CHN role should reflect Delivering for Health’s particular emphasis on the health of the elderly and those with long term conditions. Again this raises questions about whether such a large remit will compromise quality and prejudice care for specific groups (see Table 9.9).

Thus strong generalist and health elements are evident in both role templates, although there are a few distinct differences in emphasis. The notion of the CHN as first point of contact within the new service model reflects an aspiration that was also central to the envisaged FHN role. This type of generalist model is, however, contingent on support from specialist practitioners. The major difference in the new model is that the CHN merges several of the existing specialist roles (i.e. DN; HV; FHN), while the FHN was essentially adding on another type of role.

From the above analysis it becomes increasingly clear that the core difference between the two roles, as envisaged, relates to family. This is obvious at the level of naming, whereby “Family” gives way to “Community”. However, more in-depth scrutiny of the Review and the proposed CHN role shows that family care is not a focal concern. Rather it is typically couched within a recurring aspiration to care for “individuals, carers, families and communities”. This contrasts with the explicit statement in 2001 that the FHN was to be a “role founded on the principle of
caring for families rather than just the individuals within them”. Moreover it contrasts with the current argument for PHCT whole systems change towards family-centred care advanced in the Parfitt et al (2006) report and ostensibly endorsed in the SEHD’s Final Report on the FHN pilot (SEHD 2006).

Having (i) established that there is one core conceptual difference and three core conceptual similarities between the envisaged new CHN role and the original FHN role template, and (ii) noted CNO Paul Martin’s acknowledgement of the FHN pilot’s enormous influence on “developing future models for the delivery of nursing care in the community” (SEHD 2006b, p. 2), it is necessary to ask why the SEHD dropped the emphasis on family. This issue is neither explicitly acknowledged nor addressed in any of the four key documents whose publication was co-ordinated by the SEHD in November 2006. Yet the natural question that arises from reading them together is: if family health nursing is so good, why drop the emphasis on family?

As this thesis has shown, the answer that the SEHD has been reluctant to publicly acknowledge to date is that enactment of meaningful family-centred PHCT service delivery to both well and unwell persons is extremely difficult within the present system. Specifically the thesis has found that the aspiration to engage with whole families was often difficult to enact, was usually not a priority within overall PHCT service delivery, and was not incentivised in overall primary care policy and planning. Moreover, as the interview with Anne Jarvie in this thesis has shown, the SEHD’s attachment to family as a core element of the role was never absolute, despite its promotion through the pilot.

This contrasts with Anne Jarvie’s (and, by extension, the SEHD’s) more longstanding and deep-rooted commitment to the idea of a generalist community nursing role with health as a core focus. The evidence on FHN role enactment in remote and rural regions showed that most FHNs were able, at the least, to supplement their existing duties with some distinct health-focused activities. This also seems to have been the case for the supernumerary urban FHNs. Perhaps most tellingly, however, the remote and rural follow-up study confirmed the flexibility and wide scope of the FHN role in terms of providing generalist community health nursing services (Macduff 2005; Macduff 2006a). While the latter publications reported the diversity of what could be considered family health nursing practice, they also highlighted that the inherent flexibility and wide scope of the role was generally valued by colleagues and seen to enhance service provision. As noted above, the aim of the 2006 Review was to ensure a flexible and responsive community nursing service.

Accordingly, this thesis argues that it is likely that the SEHD has quietly dropped the family emphasis due to recognition that it is impractical if taken seriously and would require radical
whole systems change involving fundamental commitment from other key professional groups. In effect, the SEHD has a sufficiently large challenge in introducing a radical intra-professional reform in the shape of a pivotal generalist role which aspires to address both health and illness needs within communities. Moreover, the analysis within this thesis highlights the extent to which the SEHD is making a large “leap of faith” in its commitment to introducing the Figure 9.2 model across all of Scotland in the future. For, while the FHN role was enacted and evaluated within typical remote and rural practice, the brief urban pilot involved a very atypical supernumerary nursing role. Thus it remains very unclear whether a generalist community nursing role with an explicit health orientation (i.e. the CHN) will be suited to team working in urban areas and be feasible and affordable.

In this regard, it is unclear whether the Review considered potentially relevant evidence from broadly similar countries where broadly similar generalist roles operate. For example, in the Irish Republic the Public Health Nurse role has operated for many years and has been studied in some detail (see NCNM 2005; Begley et al 2004). However it is unclear whether this informed the Review, and as Table 9.8 indicates, the commissioned literature review does not substantively report on generalist/specialist or urban/rural differences despite its remit.

None of the argument in this section is suggesting that the SEHD is necessarily mistaken in deciding to introduce the CHN and the new service delivery model. Rather it is to seek to highlight: the relationship of the FHN to the new CHN role in terms of key similarities, differences and net influence; the reasons why the conceptual transition from FHN to CHN has progressed in this way; the limitations of arguing for the new CHN role on the basis of the findings from the urban FHN pilot; and the related lack of clarity about the evidence base for the new CHN role and associated service delivery model.
9.3.6. Using the Agency model to understand the Review of Nursing in the Community

Reflecting on Sections 9.3.4 and 9.3.5, it is useful to highlight the importance of what was not being addressed in the Review. In effect, there is very little attempt to engage with and explain community nursing in terms of the recent past. While ostensibly this seems odd, it can be understood as part of a broader strategy to achieve a kind of “tabula rasa” - free from the imprint of the past and ready for the blueprint of Delivering for Health. Although the influence of the recent FHN pilot is eventually acknowledged in the Review, there is no sustained analysis of the recent contribution of specific key disciplines such as district nursing, health visiting and practice nursing. Rather the text of the Review document aggregates the disciplines together as “community nursing” and characteristically aggregates its findings in a way that makes it very difficult to gauge: the nature of the data informing consideration of particular issues; the nature of any analytical and weighting processes; and how conclusions were reached. This can be seen as a way of minimising offence to the key community nursing disciplines that will be required to merge and lose their established identities.

