Evaluating Family Health Nursing Through Education and Practice
EVALUATING FAMILY HEALTH NURSING
THROUGH EDUCATION AND PRACTICE

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GLOSSARY OF TERMS, ABBREVIATIONS AND ACRONYMS

APL: Accreditation of Prior Learning (certificated learning). See credit exemption.

APEL: Accreditation of Prior Experiential Learning. See credit exemption.

ASLIB: Electronic data-base of UK theses.

ASSIA: Applied Social Sciences Index and Abstracts.

Auxiliary nurse: a health worker who is not a registered nurse but who assists in the care of those on the district nursing caseload.

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

CINAHL: Cumulative Index to Nursing and Allied Health.

Clinical practice assessment: Assessment of the student’s ability to achieve specific learning outcomes related to the practice of nursing. Involves a range of evidence about knowledge, skills, attitudes and understanding.

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

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

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

Community Profile: a written appraisal and analysis of the FHN’s geographical practice area (including community health issues).

Community Psychiatric Nurse (CPN): a registered nurse who has a specific specialist qualification to carry out mental health nursing work in the community.

Core (e.g. core module): applicable to all areas of community nursing practice.

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

Credit exemption: as part of APL or APEL, a mechanism whereby a student is given exemption from undertaking particular course components (e.g. module(s)) if he/she shows satisfactory evidence of relevant, current and sufficient prior learning.

Distance learning: flexible mode of learning that requires minimal attendance at an educational institution. Learning materials are usually made available to students in paper or web based formats and assessments are completed at the student’s own pace.

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

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

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

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

Family Health Nurse (FHN): a “new type of nurse” proposed by WHO Europe in 1998. Their envisaged role is community based and multifaceted. It includes helping individuals, families and communities to cope with illness and to improve their health. The full WHO Europe role definition is given at the start of Chapter 1 of this report.

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

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

Generalist: pertaining to knowledge and/or practice that is not distinctive in its boundaries and requires broad understandings across a range of subject areas.
**Genogram**: a diagram of the family constellation which depicts the relationships among family members for several generations. Their structure resembles conventional genealogical family tree diagrams and they often include the mapping of health status/issues.

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

**IBSS**: International Bibliography of the Social Sciences.

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

**Midwife**: a health professional who has a specific qualification and registration to care for women through pregnancy, childbirth and a short period thereafter.

**Module**: a self-defined part of a degree programme which has its own assessment processes. Sometimes the term “Unit” is also used in the same sense.

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

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

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

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

**Placement**: a community-based setting to which the student is allocated in order to learn from practical work experience.

**Portfolio**: a collection of evidence that aims to demonstrate prior learning related to a particular course (or course element).

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

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

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

**SCOTCAT:** an acronym for Scottish credit and accumulation transfer and refers to the academic levels of learning that students have undertaken. To obtain a Bachelors degree from a Scottish University the student would normally accumulate credit at different academic levels. The levels generally equate with the year of the course: thus Level 4 would normally be the academic work undertaken in the fourth year of a classified degree programme. In the Scottish education system there are two types of Bachelors degree. The unclassified degree which finishes at Level 3 and the classified degree which finishes at Level 4. The term SCOTCAT can also be referred to as Scottish Degree Level.

**Scottish Executive Social Research (SESR)**

**Scottish Executive Health Department (SEHD)**

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

**Specialist:** pertaining to knowledge and/or practice that is distinctive in its boundaries and requires in-depth study and understanding. Often requires educational input at advanced level.

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

**Supervisor:** in this context a registered nurse with a community specialist practice qualification whose role is to support and educate the student in the placement setting.

**Supervisory visit (also sometimes known as “social visit”)**: a rather ill-defined term used differently by different District Nurses, but usually referring to a general health checking visit. Often these are for the elderly and particularly those living alone. At some sites these are formally scheduled to take place every 3/6 and 12 months, at others they are done as and when required.

**Support visit:** again a rather ill-defined term used differently by different District Nurses, but usually referring to a more specific, targeted visit where, for example, blood pressure would be monitored.

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

Triage: a term used to describe a systematic process of assessing care needs, deciding on their relative priority and planning immediate interventions (usually in the context of competing demands)

Triple duty nurse: a nurse whose job combines 3 distinct professional roles. In remote and rural Scotland the traditional combination is District Nurse, Midwife and Health Visitor.

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

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

ZETOC: Electronic Table of Contents from the British Library.
EXECUTIVE SUMMARY

BACKGROUND

1 In 1998 the World Health Organisation (WHO) Europe proposed a new type of nurse that could be based in local communities. The envisaged role of this Family Health Nurse (FHN) was multifaceted and included helping individuals, families and communities to cope with illness and to improve their health. The FHN and the Family Health Physician were presented as the key professionals at the hub of a network of primary care services.

2 The Scottish Executive Health Department saw this as a potential solution to some of the problems of providing health care in Scotland’s remote and rural regions. In these regions there is increasing difficulty in recruiting, developing and retaining all health professionals, and within nursing and midwifery sustaining the traditional double and triple duty roles has become particularly problematic. Early in 2001 a 2 year “pilot” project began. Three regions in northern Scotland were involved initially, with a fourth joining the project in 2002.

3 A Scottish University was commissioned to provide an educational programme to prepare nurses from these regions. Initially it was envisaged that two educational programmes would be available: a shortened course for nurses with an existing community specialist practitioner qualification (e.g. District Nurses, Health Visitors) and a 40 week course for registered nurses with a minimum of two years post-registration qualifying experience. When education started in February 2001, however, only the arrangements for the 40 week course were in place. Eleven students (Cohort 1) subsequently undertook this course during 2001 and twenty students in 2002 (Cohort 2).

4 The educational course was based at a campus in Highland region but students’ clinical practice placements and some theory-based learning took place within their own respective regions. The Scottish Executive paid the students’ salaries, course fees, travel and accommodation, and the Health Trusts/Boards in the participating regions resourced temporary replacement staff. After completing the course the new FHNs returned to their home base sites and started to develop the role in practice.

5 In February 2001 the Centre for Nurse Practice Research and Development (CeNPRaD) at Robert Gordon University, Aberdeen was commissioned by Scottish Executive Health Department to undertake an independent research evaluation. The overall aim of the study was to evaluate the operation and impact of family health nursing in specific remote and rural areas within Scotland. This included evaluation of the new educational course.

6 The evaluation design was informed by two key approaches to evaluation research (Pawson and Tilley 1997; Guba and Lincoln 1989) and by case study methods (Yin in 1994). As such, the evaluation was primarily grounded in qualitative research methodologies, but it also incorporated quantitative data obtained from questionnaires.

7 The pilot project’s goal was thus to simultaneously develop and integrate a new education programme and practice role within a short space of time while under the scrutiny of an independent research evaluation. This ambition was bold, innovative and inherently challenging.
THE EDUCATION OF FAMILY HEALTH NURSES

8 The educational course award was Bachelor of Nursing in Community Studies (Family Health Nursing). The course was designed to be compatible with a curriculum suggested by WHO Europe, and with the UKCC (now NMC) framework for nursing specialist practice qualifications. Validation by the NBS (now NES) was completed in July 2001. Students attended full-time and undertook a fixed sequence of modules.

9 Evaluation of this course involved systematic collection of evidence pertaining to comparative educational processes (e.g. review of other relevant curricula), participant experiences (e.g. interview and questionnaire data from students, supervisors and teachers), and performance (e.g. observation of teaching and assessment; review of course work).

10 Between the commencement of the first and second cohorts of students (Feb 2001 and Feb 2002) a number of major curricular modifications took place. These included clarification and revision of learning outcomes; construction of a scheme for Accreditation of Prior Learning; development of a programme to prepare supervisors; and development of assessment methods and course documentation. Evaluation has focused on this more developed curriculum.

11 Evaluation was also informed through review of educational curricula documentation pertaining to community-based courses for nurses, midwives and health visitors across all Scottish University Higher Education providers. These courses differed from the family health nursing course in that they gave students more flexibility to negotiate learning outcomes and the time taken to complete the programme. They also typically shared core modular content with other community education courses.

12 The family health nursing course differs from these courses (and WHO Europe’s suggested curriculum) in that it has no modules dedicated to quality issues, teaching and supervision, management or leadership. Rather it is much more focused on its speciality and is theoretically grounded in an ideology of nursing which combines elements of Family Nursing from North America with the promotional ideas from WHO Europe.

13 However the course also incorporates a range of generic content and the combination has not always been congruent. This is seen particularly in the module on Advanced Family Health Nursing Practice where there is lack of definition, challenge and match of content to assessment procedures.

14 Eleven of the Cohort 2 students obtained some exemption under the scheme for Accreditation of Prior Learning. This meant that they did not have to attend campus during their “AP(E)L” weeks, but most had to return to their jobs, and all still had to complete the modular assessments. This was an unsatisfactory practice from the perspective of students, teachers and by any understanding of APL and APEL processes.

15 As such there is scope for course redesign and the report suggests a restructuring of modular delivery as a starting point. This involves having two modules in the first semester that could be shared with other community based programmes and facilitate credit exemption.
16 The nurses who undertook this course were typically middle-aged females with considerable experience of nursing in general, and of community nursing in their particular remote and rural location. Twenty (65%) were midwives. Twenty (65%) had no specific community specialist nurse qualification and were employed in E or F grade posts. Cohort 1 students in particular felt undervalued and underdeveloped prior to coming on the course.

17 Practice placement supervisors were typically District Nurses or Health Visitors. During the first eight months of the first year of the course, a range of problems with support and supervision was apparent. Students and supervisors concurred on the need to improve selection, preparation and support for supervisors. Many of these difficulties were subsequently addressed and Cohort 2 students were significantly less dissatisfied with their placement experiences. However some problems persisted, with supervisors still not feeling well prepared and lacking dedicated time for the role.

18 Both cohorts of students identified communication skills (e.g. interviewing, listening) and family health assessment/promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) as the most valuable skills they had learned during their clinical placements. The family health skills were seen as central to their emergent new professional identity. The single most valued aspect of campus based learning was the actual process of coming together to learn, share ideas and experiences. In addition family systems theory, communication and IT skills were emphasised, along with research.

19 Teachers also saw the balance between campus attendance and distance learning as being a strength of a course that was very much tailored to a specific market context. There was recognition that to be viable in other contexts the course would require modification. This might involve a greater proportion of distance learning through the innovative web based facility used during the course. On return to practice some of the new FHNs remained active in using the web based facility to maintain learning and support, but five lacked access to reliable internet facilities at work.

20 One of the persistent difficulties for students, supervisors and educators was the simple fact that until 2002 the FHN role was hypothetical. This entailed much uncertainty. Students were concerned about using families for assessment purposes and then moving on while the family’s care reverted to established services. The fact that this new way of working was only being used for educational purposes in the first instance raises a number of important issues regarding: the introduction and management of a new role into an established service; the ethics of using students as change agents and the expectations of the public.

21 Considerable effort has gone into the educational preparation of Family Health Nurses. The resultant programme is distinctively different from other specialist community nursing programmes and has growth potential. In this regard a number of suggestions for further curriculum development are made within this report.

22 The evaluation has highlighted strengths and weaknesses within an educational course that provides a precedent for other educational providers to reconsider their approach to specialist practice degree level education.
FAMILY HEALTH NURSING PRACTICE

23 In evaluating family health nursing practice the principle unit of analysis was the site where each FHN was working. During 2002 ten FHN sites were studied in depth. This involved extensive profiling of local context; health needs; Primary Health Care Team (PHCT) staff, roles and working practices; and caseload size and mix. Each site was visited several times to interview staff, collate data, take field notes and undertake limited observation of practice. The care of two families at each site was studied in detail.

24 From these 20 families six were selected for in-depth case study. This involved interviewing family members, the FHN, and a maximum of two other health professionals who had involvement with the family.

25 Questionnaires were sent to all the members of the Primary Health Care Team at each site prior to the introduction of the new role and again one year later. In the same way a more limited questionnaire was sent to a random selection of 20 members of the public at 7 of the sites. These questionnaires asked for views on the operation and impact of the new role.

26 Through analysis and synthesis of the above data sets it was possible to construct a typology of family health nursing practice. This identified four distinctive patterns relating to the context of the development, the process of engagement and the outcome of practice. These "CPO" patterns were subsequently given brief labels.

27 Two small island sites shared the following High scope-slow build pattern:

Context: Small, stable caseload. High pre-existing scope for nursing autonomy and practice development
Process: Gradual introduction of the role by FHN only with little/no change in other professionals’ working practices
Outcome: Positively viewed by the limited number of families who received the service, but not seen by colleagues and general public as substantially different from pre-existing service. More satisfying for FHNs but also more demanding

28 Three sites covering large geographic areas shared the following Slow build-key ally pattern

Context: FHN role super-imposed on “non-heavy” district nursing caseload within established and functional medium sized PHCT
Process: Gradual introduction of the role by FHN with active, focused support from one or more professionals within the core PHCT
Outcome: Positively viewed by the limited number of families who received the service (often specific client groups). “Normal” district nursing services maintained. FHNs generally feel they are making progress

29 Four sites shared a Slow/No go pattern, with three having the following pattern:

Context: FHN role super-imposed on “heavy” district nursing caseload within established and functional medium sized PHCT.
Process: Sporadic and limited introduction by FHN only, with little/no change in other professionals’ activities.
**Outcome:** No substantive change in practice. “Normal” district nursing services maintained, but remains stressful for FHN and colleagues.

30 One site had a distinctive **Bold build** pattern:

**Context:** “Heavy” district nursing caseload within established medium sized PHCT, but FHN not super-imposed.

**Process:** New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals’ roles. Tensions within core PHCT.

**Outcome:** Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. “Normal” district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding.

31 Thus evaluation of the first year of family health nursing practice found that the role can be developed in a limited way on top of a district nursing caseload and within pre-existing resources. This typically involved the supplementation, rather than the supplanting, of “normal” community nursing activities.

32 The presence of at least one of the following two factors appeared to be a necessary condition for progress: (i) the perceived scope/space to encourage implementing this approach (ii) the local presence of at least one active supporter who changes their own practice

33 The in-depth family assessments that the FHNs tried to undertake tended to be time consuming and difficult to orchestrate. However this new approach was generally well received by family members. Few professional colleagues were active in referring families to the service and even where the role was legitimised through referrals it could not necessarily be prioritised by the FHNs as there was a “bottom line” expectation that the pre-existing level of community nursing service must be maintained.

34 At one site the role was developed outwith the district nursing caseload and the FHN practised in a more autonomous way. Again family health nursing supplemented pre-existing services by expansion into gaps, but characteristically this involved more sustained, in-depth care programmes. This presents a different type of role that has more potential resource implications if replication is sought.

35 During the first year of practice FHNs usually operated alone and their activities were often not well understood by colleagues. This made integration problematic. There is a need for much stronger local programmes of support and facilitation if the role is to be developed and sustained. This should be part of wider review and development of PHCT working practices and should include review of caseload management and staff skill mix.
THE WIDER SCOTTISH CONTEXT

36 In order to inform our judgements about the applicability of a family health approach to community-based nursing in the wider Scottish context, we carried out 19 telephone interviews. These were held with key informants selected from other Scottish NHS Trusts and Health Boards providing primary care services and their respective Local Health Councils. Perceptions of existing community nursing services, education and the potential of the FHN role were explored.

37 These findings suggest that overall community nursing services are adapting to the policy changes which have been advocated and that current educational provision is generally perceived as good. However there were concerns about duplication of effort, territorialism and recruitment. Perceptions of family health nursing varied widely.

IMPLICATIONS FOR ROLE DEVELOPMENT

38 We found that the educational process for family health nursing has provided experienced nurses with personal and professional development encouraging a graduateness to emerge whereby the individual can reflect and analyse situations. All students have attempted to embrace the ideology behind family health nursing but so far the majority have struggled to substantively incorporate the ideas into practice.

39 We suggest that there are three areas where active facilitation is required in order that the role of those Family Health Nurses currently in post can be developed further:

- Enabling the FHN role to merge with current service provision in a meaningful way
- Developing the core primary health care team in order that they can incorporate a more systematic focus on family and health into existing services and care practices.
- Involving patients and the wider community to expect, accept and value a different approach to nursing care in particular and health care in general.

40 Furthermore we suggest that prior to introducing family health nursing as a new role service providers conduct a comprehensive analysis to plan, facilitate and sustain the development. This should include situational analysis (e.g. why is the role needed?); role analysis (e.g. what work will be done in the new role); cultural analysis (e.g. how will it fit with current practices and understandings); and business analysis (e.g. what resources are available to support and sustain the new role). As such, any development of the FHN role should be considered as part of wider service review and redesign. This would enhance the potential of the FHN role to be a solution to the particular problems of recruitment, development and retention of staff in remote and rural areas.

41 It seems likely that in the short term in Scotland there will be inherent ongoing tension between the distinctive family focus of the role and the demand within the system for generalist activities prioritised around individuals’ needs. Whether this tension proves dysfunctional or not will depend on the extent to which the role can be facilitated and the extent to which PHCTs are willing to engage in practice review and service redesign. If the latter activities are successful it is possible to envisage the *Slow build* types, and the *Slow/No
go types, developing significantly as part of more integrated, family orientated services. In turn this would lead towards a critical mass being achieved that would present a stronger argument to inform debate about changing the present UK system of community specialist practitioner roles.

42 This evaluation has studied the formative stages of the Family Health Nurse role. In attempting to simultaneously develop national policy, education and service delivery the FHN initiative in Scotland has achieved much in a short space of time, but so far the scope of the necessary change process has been underestimated. In order to capitalise on the achievements to date we suggest that:

- Planned development is facilitated with those PHCTs that include a Family Health Nurse in order that the role can be understood and developed further.
- The critical mass of FHNs is helped to grow in the remote and rural areas.
- The educational programme is further developed as suggested in Chapter 2.
- The evaluation is disseminated widely across the UK to foster debate and critical thinking about the nature of community nursing services and suitable educational preparation.

43 The evidence from this evaluation indicates that considerable effort has gone into this initiative. What has been achieved to date should neither be underestimated nor allowed to wither on the vine.
PREFACE

Since devolution in 1997 a number of distinctive policy developments have influenced the practice of health, education and social services within Scotland. Changes in the structure of the health service, a refocusing on public health and the development of policy pertaining to social justice have led to the introduction of a programme of initiatives at grass-roots level that attempt to develop services and annex previously uncharted health ground. This is exemplified by the various social inclusion programmes which have been developed across Scotland; the redesign of health services especially in remote and rural areas; and the introduction of the role of public health practitioners. The initiative to “pilot” the World Health Organisation (Europe)’s Family Health Nurse concept in remote and rural areas of Scotland can be seen as part of this greater impetus to look at new ways of working within health and social care.

In attempting the co-ordinated introduction of this new, national level, generalist community nursing role the Scottish Executive has taken forward a bold and ambitious initiative. This initiative has sought to simultaneously develop and integrate a new community nurse education programme and a new practice role within a short period of time. Such work is complex and has involved co-ordination over a large geographical area and across disciplines. Those involved in change management in primary care services will recognise the magnitude of this challenge, especially given the established culture of specialist community nurse education and practice within the UK.

Leadership work of this type entails willingness to take some risk in the process of moving forward. At the project’s inception, the Scottish Executive commissioned this concurrent, independent research evaluation so that lessons could be learned and shared about the operation and impact of family health nursing. This aspiration has enabled our work as evaluators and in this spirit the report seeks to contribute a perspective that is both critical and constructive.

The report presents a detailed account of the evaluation and is aimed at those with an in-depth interest in the subject matter (e.g. particular health service staff; educationalists; researchers). It is organised in five chapters, each of which is designed to be sufficiently free-standing that it can be viewed in isolation by the reader with a particular interest. Chapter 1 sets the scene by establishing the context of the evaluation. Chapter 2 overviews educational context before presenting a detailed examination of the educational preparation of the Family Health Nurses. Chapter 3 examines the family health nursing practice that took place during 2002. The Scottish primary care policy and practice context is then examined in Chapter 4 as a basis for consideration of the implications for further development of the FHN role in Chapter 5. The

1The adoption of the term “pilot” in the Scottish Family Health Nurse Project suggested that it would be tested, controlled and manipulated to determine its efficacy. However, like all good social experiments control over the Family Health Nursing initiative has been impossible to achieve in a dynamically charged context of primary care where change is constantly being introduced. As the evaluation progressed the term “pilot” gave way to “action research” with a few key brokers using this language in an attempt to appreciate what was happening as unforeseen developments took place. From our perspective the Family Health Nursing initiative could not truly be considered as “action research”. There was limited systematic incorporation of formative intelligence from the evaluators; practitioners or educators. At the end of the day what we have is the evaluation of a policy initiative not the strict testing of a Pilot nor the evaluation of an action research project.
The report focuses very much on the Scottish experience of implementing the Family Health Nurse concept. At WHO Europe level it was initially suggested that 17 other continental European countries would also be taking part in the development of the new FHN role through parallel processes of education and implementation. These linked national initiatives were to be termed “pilot” projects and would include evaluation of structures, processes and outcomes. During the past three years, however, it has become increasingly apparent that Scotland is very far ahead of other counties in terms of enactment. This is curious and cannot wholly be explained by the fact that different countries will start from different levels of readiness. Further investigation of the reasons for this would be beneficial to any subsequent action-based simultaneous development of nursing practice and education across different nation states.

However we hope that this report will prove of some interest to other European countries. As it seems likely that a range of different audiences may be interested in various aspects of the Scottish experience, other formats for dissemination have been prepared. In addition to this full report, a very concise summary of the research findings is available to download from the Scottish Executive Social Research website (http://www.scotland.gov.uk/socialresearch). Finally the Scottish Executive has published a concise process and policy orientated report on the project to date and this includes consideration of the evaluation findings detailed in this document.
CHAPTER ONE  THE CONTEXT OF THE EVALUATION

1.0 INTRODUCTION

This report presents the findings of a study commissioned by the Scottish Executive Health Department and carried out by the Centre for Nurse Practice Research and Development (CeNPRaD) between February 2001 and December 2002. The overall aim of the study was to evaluate the operation and impact of family health nursing in specific remote and rural areas within Scotland. This included the evaluation of a new educational course devised to prepare Family Health Nurses (FHNs) for practice.

1.1 BACKGROUND

The Family Health Nurse (FHN) concept was introduced by the World Health Organisation (WHO) Europe as a possible means of developing and strengthening family and community oriented health services (WHO 1998a). Within the HEALTH 21 health policy framework it was proposed that this new type of nurse would make “a key contribution within a multi-disciplinary team of health care professionals to the attainment of the 21 health targets set in the policy.” The full definition of the new role states that “The Family Health Nurse will: help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients’ homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family’s health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise”. (WHO Europe 1998a).

The framework posits the FHN and the Family Health Physician as the key professionals at the hub of a network of primary care services. The Scottish Executive Health Department (SEHD) saw this as a potential solution to some of the problems of providing health care in Scotland’s remote and rural regions and during 2000 began preparatory work for a Pilot project. Three regions subsequently became involved in this work (Figure 1.1 overleaf). Within these regions populations are characteristically sparse, ageing and declining in numbers. Health profiles are poor, with high incidences of cardiovascular disease and cancer, and socio-economic problems such as unemployment and poverty are relatively widespread. Geographic isolation is associated with transport difficulties, and the regions suffer from migration of the young to urban towns and cities. Recruitment and retention of skilled nursing staff has become increasingly difficult.

2 For further information about CeNPRaD see our website www.rgu.ac.uk/subj/cenprad.
Regions participating in first year of Scottish Family Health Nurse pilot

Highland

Orkney Isles Islands Area

Western Isles Islands Area

Shetland Isles Islands Area
The SEHD summarised the principles of the FHN role as:

- A skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required.
- A model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.
- A role founded on the principle of caring for families rather than just the individuals within them.
- A concept of the nurse as first point of contact.

A Scottish University was commissioned to provide the educational programme to prepare nurses from these regions. Initially it was envisaged that two educational programmes would be available: a shortened course for nurses with an existing community specialist practitioner qualification (e.g. District Nurses, Health Visitors) and a 40 week course for registered nurses with a minimum of two years post-registration qualifying experience. When education started in February 2001, however, only the arrangements for the 40 week course were in place. Eleven students (Cohort 1) subsequently undertook this course during 2001 and twenty students in 2002 (Cohort 2).

The project in Scotland was initiated by The Scottish Executive Health Department. A Project Officer was appointed to co-ordinate national and regional activities, and to liaise with other European countries. A National Steering Group was convened and met regularly during the course of the project. Local Steering Groups were also set up at regional level. During the evolution of the project a Role Implementation Group was also set up to address emergent issues around FHN documentation, activities and professional boundaries. A further remote and rural region joined the project in 2002.

Following a process of competitive tendering CeNPRaD was commissioned by Scottish Executive Health Department to undertake an independent research evaluation based on the following six objectives:

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

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

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

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

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3 A formal shortened course was not developed during the two years of the project
5 To identify relevant stakeholders’ perceptions of the FHN model.

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

This report addresses these objectives within five chapters. The current Chapter 1 develops context for the reader by critically reviewing several key concepts and by outlining the principles of the evaluation’s design. Chapter 2 examines the educational preparation of the FHNs and considers implications for course development (objectives 1, 2 and 6). Chapter 3 examines FHN practice at 10 sites, presents the typology that emerged, and draws together common themes from practice (objectives 3, 4 and 5). Chapter 4 examines the wider Scottish context in terms of policy (objective 6), community nurse education (objective 1) and primary care practice (objective 6). This sets the scene for Chapter 5 which draws together the study’s findings in order to consider the implications for further development of the FHN role through education and practice (objectives 1 and 6).

Literature searches and reviews of national policy, research documents and published information sources relevant to community-based education programmes and service development have been ongoing throughout this research. The following subject areas have been pursued through the literature:

- The Family Health Nurse as a concept and as a practised role
- Family nursing
- Community nursing (including district nursing; public health nursing and health visiting)
- Rural/remote nursing and primary health care
- Educational preparation for the above subject areas
- Research in the above subject areas

This has involved searching ASSIA, ASLIB, British Nursing Index, CINAHL, COCHRANE, IBSS, MEDLINE, Nursing Collection, Social Science Citation Index and ZETOC electronic databases for post 1990 journal publications and searching Scottish University Library databases for relevant publications in book format.

These searches have generated a great deal of literature that has informed our thinking during the project. Rather than presenting exhaustive and exhausting reviews of the above subject areas, we have chosen to use relevant literature primarily to inform interpretation of our findings. Thus the report is heavily weighted towards presentation of our own research findings. However to give a frame of reference for the reader, three key concepts are now briefly critically reviewed in relation to the Scottish context.

1.2 REVIEW OF KEY CONCEPTS

1.2.1 Community-based nursing

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

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

Brief explanations of these categories are given in the Glossary to this report. Other specialist nurses working in communities may have expertise in the care of people with specific disease (e.g. Macmillan Nurses for cancer care; Diabetic Specialist Nurses). Midwives are also active in UK communities, caring for women through pregnancy and childbirth.

This diverse array of professionals has evolved in an attempt to meet the health care demands of varied populations. However the community nursing workforce in the UK is frequently criticised as being over-specialised and fragmented (Hyde 1995) to an extent that may be dysfunctional not only for the professions, but also for the public whom they serve.

These types of concerns appear to have informed recent policy documents within Scotland. Nursing for Health (SEHD 2001) states that “The Scottish Executive will review with all interested parties the outcomes of the new public health and family health nurse programmes with a view to having only two routes to community specialist practice - the Family Health Nurse and the Public Health Nurse” (p.61).

1.2.2 Family Health Nursing

Unsurprisingly material pertaining specifically to the FHN concept as outlined by WHO Europe is limited, so most of our review on this concept pertains to the WHO publications and associated output. The definition of family health nursing as set out by WHO Europe is broad in its aspirations to meet the needs of individuals, families and communities. Thus it is almost impossible to articulate a unitary operational definition. In the WHO Europe video of family health nursing a range of very different nursing practices and practitioners are presented in order to exemplify practice. Such diversity helps to promote the ideology but causes problems for the analyst in trying to make sense of inconsistency and contradiction.

In effect the WHO Europe idea of family health nursing signifies an aspiration for a pan-European nursing role. Within the main WHO Europe document (2000) family health nursing is portrayed as the central stanchion in the “umbrella of public health and primary health care”. In a context where there is inadequate or no multi-disciplinary community health care provision then the WHO Europe Family Health Nurse-led service has the potential to be enacted with the nurse being the key co-ordinator of all services and referrals. However an umbrella is seldom the covering of choice in remote and rural Scotland, and as a conceptual framework, and as a metaphor, this portrayal is rather naïve for a context where community health care provision is long established through resource deployment, professional power dynamics and political climate.

Three concepts that have positive connotations but are notoriously difficult to define (viz. family; health; and nursing), have been combined within one role descriptor. What emerges
from reviewing this predominantly descriptive literature is the need for caution in assuming these commonly used terms have a unified meaning. Diffuse practice examples pertinent to specific cultural groups are used by WHO Europe and others to exemplify the concept and articulate the ideology of family health nursing (e.g. Chronic disease prevention and management for Type 2 diabetic patients; care of a family where the mother has breast cancer; care of a single person suffering from metastatic breast cancer; care of a family with mental health and alcohol related problems; or care of an elderly couple with poor health). Such examples suggest that a family health nursing approach to the delivery of care by nurses has universal utility. This in turn raises questions for the Scottish context where the educational award is a community specialist practitioner qualification.

There has been a tradition in North America for Family Nursing. Key authors such as Wright and Leahey (1994); and Friedman (1998) have been influential in contributing to the education of nurses, shaping practice and informing curricula development. In particular their frameworks for assessment and intervention with families have been widely deployed or used to inform practice in different countries. The frameworks draw upon ideas from a number of theoretical traditions and practice disciplines, but the dominant paradigms are systems theory and family therapy. Their frameworks are primarily designed for in-depth work where the family is the client and key unit of analysis. The influence of the Wright and Leahey (1994) and the Friedman (1998) texts is absent in the WHO Europe vision. These books, (along with Whyte 1997), have been used as core texts by the Scottish Educational provider of the family health nursing course. Two main paradoxes ensue from this observation. Firstly, is the Scottish approach a functional hybrid of family nursing and family health nursing as advocated by the key authorities or has it’s germination been affected further by the Scottish environment? Secondly, as Gillis (1999) comments the level and nature of nursing engagement proposed by Wright, Leahey and Friedman indicate a level of specialism in nursing practice. The envisaged role of the FHN from the WHO Europe, from the Scottish Executive Department of Health and the educational provider suggest that the role is one of a highly skilled generalist nurse. Is the Scottish approach therefore also an educational hybrid in terms of curriculum construction?

Generally speaking hybrids are difficult to nurture, sustain and develop where fertile species are well established. However within remote and rural Scotland concern has been increasing about the fertility and sustainability of existing species of community based nursing. In using this metaphor it is intended to articulate the potential vigour of such a hybridisation process to the construction of community-based education and the practice of nurses, midwives and health visitors especially in the remote and rural areas of Scotland. Thus we will return to these questions later in the report.

1.2.3 The remote and rural context

Literature on remote or rural health care in Canada, USA and Australia was also reviewed. In these contexts the role of the nurse practitioner or advanced practitioner has been developed as solutions to problems of remoteness. Educational courses up to Masters level have been developed to prepare these practitioners (Ross 1999). A shortage of family physicians or general practitioners coupled with the difficulty of recruiting health care professionals into
these remote or rural areas have often been cited as precursors to the development of the nursing role.

The world organisation of family doctors (WONCA) has recognised since its inception in 1992 that there is a need for special preparation of health professionals to meet the health care needs of rural people and have recently stated that “The Rural Health Team is a multidisciplinary team of health workers functioning often in a way beyond the normal boundaries of their own discipline ... Providing health care in rural areas requires a well trained and experienced health care team that works closely with a community and is responsive to their needs and preferences” (WONCA 2001 Policy on rural practice and rural health; cited in RARARI 2002a p62).

The significance of the rural context for other services has also been recognised (for example relevant work has been carried out within social work (e.g. Horobin 1986; Lishman 1984) and by social geographers who have conducted studies in the remote and rural areas of Scotland (e.g. Clark 1997). Furthermore some small-scale medical studies of GP practices in such areas (e.g. Hamilton et al 1997; Cox 1997; Deaville 2001) also illuminate the special demands of context. This body of literature suggests that rural and remote areas have special conditions in terms of living environments, transportation, community cohesion and participation. Each of which it is contended affects the role of the health professional in particular.

Health professionals working in remote and rural contexts have expressed concerns about the community and the availability of telehealth and personally responsive health services (WONCA 2001 Policy on rural practice and rural health; cited in RARARI 2002a). In the literature reviewed there has been a limited concern for the focus of health care to move away from the individual client to that of the family as client. Indeed the WHO framework for the development of general practice/family medicine in Europe (WHO 1998b) essentially views families as context, and the generalist paradigm prevails in literature from WONCA Region Europe (The European Society of General Practice/Family Medicine) and EURIPA (European Rural and Isolated Practitioners). The notion of family health nursing as promulgated in the Scottish context urges the nurse to relate to the family as the client. This again presents us with a paradox in that the notion of the client as the family contradicts with commonly held beliefs and practices of individualised health care. We will return to this observation in our examination of the actual practice of the family health nurses.

Undoubtedly remote and rural contexts have been recognised as different from urban contexts of health care. Concentrating the Family Health Nurse initiative within remote and rural areas provides us with the opportunity to evaluate its relevance and application for these contexts but does make sureness of transferability to major urban contexts difficult.

1.3 EVALUATION DESIGN

1.3.1 Overview of design

In conducting this evaluation, and in addressing the six given objectives, it has been essential to sustain research interpretations at four levels of analysis:
1. Application to the education and practice of community-based nurses, Health Visitors and midwives across Scotland.

