

The WHO Europe Family Health Nursing Pilot in Scotland Final Report

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Contents

Foreword by the Chief Nursing Officer	2	3 Impact and outcomes	23
		Delivering services closer to home	23
		Support and protection of the public	23
		Caring for older people	23
		Unscheduled care and planned care	24
		Anticipatory care, improving health, public health and reducing inequalities	24
		Supported self-care, patient empowerment and managing long-term conditions	24
		Leadership	25
		eHealth	25
1 Policy context in Scotland	4	4 Learning and key messages	27
		Learning	27
		Key messages	30
		Conclusion	30
2 Family Health Nursing	7	References	32
Role, model and framework	8		
Role	8		
Model for the role	9		
Role framework	11		
Pilot phases 1 and 2	13		
Research evaluations	14		
Multinational	14		
National	14		
Education programme	15		
Practice development	16		
Langley's Continuous Improvement Model	18		
Calgary Family Assessment Model	18		
Change management	19		

Contents

Appendix 1

National Implementation Group/
Family Health Nurse National Forum 35

Appendix 2

Conceptual model of
Family-Centred Health Care 37

Appendix 3

Research Evaluation Executive
Summary 40

Appendix 4

Education programme 43

Foreword

Foreword

by the Chief Nursing Officer



People in Scotland were very aware back in February 2001 that we were embarking on a bold experiment in community nursing as the first cohort of students on the Family Health Nursing programme took their places at Stirling University.

We could see that the Family Health Nursing project offered the potential for a different approach to the community nursing service, one which focused on families and which set health improvement and illness prevention high on its list of priorities alongside disease management.

Five years further on, we can see that our initial optimism and excitement about the role was fully justified.

Family Health Nurses have now taken their place as vital parts of community-based health services, working as members of primary care teams in the remote and rural areas of Scotland where the project was first launched. They also made significant contributions to services in urban areas during Phase 2 of the project. Patients have come to understand their role and enormously value the contribution Family Health Nurses make. They particularly like the fact that when they see a Family Health Nurse, they are seeing someone who knows them, their family and their community, and who has the knowledge, skills and tools to assess health status, offer treatment and advice and refer to appropriate specialist services when necessary.

The development of the role has been taken forward by a strong partnership involving the Scottish Executive, WHO Europe, NHS Boards, community-based health professionals, communities, educators and researchers. It has been guided by the National Implementation Group and Family Health Nurse National Forum (see Appendix 1), to whose members I pay

warm tribute for their dedication to making the role work for Scotland's communities.

This final report of the Family Health Nurse project in Scotland is a vital part of the nursing response to our national health policy, *Delivering for Health*. The report and the knowledge gained from conducting the project over the last five years have had an enormous influence on the development of the Scottish Executive Health Department action plan for nursing, midwifery and the allied health professions, *Delivering Care, Enabling Health* which will be published soon, and on developing future models for the delivery of nursing care in the community.

The Family Health Nurse multinational project has provided us with a unique opportunity to contribute to the strategy for nursing across the WHO Europe Region. Being part of the international community of nursing has enabled us to work in partnership with member states, looking beyond the borders of Scotland towards global solutions to the challenges of providing sustainable, safe and effective services to our populations.

I am proud that Scotland has responded to the challenge of testing the Family Health Nursing role. We have learned much from the project about the importance of managing the process of change and the value of the service-user's voice in shaping new roles to meet defined needs. I now look forward to the next stage in the evolution of this exciting and important nursing role.

Paul Martin
Chief Nursing Officer
Scottish Executive Health Department

Section 1

Policy context in Scotland

Section 1

1 Policy context in Scotland

“The modernisation of health services across Europe, where increasing amounts and a great variety of health care interventions are delivered in primary care and community settings, requires new roles and new ways of working by health care personnel.”

(World Health Organisation (WHO) Europe (2006) *Report on the Evaluation of the WHO Multi-country Family Health Nurse Pilot Study*. Copenhagen: WHO Europe.)

Scotland has seen a number of legislative and policy developments that affect community services since 1999, when the Family Health Nurse pilot was first proposed. The most significant of these, *Delivering for Health* (SEHD, 2005), sets out the policy infrastructure to create a fundamental shift in the way the NHS works, from an acute, hospital-driven service to one that is community-based. The policy focuses on:

- meeting the twin challenges of an ageing population and the rising incidence of long-term conditions
- preventing ill-health by equipping the health service to encourage and secure health improvement and ‘wellness’, rather than just treating illness
- treating people faster and closer to home
- developing services that are proactive, modern, safe and embedded in communities.

The new policy agenda in Scotland sets the scene for, and demands, new kinds of community-based services.

The nursing, midwifery and allied health professions response to implementing the new policy will be set out in *Delivering Care, Delivering Health*, which will provide clear direction on the way forward for nursing and

midwifery in relation to culture and context (underlying principles of practice), capability (nursing and midwifery’s contribution to health care in the future), and capacity (competency requirements for the new NHS workforce).

The Scottish Executive is currently conducting a national Review of nursing in the community in Scotland. The review so far has found much to celebrate in nursing in the community, with participants in consultations conducted during the process praising nurses’ breadth of knowledge and skills, a rich blend that enables them to undertake holistic assessments and to creatively problem-solve with individuals, families and communities.

It is important to consider this final report of the Family Health Nursing project in Scotland within the context of *Delivering for Health* and the nursing response to it - *Delivering Health, Enabling Care*. The report seeks to reflect and complement each of these initiatives. Also significant to the development of Family Health Nursing services is a raft of policy and legislative initiatives that impact on the delivery of health and social care services to communities in Scotland, including:

- *Nursing for Health - a Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health in Scotland* (SEHD, 2001)
- *Developing the Nursing and Midwifery Workforce 2003* (National Workforce Unit, 2004)
- *Rights, Relationships and Recovery – the Review of Mental Health Nursing in Scotland* (SEHD, 2006a)
- *Changing Lives: The 21st Century Social Work Review* (Scottish Executive, 2006)
- *Care 21* (OPM/Scottish Executive, 2005), and the Scottish Executive response to it (Scottish Executive, 2006a)

- *Delivering a Healthy Future* (Scottish Executive, 2006b)
- the Joint Future programme
(<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Introduction>)
- Community Care and Health (Scotland) Act 2002
(<http://www.opsi.gov.uk/legislation/scotland/acts2002/20020005.htm>)
- The Mental Health (Care and Treatment) (Scotland) Act 2003
(<http://www.opsi.gov.uk/legislation/scotland/acts2003/20030013.htm>)
- the General Medical Services Contract
(<http://www.paymodernisation.scot.nhs.uk/gms/index.htm>)
- the Agenda for Change pay modernisation initiative
(<http://www.paymodernisation.scot.nhs.uk/>).
- WHO Europe (2006) *Report on the Evaluation of the WHO Multi-country Family Health Nurse Pilot Study*. Copenhagen: WHO Europe
(<http://www.euro.who.int/document/e88841.pdf>)

Section 2

Family Health Nursing

Section 2

2 Family Health Nursing

“The workforce has to be prepared in order to have the skills and knowledge to take on new roles and responsibilities. Social and cultural understandings need to be reshaped to accept and support the introduction of new practices.”