The craft of the Review is that it defines itself in relation to the future as depicted in Delivering for Health. This creates a sense of an urgent imperative for change which community nursing must rapidly respond to. To this analyst, the nature of the Review (i.e. its remit, timescale, processes and approach to reporting) seems deliberately crafted towards finding an answer that had already been substantially found by the SEHD. To justify this interpretation further, it is useful to return to the Agency model constructed in Chapter 8 of this thesis (see Table 8.8). In this context it can be argued that the FHN’s generalist, health-orientated community nursing role (as primed by Anne Jarvie between 1998-2004) had itself become a partially realised aspiration waiting for a new centrally advocated agenda so that it could become more fully realised. In this analysis, Paul Martin and colleagues can be seen as aware that Delivering for Health (and, in particular, its workforce capacity concerns) presented an advocated agenda with which this longstanding CNO aspiration could be creatively aligned. By offering a “tested” generalist health nursing approach, the FHN provided the basis of the new CHN solution, once the extra “baggage” associated with family was shed and the new core elements (anticipatory care; self care) were incorporated.

Despite her positional authority, CNO Anne Jarvie had felt unable to explicitly articulate her vision of a future with no District Nurses and Health Visitors due to the sensitivities of these professional groups at the time. In this new situation, CNO Paul Martin and colleagues felt they had sufficient agency to recommend the merging of district nursing, health visiting and family health nursing. In this regard it is important to note that the CHN solution goes further than the solution that had been tentatively proposed in Nursing for Health in 2001 (i.e. two core
community nursing roles: FHN and Public Health Nurse). The challenge ahead for the CNO and colleagues is how best to harness collective agency through forging alliances for advancement and adapting the policy initiative advantageously.

The interpretation presented in the preceding three paragraphs necessarily contains some speculative elements, as it has been beyond the scope of the thesis to conduct empirical research into the process of the 2006 Review. As such, a theoretical explanation of these most recent events is being posited, based on what has been learned about the SEHD’s development of family health nursing between 1998-2006. This assumes that the SEHD entered the Review with a substantive outline of a preferred option for the future of community nursing in Scotland. In the absence of empirical evidence, it is acknowledged that the latter assumption in particular is open to question and debate. Undoubtedly there is a need for future research into the Review processes, and this might include interviews with the Project Officers, the Steering Group members and those leading the Review at the SEHD.
9.4 PROSPECTUS

9.4.1 Back to the future: using “MAPPED” to anticipate influences and implications

In the preceding section of this chapter, the “Agency” model was used to analyse the SEHD’s process of formulating new community nursing policy. As seen in Chapter 8, the Agency model is part of the larger Integrated Model Explaining the Development of Scottish Family Health Nursing (IMEDSFHN; Figure 8.1) which was constructed through retrospective analysis. In this final section of the chapter which looks to prospects ahead, the IMEDSFHN model is used prospectively to anticipate influences on, and implications of, the Executive’s new policy initiative. As this represents the first more general application of IMEDSFHN as an analytic template, it is useful to rename it as the “Model for Analysing Policy to Practice Executive Developments” (MAPPED). In this way it is hoped to demonstrate its potential relevance for other developments in health and social care which are: initiated essentially through executive action; advanced in a “top down” way from policy through to practice using piloting as a control mechanism; and involve new role development. Figure 9.3 re-presents the IMEDSFHN model in its generic MAPPED form.
Figure 9.3: The Model for Analysing Policy to Practice Executive Developments

### Part 1: Initial policy formulation and advancement

<table>
<thead>
<tr>
<th>Agency</th>
<th>Aspiration</th>
<th>Awareness and anticipation of opportunities</th>
<th>Alignment around advocated agendas</th>
<th>Authority</th>
<th>Alliances for advancement</th>
<th>Advantageous adaptation</th>
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### Part 2: Taking the policy initiative forward towards enactment

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<th>Level of analysis</th>
<th>Mode of technological development</th>
<th>Mode of knowledge production</th>
<th>Mode of containment</th>
<th>Mode of strategic expansion</th>
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### Part 3: Key elements influencing articulation between policy and practice

- Professional and disciplinary theory
  - Ideals
  - Education and training
  - Production of initial FHN documentation

- Research/evaluation protocol translated into practice

- Structural constraints on dynamic instability
  (central control mechanisms to co-ordinate)
  e.g. Project officer and regional implementation groups.

- Regional and local organisational structure and practices
  - Characteristics of translating organisations
  - Effectiveness of communication strategies, monitoring and feedback

### Part 4: Translation and enactment of role at local PHCT level
As indicated previously, the recommendations of the 2006 Review will initially be taken forward in a two year Implementation Project whereby the new CHN role and associated service model will be tested and refined at four Development Sites. Concurrent, integral processes also include the revision of education programmes for new practitioners and existing practitioners, workforce modelling, and a commissioned evaluation. This strongly mirrors the actions taken to advance FHN policy, and thus Parts 2 and 3 of MAPPED give a template for mapping and analysis of the major factors and processes that will be involved.