2. Relevance to remote and rural health care provision in Scotland

3. Application and relevance to the particular local contexts where the Family Health Nurses have been working

4. Application and relevance to direct face to face experience of education and in practice.

This approach to knowledge building has its scientific foundations in frameworks of social science explanation building (Newman & Layton 1984 Fiske and Taylor 1991 Becker 1950 & 1976, Bandura 1986) and relies on the construction of meaning, through interaction, filtration, interpretation and inference. Figure 1.2 (overleaf) presents a model of the interpretative research processes which were followed in order to articulate our explanations.

Such a multiplex evaluation has required the integration and synthesis of the most useful parts of two key approaches to evaluation research (Pawson and Tilley 1997; Guba and Lincoln 1989). Thus in our design⁴ we have utilised a longitudinal comparative approach to evaluate changes coupled with in-depth studies of the cultural constructions and the personal experiences of those involved in the education and practice of family health nursing.

Evaluation of the educational preparation of the Family Health Nurses entailed a systematic collection of evidence pertaining to comparative educational processes, participant experiences and performance. Details of the data collection and analysis procedures involved are presented in Chapter 2.

In evaluating practice our overall aim was to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot. This approach adapts Pawson and Tilley (1997)’s realistic evaluation framework in order to clarify what FHN practice is in these settings, and then clarify how, and to what extent, the FHN role works under various circumstances. As such, the ten FHN sites active during 2002 were seen as the main units of analysis in this study. Explanatory case study methodology (Yin 1994) also informed this approach. Details of the methods and procedures for data collection and analysis are presented in Chapter 3, Annex 1 and Annex 2.

Examination of the wider Scottish primary care context was undertaken through a combination of policy literature review and telephone interviews with key informants. Details of the data collection and analysis procedures involved are presented in Chapter 4.

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⁴ Full details of data collection tools are given in a supplementary CD Rom which is available from the authors.
Interpretative Research Processes

EVIDENCE

Filtration

Practitioner
Local context
Remote and rural
Scotland wide

Sureness of explanation

Interpretation process

Scotland Wide
Remote and Rural
Local Context
Practitioner

Strength of Application
1.3.2 The role of the evaluators

The research was designed to respond with some flexibility to an evolving project. This is a very necessary requirement for the evaluation of a policy initiative, as is an awareness of the inherently political nature of the undertaking. During the process of the evaluation there was a need to feed-in some intelligence (e.g. ethical clearance and access, reports to the advisory group, concerns over service issues, and assurances about the evaluation processes). We have also been aware of: the differential power of various voices, and the actual and imputed influence of these on the education and practice of Family Health Nurses (e.g. the Steering Group members; the FHNs themselves, the patients, key allies and professional rivals in primary health care teams). As evaluators there was always tension between getting close enough to engage with the experiences of the participants and maintaining independent, critical perspective.

Contemporary debate within the world of evaluation research is concerned about explicating the role of the evaluator. Leading theorists (Scriven 2003, Eisner 2001) have suggested that evaluators make judgements by bringing to bear a connoisseur’s perspective which guides the reader and the sponsor to an appropriate judgement. Other evaluation researchers (House and Howe 1999) have argued that the evaluator should add intelligence into the evaluation context in order that those involved can make better judgements. Finally there are those (Lang 2001) who argue that evaluators have no warrant to make a judgement rather they should act as brokers to provoke and support the judgement of others.

We incline more to the first two positions and will endeavour in the ensuing three chapters to make explicit our evidence for judgements about key aspects of the education programme, family health nursing practice, and the wider Scottish context. However we are also mindful of the creative writing adage “show, don’t tell” and have aspired to include sufficient qualitative data within the main text and annexes to allow the reader to draw his/her own conclusions.
CHAPTER TWO       EDUCATING FAMILY HEALTH NURSES

2.0       INTRODUCTION

The establishment of degree level education for those nurses who work or seek to work in community and public health settings has resulted in an array of specialist qualifications designed to meet the health care demands of varied populations. In 1994 the former UKCC (now NMC) stated that:

“Specialist practitioners should be able to demonstrate higher levels of clinical decision making and will be able to monitor and improve standards of care through supervision of practice, clinical audit; the provision of skilled professional leadership and the development of practice through research, teaching and the support of professional colleagues” p3

Consequently community-based educational programmes have been constructed around these professional values. This part of the report aims to evaluate the curriculum of the family health nursing educational programme in order to consider how well it fits into the Scottish context of community based education and service requirements.

In addressing this aim a considerable volume of research, policy, educational and service information has been synthesised and simplified for reporting purposes. The knowledge utilisation processes adopted have been explained in Chapter 1.3.1 and Figure 1.2.

2.1       RESEARCH PROCEDURES

Prior to commencing the research procedures the research protocol was subjected to peer review and ethical review by the appropriate committees5

For the duration of the project 2001 – 2002 information has been gathered through processes of negotiation, conference and consultation. Such information has resulted in a record of

5 As proposed there has been a systematic collection of evidence pertaining to comparative educational processes, participant experiences and performance during the two-year period. Full details of these procedures and the data collection tools used are given in a CD ROM that is available from the authors. The methods used to collect this information included:

1. Review of pertinent research policy and informative literature
2. Retrieval and review of educational curricula pertaining to community-based courses for nurses, midwives and health visitors across all Scottish University Higher Education providers.
3. Telephone interviews with key informants from Primary Care Trusts across Scotland
4. Collation of recorded and supplied verbal information to construct student profiles
5. Distribution of questionnaires pertaining to self–reported rating of competency
6. Distribution of questionnaires pertaining to stress and job satisfaction
7. Distribution of questionnaires pertaining to quality of working life
8. Distribution of questionnaires pertaining to the student experience
9. Distribution of questionnaires pertaining to the supervision process
10. Review of student assignments; reflective summaries and practice profiles
11. Observation of teaching.
12. Observation of assessment procedures
13. Review of external examiner reports
14. Interviews with academic staff (university and service based) who are responsible for delivering the Family Health Nursing Programme.
15. Group discussions with students on campus
16. Field notes and research journal
complicated field notes and the construction of a research journal. These sources have enabled the educational, managerial and practical aspects of the family health nursing project to be articulated and reviewed. This information has contributed to the building of an explanation of what has been happening and why.

The following table outlines the modes of analysis used with each source of information.

**Table 2.1 Sources of information and modes of analysis**

<table>
<thead>
<tr>
<th>Source of information</th>
<th>Mode of analysis</th>
<th>Level of interpretation and application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature</td>
<td>Synthesis of ideas and appraisal, Critique of language</td>
<td>Across all four levels of analysis</td>
</tr>
<tr>
<td>Educational curricula</td>
<td>Situational analysis and thematic content</td>
<td>Scotland wide and Local</td>
</tr>
<tr>
<td>Student profiles</td>
<td>Description and descriptive statistics</td>
<td>Practitioner</td>
</tr>
<tr>
<td>Competency questionnaires</td>
<td>Comparative statistical analyses using SPSS synthesis of qualitative comments</td>
<td>Practitioner</td>
</tr>
<tr>
<td>Stress and job satisfaction questionnaire</td>
<td>Comparative statistical analyses using SPSS synthesis of qualitative comments</td>
<td>Practitioner</td>
</tr>
<tr>
<td>Quality of working life questionnaire</td>
<td>Comparative statistical analyses using SPSS synthesis of qualitative comments</td>
<td>Practitioner</td>
</tr>
<tr>
<td>Student experience questionnaires</td>
<td>Comparative statistical analyses using SPSS synthesis of qualitative comments</td>
<td>Local context: university course</td>
</tr>
<tr>
<td>Supervision process questionnaires</td>
<td>Comparative statistical analyses using SPSS synthesis of qualitative comments</td>
<td>Local context: university course and service provision</td>
</tr>
<tr>
<td>Student assignments</td>
<td>Thematic analyses of educational level and application of theory to practice</td>
<td>Local context university course</td>
</tr>
<tr>
<td>Observation of teaching</td>
<td>Identification of strengths and weaknesses of various approaches to education</td>
<td>Local context university course</td>
</tr>
<tr>
<td>Observation of assessment procedures</td>
<td>Thematic analysis of observation notes</td>
<td>Local context: university course and service provision</td>
</tr>
<tr>
<td>External examiner reports</td>
<td>Thematic analysis of educational level and application of theory to practice</td>
<td>Local context university course</td>
</tr>
<tr>
<td>Staff interviews</td>
<td>Thematic and content analysis of strengths and weaknesses</td>
<td>Local context: university course and Scotland wide</td>
</tr>
<tr>
<td>Group discussions with students</td>
<td>Thematic analyses of notes taken</td>
<td>Practitioner and local context</td>
</tr>
<tr>
<td>Field notes pertaining to interviews with students and supervisors in context</td>
<td>Thematic analyses</td>
<td>Face to face and local context (university course and service)</td>
</tr>
</tbody>
</table>
Details of student response rates to the questionnaires are given below in Table 2.2

Table 2.2 Response rates to questionnaires sent to student FHNs (and qualified Cohort 1 FHNs in July 2002)

<table>
<thead>
<tr>
<th></th>
<th>Cohort 1 (11 students)</th>
<th>Cohort 2 (20 students)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 01*</td>
<td>July 01</td>
</tr>
<tr>
<td>Nursing Competencies</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Stress and job satisfaction</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Quality of working life</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Summative evaluation of campus based learning experiences and clinical placements</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*At these time points the students were asked to complete these questionnaires retrospectively (i.e. thinking of their functioning in the four months prior to starting the educational course). This was because ethical approval for the research was not obtained until May 01 and therefore we could not start to issue questionnaires before this.

Details of response rates to questionnaires sent to supervisors of FHNs are given below in Table 2.3

Table 2.3 Response rates to questionnaires sent to supervisors of FHNs

<table>
<thead>
<tr>
<th></th>
<th>Cohort 1 (10 supervisors; 11 students)</th>
<th>Cohort 2 (18 supervisors; 20 students)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec 01</td>
<td>Dec 01*</td>
</tr>
<tr>
<td>Summative evaluation of experiences of supervising FHN student</td>
<td>8 (73%)</td>
<td>15 (75%)</td>
</tr>
</tbody>
</table>

Data from the above questionnaires were entered on to SPSS V10 databases and data entry checking was undertaken. Frequencies were generated in order to summarise and describe quantitative data. Where inferential testing was appropriate, nonparametric statistics were used (following the principles in Pett, M (1997)). The main tests used were the Mann-Whitney U test to compare separate groups of subjects, the Wilcoxon test to compare consecutive data generated from one group of subjects, and Cohen’s kappa statistic which measures agreement taking into account what would be expected through chance. Textual comments were collated and analysed in terms of content frequency and thematic coverage.

The remainder of this part of the report has been structured to enable the analysis to move from the general to the particular and back again: from consideration of all specialist practice educational curricula to a detailed evaluation of the family health nursing programme. Observations and findings are presented and discussed in such a way as to identify the major issues for consideration.
2.2  SPECIALIST PRACTICE EDUCATION: AN OVERVIEW OF STRUCTURE AND CONTENT

Service redesign and organisational change in the delivery of primary care services have resulted in a range of new roles for members of the nursing, midwifery and health visiting professions. Furthermore the establishment of a clinical governance management system across the NHS has required employing organisations to assess risk alongside professional liability in order to ensure that there are: clear lines of accountability and responsibility in clinical care; quality improvement systems in place; and clear policies for the management of risk and professional performance. Overall the combination of service redesign and clinical governance should provide a decision-making framework to determine the optimum mix of generalist, specialist and advanced practitioners needed in the nursing workforce in primary care. In operation the rationality behind developments is often obscured and difficult to articulate. This is the case for family health nursing both in terms of the education and the practice. The challenge for us, as evaluators, was to try and understand this educational and practice initiative which aimed at producing “generalist specialist” nurses who would work in primary care in selected remote and rural areas of Scotland. Clarifying the perceived benefits of any new role and innovative approach to community-based education poses general problems for evaluators. In this particular case, however, the combination of a broad range of educational preparation coupled with a very particular concern for personal practices in remote localities required immersion in fieldwork and a constant comparative approach to our analyses.

2.2.1 Overview of specialist practice curricula

Currently within Scotland there are nine Universities providing education for nurses and midwives who are working or seeking to work in primary care. The courses offered range from short courses with a specialist focus to Master’s Level degree programmes. The curricula which have been reviewed pertain to those degree programmes which combine an academic award with a specialist practice qualification.

Thus curricula were obtained from the five Universities in Scotland offering community-based degree programmes with specialist qualifications across the following areas of practice.

- General practice nursing
- Community mental health nursing
- Community learning disabilities nursing
- Community children’s nursing
- Public health
- Health visiting
- Occupational health nursing
- District nursing
- Family health nursing

The following Tables 2.4-2.6 provide an overview of the established programmes of study by degree award type rather than by Institution. Thus the Tables provide an overview of
academic award; level\(^6\) and credit transfer allowed using either the Assessment of Prior (Certificated) Learning (APL) or the Assessment of Prior Experiential Learning (APEL)\(^7\); the nature of core and specialist modules\(^8\); the mode of delivery and the general means of assessment.

Such an approach has enabled a summary situational analysis of educational curricula to be conducted in order to appreciate and distinguish the family health nursing curricula from the others. A range of judgements internal to the actual curricula has been made based on the following criteria: philosophy of health care and education advocated; concordance with regulatory frameworks; strengths, weaknesses and values inherent in the overall curricula; resources: human physical and financial.

External judgements have also been sought with regard to the nature of educational provision. This external process has involved seeking the views of key informants across Scotland with regard to the strengths and weaknesses of extant community-based services, educational provision for community-based nurses, midwives and health visitors and what health service deficiencies might be provided for by family health nursing. The findings from these interviews are presented in Chapter 4.

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\(^6\) SCOTCAT is an acronym for Scottish credit and accumulation transfer and refers to the academic levels of learning that students have undertaken. To obtain a Bachelors degree from a Scottish University the student would normally accumulate credit at different academic levels. The levels generally equate with the year of the course: thus Level 4 would normally be the academic work undertaken in the fourth year of a classified degree programme. In the Scottish education system there are two types of Bachelors degree. The unclassified degree which finishes at Level 3 and the classified degree which finishes at Level 4. The term SCOTCAT is also referred to as Scottish Degree Level and abbreviated to SD. The European credit equivalent was not given in any of the curricula reviewed.

\(^7\) As nursing has moved into the higher education sector it has been necessary to develop systems to recognise academic levels of learning and the potential for exemption. APL and APEL are two such processes which are used primarily, though not exclusively in vocational degree programmes.

\(^8\) The term module will be used to refer to the components of all degree programmes. This term has been chosen because of its transferable meaning viz: a self defined part of a degree programme which has its own assessment processes, and in order to avoid the confusion of terminology which prevails.
## Table 2.4 Overview of community-based educational programmes leading to the academic of award of Bachelor of Science (BSc) and specialist qualification

<table>
<thead>
<tr>
<th>Academic Award; level and credit exemption</th>
<th>Indicative shared core module content</th>
<th>Indicative specialist module content</th>
<th>Mode of delivery</th>
<th>Indicative assessment techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCOTCAT Level 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APL and APEL up to 60 Level 4 SCOTCAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme for supervisors available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSc (Ord)</strong></td>
<td>Clinical practice development Approaches to care delivery Clinical practice leadership Community principles Community practices</td>
<td>Relevant to specialist practice but covering service development, service provision, principles and practices, assessment, role, and therapeutic interventions</td>
<td>Full time and part-time open learning</td>
<td>Portfolios, community profile, essay, examination Supervised practice</td>
</tr>
<tr>
<td>SCOTCAT Level 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time and part-time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APL and APEL up to 50% of the programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme for supervisors available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSc (Ord)</strong></td>
<td>Clinical judgement and decision making Managing for quality Research for practice Work-based teaching</td>
<td>Community perspectives Principles Work based modules on systems promoting health and specialist practice as applied to specialist qualification Series of elective choices</td>
<td>Full time or part-time</td>
<td>Essay, portfolio, action plan, service profile supervised practice</td>
</tr>
<tr>
<td>SCOTCAT Level 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access modules</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APL and APEL up to 60 Level 3 SCOTCAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme for supervisors available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Table 2.5** Overview of community based educational programmes leading to the award of Bachelor of Arts (BA) and specialist qualification

<table>
<thead>
<tr>
<th>Academic Award; level and credit exemption</th>
<th>Indicative shared core module content</th>
<th>Indicative specialist module content</th>
<th>Mode of delivery</th>
<th>Assessment techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA(Ord) SCOTCAT Level 3 APL and APEL up to 60 SCOTCAT Programme for supervisors available</td>
<td>Management and leadership issues. Supervision and teaching Research based practice Quality and audit</td>
<td>Analysis of specialist practice and specialist issues including nurse prescribing for DN and HV</td>
<td>Full or part-time distance learning</td>
<td>Essay, portfolio, action plan, teaching plan examples of good practice Supervised practice</td>
</tr>
<tr>
<td>BA (Ord) SCOTCAT Level 3. Level 2 modules available Not normal to award APL, APEL Programme for supervisors available</td>
<td>Evidence based practice and clinical effectiveness Education for health and practice Health policy and health promotion Lifespan development Social perspectives on health</td>
<td>Clinical practice and development care and programme management development of professional leadership and nurse prescribing for public health nursing and nursing in the home.</td>
<td>Part-time</td>
<td>Critical incident literature review teaching package Exam, Observed Structured Clinical Examination (OSCE), case study seminar presentation, portfolio Supervised practice</td>
</tr>
</tbody>
</table>

**Table 2.6** Overview of community based educational programmes leading to the award of Bachelor of Nursing (BN) and specialist qualification

<table>
<thead>
<tr>
<th>Academic Award, level and credit exemption</th>
<th>Indicative shared core module content</th>
<th>Indicative specialist module content</th>
<th>Mode of delivery</th>
<th>Assessment techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>BN SCOTCAT Level 3 APL, APEL up to 60 Level 3 Programme for supervisors available</td>
<td>Partnerships in learning Nursing accountability From identified problem to research proposal</td>
<td>Learning for action Specialist education and practice</td>
<td>Part-time</td>
<td>Work-based learning folders, clinical essays, research proposal, evidence based guideline Supervised practice</td>
</tr>
</tbody>
</table>
Reading through the curricula there are similarities in content and structure in accordance with the principles and specifications of the regulatory body (UKCC 1994 and 1995). The curricula are constructed around the four specialist domains9 specified and generally speaking the learning outcomes of the programmes are mapped against these domains. In addition the curricula have identified core education for all nurses, midwives and Health Visitors working in community health services which aims to: monitor and improve standards of care; inform and facilitate the supervision of practice; contribute to research; inform the teaching and support of colleagues. Finally the curricula have been designed within the framework of post-registration education and practice (PREP) which is embedded in the following values: reduction of risk, enhancement of care, provision of support to patients and colleagues and the development of education and practice.

Three academic awards are available: Bachelor of Science (BSc), Bachelor of Arts (BA) and Bachelor of Nursing (BN). In making these academic awards there are strong arguments in the curricula documents supporting the educational theory of andragogy and a taxonomic approach to learning outcomes. The management of services and the importance of research are given prominence and generally all the curricula have been constructed in partnership with health service providers. Nursing and social science theories are deployed in the curricula but there is no curriculum based on a particular theory of nursing or health. Such an approach fits with the notion of “graduateness” in that the education is enabling the practitioner to utilise appropriate knowledge in a given context. Core modules are shared in an attempt to make explicit what is common to all community-based nurses, midwives and health visitors.

The word family appears in all the curricula with varying emphasis and sustained attribution. From the educational curricula there is limited insight into the way in which the concept is handled in the various specialist practice programmes. The sociological complexities; cultural biases; legal and fiscal confines or the psychological dynamics of kinship to the meaning or understanding of ‘family’ are either assumed or ignored. It is impossible to tell from what is written in the curricula documents. There is limited evidence in the curricular documents regarding what is actually taught about the family in any course. Generally the concept of family is treated in a stereotypical way and is elided linguistically as in the following examples from learning outcomes or course objectives: “Assess the health and health related needs of patients, clients, families and other carers” (district nursing, community mental health nursing, learning disabilities nursing, general practice nursing) “Discuss health profiling methods applied to individuals, families, groups or communities” (health visiting course).

All but one BA programme offer student exemption for up to 50% of the programme and all have elaborate processes for recognising prior learning. An array of assessment processes is used generally relying on the submission of written work and the completion of practice based portfolios of evidence. For the majority of the programmes the specific practice-based learning objectives and the content of the assessment portfolio are negotiated between the student, clinical supervisor10 and academic supervisor.

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9 Clinical nursing practice; Care and programme management; Clinical practice leadership; Practice development
10 The term supervisor is used as a generic term of reference for those with responsibility for the education of the student within a practice setting

20
Only one of the programmes offers the academic award at SCOTCAT Level 4. The rest are all at Level 3 (although some Universities also have the provision for specialist awards at Master’s Level). As the pre-registration qualifications move to degree level (SCOTCAT Level 3 or 4) so the academic level of post-registration education for specialist practice will have to alter.

Students are generally recruited from the existing nursing workforces and undertake the educational programmes as part-time students. Some receive support from their employer (either in the form of payment of fees or in the form of paid study leave), many are self-funding and utilise time off from work and annual leave entitlement for study purposes.

The new public health nursing programmes in Scotland have been developed concurrently with, but separately from, the FHN project. They have involved a revision of the pre-existing health visiting courses to combine health visiting and school nursing. The Scottish Executive directly funded 128 places, including 48 for existing school nurses. By December 2002 172 public health nurses had successfully completed the programme and were back in practice (Nursing for Health Two Years On; SEHD 2003). As such this initiative is on a larger scale than the FHN project yet there is no similar research evaluation of the impact on practice.

Thus what emerges is a flexible approach to education provision in which students can negotiate: learning outcomes; the time taken to complete the programme; and the amount of credit exemption in accordance with regulatory requirements. Furthermore the array of programmes on offer within one University ensures a pool of experienced academics who can contribute to various programmes and utilises resources in an efficient way.

The focus of this evaluation was not to assess the effectiveness and efficiency of all community-based education programmes but rather to use knowledge of these to facilitate the evaluation of the family health nursing programme. We now turn our attention to detailed consideration of this.

2.3 FAMILY HEALTH NURSING CURRICULA MARK 1 AND MARK 2

The original family health nursing curriculum was developed during the latter part of 2000 and in the first year of the course significant modifications took place. The overall structure of the programme and its constituent modules did not change, but many other aspects were substantially reviewed and developed in response to: the process of professional validation by the National Board for Nursing, Midwifery and Health Visiting; influences from the Scottish Executive Health Department and the NHS Boards and Trusts involved in the initiative, and through an ongoing process of review by the educational team and the students. Between the commencement of the first and second cohorts of students (Jan 2001 and Jan 2002) the following major curricular modifications took place:

- The unit outcomes and associated clinical outcomes were clarified and revised
- A scheme for the Accreditation of Prior Learning was constructed.
- A programme for the preparation of supervisors was enhanced and a new short course offered.
- The assessment methods, particularly the Objective Structured Clinical Examination (OSCE) were developed
• Course documentation, particularly the Course Information Booklet and the Clinical Profile documents were substantially revised and developed.
• The course content, particularly the workshops offered in the module “Advanced Family Health Nurse practice”, was developed.
• A Project Director was appointed during the year to lead curriculum development.

While some modifications would be expected with all new programmes, these constituted substantial changes over a short time period. In approving the programme on 12th July 2001, the NBS acknowledged that its unique nature meant that development and modification would be ongoing throughout the pilot period. With so much development taking place it became difficult to know what we were evaluating at times and whether it would be possible to compare two cohorts of students.

For most purposes the evaluation has used the revised curriculum detailed in the Course Information booklet of October 2001. This is not to ignore the existence of the original curriculum, as we have considered both students and supervisors experiences of it. Rather it is to recognise that a number of perceived deficiencies in the original curriculum were acknowledged and addressed by the educationalists. The object of this evaluation is to be constructive in its frame of reference and analysis in order to fully appreciate what has happened and to give suggestions for future development.
### Table 2.7 Extant Curricula for Family Health Nursing

<table>
<thead>
<tr>
<th>Curricula</th>
<th>Academic level</th>
<th>Specialist module content</th>
<th>Duration</th>
<th>Assessment techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO Europe Curriculum</td>
<td>Post-graduate level</td>
<td>Concepts, practice and theory</td>
<td>Total of 40 weeks</td>
<td>Essay, exam, course work practical assessment</td>
</tr>
<tr>
<td></td>
<td>Academic award</td>
<td>Provision of care working with families</td>
<td>2 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>plus specialist practice award</td>
<td>Decision making</td>
<td>10 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No core modules</td>
<td>Information management &amp; research</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of care working with communities</td>
<td>6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managing resources</td>
<td>10 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leadership and multi-disciplinary working</td>
<td>4 weeks</td>
<td></td>
</tr>
</tbody>
</table>

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

The first curriculum summarised in Table 2.7 is that originally suggested by the WHO Europe (2000). This curriculum aims to develop each FHN to become competent in the following five core functions: **care provider; decision maker; communicator; community leader; manager**. Similarities with other community-based programmes are evident through the title of some modules and although no shared core modules are cited, decision making, information management and research, managing resources and leadership and multidisciplinary working could be core modules to be shared in the broad church of community nursing. The inclusion of this overview enables comparisons to be made with existing community–based programmes and the Family Health Nurse programme used in this initiative.

The validated Scottish curriculum leading to a Bachelor of Nursing (Family Health Nursing) award and specialist practice qualification (Table 2.7) differs from earlier curricula reviewed in that it has no common modules shared with other community nurses. Some content has
been identified as core but this is drawn from three modules: Working with families, Communication and Research, decision-making and evaluation in clinical practice.

As can be seen from Table 2.7 there are no modules dedicated to quality issues, teaching and supervision of others or the management of services, although aspects of these topics are referred to in the modules. This curriculum is different from other specialist programmes in that it has been partially built around an ideology of nursing which combines elements of Family Nursing from North America with the promotional ideas from the World Health Organisation. In addition the curriculum has incorporated specific content to suit the nature of remote and rural nursing in Scotland. In short it is a customised degree programme.

Within the course curriculum document the rationale for the content and the integration of theory, practice and assessment is addressed in a complex conceptual framework which captures the theoretical foundations, operational practices, holistic family-based care and models of assessment, intervention and health strategy. This diagram highlights the range of knowledge and skills required for a role that is expected not only to work in-depth with families but also to do so with individuals and to work with communities. It is theoretically grounded both in its educational approach and in nursing values. The articulation of these issues indicates that this curriculum is attempting to be different from the WHO Europe curriculum and from other specialist programmes. The construction of the specialist award has been simplified and all effort has been concentrated on the speciality of family health nursing at the level of practice, education and assessment.

The isolation of family health nursing from other community-based specialist education programmes has neither facilitated the professional understanding of the role nor allowed the debate to take place between practitioners about role boundaries and optimum skill-mix in various contexts of practice. However running the programme in a University with no history of community based post-registration nursing education has advantages as well as disadvantages. On the one hand it can be argued that this isolation may have contributed to the confusions and perceived threats to established nursing, midwifery and health visiting roles and consequently may have impeded the adaptation and development of a family health nursing approach to community-based health care. On the other hand however, the lack of cultural legacy with regard to community nursing educational provision has contributed to curricula innovations as described above and a willingness to think differently about the provision of nursing in remote and rural primary care contexts.

The stated criteria for student selection on to the programme stipulated a minimum requirement that students would have two years post-basic experience. Health service managers in the participating regions were instrumental in the selection and nomination of interested personnel. Our enquiries into local managers’ criteria for selection suggest that these varied in nature and weighting. The process was undertaken under considerable time pressure prior to the first course starting. Service development and succession planning issues informed this process but these were hindered to some extent by uncertainties about the nature and scope of the FHN role. Initially interest in participating in this initiative varied across personnel in the different regions, but overall there were less candidates who might realistically be released to undertake the course than had been hoped. Student motivation to do the course and the logistics of facilitating cover for a year seem to have been the two primary factors that determined who joined the cohorts. One region explicitly aimed at good geographic spread when recruiting potential students. Prior to the second year of the course
the regions were encouraged to try to recruit some students with health visiting and other community specialist practitioner qualifications besides district nursing.

The educational course was based at a campus in the Highlands of Scotland and the students’ clinical practice placements were within their own region. This course, like other specialist programmes, required students to undertake clinical placements as part of the educational process. Students’ course fees, travel and accommodation were paid from a specially designated central budget which also paid the students’ salaries whilst they were undertaking the course. As the students were existing employees, their employers in the participating regions could use the money saved on salaries as “backfill” monies, to resource temporary replacement staff to undertake the work previously carried out by the student. After completing the course it was anticipated that the new FHNs would return to their home base sites and start to develop the role in practice.

2.4 EVALUATING THE FAMILY HEALTH NURSING CURRICULUM

The educational curriculum for family health nursing was responsive to developments and changes and the teaching team generally adopted a dynamic student-centred approach to education. Throughout the programme the students were encouraged to reflect on their experiences and to submit these written accounts to the teaching team. Encouraging reflexivity in professionals has long been recognised as being of educational value. By reflecting on an event and responses to it the individual can learn through introspection. In this educational programme the students’ reflections were used for additional purposes namely: to inform the teaching team of areas of satisfaction, growth, concern and confusion; and to inform the evaluators of the students’ perceptions of events. The issues selected for detailed attention in the evaluation are those issues of concern to the students, teachers, other respondents and the evaluators themselves. Generally evidence has been synthesised from multiple sources prior to presentation.

In constructing the curriculum a range of generic and specialist content has been combined with complicated assessment processes. This combination has not always been congruent and has made for difficulties. This is best exemplified through a critique of the following: credit exemption processes; selected course content; specific assessment procedures and the sequencing of modules.

2.4.1 Credit exemption processes

No students from the first cohort obtained exemption based on accreditation of prior learning. In the second cohort however eleven students out of twenty obtained partial exemption under the course APL scheme. This meant that they did not need to attend for campus-based teaching but still were expected to undertake the modular assessment. Students were given between 4 and 8 weeks exemption from attending classes during semesters 1 and 2 when the modules on Communication, Working with families and Advanced Family Health Nurse practice were being offered. If granted time exemption these students were expected to return to their usual place of work and undertake duties as per their former role. This was an unsatisfactory practice from the perspective of students, teachers and by any contemporary understanding of APL and APEL processes.
The students’ reflective accounts provide insight into the conflict caused by this approach

“I have APEL for 4 weeks which has caused, is causing me a degree of unhealthy stress. Once I get past the next few weeks I know this will settle, but getting there is no picnic”. (Cohort 2 student).

“I have been fortunate enough to be given the names and phone numbers of my families but feel guilty if I contact them whilst on APEL” (Cohort 2 student).

“APEL is unsettling now back to work (Week3) have to keep explaining why I’m back in post”. (Cohort 2 student).

“On returning to the community it was strange being an FHN student but also having APEL – caught in the middle of nowhere” (Cohort 2 student).

The APEL and APL processes and procedures need to be developed further in order that full and proper academic credit can be given. To do so may require the reshaping of modular content in order that there are credited components of each module which are assessed in such a way to enable students to obtain full exemption.

2.4.2 Selected course content

In the Advanced Family Health Nurse practice module in-depth material on specialist family nursing is covered alongside a number of skills workshops on a range of diverse topics. The aim of this module is “provide the opportunity for a period of sustained study and practice of those therapeutic skills considered necessary for effective clinical practice with families and communities” (Extract from course unit descriptor). The unit is assessed by means of: a community portrait as specified by the Open University (1996); an Objective Structured Clinical Examination (OSCE) and the production of health promotion resource. Over the two years the module has undergone considerable change to incorporate locality-based learning and to develop the OSCE assessment process. The observations forthwith pertain to the experiences of Cohort 2 thereby keeping a constructivist approach to the overall evaluation.

The following Table 2.8 provides an overview of the suggested content of the skills workshops from the curricular documents; and summarised details of the actual workshops which were held within each of the four participating regions. The indicative content given in the curricular documents is elaborate and integrative of a range of competency domains. From the cited content in Table 2.8 it is difficult to know what would not be eligible to be considered as Advanced Family Health Nurse practice. Furthermore it is difficult to discern what makes this content “advanced” since the majority of the actual content delivered is basic community health care. The negotiation of the content was decided by the students and the clinically-based teaching staff. This raises some questions about the quality of the educational experience in terms of parity and equity of experience; variation in content; standards of teaching and application to the practice of family health nursing.

The complexity and generality of this module is of concern when thinking of the academic level of specialist practice and the use of the word “advanced” in the title. The content and learning outcomes of the skills-based workshops at first seem at odds with the notion of
higher level practice. If the skills covered in the workshops are deemed to be specialist and advanced by practitioners and service managers then it is essential that the educational process facilitates deeper levels of understanding with regard to principles, theories and evidence base underpinning the skills.

Table 2.8  **Content of skills based workshops for Advanced Family Health Nurse practice**

<table>
<thead>
<tr>
<th>Content as suggested in curricular documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for health; Stress; Policy changes; Caseload management; Problem solving</td>
</tr>
<tr>
<td>Risk management; Tissue viability</td>
</tr>
<tr>
<td>Nursing diagnosis; Facilitation of early discharge and admission to hospital; Family nutrition; Cardiovascular health; Family care giving; Family health in relation to reproduction; Breastfeeding support</td>
</tr>
<tr>
<td>Child health support and parenting skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Content delivered in Region 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting breastfeeding; Parenting skills and child health support; Health promotion</td>
</tr>
<tr>
<td>Dental health; Diabetes update; Child protection; Alcohol and harm reduction</td>
</tr>
<tr>
<td>Early discharge and informed admission</td>
</tr>
<tr>
<td>Palliative care; Principles of rehabilitation; Doppler assessment 4 layer bandaging</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Content delivered in Region 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care; Chemotherapy; Stoma/breast care update; Diabetes update; Public health agenda; Adolescent care; Aspects of pain</td>
</tr>
<tr>
<td>Stroke liaison team; Dental health; Tissue viability and leg ulcer care; Doppler assessments; Research based practice; Role of the dermatology nurse; Health promotion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Content delivered in Region 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles of wound healing; Aetiology and management of leg ulcers; Doppler assessment, compression bandaging; Blood borne viruses; Theories of health promotion; Developing health promotion/community development project; Setting up and working with groups; Working with parents and families; Screening and diagnosis of diabetes; dietary perspectives on diabetes; Role of diabetes nurse specialist; Identification and management of diabetes in children; identification of complications and clinical problems related to diabetes; Rehabilitation; role of various professionals in rehabilitation; role of integrated outreach team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Content delivered in Region 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental health; Hearing health cradle-grave; Tissue Viability; Diabetes update; Planning for health improvement; Drugs and alcohol; Doppler assessment and four layer bandaging; Public health; Child protection; Trauma; Palliative care/pain control.</td>
</tr>
</tbody>
</table>

Students were asked to evaluate these workshops as part of the educational process. The questionnaire used by the teaching team asked whether the content was relevant to their own family health nursing practice; met their own learning needs; and provided adequate resource materials. In general these workshops were seen as relevant to practice, informative and interesting and met the student’s needs.