(WHO Europe (2006) *Report on the Evaluation of the WHO Multi-country Family Health Nurse Pilot Study*. Copenhagen: WHO Europe.)

The Family Health Nursing project in Scotland is part of a wider WHO Europe initiative.

Changing demography and disease patterns have challenged WHO Europe member states to review the ways in which they deliver health care services. New health problems such as HIV/AIDS have emerged. Non-communicable

diseases have reached epidemic proportions in developed and developing countries. Ageing populations and declining birth rates prevail in some member states. And chronic conditions and environmental risks present challenges for most health care systems (WHO, 2003).

Nursing and midwifery education and practice have reformed in many ways in response to this changing health map. An example of this can be found in the multinational pilot of the Family Health Nurse role.

The Family Health Nurse initiative was developed following a recommendation from HEALTH21 (WHO, 1998). WHO Europe described the role of the Family Health Nurse as one that contains elements of existing roles of several nursing disciplines working in primary care settings across the European region. The particular combination of elements - the focus

BOX 2.1 The family unit

The Family Health Nursing concept is based on the idea of the ‘family unit’.

A family unit may include:

- individuals with geographically distant relatives
- friends who provide a supportive role in a similar way to a family member
- a traditional nuclear family, with different generations being geographically close.

This broad definition of ‘family’ is consistent with current international thinking on relationship units within contemporary society. The focus on this type of kinship unity is increasingly being recognised as central to targeting and addressing health challenges. The World Bank (2004), for instance, states:

“Households matter in the health sector – more than most policymakers acknowledge. Improving the health of households is what the health sector is all about. People rely on their health in their everyday lives, and for poor households, health is one of their major assets. Households are also key actors in the production of health. Indeed they play a dual role – as users of health services delivered by professional providers and as producers of health through the delivery of home-based interventions and in their everyday health behaviours.”

on families and on the home as the setting in which family members can jointly address their health problems and create a 'healthy family' concept (WHO, 2000; Scottish Executive Health Department 2003a) (Box 2.1) – is what gives Family Health Nursing its unique characteristics.

The global meeting of Chief Nursing Officers held in May 2006 agreed to review the European model of the Family Health Nurse and share experiences of other generic community nursing roles through a 'community of practice models approach', which includes exploring further the role of the Family Health Nurse in pilot countries.

Role, model and framework

Role

The vision of Family Health Nursing in Scotland is closely aligned to WHO Europe and the World Bank's emphasis on developing family-focused care as a vehicle for strengthening and developing community-orientated health services.

The role has a strong focus on the family and takes into account wider family, social and environmental influences on health. The overall aim is to maximise health and well-being, enabling empowerment of individuals, families and communities by motivating them to take responsibility for their own health.

The role in Scotland has been underpinned by three principles:

- a 'generalist' approach to practice that encompasses a broad range of duties, with the Family Health Nurse acting as the first point of contact for individuals and families and referring on to specialists when greater expertise is required

- a model based on health as well as illness – the Family Health Nurse is expected to take a lead role in preventing illness and promoting health in addition to caring for members of the community who are ill and require nursing care
- a role founded on the principle of caring for families as well as the individual.

Fundamental to the role is the unique approach to family assessment and care, which is highly valued by service users (Parfitt et al, 2006). Working in a family-focused way is key to developing trust and building the confidence of families to take greater responsibility for their own health. The following quotation from a Family Health Nurse provides insight into what can be achieved through this way of working.

"Often there are many issues affecting a family from environmental, financial, educational, health related and social, therefore it is important to identify any barriers that might affect the family's ability to achieve their goals. A lot of my time is spent helping families to work through these issues and helping them to identify possible solutions e.g. a family suffering from social isolation and stress as they have just moved into a new community and have no family or friends. We would look at developing a support network and encouraging them to get involved in community events. Once a support network is in place the family's stress would reduce and they would feel more of a part of the community and this would impact their health and well-being."

Working from the premise of a family-focused health care system that sees **the community as the client**, rather than defining a range of separated and non-linking specialist caseloads, could avoid fragmentation of service provision (Parfitt et al, 2006).

Model for the role

The Family Health Nursing model for the role described by WHO Europe (2000) is one of ‘a skilled generalist with a support network of community nurse specialists who may be geographically distant’ (Figure 2.1). This model provided the conceptual framework for the education curriculum and development of the role within the Scottish pilot.

Using a generalist approach in the Family Health Nursing model requires advanced clinical skills acquired through experiential and formal learning combined with public health knowledge.

Figure 2.2 presents a conceptual model summarising the key features of a family-focused health care system located within a generalist model of care delivery. The model was developed from evidence gathered from the final piece of research on the Family Health Nursing role in remote, rural and urban sites (Parfitt et al, 2006).

The community is at the centre of the model, with the Family Health Nursing role adopting a dual health improvement and disease management function delivered through an integrated team network.