Clearly the process of preparing FHNs has illuminated the nature of some of the educational challenges (left hand side of Figure 9.3, Parts 2 and 3). In this regard two major issues are highlighted for future programme developers. Firstly, how can an optimal mixture of content be achieved when district nursing, health visiting and family health nursing have already developed areas of in-depth, “specialist” knowledge? Commentators such as Kelly and Symons (2003) argue that in this context “shared educational programmes can only lead to inferior standards of care” (p. 142). Clearly the new seven core elements for community nursing roles will serve as foci for the marshalling of appropriate educational content, but this thesis has shown that the gap between a new conceptual model and the prevailing expectations for service delivery in practice can create significant confusions and tensions.

The second, related, issue concerns transition from established cultures of professional identity. As Williams and Sibbald (1999) note, erosion of professional identity can lead to demoralisation and diminished autonomy. The FHN educational programmes in Scotland were notable for the way in which they fostered a “new” professional identity based primarily around the family element which itself incorporated distinctive North American theoretical underpinnings. The challenge for the new CHN programme developers will be to develop educational content that will credibly underpin the core constructs of the proposed role so as to enable a motivating, unifying new professional identity to emerge.

Underlying both of these educational challenges are questions about the nature of the proposed changes to community nursing practice. In particular: how different is the new role going to be to its predecessors? (Figure 9.3; Part 4). Again the research in this thesis is relevant, in that it suggests that simply superimposing a new role title and its associated aspirations onto members of unchanged PHCTs is likely to produce minimal change. In the case of family health nursing, this meant that the family and health aspects of the new role had limited development as the primary care system required that they prioritise ill-health related needs of individual patients. One of the strengths of the proposed new CHN role is that it will be developed within the context of a new service model requiring redesigned core nursing teams.
As alluded to earlier in this chapter, Draft 5 of the Review had raised the prospect that these core nursing teams would predominantly address the needs of geographical communities within the 41 recently developed Community Health Partnerships (CHPs) which plan the integration of local health care and social service delivery in Scotland. Arguably this would have enabled the teams to work to a public health influenced template rather than a primary medical services one.

Interestingly, twenty years previously, the Cumberledge Report (DHSS 1986) recommended a broadly similar template for neighbourhood nursing teams in the UK. However this failed to evolve in practice, mostly due to GPs’ opposition to written agreements on PHCT objectives that seemed to imply that nurses “would be making an agreement as equal partners with GPs on what services should be delivered, how they would be delivered and by whom” (Walsh and Gough 1999).

As has been noted, the 2006 Review Final Report devolves any such decision on geographical or GP attached working to Health Board level (Figure 9.3; Parts 3; right hand side). As such, it is necessary to ask: what will change for community nurses in terms of teamwork and relationships with other professionals? (Figure 9.3; Part 4, Level 2). As the role of the Practice Nurse is not addressed in the Review’s new service model, it seems likely that there will be ongoing tension between general medical services and community nursing agendas. Within this context the role of community nursing leadership (Figure 9.3; Parts 2 and 3; right hand side) is highlighted, and the 2006 Review calls for courage and strong leadership, However, it is unclear how this will be fostered, supported and effected.
9.4.2 Back to the future: revisiting Kesby’s seven steps

As an intra-nursing initiative, the 2006 Review can be seen as radical in that it merges three disciplines and sets out a new service model. From the analysis of family health nursing undertaken in this thesis, however, it is necessary to question the extent to which the future development of community health nursing will be shaped by the hands, hearts and minds of nursing itself. In order to develop this point, it is useful to refer to the seven steps on the road to UK family health nursing that Kesby ambitiously set out in 2000 (p.122). Table 9.10 presents these.