“*Brill workshop. Very useful and relevant to FHN course*” (Student from Region 2 on dental health session). For many of the students the workshops provided a refresher course on a
particular topic. “Good to get refreshed and reassured that I am not completely rusty” (Student from Region 1 on diabetes sessions). In addition the students also commented on how useful in general were the resource materials which were provided. “Networking, leaflets, and web addresses very helpful” (Student from Region 3 on Rehabilitation session). Finally the majority of students appreciated the “hands on” nature of many sessions as exemplified by “Very informative session. Enjoyed audio-tapes to help us identify what people with hearing losses hear. Practical tips for caring for hearing aids very helpful.” (Student from Region 4 on hearing– cradle to grave session)

It would appear that much of the educational content of this module did not challenge the students sufficiently. The assessment processes however certainly provided challenges for all students. In constructing and delivering this module it is contended that the academic team have burdened the student with assessment content and processes for which the module did not prepare them well. The assessment process was highly specialised yet the majority of content related to typical community nursing activity.

2.4.3 Specific assessment procedures

The following Table 2.9 presents an overview of the observations made about the assessment procedures and processes. To recap these observations were based on: scrutiny of the students’ assignments; external examiners comments; teachers’ feedback and assessment comments and direct observation by the evaluators of the OSCE procedures.

Table 2.9 Observations on assessment procedures and processes

<table>
<thead>
<tr>
<th>Module</th>
<th>Method of assessment per module</th>
<th>Observations on assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with families in the community</td>
<td>Case study</td>
<td>Applicable to content; ethics of family assessment processes lacking; interview skills of students weak; writing skills of students reasonable; exam answers personalised with limited use of literature. All students passed.</td>
</tr>
<tr>
<td></td>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical assessment</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Video with 1000 word account of preparation</td>
<td>Problems with video equipment in some cases. Applicable to content; writing skills reasonable. Resubmission mechanism used. All students passed.</td>
</tr>
<tr>
<td></td>
<td>Case study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical assessment</td>
<td></td>
</tr>
<tr>
<td>Advanced Family Health Nurse practice</td>
<td>OSCE</td>
<td>Mismatch with content; unrelated components in assessment; writing skills of students good; health promotion resources variable; OSCE inappropriate use of term and limited value. All students passed.</td>
</tr>
<tr>
<td></td>
<td>Community portrait</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health promotion resource</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical assessment</td>
<td></td>
</tr>
<tr>
<td>Research, decision making and evaluation in clinical practice</td>
<td>3 Annotated case reports</td>
<td>Applicable to content; supported by web CT; writing skills of students good. Deploying literature more effectively. All students passed.</td>
</tr>
<tr>
<td></td>
<td>Systematic review of clinical cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical assessment</td>
<td></td>
</tr>
</tbody>
</table>
Across the assignments there is some indication of academic progression and development for all students which is primarily observable through the standard of their written work. Although this is a modular course students are expected to follow a designated sequence of modules and cannot choose their own route through.

There is limited information from the external examiner’s reports to comment upon with the exception of the suggestion that there is a need to separate out the health promotion resource from the OSCE.

This course has an elaborate assessment process per module which aims to integrate theory and practice. Some of the assessment procedures are requiring students to carry out activities before cognitive assimilation has taken place. This is most evident in the first case study assignment of the first module. Students were asked to conduct a family assessment using a genogram and an ecomap. Genogram assessments are based on eugenic principles and aim to identify hereditary disease patterns. Ecomaps are derived from the principles of social interaction, group dynamics, and intervention therapy. Some of these major social science concepts are addressed in the communication module, however, there is limited content in this module on the science of epidemiology or genetics; the ethics of assessment; or the psychology of control. It is questionable if such family assessments should be conducted by naïve students at the beginning of a course. The process however is most appropriate to the assessment of the Advanced Family Health Nurse practice module and would allow for the integration of knowledge from across the modules.

2.4.3.1 Objective Structured Clinical Examination

Two series of these assessment processes were observed by the evaluation team and the following observations were made. This assessment procedure is complex, is conducted on site with individual students and clients and is time limited due to the human resource implications. The usual procedure involves all students being assessed by two members of the teaching team during the same week. Given the geographic remoteness of some students the travel logistics of this process require to be well co-ordinated. The following quote from one of the clinically based teachers illustrates the potential for farce.

“But the OSCE well ... Whistle stop, whizz around it was horrible ..., we had very restricted time limitations and it was like 90 miles an hour” (Teachers view of Cohort 2 OSCE)

The examination relies on a standardised approach to questioning. The schedule used has a range of thematic questions pertaining to Family assessment (19 questions); Individual goal setting (10) Family goal setting (10) Community goal setting (10) Family Health Nurse intervention plan (13); Health promotion resource (17); Therapeutic letter (9); Family Health Nurse documentation (5). Some of these questions are answered by scrutinising the written work submitted at the time of the exam others are asked directly of the student during the OSCE.

“There were many, many questions that repeated themselves and we took out probably half of what was in the original and reworded. A lot of the wording was ambiguous and the students all stumbled over the same questions which would tell you that the question was badly worded” (Member of teaching staff).
The students found the OSCE stressful and commented on the problem of finding a family member to bring along, and talking about this person without fully involving them in the discussion.

“the OSCE is looming large on the horizon with only one practice week to fully establish and develop our relationship, complete the documentation and prepare us all for the visitation” (Cohort 2 student)

A family member accompanied the student for the first part of the examination when the family assessment was discussed. Very few were incorporated into the discussion. Apart from occasionally verifying (through nodding of the head) the comments made by the student only 2 family members out of 12 observed actively participated in the discussion. The role of the family member in the proceedings has not been worked out.

“I hope I did the right thing for Una (the FHN). Was it all right? Has she passed? I don’t want to let her down” (Young woman; island location).

This assessment procedure has potential as it does facilitate the integration of theory and practice but requires to be developed so as to:

- Reduce the number of questions.
- Restructure the schedule to separate out general questions about each of themes
- Restructure the schedule to pull together the specialist questions pertaining to the particular family.
- Ensure that genograms, ecomaps and nursing assessment documents are scrutinised prior to the oral exam.
- Clarify the role and involvement of the family member
- Remove the health promotion resource from this assessment

2.4.3.2 Clinical practice assessment

The documentation used for this assessment process was developed over the two years and is called a clinical practice profile. It is highly structured in specifying learning outcomes; and asking for verification of outcome achievement. Students, supervisors, and academic staff have recorded their comments in the profile in a very generalised way which provides limited information about the students learning experiences; capabilities and areas for further growth and development. The following quotes help to illustrate these observations:

“Video recorded interview of family interaction … Submission of communication assignment … Analysed communication skills and passed assignment … Positive feedback from families; … Discussion with family and informal carers – sharing information and design of care plan” (Extract from student’s evidence statement pertaining to working with families in order to support achievement of clinical learning outcomes).

The supervisor’s comments with regard to her verification of these statements “By discussion and demonstration … Good”
The maintenance of clinical learning profiles or portfolios is difficult to do well. It requires time and commitment from all parties. In other specialist practice education programmes the student generally negotiates his or her learning needs with the supervisor and devises a portfolio of evidence to support the negotiated learning contract. Such an approach is partially incorporated in this programme through additional documentation entitled “personal learning objectives”. It is suggested that the clinical assessment process is developed formally to:

- Reflect the idea of a negotiated learning contract which is student centred
- Focus distinctively on clinical learning outcomes as pertaining to the skills workshops and specialist activity (e.g. family assessments; goal setting and evaluation of interventions).

### 2.4.4 Sequencing of modules

The route of progression through the course over three semesters followed this sequence of modules:

- Working with families
- Communication
- Advanced Family Health Nurse practice
- Research, decision-making and evaluation in clinical practice.

The rationale for the module sequence is given in terms of academic credit of the modules. Several members of staff and several students have suggested that the research, decision-making and evaluation module should come earlier in the sequence as the skills are required in the other modules. This particular module has two distinct themes and has been constituted as a double credit module: learning how to retrieve and use evidence to inform and guide practice and a casuistic approach to learning which relies on effective supervision, in the practice context, and through the use of Web CT. Casuistry is a branch of philosophy which aims to resolve particular moral dilemmas that arise from general moral rules. Such as: typical intergenerational conflicts which arise in families; or the specious reasoning of the remit of one professional group compared to another. Having such knowledge before embarking on Advanced Family Health Nurse practice would enhance student’s learning and facilitate a more sustainable interaction with families and professional colleagues.

“I wish we had this earlier”. (Student Cohort 1)

“The research module should come earlier cause we need the skills in all our course work”. (Student Cohort 2)

“I think maybe the research should come earlier in the programme. Lots of the students have suggested this. It makes sense really”. (Academic staff)

Considering how to restructure the modular delivery is essential for APEL/APL purposes and for educational development. The following sequence is suggested as a discussion point to develop the existing course.
Table 2.10  Suggested modular sequence for course redesign

<table>
<thead>
<tr>
<th>Semester</th>
<th>Module</th>
<th>Credit exemption</th>
<th>Added value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Research and evidence based practice.</td>
<td>Identifiable content from other post-registration courses</td>
<td>Could be shared with other community based programmes</td>
</tr>
<tr>
<td>First</td>
<td>Communication and education</td>
<td>Identifiable content from other post registration courses</td>
<td>Could be shared with other community based programmes</td>
</tr>
<tr>
<td>Second</td>
<td>Working with families</td>
<td>Specialist content</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision making, quality and evaluation in family and community care</td>
<td>Specialist content</td>
<td></td>
</tr>
<tr>
<td>Third</td>
<td>Advanced Family Health Nurse practice</td>
<td>Specialist content</td>
<td></td>
</tr>
</tbody>
</table>

This revised structure allows for the development of transferable educational and learning skills; full credit exemption to be awarded; the incorporation of management content as identified in the WHO Europe curriculum and the availability of three specialist modules which could be taken by community nurses or midwives with other specialist qualifications.

2.5 EVALUATING STUDENTS’, SUPERVISORS’ AND TEACHERS’ EXPERIENCES

This section provides insight into the experiences of students, supervisors and teachers whilst engaged in the educational programme.

2.5.1 Profile of the FHN students

The following table provides a profile of the two cohorts of students:

Table 2.11 Profile of FHN students

<table>
<thead>
<tr>
<th></th>
<th>Cohort 1 (11 students)</th>
<th>Cohort 2 (20 students)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median age</strong></td>
<td>43 (range 29-53)</td>
<td>42 (range 29-57)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>All female</td>
<td>Female =19; male =1</td>
</tr>
<tr>
<td><strong>Median number of years</strong></td>
<td>8 (range 2-17)</td>
<td>9 (range 3-22)</td>
</tr>
<tr>
<td><strong>experience as a community nurse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number who had worked more</strong></td>
<td>10 (91%)</td>
<td>14 (70%)</td>
</tr>
<tr>
<td><strong>than 6 years at their home base</strong></td>
<td>prior to starting course</td>
<td></td>
</tr>
<tr>
<td><strong>Number who had worked more</strong></td>
<td>6 (55%)</td>
<td>7 (35%)</td>
</tr>
<tr>
<td><strong>than 6 years at their home base</strong></td>
<td>prior to starting course</td>
<td></td>
</tr>
<tr>
<td><strong>Number employed part time</strong></td>
<td>2 (18%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td><strong>Number employed in G grade</strong></td>
<td>4 (36%)</td>
<td>5 (25%)</td>
</tr>
<tr>
<td><strong>post prior to starting course</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number with district nursing</strong></td>
<td>0</td>
<td>3 (15%)</td>
</tr>
<tr>
<td><strong>qualification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number with health visiting</strong></td>
<td>7 (64%) Majority still practising at start of course</td>
<td>13 (65%) Majority still practising at start of course</td>
</tr>
<tr>
<td><strong>qualification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number with midwifery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>qualification</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2.11 clearly shows that the two cohorts of FHN students shared a very similar profile. The nurses who undertook this course were typically middle-aged nurses with very considerable experience of nursing in general, and of community nursing in their particular remote and rural location. Most were midwives. Most had no specific community specialist nurse qualification and were employed in E or F grade posts. Cohort 2 had a lesser proportion who were in part-time employment pre-course, and had a small sub-group who had only spent a few years working at their home base site and were typically rather younger. In general these were experienced nurses the majority of whom had established histories of practice in remote and rural contexts. Trying to understand why they should wish to undertake this programme of education has been illuminating. Quotes from the students own reflective summaries and the research field notes provide some insight. “On commencing the FHN course I felt very excited and motivated about taking part in this pilot study. I also felt very positive about the family health nurse concept” (Cohort 2 student reflective summary).

“Now I have to train myself to stop thinking like a nurse, task oriented, lost if I can’t physically do something for people” (Cohort 2 student reflective summary).

“... watched a video on family health nursing. Ideas behind it that nurses should take a more holistic view and get a lot of family knowledge. Good to have a framework for that”. (Cohort 1 student field notes).

“The course provided the opportunity for a specialist award ... I was doing another course ... put that on hold when this came up”. (Cohort 1 student field notes).

As external evaluators we were also interested in profiling baseline competencies of the nurses who undertook this course. Due to pressures of time and logistics it was decided to use a self-report questionnaire for this purpose. The Nursing Competencies Questionnaire (Bartlett et al 1998) was chosen as it appeared practical, had proved the most valid and reliable (Norman et al 2000) and it had been used with post-registration nurses (Bartlett et al 2000). This questionnaire covers the constructs or domains of: leadership; professional development; assessment; planning; implementation; cognitive ability; social participation; and ego-strength. As such it also seemed broadly comparable to the five core family health nursing competencies indicated in the WHO Europe curriculum and the four specialist domains of practice advocated by the former UKCC.

Thus early in the course students from both cohorts were asked to complete the questionnaire by considering their perceived levels of competency across eight domains immediately prior to coming on the course. Six months after completing the course, Cohort 1 nurses received the questionnaire again. Table 2.12 presents mean percentage competency scores for each construct.
Table 2.12  Mean percentage competency scores for each construct *(range of scores in brackets)*

<table>
<thead>
<tr>
<th>Construct</th>
<th>FHN Cohort 1 Pre course</th>
<th>FHN Cohort 1 Post course</th>
<th>FHN Cohort 2 Pre course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>87 (83-96)</td>
<td>85 (67-98)</td>
<td>77 (65-92)</td>
</tr>
<tr>
<td>Professional development</td>
<td>86 (72-100)</td>
<td>84 (69-94)</td>
<td>75 (61-92)</td>
</tr>
<tr>
<td>Assessment</td>
<td>87 (75-100)</td>
<td>83 (69-100)</td>
<td>78 (59-100)</td>
</tr>
<tr>
<td>Planning</td>
<td>85 (75-96)</td>
<td>85 (75-100)</td>
<td>82 (64-100)</td>
</tr>
<tr>
<td>Intervention</td>
<td>87 (77-99)</td>
<td>87 (74-99)</td>
<td>85 (69-96)</td>
</tr>
<tr>
<td>Cognitive ability</td>
<td>83 (75-96)</td>
<td>83 (67-96)</td>
<td>79 (58-96)</td>
</tr>
<tr>
<td>Social participation</td>
<td>59 (39-81)</td>
<td>65 (47-95)</td>
<td>61 (39-89)</td>
</tr>
<tr>
<td>Ego strength</td>
<td>81 (71-96)</td>
<td>83 (58-100)</td>
<td>75 (50-96)</td>
</tr>
</tbody>
</table>

There were no statistically significant differences between the pre and post-course mean construct scores of Cohort 1. When the mean pre-course scores of Cohort 1 and Cohort 2 students were compared, the latter group scored significantly lower in terms of leadership *(p=0.007)*, professional development *(p=0.016)* and assessment *(p=0.031)*.

Analysis of individual responses, however, suggested a need for caution in the interpretation of aggregate before and after results, in that one respondent from Cohort 1 scored lower for every construct and had clearly revised her interpretation of personal competency across all the domains. This may be an example of “the more you know, the more you know how little you know” which is embedded in the introspective nature of critical reflection advocated in the education programme, or in Allison et al (1997)”s terms “*intra-subject construct dynamism*” where there would be an expectation of dynamic change within the domains in any direction.

Comparison of pre-course results is more informative, and it is noteworthy that the level and pattern of scoring across all constructs, is very similar to the data reported by Bartlett et al (2000) for recently qualified nurses. This raises some questions over the questionnaire’s sensitivity when used with very experienced staff. Ceiling effects must be considered as a possibility. The relatively low scoring of respondents in the domain of social participation is consistent. This particular construct is concerned with awareness and activity in relation to social issues, health-related policy issues and research. In comparison to other community specialist courses studied, the family health nurse course certainly devotes less coverage to health and social policy issues and the raising of political awareness. Thus overall we have self-reported high levels of perceived competence.

These students were part of a highly publicised and politicised initiative and, as such, some had feelings of needing to prove themselves and be highly competent whilst in a shifting spotlight. They were concerned to manage the course, improve their practice and develop themselves. Some of their reflective comments help to illustrate these observations.

*“The year was a challenge but I have valued greatly being given the opportunity to study for a degree in FH nursing. My previous work as a community nurse has been a good job and has provided me with a great deal of personal and professional satisfaction. My expectation is that putting the FHN degree on top of that will be even more stimulating and a source of even greater satisfaction”* (Cohort 1 student).
“Each semester had its own terrors at the beginning and sense of satisfaction at the end” (Cohort 1 student).

“I am now back in charge of my caseload, which has swollen so dramatically since I left it in the capable hands of my replacement. I am quite nervous about having the reins again and wonder if I will be compared unfavourably against her.” (Cohort 2 student).

### 2.5.2 Students’ perceptions of stress and job satisfaction

Further exploration of the student experience was undertaken by asking each student to complete a Stress and Job Satisfaction questionnaire at different points during the project. Table 2.13 provides details of these time points for each cohort:

#### Table 2.13 Time points for stress and job satisfaction questionnaire

<table>
<thead>
<tr>
<th>FHN Cohort1</th>
<th>FHN Cohort2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June 2001</strong> (asked to complete it by thinking retrospectively of conditions in the four months prior to coming onto course)</td>
<td><strong>March 2002</strong> (asked to complete it by thinking retrospectively of conditions in the four months prior to coming onto course)</td>
</tr>
<tr>
<td><strong>July 2001</strong> (thinking of course experiences in past 4 months)</td>
<td><strong>July 2002</strong> (thinking of course experiences in past 4 months)</td>
</tr>
<tr>
<td><strong>July 2002</strong> (thinking of FHN work experiences in past 4 months)</td>
<td></td>
</tr>
</tbody>
</table>

A community-nursing specific questionnaire was selected for this purpose (Snelgrove 1998). This questionnaire asks respondents to rate themselves in relation to 46 possible sources of pressure for community nurses and an aggregate score can be derived. Smaller groups of questions similarly elicit feelings of stress and job satisfaction.

The content of the questionnaire emerged as very relevant to the students and their experiences. For Cohort 1 the main sources of pre-course stress were related to:

- change and instability at work (e.g. future of job; uncertainty about role; lack of involvement in decision making; not being notified of changes before they occur; lack of knowledge of role by other professionals; relationships with other professionals).
- work content (e.g. tedious routine work; getting cover; attending meetings). In one region in particular the nurses felt unable to use existing skills to full potential.

The actual demands of working with clients were cited as stressful less often, although there were some feelings of worry and isolation over decision-making. This was offset, however, by most of the nurses feeling free to choose their own method of work and being satisfied with their working hours. In general nurses were dissatisfied with: pay; career development opportunities; support and guidance from their supervisors, and quality of supervision.

Thus a general picture emerges of a Cohort of experienced rural community nurses who were feeling undervalued and under-developed prior to starting the course. A personal quote from one of the students helps to illustrate this observation.
“Looking back on the last 10 months I can trace a development process from an isolated District Nurse to a confident Family Health Nurse mentality with the associated diversification and extension in health care outlook”. (Cohort 1 student)

During the first part of the course, stress relating to uncertainty about future job and role continued at a similar level. The students were particularly concerned about perceived lack of knowledge about their role by other professionals. Work content was generally less stressful and more interesting, with much better opportunities to use abilities. There was still relatively little stress reported in relation to direct involvement with clients but only 3 out of the 11 students were satisfied with their placement supervision at this time.

Perceived lack of knowledge about their role by other professionals proved a persistent theme during the first 6 months of working as FHNs. Other prominent concerns related to the organisation and content of work e.g. organisation of caseload; lack of time on visits; work overload; record keeping and quantifying work. However these Cohort 1 students were significantly less dissatisfied with their jobs after the course than they were prior to undertaking the course (p = 0.044). This trend was confirmed in the findings from the Quality of Working Life questionnaires which were administered at the same points in time.

Sources of pre-course stress for Cohort 2 were very similar to those emphasised by Cohort 1, but Cohort 2 were significantly less dissatisfied with their pre-course job situation than their predecessors (p=0.035). Feelings of isolation and concern over decision-making were of more concern for Cohort2.

During the first half of their course Cohort 2 students continued to feel stress in relation to role uncertainty and lack of knowledge about the role by other professionals. However, in sharp contrast to Cohort 1, none of the students were dissatisfied with the quality of their placement supervision. Indeed Cohort 2 were significantly less dissatisfied with their student experiences up to this point than Cohort 1 (p=0.031).

Two quotes from personal reflections help to further illustrate the positive experiences of students from the second cohort.

“The course drew attention to my social and physical isolation, to the fact that my nursing practice was in need of urgent overhaul, that my attitude was negative” (Cohort 2 student)

“I am pleased to have done this course ... It is not just in the way of being glad to have stopped banging my head against a wall. But it has been very well worth pushing myself along the flinty road ... even though it didn't seem like the right one to be on and surely I should be somewhere else? ... I am not a natural student ... so to have got me this far at my advanced age is nothing short of miraculous” (Cohort 2 student)

Thus what emerges overall is an indication that stress around role ambiguity and professional understandings are of concern to both cohorts of students. The deficiencies in the educational curriculum which led to stress were resolved for the second cohort.
2.5.3 Placement support and supervision

Providing support and supervision for family health nurse was a difficult undertaking as there were no role models or experienced supervisors who had worked as family health nurses. In addition the role of the family health nurse was evolving during the course of the evaluation.

Evaluation of the support and supervision received by the students during their community placements drew on a number of different information sources including a specifically designed questionnaire which was administered to students and supervisors at the end of the course. This was piloted with a small group of Community Specialist Nursing students at another University and minor revisions were made prior to use with the family health nursing students and their supervisors. The questionnaire was designed so that students and supervisors could rate a number of different aspects of the placement supervision experience (e.g. the initial matching process; the supervisor’s understanding of the course and its learning outcomes). In addition it also sought information on the frequency of in-person and remote-mode supervision activities. Aggregate scores for perceived quality of placement supervision were subsequently derived from the students’ responses, and comparison of students and their respective supervisors’ ratings of a subset of matched questions were analysed using Cohen’s kappa statistic (measuring level of agreement).

Table 2.14 Profile of supervisors

<table>
<thead>
<tr>
<th></th>
<th>Cohort 1 (10 supervisors; 1 supervised 2 students)</th>
<th>Cohort 2 (18 supervisors; 2 supervised 2 students)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number working as District Nurse (often also with active midwifery role)</td>
<td>5 (50%)</td>
<td>10 (56%)</td>
</tr>
<tr>
<td>Number working as Health Visitor (often including school nursing)</td>
<td>5 (50%)</td>
<td>4 (22%)</td>
</tr>
<tr>
<td>Number working as triple duty nurse (DN+HV+MW)</td>
<td>0</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>Number working as lead nurse (triple duty background)</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Number working as community psychiatric nurse</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Number who were graduates</td>
<td>3 (30%)</td>
<td>4 (22%)</td>
</tr>
<tr>
<td>Number who had experience supervising diploma nursing students in past 5 years</td>
<td>9 (90%)</td>
<td>15 (83%)</td>
</tr>
<tr>
<td>Number who had experience supervising post-registration community specialist practitioner students in past 5 years</td>
<td>3 (30%)</td>
<td>6 (33%)</td>
</tr>
<tr>
<td>Number who undertook specific pre-course preparation to supervise FHN students</td>
<td>0</td>
<td>6 (33%)</td>
</tr>
</tbody>
</table>

As can be seen from Table 2.14 there are many similarities between the first and second cohort of supervisors. The main differences pertain to the spread of professional working practice and the supervisory preparation undertaken.
Cohort 1 students’ experiences of practice supervision were mixed, but were predominantly perceived as unsatisfactory. This is seen in the students’ ratings of overall level of support from supervisors during the course (Table 2.15).

### Table 2.15 Students’ ratings of overall level of support from placement supervisors

<table>
<thead>
<tr>
<th>Rating</th>
<th>FHN Cohort1</th>
<th>FHN Cohort2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>2 (18%)</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>Good</td>
<td>2 (18%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Fair</td>
<td>3 (27%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Poor</td>
<td>3 (27%)</td>
<td></td>
</tr>
<tr>
<td>Very poor</td>
<td>1 (9%)</td>
<td></td>
</tr>
</tbody>
</table>

A range of problems was apparent, especially during the first eight months of the first year of the course. Students and supervisors concurred on the main aspects needing improvement. These were:

- better arrangements for selection of supervisors with supervisors being allowed to refuse to take supervision on if too busy or if their skills are not suitable
- preparation of supervisors so that they have information and a clear understanding of their role and that of the FHN before the course starts
- allocated time for supervisors to provide supervision.

As Table 2.15 shows, Cohort 2 students’ experiences were less mixed and more positive. Other questionnaire data confirmed that their perceived quality of clinical placement supervision was significantly better than that reported by Cohort 1 (p=0.004), with 90% thinking that the match between their supervisor’s knowledge/skills and the knowledge/skills required for the FHN course were good/excellent. This compares to a figure of 46% for Cohort 1.

Nevertheless Cohort 2 supervisors felt that the process of preparing them to supervise was not good. Table 2.16 gives details of their perceptions alongside those of the Cohort 1 supervisors.

### Table 2.16 Supervisors’ perceptions of their preparation process

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number of Supervisors Cohort 1</th>
<th>Number of Supervisors Cohort 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>1 (13%)</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Fair</td>
<td>3 (38%)</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Poor</td>
<td>1 (13%)</td>
<td>6 (40%)</td>
</tr>
<tr>
<td>Very poor</td>
<td>3 (38%)</td>
<td>1 (7%)</td>
</tr>
</tbody>
</table>

These perceptions persisted despite the University providing a customised short course to prepare supervisors prior to the start of the course. In addition some of the participating NHS Trusts offered places on a generic supervision skills course. There was still a feeling for many supervisors that they lacked allocated time for supervision and some had concerns about the lack of guidance given by the University.
“After a shaky start I now feel (at the end of the first semester) a bit clearer about the role of supervisors” (Cohort 2 supervisor).

Contact and communication problems arose for those supervisors who did not work in the same geographic area as the allocated student. However the use of telephone and/or e-mail modes of contact for supervision purposes was significantly less of a feature of Cohort 2 supervision than it was for Cohort 1 (p=0.028). Fifty eight percent of Cohort 2 students reported that their supervisor had never been present in person when they were working with families during the course (corresponding figure for Cohort 1 = 64%). Interestingly, supervisors were asked the same question. In 69% of the matched cases for Cohort 2 there was agreement between students and their supervisors that in-person supervision with families had never taken place (corresponding figure for Cohort 1 = 50%). If the more rigorous kappa statistic (which takes into account the amount of agreement that would be expected by chance) were applied these percentages would fall further. Indeed none of the kappa statistics we calculated to measure agreement between students and their supervisors on matching questions came near to the 0.8 (80%) figure generally used to infer good levels of agreement. This highlights how people often retrospectively view the same sequence of events in different ways, even where a matter of objectively verifiable fact (e.g. being there in person) is concerned. Moreover the likelihood of social desirability bias from respondents should be kept in mind with the latter example.

“Although this is my first year as a supervisor, I was one of “the converted” almost from the pilot outset; my understanding of the concept has been further assisted by working alongside qualified FHN. I feel that this positive perception of family health nursing has enabled myself and my student to get onto an even keel fairly quickly after a rather fragmented first month (due to APEL, orienting ourselves family dynamics etc)” ( Supervisor Cohort 2 first semester).

We found that when experiences of support and supervision were explored with students and supervisors in private interview, many were much more critical than might be inferred by reading their collated reflective comments. Many supervisors felt that they should be getting some local support so that they could ring-fence time for supervising the students. A few received increased remuneration related to their supervisory activities. Both supervisors and students found the course documentation very hard to understand and work with. This resulted in some supervisors admitting that they were not at all sure what they were signing for. Several others were unclear about the criteria for selection of families for the FHN students on placement. These varied from ideas of incremental progression (i.e. selecting families with more simple needs/problems at first) through to selecting a range of families representative of the major prevalent health problems in the area. The supervisors often relied on the students for guidance in this and other matters such as the documentation.

2.5.4 Practice–based experiences

Both Cohorts of students were in close agreement, when it came to identifying the most valuable skills they had learned during their clinical placements. Overwhelmingly they identified communication skills (e.g. interviewing, listening) and family health assessment/promotion skills (e.g. use of genograms; understanding family dynamics; empowerment) as the most valued.
Working with families was the focus of the practical work experiences. For some of the students this required that they spent the first semester of the course working in a different locality and with different health professionals. From semester 2 onwards, however, the vast majority of Cohort 1 and Cohort 2 students had returned to their usual context of employment for their practice-based education.

Interestingly in the students reflective summaries several commented on the difficulty of finding families to work with. “I feel I am rushing to extract goals from my family without building a proper relationship first” (Cohort 2 student).

“Finding new patients for semester two was a difficult task” (Cohort 2 student).

“Gathering families slowly (I have heard that Rome wasn’t built in a day). As far as the paperwork goes I’m still not happy with it but at least I understand it now. Last family I admitted and assessed were great. Went through the whole process with them, to discover that they really don’t need me, but for them that was good, its reinforced the fact that they are coping well despite their problems”. (Cohort 2 student).

Students were also concerned about using families for assessment purposes and then moving on and the family’s care reverting to established services. The fact that this new way of working was only being used for educational purposes in the first instance raises a number of important issues regarding: the introduction and management of a new role into an established service; the ethics of using students as change agents and the expectations of the public. Service development requires a process of change management to be planned, articulated and facilitated. The evolving nature of the nursing role and its fit with service delivery posed many challenges for all of those involved.

2.5.5 Campus-based experiences

There was similarly emphatic agreement between the Cohorts when asked to identify the three aspects of campus based learning that they found most valuable. Overwhelmingly they identified coming together on campus to learn together, share ideas and experiences as major benefits. In addition family systems theory, communication and IT skills were emphasised, along with research.

The least valuable aspects of campus-based learning were seen as the content of some of the workshops in Semester 2 (especially for Cohort 1); problems with availability and functioning of IT equipment (especially in the first year of the course); limited time between assignments (especially in Semester 3); and guidelines for assignments being unclear or changed (especially in the second year of the course).

Students were asked to identify any topics that were not covered on the course that should have been. Some respondents from each Cohort identified input on child development and other health visiting skills as being lacking. Topics in the Cohort 2 responses included counselling skills; role-play and joint working with social work. Students were also asked to identify any topics that were not covered well. Both Cohorts identified various workshop sessions which could have been better (e.g. dietetics and coronary heart disease). Topics in the Cohort 1 responses included management skills and mental health, whereas a number of Cohort 2 respondents felt that the input on research should have come much earlier on in the
course. Overall, however, both student Cohorts were very positive about their campus-based learning experiences and very much valued the input by teaching staff. The following quotes help to illustrate these points.

“Reflection for me has been a way forward and has assisted me to look at situations and critically analyse various situations where a scenario could have been avoided or improved upon”. (Cohort 1 student).

“I feel I can ask the right questions and discuss sensible solutions, and now I think I may deserve the title – FHN” (Cohort 2 student).

“The Cohort has been supportive of one another and has been a great asset and strength. We have a unity that is fragile because 20 is a large social group and we are scattered far and wide. However we have a weapon – the bulletin board. We must continue to communicate through it and I take this opportunity to encourage everyone ... to use it” (Cohort 2 student).

The last quote refers to one of the major innovations of this programme namely the use of information technology through a Web CT system which has encouraged the sharing of ideas between students and with staff. This system has provided the means of maintaining an action learning set at distance with very good effect.

“The Web CT has been a godsend for me. To have contact with the other students was all that kept me going” (Cohort 1 student).

“It has been brilliant ... I don't know how we would speak ... [otherwise]. Web CT is very interesting ... now what you will find ... , I don't know if you have read the bulletin board ... but the girls this year seem to like the bulletin board rather than chatting privately so it is like what's meant to be ... Supervisors are an interesting lot as they were all given the same training. They haven't used it once not once, now I thought that this would have been very useful ... but they don't use it”. (Clinically based teacher and supervisor).

The Web CT has the potential to be developed further to provide student and supervisor support. Some formal structuring of academic sessions along with student initiated contact enables facilitation and involvement across the modules. This particular approach has worked well and could provide a model for other distance learning opportunities. Formally there is need to make explicit the educational principles behind the processes, namely action learning; simulated learning and peer review.