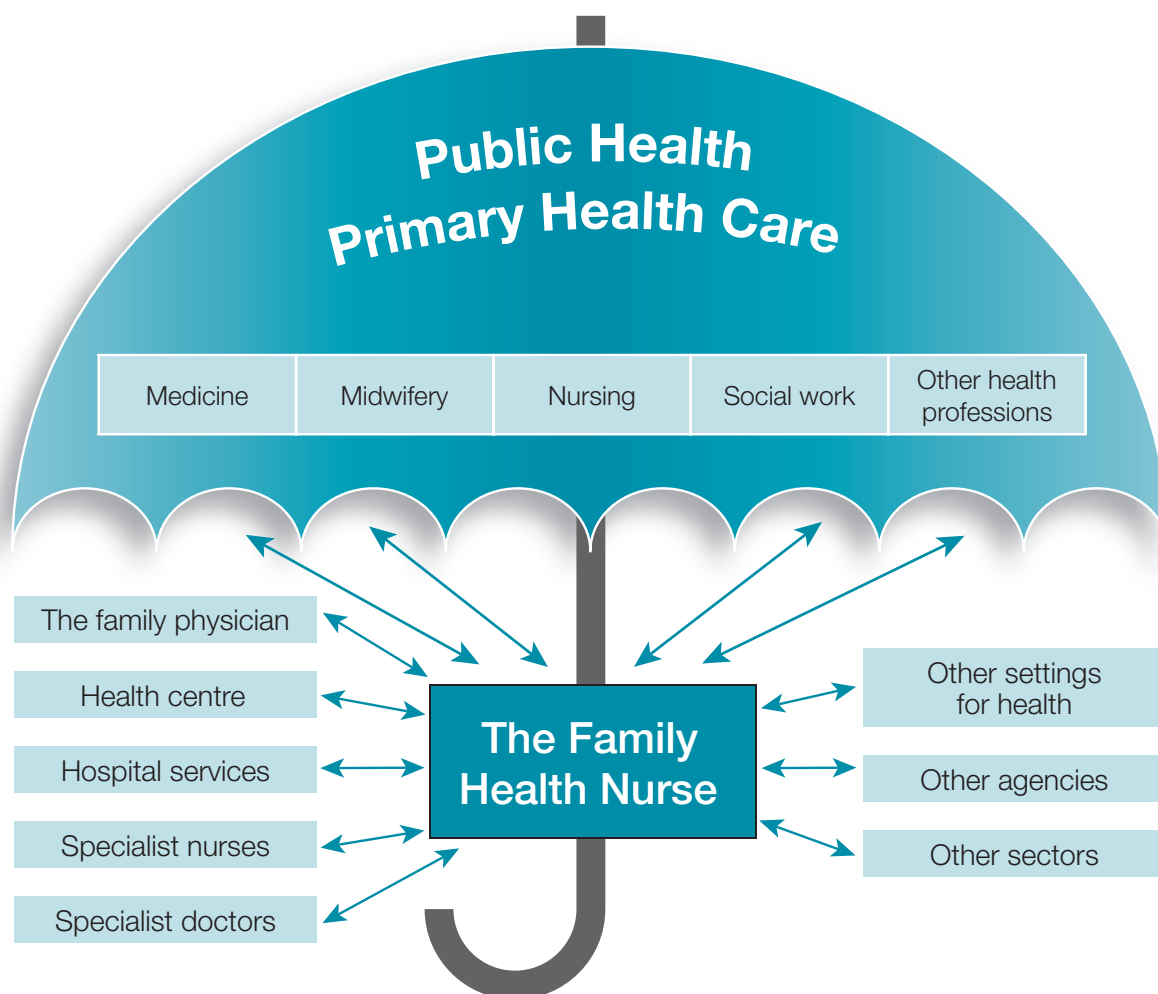


Figure 2.1 The Family Health Nurse under the ‘umbrella’ of public health and primary health.

This model is built on a systems approach that is dependent upon three inputs:

- an education culture that takes account of formalised programmes of education and a team ethos of shared learning that embraces the family health approach to care
- integrated team working involving specialist and generalist roles from within nursing and across other professional groups and agencies
- professional expertise underpinned by a portfolio of skills and knowledge on family health approaches that include assessment and health planning.

These interlocking *inputs* interact with the community setting where health care is delivered to individuals and families to enable the *output* of family-centred care. If any of the inputs are not present or there are barriers to their implementation, family-centred health care cannot evolve.

The key shift to take place in this model is from an emphasis on single clients to a focus on communities and the individuals and families who live and work within them.

The process described in this model would enable the Family Health Nurse to function as described by WHO Europe in Figure 2.1.

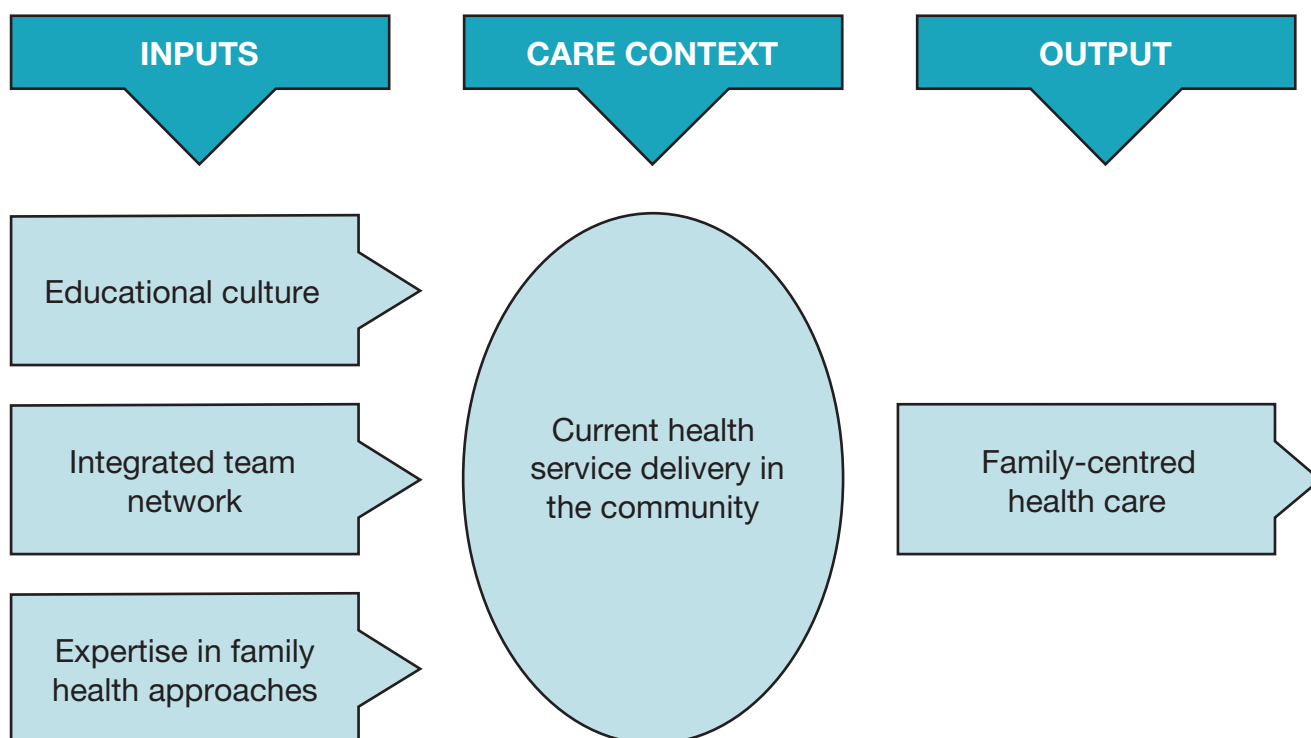


Figure 2.2 Conceptual model for Family Centred Health Care¹ (Parfitt et al, 2006)

¹ A detailed analysis of the components of the conceptual model is presented in Appendix 2.

Role framework

As Family Health Nursing was a new role, it was necessary to create a framework for practice. The framework built on work carried out by WHO Europe (2000) and NHS Education for Scotland (2004)² and helped to demonstrate similarities and differences between the Family Health Nursing role and other roles in primary care.

A nominal group voting technique³ was used by Family Health Nurses to identify the four most

important indicators within each of the WHO Europe Family Health Nursing principles:

- ways of working
- health improvement
- family focus
- generalist model (Figure 2.3).

This approach ensured that Family Health Nurses had 'ownership' of the indicators and also drew on the expertise they had developed within their practice.

² The competency document can be accessed at: http://www.nes.scot.nhs.uk/docs/publications/fhn_publication.pdf

³ In nominal group voting, each group member individually ranks options presented to him or her. The rankings of all group members are then collated to produce a group consensus.

Ways of working

Define and showcase FHN role to raise professional awareness

Define the FHN client group as a population rather than a caseload

Create and implement FHN documentation in line with NHS Board policy

Demonstrate the use of evidence to underpin practice

Contribute to the evidence base for FHN practice

Demonstrate leadership through initiating change within practice team and wider community.

Health improvement

Identify and respond to local population health needs

Undertake collaborative health improvement initiatives at individual, family and community level

Respond to local, national and international health targets (GP Contract/NHS Scotland/WHO Europe)

Use the health continuum model to maximise the health and well-being of individuals and families.

National Practice Indicators

Family Focus

Apply relevant theoretical frameworks to underpin practice (family systems, development, communication and interaction)

Conduct family assessment to determine needs and agree health plan

Gather and use data from three generations to identify family health traits

Assess social and support networks, relationship functions and risk factors within families.