Table 9.10: Kesby’s seven steps on the road to family health nursing

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<tr>
<td>1</td>
<td>Strengthen nursing policy in regard to its proactive contribution to health and social policy and in regard to devising nursing own policy, which will be capable of determining nursing practice and remit for purposes of protecting and preserving patients’ interests and the care they receive. This will determine what nursing care shall be and thus will define the nursing destiny.</td>
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<td>2</td>
<td>Reconnect the nursing executive with nursing practice and education, and thus unify nursing policy and strategic planning with practice and education.</td>
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<td>3</td>
<td>Take up the challenge of the present presented by the RCN and let nurses take charge of their own employment by setting up independent community nursing trusts and/or creating nurse team leaders as independent primary care practitioners who would be partners to GPs. The latter would need to be supported by local nursing committees to match the local medical committees, or there could be one local primary care committee.</td>
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<td>4</td>
<td>Ask the very important questions that were not asked in the 1960’s: Do the patients, their families and local population need a family health nurse? Is family health nursing the most effective way to continually meet the health needs of individual people, families, and the local population.</td>
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<td>5</td>
<td>This implies that the first step on the road is a revisit to needs assessment and population profiles in relation to family health nursing.</td>
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<td>6</td>
<td>Clarify the concept of family health nursing accordingly, leading to a shared vision as to what this is with implications for its realization, development and maintenance.</td>
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<td>7</td>
<td>Define, or redefine, as appropriate, the nursing roles in the integrated community nursing teams, including the team leader as the family health nurse, and revise their content in relation to one another. The team in its entirety should match the concept, and in its specific structure and function should match the needs and profile of the population that it has been designed to serve.</td>
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As Table 9.10 shows, Kesby was calling for UK nurses to rally round family health nursing so as to shape community nursing’s own destiny. As this thesis shows, this simply did not happen. Nevertheless, the 2006 Review of Nursing in the Community suggests that several of these steps are now being taken in Scotland, on the road to new community health nursing. If community health nursing replaces family health nursing in Table 9.10, it can be argued that the SEHD Review has positively addressed point 7. In its own distinctive way, the Review has also attempted to address points 2 and 4. Moreover the Implementation Project will necessarily involve attempts to systematically clarify the concept of community health nursing for Scotland (point 6).
From an SEHD perspective it could also be argued that the Review has addressed point 1, in terms of the creation of a new framework for practice and a new service model. While this might seem plausible on initial inspection, this thesis would question whether this really amounts to devising nursing’s own policy in a way that determines what nursing care shall be and defines its own destiny. Rather, community nursing is being reshaped once more in the image of the new policy preoccupations, with a premium on flexibility. This is not to say that the 2006 Review’s new vision of a generalist model is wrong. What evidence there is on the respective benefits of generalist and specialist community nursing models is essentially equivocal (e.g. McKenna, Keeney and Bradley 2003). It is, however, to be clear that essentially community nursing is responding to, rather than driving, change.

This highlights the importance of point 3 in Table 9.10 which calls for community nurses to take charge of their own employment by setting up independent community nursing trusts and/or creating nurse team leaders as independent primary care practitioners who would be partners to GPs. These more radical steps are not part of the Scottish Review, although Community Nurse Consultants become part of the new service model. It is pertinent to note that nurse “entrepreneurship” is being actively talked up in the more market influenced NHS in England (Pollock 2005), both by the government and by nurse leaders (e.g. Cook 2005). Moreover, the recent Revision of the Prescription of Medicines Act (2006) opens up prescription rights radically, enabling suitably qualified nurses and AHPs to prescribe a very wide range of medicines. As such, there are considerable opportunities for more autonomous community nursing practice. The analysis in this thesis clearly suggests that a less supine posture from community nurses and their leaders could do much to open up new nurse-led approaches to care delivery.

A relevant international perspective is provided by Lauder, Sharkey and Reel (2003) who advance an argument that Australian remote and rural primary care provision should engage in a root and branch restructuring. This would see Family Nurse Practitioners and GPs as the first point of contact for rural and remote communities and Family Health Nurses as the main care providers. Based on evidence of the current system’s failure to meet health needs, and evidence of the effectiveness of Nurse Practitioners, the authors argue for redesign of the whole system rather than the “fragmented and over-cautious manner in which nurse practitioners have, and are currently being, implemented in Australia” (p.3). In doing so they make the important point that at times nurses already undertake the GP role due to the demands of context. Accordingly they propose a national plan that explicitly addresses these issues through integrated redesign of services and educational preparation. Predictably this paper produced controversy and
opposition from some GPs, nurses and members of the Australian public who did not wish to see any erosion of medical cover.

Within Scotland a similar reaction could be expected to any proposal which overtly suggested that a group of community nurses should have independent contractor status like GPs and/or should substantively substitute for them in an explicit way. It has already been noted how the FHN development was managed to avoid any such associations. Indeed it also avoided exploration of how the FHN role might articulate with, or contribute to, any more radical Nurse Practitioner role. Nevertheless it was clear in the interview with Anne Jarvie that she saw integrated redesign of all PHCT roles (including the GP role) as the key for holistic community nursing development. In this respect it seems likely that there were again constraints on what could be publicly articulated by a government chief nurse. In this analysis, the FHN policy initiative and the 2006 Review can be seen as maintaining caution in regard to inter-professional boundaries, despite being seen as radical within the nursing profession itself.

The great leap forward would involve community nursing having explicit, substantive and influential policy input into the redesign of public health and primary care services as a whole. In this way community nursing development could move beyond “Type 1” change. The analysis in this thesis suggests that there are significant limits on the agency and advocacy that government nurses can or will exercise in this regard. As such, there is an onus on the nursing profession’s academics, managers, practitioners and professional representatives to more effectively advocate the potential contribution of community nursing to these public services.
9.4.3 The European prospectus

The foregoing call for advocacy will have resonance for many of the community nursing leaders involved in the WHO Europe pilot. The multi-national evaluation research report (WHO 2006), which was also published in November, details the efforts that have been ongoing in various European countries to develop family health nursing. As indicated in Table 9.1, the summative picture that emerges is one of very mixed progress within and across countries. While “the results demonstrate that there is a strong commitment by policy makers, stakeholders and providers about the FHN role” (WHO 2006; p. 4), the report also finds widespread problems in relation to: public and professional understandings of the role of the FHN; change management; and funding and sustainability.