2.5.6 The teachers’ experiences

Over the two-year period consultations were held with various members of the academic teaching team. All made time for us and were very supportive and helpful in providing information, facilitating access to students whilst on campus and generally looking after us when we arrived at the University.

A formal interview was held with each member of academic staff who had a key role to play in delivering the programme. These interviews aimed to explore the strengths and weaknesses of the course and to identify the lessons learned and the areas for potential
development. Enabling reflexivity was one of the challenges of these interviews as a certain amount of guarding took place. Like the students, the teachers had been in the shifting spotlight and part of a highly politicised process for the last two years.

Questioning began by asking about the strengths and weaknesses of the curriculum; before reflecting on its fit with regulatory learning outcomes; the parity and quality of student experiences and learning; the role of the FHN; and finally focusing on their own personal experiences of being involved in the initiative.

The following Table 2.17 presents a summary of the common strengths and weaknesses as identified by teaching staff.

**Table 2.17 Strengths and weaknesses of the curriculum**

<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>

When asked about the role of the FHN comments were made regarding the project not connecting enough with the students’ line managers to enable the role to be enacted more fully. The teachers recognised that there is a need to work in partnership with NHS providers to facilitate service redesign and to provide appropriate education for practitioners.

Several comments were made about the amount of course content which could be taught locally to avoid the students coming on campus. A few words of caution were expressed from the more experienced teachers saying that the students really needed time together on campus and that e-learning suits the educational establishment and the employer but not necessarily the students. Certainly these sentiments were borne out by the students stating how much they valued contact with one another on campus.

Finally comments were made about the way that the initiative was rushed through; the difficult validation processes; the functioning of the Steering Group and the personal strains experienced.

In their own words:

“*The course was a very rushed affair with much of the lead in time devoted to contract negotiation and other structural issues. Consequently we pieced together a course in quick time*.”

“*Uni is committed to a range of assessments. OSCE stretched the concept of OSCE beyond or almost beyond recognition. What it is trying to do is examine across a wide range what an FHN is doing as part of the practice of her work*.”

“*There are things that this course is doing because of the pilot nature of it. If you get down to harsh economics things would have to go and I feel that the visits to clinical areas might go beyond what other courses provide*”
“It would be great to go out and spend time with students working with families. But that’s what we want supervisors to do. The Health Visitor Fieldwork Practice Teacher Role is one that we would aspire to ... but we don’t have FHNs to fulfil the role”.

“... another potential area for development is that we deliver some of the FHN programme to community staff nurses ... I think we need to think about what community staff nurses need to make them more effective ... this is where our programme originally started”

“Things have worked out better than what I imagined ... Lots of possibilities. I've been a wee bit disappointed when you get someone ... you know ... who's never going to change”.

“I think quite a lot of work has to be done around how people understand family. I think there has been some misconceptions about that. I wouldn’t like to see the name changed, cos I think we’ve come quite far in terms of getting the students to think of themselves as family health nurses rather than community nurses”

“The course should continue to be a judicious use of campus and on line learning. I think the most useful learning was the creation of virtual learning networks which could usefully be a model for all rural health care workers”

2.6 SUMMATIVE DISCUSSION

Evaluation of the educational course showed its structure and content to be distinctively different from the other community nurse specialist practitioner courses on offer within Scotland. The FHN course was less flexible in format, did not share core content with other community education courses, and did not dedicate modules to quality issues, teaching and supervision, management or leadership. Rather it emerged as much more focused on its speciality, being theoretically grounded in an ideology of nursing which combined elements of Family Nursing from North America with the promotional ideas from WHO Europe.

This mixture of content differed significantly from WHO Europe’s own suggested Family Health Nurse curriculum. The WHO Europe curriculum has more emphasis on management and leadership. Indeed advocates of the FHN role (e.g. Kesby 2002) see the FHN as a nurse leader on equal partnership status with the GP. However the latter interpretation was not a prominent feature of the Scottish initiative. Rather these very experienced community nurses were educationally prepared in such a way that they would be enabled to personally deliver this particular family health nursing approach within their communities.

During the first year of the course a number of major curricular modifications took place, and generally the first cohort of family health nurse students were more dissatisfied with their educational experiences than the second cohort. Most modifications resulted in improvement, but some (such as the introduction of the course APL scheme) were also problematic. Congruence between generic and specialist content within the course curriculum remained difficult to achieve.

Our scrutiny of the educational course has resulted in a number of suggestions for further curriculum development. Table 2.18 summarises these:
<table>
<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>

In many ways the difficulties that arose should not be surprising given the nature of the challenge which the educators faced. In essence they had to accommodate the need for a range of relevant generic content while developing a distinctive new specialist focus that also satisfied the requirements of the UKCC framework. This was a tall order, especially since the role of the FHN was essentially hypothetical during the first year of the course.

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

The latter aspect was also tied to the concurrent development of policy and practice. This linkage was innovative and to some extent challenged the existing UKCC specialist practice framework. The simultaneous developmental change process undertaken in the Family Health Nurse initiative did impose particular demands in terms of rapid initiation, creativity and responsiveness, and the effort sustained by individuals (teachers, students and professional colleagues) has been immense and very impressive.

The resultant programme is distinctively different from other specialist community nursing programmes. It emerges as a distinctive Scottish educational hybrid which has produced a skilled and knowledgeable generalist community nurse who has been specially prepared to work in remote and rural health care. It has growth potential unto itself, but it also provides a precedent for other educational providers to reconsider their approach to specialist practice degree level education.
In this regard it suggests the potential value of:

- developing clear theoretical and philosophical bases for specific programmes which encapsulate a strong value based approach to nursing, midwifery or health visiting in the context of primary care.
- working in conjunction with service providers to customise courses for specific markets.
- incorporating e-learning approaches and work-based learning strategies alongside more traditional teaching and learning methods.
- working in conjunction with policy makers and service providers to facilitate an incremental approach to service and educational development.
CHAPTER THREE  THE PRACTICE OF FAMILY HEALTH NURSING

3.0 INTRODUCTION

This chapter of the report presents the main findings from our investigation of the practice of family health nursing during the first year of this new role. To recap, the Scottish Executive Health Department summarised the principles of the role as:

1. A skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required.
2. A model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care.
3. A role founded on the principle of caring for families rather than just the individuals within them.
4. A concept of the nurse as first point of contact.

The chapter is composed of four sections:

Methods: a summary of the methods used to investigate and evaluate FHN practice
Typology of FHN practice: this part presents the typology of family health nursing that emerged through comparing and contrasting practice at different sites. The typology is explained through summary analyses of the ten sites where the family health nursing role was introduced and partially developed.
Overview of FHN practice: this part draws together common themes that emerged across the ten sites and aggregates quantitative data to give an overview of FHN practice
Discussion: the final section summarises and analyses the findings

3.1 METHODS

Concurrent evaluation of an evolving, multi-factorial, and geographically diverse development such as the Family Health Nurse initiative mitigates against the use of quasi-experimental research designs that depend on notions of control. Accordingly our research is grounded more in the traditions of qualitative enquiry, while also incorporating survey methods.

In evaluating practice our overall aim has been to identify emergent patterns of context, process and outcome that might characterise each of the local sites involved in the pilot (i.e. context of development; process of engagement and outcome of practice). This approach adapts Pawson and Tilley (1997)’s realistic evaluation framework so that process rather than mechanism is studied. The goals have been to clarify what FHN practice is in these settings, and then clarify how, and to what extent, the FHN role works under various circumstances. As such, the ten FHN sites active during 2002 are seen as the main units of analysis in this study. Explanatory case study methodology (Yin 1994) informs this approach and knowledge was built at two distinct levels in order to address objective 4 (i.e. to explore the operation of
the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites).

Firstly, at the *micro* level, a set of case studies was conducted which focused on the care received by six families in different locations where Family Health Nurses were employed. This involved in-depth, semi-structured interviews with family members, the Family Health Nurse and a maximum of two other key health care professionals involved in delivering care. These cases were selected from a pool of 20 “tracer families” (2 for each FHN site) whose progress was followed during the latter part of 2002. Details of the selection of tracer families and case study families are given in Annex 1. The family members who took part in the case studies were also asked to complete a consultation satisfaction questionnaire (Poulton 1996).

Study of the operation of the FHN model was further contextualised through the researchers making several visits to each site during the course of the project. Profiles of these sites were constructed based on the following data sets:

- Available documentation on the epidemiology and demography of each site location, including any extant health needs assessments
- The FHN students’ community portraits
- Summary profiles of all health care staff comprising the core Primary Health Care Team for each site. Summary profiles of all other relevant health, community and social care staff involved closely with the PHCT at each site (e.g. social workers; voluntary sector workers; teachers). Together these groups comprised the “professional stakeholders”
- Community nursing caseload\(^{11}\) and mix data available from routine collations (variable in quality) and specifically obtained in-person by the research team
- Field notes from interviews with key site personnel. These gathered details of cultural context; working practices; referrals; local resources etc
- Field notes from telephone discussions with practising FHNs (made throughout project)
- Field notes from direct observations of FHNs’ work with selected families
- Scrutiny of the nursing case notes of the 20 “tracer families”

Much of this work was undertaken during 2001 as a baseline from which to address objective 3 (i.e. to compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN). The identification of professional stakeholders was also a first step in addressing objective 5 (i.e. to identify relevant stakeholders’ perceptions of the FHN model). In November 2001 we mailed a questionnaire\(^{12}\) to professional stakeholders at each site seeking their baseline perceptions of the FHN role. This was repeated a year later using a similar questionnaire to gauge the emergent impact of the development.

Details of overall response rates to the professional stakeholder questionnaire on both occasions are given in Table 3.1

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\(^{11}\) Please see explanatory notes in glossary and in Annex 3 on the nature, definition and problems associated with the term *caseload*

\(^{12}\) Full details of all questionnaires and interview schedules used in the evaluation of practice are available on CD Rom from the authors
Table 3.1  Overall response rates to the professional stakeholder questionnaire

<table>
<thead>
<tr>
<th></th>
<th>December 01</th>
<th>December 02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number sent*</td>
<td>149</td>
<td>110</td>
</tr>
<tr>
<td>Number returned</td>
<td>117</td>
<td>95</td>
</tr>
<tr>
<td>Overall response rate</td>
<td>79%</td>
<td>74%</td>
</tr>
<tr>
<td>Useable responses</td>
<td>110 (74%)</td>
<td>88 (68%)</td>
</tr>
</tbody>
</table>

*Includes the site which wasn’t subsequently studied in 2002 as the FHN was on maternity leave. Also includes the FHNs themselves. The replies from the FHNs were handled separately and are not included in any of the site summary analyses or other data aggregations used in this chapter of the report

** Excludes the site which wasn’t subsequently studied in 2002 and includes the FHNs themselves. Between Dec 01 and Dec 02 some stakeholders left and consequently were not sent questionnaires in Dec 02. Also a number of new stakeholders were identified during 2002 and were sent questionnaires in Dec 02

Response rates for each site are given in Table 3.2

Table 3.2  Response rates to the professional stakeholder questionnaire at each site

<table>
<thead>
<tr>
<th>Site</th>
<th>Overall response including FHNs</th>
<th>Useable responses excluding FHNs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>December 2001</td>
<td>December 2001</td>
</tr>
<tr>
<td></td>
<td>Number sent*</td>
<td>Number returned</td>
</tr>
<tr>
<td></td>
<td>Number returned</td>
<td>Overall response rate</td>
</tr>
<tr>
<td></td>
<td>Useable responses</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>6/9 (67%)</td>
<td>7/8 (88%)</td>
</tr>
<tr>
<td></td>
<td>4/8 (50%)</td>
<td>6/7 (86%)</td>
</tr>
<tr>
<td>B</td>
<td>10/10 (100%)</td>
<td>9/9 (100%)</td>
</tr>
<tr>
<td></td>
<td>8/9 (89%)</td>
<td>8/8 (100%)</td>
</tr>
<tr>
<td>C</td>
<td>8/8 (100%)</td>
<td>5/8 (63%)</td>
</tr>
<tr>
<td></td>
<td>7/7 (100%)</td>
<td>3/7 (43%)</td>
</tr>
<tr>
<td>D</td>
<td>10/12 (83%)</td>
<td>10/12 (83%)</td>
</tr>
<tr>
<td></td>
<td>9/11 (82%)</td>
<td>9/11 (82%)</td>
</tr>
<tr>
<td>E</td>
<td>16/20 (80%)</td>
<td>13/22 (59%)</td>
</tr>
<tr>
<td></td>
<td>15/19 (79%)</td>
<td>12/21 (57%)</td>
</tr>
<tr>
<td>F</td>
<td>12/16 (75%)</td>
<td>10/14 (71%)</td>
</tr>
<tr>
<td></td>
<td>10/15 (67%)</td>
<td>8/13 (62%)</td>
</tr>
<tr>
<td>G</td>
<td>13/18 (72%)</td>
<td>12/19 (63%)</td>
</tr>
<tr>
<td></td>
<td>11/17 (65%)</td>
<td>10/18 (56%)</td>
</tr>
<tr>
<td>H</td>
<td>5/9 (56%)</td>
<td>6/9 (67%)</td>
</tr>
<tr>
<td></td>
<td>4/8 (50%)</td>
<td>3/8 (38%)</td>
</tr>
<tr>
<td>I</td>
<td>10/13 (77%)</td>
<td>14/15 (93%)</td>
</tr>
<tr>
<td></td>
<td>7/12 (58%)</td>
<td>13/14 (93%)</td>
</tr>
<tr>
<td>J</td>
<td>10/13 (77%)</td>
<td>9/13 (69%)</td>
</tr>
<tr>
<td></td>
<td>8/12 (67%)</td>
<td>6/12 (50%)</td>
</tr>
</tbody>
</table>

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. Details of overall response rates to the lay stakeholder questionnaire on both occasions are given in Table 3.3

Table 3.3  Overall response rates to the lay stakeholder questionnaire

<table>
<thead>
<tr>
<th></th>
<th>December 01</th>
<th>December 02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number sent*</td>
<td>140</td>
<td>130</td>
</tr>
<tr>
<td>Number returned</td>
<td>69</td>
<td>51</td>
</tr>
<tr>
<td>Overall response rate</td>
<td>49%</td>
<td>39%</td>
</tr>
<tr>
<td>Useable responses</td>
<td>59 (42%)</td>
<td>45 (35%)</td>
</tr>
</tbody>
</table>

*Within each of 7 FHN sites, 20 questionnaires were sent to residents who had been selected at random from the electoral roll. One regional ethics committee refused permission for this one particular aspect of the study, therefore 3 sites were not included

** In Dec 01, 10 envelopes had been returned by postal services indicating addressee no longer resident. Therefore we did not send questionnaires to them in Dec 02

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13 One regional ethics committee refused permission for this one particular aspect of the study. Therefore 3 of the 10 sites were not sent "lay stakeholder" questionnaires. Otherwise all the research protocols used in this study were approved by the respective regional ethics committees
Percentage response rates for each site are given below in Table 3.4

<table>
<thead>
<tr>
<th>Site</th>
<th>Overall response</th>
<th>Useable responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>December 2001</td>
<td>December 2002</td>
</tr>
<tr>
<td>A</td>
<td>14/20 (70%)</td>
<td>11/16 (69%)</td>
</tr>
<tr>
<td>B</td>
<td>11/20 (55%)</td>
<td>7/18 (39%)</td>
</tr>
<tr>
<td>C</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>D</td>
<td>9/20 (45%)</td>
<td>5/20 (25%)</td>
</tr>
<tr>
<td>E</td>
<td>10/20 (50%)</td>
<td>6/17 (35%)</td>
</tr>
<tr>
<td>F</td>
<td>7/20 (35%)</td>
<td>7/20 (35%)</td>
</tr>
<tr>
<td>G</td>
<td>8/20 (40%)</td>
<td>7/20 (35%)</td>
</tr>
<tr>
<td>H</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>I</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>J</td>
<td>10/20 (50%)</td>
<td>8/19 (42%)</td>
</tr>
</tbody>
</table>

Questionnaire data was entered into an SPSS V10 database and analyses followed the same procedures as described in Chapter 2.

Thus it was possible towards the end of 2002 to draw on all the data sets in order to analyse the emergent patterns of practice in terms of context of development, process of engagement and outcome of practice at each FHN site\(^\text{14}\). This in turn allowed knowledge to be built at the macro level whereby the ten, site-specific case studies could be compared and contrasted so as to draw conclusions about what worked under what circumstances and for whom. Although the focus was very much on the first year of work by qualified FHNs, we also visited almost all of the twenty FHN sites scheduled to become active in 2003 and constructed limited profiles.

Figure 3.1 overleaf summarises the evaluation process pictorially.

\(^{14}\) An overview of this process of analysis and synthesis is provided in Annex 2
The evaluation of family health nursing practice

Outcomes then related to education and current understanding of family health nursing.
Emergent typology.

Building knowledge at macro level
Exploring plausible alternative interpretations

Constant comparison; checking; re-checking
Building knowledge at site level

Follow-up professional & lay stakeholder questionnaires

Building knowledge micro level (families)

Meetings with regional & local managers
Documentary evidence re. local health needs & care
Site visits, Meeting PCT members Interviews on roles and working practices. Field notes
Caseload size & mix
Regular phone interviews with FHNs
Baseline professional and lay stakeholder questionnaires
Pilot of case study interview methods
Further site visits
Identification of tracer families
Site visits Fieldwork and observation of practice
Selection of 6 family case studies
6 in-depth family case studies carried out

3.2 TYPOLOGY OF FHN PRACTICE

Before presenting the typology of family health nursing that emerged, it is useful to clarify the context of practice. During 2002 there were ten sites where an FHN sustained activity over the whole year. The eleventh FHN who had completed the education programme during 2001 was on maternity leave for a major part of 2002 and consequently we did not attempt to study practice at her home site.

It must be emphasised that all 10 FHN sites are remote and rural as defined by The Scottish Household survey (SEHD 2000). That is, their main settlements all have a population of less than 3000 and are more than a 30 minute drive time from a settlement of 10,000 people or more. All the sites we studied fit easily into this definition.

Secondly it is useful to highlight two operational definitions:

**Family Health Nurse site (FHN site):** a distinct geographic area whose population are served by one (or occasionally two) district nursing team(s) and wherein an FHN is working. Other health professionals whose work involves the provision of primary care services to the population of this site are known as the Primary Health Care Team.

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

At the FHN sites nursing personnel were usually located in buildings where local GP services were based. However the Practice Nurses were the only group employed directly by GPs and the only group whose work was necessarily confined to one GP practice list.

We categorised the sites primarily in terms of common contextual features related to their geography, population density and organisation of primary care services (Table 3.5).
## Table 3.5  FHN sites categorised by common contextual features

<table>
<thead>
<tr>
<th>Category</th>
<th>Common contextual features</th>
<th>Number of sites in this category ( and site codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Site whose predominant feature is a population of less than 500 people living on a small island. The number of health professionals living on site is very low (4 or less). The FHN is responsible for providing nursing services to the whole island population</td>
<td>2 (sites A and B)</td>
</tr>
<tr>
<td>2</td>
<td>Site whose predominant feature is a sparsely distributed population of between 500 and 3,600 living within a large, spread-out geographic district where travelling times and distances are high. The number of health professionals within the core PHCT may be between 4 and 19 and there are usually at least two distinct PHCT bases within the overall site. Within the site the FHN usually has been allocated a specific geographic “patch” of her own</td>
<td>6 (sites C,D,E,F,G,H)</td>
</tr>
<tr>
<td>3</td>
<td>Site whose predominant feature is a population of between 1000 and 2,500 which is slightly more densely distributed than in Category 2 sites. The number of health professionals within the core PHCT is typically around 10 and there is one predominant PHCT base within the overall site. The FHN is responsible for family health nursing for the whole site, rather than having a specific geographic “patch” of her own</td>
<td>2 (sites I and J)</td>
</tr>
</tbody>
</table>

This categorisation provides context for the typology of family health nursing practice that emerged through comparing and contrasting practice at the 10 different sites (Table 3.6 overleaf). Summary details of the particular sites are given in relation to their respective codes in Annex 3.
<table>
<thead>
<tr>
<th>Site category</th>
<th>Site codes</th>
<th>Characteristic context/process/outcome pattern (CPO)</th>
<th>Evaluators judgement</th>
<th>Type name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A, B</td>
<td></td>
<td><strong>Context</strong> Small, stable caseload. High pre-existing scope for nursing autonomy and practice development</td>
<td><strong>Process</strong> Gradual introduction by FHN only, with little/no change in other professionals working practices</td>
<td><strong>Outcome</strong> 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>
</tr>
<tr>
<td>2 C, D, E</td>
<td></td>
<td><strong>Context</strong> FHN role super-imposed on “non-heavy” district nursing caseload within established and functional medium sized PHCT</td>
<td><strong>Process</strong> Gradual introduction by FHN with active, focused support from at least one other professional within the core PHCT</td>
<td><strong>Outcome</strong> 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>
</tr>
<tr>
<td>2 F, G, H</td>
<td></td>
<td><strong>Context</strong> FHN role super-imposed on “heavy” district nursing caseload within established and functional medium sized PHCT</td>
<td><strong>Process</strong> Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices</td>
<td><strong>Outcome</strong> No substantive change in practice. “Normal” district nursing services maintained, but remains stressful for FHN and colleagues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---------</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td>I</td>
<td></td>
<td>“Heavy” district nursing caseload within established and functional medium sized PHCT, but FHN role <strong>not</strong> super-imposed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Process</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some frictions at the boundaries of other professionals’ roles. Tensions within the core PHCT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Outcome</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></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>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Substantial FHN role development</strong></td>
<td><strong>Bold build</strong></td>
</tr>
<tr>
<td>3</td>
<td>J</td>
<td></td>
<td>FHN role super-imposed on local management role at time of change towards an integrated hospital/community team. Background of “heavy” district nursing caseload within established medium sized PHCT.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Process</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Outcome</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No substantive change in practice. FHN role not a priority as wider service management changes necessary first “Normal” district nursing services maintained, but stressful for FHN and colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Very little/thwarted FHN role development</strong></td>
<td><strong>Slow/No go</strong></td>
</tr>
</tbody>
</table>
Explanation and illustration of each pattern within the typology is now undertaken using summary analyses of the FHN sites. These site analyses draw on a number of data sources. Where professional and lay stakeholder data is utilised this is based on useable responses (see Tables 3.2 and 3.4 respectively). Firstly High scope-slow build is examined through analyses of the two sites characterised by this pattern.

3.2.1 High scope-slow build

As Category 1 denotes (see Table 3.5), these two small island sites shared common contextual features. The district nursing caseloads were small and had relatively few patients needing regular, intensive nursing input. Workload fluctuated but on the whole there was high scope for autonomous practice development within the existing staffing complement. On the other hand there was the responsibility to provide nursing services for the whole island population and this brought with it the particular demands of being almost constantly on-call and being expected to deal with a very wide range of clinical eventualities.

This situation was particularly pronounced at Site A where nursing is the only resident health service for an island with around 70 permanent residents. In this situation the nursing caseload is synonymous with the whole island population and nursing assessment is bound up in everyday social contacts with a substantial proportion of the population. Prior to undertaking the course, the FHN had a long established role as the island’s District Nurse and Midwife.

Response to the lay stakeholder questionnaire was particularly good. Prior to the introduction of FHN practice, seven out of ten respondents (70%) had heard about the new role and they generally saw it as congruent with, and virtually indistinguishable from, pre-existing nursing. By the end of 2002 only one out of 10 of respondents (10%) viewed the FHN as a different kind of service:

"There has been no change"

"I think the FHN is ideally suited to our local situation in principle: in practice it has made no difference at all"

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

Professional stakeholder responses told a broadly similar story and again there was a feeling that the pre-existing service was satisfactory in meeting family needs. Interestingly, however the FHN herself felt that she was seeing practice differently in that the focus on family drew together many different elements of care. She was gradually working to transfer individual’s nursing records to Family Health Nurse documentation, but this process was slow (7 of the island’s 35 families were on FHN notes by the end of 2002). This was partly attributed to the need for full family assessment to occur but also to difficulties in using the FHN
documentation\textsuperscript{15} and doubts about its appropriateness for individuals needing only very specific nursing interventions.

Frustration with documentation was also a theme at Site B. The pre-existing district nursing caseload numbered around 15 clients, many of whom required regular input. Most of these clients and the relatives involved in their care have been assessed using the FHN documentation. Again, however this documentation is not seen as ideal for the nursing needs of some individuals (e.g. those with leg ulcers; wound care), therefore elements of the pre-existing nursing documentation are also incorporated. This has resulted in a number of “hybrid” notes.

New referrals for nursing input who were assessed as having more than very short-term needs were also then given fuller assessment using FHN documentation. This provided a “way in” to include other family members (the “FHN caseload” now totals around 35 individuals) but the depth of development of the assessment and intervention processes is very varied. This variation is not only in response to individual family members’ needs but also a result of the FHN finding that such in-depth assessment is time consuming and practically difficult with family members who are out working. There is an aspiration to eventually have all the island’s 450 residents as “the caseload”, but also a realisation that this would take several years and would entail seeing “caseload” in a very different way.

None of the nine respondents to the lay stakeholder questionnaire at Site B had heard about the new role prior to its introduction. Only one respondent felt it might take away from pre-existing local services. This is relevant because the new FHN had been relief nurse on the island for many years but was now effectively replacing the triple duty nurse who had recently retired. At the end of 2002 there were still few respondents who knew about the role, but none felt that family health nursing was taking away from local services.

Professional stakeholders saw the FHN development as well suited to the site prior to its introduction. They continued to be positive at the end of 2002 with no respondents feeling that the development had been unsuccessful so far:

"Some families benefited considerably"

"They have benefited from the wider remit of the FHN vis a vis the District Nurse"

However opinion was divided about whether there was a specific need for the FHN role.

\textsuperscript{15} The Family Health Nursing documentation used by the FHNs in practice during most of 2002 was developed during the educational course in 2001. The documentation incorporated in-depth assessment sections based on the Calgary Family Assessment Model (e.g. use of genogram and ecomap) and included in-depth questions on family power structure, dynamics, strengths and weaknesses. It ran to over 12 pages and during 2002 the FHNs all made extensive individual adaptations in the light of practice. This resulted in a range of hybrid notes that generally incorporated elements of pre-existing standard community nursing notes. During 2002 the Project Steering Group set up a Role Implementation group whose remit included review of family health nursing documentation and towards the end of the year new documentation was produced. This retained the genogram and ecomap but dispensed with recording other parts of the Calgary Model. It incorporated an adaptation of the Omaha Activity Recording System for family health nursing, but at the time of writing the use of this new documentation is just beginning.
At both sites some close professional colleagues still did not fully understand the nature and scope of the FHN role. This seems related to the development of the role being confined to the individual FHN, with relief nurses having minimal involvement in the new style of family assessment that has taken up a lot of FHN time. As such, much of the FHN activity was visible only through the new hybrid documentation. Accordingly these local professional stakeholders comments are not surprising:

"I see no difference from what the nurses were already providing"

"Has always been good interdisciplinary working and this continues with FHN"

"Although well suited to island communities I think the FHN role still needs clarifying to fellow professionals as well as public"

Referrals from professional colleagues have continued to be for usual district nursing type problems (i.e. individual patients). There have only been very isolated occasions when a family has been referred. In effect, the bottom line for the development at both sites has been that the usual district nursing service (which tends to be focused on individuals with health problems) must continue with no detriment and that the new role should be supplementary to normal service. This has been achieved so far because there was already scope for supplementary development but it has meant that progress has felt slow to the FHNs.

Nevertheless they have both managed to develop different, new aspects of practice. At Site A, Healthy Living group-based sessions have been developed with the local community. At Site B, the FHN and local GP jointly initiated a mens’ health clinic that has been well received, with substantial uptake of the service.

Role boundaries remain completely unchanged. On local islands where there is no resident Health Visitor or Community Psychiatric Nurse, the District Nurse has always carried out some informal monitoring of general child development and of clients with mental health problems. This has carried on. However, throughout the project there has been a degree of tension locally with the health visiting service due to a perception that FHNs might start to formally carry out child developmental assessments. This possibility was in fact rejected by a regional committee fairly early in 2002 but residual concerns about the definition and scope of the FHN role have persisted.

During the first year of FHN practice there has been no substantive change in the nursing staffing costs at both sites. The characteristic typology for both sites can be summarised as:

**Context:** Small, stable caseload. High pre-existing scope for nursing autonomy and practice Development.

**Process:** Gradual introduction by FHN only with little/no change in other professionals’ working practices.

**Outcome:** Positively viewed by the limited number of families who received the service, but not seen by colleagues and the general public as substantially different from pre-existing service. More satisfying for FHNs but also more demanding.
3.2.2 Slow build-key ally

Three of the six Category 2 sites (C, D and E; see Table 3.5) were found to share the characteristic Slow build-key ally pattern (see Table 3.6). These sites also shared the following common characteristics as a baseline:

- The FHN was trying to introduce the role on top of a pre-existing district nursing caseload. Two of the FHNs had been allocated a distinct geographic patch within their PHCT site and their work was normally restricted to that patch unless called on to cover sickness or holidays.
- The district nursing caseloads inherited by the FHNs typically comprised 30-48 people, the majority of whom were elderly. The caseloads were not perceived as heavy and had relatively few patients needing very regular, intensive nursing input. Workload fluctuated (e.g. with terminal care cases) but on the whole there was scope for FHN practice development without changing the pre-existing working practices of the district nursing teams at these three sites.

Study of these sights yielded a further key characteristic that emerged during the year:

- The FHNs had one or more key allies within the core PHCT who recognised the need for the role and actively supported it through their routine working practices (e.g. by referring families to them).

At Site C the FHN was still practising as a Midwife and she expanded the FHN role from the basis of her small midwifery caseload. This was done by continuing to care for families after the usual 10 day post-natal period of community midwifery input ceased. She was very actively supported in this by a Health Visitor colleague who shared the same home base site. Joint visits to the families were conducted initially and there was sharing of skills. While an element of duplication was acknowledged (particularly as several different sets of notes were in use), this was seen as a useful joint basis from which to develop more complementary working. Because the HV covered such a wide geographical area, she felt that she tended to have to concentrate on child health, whereas the FHN seemed better placed to have more in-depth input with these local families. This would include doing routine child developmental checks when there was mutual agreement on competency.

With the encouragement and support of the local GP, this FHN also developed a hypertension clinic (there was no Practice Nurse locally). This was successful in terms of a service for individual patients but raised some dilemmas for the FHN in terms of how, when and why a specific family health nursing approach might be applied. She developed FHN notes for a few families through this clinic.

Prior to the introduction of the new role, professional stakeholders at Site C were generally supportive with none feeling that the development was unsuited to local context. The three respondents at the end of 2002, all positively saw the need for a distinct FHN role locally.

Initial opinions about the suitability of the FHN development were more mixed at Site D. Subsequent FHN working at this site involved some joint working with an HV, but it was less sustained than at Site C as the HV was based elsewhere. The FHN developed good working relations with the local Primary School and now has weekly sessions doing health
She also developed some health educational materials for the local farming community.

The FHN has been supported in these endeavours by the local Practice Nurse whose routine work with the elderly of the local community involves some home outreach activities (e.g. blood pressure and pulmonary monitoring) and is well integrated with other services. Thus the FHN has had more chance to develop the child health/community aspect of her role. By the end of 2002 five out of nine professional stakeholders at Site D (56%) positively saw a need for a distinct FHN role locally and no-one thought the role unsuited to local context. The response rates for the lay stakeholder questionnaires were low at this site, but respondents were generally supportive of the idea in principle.

At Site E the FHN has developed a particular strand of her role in the area of mental health. This involves spending more time with individuals and families in the local community who are having problems with substance misuse (almost exclusively alcohol). Much of this has involved building trust. She has been supported in this work by the local Community Psychiatric Nurse and Substance Misuse Worker, who in turn have benefited from more regular linking. One local GP has also been particularly active in encouraging the FHN role and has referred several families to the service.

Site E is interesting in that prior to the introduction of the FHN role eight out of fifteen professional stakeholders (56%) saw it as unsuited to the locality and six (40%) thought it likely to fail. By the end of 2002 there was little change in the former figure, a slight reduction in the latter figure, and only three professional stakeholders out of twelve (25%) saw a positive need for a distinct FHN role locally. As such this site demonstrates the gradual development of a specific aspect of the role despite fairly high levels of doubt amongst fellow professionals. It also shows the importance of interpreting the stakeholder data in the light of site visits, in that some professional stakeholders are more active and influential than others in their ability to support role development. The majority of lay stakeholders who responded knew little about the FHN development but were generally supportive of the idea.

These three summaries show different aspects of the FHN role being developed. As yet most of these are small scale expansions into areas where there is an opportunity for service development and/or an acknowledged local gap in services. Sometimes there have been elements of duplication and not all professional stakeholders have seen the need for the role. The development of the role has typically occurred only within the specific FHN geographic patch and this may explain why some other members of the same PHCT have not been aware of any particular process or impact. It was notable that the key allies were always based in the same specific geographic patch as the FHN, rather than at a different base within the whole PHCT site.

The FHNs themselves have tried to apply their new way of nursing so that the whole emergent caseload is conceptualised as family health nursing. This has not always proved easy however and often there has been inherent tension amongst the constituent parts. These constituent parts would typically consist of the district nursing caseload of individual patients; a small number of families who have been fully FHN assessed and are receiving active interventions (some of whose members may be individual patients); and all the general public in the “patch” (i.e. the local community).
However the role development has been more sustained in these sites compared with the other Category 2 sites and the active support of one or more key allies emerged as an important contributory factor. Typically there has been no net increase in nursing staff/budget at these sites.

The characteristic pattern can be summarised as:

**Context:** FHN role super-imposed on non-heavy district nursing caseload within established and functional medium sized PHCT.

**Process:** Gradual introduction by FHN with active, focused support from one or more professionals within the core PHCT.

**Outcome:** Positively viewed by the limited number of families who received the service (often specific client groups). Normal district nursing services maintained. FHNs generally feel they are making progress.