Generalist Model

Apply FHN principles to all areas of practice

Respond to clinical and public health needs within scope of practice with individuals, families and the community

Work across lifespan of client group (any age or stage in life)

Act as a navigator/co-ordinator/key worker – a lynchpin for families and individuals.

Figure 2.3 National Family Health Nurse (FHN) Practice Indicators

Pilot phases 1 and 2

Scotland joined the WHO Europe Family Health Nursing multinational study in 1999 as the lead pilot country (Scottish Executive Health Department 2003a). A National Implementation Group (Appendix 1) was appointed to oversee the pilot, involving representation from interested parties such as nursing and medical professional groups, practitioners, educators, researchers and members of the public.

The pilot was introduced in two phases:

- Phase 1 (2001-2003): the evaluation of the Family Health Nursing role in remote and rural settings and the education preparation, involving 31 Family Health Nurses
- Phase 2 (2003-2006): the evaluation of the Family Health Nursing role in remote, rural and urban locations, involving 18 Family Health Nurses.

Four NHS Board areas participated in Phase 1 - NHS Highland, NHS Argyll and Clyde, NHS Western Isles and NHS Orkney. Thirty-one Family Health Nurses completed their education programme and 29 returned to work with clients from their previous caseloads⁴ on completion of their education programme at Stirling University. Two Family Health Nurses moved into other roles outwith the area. Students and mentors were supported by clinical teaching fellows based at Stirling University during Phase 1.

Researchers from The Robert Gordon University conducted an independent evaluation of the education programme and the practice of Family Health Nursing following

Phase 1 (Scottish Executive Health Department 2003b). The research suggested three ways in which the role could be further developed:

- enable the Family Health Nurse role to merge with current service provision in a meaningful way
- develop the core Primary Health Care Team (PHCT) to incorporate a more systematic focus on family and health within existing services and care practices
- involve individuals and get the wider community to expect, accept and value a different approach to nursing care in particular and health in general.

These findings, combined with the views of the National Implementation Group, influenced Phase 2. This was designed to consolidate the learning of Family Health Nurses in existing sites and to establish an urban pilot. Family Health Nurses in the urban setting became additional members of nursing teams and established new client caseloads. As part of the preparation for Phase 2, a situational analysis (recommended by the evaluation of Phase 1 (Scottish Executive Health Department 2003b) informed the selection of practice sites. The analysis included:

- *role analysis*, outlining what work would be carried out by the post holder
- *cultural analysis*, detailing how the role would fit with existing services and consideration of the perceptions of others affected by the change
- *business analysis*, identifying requirements to support and sustain the role
- *situational analysis*, considering gaps in service provision and changes required to accommodate new role.

⁴ There was one exception, a nurse who joined a new team and created a Family Health Nurse caseload.

Practice facilitators (Box 2.2) were also introduced in Phase 2 to support Family Health Nurses and their teams in all areas in implementing their role.

Research evaluations

Multinational

WHO Europe researchers conducted a multi-country evaluation across all pilot countries to explore inputs, processes and outcomes (WHO Europe, 2006).

The results demonstrated a strong commitment from policy makers, stakeholders and service providers to the Family Health Nursing role. The role was found to be similarly implemented within countries, but was capable of adaptation to meet the needs of national health and education systems. It was perceived as creating a greater focus on public health and improving communications within teams as they worked towards a common family-focused goal.

Most countries experienced challenges in relation to change management, which tended to manifest in misconceptions about the role. 'Receiver' resistance was a recognised change management issue; this has implications for the future integration of new roles into existing service provision.

National

As part of the ongoing evaluation of the project within Scotland, a piece of research was conducted by Glasgow Caledonian University (Parfitt et al, 2006). This complemented previous research conducted during the initial phase of the project. The aims of the study were to:

- evaluate the role of the Family Health Nurse in the urban pilot area by identifying the impact of the role from the perspectives of Family Health Nurses, their colleagues and service users

BOX 2.2 Practice facilitator development

Practice facilitators, introduced in Phase 2 of the project, provided a diverse resource of experience and expertise to the development programme. A key function was to raise awareness and understanding of the Family Health Nurse role through activities such as road shows, newsletters and team development work.

The practice facilitators participated in three-monthly workshops to develop their thinking in relation to the role of the Family Health Nurse. The workshops created a learning environment in which the facilitators could develop new skills and knowledge in practice development, change management and project leadership. Together, they shared experiences and challenges, explored solutions and grew professionally and personally.

To support implementation of the Family Health Nurse role, the practice facilitators prepared learning tools and organised two workshops on 'Family Health Nursing Practice Indicators' and 'The Continuous Improvement Model'. These enabled practitioners to explore the role of the Family Health Nurse and to develop the role and their practice through the use of a change management process.

- assess the impact of the Family Health Nurse role after 3-4 years of practice in the remote and rural settings
- identify factors that have helped or hindered the implementation process across all settings.

The evidence from this study highlighted the following key issues:

- care enhancement was shown through service users valuing the role's ability to offer a first point of contact and provide a professional who understood their health needs and those of their family
- in addition to clinical and public health, the knowledge and skills found to be of most value in the role included: counselling, negotiation, facilitation, family development, dynamics and interaction, and change management. These were all included as topics in the education programme
- although challenges were identified in the integration of a generalist approach into a system of specialist nurses, there was agreement that Family Health Nurses were able to identify people who do not fall under the remit of other services
- building relationships with families required significant time, which was not always easy in a context of large client caseloads
- the role was able to provide inter-generational care within families to help them address and cope with existing health issues and look towards reducing risk factors
- change management was an important aspect of the practice development process and was essential in supporting people involved both directly and indirectly in the project.

Specific findings from the study are integrated within the remainder of this report. An executive summary is provided in Appendix 3.

⁵ <http://www.nm.stir.ac.uk/undergrad/intro.htm>

⁶ The competency document can be accessed at: http://www.nes.scot.nhs.uk/docs/publications/fhn_publication.pdf

Education programme

The Family Health Nurse education programme was developed by Stirling University from a competency-based, multinational curriculum for Family Health Nursing (WHO Europe, 2000). The programme was subject to internal and external evaluation over the course of the two phases of the project⁵.

On completion of the programme, the Family Health Nurse was expected to be competent as a:

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

NHS Education for Scotland assisted in the evolution of the programme through the development of a revised set of competencies for Family Health Nursing (NES, 2004)⁶. This piece of work also underpinned the practice role.

The education programme was based on a systems framework incorporating the following elements (University of Stirling, 2006):

- socio-economic, demographic, epidemiological and service networks
- family dynamics and theoretical and ethical constraints
- development, life events, normality and crisis
- evaluation of interventions in the family system using case study and single-case experimental design.

The programme was delivered full-time over 45 weeks using mixed-mode learning techniques, including computer-based learning (WebCT)

and other distance-learning approaches integrated with campus-based study. Clinical practice constituted 50% of the programme. Eighteen students from urban and remote and rural settings undertook the final education programme of the project. Accreditation of prior learning (APL) was developed to enable recognition of students' previous education and clinical experience, particularly those who had already completed a district nursing or health visiting programme, who were able to take a shortened programme.