As such, the future for family health nursing across Europe is unclear. With the lead country dropping the family focus, there may not be enough critical momentum to collectively advance family health nursing. This impression is sustained in the 2006 Review of Nursing in the Community in Scotland which reports that National Chief Nursing Officers agreed at a recent global meeting to review the European FHN model and share experiences of other generic community nursing roles through a “community of practice models approach” (SEHD 2006c, p. 9). In a sense, this brings the thesis story back full circle to its starting point in Chapter 3 where the generalist community nurse first emerged on the policy agenda at the Vienna Conference.
SUMMARY

In order to examine the influence and implications of the development of Scottish family health nursing, this chapter firstly undertook retrospective review of contingent, concurrent developments between 1998 and 2006. At European level, the progress of family health nursing was found to have been much slower than anticipated and very mixed in nature. Differences in structures, systems, finance, healthcare needs and priorities across different countries contributed to a diverse, fragmented picture.

Trends in the development of primary healthcare in the UK, such as the GMS contract, were seen to militate against family being the primary focus for care delivery. Leadership of community nursing continued to be particularly weak. In this regard the Scottish family health nursing pilot can be seen as relatively bold and radical, as it was essentially initiated from within nursing. Other UK countries were much more guarded about the idea of introducing a higher level generalist community nurse. Nevertheless, the SEHD kept options open by initiating the second phase of the FHN pilot in 2003, and by concurrently developing practice nursing. A new round of Scottish health care policy making got underway during 2005 and the resultant policy document, Delivering for Health, became the main driver for Scottish nursing policy.

The “perspectus” part of the chapter, viewed and reviewed Scottish family health nursing in the light of four significant documents which were published in a co-ordinated way during November 2006. The SEHD Final Report on the FHN pilot in Scotland affirmed the value of both phases of the pilot and presented a model for family centred healthcare which required whole systems change within primary care. Concurrently the swiftly undertaken SEHD Review of Nursing in the Community in Scotland was published. This presented a new service model with a new higher –level generalist nursing role at its heart, the Community Health Nurse (CHN). The envisioned new CHN role emerged as being very clearly related to the previously envisioned FHN role. The main difference was the dropping of the family focus, and the thesis argues that this was because enacting such a focus in practice was found to be too difficult. Thus the model for family centred healthcare advocated in the “sister” publication was not incorporated in the main Review. Rather the whole systems change was applied in an intra-nursing way, so that the disciplines of district nursing, health visiting and family health nursing were merged into the Community Health Nurse role. Within UK nursing, this can be seen as a radical reform. The process of formulating this policy change was analysed using the “Agency” model constructed in Chapter 8.
The last part of the chapter looked ahead to consider implications and future prospects. The explanatory model posited at the end of Part 3 of the thesis was deployed prospectively in its revised, generic “MAPPED” format in order to analyse the new Scottish development. This highlighted many issues similar to the FHN development. The question of optimal content for an educational programme to prepare CHNs, and the related question of an appropriate theoretical basis, both loomed large. Moreover, application of MAPPED raised questions about the extent to which practice will actually change for CHNs and their nursing teams, and whether community nursing leadership can influence the policy and practice contexts sufficiently.

The chapter concluded by considering possibilities for more radical nursing development, drawing from developments outwith Scotland. In this regard, there was also reflection and projection on the WHO Europe project as a whole.

In summary, this chapter has provided retrospectus, perspectus and prospectus. The former has enabled the findings from Parts 1-3 of the thesis to be examined in the light of other contemporary community nursing and primary care developments in order to understand influence and implications. The perspectus that emerged through analysis of new Scottish policy in 2006 highlights the importance of family health nursing in shaping the new Community Health Nurse (CHN) role.

Moreover, the integrative model that has helped to explain the development of family health nursing has also proven of value when deployed prospectively in its generic MAPPED format to analyse the new policy formulation advancing the CHN role. On this basis, the MAPPED model can be seen as potentially valuable for the analysis of other developments of this type that require purview from policy through to practice.
PART 5

CONSPECTUS

A summary of the knowledge that has been built in the thesis and its significance.

“But this is history. Distance yourselves.

Our perspective on the past alters. Looking back, immediately in front of us is dead ground. We don’t see it and because we don’t see it this means that there is no period so remote as the recent past and one of the historian’s jobs is to anticipate what our perspective of this period will be...”

Excerpt from a speech by Irwin, modern history teacher in Alan Bennett’s play, “The History Boys” (2004)
CHAPTER 10

SO WHAT?

Overview

This final chapter of the thesis aims to provide conspectus, or summary, of what has been learned about the development of family health nursing in Scotland and what this means in a wider sense. This relates to the final thesis research question which is cumulatively addressed within this chapter i.e. what significance has the resultant analysis for understandings of nursing and health care policy, education, practice, theory and research? Or to use the question that Labov (1972) sees as underlying all narrative performances: so what?

The conspectus is structured in three sections. The first considers what has been learned about family health nursing. The second considers what this means within the context of community nursing and primary healthcare. The last section considers what other useful learning has been generated. Within each of these sections there is also summary of the contribution of the thesis, its limitations, gaps in knowledge, and related recommendations.

10.1 WHAT HAS BEEN LEARNED ABOUT FAMILY HEALTH NURSING?

The above question can best be addressed by returning to research questions 1-3.

10.1.1 Why develop family health nursing?

The enquiry in the thesis has found that family health nursing developed in Europe as a continuation of an ongoing initiative to develop generalist community nursing with a strong public health dimension. However two key policy initiators (Dr Jo Asvall and Ainna Fawcett-Henesy) introduced the distinctive family focus in 1998 and aligned it with wider advocated policy. This reflected the beliefs that family is the key unit in society, and that nurses are well placed to engage with families on both health and illness matters. Chief Nursing Officer, Anne Jarvie, exercised similar agency in Scotland that enabled the FHN pilot project to start in 2001, although commitment to the family focus at policy level was less absolute.