The final two context-process-outcome patterns that emerged were the Slow/No go and Bold build patterns. Explanation and illustration of these patterns will continue with summary analyses of sites with these characteristics.

However, further illumination can be found in Annex 4 where one in-depth site case study is presented in relation to each pattern. We have chosen to do this as the Slow/No go and Bold build patterns represent different ends of the spectrum of family health nursing that we studied. Within this contrast lies a great deal of useful knowledge about how the FHN role may or may not work. These in-depth site case studies have been constructed to illustrate particular themes that are characteristic of these patterns. In doing so they also offer the reader further insights through the words of Family Health Nurses, family members, professional colleagues and the researchers. As such, Annex 4 supplements the more basic summaries that now follow.

### 3.2.3 Slow/No go

The remaining three Category 2 sites (F,G and H; see Table 3.5) were found to share the characteristic Slow/No go pattern (see Table 3.6). These sites shared the following common characteristics as a baseline:

- The FHN was trying to introduce the role on top of a pre-existing district nursing caseload. Two of the FHNs had been allocated a distinct geographic patch within their PHCT site and their work was normally restricted to that patch unless called on to cover holidays or sickness.
- The district nursing caseloads inherited by the FHNs typically comprised 33-55 people, the majority of whom were elderly. The caseloads were perceived as heavy. Workload did fluctuate, especially in relation to terminal care cases, but there was a general feeling of little time being available in which to develop the FHN role. One of the sites in particular was short in its staffing complement during the year of practice studied.
At Site F the FHN was allocated a distinct geographic patch within the PHCT site, but lacked access to any office amenities when working there. This resulted in long travel times. The FHN continued to practise as a midwife, providing ante natal and post natal care to a very small number of mothers.

Prior to the introduction of the new role most of the professional and lay stakeholders who responded were unsure whether it would be suited to the local context. During the ensuing year the FHN found it difficult to develop momentum in taking the role forward, despite her feeling that there was much potential in the area. She perceived the “hands-on” work demands of the district nursing caseload to have priority over her own goal of assessing families needs and developing related care packages. During the year she did achieve the latter with two families who had members who were already receiving district nursing interventions. Furthermore she developed her work with three families whom she had seen as a student. Generally, however, work with these five families was sporadic and fitted in around the demands of traditional district nursing caseload work. When the FHN was on holiday these families would not receive input unless there was a need for district nursing contact.

The FHN felt that she was now more aware of family problems in the course of her district nursing caseload work. However she would not necessarily use the full FHN documentation in these situations as she felt that it might open up a range of related issues that she would not have time to fully address. This caused the FHN significant intra-role conflict and she tended to use the traditional nursing notes to record relevant family issues in a more limited way. Although treatment and intervention work tended to take precedence, the FHN managed to develop a local health support group with a particular focus on weight management and the prevention of related health problems. This was supported by the local dietician. Nevertheless most of the FHN work at this site was solitary in nature and this is reflected by the fact that she received no referrals of families from any colleagues during the first year of practice. By the end of the year only one of eight professional colleagues (13%) saw substantial change in professional working practices or service delivery. Similarly only one saw a positive need for a distinct FHN role locally. Despite this significant degree of professional isolation the FHN remained fairly optimistic that a family health nursing approach could be successful if it was supported through a team approach.

Professional isolation was also a feature at Site G despite colleagues being very personally supportive towards the FHN. The introduction of the FHN role at this site is described in greater detail in Annex 4, but one of the interesting features was the way that the core PHCT set up an open diary for ongoing team reflection on the process of implementing family health nursing. Professional stakeholders initially reported mixed perceptions in regard to the impending introduction of the role, with five out of eleven (46%) believing it to be unsuited to the local area and two (18%) thinking it well suited.

The FHN had previously worked at the site for many years as a District Nurse. Late in 2001 she was allocated a specific FHN geographic patch within the district. During the first three months of practice there were several terminal care cases within this patch and very regular, sustained input was required. This inhibited early development of the FHN role beyond the district nursing caseload. Yet throughout the year it also proved difficult to expand activity within families who already had a member receiving district nursing input. Again the
demands of the district nursing caseload and lack of time were seen as the main reasons for this.

It proved possible to engage in sustained, in-depth family work with less than five families during the year. Customised documentation was used for these families. This involved a fusion of the full FHN notes with traditional nursing notes. The resultant documents provided comprehensive evidence of care but were unwieldy. Although the FHN enjoyed good relationships with patients and other family members within her patch it did not necessarily follow that she was seen as the first point of contact. Local custom was to contact the district nursing service or seek direct medical input as required, and this did not change during the first year of FHN practice.

Some health promotion and screening work was developed in the local primary school by the FHN with some support from the local HV. Again this activity was sporadic and difficult to sustain due to other perceived priorities. For the FHN’s colleagues the priority was that normal district nursing service delivery within the whole district should not be adversely affected by the introduction of the new role, and this belief was largely shared by the FHN herself. The open diary entries included colleagues’ concerns that the routine data returned monthly on patient contacts did not properly reflect their own input to the FHN patch.

During the year some extra nursing auxiliary hours were allocated to assist the development of the role, but by the end of the year there was general consensus that the role wasn’t working. For the FHN and many of her colleagues the problem lay in the role being based on a busy district nursing caseload. Although a specific geographical patch had been hived off for the FHN, the advent of the new role was not seen as an opportunity for any substantive review of nursing caseloads or working practices within the team. During the year there were less than five referrals of families to the FHN.

Many colleagues felt that it would have been better if the FHN role had been supernumerary and not cover a district nursing caseload. When this scenario was explored in greater depth however, it became clear that the problem was more fundamental. In effect the PHCT felt that existing services for local families were already very good and there was no gap to be filled. Generally the team had not felt well consulted about the initial introduction of the role, and by the end of the year only one out of ten professional stakeholders (10%) felt that there was a positive need for a distinct FHN role. Most of the lay stakeholders who responded felt unable to give an opinion on the implementation of family health nursing so far.

Understandably the FHN at Site G felt frustrated that development of the FHN role had been so difficult to achieve. This feeling was shared by her colleague at Site H where there had been a persistent shortage of staff during the first half of 2002. This had resulted in the FHN having to cover the whole district during this time. In turn this had entailed particularly long travel times and she felt that the ongoing demands of the district nursing caseload (and the episodic demands of her small midwifery caseload) took priority.

Accordingly she was only able to develop the FHN role more fully with a few families during this time and her level of input varied. She found the full FHN documentation cumbersome and tended to customise the existing nursing notes. Professional colleagues were generally well disposed to the FHN concept prior to its introduction and they remained so during the first year. However they were small in number, geographically scattered and tended to be pre-occupied with maintaining pre-existing levels of service delivery.
Matters improved in the second part of the year with the recruitment of more staff, but it still proved difficult to gain momentum in developing work with families. At the end of the year one of the three professional stakeholders who responded saw a positive need for a distinct FHN role within the district. Nevertheless the FHN remained hopeful that family health nursing might develop well in the district if it could be supported and integrated within the overall team approach. This prospect was felt to be realistic as she already had close support from an FHN working in an adjacent district, and a further FHN was due to start work within Site H in 2003.

These three summaries of FHN role development at Category 2 sites show progress to have been slow or at a standstill during the first year of practice. While the presenting cause for this has usually been cited as the time demands imposed by heavy district nursing caseloads, there has been a more fundamental underlying lack of active support for the new role at these sites. Other team members have generally not engaged with the role to the extent that it could be seen as at all integrated with team practice. Rather there has been a pre-occupation with the maintenance of existing services and service priorities. Often this has reflected persistent professional perceptions that there is no clear need for this sort of new role in these districts. Typically there has been no net increase in nursing staff/budget at these three sites.

In summary family health nursing at these sites can be characterised as:

- sporadic, and seldom developed or sustained, despite much effort
- not necessarily seen as needed by professional colleagues

The characteristic pattern can be summarised as:

**Context:** FHN role super-imposed on “heavy” district nursing caseload within established and functional medium sized PHCT.

**Process:** Sporadic and limited introduction by FHN only, with little/no change in other professionals’ activities.

**Outcome:** No substantive change in practice. “Normal” district nursing services maintained, but remains stressful for FHN and colleagues.

A variant of this characteristic pattern was also seen at one of the Category 3 sites (Site J). This site is interesting as the FHN had been working as G grade leader of a fairly large community nursing team prior to starting the course. As such there was the possibility that the site might offer particular potential to study the FHN as a team leader for a whole district. During the year, however, wider service management changes resulted in the FHN becoming Lead Nurse for the district. This brought with it the responsibility to lead the integration of community nursing services with local community hospital services. Preoccupation with this agenda meant that the development of the FHN role was never a priority. Accordingly assessment and planning of care for families using FHN documentation tended to be infrequent and fitted in around other work demands. As a practising midwife, however, the FHN did feel that the roles integrated well and enhanced her input with mothers and babies.

There was little substantive delegation of family health nursing work (rather than district nursing work) to other members of the team. In effect the FHN role remained marginal to service provision and this is reflected in the feedback from the six professional stakeholders.
who responded at the end of 2002. None perceived any substantive change in professional working or service delivery. None felt that the role was succeeding and none saw a positive need for a distinct FHN role locally.

This variant of the Slow/No go pattern can be summarised as:

**Context:** FHN role super-imposed on local management role at time of change towards an integrated hospital/community team. Background of “heavy” district nursing caseload within established medium sized PCT

**Process:** Sporadic and limited introduction by FHN only, with little/no change in other professionals working practices

**Outcome:** No substantive change in practice. FHN role not a priority as wider service management changes necessary first “Normal” district nursing services maintained, but stressful for FHN and colleagues

### 3.2.4 Bold build

The distinctive Bold build pattern (see Table 3.6) was found to be unique to Site I. Development of the role at this Category 3 site (see Table 3.5) is examined in greater detail in the site case study presented in Annex 4.

At Site I the FHN was responsible for family health nursing for the whole site, rather than having a specific geographic patch of her own within the site. The real novelty of the FHN role in Site I though, was that it was not superimposed on the existing district nursing caseload. Rather the FHN built up a group of clientele “from scratch”, primarily through referrals from other health and social care professionals, but also through direct self-referrals from local people.

Prior to the educational course the FHN had been employed at the site as an E grade community staff nurse for 15 hours per week. During the education course the FHN and colleagues from the project team initiated meetings to try to explain the new role to professional colleagues and the local public. The FHN’s colleagues generally felt, however, that they had been poorly consulted prior to the introduction of the role and many were unclear about what the role involved and did not involve. From the start of 2002 the new G grade full time FHN role was developed in such a way that it was distinct from the district nursing service. The process of introducing and establishing the role entailed considerable stress for the FHN and a number of colleagues within the core PHCT.

Nevertheless most colleagues within the team soon became active in making referrals. Some patients from the district nursing caseload were actively referred for family assessment and this resulted in a small number of patients receiving both services concurrently. As the year progressed the FHN developed work with a core group of around 20-25 families at any one time. Site I had a particularly high proportion of elderly patients with chronic conditions and much of the FHN’s work focused on secondary and tertiary prevention work with these patients and their families.
Such work often involved regular and sustained input, with visits typically lasting between 60 to 90 minutes. FHN documentation was used comprehensively with evidence not only of assessment but also of very detailed care planning, interventions and evaluation of progress. Within the core PHCT it was generally acknowledged that the FHN service was providing this group of families with in-depth care and some colleagues saw it as a positive response to a real gap in service provision. These professionals felt that they themselves often didn’t have time to provide this level of service. This view was not unanimous however and other colleagues felt that the pre-existing level of service was satisfactory and were unconvinced of any extra benefit that might be attributable to the new role.

Within the core PHCT there was also some concern about who should receive this new service and whether a “two-tier” situation might be arising. These concerns were related to perceptions that the FHN caseload was separate and finite, and that the role was not integrated in the sense of being a necessary part of an open, on-call primary care service that would have to respond to the full range of community nursing and/or medical priorities. In this regard colleagues questioned whether an FHN could truly be the first point of contact for local families.

As the year progressed the FHN vigorously developed more broad-based community work that focused on health promotion and empowerment. This came to assume around 30% of the FHN workload. Such activity included a regular, open general health clinic in the GP surgery; work as the health link person for the local community centre which included offering teenage girls the chance to discuss contraception and other health and lifestyle issues; joint facilitation of an exercise, music and health group for over 65s in the village; weekly visits to the local Day Care Centre offering ad-hoc health checks and information/advice; and setting up a community reference group to enable the local community to pass on their views on local health needs.

This work was particularly well received by professional stakeholders within the wider health and social care community at this site. Within the core PHCT however, some concerns remained that these FHN services were being developed in isolation from overall PHCT services. Anxieties over infringement of role boundaries remained a persistent feature during the first year of FHN practice at this site.

Nevertheless by the end of the first year four out of thirteen professional stakeholders (31%) locally did see it as providing a substantively different service, while two (15%) actively took an opposite view. This contrasts markedly with all the other sites and tends to confirm the distinctiveness of this FHN role development. Seven respondents (54%) felt the development to be well suited to the area. Eight (62%) thought it likely to lead to an improvement in local health service and none characterised it as a failure. Five respondents (39%) felt the development had involved substantial change for professionals in the way they work together.

The majority felt that the development had added to, rather than taken away from, pre-existing local services. This perception was not universally shared, however, and amongst the district nursing team there remained a feeling that they had lost 15 hours of service provision from their team. This highlights that family health nursing was being seen within the core PHCT as a different kind of service that should be supplementary to the maintenance of normal service, rather than supplanting it. Indeed district nursing activities continued very
much as normal during the year. There was a small net increase in spending on the total nursing staff budget at the site during the period that FHN practice was introduced.

By the end of the first year six of the thirteen professional stakeholders who replied (46%) felt there was definitely a need for an FHN locally. Four did not know (31%) and two felt that there wasn’t (15%). The fact that most of the core PHCT had actively referred families to the FHN in sufficient quantities to form a new caseload tends to confirm the need for an additional service of some kind. There were still doubts, however, about what the format of that service should be.

The characteristic pattern of FHN development at this site can be summarised as:

**Context:** “Heavy” district nursing caseload within established medium sized PHCT, but FHN not super-imposed.

**Process:** New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals’ roles. Tensions within the core PHCT.

**Outcome:** Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. “Normal” district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding.

### 3.3 OVERVIEW OF FAMILY HEALTH NURSING PRACTICE

In drawing together common themes that emerged across the ten sites, we can now make a number of more general points about the nature, coverage and extent of primary care nursing services pre and post introduction of the FHN role.

Firstly it is noteworthy that in our contacts with families and through the consultation with lay stakeholders there was very little evidence that local people were dissatisfied with pre-existing service provision. On the contrary several families compared the level of service very favourably with that received in other parts of the UK and abroad. These families valued the range, depth and personal nature of the health services provided and there was concern that these elements should be maintained and not eroded.

During the first year of practice the majority of families who had involvement with an FHN did so because a family member was on the district nursing caseload. Where the FHN role failed to thrive that involvement remained focused predominantly on the individual and was virtually indistinguishable from “normal” district nursing. However it is important to note that all the FHNs felt that they were seeing these families much more as a whole and that this gave their practice a different quality. The difficulty was that this was not tangible for many of their close professional colleagues. To some extent this relates to the more general problem of the invisibility of nursing work conducted in peoples’ homes.
Across the 10 sites there was an embedded “bottom line” that the introduction of the new role should not adversely affect the pre-existing level of district nursing service. This was a belief held not only by professional colleagues but by the FHNs themselves who inherited district nursing caseloads. Although there have been stresses for colleagues in cross-covering FHN “patches”, and some instances of FHNs insisting that they could no longer do some of the former routine work, on the whole the pre-existing district nursing services have remained unchanged. Indeed the FHNs have usually felt obliged to prioritise this sort of work over overt family health work.

This means that where the role has been developed it almost always supplements rather than supplants existing service. As the previous explanation of the typology illustrates, this has given rise to some interesting and varied developments of primary care nursing services. At some sites (e.g. Slow build-key ally) these developments were planned actively with colleagues and could be seen more as integrated PHCT initiatives for the local community. More often they were developed by the FHN alone as an opportunistic response to perceived need. Such need did not emanate solely from their assessment of services in their communities but also from their own felt need for a visible community role that broke free from the district nursing caseload.

Thus many FHNs started to run “healthy living” groups in the evenings that were open to all. These have allowed development of primary prevention work often focused on weight and diet. Such groups have had mixed success so far (men almost never attend) but have been a way of making the FHN service more accessible to the public. FHNs have also used local shops and media to advertise their role, and recently a generic information leaflet has been produced that can be distributed in communities.

Between this type of open outreach and the confines of the district nursing caseload there has been difficult ground to negotiate. One lay stakeholder’s comments capture the dilemma:

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

None of the FHNs have done “cold calls” knocking on doors to offer the service, but some have made introductory phone contact with new families moving into these small communities.

In effect the FHNs have been dependent on professional colleagues for a “way-in” to families who do not already have contact with district nursing services. This was required when the FHNs were students on placement during the educational course, but since then referrals of families have been relatively low (78 professional colleagues replying to the stakeholder questionnaire reported referring a total of 30 families in all). The majority of referrals to FHNs have continued to be for district nursing type service to individual patients. There was evidence from site visits and stakeholder questionnaires that the new FHNs were themselves active in referring individual patients and families to other colleagues and services.

Preventative work usually involved FHN input at secondary and tertiary levels for couples of the same generation, two generational families, and single people living alone (i.e. the typical client groups for district nursing). However most FHNs had ongoing input with at least one
family with young children and some of these families had more complex structures (e.g. two generations with two families coming together through re-marriage; three generational families with several households). The input here was usually primary prevention relating to common aspects of family living (e.g. diet; exercise). In the first year of practice very little FHN work has taken place in common dwellings such as residential homes or nursing homes, but some of the sites had no amenities of this sort anyway.

Operationalising the family-as-client philosophy became more difficult where several households were involved, but this does not mean it was easy within single households. The logistical difficulties of trying to see members of a family group individually and in combination cannot be overstated. Often evenings or weekends would be preferred by families, but regular work at these times was not provided for in FHN contracts and would not necessarily have been welcomed by all FHNs. Working men in particular had little contact with FHNs.

Moreover the nature of the family assessment process itself raised particular challenges. Completing a genogram and ecomap with family members was found to be a very time consuming process that typically involved a number of lengthy home visits. The 1-2 hour long visits referred to in the Site I case study were typical for FHN assessment visits. The following extract from another case study interview with an FHN highlights some common difficulties:

FHN: ... so this took a wee while and she then trusted me and had confidence in what she was saying to me. It took quite a few visits too and then once it was opened, where was the cut off point? You know there was so much that she has unspoken and then well a lot of it you just didn't record.

Researcher: I think again it is interesting when you elicit so much information there is only so much that you would be putting into the document.

FHN: There is also the confidentiality side when you have other professionals who could have access to your notes.

Researcher: It does raise the question for me of how you use the genogram then. Who is it for and what use is it?

FHN: Well exactly. It is only really for the FHN. I mean nobody else would understand the genogram, you know the ins and outs unless you are taking them through it. I mean I do outline to the family the reasons for the genogram and the ecomap to highlight strengths and weakness as you know.

Researcher: Do they have a copy of it?

FHN: No they don't have a copy of any of the notes, I keep the notes back here.

Researcher: But in terms of other professionals, they wouldn't ...

FHN: I wouldn't show them myself.
Thus we see the power of the family health nursing assessment to elicit a range of narrative over time that gives insight into family health, background and functioning, but also the associated dilemma of what to do with such information and the resultant tendency for it to become the sole property and province of the FHN. None of the six families that we studied in depth actually had a copy of the genogram or ecomap in the house. This may be related to another practical ethical problem concerning confidentiality between individuals within families.

The original comprehensive FHN documentation developed during the educational course included in-depth questions on family power structure and dynamics. In practice such an overt focus on typically covert issues was found to be unsuited to Scottish Highland and Island culture. FHNs felt that such questioning could often be uncomfortable and inappropriate for family members, especially if several were present. It is interesting to note that the North American influence is much reduced in the most recent FHN documentation produced through the Role Implementation Group.

Some of the discomfort alluded to above undoubtedly belonged to the FHNs themselves. There was no doubt that insights into power and dynamics could be useful to inform care, but these could often be gleaned more subtly than by direct questioning. Some of the FHNs reported encountering families/family members who didn’t wish to participate in the sort of in-depth assessment being offered, and this was usually because they found it intrusive and/or didn’t see why it was needed. These sort of overt refusals were relatively rare and this is almost certainly attributable to the fact that the FHNs were very experienced community nurses who used their inter-personal skills to tailor the assessment content to the situations encountered.

Much of the explicit FHN activity during 2002 involved the assessment of local families. The depth and development of this work varied but, with the exception of Site I, it generally proved difficult for FHNs to progress sustained, in-depth programmes of interventions and evaluations for more than a few families. Although plans with goals were usually explicit in the FHN documentation that we studied, we found that family members usually struggled to identify any joint family plan or specific individual goals, and never portrayed themselves as active participants in a specific shared contract. Perhaps this is more a reflection of a general culture of patient passivity than a reflection on the efforts of the FHNs. This mother and daughter were typical:

Researcher: At the moment is there any sort of plan, if you like, for your health that you are working on with Una(FHN)? Any kind of plan?

Mother: She hasn’t mentioned anything has she?

Daughter: No she hasn’t.

Mother: And I’ve not thought to be honest. I haven’t really thought about anything.

Nevertheless the family members that we interviewed were knowledgeable about the range of health services in their respective areas and it was interesting to note that they did not necessarily see the FHN as their first point of contact for a health problem. Typically they would say that it depended on the nature of the problem and who would be most suitable and readily available. Even where the problem was specifically within the nursing domain, it was
not axiomatic that the FHN would be the first choice (unless at sites where only an FHN was available). These families valued FHN input, but they also valued choice of a range of responsive services. Talking of the FHN, HV and GP this couple said:

**Pregnant mother:** ... so you know that if you’ve got a problem you can just lift the phone and you’d get one of them.

**Male partner:** They have an understanding of what we’re about- of the problems that we might encounter or how we deal with things ... I guess it just prepares them more to give us a better level of care than just, you know, Glasgow or Aberdeen and walking in somewhere and you’re a number.

Confirmation that these families were satisfied with FHN care was evident from their responses to the adapted version of the Consultation Satisfaction Questionnaire (Poulton 1996) that they completed towards the end of 2002. These highlighted the inter-personal skills of the FHNs and the value family members placed on the time that had been spent with them.

### 3.3.1 Professional stakeholders' views

The end of the year also saw the collation of responses from the follow-up professional stakeholder questionnaire. Although this material has been analysed primarily at the level of each site, there is some value in its aggregation to give an overview of colleagues’ perceptions of the FHN development so far. Table 3.7 presents professional stakeholders’ responses to a number of statements in the follow-up questionnaire (December 2002). The table is based on responses from a total of 78 professional colleagues of the FHNs.
Table 3.7 Professional stakeholders’ responses to questions post introduction of FHN

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</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 <strong>different</strong> type of service to what is currently available</td>
<td>12 (15%)</td>
<td>35 (45%)</td>
</tr>
<tr>
<td>I think the FHN delivers a <strong>similar</strong> type of service to what is currently available</td>
<td>29 (37%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</th>
<th>I think the FHN has <strong>added on</strong> to pre-existing local services</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN has <strong>taken away</strong> from pre-existing local services</td>
<td>7 (9%)</td>
<td>46 (59%)</td>
</tr>
<tr>
<td>I think the FHN has <strong>added on</strong> to pre-existing local services</td>
<td>22 (28%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</th>
<th>I think the FHN development has involved <strong>minimal change</strong> in the way that services are delivered to patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development has involved <strong>substantial change</strong> in the way that services are delivered to patients</td>
<td>6 (8%)</td>
<td>34 (44%)</td>
</tr>
<tr>
<td>I think the FHN development has involved <strong>minimal change</strong> in the way that services are delivered to patients</td>
<td>33 (42%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</th>
<th>I think the FHN development is <strong>not well suited</strong> to our local context</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development is <strong>well suited</strong> to our local context</td>
<td>23 (29%)</td>
<td>31 (40%)</td>
</tr>
<tr>
<td>I think the FHN development is <strong>not well suited</strong> to our local context</td>
<td>19 (24%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</th>
<th>I think the FHN development will lead to a <strong>deterioration</strong> in local health service</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development will lead to an <strong>improvement</strong> in local health service</td>
<td>26 (33%)</td>
<td>41 (53%)</td>
</tr>
<tr>
<td>I think the FHN development will lead to a <strong>deterioration</strong> in local health service</td>
<td>5 (6%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Unsure</th>
<th>I think the FHN development is <strong>not succeeding</strong> locally</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development is <strong>succeeding</strong> locally</td>
<td>16 (21%)</td>
<td>37 (47%)</td>
</tr>
<tr>
<td>I think the FHN development is <strong>not succeeding</strong> locally</td>
<td>17 (22%)</td>
<td></td>
</tr>
</tbody>
</table>

The above results show that professional colleagues are still unsure about the impact of many aspects of the FHN development, but also that the status quo has not been substantially altered so far. Few see the FHN as taking away services and engendering deterioration. A comparison was also made using data from the 53 professional stakeholders who responded on both occasions (Annex 5). This shows that there has been very little overall shift in these stakeholders’ perceptions.

At follow-up we also elicited professional stakeholders’ views on whether they saw the need for a distinct FHN role locally. Overall opinion was fairly evenly divided, with 31% seeing a need, 33% not seeing a need and 28% indicating that they didn’t know. When this data is broken down into responses from distinct professional groupings the results are interesting. Table 3.8 provides details.
Table 3.8  Professional groups’ responses at follow-up to question Is there a need for a distinct FHN role locally? Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages of each row

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Response</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>No answer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>District nurses</td>
<td></td>
<td>2 (33)</td>
<td>4 (67)</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Community staff nurses &amp; auxiliaries</td>
<td></td>
<td>4 (27)</td>
<td>6 (40)</td>
<td>3 (20)</td>
<td>2 (13)</td>
<td>15</td>
</tr>
<tr>
<td>Health visitors</td>
<td></td>
<td>2 (22)</td>
<td>4 (44)</td>
<td>2 (22)</td>
<td>1 (11)</td>
<td>9</td>
</tr>
<tr>
<td>Practice nurses</td>
<td></td>
<td>1 (10)</td>
<td>4 (40)</td>
<td>5 (50)</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>GPs</td>
<td></td>
<td>7 (37)</td>
<td>6 (32)</td>
<td>6 (32)</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Other health professionals (e.g. physiotherapists; dentists; midwives; occupational therapists; specialist nurses; local nurse managers)</td>
<td></td>
<td>4 (31)</td>
<td>2 (15)</td>
<td>4 (31)</td>
<td>3 (23)</td>
<td>13</td>
</tr>
<tr>
<td>Workers in wider community (e.g. voluntary sector; social worker; school teacher; project worker; home care co-ordinator)</td>
<td></td>
<td>4 (67)</td>
<td>0</td>
<td>2 (33)</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>24 (31)</td>
<td>26 (33)</td>
<td>22 (28)</td>
<td>6 (8)</td>
<td>78</td>
</tr>
</tbody>
</table>

These results suggest that the other professional nursing groups at the core of PHCTs tended to be less receptive to the new role than the wider spectrum of professional colleagues. This affords opportunity to briefly summarise the perceptions of the different professional groups about the FHN development.

3.3.1.1 District Nurses, community staff nurses and auxiliary nurses

This group was generally the most affected by the FHN role development. Some adjustment of working arrangements was usually necessary to accommodate the new role, but this usually took the form of separation of FHN work into a “patch” rather than substantive, integrated site review of caseload management. Nevertheless at some sites there were strains relating to cross-cover especially when there was staff illness or shortages. Very few of these staff were hostile to the FHN role, but more felt that family nursing happened already and could not understand the new role and the need for it. It is important to note that four of the new FHNs were already qualified District Nurses and most of them found that colleagues and clients still saw them in their former role.

3.3.1.2 Health Visitors

At national level this is the group that voiced most concerns about the new role when it was first mooted. During the first year of FHN practice, however, there was very little substantive impingement on the work of the Health Visitors at the ten FHN sites. With the possible exception of Site I, FHN forays into overt child health work and community health promotion have been on a small scale. Some local HVs have welcomed this as extra help and worked closely with the FHNs to share skills and avoid future duplication. With their geographically widespread caseloads, these HVs have taken the view that another health worker could help address the needs of some family members that they don’t often see (e.g. the elderly and men). Others have been more resistant and have either not engaged at all with the
development or sought to re-enforce professional boundaries (often formal child health development checks are seen as “the line in the sand”). Many continue to have concerns about the integration of the FHN role into PHCT service provision.

3.3.1.3 Practice Nurses

There were Practice Nurses at seven of the ten FHN sites. Many had very little working contact with FHNs and felt unsure about what the new role entailed. At one site several Practice Nurses felt that the development had disrupted team working practices in that the FHN was no longer so willing to be involved in elderly assessments and immunisation programmes. Only one Practice Nurse was markedly enthusiastic about service development opportunities for the new role.

3.3.1.4 General Practitioners

GPs are key players in all PHCTs. A striking aspect of the FHN initiative was the extent to which it was kept separate from concurrent debates about recruitment and retention of GPs in remote and rural areas of Scotland (see RARARI 2002b). GPs generally did not feel threatened and felt there was little impact on their own roles. They were divided on the need for the FHN role but few were overtly opposed as long as normal nursing services were seen to be maintained. Some more actively supported the development of the role by referring families and sharing skills in a structured way.

3.3.1.5 Midwives

It is also important to emphasise the extent to which the FHN initiative was kept separate from concurrent review of midwifery services in remote and rural areas of Scotland. In these areas the community Midwife has traditionally been a key health professional and the role has usually been carried out in combination with a nursing role (i.e. “double duty” District Nurse and Midwife; “double duty” community staff nurse and Midwife; or “triple duty” District Nurse, Health Visitor and Midwife). Six of the ten FHNs were qualified midwives and five continued to practice during 2002. Their midwifery caseloads are typically very small, with home births in these areas now very rare indeed. Rather the majority of their care is ante natal and post natal. Where working relationships with Health Visitors have been good, some of the FHNs have taken the opportunity to continue and expand their work with young babies and their families beyond the traditional time when families are handed over to the Health Visitor. Such work is in its infancy just now but has usually involved some joint assessment whereby both professionals meet at the developmental milestones.

At sites where the FHN was not a Midwife, the role was usually carried out by a “single duty” Midwife who was part of a team based in an adjacent area. Generally the FHN development had little effect on this group.
3.3.1.6 Nurse managers

Managers of community nursing services in the regions studied were only included in the stakeholder questionnaires if they were identified exclusively with a particular site. This was rare as nurse managers were few in number and usually geographically remote from the FHN sites. More often we interviewed nurse managers individually. As a group they had mixed feelings about the introduction of the FHN role and different perceptions of why it might be being introduced. Facilitating student participation in the educational course required that replacement staff be found at short notice in 2001. By the end of 2002 most of the managers were cautiously positive about the FHN development but were waiting for the outcome of the evaluation before initiating any related action.

3.3.1.7 Other health professionals

As Table 3.8 shows, other health professionals who had some engagement with an FHN were broadly supportive. This included other community specialist nurses such as CPNs and Macmillan nurses.

3.3.1.8 Workers in the wider community

Again, as Table 3.8 shows, workers in the wider community at these sites who had some engagement with an FHN were enthusiastic about the role. Many welcomed the contact and found it useful to have the extra resource and support from the FHN.

3.3.2 Lay stakeholders’ views

Finally by aggregating responses from lay stakeholders across the ten sites it is possible to obtain an overview. Table 3.9 shows data from the 34 individuals who responded on consecutive occasions.
Table 3.9 Comparison of the perceptions of 34 lay stakeholders who responded to the questionnaire pre and post introduction of FHN (* denotes wording used when questionnaire sent post FHN introduction). Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 34 this indicates that the remainder of the respondents did not answer that particular question.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>I think the FHN will deliver (delivers*) a different type of service to what is currently available</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN will deliver (delivers*) a different type of service to what is currently available</td>
<td>7 (21%)</td>
<td>6 (18%)</td>
<td>14 (41%)</td>
<td>11 (35%)</td>
<td>10 (29%)</td>
<td>10 (29%)</td>
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<tr>
<th>Statement</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>I think the FHN will deliver (delivers*) a similar type of service to what is currently available</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN will deliver (delivers*) a similar type of service to what is currently available</td>
<td>3 (9%)</td>
<td>3 (9%)</td>
<td>19 (56%)</td>
<td>15 (44%)</td>
<td>11 (32%)</td>
<td>9 (27%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>I think the FHN development is well suited to our local context</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development is well suited to our local context</td>
<td>19 (56%)</td>
<td>15 (44%)</td>
<td>10 (29%)</td>
<td>9 (27%)</td>
<td>3 (9%)</td>
<td>3 (9%)</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>Pre</th>
<th>Post</th>
<th>Unsure</th>
<th>I think the FHN development will lead to an improvement in local health service</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the FHN development will lead to an improvement in local health service</td>
<td>12 (35%)</td>
<td>12 (35%)</td>
<td>20 (59%)</td>
<td>15 (44%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3.9 shows little change in these respondents’ views. They remain unsure about several aspects of the FHN development but they have also maintained a generally supportive attitude towards it. Fear of service withdrawal does not emerge numerically as a big issue but it was prominent amongst initial comments:

"I hope the FHN is in addition to those here already- not taken or seconded from other staff"

"It is important that it is in addition to the service already provided and not in place of"

Pre-introduction of the role, sixteen respondents (27%) had heard at least something about it, usually through a friend/relative or a health care professional. By the end of 2002, ten respondents (22%) had been in contact with an FHN and some of this involved care for themselves or their family. These respondents generally saw the FHN as a similar service but one that they viewed positively.