Table 2.1 outlines the format of the programme, and further information on the modules is given in Appendix 4.

Mentorship preparation was essential to ensure students were supported during periods of clinical placement. A preparation and support programme was created which included study days, the appointment of a clinical teaching fellow and a dedicated discussion area on WebCT.

Evaluation of the programme was conducted as part of higher education quality processes. Key points of learning from this were:

- students, particularly those in remote and rural areas, found WebCT crucial from both learning and peer-support perspectives
- students felt the programme had changed their thinking and had enabled them to develop professionally
- some students felt challenged during practice because of lack of support and perceived negativity from colleagues
- students identified limitations with the shortened programme in relation to material having to be repeated or delayed until Semester 2

- some mentors found their role challenging, which impacted on the support they provided to students
- few mentors used the WebCT site, but they found the support of the clinical teaching fellow important
- where mentorship was successful, the role provided an important champion and support for students (University of Stirling, 2006).

Practice development

Practice development work for Phase 2 of the project, which focused on further developing graduates from Phase 1 who were now practising as Family Health Nurses in their own areas, was based on agreed national and local practice objectives, which were to:

- clarify perceptions about and understanding of the Family Health Nursing role
- identify barriers and enablers for the development of Family Health Nursing
- implement and evaluate a development programme to enhance family health practice
- support and enable changes within local teams to develop the full potential of the role
- develop Family Health Nursing in each of the sites.

Practice development work was led by the practice facilitators and was built on the ethos of developing local ownership of the project through creating implementation groups in each NHS Board, encouraging stakeholder involvement and providing an active facilitation process.

An action learning approach was followed in all pilot sites (Box 2.3), with a locally focused practice development programme tailored to meet individual team needs.

Modules	Semesters
Research, Decision-making and Evaluation in Clinical Practice (Practice Frameworks)	<p>One 15 weeks</p> <p>Introductory Week 1 week</p> <p>1 week campus-based (attended by APL students as well)</p> <p>9 weeks practice-based learning; 6 weeks campus-based learning. Clinical practice – 4 days per week engaging with families and the community and 1 day student learning, some of which is directed study.</p>
Working with Families in the Community Communication	<p>Two 12 weeks</p> <p>8 weeks practice-based learning; 4 weeks campus-based learning.</p> <p>Clinical Practice – 4 days per week engaging with families and the community and 1 day student learning, some of which is directed study.</p>
Principles and Practice of Family Health Nursing	<p>Three 12 weeks</p> <p>8 weeks practice-based learning; 4 weeks campus-based learning.</p> <p>Clinical Practice – 4 days per week engaging with families and the community and 1 day student learning, some of which is directed study.</p>

Table 2.1 Education programme

BOX 2.3 Action learning

An action learning approach was used to underpin the development programme. Through action learning, individuals learn with and from each other by working on real problems and reflecting on their own experiences.

The approach used by practice facilitators was one of joint learning with the Family Health Nurses, perceiving them as reservoirs of knowledge and skills on which to build and encouraging them to take control of their own learning. The role of the facilitator was to support and guide them through this process.

Langley's Continuous Improvement Model

Langley's Continuous Improvement Model (1994) was selected for the practice development work because of its flexibility, simplicity and focus on achieving change through small-scale actions. It is based on the principles of action research and has been used successfully in different clinical settings, providing practitioners with a tool to enable them to develop, test and implement change focused on creating improvements (Figure 2.4). One of the real strengths of this approach is that it enables the practitioner to take ownership of changes in his or her practice and develop leadership skills. Each of the actions in the model is essentially one cycle that is planned, implemented and evaluated before moving on to the next one. Each change cycle is small, reducing associated risk. Every idea consequently progresses through successive cycles until the practitioner has achieved his or her desired outcome.

A guidance pack developed by the practice facilitators was provided on an individual and team basis. This enabled Family Health Nurses to work with their teams on shared and individual practice development activities linked to clinical and health improvement work.

Calgary Family Assessment Model

Family Health Nurse assessment and documentation is based on the Calgary Family Assessment Model, adapted to meet statutory and NHS Board requirements. The assessment of families involves six broad categories (Friedman, 2000; Wright and Leahey, 2000) which provide a framework for Family Health Nurse documentation:

- identifying data
- developmental stage and health history (including a genogram – a family health history)
- environmental data
- family structure
- family functions
- family stress and coping (including an ecomap – a map of the family social history and their network of support).

The assessment process is underpinned by advanced communication and interviewing skills which enable relevant areas to be explored in more depth, including family needs and risk factors. Interventions are directed towards goals collaboratively generated by the Family Health Nurse and the family. Family health plans may include clinical care, screening and health improvement strategies.

An example of how the genogram and ecomap are used with families is illustrated in the following quotation from a Family Health Nurse.

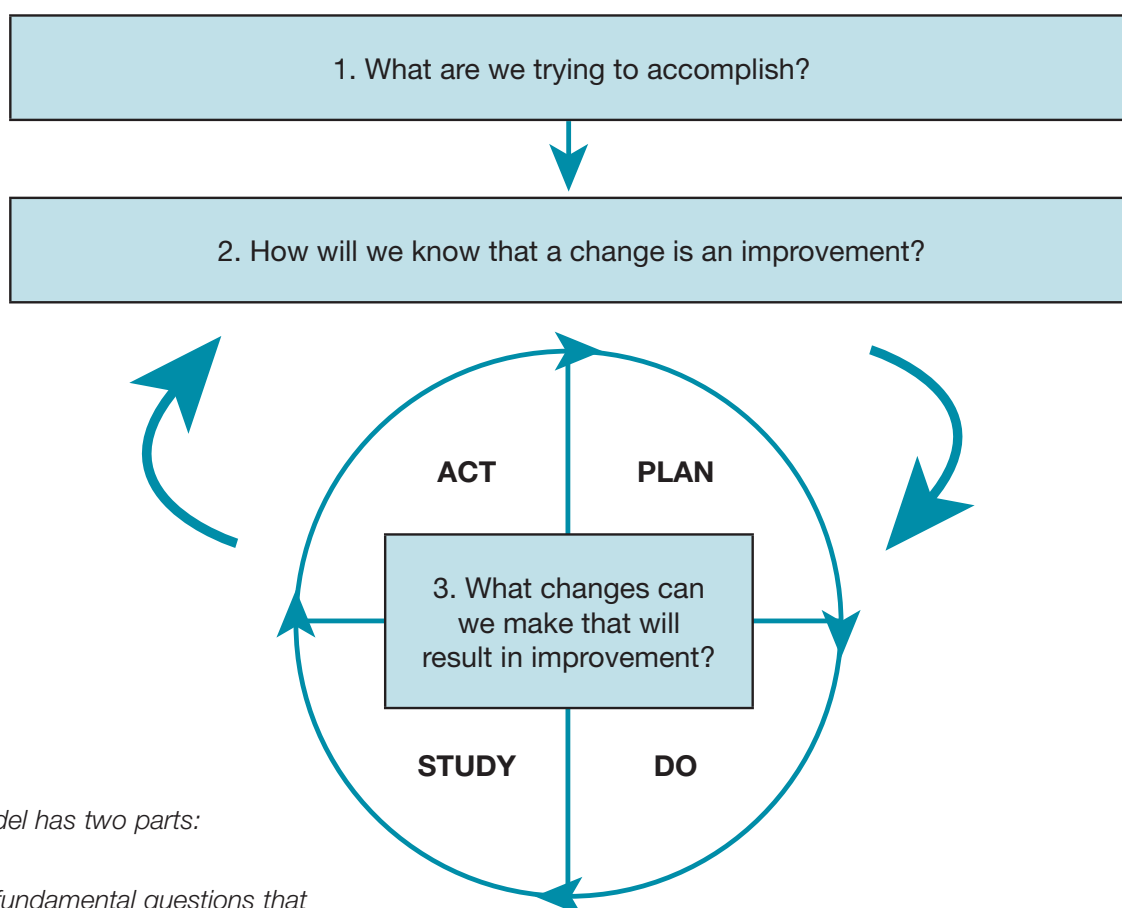
"I use the genogram and ecomap at the second or third visit. Both are powerful tools which have great impact on the individual and their families. Each individual member of the family reacted differently to the information provided and required (at times) intense interaction with the Family Health Nurse. I also help them to look at strengths and weaknesses within the family and try and encourage them to be aware of their strengths which can help improve their problems."