The significant original contribution of this thesis is its critical analysis of: this policy formulation; the associated development of the FHN concept; and the initial advancement of family health nursing as a policy initiative in Scotland. In doing so, it has been necessary: to question assumptions that have gone unchallenged in the largely promotional literature on the topic; to further enquiry through interviews with key policy initiators; and to build understanding further by applying relevant theoretical perspectives. This has culminated in
construction of the new “Agency” model. It is contended that this model will be useful for analysis of related policy developments and an example of application has been given within Chapter 9.

The limitations of this cognate area of the thesis relate to the extent to which it is ever possible as an outsider to fully understand the political processes and influences involved in specific policy formulations. Nevertheless, it is contended that the interviews summarised in Annex 3 are notably reflexive in nature and yield considerable insights. Accordingly, two policy analysis recommendations can be made:

1) That further research is undertaken with key policy informants at European and Scottish levels to elicit their understandings of what has been learned overall from the WHO Europe FHN pilot project.

2) That, more generally, nursing researchers exploit the potential learning available by interviewing senior nurses about historically important developments in which they have had a leading role.

The thesis has also undertaken analysis of the “receiving” context for family health nursing in Scotland by examining historical, geographical and cultural influences on community nursing in the Highlands and Islands. This highlighted the lack of systematic study of community nursing practice in and across these regions. It is therefore recommended:

3) That an integrative academic study of the history of community nursing in the Highlands and Islands of Scotland 1912 – present is undertaken.
10.1.2 How did family health nursing develop in remote and rural Scotland between 2001 and 2004?

The answer to this question is best summarised by Table 6.2 which presents the set of primary understandings constructed through empirical research. After initial difficulties, and despite tensions between generic and specialist content, the educational programme for FHNs developed in an innovative way. The enaction of the FHN concept as a practice role also faced difficulties relating to operational definition, but it was possible to identify four typical patterns of practice development. Looking across these, the FHN role typically supplemented rather than supplanted pre-existing services. By 2004, FHN practice was diverse, and the overall picture of progress was a mixed one. Application of Walker and Avant’s concept analysis framework enabled comparison of the envisioned FHN concept with the enacted FHN role, and highlighted the different criteria that were being used to assess role development.

This empirical research into education and practice has been important as a basis for understanding the enacted development. In the process an innovative evaluation framework has been designed and applied, and knowledge has been built through typology construction and testing. The research summarised in Chapters 5 and 6, detailed in Annexes 1 and 2, and published in the five bound-in papers comprises a substantive and original body of work that provides the most in-depth textual analysis of this phenomenon to date. This work has already influenced Scottish policy. The main limitations of this work are that it: examines some time periods in more depth than others; addresses professional perspectives more than those of patients and families; and is based on limited study of community nurse managers’ perspectives. Moreover, it was originally driven by prescribed SEHD objectives.
10.1.3 Why did family health nursing develop in the way that it did in Scotland?

The thesis has had the more ambitious goal of building understanding of why matters progressed as they did, particularly in relation to policy and practice. Table 8.11 provides a narrative answer to this question by presenting an explanatory synoptic story constructed through the application of relevant theoretical perspectives to the previous set of primary understandings. This story incorporates the significant factors which influenced the behaviour of key actors, and thereby shaped the development.

These key factors and related processes are presented in a different, but complementary, format in Figure 8.1. This integrated explanatory model posits the importance of: the agency involved in FHN policy initiation and formulation; the multiple contingencies present when FHN policy was advanced towards enactment through a piloting mechanism; the key elements that were found to influence articulation between policy and practice (e.g. professional education, research protocol, and organisational structures and practices); and the importance of locally situated power, established service priorities, and the embedded culture of place in influencing the translation of policy into enactment as family health nursing practice. In doing so, the model develops relevant existing theoretical perspectives (e.g. Bergen and While’s model and May et al.’s model) in the light of new empirical knowledge of policy, education and practice.

While the integrated model is useful for focusing on one particular development, it must also be acknowledged that a range of other initiatives/developments will be impacting concurrently at any time in the practice setting. With this in mind, the thesis has also developed the “Living Plaid of Remote and Rural Primary Care Model” (Figs 7.5 and 7.6).

It is contended that both of these models offer useful new ways of visualising and understanding healthcare developments that require purview from policy through to practice. In a new generic formulation called Model for Analysing Policy to Practice Executive Developments (or MAPPED for short), the explanatory model has been applied within the thesis to analyse the planned new 2006 Scottish community nursing development. However, the limitations of the new models constructed in this thesis relate to their specificity and limited application to date. Accordingly two further recommendations can be made which relate to theory development:

4) That the explanatory value of MAPPED is explored and developed in research involving other community nursing/primary care policy initiatives which are “top-down” in nature and involve new role development in practice.
5) That the explanatory value of the Living Plaid model is explored and developed in research involving remote and rural, and other community nursing/primary care developments.
10.2 WHAT DOES THIS MEAN WITHIN THE WIDER CONTEXT OF COMMUNITY NURSING/PRIMARY HEALTHCARE?

This section of the conspectus is concerned with the meaning of the development beyond the particular world of family health nursing. In this regard it relates specifically to research question 4: what does this mean in terms of the development’s influence and implications? Given that the thesis has sought to build an explanation of a phenomenon in contemporary nursing history, this section also engages with Alan Bennett’s challenge to view the development in historical perspective.