3.3.3 Perceptions of consultation

During 2001 and 2002 work to explain the new role to local professionals and the public was co-ordinated at national and regional level. When professional stakeholders were asked at the end of 2002 whether they had been adequately consulted on the introduction of the FHN role twenty six (33%) replied positively, forty four (56%) said no and seven (9%) did not know. We also asked professional stakeholders whether they felt that consultations with the local...
public about the introduction of the role had been adequate. Ten (13%) responded positively, thirty eight (49%) said no, and twenty nine (37%) did not know.

3.4 SUMMATIVE DISCUSSION

Our evaluation has studied the first year of family health nursing practice in remote and rural Scotland. As a basis for drawing conclusions it is useful to map progress so far against the Scottish Executive’s summary of the principles of the FHN role (see 3.0).

Looking first at points 1 and 4, it can be seen that during the first year the FHNs usually functioned as skilled generalists encompassing a range of duties. For many, however, the range of duties did not differ substantially from the traditional work and concerns of the district nursing role. As such there was usually little change in terms of them being first point of contact (i.e. some FHNs were necessarily the first point of contact as there was no other type of nursing service immediately available; others would potentially be the first point of contact for their “inherited” district nursing caseload patients and a small number of other families). There was evidence that typically the FHNs were active in making referrals where more particular expertise was required.

Points 2 and 3 relate to the essential identity of the new Family Health Nurse role. Our study of practice showed that all the FHNs actively tried to take forward some work encouraging healthy living and preventing ill-health. Sometimes this was at a primary level within communities, but more often it was at secondary and tertiary levels with individual patients and other family members. For most FHNs, however, the main part of their job remained caring for ill members of the community requiring nursing care. This made it difficult for them to really develop a lead role in preventing illness and promoting health at their home sites. The FHN at Site I was a notable exception in this regard.

Irrespective of circumstances at their sites, all FHNs reported approaching their daily work with a changed and enhanced awareness of the importance of the family dimension. As has been seen their capacity to implement the family-as-client concept through in-depth assessment often seemed to be inhibited by the traditional demands for primary care work focusing on individuals. In turn this raises questions about the extent to which caring for families is already integral to the work of local primary care health teams, and whether there is shared perception of a need for change.

Consideration of the above four principles of the FHN role also highlighted some of the differences that emerged through the typology, leading to the question: what factors make an FHN role work? From our findings so far it seems that there are two basic factors:

1. The perceived scope and space to encourage implementing this approach. This was seen to pre-exist in the context of the High scope-slow build pattern and was also seen in the context of the Bold build pattern where the FHN role was separate from the district nursing caseload.

2. The local presence of at least one active supporter who changes their own practice. This was evident in the process of implementation at sites that shared the Slow build-key ally pattern.
The presence of at least one of these factors appeared to be a necessary condition for progress. Where neither of the foregoing conditions existed, family health nursing failed to thrive. During the evaluation we were also aware that the individual creativity and drive of the FHN were influential factors.

Whether these factors together are sufficient to further develop and sustain the role is doubtful. In our judgement the following factors have largely been absent during the first year of family health nursing practice and would be worth considering as a basis for future development of the role

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

In effect we found that the role can be developed in a limited way on top of a district nursing caseload and within pre-existing resources. Its introduction in these circumstances officially legitimises and raises awareness of nursing that has a strong family and health orientation in general. We would argue that this orientation is already apparent in some existing nursing practice within the Highlands and Islands of Scotland.

However the distinctive systematic approach that characterises family health nursing is new and different for the area. So far, many colleagues have found it difficult to engage with, and understand the need for, this particular approach. As such it has struggled to become a role in the sociological sense. Even where it has been legitimised through recognition (e.g. through referral of families by key allies within the PHCT) it cannot necessarily be prioritised if traditional community nursing service is to be maintained unaltered.

One of the key aspects that potentially gave the new role definition was the distinctive in-depth framework for assessment and intervention. From our study of the educational course it was clear that the FHN students saw this as a core element that was central to their new professional identity. The newly qualified FHNs spent much time trying to operationalise this framework within the context of other demands on their time. Many teething problems with the documentation were resolved creatively but during the first year it became particularly clear that the assessment process for a whole family was often complex, time consuming and difficult to orchestrate in practice. This caused intra-role conflict for the FHNs and sometimes inter-role conflict in terms of team functioning.

Through the use of community profiling the educational course also encouraged the students to conceptualise their whole home base site as the legitimate focus for their new role. This approach to practice would address the needs of individuals, families and communities. On return to practice, however, it has proved difficult for many of the FHNs to operationalise this vision in a balanced and meaningful way. For the community nursing culture from which they came, and into which they returned, tends to be permeated by the concept of caseload.

These listings of people receiving intervention/s serve to define the focus and limits for the organisation and delivery of care. In the context of introducing family health nursing so far the most relevant and dominant caseloads have undoubtedly been those of the district nursing
service. Therefore it is not surprising that the FHNs who have had to develop the role at their sites from a basis of at least maintaining the current level of district nursing service have struggled to re-conceptualise and re-prioritise their working practices. When we studied current caseload lists there was often the traditional district nursing listing followed by a small list of family names. Integration of these listings was difficult as the family health nursing work was typically seen as done by the FHN herself while the rest of the team usually only focused on the main listing. Thus family health nursing activity tended to supplement rather than supplant traditional district nursing activity. Moreover, even in small remote and rural settings, re-conceptualisation of the notion of caseload could not occur without the active engagement of other key team members in the process.

The development of family health nursing at Site I offered possible solutions to some of the above difficulties. Here the role was developed outwith the district nursing caseload and with the FHN defining the role’s boundaries in a more autonomous way. In some ways this led to a more specialist role, with referral patterns and caseload dynamics more analogous to those of a Macmillan nurse or diabetic nurse specialist. The specialism aspect was pronounced for the family part of the role, but also for the health part in terms of the primacy it gave to health education and promotion. A key feature was that this health work could cover a very large range of subject matter and client groups. The breadth of this health work brought with it some features of generalism, in the sense of having to have a broad knowledge base about a large number of topics. The key point, however, was that this FHN did not necessarily have to be generalist in the sense of concurrently addressing all the role expectations traditionally associated with the district nursing caseload. Within the existing primary care system, however, this made it more difficult for her to often act as the first point of contact.

Rather this role gave an in-depth service to a smaller number of patients and families. At the particular site we studied, the role only became very partially integrated within core, mainstream primary care team activity. However in a short space of time it made a substantive contribution to the development of health and social care in the wider community. There was some duplication of activity with the district nursing and health visiting services but the majority of the FHN activity was supplementary to the existing service. Compared to other sites, professional colleagues at Site I were more likely to see the FHN as providing a different kind of service.

As such there would appear to be cost implications if the Bold build pattern were to be developed and replicated in this way, in the absence of re-appraisal of existing PHCT roles and working practices. In essence a new, supplementary community nursing role would be created. One of the inherent aspirations of the Scottish Executive initiative has been that any viable change would be sustainable from within existing resources. In this regard it is worth noting that our previous suggestions for developing the other patterns of practice towards sustainability would also be likely to require some additional deployment of resource.

Before moving on from our analysis of practice it should be noted again that we have not studied the practice of the second cohort of FHN students. For this larger group are now qualified and currently developing the FHN role at their local sites. This includes three Health Visitors, and even within this sub-group it appears probable that distinctly different interpretations of the role may emerge.

One of the regions participating in the initiative has also been exploring the possibility of the family health nursing course being the basis for a more advanced nurse practitioner role. This
remote and rural region has particularly acute problems with the recruitment and retention of GPs, especially in a number of small islands. The region already has at least one nurse practitioner who is the key health professional delivering services to the population of a small island with no resident GP. This role has a relatively high degree of autonomy that includes limited diagnostic capacity, management of social services and use of nurse prescribing.

Thus there are possibilities for other patterns of practice to emerge and other ways that the role might be developed in practice. For the Scottish primary care sector is currently diverse and dynamic. In order to examine this more fully, and to provide wider perspective to our findings in Chapters 2 and 3, we now consider the wider Scottish context.
CHAPTER FOUR THE WIDER SCOTTISH CONTEXT

4.0 INTRODUCTION

This part of the report considers contemporary policies which have influenced primary health care in general, and then moves on to an analysis of the effectiveness, deficiencies and requirements of community-based nursing, midwifery and health visiting services across the Scottish primary care sector.

4.1 CONTEMPORARY POLICY ISSUES

Over the last five years the popularisation of former academic interests in the determinants of health, differences in rural and urban life patterns and styles, and the functioning of health professionals has led to policy reviews; new legislation; new directives and administrative initiatives which have sought to redress concerns\(^{16}\). In doing so central policy has changed, and a programme of initiatives have been introduced at grass-roots levels in an attempt to develop services and annexe previously uncharted health ground. The family health nursing initiative was one such of these. Other comparable initiatives can be seen in the various social inclusion programmes enacted across Scotland and the development of the role of public health practitioners. Funding for such initiatives has multi-various sources (e.g. National Lottery, New Opportunities Fund, NHS providers, Local Authorities and Scottish Executive Health Department) with the majority being time-limited thereby inviting problems of sustainability and proven long-term effectiveness.

4.1.1 Functioning of health professionals

Before considering some of the wider aspects of community-based nursing, midwifery and health visiting services it is worth reflecting on some of the restructuring processes which influence the working of health professionals. Local Health Care Co-operatives (LHCCs) were introduced to provide a different approach to primary care provision in Scotland. Service providers were brought together with the aim of facilitating community involvement in the design and delivery of primary health care services. Across Scotland there is no universal model for constructing LHCCs and the policy argument states that this is intentional to allow services to develop in accordance with local needs, conditions and circumstances. So we have diversity in primary care provision, not only in the remote and rural areas of Scotland, but across the country as a whole. During the time of the evaluation the notion of an LHCC has been revised for many localities. In remote and rural contexts and elsewhere in Scotland there have been shifts in service organisation in accordance with contractual agreements and service redesign\(^{17}\) within primary care. This has added another

\(^{16}\) Much of this policy change has relevance to the wider United Kingdom but for present purposes we shall be focusing on Scotland in particular. Since Scottish devolution in 1997 changes in the structure of the health service, a refocusing on public health and the development of policy pertaining to social inclusion and social justice have influenced the practice and development of health, education and social services. The current evaluation of family health nursing has been conducted against this policy backdrop.

\(^{17}\) These changes are related to GP contracts; restructuring of midwifery services and planned developments for health visiting and public health nursing.
dimension to the analysis of the role of the FHN: namely in what framework of care or at what level in an organisational structure do family health nurses operate?

4.1.2 Influences on health

Many factors are known to affect the health of individuals and groups within society. These range from infra-structural inequalities (such as inadequate provision of housing, transport, educational services and health services) to more socio-cultural issues (such as poverty, highly differentiated employment practices and institutionalised prejudices). Variations in health care outcomes have been identified within rural communities both in Scotland and elsewhere (Campbell 2000, Jones, Bentham and Horwell 1999). In addition there have been concerns expressed about the recruitment and retention of health care staff into remote and rural areas. These issues along with others have contributed to a range of localised resource development initiatives being set up under the auspices of Scottish Remote and Rural Areas Resource Initiative (2002b).

Changing patterns of working-life; relaxation of the social mores regarding marriage and child rearing; and the sub-contracting of care for children and older people have all contributed to the reconstruction of family. It is no longer an objectified entity but rather it has become a subjective expression of individual agency i.e. it means what the individual says it means.

The evaluated Family Health Nursing educational programme has attempted to be inclusive of all permutations of family, been specific in its remote and rural focus and has relied on the assessment process to identify the complex nature of post-modern living and social networks. The assessment framework used to construct the official health records has caused problems for service managers across the regions. At present there are serious doubts about the utility of these family health nurse documents to other health professionals or to the patients themselves. The recording of quasi-genetic/hereditary data alongside value judgements about the dynamics of power in a family and the health care needs of individuals does raise many unresolved questions. Firstly the ownership of the records: (e.g. do they belong to the family health nurse; the family themselves; or a dominant member; or does it belong to the wider primary health care team?); secondly the utility of the information disclosed and the ability of the FHN to act on it; thirdly the value of the record to other health care professionals; fourthly incorporating the content of this record of health assessment, goals and care interventions with the proposed “Integrated Care Record” (SEHD 2003) will be problematic due to non-compatibility with existing record systems.

4.1.3 Nursing policies and public health

A number of nursing policies have been published during the research period, ranging from Nursing for Health and Caring for Scotland (SEHD 2001) through to the UKCC’s Consultation on requirements for programmes leading to registration as a Health Visitor.

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18 Indeed the concern to understand these complex issues more fully is evident in the ongoing Economic and Social Science Research Council programme aimed at exploring the connections between social policies and ill-health across Europe.
(UKCC 2001) and subsequent revision of health visiting competencies (NMC 2002). In addition we have seen the production of a strategy for nursing and midwifery research in Scotland (SEHD 2002) and a consultation document pertaining to the revision of the professional Register which has suggested the possibility of a third part of the Register pertaining to public health. Finally and most recently a new White Paper has been produced which advocates partnership working at multiple levels within the health service (SEHD 2003).

The contextualisation of this evaluation in the world of policy has been necessary in order to remind the reader of the complex influences on health care provision in primary care settings and the potential demands made of service providers. For the next section of the report tries to explore the application of policy in practice at the level of community–based health services across Scotland. This stage of the evaluation research was designed to inform our judgements about the applicability of a family health approach to community-based nursing in the wider Scottish context. Reservations about the automatic transferability of our findings, which were derived from studies of distinctive education and practice in remote and rural contexts, into the wider Scottish world of community care, have already been stated. In this section, however, we aim to identify common concerns about community nursing services in Scotland generally and to explicate requirements for the further development of services, education and practice with special reference to family health nursing.

4.2 COMMUNITY NURSING SERVICES: STRENGTHS, WEAKNESSES AND SCOPE FOR DEVELOPMENT ACROSS SCOTLAND

A series of telephone interviews were held with key informants selected from Scottish NHS Trusts and Health Boards providing primary care services and their respective Local Health Councils. Those Trusts and Boards involved in the initiative were excluded. A total of 22 telephone interviews were planned. Informants were asked to consider the strengths and weaknesses of existing community nursing services in their locality; the strengths and weaknesses of educational and continuing professional development activities; how they perceived the role of the Family Health Nurse and where they saw this role fitting or not with their existing service provision.

The initial point of contact was with the Directors of Nursing. They were invited to participate personally and to assist in the identification of a senior nurse at LHCC level who would be willing to participate and another senior person (either manager or chairman of an LHCC) from a non-nursing professional background) who would be willing to participate. In addition the chairman of the Local Health Council was independently invited to participate by the researchers.

19 Details of the letter of invitation, planning and nomination documents, the advanced organiser which was used to guide the interview, and an information document about Family Health Nursing which was distributed with the other materials are provided on CD Rom. This last document was included as we were confident that some non-nursing informants who would be interviewed would not necessarily know anything about family health nursing. (This assumption was borne out as most of the doctors and key people in Local Health Councils whom we interviewed knew nothing about family health nursing). This in itself is an interesting observation given the imputed potential of family health nursing.
Annex 6 presents details of those who were interviewed, along with the evaluators' judgements about the level of knowledge that the interviewee had about community nursing services and the education of community nurses in general; the personal stance of the informant; the quality of the interview and a synopsis of the most interesting parts of the interview. The judgement about level of knowledge has been made to accommodate clichéd or stereotypical responses whereas the quality of the interview has been judged in order to try and identify differences between informants with regard to their analysis of complex and varied situations. Those interviewed are referred to as Key Informants in the sense that to understand what they are saying requires the researcher to move away from the notion of grand knowing (as though there is one definite answer) to an appreciation that the job is to build a science of personal perspectives which are localised, pragmatic and constructed based on personal experiences and actions. In this way it is possible to enter into a process of collaborative and co-operative enquiry (Heron 1996, Reason 2001) where meanings are checked out and compared both within and between informants.

Thus a total of 19 people were interviewed (12 senior nurses, 2 doctors, 2 representatives of the allied health professions and 3 chairman of local health councils). Another three interviews were planned but these were cancelled by the informants and no alternative arrangements were made. As illustrated in Table 4.1 the perspectives ranged from very localised levels of knowledge and understanding or a myopic individuated view of the world; to those with wider vision who attempted to incorporate fundamental values about health care provision; or nursing development; or strategic national directives.20

The following table provides a summary of recurring themes which emerged from the elicitations and subsequent narrative analysis carried out on the audio-tapes of the telephone interviews.21 Themes have been selected for inclusion when more than two people made reference to the same issue. The phraseology used to articulate the theme has been taken from the language used by the respondents during the interviews.

20 Such a range of perspectives has also been evident in the views of Steering Group members who have been overseeing the Family Health Nurse initiative. Minutes of these meetings along with observation of a key meeting to determine the way forward have been used to inform the evaluation.
21 This particular approach to analysis has been developed by the evaluators and has its roots in Psychology especially the work of Kelly (1954) Personal Construct Theory Vols I and II; Bruner (1991) Acts of Meaning and Sarbin (1986) Narrative Psychology: The Storied Nature of Human Conduct
Table 4.1  Narrative analysis of recorded telephone interviews

<table>
<thead>
<tr>
<th>Expressed strengths of existing services</th>
<th>Expressed weaknesses of existing services</th>
<th>Common concerns about introducing Family Health Nursing</th>
<th>Perceived benefits of Family Health Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of time in post and experience of workforce</td>
<td>Duplication of effort between different team members</td>
<td>Is this a correct role for community nursing services? The public are already confused about the range of people providing care.</td>
<td>Will work in rural context where team sizes are limited</td>
</tr>
<tr>
<td>18 respondents</td>
<td>15 respondents</td>
<td></td>
<td>12 respondents</td>
</tr>
<tr>
<td>Commitment of existing workforce</td>
<td>Recruitment in general</td>
<td>Maybe better to develop existing roles with some Family Health Nursing ideas</td>
<td>Solve recruitment problems into rural areas</td>
</tr>
<tr>
<td>12 respondents</td>
<td>10 respondents</td>
<td></td>
<td>12 respondents</td>
</tr>
<tr>
<td>Flexibility of existing workforce to adapt to demands</td>
<td>Lack of service integration and territoriality of professionals</td>
<td>The idea of the FHN as first point of contact; patients would not go to her first and who would refer first to an FHN</td>
<td>It should prevent duplication of effort if one person is co-ordinating in rural areas.</td>
</tr>
<tr>
<td>10 respondents</td>
<td>10 respondents</td>
<td></td>
<td>11 respondents</td>
</tr>
<tr>
<td>Strength of team working</td>
<td>No clear understanding of workloads</td>
<td>Too much resistance fixed professional boundaries</td>
<td>Applicability in rural contexts as triple duty nurses become rarer.</td>
</tr>
<tr>
<td>8 respondents</td>
<td>9 respondents</td>
<td></td>
<td>8 respondents</td>
</tr>
<tr>
<td>The general level of the education of the existing workforce</td>
<td>Lack of matching workforce skill mix to population needs</td>
<td>Lack of consolidation of existing nursing roles without introducing another</td>
<td>Complement role of Public Health Nurse and other roles</td>
</tr>
<tr>
<td>6 respondents</td>
<td>5 respondents</td>
<td></td>
<td>5 respondents</td>
</tr>
<tr>
<td>Integrated record systems</td>
<td>Limited delegation or devolution of work between groups</td>
<td>Another tier of nurses is not a good idea.</td>
<td>FHN would make a good team leader to co-ordinate services</td>
</tr>
<tr>
<td>5 respondents</td>
<td>4 respondents</td>
<td></td>
<td>5 respondents</td>
</tr>
<tr>
<td>Innovations with specific client groups especially vulnerable groups</td>
<td>Community Nurses Midwives and Health visitors do not use existing autonomy</td>
<td>Would it work alongside traditional district nursing is there a risk of DN being deskilled?</td>
<td>It’s really to do with the education of the nurse. A different way of looking at and carrying out care</td>
</tr>
<tr>
<td>4 respondents</td>
<td>3 respondents</td>
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<td>3 respondents</td>
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<tr>
<td>Availability of local training to develop services.</td>
<td>Human resource model of GP attachment</td>
<td>Good training for midwives: a multi-skilled role in rural areas</td>
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<td>3 respondents</td>
<td>3 respondents</td>
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Thus what emerged from these interviews was a general perception that the strengths of existing services lay in the experience, the flexibility, the adaptability and the team-working potential of the nursing workforce.
“Our strengths lie in our diversity of services and the people themselves. We have good relationships with three education providers and we have been working at up-skilling our health visitors, encouraging joint working with D/Ns, CPNs Learning Disability and Health Visitors” (Director of Nursing)

“We have good enthusiastic practitioners. A skilled workforce linked in with general practice” (Director of Nursing).

“Community management is good and the skill-mix is good. Community nursing teams keep close links with general practice … There is very effective core training for at G grade levels. The LHCC have been up-skilling nurses and there are opportunities for nurses to be involved in projects” (Medical Chairman LHCC).

“Out in the shire services are developed in terms of knowledge of the population, the health professionals know the people and have good local knowledge. The LHCC is a major strength it gives support to team-working. In some areas there is more multi-disciplinary team working and the nurses are all experts. There have been no concerns raised through the patient line. It is more difficult in the big cities for the staff to know people” (Chairman Local Health Council).

Another minor theme, which was discussed in terms of strengths of the services, pertained to the use of record systems. A few respondents spoke of developments with “single shared assessments” or the attempt to plan your workforce and skill-mix in terms of patient need.

“We have nursing care plans linked in to Reid codes for ISD purposes. We can measure our care plan needs and match these to time for care and the allocation of appropriate staff. The whole system is also linked in to GPASS. At the moment it is based in district nursing but health visitors are feeding in to it slowly and we have 8 pilot sites working on a single shared assessment. We are trying to have our nursing data-bases [for management and care] mirror developments in policy.” (Senior nurse LHCC).

“We have introduced a corporate case load for Health Visiting which is geographic and links with Schools … That’s made for a strong service” (LHCC manager allied health professional)

The weaknesses of the services were described in terms of duplication of effort, recruitment problems, and the nature of the workload involved whether in rural or urban contexts.

“Not having a clear handle on workload and not employing staff on a basis of workload – rather we attach staff to GP practices. There is territorialism within community nursing. Pure territorialism … over the way we look after some clients … children and families. For years health visitors have done nothing in nursing and district nurses have not even thought about health”. (Director of Nursing)

“Weaknesses in one area impact on others. For us the geography of the area and how we attract nurses. The main public issue is that we are not obtaining staff here” (Local Health Council Chairman).

“Recruiting staff with the right qualifications might take two rounds” (Director of Nursing).
“Recruitment and retention are weaknesses we have no HVs in the Bank. Starting Well and other national projects … you must feel this with NHS 24? … Siphon off key staff without any consultation with service providers” (Medical Chairman of LHCC)

“Staff recruitment and retention and the diversity of care needs are challenging. The way the teams divvy up work is a weakness” (Senior Nurse LHCC).

When asked about education and training the majority of respondents saw strengths in the current provision and reported that weaknesses were to do with placements and funding.

“We have joint appointees and have been commended on our service education collaboration. The supervisors preparations are good the main weakness in finding placements for pre-reg students” (Director of Nursing)

“Our post-reg courses are better now we have more control in terms of course content. The immediate post-reg bit is dodgy. We need a staff nurse development programme built on family” (Senior Nurse LHCC).

“Education that produces a community nurse who is generalist might meet service needs but what the public require is a specialist. You see this … a lot in cancer … people say we want a specialist nurse” (Chairman Local Health Council).

“Distance learning is a saviour … made a big difference to us … District nursing and health visiting have a common language in many issues … common core of learning … Everybody understands district nurse and health visitor. I can’t see what Family Health Nurse will solve or mean … Public health is targeted to the health visitor ... District nursing needs a boost”. (Senior Nurse Executive Level)

The concerns raised about family health nursing as an approach to community nursing focused primarily on the scope for public confusion. Invariably at this point in the interview, the interviewer was asked many questions. The issues that were raised covered the following: How will the public health nurse role fit with this? (12 respondents) Who is going to look after sick people? (8 respondents) Why has there been such a lack of good quality information about this project (6 respondents). Answering these questions involved a dialogue of exchange to gauge insight - as there were no answers to give. The information gained during these additional discussions has informed some thinking about the nature and management of the initiative and the main work of community-based nurses, midwives and health visitors.

Other specific concerns about skill-maintenance of a generic community nurse and how Family Health Nurses would fit with existing community nursing services.

“I am concerned about the skills these nurses need and how they can be maintained”. (Senior Nurse LHCC).

“I am worried about how it [family health nursing] fits into the existing system. It’s not good enough or acceptable just to keep changing course names” (Senior Nurse LHCC)

“Family health nursing was seen as a solution to problems of recruitment. It’s a mixture of everything. There may be a need for a role like this in very rural areas. Community nursing
services are like fried eggs in a pan. When you fry eggs the whites mingle the yolks stay separate. Good teams mingle in places but each keeps their distinctive parts”. (Senior nurse LHCC).

“You need to watch the erosion of specialisms” (Director of Nursing)

"It would be good to try it [family health nursing] in a big town area and see if it works. Staff here feel it is a jack of all trades approach and causes dilution of specialism. They can see that the role of the family is important” (Manager of LHCC Allied Health Professional)

Finally the informants identified the perceived benefits of Family Health Nursing primarily in terms of its applicability to remote and rural health care.

“The Family Health Nurse idea appeals. I am a great believer in holism, family and community, promoting health and treating illness. It would fit with our ideas of a healthy living centre” (Chairman Local Health Council).

“ I am looking for ways it could fit. Possibly district nursing education ... bring in family ... also at pre-registration levels. We tend to be a bit over focused on deliverables but I think we could develop services using family health nursing concepts ... in a home grown way rather than inventing another group of staff” (Director of nursing services)

“The family group as the client has potential when families at younger age ... Reconfiguring the work of community nurses into geographic collectives with the family as focus ... the blurring of roles might be better for city wide management” (Medical Chairman of LHCC).

“ I like the idea in the rural area ... you could redesign the staff nurse role ... it fits with our ideas of practice teams” (Senior Nurse LHCC).

“The Family Health Nurse is a positive move for rural areas ... it could be an attractive post for people to move into area. May even help in recruiting staff to stay ... It adds to the public health agenda” (Manager of LHCC Allied Health Professional).

“It’s to do with the education of nurses. Not just another level of nurse. There is a danger of confusing nurses ... Our approach to care and caring skills are fundamental” (Senior Nurse LHCC).

“As I see it there could be two ways of developing services, one where the FHN is a specialist alongside other specialists like Public Health Nurses and Clinical Nurse Specialists. So family health nursing is a development of a new district nursing. The other approach is to consider the Family Health Nurse as the community nurse who then refers on to other specialists. This wouldn’t work especially if they are all G grades. One nurse who looks at the whole family and builds up a relationship over a period of time would be good ... District nursing and practice nursing have lost nurse-led services and confidence and have become medicalised. The role of the midwife needs to move into wider aspects of women’s health maybe family health nursing would fit”. (Director of Nursing Services).
4.3 SUMMATIVE DISCUSSION

These findings suggest that overall community nursing services are adapting to the policy changes which have been advocated and that current educational provision is generally perceived as good. Nevertheless a number of problem areas were highlighted, most notably duplication of effort, territorialism and recruitment problems. There was also a recognition that newly qualified staff may require additional education to work in the community and that family health nursing may enhance the role of the District Nurse, Community Staff Nurse or Midwife.

Informants’ perceptions of family health nursing varied widely and there were some concerns about quality of information and public confusion. The majority agreed that remote and rural areas have special needs with regard to recruitment of staff and the design of services thereby suggesting that family health nursing has special meaning in these contexts. Such a value stance has been informed in some cases by experience of managing services in remote and rural areas but also by the fact that the initiative took place in remote and rural areas.

A further analysis of the interview data has identified an array of contemporary problems which are affecting community nursing services. These are summarised in Table 4.2.

<table>
<thead>
<tr>
<th>Table 4.2 Contemporary problems affecting community nursing in Scotland</th>
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<tr>
<td>the age of the workforce</td>
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<td>referral criteria</td>
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<td>methods of caseload management</td>
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<td>equity of service provision</td>
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<td>equity of out of hours service provision</td>
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<td>use of evidence based practice</td>
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Many of these issues also emerged as common problems at the Family Health Nurse sites.

This research was not primarily concerned to evaluate the nature or quality of community nursing services across Scotland, but rather to gain insight into common issues in order to consider how family health nursing may be extended to other remote or rural or urban areas of Scotland.

It is worth noting, however, the dearth of research-based evidence on the nature and quality of community nursing services across Scotland. This makes it difficult to know what baseline, pre-existing services are doing and how they are performing. Some of the difficulty for policy makers, service planners and researchers stems from the fact that community nursing is not a unitary discipline and has such a wide range of professional roles and entrenched interests. Moreover professional roles may be interpreted very differently within regions and even within local teams. Routinely collated data on professional activity is often of very limited value due to problems with its scope and its reliability. Thus reliable comparisons within and between regions at one point in time are difficult, and reliable longitudinal comparisons of service developments are even more problematic.

As such our interviews with key informants represent an attempt to elicit a range of relevant contemporary understandings of community nursing and family health nursing in Scotland.
The final chapter of this report considers this evidence alongside our other research findings and evidence from wider perspectives in order to draw out the implications for development of the FHN role and to make explicit the lessons learned from this evaluation.
CHAPTER FIVE  IMPLICATIONS FOR THE DEVELOPMENT OF THE FAMILY HEALTH NURSE ROLE

5.0 INTRODUCTION

From the basis of the findings reported in the previous three chapters, this chapter now considers implications for development of the FHN role. This is done firstly in relation to the role as it currently exists in a number of remote and rural areas of Scotland. This leads to consideration of its possible introduction within other areas of Scotland. The final section of the report reflects on the nature of the Scottish project before exploring its potential to inform debate about practice development and nurse education within the UK and beyond.

5.1 THE FAMILY HEALTH NURSE ROLE AS IT EXISTS

Firstly it is necessary to re-iterate that this research has been conducted over a relatively short period of time which includes only the first year of FHN practice. As such we have studied the formative stages of the role as it exists and our initial understandings should be seen in this light. The emergent typology shows four distinct patterns of FHN practice, but the majority share a significant common feature: the pervasive influence of the traditional work and concerns of the district nurse role.

Given the professional backgrounds and employment contexts of the first cohort of family health nurses this should not be surprising. In Chapter 2 it was seen that the educational process for family health nursing provided these experienced nurses with personal and professional development, encouraging a graduateness to emerge whereby they could reflect and analyse situations. All students have attempted to embrace the ideology behind family health nursing, and this is seen particularly in their enthusiasm for trying to operationalise the distinctive assessment process. However, so far, the majority have struggled to substantively incorporate the ideas into practice.

The real world of primary health care is a psychodynamic place full of cultural history, hidden meanings and assumptions. For a role to be recognised and enacted requires joint action in concordance with other people. An overt and positive need for the role was generally not recognised within the core Primary Health Care Teams at most of the sites studied. Moreover there has been limited facilitation of the role to enable enactment to take place. In effect the nature and scope of the necessary change process has been underestimated.

Although a small number of key allies emerged during the year, there was generally a lack of active “champions” for the role at local grass roots level. Others within the core PHCTs didn’t necessarily feel a need to actively engage with the new role and modify their practice. This has made it difficult for the new FHNs to develop and sustain their own new vision. For to meaningfully enact the concept of the whole family as the client would require at least a commitment to systems and role review within PHCTs whose service provision is typically predicated and prioritised on the basis of response to individuals needs. The practical difficulties around making the FHN the first point of contact illustrate the nature of the challenge involved in regard to integration of the role within PHCTs.
Figure 5.1 overleaf illustrates the context for role development. Using the principles of mapping we have identified the relative strength of associations between the major influences on the development of the FHN role.
Having conducted this eco-assessment we are able to identify the areas for planned intervention and development by means of a process of facilitation. As Figure 5.1 shows there are very strong associations between current service provision (i.e. pre family health nursing) and the expectations of the public and the professionals involved in care delivery. Theories about family, health and assessment and the attempt to utilise this knowledge in practice were strong whilst the family health nurse was a student undertaking the education programme. Utilisation of comparable knowledge by the core PHCT is weaker as is the FHNs ability to utilise this new approach to nursing in the context of current service provision.

In effect the educational programme has attempted to lead practice. There is a need now for service development to be given more emphasis so that in turn it can inform future educational development. Having already made specific proposals for course re-design in Chapter 2, we suggest that there are now three areas where active facilitation is required in order that the role of those Family Health Nurses currently in post can be developed further.

1. Enabling the FHN role to merge with current service provision in a meaningful way.
2. Developing the core primary health care team in order that they can incorporate a more systematic focus on family and health into existing services and care practices.
3. Involving patients and the wider community to expect, accept and value a different approach to nursing care in particular and health care in general.

### 5.2 THE POSSIBLE INTRODUCTION OF THE ROLE ELSEWHERE IN SCOTLAND

The application of family health nursing to other remote and rural areas of Scotland or to the wider Scottish context requires careful consideration. A multi-skilled generalist nurse who can provide a range of services should be suited to remote and rural areas of Scotland where small teams exist and recruitment problems prevail. Whether the optimum knowledge and skill-base for this individual is premised on family health nursing requires careful assessment by service providers.

For in effect this initiative has served to open up a spectrum of possibilities. The Bold build pattern represents one end of the practice spectrum. This casts the FHN as a further specialist community nurse whose work involves more in-depth programmes of care for families than those typically offered by District Nurses and Health Visitors. Although the way that Bold build developed involved some duplication of service, it was mostly supplementary to existing services. Therefore if this role were to be developed in other villages or cities, with no concurrent revision of existing roles, this would be an extra service with cost implications.

At the other end of the spectrum the FHN is virtually synonymous with the District Nurse. In this context our research has shown that sustained development of family health care programmes is difficult if all other existing services are to remain unchanged. This was the case even where teams and caseloads were relatively small and stable. This would suggest

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22 Facilitation has long been recognised as a reliable means of supporting and effecting change in practice settings (e.g. Harvey et al 2002)
more difficulty if the role were simply to be super-imposed on busy urban caseloads where throughput of individual patients may be much higher. Relevant research from other parts of the UK (Audit Commission 1999) and Aberdeen (McAskill 2002) strongly suggests that demand for an illness focused, medically responsive district nursing service remains a very high service priority.