The principles of Family Health Nurse assessment have been shared with teams and other colleagues to provide a better understanding of this approach and some members have integrated them into their own practice.

Change management

The multinational evaluation of all countries taking part in the pilot carried out by WHO Europe (WHO Europe, 2006) emphasised the importance of change management in the implementation of the Family Health Nurse role. Bainbridge (1996) outlines the progressive stages for effective change management:

- **design stage**, to identify requirements for change
- **definition stage**, to outline the design of proposed change
- **development stage**, which incorporates preparation, education and restructuring
- **dismantling stage**, where reform is carried out to remove or convert redundant parts of the system
- **deployment stage**, where new parts are integrated into the organisation.



The model has two parts:

- three fundamental questions that enable practitioners to focus on an area of their practice that they wish to develop
- the 'Plan-Do-Study-Act' (PDSA) cycle to implement and test changes in real work settings.

Figure 2.4 Langley's Continuous Improvement Model (Langley, 1994)

The multinational evaluation suggested that many countries are in the **development stage** of Family Health Nurse implementation.

Change management was key to role implementation. The project in Scotland was conducted at a time of major organisational change, particularly within the urban site. It was important to recognise the different ways in which resistance to change could be expressed. Some colleagues felt vulnerable and anxious about the impact of the role on their practice, and others chose not to engage in the process of implementation. Similar experiences emerged from the multinational study.

Change was necessary at different levels within the organisation. Box 2.4 offers a reflection from an observer on how a Family Health Nurse worked through the process of role integration and acceptance in her practice. It provides a good example of how the team addressed the challenging issue of ensuring a balance between clinical care and public health issues.

More information on the development work can be found in the local reports of implementation of the Family Health Nursing model.⁷

⁷ More information on the development work is contained within the local reports produced by Family Health Nurses and practice facilitators. These can be accessed at:

NHS Orkney www.show.scot.nhs.uk/ohb

NHS Western Isles www.wihb.scot.nhs.uk

NHS Greater Glasgow and Clyde <http://www.nhsgg.org.uk/content/>

NHS Highland

<http://www.nhshighland.scot.nhs.uk/Publications/Public%20Health/HighlandLAFinalReportFHN30905.pdf>

Stirling University <http://www.nm.stir.ac.uk/undergrad/intro.htm>

BOX 2.4 Reflections on time spent with a Family Health Nurse

In 2004, I was in the fortunate position to spend a day with a Family Health Nurse. The purpose was to 'shadow' her to identify how she, working as a generalist nurse, managed the caseload and ensured that the needs of the practice population were met.

A large proportion of her time was initially spent in assessing, care planning and agreeing with other members of staff who was the most appropriate nurse within the team to deliver on the care plan. A development plan for the team was agreed with the Family Health Nurse attending short courses to further develop her skills in dealing with children within the practice. This included a breastfeeding course, a parenting skills course and some further 'in-house' training in child protection.

Once the post was established and the Family Health Nurse had completed her analysis work, the practice met as a team to agree what, if any, gaps in service had emerged. They decided not to employ a health visitor for the practice, but would call on one from another area when the Family Health Nurse felt the care required was outwith her bounds of her skills and competencies (a GP practice in another area agreed to this plan). They team agreed that they might need to employ another part-time staff nurse for support.

The team met as a group to discuss who should take referrals. It was agreed that the Family Health Nurse would take over the care of all children aged under five years and their families after the health visitor had carried out her first visit. The health visitor would attend the surgery as required to assist the GP with developmental checks. If the Family Health Nurse felt a family had needs she could not meet, she would discuss these with the health visitor. The health visitor would either offer advice or carry out a visit to further assess the situation.

The Family Health Nurse and district nurse would agree who should take any particular referral, depending on whether a short intervention was required or the family needed more intensive support.

Although the post was still being established at the time I visited, I was impressed with the team approach and how they had shared the workload equitably, taking cognisance of the skills of each member of the team. The general consensus was that the Family Health Nurse model was beneficial to patients and worked well within the area. As a result of adopting a different way of working, time had been freed up to allow the nursing team to engage more meaningfully in community development and other health promoting activities.

Section 3

Impact and outcomes

Section 3

3 Impact and outcomes

“The [Family Health Nursing] course has prepared me well for my future role and I plan to continue with evidence-based practice and encourage my colleagues to do the same.”

Family Health Nurse student

The achievements of the Family Health Nurse pilot are represented in this chapter by mapping some outcomes against the core ‘capability’ elements from *Delivering Health, Enabling Care*. Some are person-related outcomes, while others point to lessons learned from the process of developing and testing a new role.

Evidence from a variety of sources is used to support commentary on the impact and outcomes of the role. This includes empirical research, discussions at the National Implementation Group and achievements reported as part of the practice development work.

It is recognised that outcomes tend to arise as a result of collective action by a number of stakeholders, including families, and are not dependent on input from any single professional group. It is also recognised that work carried out by Family Health Nurses with individuals, families and communities may also be undertaken by other community and public health nurses.

Delivering services closer to home

Using a generalist model, the Family Health Nurse can act as the ‘lynchpin’ for a family and offer a single point of contact with services. In the Glasgow Caledonian University research project (Parfitt et al, 2006), several service users described the security they felt in having someone close by they could talk to about their anxieties. Most said they would contact the Family Health Nurse in the first instance about

presenting health issues; they felt she knew them and they trusted her ability to help them find the best solution to their problem.

In the absence of a Family Health Nurse, some said they would either not seek help from any other community nurse or would contact the GP directly. This highlights a key strength identified by Family Health Nurses, colleagues and service users in the research - the role has responded to unmet need.

Support and protection of the public

The focus on protection issues has largely, but not exclusively, been fixed on protecting children and young people. Many of the Family Health Nurses in remote and rural areas worked closely with school health services and health visitors and made contributions to health programmes within schools. One Family Health Nurse set up self-awareness sessions for young parents in the community through a joint initiative with Woman’s Aid and the Child Care Partnership Forum. Another is running a weekly drop-in session that has been used by local teenagers to seek confidential advice on addiction and family problems.