10.2.1 The beginning of the end: a family loss

This challenge was addressed within Chapter 9 where the Scottish FHN story was re-framed, interpreted and updated in the light of relevant concurrent and contingent developments. This means that the thesis spans the birth, development and ostensible demise of family health nursing in Scotland. However, as the analysis in Chapter 9 shows, the new CHN role proposed by the 2006 Review of Community Nursing in Scotland can be seen as a direct descendent of the FHN. Thus, at time of writing at the end of 2006, it is either the beginning of the end for Scottish family health nursing, or the end of the beginning.

If the former interpretation is made, it is predicated on losing the FHN title and the distinctive family focus. As has been seen, the educational programme was successful in fostering this focus through the family systems approach which sees the family as the unit, client and focus of care. However one of the key lessons to emerge from this thesis is that the aspiration to engage seriously with whole families across a range of health and illness issues is very ambitious and very difficult to enact within the current primary care system. For the FHNs this was exacerbated by the generalist requirement to concurrently address individuals and communities’ needs. The thesis has shown how the breadth of the FHN concept at both WHO Europe and SEHD levels, made it difficult for professional colleagues and patients to understand the proposed role (particularly the family focus) and why it was needed. Moreover during the Scottish pilot there was considerable lack of clarity over: what FHNs were expected to achieve in terms of the breadth and depth of their family care; related prioritisation within the delivery of family care; and the relationship of this work to the servicing of caseloads of individual patients. As the thesis has shown, this was usually resolved at practice level by the latter demand being given priority. All these points have direct relevance for the development of the new CHN role.

This is not to suggest that all families missed out on necessary care from the individual FHNs. Rather the thesis argues that it is very difficult to systematically operationalise meaningful
family focused/centred care if it is not a priority for other colleagues and it is not incentivised through policy. Despite appearing in the Final Report on the FHN pilot to endorse Parfitt et al’s model for just such a whole systems change in primary care, the SEHD position in the Review of Community Nursing shows that it does not intend to pursue this.

In a sense the whole 1998-2006 historical episode can therefore be seen as a first, and possibly last, stand for a family focused generalist role within Scottish community nursing. As the thesis has shown, the explicit family focus was out of kilter with trends in primary care provision. A close reading of the GMS contract shows that family care is essentially a contextual, rather than a focal, requirement for GPs, and that the phrase “Family Practice” is largely retained rhetoric. Beyond primary healthcare, it is interesting to note that social work has long recognised the tension between family-as-context and family-as-client in the practice setting (e.g. Horobin 1986).

In effect, the end of the episode leaves a cadre of just under 50 nurses with a distinct NMC recordable qualification that seems set to become one of the relics of the register. As they will presumably be offered the facility to become CHNs, there is further potential to learn from their experiences. Consequently it is recommended:

6) That a follow-up study be undertaken 3-5 years hence to elicit these FHNs reflections on the episode, and the key similarities and differences between the FHN role and CHN role in practice.
10.2.2 The end of the beginning: informing the future development of the generalist community nurse

Thus, the particular title of FHN will soon be defunct. If this is seen as the end of the beginning of a continuous cycle of development of the generalist community nurse, however, it is useful to summarise the transferable knowledge that has accrued.

With family removed from the centre of the picture, the relevance of the family health nursing development to broader discourse within community nursing lies in its contribution to the debate between generalism and specialism. In this regard the thesis is the first systematic study of the first national-level attempt within the UK to introduce a higher-level generalist community nursing role into the specialist-dominated present system. Nevertheless, the findings do not conclusively support either side of this debate. In effect they show that a generalist role in remote and rural regions is very useful for community nurses, their PHCT colleagues, patients and families, and communities at large. However this has not been seen to preclude the value of other specialist nursing posts that have continued to co-exist while family health nursing has been developed. Moreover, family health nursing is by no means the first generalist community nursing role to exist in the Highlands and Islands of Scotland, as triple and double duty nurses will testify.

The flexibility of the generalist nurse emerges strongly from the thesis, and there was little evidence that the new educational preparation and role aspirations were detrimental to the nurses themselves, or others. These were experienced community nurses who were able to adapt creatively to the intra-role conflicts involved. Moreover they were given much flexibility to interpret the role as they saw fit in practice. However it is difficult to know whether the advantages of generalism found in the remote and rural context would extend to the urban contexts in Scotland. The supernumerary status of the urban FHNs is too atypical to make inference in this regard.

Nevertheless, the thesis findings suggest three points of particular relevance to the new CHN role:

- preparing a new generalist higher level community nurse is a significant challenge in terms of programme content and theoretical underpinnings. The programme for Scottish FHNs showed some innovative ways forward as well as some of the pitfalls
- community nursing practice is very much influenced by local needs, context and pre-established roles. Simply re-naming a role will not ensure change. Rather, PHCT priorities and shared understandings have to be addressed
where there is intra-role conflict because of role overload, family and health focused work tends be accorded less priority than the illness-related problems of individuals.