What emerges strongly across the practice spectrum that we studied is the need for any introduction and development of the FHN role to be considered as part of wider service review and redesign. Thus we suggest that prior to introducing such a role service providers conduct a comprehensive analysis to plan, facilitate and sustain the development. This may require the deployment of an incremental approach to change management. We suggest there are four phases of analysis to be considered before deciding to introduce Family Health Nurses into the workforce.

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

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

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

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

In considering each of these questions clarity of purpose for role development begins to emerge in such a way as to facilitate the customised integration of new roles into current service provision. These considerations would have relevance to urban applications and enhance the potential of the FHN role to be a solution to the particular problems of recruitment, development and retention of staff in remote and rural areas.

Given the diverse perspectives within Scottish community nursing and primary care that emerged in Chapter 4, and given the related concerns over public confusion about the FHN role, clarity is at a premium. It is hoped that this report proves useful in this regard, but it should also be noted that the situation is dynamic. As has been noted in Chapter 3, new interpretations of the role may emerge through the practice of the Cohort 2 students. Moreover the new Public Health Nurses, whose preparation combines Health Visiting and School Nursing, have recently started to practice in Scotland. This adds another element into the mix and many of the key informants interviewed in Chapter 4 were seeking more understanding of how this role will integrate with the emerging FHN role.

During the initiative it was sometimes suggested that the FHN role could be particularly well suited to distinct client groups such as travelling people, asylum seekers or the homeless. This
could imbue the role with a particular specialist element. We have also already noted that one of the regions participating in the initiative has been exploring the possibility of the family health nursing course being the basis for a more advanced nurse practitioner role.

In many ways our considerations of the possible introduction of the FHN to other areas of Scotland are permeated by the idea of service design, and redesign, starting from the basis of local need. As indicated in Chapter 4, this is reflected to some extent in existing Scottish Executive policy towards the construction and working practices of LHCCs. Nevertheless it is easy to see how more local interpretations could lead to further expansion of the FHN typology and consequent diversity, rather than necessarily creating one distinct, defined role. This tension between local needs and the need for national/international health services to share common understandings of nursing roles sets the scene for our final reflections on the Scottish experience so far and our projections about its potential to inform practice development and nurse education within the UK and beyond.

5.3 REFLECTIONS AND PROJECTIONS

5.3.1. Changing community nursing: the wider issues

Although the Scottish initiative has so far been restricted in scope to remote and rural regions, it has raised many more general issues about change management, role development, practice development and the nature of health/healthcare services. Through the mechanisms of a national project Steering Group and a Project Officer concerted efforts have been made within a short space of time to introduce and nurture the new role. To date, however, it appears that the scope of the necessary change process has been underestimated, especially in terms of facilitating local engagement. While some of the reasons for this may be project-specific, we feel that further perspective can be gained through a brief consideration of other wider issues.

Over the past twenty years professional role development within UK nursing has been characterised by moves towards more specialist and advanced practice, bringing with it a profusion of new job titles (Tolson and West 1999; Cameron 2000). Community nursing has reflected this trend and often local necessity has driven evolution with professional education lagging somewhat behind (Spencer 2001). The UKCC educational framework published in 1994 was an attempt to address this but it can be argued that it has had the effect of reifying a fragmented and anomalous specialist superstructure for community nursing practice in the UK. For concurrently much of the nursing care delivered in communities has been devolved to registered nurses, nursing assistants and, arguably, home carers.

Therefore it is not surprising that, for some, resolution is seen in the form of a much more generic community nursing role. The WHO Europe FHN role represents one particular form of this through its focus on the family. The Scottish experience is interesting in that, to our knowledge, it represents the first UK attempt to systematically introduce at national level a new higher-level generalist role into a field that is now characterised by differentiated specialist roles. It is important to re-iterate that the introduction of the role was being underpinned by an educational course that had to also satisfy the requirements of the pre-existing specialist practice framework.
The initial process of introducing and managing this change has been driven forward within a relatively short period of time. During the first year of the initiative the efforts of the Steering Group and the Project Officer to engage with relevant members of the professions and the public through consultation were hampered by the fact that the FHN role was:

- hypothetical in nature and lacking in precedent
- very broad in its aspirations therefore difficult to define in operational terms
- consequently difficult to understand and therefore predisposing to disengagement or perceived threat
- not necessarily addressing a priority need as perceived by staff (i.e. in some areas there was a feeling that services for families were already very good)

Thus it is easy to see how the initiative could be viewed as essentially “top down” in nature. In a sense the importation of a concept such as the Family Health Nurse necessarily has something of this character. At this level there are plenty of broad precedents and parallels within recent nursing history such as regional introductions of the nursing process or specific nursing models.

Nevertheless lack of role clarity can also be a feature of new roles that evolve from very localised “bottom-up” developments. Cameron and Doyal (2000) cite findings from the Department of Health’s “Exploring new roles in practice” project which suggest that new postholders, their colleagues and managers all experienced confusion in relation to expectations of new roles that had evolved in this way.

It is moot to consider how much the ground can be prepared for the introduction of a new role like the Family Health Nurse. To return to our horticultural metaphor of Chapter 1, the community nursing garden in Scotland has a number of mature, established species including some that poorer countries in Europe might consider exotic blooms rather than the hardy perennials that they are. New seeds have been sown quickly during the course of the Family Health Nurse initiative and so far the remote and rural Scottish soil has indeed produced some hybrids. Only one of the distinctive Bold build type has flourished. The other Slow build types have raised small shoots, while the Slow/No go type has lacked space and light.

This raises an obvious question about the growth and spread of pre-existing species. During our research some professionals raised the possibility of family health nursing replacing district nursing. Moreover this is implicitly suggested within recent Scottish policy (SEHD 2000). Our research suggests that simply replacing district nursing with family health nursing is likely to produce relatively minor change if the new incumbents are expected to maintain existing service priorities and work with families only when they have time.

In effect the FHN initiative raises a much broader question about the nature and scope of primary care provision. Hartrick (1997) highlights the tension between primary care provision of a service that is primarily problem-focused and the aspiration to enhance family capacity through health promotion. The latter wish is almost limitless in scope and poses both profound and practical questions for service managers if the whole family-as-client concept is to be integral to service provision. The Bold build type represented the most developed and sustained implementation of the family-as-client concept, and in doing so raised within the PHCT questions about relative equity and priority that were usually either dormant or unrecognised.
As Hanafin et al (2002) note, need is a contested concept. These authors propose a new model for provision of the public health nursing service in the Irish Republic based on revised understandings of the need for service at the point of delivery. The Irish experience is relevant in that the role of their long-established public health nurses is in many ways very similar to the aspirations of the FHN role (e.g. having a nurse who works with a wide range of client groups across the lifespan, and who may focus service on primary, secondary or tertiary nursing care). Hanafin et al (2002) note the increasing pressure on this generalist role and the relentless pull of specialisation. As such it provides a fascinating contrast for any country considering trying to move from specialism to a more generalist community nursing role like the FHN.

Such a large scale aspiration is not yet overt in recent primary care policy within England (DOH 2002). Valuing generalists is emphasised in relation to support workers/health care assistants and registered nurses, rather than FHNs. Although some examples of innovation in family-focused care are cited in this document there is no particular policy emphasis or priority ascribed to the care of whole families. Rather a new framework for nursing in primary care sets out three core functions for nurses, midwives and health visitors:

1) First contact/acute assessment, diagnosis, care, treatment and referral

2) Continuing care, rehabilitation, chronic disease management and delivering National Service Frameworks

3) Public health/health protection and promotion programmes that improve health and reduce inequalities

Mapping the WHO Europe and Scottish Executive vision of the FHN against this framework, it can be seen that the FHN would be expected to cover all three of these functions. Most of the FHNs in Scotland so far have been attempting this, but it is interesting to note how the Bold build type tended to concentrate effort on the last two of these functions as it was not super-imposed on a district nursing workload. It is also interesting to note how the ordering of the three functions in the DOH 2002 document reflects the hierarchy of priorities so often cited to us in relation to the other relevant role that would be attempting to cover all functions: the triple duty nurse.

Consideration of current primary care policy in England is relevant as it raises the question: if you did want a new, higher level generalist community nursing role, would it be useful to put such an overt emphasis on family? During the first year of the Scottish initiative the FHNs tried very hard to address whole families’ needs through a detailed assessment and intervention framework that derived directly from the Calgary model. By the end of the year new abbreviated documentation had been produced which made the influence of this model much less overt, while simultaneously introducing an adaptation of the Omaha Activity Recording System. This reflects a pressure to spend less time on assessment and to adapt the more family specialist aspects of the role to the general demands of primary care practice.

It seems likely that in the short term in Scotland there will be inherent ongoing tension between the distinctive family focus of the role and the demand within the system for generalist activities prioritised around individuals needs. Whether this tension proves dysfunctional or not will depend on the extent to which the role can be facilitated and the extent to which PHCTs are willing to engage in practice review and service redesign. If the
latter activities are successful it is possible to envisage the Slow build types, and the Slow/No go types, developing significantly as part of more integrated, family orientated services. In turn this would lead towards a critical mass being achieved that would present a stronger argument to inform debate about changing the present UK system of community specialist practitioner roles.

5.3.3 Educational development: the wider issues

The notion of changing the whole system has been a tangible element of the macro climate in which this initiative has evolved. At times it has cast the Scottish FHN initiative as something of a sparkling light in a new dawn for community nursing. At others it has hung like a dark cloud, imposing a heavy burden of expectation on one small project. Part of the climatic turbulence in the UK relates to proposed changes to the nursing register and their possible consequences for education as well as general concern about the nature and scope of specialist practice amongst educationalists and service providers.

It seems likely that educational providers in the UK may soon have to reconsider their approach to specialist practitioner degree level education. In September 2002 the NMC agreed the new structure and parts of the UK register. The new register will have only three parts: nursing, midwifery and specialist community public health nursing. Entry to the latter part can only follow initial registration as a nurse or midwife. Further consultation on the standards for the specialist community public health nursing part of the register are due to take place in autumn 2003, but the council has already “recognised the distinct difference between nursing and public health nursing and agreed that standards for health visiting clearly demonstrated the level of specialisation required for public health nursing” (NMC 2003).

This raises the question as to whether all the other existing specialist practitioner qualifications will have a similar claim and, in particular where family health nursing will fit in. Will health visitors have a monopoly on this part of the register or will others have legitimate claims that public health is their primary and/or definitive function? A further sub part of the register is likely to be developed for a level beyond initial registration. It may be possible that some of the other existing specialist practitioner qualifications will live within this category.

The following Figure 5.2 overleaf represents a fusion of current influences on professional education for nurses, midwives and health visitors and begins to conceptualise the main differences between the Scottish family health nursing curriculum and other specialist practice degree programmes. Some of the influences, referred to in Figure 5.2 as imploding forces, have resulted in educational curricula being more confined by regulation. Role development provides the opportunity for curricula to expand and explode into new structures. The Scottish family health nursing curriculum has weakened the pull of the imploding forces and allowed itself to explode (not always in a controlled way) into role development, health technology, evidence-based practice, the scope of practice, patient client expectations and career pathways. In doing so it has helped to prepare the ground for re-conceptualising specialist practice in community–based education.
Influences on Nursing, Midwifery and Health Visiting Education

**Imploding forces**
- Medical, social and health science knowledge
- Cultural context of higher education
- Academic regulation
- Politics of the NHS
- Economic control
- Professional regulation
- Demographic change

**Exploding forces**
- Health technology
- Evidence-based practice
- Patient/client expectations
- Internal and external auditing
- Career pathways
- Scope of practice
- Joint interagency working

**Role Development**
5.4 CONCLUSION

This report has presented an evaluation of family health nursing through education and practice. In doing so it has highlighted strengths and weaknesses that have emerged during the two years of the Scottish initiative. The development of education, national policy and service delivery simultaneously is a very considerable challenge. The extent of the change required has been underestimated. Suggestions for potential development have been made throughout the report. To conclude, we now offer a brief synopsis of these based on the main lessons learned.

In order to capitalise on the achievements to date we suggest that:

- Planned development is facilitated with those PHCTs that include a Family Health Nurse in order that the role can be understood and developed further.
- The critical mass of FHNs is helped to grow in the remote and rural areas.
- The educational programme is further developed as suggested in Chapter 2.
- The evaluation process and resultant evidence is disseminated widely across the UK to foster debate and critical thinking about the nature of community nursing services and suitable educational preparation.

The evidence from this evaluation indicates that considerable effort has gone into this initiative. What has been achieved to date should neither be underestimated nor allowed to wither on the vine.
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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 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.

1. Single parent l/w adult son and daughter, (one disabled)
2. Pregnant mum l/w 3 daughters and male partner whose own children from previous relationship live elsewhere
3. Lady (77) l/w adult son & daughter
4. Lady (58) l/w husband & daughter
5. Lady (79) living alone
6. Lady (73) living alone
ANNEX TWO

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)
<table>
<thead>
<tr>
<th>Site code</th>
<th>Approximate population served by site PHCT</th>
<th>District* nursing caseload for whole PHCT site (and % receiving input every week or more often)</th>
<th>Staff complement covering District nursing caseload (mid-2002)</th>
<th>Number in core PCT (eg. GPs, DN, other nurses, HV)</th>
<th>“Inherited” District* nursing caseload for FHN “patch” (and % receiving input every week or more often)</th>
<th>FHN role, grade and hours pre-course</th>
<th>FHN role, grade and hours post-course</th>
<th>Any substantial change in staffing complement for DN caseload during year of FHN introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>70</td>
<td>70 (4%)**</td>
<td>1 G FHN f/t, 1 relief nurse p/t</td>
<td>2 on site 4 associated</td>
<td>70 (4%)**</td>
<td>DN/Midwife G; f/t</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>400</td>
<td>15 (47%)</td>
<td>1 G FHN f/t, 1 relief nurse p/t</td>
<td>4 on site 3 associated</td>
<td>15 (47%)</td>
<td>SN; G; f/t</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>520</td>
<td>31 (29%)</td>
<td>1 G FHN f/t, 1 Aux nurse 20hrs + bank</td>
<td>4</td>
<td>31 (29%)</td>
<td>SN/Midwife F; f/t</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>D</td>
<td>2500</td>
<td>90 (59%)</td>
<td>1 G FHN f/t, 1 G DN f/t, 1 D SN 30hrs, 1 Aux nurse 12hrs</td>
<td>9</td>
<td>34 (44%)</td>
<td>SN; E; f/t</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>3600</td>
<td>202 (30%)</td>
<td>2 G DN f/t, 1 G FHN f/t, 2 E SN 30hrs, 2 Aux nurse p/t</td>
<td>19</td>
<td>48 (31%)</td>
<td>DN; F; 30 hrs</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>F</td>
<td>1900</td>
<td>79 (50%)</td>
<td>1 G DN f/t, 1 G FHN f/t, 1 E SN 30hrs, 1 Aux nurse f/t</td>
<td>9</td>
<td>33 (50%)</td>
<td>SN/Midwife F; 30 hrs</td>
<td>FHN; G; f/t</td>
<td>No</td>
</tr>
<tr>
<td>G</td>
<td>1700</td>
<td>202 (21%)**</td>
<td>1 G DN f/t, 1 G FHN 30hrs, 2 SN f/t (one F &amp; one E), 1 Aux nurse f/t</td>
<td>12</td>
<td>46 (30%)</td>
<td>DN; F; 30 hrs</td>
<td>FHN; G; 30 hrs</td>
<td>No</td>
</tr>
<tr>
<td>H</td>
<td>1250</td>
<td>100 (29%)</td>
<td>1 G FHN f/t, 1 G DN f/t, 1 D SN f/t, 1 Aux nurse 20hrs</td>
<td>8</td>
<td>55 (23%)</td>
<td>SN/Midwife F; 15-30 hrs</td>
<td>FHN; G; f/t</td>
<td>No, but short staffed for 6 months until G grade DN recruited</td>
</tr>
<tr>
<td>I</td>
<td>2200</td>
<td>120 (58%)</td>
<td>2 G DN f/t, 2 F SN 15 hrs each, 2 Aux nurses 10 &amp; 13.5 hrs</td>
<td>10</td>
<td>N/A</td>
<td>SN; E; 15 hrs</td>
<td>FHN; G; f/t</td>
<td>Yes, small net increase (see case study)</td>
</tr>
<tr>
<td>J</td>
<td>1150</td>
<td>36 (61%)</td>
<td>1 G FHN f/t, 1 F SN 22.5 hrs, 2 relief nurses (DN &amp; SN), 1 Aux nurse (bank hours)</td>
<td>10</td>
<td>36 (61%)</td>
<td>DN/Midwife G; f/t</td>
<td>FHN; G; f/t &amp; lead nurse</td>
<td>Yes, service integrating with hospital staff</td>
</tr>
</tbody>
</table>

*CASELOAD FIGURES: These figures should be treated with much caution. Firstly they are based on snapshots when visiting sites during 2002. Secondly practice varied so much as to what constituted a caseload (eg. what people were visited for; frequency of visiting; entry and exit from caseload list) that meaningful comparison was very difficult. Routinely collected data on nursing activity was virtually worthless in this regard as recording practices varied so widely. Accordingly the “percentage receiving input every week or more often” figure is our very crude attempt at meaningful comparison. However this does not allow for the type or amount of input (eg. several concurrent terminal care cases at Site G when FHN took on “patch”). At the end of the day, perceived burden of caseload (ie. non-heavy or heavy) proved as useful a proxy indicator as any, especially since this was cross-checked with other members of the PHCT. Thus we have used this indicator in our typology of practice.

** Extreme low percentages often merely reflect the limitations of using the percentage receiving frequent input measure. At Site A the whole population is the caseload. Formal frequent district nursing input is very low, but weekly contact with most of the population is unavoidable and will usually involve informal assessment. At Site G the community nursing register includes a very large proportion of infrequent supervisory or support visits (eg. for over 75 assessment). This large denominator makes the resultant percentage low (despite 42 patients needing frequent input).
ANNEX FOUR   TWO CASE STUDIES OF FAMILY HEALTH NURSE PRACTICE

INTRODUCTION

These in-depth case studies have been constructed in order to offer the reader greater insights into the world of family health nursing through the words of the Family Health Nurses themselves, family members, professional colleagues and researchers. Sites exemplifying the Slow/No go and Bold build patterns have been selected as they represent different ends of the spectrum of family health nursing practice that we studied. Within this contrast lies a great deal of useful knowledge about how the FHN role may or may not work. The case studies have been constructed to illustrate particular themes that are characteristic of these patterns. They also aim to offer some insights into the interview methods used by the researchers. It is important to note that these case studies are based on data from the first year of FHN practice and only reflect the evolution of the role up until autumn/winter 2002.

Each site case study starts by “going in through the eye” of a family case study done at the site. The working of the FHN model with this particular family is then considered in relation to FHN practice with other local families, district nursing practice at the site, and the practice and perceptions of the wider Primary Health Care Team and local community.

Extracts of dialogue from interviews have been selected for analytical purposes but at times also fulfil a narrative function. These extracts are used verbatim except for the very occasional editing out of any excessively personal material. Different names have been used to help protect the identities of those family members who kindly took part in interviews. FHNs are referred to as “FHN” except for in the body of dialogue where they are referred to as Una (as Cohort 1 were pioneering this role). Other health professionals who had knowledge and close involvement in the case are all referred to as “Colleague”. Finally, somewhat predictably, the researcher is referred to as “Researcher”.

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The context for this case study is a large geographic district (Site G) with a sparsely distributed population of around 1700 people. The district has one predominant settlement where almost all the Primary Health Care team members are based. The FHN has been allocated a distinct geographic “patch” within the district. Cardiovascular disease, cancers and diabetes are all prominent health problems within the community.

The focal case involves the following family who are native to the area:

Grace, a 77 year old lady who for many years has required district nursing input for recurrent problems with varicose leg ulcers. She lives with her daughter Heather (42) and son Calum (44).

**Researcher:** ... generally, what have you been trying to achieve with this particular family?

**FHN:** What I set out to achieve I haven’t because of other pressures within the caseload. With terminal care I’ve had quite a few ill people. I haven’t been able to cause I had to prioritise. When I originally spoke to them the mother had got varicose ulcers, Calum had been diagnosed diabetic and Heather has been under investigation just now, but she’s been having this skin problem......

This extract exemplifies the theme of thwarted case development that frequently emerged for those trying to implement family health nursing on top of busy district nursing caseloads. The FHN was typically going in once or twice a week to attend to Grace’s ulcer, and other members of the community nursing team provided back up:

**Colleague:** ... our input now with Grace is purely on a relief basis for Una (FHN). You know if Grace is pencilled in for a visit on Una’s days off or she is on holiday, then we go in and do that visit and record it on Una’s notes.

**Researcher:** Can I ask you about Una’s notes, do they stay in the house or do they stay in here (site base)?

**Colleague:** Here.

**Researcher:** Is that them you’ve got there?

**Colleague:** Yes, it’s the same notes, the same but different. They are the same as our own notes, except Una’s got extra bits for the genogram and ecomap.

This customisation also incorporated completed assessment sheets pertaining to family dynamics (such as power structure, roles, strengths, stresses and coping) and culminated in a family plan: To discuss dietary habits with family in view of Calum’s hypertension and diabetes, and Heather’s anaemia. A family “progress sheet” recording sheet had two entries by the FHN, one of which was Unable to have family discussion due to visitors being present. This family assessment material supplemented sections with individual traditional nursing notes for all three
family members, with comprehensive information relating to the range of medical problems that were existing and emergent. As such the notes provided comprehensive evidence of care and represented a sustained, if rather unwieldy, attempt to reconcile family health nursing and district nursing documentation.

The FHN had made a start to the plan by giving the family a number of leaflets on healthy eating, but had not had a chance to follow this through. The other community nursing staff did not have any specific input with the family in this regard.

**Researcher:** So has there been any need to change your diet, to use these booklets?

**Grace:** No.

**Heather:** We were going to look them up to do with losing weight.

**Researcher:** Is that something you’ve made any progress with?

**Heather:** Haven’t started. You haven’t tried to lose weight yet, have you?

**Grace:** I don’t take sweet things or anything. Maybe I could do more walking and that. That would help.

However the family members interviewed were very appreciative of all nursing input received, and made special mention of the FHN’s listening skills. Indeed the FHN herself felt that some progress had been made.

**Researcher:** Is the contact you’ve been having with the family similar to your previous way of working before you came on the course? Are you doing anything different?

**FHN:** Probably not. I’ve arranged more with them. Probably as a DN you’d go in twice a week on the same days. It’s a bit more flexible and has their agreement that the days get changed. The times are more flexible.

**Researcher:** Is that more flexible to suit you or to suit them?

**FHN:** Well, if it suits us both. I discuss it with them. What suits them.

**Researcher:** And previously would it have mattered if you’d seen Heather? I mean you were going in anyway to do the dressing. But do you think in the past if Grace had said to you 2 or 3 years ago when you were doing the dressing that she had some worries about Heather or Calum, what would you have done?

**FHN:** Spoken to them and spoken to the GP. And would have been involved then if there was anything nursing wise. I feel Grace is more communicative with me, talking more, certainly, and she’s coming across with more of her feelings.
Researcher: Do you think that’s been influenced by your attempt to sort of formally assess them by spending time with them?

FHN: I think maybe it is. Just getting to know her better and building up trust.

Researcher: Would that have been legitimate activity before in terms of your DN work? If you had said to your colleagues or decided that it seems as if Heather has got some needs here, I’m going to spend some time trying to get to the bottom of this, would that have been a reasonable thing to do in terms of your normal work?

FHN: Yes.

At the time of interview Heather was receiving input from the local GP and Calum saw the diabetic specialist nurse periodically.

Researcher: I suppose I’m hunting for what extra dimension, if any, you feel that the FHN brings to a family like this?

FHN: I think had I more time it could have been more. More meetings with them. More discussion. More in-depth. Which is what I planned to do, but then there were other priorities on the caseload and really in the past two months they’ve had to come further down my list. I haven’t been able to spend time with them or do what I initially set out to do.

Confirmation was provided by the family that a new approach to care hadn’t yet been established:

Researcher: Who would you contact first if you had a problem with your health; that is yourself? Would it be the doctor, the family health nurse or the District Nurse?

Heather: Probably the District Nurse.

Researcher: For yourself?

Heather: Probably. I only go to the doctor when I have to. Eventually.

Researcher: And for your mum, would it be........?

Heather: Probably get in touch with the nurse, like going to the District Nurse in Maintown. Either phone the doc, or to the hospital.

Researcher: So the district nursing service you’d contact rather than Una (FHN) herself?

Heather: Yes. Yes.

Researcher: Do you think what Una is doing is, as far as you can tell, any different from what happened before with the family?
Heather: Well there wasn’t really a before so I can’t tell you.

Researcher: Yes, there was just the District Nurse coming in. As far as you are aware, is there any sort of plan for the family’s health, or anything like that?

Heather: No.

The above extract also confirms the FHN’s assessment that there is a need and opportunity for some integrated secondary prevention work with this family as a whole. However the challenge of delivering sustained work of this sort (eg. working on attitude change) within the present local working arrangements had so far proved insuperable. Moreover there was still the question of how much individual members, and the family as a whole, might want to engage in any more pro-active, health focused model of service delivery. There was no suggestion of any dissatisfaction with pre-existing health care services.

This affords good opportunity to broaden discussion towards analysis of working practices at the site as a whole.

Overall the core PHCT comprises the FHN (G grade 30 hours per week); one full-time District Nurse who is team leader; two full time community nurses (one F grade, one E grade); one community nurse who does “bank, relief” work; a full time auxiliary nurse; two Practice Nurses, and 3 GPs. The nursing caseload for the whole geographic district numbers around 200 patients and is dominated by chronic health problems of over 75s. Many supervisory visits take place. Bathing is mostly done by the auxiliary nurse, but nurses do some. The FHN’s distinct “patch” within this site typically has 40-50 community nursing patients. A team midwifery system operates locally from a different base. Although many of the core primary care team listed above are midwives, none now are practising.

The Health Visitor covers an even wider geographic area. Within the part of her patch that is coterminus with this primary care team, she carries out a range of work. Much of this work is with children and mothers (around 30 children who receive developmental screening and related interventions if necessary). She also does health checks and health teaching in the local primary school; sees a limited number of adults individually to help them with smoking cessation and/or cardiac rehabilitation; and runs a variety of evening groups in the area (eg. womens’ “look after yourself” group).

Within this team context the FHN has been trying to make the role work:

FHN: I feel that I’m not really working on my own, yet I’m not really part of the team as I was either.

Researcher: So, in between?

FHN: I feel I’m missing out. I haven’t been able to do anything sort of community based.
In fact there was evidence that the FHN had been active in some health promotion and screening work with the local primary school. Some of this was in collaboration with the Health Visitor, but there had not been sustained development of this activity. Work with specific families was slow and it had been possible to engage in sustained, in-depth family health work with less than five families since starting the post.

Researcher: I'm interested in what makes someone a family health nurse case, or what makes a family a family health nurse case, and the example you are giving here is where there’s quite a lot going on in terms of health needs.

FHN: Probably for education.

Researcher: Yes and you are also saying that it’s possibly easier for you to take on people or families who haven’t had previous DN involvement. But from what I understand the vast majority of your work so far has actually been with the traditional DN caseload in your area. In a few cases like this family, you’ve tried to branch out from that caseload to other family members. Would...

FHN: What I’m finding is hard. There’s another family as well that I’ve done an assessment on and it’s the daughter in that family that’s diabetic and the mothers diabetic, but when I go in primarily as a DN I’ve been going in to visit the mother. And because they’re all so polite they get out the room to let me speak to mother, and I find it very difficult to get them to come back in to the room as a family committee. Because of what traditionally happened. But I find it easier if there’s been no involvement, then from the beginning I can get the family together and have discussion.

From the beginning of the project the rest of the primary care team were very supportive of the FHN’s personal professional development and of her aspiration to make the role work. There was already a good pre-existing culture of regular, open team meetings and the team set up an open diary for ongoing team reflection on the process of introducing family health nursing. Negative comments tended to predominate. One particular issue for the rest of the team was that the routine data returned monthly on patient contacts and activities did not properly reflect their input in covering the FHN’s patch. By the end of the year there was general consensus that the role wasn’t working:

Researcher: So there’s a question about where it fits in. Is it providing a similar or a different service?

Colleague: At the moment Una (FHN) is doing DN under a different title. But then that’s not Una’s fault. Cause Una was brought back into the community as a member of the team. And she was given a caseload, so she had to carry that caseload and she had to continue doing the work that was done before. And we all felt that it would have been better if Una had been brought back supernumerary, and if they had come out as new nurses and developed their caseload, rather than taking on what was already there and having to continue doing what was already being done.
The above extract exemplifies a strong theme that emerged at this site and indeed the vast majority of other sites. That is the embedded need for the community nursing service to continue as normal. At this site a specific geographical sub-patch had been hived off for the FHN but it was not seen as an opportunity for any substantive review of nursing caseloads and working practices. Given that the family health nurse initiative was presented as a time-limited experiment this is not surprising, but it does suggest that the team at the site saw it more as an experiment on them, rather than by them. The professional stakeholders’ comments about consultation on the introduction of the role support this interpretation:

"I don’t think the concept and where the FHN fits in vis a vis community nursing and health visiting was explained to us at all"

"Consultations have been mainly with evaluators. Nothing prior to project start"

At a more fundamental level team members struggled to see the need for a new role

**Researcher:** How do you feel that the role of the FHN fits in with local services in general?

**Colleague:** Well it was felt, we all felt, that it’s a difficult one because there’s already a framework in place for the delivery of service. You know there’s already the DN service, the HVs, there’s health promotion.....

At the end of the year only one of the ten professional stakeholders who replied (10%) said there was a positive need for a distinct FHN role. Three (30%) felt there wasn’t, and the remainder didn’t know. Explanatory comments revealed a range of perceptions:

"I think it should be decided whether we have DN or FHN. There is so much duplication of remit that it is otherwise confusing to the public"

"I feel the role is that of the present Health Visitor. Duplication not needed"

"Good community nursing care is already given and it would be better to extend the district nursing role. Health visiting service is very good also"

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

Amongst the team there was little recognition of any substantive gap in current service provision

**Researcher:** I don’t know if you would have a chance to discuss this as a team but in that event, which is now hypothetical, but if she’d been brought back as a supernumerary person, do you think you could see the need for that?

**Colleague:** No, I don’t really know. I think we would be doubtful about that. Again because, and you can correct me if you’ve got information that I don’t have, but you know things are pretty well covered.
Researcher: Yes and you mentioned that health promotion are covering a number of areas, District Nurses ... But I suppose if we take the elements of this new title, family health nurse, emphasising health, do you think there is anything missing in terms of the care of families?

Colleague: In respect of the DN service?

Researcher: In respect of the whole team: the net effect?

Colleague: Maybe because we are rural and nearly everyone knows everyone else, I think it’s pretty much covered because the HV, the DNs, the Practice Nurses, we do pick up things with families. We do pick them up and you find out, you know word of mouth, you pick up what’s happening.

Researcher: Maybe not in the way that’s in these notes (FHN) where, if you like, there’s a systematic...

Colleague: Yes. I don’t know, Una (FHN), whether she’s had any problems, but especially the Highland and Island personality is quite reluctant to change. And I don’t know how well people will take to these forms which are quite probing. And I think there might be some...

Researcher: Do you think that some of that’s a bit too intrusive?

Colleague: Well I think that people might find that.

Most of the lay stakeholders who responded felt unable to give an opinion on the implementation of family health nursing so far, but one respondent saw possibilities:

"I believe that this would be a valuable service and prevent illness if individuals and family unit were assessed as a whole, not mainly when medical assistance is required for specific illness"

While a few of the professional stakeholders indicated that the development had caused disruption to the team (especially when the FHN was away on the course), many also commented positively on the FHN’s professional development and saw her recent training and experience as a useful resource for the team. However referral activity continued to be almost exclusively for traditional district nursing input with individual patients. During the year there were less than five referrals of families to the FHN. When asked to comment on any change for professionals in the way they worked together, one stakeholder commented:

"It should have but hasn’t – needed more facilitation and support"

The FHN provides summation

Researcher: If you could change one thing about your current role, what would that be?

FHN: What I’m doing just now? I would change it totally.
**Researcher:** Totally? Right, let’s hear about it!

**FHN:** I don’t think the FHN is working and will work in this area based on a DN caseload as there is too many other things going on. The area I’m working in has a lot of elderly and initially when I started there was a lot of general nursing care which I had never minded doing. But when there’s auxiliaries and carers that can do the role, I think I should have been doing things that I’d been trained to do.

During the year some extra auxiliary nursing hours were allocated to assist the development of the role, but these came from within existing resources and there was no net increase in nursing resource at the site during the first year of implementation.

In summary, the FHN development in this Category 2 site (see Table 3.5) can be characterised as:

- sporadic, and seldom developed or sustained, despite much effort
- not really seen as needed by professional colleagues, but the team tried to support the FHN

The characteristic pattern can be summarised as:

**Context:** FHN role super-imposed on “heavy” district nursing caseload within established and functional medium sized PHCT

**Process:** Sporadic and limited introduction by FHN only, with little/no change in other professionals’ activities

**Outcome:** No substantive change in practice. “Normal” district nursing services maintained, but remains stressful for FHN and colleagues.

Two other sites (F and H) shared this characteristic pattern (see Table 3.6). Like Site G, each of these sites had some difficulties with staff shortages and sickness during 2002.
The context for this case study is a large geographic district (Site I) with a population of around 2200 people. This population is sparsely distributed apart from one relatively isolated large village with a distinctive post-industrial heritage. The majority of the core Primary Health Care team members are based in this village. The FHN does not have a distinct geographic “patch” within the district, but much of her work is focused on the needs of people in the village. The village has a particularly high proportion of vulnerable groups (the elderly, unemployed, single parent families, cultural minorities and socially deprived families). Cardiovascular disease, cancers and mental health problems are all prominent health issues within the community.