Caring for older people

Although Family Health Nurses were frequently involved in delivering clinical care to older people and supporting their carers, they also had a developing role in health improvement work with this group. Two Family Health Nurses set up a mature swimmers’ group which provided supportive and therapeutic functions. One member of the group reported that the water exercises had resulted in her cancelling a referral to the physiotherapy service, highlighting the importance of proactive health improvement work. In another area, an exercise group for people over 50 was set up in response to local identified need.

Unscheduled care and planned care

The generalist model provides 'a one-stop-shop' approach to care delivery that complements services provided by the GP. The success of the model, however, is dependent on access to specialists who can support the Family Health Nurse and to whom he or she can refer service users when appropriate (Parfitt et al, 2006).

One service user explained how valuable the holistic perspective of the Family Health Nurse was. She felt that the specialist practitioners she consulted did not have time to gain the full picture of her multiple health problems. The only person to explore these issues with her was the Family Health Nurse, who was able to share the knowledge with specialists and advocate on the individual's behalf.

Many of the Family Health Nurses have gone on to complete programmes of nurse prescribing, which enables them to diagnose and treat certain symptoms and conditions. One has a specialist interest in acupuncture which developed when the GP who previously provided this service moved from the area. A request from the community resulted in the Family Health Nurse undertaking training to enable her to diagnose and treat specific conditions.

Another found that patients in her community were waiting six weeks following myocardial infarction (heart attack) before commencing a rehabilitation programme in the local hospital, with no support being provided in the intervening period. She started working with individuals during this period and made links with the rehabilitation team.

Anticipatory care, improving health, public health and reducing inequalities

Identification of risk factors and early intervention are key to improving health. The Family Health Nurse approach to family

assessment was seen as a valuable strategy in identifying and assessing risk factors.

A short audit of a men's health group concluded that Family Health Nursing was a valuable service. Initially, the young men were reluctant to discuss subjects related to sexual health and low self-esteem was noted in their verbal communication, but over a period of time, the Family Health Nurse was able to work with them to achieve better health outcomes. The men found it easier to understand the risks posed to their health through using the genogram (family health tree) as a visual aid. Data gleaned from the family health assessment and genogram are important for the practice profile, not only in terms of identifying individual family risk factors and recognising local trends in disease or dominant health problems, but also in acting as a motivator for families to explore lifestyle change.

Family Health Nurses in a remote and rural setting have responded to a request from the local community to conduct health checks within the workplace. They have developed an electronic version of the genogram to encourage people to look at health risks and consider lifestyle improvement. The approach demonstrates a way to target a sometimes hard-to-reach group within the community. As the intention is also to include other community-based nurses in the work, the approach provides a vehicle through which skills and knowledge can be shared in pursuit of a common goal.

Supported self-care, patient empowerment and managing long-term conditions

One Family Health Nurse was approached by a person with a long-term condition who was informed of the role by a social worker. The person had previously declined services from other staff, as they felt they did not require

nursing care. The Family Health Nurse is now working with the family to help identify personal strengths and areas for development. The family has increased their awareness and are taking responsibility to improve their quality of life while supporting the family member with the long-term condition.

Family health genograms have helped individuals and families make decisions about lifestyle changes in relation to obesity, smoking and alcohol consumption. One family with a history of diabetes has engaged with the Family Health Nurse to improve their health through a programme of healthy eating and physical activity to reduce risk factors.

Leadership

Most of the Family Health Nurses identified the need to consolidate their learning from the programme before taking on an active leadership role. Consolidation is key to developing expertise and confidence to enable leadership to flourish. While some Family Health Nurses had previously worked as team leaders, others had been practising as community staff

nurses prior to the pilot. Several undertook the national leadership programme and found this a valuable 'add-on' to their existing skills toolkit.

There are numerous examples of where Family Health Nurses have taken a lead in aspects of practice. Box 3.1 shows how two Family Health Nurses took the lead to work with communities in a different way.

eHealth

Information technology systems have been problematic in some remote and rural areas, with limited access to hardware and difficulties with e-mail systems. This is also a recognised problem for other nurses working in some community settings.

Having a robust IT system is crucial in enabling Family Health Nurses to contribute to the national eHealth programme. One Family Health Nurse has developed expertise in this area and has a part-time remit to develop electronic records locally and to contribute to the national electronic community health information project (eChip).

BOX 3.1 Engaging with the local community

A Family Health Nurse team based within a local community centre gathered information from members of the community using a suggestion box and poster display seeking ideas on what kind of activities they would like. The topics requested included weight management, physical activity, first aid and social events for older people. In response to this, a number of initiatives have been developed:

- a six-week programme of physical activity and healthy eating talks with cookery demonstrations was funded after networking with the healthy living co-ordinator
- the NHS Board resuscitation officer has provided basic life support training to community members
- two members of the community have undertaken training in running weight management courses
- there is a 'drop-in' afternoon for older people which has involved a number of activities, including belly dancing!

Section 4

Learning and key messages

Section 4

4 Learning and key messages

"I find I have increased awareness of family function and dysfunction and the part it plays in family health. Underlying tensions can be very destructive and being instrumental in helping to resolve these can be rewarding."

Family Health Nurse

Learning

WHO Europe and the World Bank recognise the importance of the 'family unit' in identifying risk factors and targeting interventions to avoid health problems now and for the future. With its family and health improvement focus, the Family Health Nursing role can make a significant contribution to achieving health benefits for individuals, families and communities.

BOX 4.1 A day in the life of a Family Health Nurse in Scotland

The Family Health Nurse role is based on a generalist model. This means my role is very flexible and can change according to the needs of my caseload and the community. I try to target my services to meet those changing needs. Most of my families are visited at home but I will go wherever is appropriate for that individual or family. Care is planned in collaboration with the family or individual to meet their needs or referred on to more specialist services where appropriate.

First two visits of the day are to see individuals who recently had orthopaedic surgery. An assessment is made of the families coping mechanisms as a result of the reduced mobility. Exercises given by the Physiotherapist are reinforced and dietary advice is provided.

10.45 and it's off to do a joint visit with the GP to see an elderly person who had recent surgery and has a possible wound infection. This individual had a family health assessment carried out 2 months prior to their hospital admission. Issues that were concerning them and the family were discussed which had promoted the individual's independence since discharge from hospital. The use of the ecomap (map of family social network) had been a successful tool for this family.

Back to the Health Centre for 11.30am to meet with the care manager, home care co-ordinator and GP for a complex case review of a family with chronic illness and ever changing health and social care needs.

After attending the funeral of a long-standing patient it's back to the office. Telephone call to the specialist team to discuss a teenager who I am seeing regularly.

Healthy lifestyle group 3.30-4.30. This group meets fortnightly at the Health Centre where each individual has a planned programme of lifestyle modification. Just about to go off duty when we receive a phone call from a resident who has had an injury that requires suturing.