The major differences in the new scenario envisaged in the 2006 Review of Community Nursing in Scotland are that:

- The new CHN role incorporates existing FHN, DN and HV roles, rather than just adding on a new one
- There are seven new core elements for community nursing practice and an associated new service delivery model to structure nursing teamwork

As has been seen, concerns voiced within Scotland have centred on dilution and loss of specialist skills, and related fears that health promotion and public health work will not be prioritised within the new generalist role. The thesis offers some support for such concerns, in that this was the case for many FHNs when workload was busy and triple duty nurses often described a hierarchy of priorities with community development work at the bottom.

There is also some support for such concerns about practice and educational preparation within community nursing literature (e.g. NCNM 2005; Begley et al 2004; Kelly and Symonds 2003), but relevant empirical studies are few and far between. Perhaps McKenna, Keeney and Bradley (2003)’s paper best captures the equivocal nature of the evidence in this debate. On the one side, they outline the problems associated with an over-generic community nursing workforce, using the Republic of Ireland as an example. These problems are similar to those mentioned above. On the other, they outline the problems associated with an over-specialised community nursing workforce, using Northern Ireland as an example. In the latter category, the risk of role duplication, overlap and an associated lack of one identifiable co-ordinating nurse is most prominent. It is interesting to note that the introduction of the FHN in remote and rural regions seemed to change little in this regard, because it essentially supplemented other established specialist roles.

Thus the thesis highlights both useful and more problematic aspects of the generalist role in practice, and adds to this particular debate rather than resolves it. However, there is clearly imminent opportunity to study transition from several key specialist roles into the one new generic role. The SEHD have signalled that this will be part of a commissioned evaluation. To this end, it is pertinent to recommend:

7) That evaluation of transition to the CHN role incorporates sufficient opportunity to study previous practice so that any change can be gauged and understood in context.
10.2.3 The Scottish FHN development as an exemplar

The thesis offers a particular contribution to understandings of how community nursing policy can be initiated and developed. As the thesis has argued, the FHN development in Scotland can be seen as a relatively rare example of a nursing-initiated policy, albeit one whose advancement was couched in the risk management strategy of a pilot. Within the ambit of UK community nursing, both the FHN and CHN policy initiatives can also be seen as relatively radical in comparison to the approaches advanced within the other three UK countries. Moreover, both initiatives have implications at UK national level in terms of their status on the NMC register. In this context, the development of family health nursing in Scotland 1998 – 2006 can be seen as a vanguard community nursing development. Therefore it is important that study of it is widely disseminated. To this end, it is recommended:

8) That a paper giving purview of the FHN development from policy to practice is submitted for publication, based on the work in this thesis.

In effect, one of the underlying questions with which the thesis has grappled is: how do you effect major change in community nursing? In this regard the thesis has shown the need to anticipate important factors, processes and potential problems within an integrated plan. As MAPPED has emerged as very pertinent to the new Scottish community nursing reforms, it is recommended:

9) That MAPPED is used specifically to inform the evaluation of the new Implementation Project arising from the 2006 Review of Nursing in the Community in Scotland.

This thesis has also identified the need for clarity about the nature of any new role and the change envisaged, so that other members of PHCTs may understand and support what is being developed. The Living Plaid model, developed in the thesis, may be useful in this regard as it encourages consideration of the place of any development within a particular context. Study of the Scottish FHN development shows that there is scope for innovation within community nursing at policy, education and practice levels, but that community nursing operates in a wider context dominated by medical and health service management priorities. The strength of the new 2006 Scottish community nursing reform is that it seeks to redesign the whole nursing team, rather than just fit in another role. Its weakness is that it remains essentially an intra-nursing development, with little apparent influence on the fundamental design of primary healthcare delivery systems.
10.3 WHAT OTHER USEFUL LEARNING HAS BEEN GENERATED?: THE THESIS AS AN EXEMPLAR

The thesis has pursued and analysed the development of an idea in Copenhagen, through its reformulation as a policy initiative on Calton Hill, through its enactment in classrooms in Inverness and croft houses in the Outer Hebrides, and back again. Studies of this scope are relatively rare in nursing. As Hennessy (1999) points out, studying policy and implementation processes retrospectively is potentially very valuable, but is time consuming and usually left to academics. Perhaps this study is even more unusual in studying some of these processes concurrently.

In this regard it is contended that the thesis exemplifies an innovative approach to analysing the history of an idea. The thesis design, as summarised in Figure 1.3, provides a useful framework within which the conceptual and chronological development of an idea can be explained. The challenge in this approach is that it involves a slightly different way of conceptualising and presenting a thesis (e.g. eschewing one literature review chapter). While in this instance the design framework has been applied to explain the “top-down” type of transmission and translation of an idea, it may be that it is also suited to other story types or archetypes. Moreover, it seems likely to have more generic application beyond the particular world of nursing and other practice based professions. Thus it is recommended:

10) That the thesis design framework be further disseminated as an exemplar for scholars undertaking studies of the history of ideas.
10.4 CONCLUSION

This thesis has addressed and answered five central research questions. In doing so, it has presented an original explanatory analysis of a significant development in the history of Scottish and UK community nursing, and has examined its influence and implications. The analysis within the thesis has been shown to have:

- significance for nursing policy, practice, research and theory in terms of its generation of specific new knowledge about family health nursing
- significance for healthcare policy, practice, research and theory in terms of its generation of new analytic models
- relevance for scholars in terms of its design approach
- relevance for community nursing’s educators and students in terms of its analysis of the role of education within the wider development

On this basis it is contended that the thesis makes a useful academic contribution which can inform further development in the above areas.
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