The focal case involves the following person who had raised her family in the area:

Jean, a 74 year old widowed lady who lives alone and has a large number of chronic health problems. Jean has four grown up children who live outwith the immediate district but keep in regular contact.

**Researcher:** What was your first contact with Jean?

**FHN:** Well she approached me. I met her in the surgery waiting room when she was waiting to go in to the doctor, and she said “Oh I hear you’ve been away on a course” and she asked me if I could come in and speak to her. She’d recently been diagnosed with diabetes and was unsure about her diet and different things, and she was wondering if I could help her with that. So I said “Yes, that would be fine, I’ll come and see you”. And then I cleared it with my colleague and saw her, and from then on I’ve been seeing her on a weekly basis most of the time. I think probably now we’ll be tailoring it down a bit, but it has been weekly so far.

**Researcher:** What is the main thing you’ve been trying to achieve?

**FHN:** Really trying to improve her basic knowledge of diabetes. How it affects her, how it affects her life, and also the other medical problems she’s got, cause she’s got a whole host of medical problems on her list. But diabetes was the first thing and through that we’ve just been discussing her and realised that she was wanting more information on angina, her chronic obstructive airways disease and things like that. She wasn’t sure about what they were, or how they affected her, and what she could do to help, so its really been a lot of health education we’ve been doing together, and also looking at building up her independence and trying to reduce stress as she finds coping on her own quite hard.

This input from the FHN had been sustained over the past 8 months.

**FHN:** ... so I think, as far as the diabetes management, I know from asking her myself how she feels she's getting on, as its her targets that we stick to, and she feels that she has quite good knowledge of the diabetes, how it affects her and what her diet should be and what the complications are and how to reduce the chances of developing any more. So I think the progress from that part has been good.
... Cause if I was a community nurse I would come in, give the info, do what I have to do and then that would be it finished, whereas with this I've been going over it over a month and building up slowly. Going back over things cause quite often you can tell someone something and they say "Oh yea I understand that" and then a few months down the line they think "I didn't really quite understand that, can we go back over that again" So its been quite a back and forth programme.

Researcher: And while we're on that pre-FHN, why would you not have spent so much time on health education? Was it because you lacked the knowledge yourself or did you have other things to do?

FHN: Usually because I had other things to do. Cause that was always what frustrated me about being a community nurse, being stuck in that situation where you didn't have the time to give properly to your patients, and you would give ad hoc kind of info that you knew that the patient couldn't actually use very well. But you felt you were doing your job right if you did it anyway.

This perception of a more in-depth service was confirmed by colleagues within the core PHCT, but the view of community nurse information giving expressed above was by no means universally held within the core PHCT. There were also differing perceptions as to how much this service was needed and whether any extra quality/benefit was actually being delivered.

Colleague 2: ... also you have problems trying to cope with people who are needing a lot of support and input, and Una (FHN) filled the gap.

Colleague 1: I'm not entirely sure the benefit an FHN can give to Jean that would not already be addressed by the GP, the Practice Nurse and the District Nurse.

In the context of diabetes care a number of services were already available within the site. These included the practice nurse, a dietician who visited the site weekly and a Nurse Specialist in Diabetes Care based outwith the site. Jean had some contact with these services prior to the FHN becoming involved and occasional contact with the practice nurse and Nurse Specialist thereafter.

Jean also continued to have fairly regular contact with other members of the core PHCT, particularly the district nursing service which continued to visit weekly in order to co-ordinate Jean’s complex oral medication arrangements. These visits were typically brief (around 10-15 minutes) and occurred at the other end of the week from the FHN visits. This arrangement was initially seen as beneficial by all parties in that it gave more regular support to Jean, but in recent months the district nurse and the FHN had recognised that the arrangement involved some unnecessary duplication. Despite mutual recognition that the FHN alone could cover all home input for Jean, however, both services continued to visit and record brief details on continuation sheets within a summary nursing care plan kept in Jean’s home.

FHN notes were kept at the nursing base. These were comprehensive and incorporated two main sections. Firstly there was a full FHN documentation including a genogram, an ecomap, and assessment of family roles, functions, values, activities and strengths. Secondly there was a
section comprising individual health history sheet, medication record sheet, a variety of diabetic monitoring sheets, and finally need-goal-intervention plans for six different health needs. The latter plans were very detailed, had been evaluated on each FHN visit and included Jean’s own perceptions of progress.

The genogram highlighted a family history of cardiovascular problems.

**Researcher:** Even though ostensibly you’re dealing with one individual, do you feel its been worthwhile doing the genogram?

**FHN:** Definitely because Jean herself found it very interesting. Just looking at the family members and looking at the links, because not many people realise, until its down in black and white, you can be talking about past family history and they know that things travel in families, but until they see something like this they cant actually get that into their head and see how important it is to encourage a healthy lifestyle throughout the generations.

Although the FHN did not have professional contact with Jean’s children, she indicated that Jean herself had raised the topic of lifestyle issues with her sons and daughters. Jean derived a great deal of psychosocial support from the FHN’s visits.

**Jean:** She's got a good listening ear.

**Researcher:** Is that one of the important things?

**Jean:** Yes very much so.

**Researcher:** What sort of things do you tell her?

**Jean:** Sometimes the way I feel and things like that. It's hard to say really. I'd be lost without her, she makes my day.

**Researcher:** So it gives you a support?

**Jean:** Definitely. If I need any help or aid she'll try and get it for me.

**Researcher:** Financial?

**Jean:** Yes. She's supposed to try the internet for it, but she hasn't got access yet.

**Researcher:** So that's a bit different from the district nursing?

**Jean:** Oh aye, different entirely.

The FHN highlighted one of the major differences.
Researcher: I found it very useful that latterly in your notes you'd actually write down how long some of your visits had been taking. It’s very helpful and gave me an idea that you were often there for an hour or so, and that’s quite intensive work?

FHN: That’s right it’s a long time. And I do find on average most of my visits are about an hour to everyone that I see really, and I was clocking up so I thought I would write it down in the notes as it does reflect that it is very different from community nursing where you average visit is 15-20 minutes in and out, whereas mine last year has been on average one hour to one and a half hours.

The FHN was working towards reducing her input with Jean and recognised that dependency was a potential problem. Colleagues shared this concern.

Colleague 2: Its difficult for Una (FHN) as well, if she's going to restrict herself down to X number of families and they've all got problems that are not going to go away today. She's going to have them on her books for months & months, that’s a problem. I mean I don't know how many families she's supposed to have in all, but I think she's pretty near full, if not full. What can you do in that situation?

Indeed the FHN’s colleagues had a number of broader concerns about the development of the role and how it fitted in with core PHCT activities. As such this is a good point at which to broaden discussion towards analysis of working practices at the site as a whole.

The core primary health care team based in the main village comprises one full time G grade District Nurse; one F grade community staff nurse (15 hours per week); one auxiliary nurse (10 hours per week); one Practice Nurse (10.5 hours per week) and two GPs. Prior to undertaking the course, the FHN had been working locally as an E grade community nurse for 7.5 hours per week in this village and 7.5 hours per week in a smaller village. Since completing the course the FHN was now working full time at G grade (Monday to Friday). Although based in the main village the FHN provided family health nursing services across the district.

The rest of the core PHCT for the district are based in a smaller village and comprise one full time G grade District Nurse; one F grade community staff nurse (15 hours per week); one auxiliary nurse (13.5 hours per week); one full time Health Visitor. The Health Visitor’s work within the district was predominantly with children and mothers, and involved work in a number of local schools. Her remit also involved working in schools outwith the district.

The district nursing caseload for the district as a whole numbers around 120 and is dominated by elderly people with chronic health problems. Many supervisory visits take place and these are seen within the district nursing team as part of the family dimension of their care. Bathing is mostly done by the auxiliary nurse, but nurses do some. A team midwifery system operates locally from a base just outwith the district.
The mode of FHN role development at this site was found to be unique in our study of practice:

Researcher: If there's a whole lot of people with needs, how do you choose who you prioritise?

FHN: Very difficult.

Researcher: Is that, .... it sounds like its been an issue, or has it?

FHN: Not for me personally, because I haven't been choosing my patients. I've had all my patients have been referred to me directly, either by self or by DN, GP other community professionals, (midwives, practice nurses), so I haven't in a sense been choosing them because of their need; they haven't been getting priority over other people. I take anyone or anything it doesn't matter.

Researcher: Right, cause that’s an interesting way. You've developed the caseload pretty much from scratch, haven't you?

FHN: Yes.

Researcher: And you're telling me that you've developed it from referrals from other professionals. So the need has been recognised by them?

FHN: Yes.

Researcher: And would you ever say "no" to some of the people?

FHN: Yes. And I have done. If I feel that the caseload is too heavy, or I'm too busy and I feel that I cannot give that fairly equal time and proper input, then I would say could you either defer this, or I have a waiting list of a month, and I'll get round to seeing them in a months time. And that’s worked OK so far.....

Assessment of referrals often proved interesting

FHN: ... if there is somebody that they send me that I think will probably, may not be suitable, I'll see them and try and work out things. But often actually sometimes from what the referring person perceives as that persons problem, when that person comes to me and I assess them, sometimes its quite different. What the patient sees their problem is and why they think they've been sent to me. And then it can actually turn out that they are an ideal candidate for an FHN, but I wouldn’t have known that sometimes from the assessment. So every patient that I’m referred I do see, if only once to ascertain that they are not falling within my jurisdiction...

The client led aspect of the service was highlighted by the FHN:

Researcher: ... from what you're saying its different?
**FHN:** It is different, definitely. I think it meets the clients needs more because I ask the client what they need. Often as a DN you go in, because the doctors told you that you've got a diabetic patient that’s on heaps of medication, can you sort it out? You're not going in under any other terms, that's your task go and do it. But with this its much more open, it's often at patient's request, or at other reasons to go in. So it's much more client-led and so it's quite different.

**Researcher:** Sticking on that client-led nature, and Jean, how many more cases like her could you have on your caseload where you are going in quite frequently (eg. weekly)?

**FHN:** I am not sure. I've got about 24 caseload at the moment. I've lost a few in the past few weeks. I manage that just, but I do a lot of other stuff.

However the client-led aspect did not necessarily fit easily into the overall system of service provision locally:

**Colleague 1:** So I'm not sure how productive it is for Una (FHN) to be spending time with a patient selected out of all the other ones, with no particular reason why its this patient as opposed to other patients with chronic heart, lung, diabetes.

... There are lots of people, so how do you select, I mean which ones get the sort of intensive care (as in one is worthy of more attention than the other) and my criticism is that we are not making best use of the PHCT.

The way that family health nursing was developed at this particular site raised issues about the equity of the new service amongst several members of the core PHCT, and in turn engendered reflections about the equity of pre-existing services at this site. These included the service coverage for particular client groups.

**Colleague 2:** I think we're very well provided for here really. But if Una (FHN) wasn't here, excluding her, the PHCT team would work but there would be various things like the clinics she's doing down there wouldn't be getting done and again these problem families wouldn't be getting covered because you'd be running in and running out. Whereas Una can sit and say "right just exactly what is it you want?". Right, I'll refer you to OT whatever and go through the assessment. We do the assessment but it’s not in as much depth.

**Researcher:** Last time we spoke you raised the question of a possible 2 tier service.

**Colleague 2:** It is actually still a worry. I feel that it’s a service that probably everyone should have, but that’s an ideal situation. But everyone should have that sort of assessment to start with...

During the first year of FHN practice though, this single FHN had necessarily only been able to provide the service to a limited number of individuals and families. Moreover from the FHN perspective this new service was based entirely on expressed need (ie. referrals from other health professionals and by local people self-referring) and everyone who was referred was assessed.
The possibility of widening FHN service coverage through delegation was explored:

**Researcher:** Thinking of your own work with Jean, as an FHN, are there any aspects of your own work that you would think about delegating, or that could be done by someone else feasibly?

**FHN:** Yes, I suppose a lot of it...well not a lot of it, but part of it could be delegated. Maybe the weekly, day-to-day visiting of families could be done once a case plan is put in motion and the assessment done. Some of the support could be done by somebody else. And the health education part of it as well, there is no reason why a community nurse who has a special interest or knowledge in that area couldn’t do that too. And a lot of the documentation and planning and organising of groups could also be done by somebody else. And lots of kind of letters you write, that could be delegated. I don't know, it's difficult to answer that in this context at the moment because it's just me and there's no-one I can kind of delegate to.

This highlights that integration with mainstream community nursing had not been achieved during the first year of FHN practice. The reasons underlying this were contested within the site. During the educational course the FHN and colleagues from the project team initiated meetings to try to explain the new role to professional colleagues and the local public. The FHN’s colleagues generally felt, however, that they had been poorly consulted prior to the introduction of the role and many were unclear about what the role involved and did not involve:

"We were told that this was going ahead. We had no choice"

"Initial information patchy. Caused upset and confusion with health care professionals"

The process of introducing and establishing the role entailed considerable stress for the FHN and a number of colleagues within the core PHCT. From the FHN perspective there was the very difficult challenge of trying to grow this distinctive new role while simultaneously trying to fit into the established core team approach. From the perspective of some, but not all, colleagues within the core PHCT there was an ongoing feeling that:

- the role was being imposed from outwith the site
- there was no clear need for the role
- its introduction reflected badly on pre-existing services

Unsurprisingly this gave rise to some sustained working difficulties. During the first nine months in particular there had been some conflict between roles:

**Colleague 1:** ... she’s got some resentment from people she works with as to taking over their patients.
In a more general sense some colleagues within the core team did not see the FHN role as being part of an open, on-call primary care service that would necessarily have to respond to the full range of community nursing and/or medical priorities.

**Colleague 1:** ... the FHN has a far smaller number of cases. The other thing with the DN is that she's got an open model - she can't turn down any work. If someone gets discharged from hospital tomorrow she's got to take on the case. The distinction is that you have an open workload for the DN which is whatever work that happens to be needed for the day, and a closed workload which is controllable - I can see that it's far better - I mean I would like it if you could start the day and you knew exactly what you were going to do and nothing else - it takes all the stress out of it, no worries.

This point is important as, unlike the other FHN practice that we studied, this FHN did not necessarily have to be generalist in the sense of concurrently addressing all the role expectations traditionally associated with the district nursing caseload. This enabled the FHN to have more autonomy to determine and act on FHN priority:

**Researcher:** Well that's a useful explanation of priority within an FHN caseload, because I'm thinking of, when I talk to triple duty nurses for instance, they will often give you the hierarchy of work which usually goes along the lines of, midwifery or acute DN care first, going through to less acute DN work, to health promotion, to notionally community development work if that's even on the agenda, that's what I hear.

**FHN:** Cause health promotion and education to me is my top priority.

**Researcher:** Is it?

**FHN:** Yes, Cause what we are trying to do. We're trying for the long run, for the future. We're trying to educate these families to live with their chronic conditions and to empower them, and for them to be able to be independent, and not need so much from health service in the future. So its vitally important, and yes if they have an acute problem I would deal with that (obviously I'd have to) but if it was just a well individual that I was going to see my first priority would be the health promotion/education, lifestyle issues that they had, that I was going to see them with. That's really what we are doing, or what I'm doing anyway.

What this model of family health nursing implementation also did not necessarily do, within the present system, was make the FHN the first point of contact:

**Colleague 1:** You see it mentions in this Scottish Executive thing about the nurse as the first point of contact for patients. I think that’s daft, as I don't see how she can be - she hasn't got a role that makes her the first point.

... So the first contact concept seems a bit hopeful to me, totally impractical in fact. If you've only got one. If you're thinking of this person as a nurse practitioner, that nurse is the first contact with patients so it makes sense to have her as a prescriber and as someone who is going to
consult, make a diagnosis and management plan. That I could see as person who is going to have first contact, but not your FHN.

By the end of the first year of practice the FHN had actually become an extended nurse prescriber, but she remained the only provider of family health nursing services and this limited her capacity to necessarily be the first point of contact for nursing and/or other primary care services.

In some ways the FHN's model of consultation at this site had more in common with the ideals of health visiting than district nursing (eg. overt prioritisation of health work). In addition to addressing the needs of individuals and families, the FHN had considered need at the general community level in her community portrait (completed during the educational course) and was using this to underpin the development of more broad based community work. By the end of the year the following activities had been developed which together comprise roughly 30% of the FHN workload:

- a fortnightly general health clinic in the main village which is open to anyone who wants to discuss a health issue or concern. This has been advertised in local media. Appointments are encouraged but people can drop-in and still be seen. Typical consultations have involved short-term input for smoking cessation; weight checks and healthy eating advice; immunisations; and mental health problems
- working as the health link person for the local community centre. This has involved a key role within a local Social Inclusion Project which has been offering teenage girls the chance to discuss contraception and other health and lifestyle issues. It has also involved joint facilitation of an exercise and music group for over 65s in the village, with health checks are incorporated into the programme
- weekly visits to the local Day Care Centre offering ad-hoc health checks and information/advice
- setting up a community reference group to enable the local community to pass on their views on local health needs. So far this has proved more difficult to establish and sustain
- consulting with others regarding setting up a Carers Group, having found that there are many young carers in the village with unmet needs
- consulting with others (eg. community OT for mental health) regarding setting up a Stress and Anxiety management group

Within the activities outlined above there are many that appear to be addressing gaps in wider health and social care provision locally. Professional stakeholders from the wider health and social care community (eg. community workers) viewed the FHN role as a very positive development indeed:

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

"Huge impact on my ability to address health issues in an informal setting but with professional knowledge and back up"
"Our FHN has been very supportive of our project, she is always available if we need to talk. She gives talks on health issues and does checks whenever she can"

"Highlights the appropriateness and positive impact of bringing health issues into the “community” sphere of work"

Some of these community based activities (e.g. immunisation; sex education for teenagers; assessment of the elderly) clearly overlap with the role boundaries of other core service providers within the PHCT (e.g. GP; Health Visitor; Practice Nurse). Again there were concerns among some of the core team that these FHN services were being developed in isolation from overall PHCT services and that, from their perspective, further fragmentation rather than integration would ensue. Anxieties over infringement of role boundaries were a persistent feature during the first year of FHN practice at this site. Given the very broad range of activities being undertaken by the FHN, and their relatively vigorous development, this is not surprising.

Colleague 1: ... it (FHN) seems to be such a big job, it seems to be everything. I mean this specialist/generalist thing is anything you can think of.

Indeed a key feature of this FHN’s health work was that it could cover a very large range of subject matter and client groups. There was a particular focus on secondary and tertiary prevention work for elderly patients with chronic conditions. This is a client group that some people locally saw as “falling through gaps in the net”. Some work with families with young children was undertaken but there was very little joint working with the Health Visitor.

The breadth of the health work undertaken brought with it some features of “generalism”, in the sense of having to have a broad knowledge base about a large number of topics. However the FHN also emphasised the distinct, specialist nature of the role:

Researcher: Thinking of future development, how would you like to see the FHN go, would you like to see it fit in alongside other existing specialist community nursing roles such as HV, DN FHN in one team like this, or do you think it could replace these roles?

FHN: In this situation I don't think it could replace any of these roles because of the population and the kind of area. But maybe a smaller area and where you have a set population or a very tight geographical area where influx was not going to be a huge amount, you could, have just an FHN I suppose. But I think the real strength of the FHN role lies in it being a speciality. In it being separate from DN & HV. Because I do think it's a completely different role. It complements DN & HV, because it takes it that step further.

Four out of thirteen professional stakeholders locally (31%) did see it as providing a substantively different service by the end of the first year, while two (15%) actively took an opposite view. This contrasts markedly with all the other sites and tends to confirm the distinctiveness of this FHN role development. A key feature within this site was that the FHN was seen as providing a much more in-depth, intensive and sustained service to a small/medium caseload of families. Professional stakeholders generally felt poorly consulted in the early stages of the development, but by the end of the year seven respondents (54%) felt the development to
be well suited to the area. Eight (62%) thought it likely to lead to an improvement in local health service and none characterised it as a failure. Five respondents (39%) felt the development had involved substantial change for professionals in the way they work together.

The majority (54%) felt that the development had added to, rather than taken away from, pre-existing local services. This perception was not universally shared, however, and amongst the district nursing team there was still a feeling that they had lost 15 hours of service provision from their team (prior to undertaking the course, the FHN had been working locally as an E grade community nurse for a total of 15 hours per week). This highlights that family health nursing is being seen within the core PHCT as a different kind of service that should be supplementary to the maintenance of normal service, rather than supplanting it. Indeed district nursing activities continued very much as normal during the year. While the introduction of the FHN was not seen as a catalyst for substantive review of community nursing caseloads, a number of families were referred to the FHN. Sometimes the FHN subsequently delivered all their care, but often there was concurrent input from both services.

Looking at the net change in site staffing over the first year of implementation, there has been:

- loss of 15 hours of E grade community staff nurse
- gain of 37 hours of G grade FHN
- one F grade community staff nurse (15 hours) has been replaced by an E grade community staff nurse (15 hours)

Accordingly there has been a small increase in the nursing budget during the period that FHN practice was introduced.

By the end of the first year six of the thirteen professional stakeholders who replied (46%) felt there was definitely a need for an FHN locally. Four did not know (31%) and two felt that there wasn’t (15%). The fact that most of the core PHCT had actively referred families to the FHN in sufficient quantities to form a new caseload tends to confirm the need for an additional service of some kind. There were still doubts, however, about what the format of that service should be:

"I am not sure if its about creating a further role to DN and HV or about ensuring that the FHN role is accepted as being the way DN’s should work, and their role changed accordingly"

"The FHN is really a “licensing” or permission for time and space to work in the way many of our health professionals already do on their own initiative"

**Colleague 1:** I think it’s a bad idea to have yet another category of nurse full stop. It doesn't matter what she is doing or the quality. There is too many categories of nurses already....

The characteristic pattern of FHN development at this site can be summarised as:

**Context:** “Heavy” district nursing caseload within established medium sized PHCT, but FHN not super-imposed
**Process:** New FHN caseload built vigorously through referrals from professionals and public. Autonomous workload management with high community outreach element. Some friction at the boundaries of other professionals’ roles. Tensions within the core PHCT

**Outcome:** Positively viewed by the families who received the service and by a range of groups in the wider community. Some change in referral practices for a number of professionals. “Normal” district nursing services maintained, but persistent core PHCT concerns about perceived lack of integration of the FHN role and the resultant equity of the overall service. More satisfying for the FHN, but much more demanding
ANNEX FIVE

COMPARISON OF THE PERCEPTIONS OF THE 53 PROFESSIONAL STAKEHOLDERS WHO RESPONDED TO THE QUESTIONNAIRE PRE AND POST INTRODUCTION OF FHN

* denotes wording used when questionnaire sent post-FHN introduction. Figures in bold text indicate actual number of respondents in each category and figures in brackets are percentages. Where row totals are less than 53 this indicates that the remainder of the respondents did not answer that particular question.

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<td>21 (40)</td>
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<tr>
<td>I think the FHN development is well suited to our local context</td>
<td>Unsure</td>
<td>I think the FHN development is not well suited to our local context</td>
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<tr>
<td>I think the FHN development will lead to an improvement in local health service</td>
<td>Unsure</td>
<td>I think the FHN development will lead to a deterioration in local health service</td>
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<td>12 (23)</td>
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<td>33 (62)</td>
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<tr>
<td>I think the FHN development is likely to succeed (is succeeding*) locally</td>
<td>Unsure</td>
<td>I think the FHN development is unlikely to succeed (is not succeeding*) locally</td>
<td></td>
<td></td>
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<td>8 (15)</td>
<td>26 (49)</td>
<td>28 (53)</td>
<td>13 (25)</td>
<td>13 (25)</td>
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<tr>
<td>Signifier and duration of interview</td>
<td>Perspective (discipline and level)</td>
<td>Level of Knowledge and personal stance</td>
<td>Quality of interview</td>
<td>Most important part of interview</td>
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<tr>
<td>A 40 mins</td>
<td>Strategic national regional and operational Urban and rural Nursing</td>
<td>High Pro FHN Suggested urban pilot</td>
<td>Very good information. Frameworks suggested</td>
<td>Section on Integrated approach and framework towards end of interview.</td>
<td></td>
</tr>
<tr>
<td>B 30 mins</td>
<td>Health Council Local</td>
<td>Moderate Sees nursing as looking after sick</td>
<td>Good in places. Concerned about plethora of nurses and titles and specialisms</td>
<td>Section on non-medical model and notion of family.</td>
<td></td>
</tr>
<tr>
<td>C 45 mins</td>
<td>Strategic to regional and operational Nursing</td>
<td>Moderate Pro HV Anti Dr</td>
<td>Good Tuned into the morale of D/Ns feeling devalued.</td>
<td>Section at the beginning on the strengths and use of models and records.</td>
<td></td>
</tr>
<tr>
<td>D 30 mins</td>
<td>LHCC Urban Nursing</td>
<td>Moderate Aware of deprivation and poverty issues. Post code health</td>
<td>Good Sees need for more integration to avoid duplications</td>
<td>Section on education of community staff and section on the difficulties of the DN</td>
<td></td>
</tr>
<tr>
<td>E 25 mins</td>
<td>Local Nursing</td>
<td>Low Lack of knowledge</td>
<td>Average Emphasised potential for confusion amongst public.</td>
<td>Section on beefing up general skills of community nurses.</td>
<td></td>
</tr>
<tr>
<td>F 60 mins</td>
<td>Strategic operational and national Rural and urban Allied health professional</td>
<td>High Good intellectual approach to the issues. Analytical problem solver Learning from other contexts</td>
<td>Very good Gave several leads for us to follow up. Keen on nursing development.</td>
<td>Section on Strengths and description of cohesive services. Section on Education and Multi-disciplinary approach and final section on FHN.</td>
<td></td>
</tr>
<tr>
<td>G 20 mins</td>
<td>Health council Local</td>
<td>Low Lack of knowledge acute and primary care differences</td>
<td>Average Enthusiastic for nurse-led services</td>
<td>Section on patient assessment towards end.</td>
<td></td>
</tr>
<tr>
<td>H 25 mins</td>
<td>LHCC urban Medical</td>
<td>Moderate Concerned about national projects which siphon off good staff</td>
<td>Average Concerned about pace of change. Curative and treatment elements of care</td>
<td>Section on weaknesses re conflict and final statement about pace of change.</td>
<td></td>
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<tr>
<td>Signifier and duration</td>
<td>Perspective</td>
<td>Knowledge base and personal stance</td>
<td>Quality of interview</td>
<td>Most important part of interview</td>
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<tr>
<td>I 50mins</td>
<td>Strategic operational and national Nursing</td>
<td>High Concerned about professional boundaries and need to free people’s minds</td>
<td>Good Gave insight into matching workforce with population needs</td>
<td>Section on weaknesses and also one on up-skilling</td>
<td></td>
</tr>
<tr>
<td>J 35mins</td>
<td>LHCC Remote and urban Allied health professions</td>
<td>Moderate Optimum use of workforce a concern</td>
<td>Good Gave insight into notion of corporate caseload</td>
<td>Section on strengths and section on the FHN role as an aid to recruitment</td>
<td></td>
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<tr>
<td>K 30mins</td>
<td>LHCC Urban &amp; rural Nursing</td>
<td>Moderate Pro HV perspective</td>
<td>Average Gave some insight into needs assessment and staffing levels</td>
<td>Section on skills of FHN at end and section on staffing levels.</td>
<td></td>
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<tr>
<td>L 25mins</td>
<td>Local rural Nursing</td>
<td>High Keen on developing existing services and thinks DN service should be given a boost.</td>
<td>Good Appreciates value of distance learning Strength of existing service</td>
<td>Section on distance learning and section on FHN</td>
<td></td>
</tr>
<tr>
<td>M 50 mins</td>
<td>LHCC Urban Nursing</td>
<td>High Concerned about short-termism in the NHS. Very pro nurse</td>
<td>Good Raised issue of supervision and concern about just keeping changing nursing courses</td>
<td>Section on education and FHN at the end and section on need to roll out short term projects which work well.</td>
<td></td>
</tr>
<tr>
<td>N 45mins</td>
<td>Strategic and operational urban Nursing</td>
<td>High Need to integrate education practice and research</td>
<td>Very good Raised awareness of care recording systems. Concerned about how FHN would add to service. Need to conduct service reviews to match workforce to patient needs</td>
<td>Section on reviews of service and section criticising literature available</td>
<td></td>
</tr>
<tr>
<td>O 25mins</td>
<td>Health council Local</td>
<td>Moderate Still coming to terms with problems faced as a carer herself.</td>
<td>Good Brought to awareness the patient line.</td>
<td>Section on holism as it brings in personal experiences and ideological beliefs.</td>
<td></td>
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<tr>
<td>Signifier and duration</td>
<td>Perspective</td>
<td>Knowledge base and personal stance</td>
<td>Quality of interview</td>
<td>Most important part of the interview</td>
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<tr>
<td>P 20mins</td>
<td>LHCC semi rural Nursing</td>
<td>Low Pro HV Anti FHN without any real argument</td>
<td>Average Raised issue that FHN was set up to solve recruitment problem only</td>
<td>Section at the beginning of the FHN conversation.</td>
<td></td>
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<tr>
<td>Q 20 mins</td>
<td>LHCC and national primary care Medical</td>
<td>Moderate Concerned with out of hours services and reshaping services</td>
<td>Good Raised issue to workforce organisation</td>
<td>Section on practice attachment and geographic working</td>
<td></td>
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<tr>
<td>R 55mins</td>
<td>LHCC Operational educational and developmental Nursing</td>
<td>High Concerned about patient expectations</td>
<td>Good Provided insight into a framework for staff development</td>
<td>Section on demands under weaknesses and section on frameworks.</td>
<td></td>
</tr>
<tr>
<td>S 45mins</td>
<td>Strategic operational and national Nursing</td>
<td>High Concerned to match workforce skill mix to patient need Pro FHN</td>
<td>Very good Provided insight into use of Arbuthnott Problems of remote nursing Links with mental health nursing &amp; gaps in education</td>
<td>Section On Arbuthnott and bench marking also contact economist cited. Section on FHN</td>
<td></td>
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An Evaluation of Section 18 of the Mental Health Implementation of Part 5 of the Adults with Incapacity (Scotland) Act 2000: Julie Ridley, Lyn Jones, Anne Robson, Scottish Health Feedback. (2002) (£5.00)
Summary available: Health and Community Care Research Findings No.18

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Providing Free Personal Care for Older People: Research commissioned to inform the work of the Care Development Group: edited by Diane Machin and Danny McShane. (2002) (£10.00)
Summaries available: Health and Community Care Research Findings Nos.3, 4, 5, 6, 7 and 8

Summary available: Development Department Research Findings No.132

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Consultation with Children and Young People on the Scottish Executive’s Plan for Action on Alcohol Misuse: Kathryn Potter. (2002) (£5.00)
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Evaluation of New Deal for Young People in Scotland: Phase Two: Dorothe Bonjour, Genevieve Knight, Stephen Lissenburgh. (2002) (£5.00)
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Summary available: Development Department Research Findings No.136

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Evaluation of the West Lothian Driver Improvement Scheme: Steven Hope, Dave Ingram and Becki Lancaster (NFO System Three Social Research). (2002) (£5.00)
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Monitoring the National Cycling Strategy in Scotland: Scottish Cycling Development Project. (2002) (£4.00)

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Good Practice Guidance-Consultation with Equalities Groups: Reid-Howie Associates. (2002) (£5.00)
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A Rural Community Gateway Website for Scotland - Scoping Study: Jenny Brogden, Joanna Gilliatt and Doug Maclean (Lambda Research and Consultancy Ltd). (2002) (£5.00)

City Region Boundaries Study: Derek Halden Consultancy (2002) (£5.00)

Why Do Parents Drive Their Children to School?: George Street Research. (2002) (£5.00)


Disciplining Children: Research with Parents in Scotland: Simon Anderson and Lorraine Murray (NFO System Three); Julie Brownlie (Stirling University). (2002) (£5.00)

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Business-Related Bankruptcies Under the Bankruptcy (Scotland) Act 1985 (As Amended) - Phase 1: Scoping Study: Lambda Research and Consultancy Ltd. (2002) (£5.00)

Evaluation of the "Know the Score" Drugs Campaign: Doug Maclean, Joanna Gilliatt and Jenny Brogden (Lambda Research Consultancy Ltd). (2002) (£5.00)

A Review of the First Year of the Mandatory Licensing Scheme in Houses in Multiple Occupation in Scotland: Hector Currie (School of Planning & Housing, Edinburgh College of Art/Heriot Watt University). (2002) (£5.00)

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Evaluation of Individual Learning Accounts - Phase 1: York Consulting Ltd. (2002) (£5.00)

Delivering Work Based Learning: Andrea Glass, Kevin Higgins and Alan McGregor, Glasgow University. (2002) (£5.00)
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Review of International Best Practise in Service Delivery to Remote and Rural Areas: Frank W. Rennie, Wolfgang Greller and Mary Mackay (The Institute of Rural and Island Studios and The Scottish Centre for Information Research, Lews Castle College, UHI Millennium Institute, Stornoway). (2002) (£5.00)
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Getting Involved in Planning: Analysis of Consultation Responses: Geoff Peart Consulting. (2002) (Free)
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Getting Involved in Planning: Perceptions of the Wider Public: Dr Paul Jenkins, Karryn Kirk, Dr Harry Smith (Centre for Environment and Human Settlements, School of Planning and Housing, Edinburgh College of Art/Heriot-Watt University). (2002) (Free)
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Summary available: Land Use and Rural Policy Research Findings No.4/2003 (Web only)

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Public Attitudes to Windfarms: Simon Braunholtz (MORI Scotland). (2003) (£5.00)
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Summary available: Health and Community Care Research Findings No.32/2003

Summary available: Enterprise and Lifelong Learning Research Findings No.7/2003

Further information on any of the above is available by contacting:
Scottish Executive
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Or by accessing the World Wide Website:
http://www.scotland.gov.uk/socialresearch
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