Family Health Nurse

The Family Health Nursing role responds to the needs of the community, as determined by community and GP practice profiles. Family Health Nurses have a clinical remit and an individual, family and community health improvement focus, a multifunctional approach that has been highlighted positively in all research evaluations associated with the pilot (SEHD 2003b; WHO Europe, 2006; Parfitt et al, 2006). The combination of clinical care and public health has been most successfully achieved where team members have worked collectively on presenting health needs. Box 4.1 describes a typical day in the life of a Family Health Nurse, demonstrating this blending of care and health improvement.

An integrated approach which involved input from researchers, policy makers, educationalists, practitioners and nurse leaders contributed greatly to the success and sense of collective ownership of the project.

Each of the NHS Boards involved in the two phases of the pilot has distinct cultures linked to geography, language and health priorities. Remote and rural areas are faced with the challenge of providing accessible services to sparsely spread populations, while Family Health Nurses in the urban site work in a densely populated area providing services to an increasingly culturally diverse population. As such, the role needs to be flexible to adapt to different demands across remote, rural and urban sites.

For a number of reasons, the 'skilled generalist' model underpinning the Family Health Nurse role has been a difficult one for practitioners to pursue. Creating a generalist role within the context of existing specialist nursing roles has been challenging, and changing attitudes has been difficult to achieve. Strong leadership is necessary to support staff, individuals and

families to understand the role Family Health Nurses play and the benefits they bring, and to make the sometimes difficult decisions required to progress thinking within organisations.

The Glasgow Caledonian University research (Parfitt et al, 2006) shows that care enhancement has been achieved by the Family Health Nursing role. The research indicates that this was particularly the case with Family Health Nurses working with families with complex needs, often linked to long-term conditions (Parfitt et al, 2006). For some of these families, the Family Health Nurse played a key 'lynchpin' role in co-ordinating the inputs from several specialists; for others, she provided a valuable lifeline to people who did not fall within the remit of any single specialist service.

The extent of care enhancement delivered by the role, however, depends upon a range of factors, including the effectiveness of the change management process put in place to introduce the role and the system of referral of individuals and families to Family Health Nurses by other professionals and services. Care enhancement was greatest when:

- change management was recognised as being central to the successful introduction and ongoing development of the role, and where all parts of the system understood the need for change to reflect new perceptions of the way members of the primary care team should function
- the Family Health Nurse was seen not to have a defined and limited client caseload, but considered the entire community as her caseload (see Appendix 2 for further discussion of the concept of 'community as caseload').

Change management is therefore crucial to the process of introducing Family Health Nurses into the service, with the development of the

practice facilitator role being seen as key to moving forward recommendations from Phase 1 of the project. Because of the challenges associated with 'real life' change management, support is needed for staff at all levels of organisations, from educators, to practitioners, to practice facilitators, to managers. Systems change requires education and continuing professional development (CPD) activity at different levels to facilitate behaviour change by all members of the team.

There is a need to ensure whole-systems approaches to change are adopted within organisations, which should include the redesign of processes (many of which are based in historical precedent rather than defined benefits for service users) that may hinder individuals' and families' access to services. A clear system of referral protocols at NHS Board level is essential in ensuring that individuals and families are cared for and supported by the most appropriate member of the team, with integrated teamwork ensuring effective use of both generalist and specialist team members. Community Health Partnerships (CHPs) offer an opportunity to lead and develop innovative approaches to multidisciplinary team working which maximise professional roles to ensure prompt and smooth service 'journeys' for individuals and families.

Effective Family Health Nursing depends on the development of positive ongoing relationships with families. This calls for the investment of time in the early part of relationships to build understandings and dialogue. The benefits of this investment will be seen over time as families, supported by the Family Health Nurse

practising to the principles underpinning the role, move away from being dependent on professional services towards developing coping strategies that enable them to manage their own health, particularly in relation to long-term conditions. Investing time in the early stages of the relationship is therefore time well spent in the long term.

Traditional caseload models which focus on numbers of patients seen and tasks performed do not enable the role to achieve its full potential, nor does it provide sufficient qualitative measures of effectiveness of the Family Health Nursing model, the research found. More appropriate models designed to measure benefits to families' health over the long term are required, as this is the central focus of the Family Health Nursing role and the ultimate arbiter of its success.

Raising awareness of Family Health Nursing with stakeholders and communities was a key part of practice facilitators' roles. They were involved in activities such as road shows, newsletters, team-building activities and media coverage. The challenge is not only in providing such opportunities, but also in encouraging people who feel most anxious about the piloting of the role to attend and engage in dialogue. Despite a wide programme of awareness raising, some stakeholders felt they did not receive sufficient information on the project, and findings from all evaluation research studies showed that while there was a clear understanding of the Family Health Nurse role among those directly involved in the pilot, some of those outside the pilot carried misconceptions.

Key messages

Findings from the project offer potential solutions to developing a modernised health care system, as described in *Delivering for Health*. Key areas where the findings can inform thinking are set out below:

- the Family Health Nursing model has offered benefits to families in remote, rural and urban communities
- service users showed an enthusiasm for the Family Health Nursing model. Although many were also positive about other nursing services, they valued the added contribution of the Family Health Nursing role, which was focused on having someone who understood and responded to the clinical care and health needs of all family members. They welcomed a single point of contact into the health care system, especially those who did not fall within the remit of specialist services
- the creation of a multi-skilled advanced-level generalist who can respond flexibly to the intergenerational needs within a family unit, providing clinical care alongside health improvement activities, offers a positive response to needs in the changing demographic landscape of Scotland
- Family Health Nursing can contribute to managing the problems of an ageing workforce through supporting existing practitioners to develop a new portfolio of skills and knowledge to ensure fitness for purpose in responding to future health care demands

- there may be benefits in combining the family care elements of the Family Health Nursing education curriculum with the strengths of existing programmes of education at pre- and post-registration level to ensure fitness for purpose as stated in *Delivering Health, Enabling Care*. The Family Health Nursing curriculum can make a significant contribution to achieving this aim
- the recommendation from previous research carried out by the Robert Gordon University (Scottish Executive Health Department 2003b) that a situational analysis should be carried out as part of the feasibility phase for the introduction of new roles is strongly supported.

Conclusion

The project has highlighted the Scottish Executive's commitment to investing in infrastructures within small communities, particularly within remote and rural areas, and to addressing the complex and fast-changing health needs of people living in large urban communities.

The Family Health Nurse model underpins the development of family-centred care in a way that reflects the Scottish health policy focus on delivering care that is based on health improvement and disease management. Findings from the project will inform the future policy development for nursing in the community and will contribute to the wider debate being taken forward within WHO Europe on the exploration of different models of generalist practice in member states.

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Appendices

Appendix 1

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*Denotes reference to post held during the project.

Appendix 2

Conceptual model of family-centred health care

*a different way of thinking,
a different way of practising, and
a different way of working together.*

For Family Health Nursing to reach its full potential, it should be located within a health care system committed to family-centred health care. Family-centred health care has a dual

health improvement and disease management mandate, and is delivered through an integrated team network. Full implementation of Family Health Nursing entails not only transformation of nurses' roles, but also changes to the other parts of the health care system. This conceptual model describes the process of change required for Family Health Nurses to be able to implement their role as part of family-centred health care (see figure below).

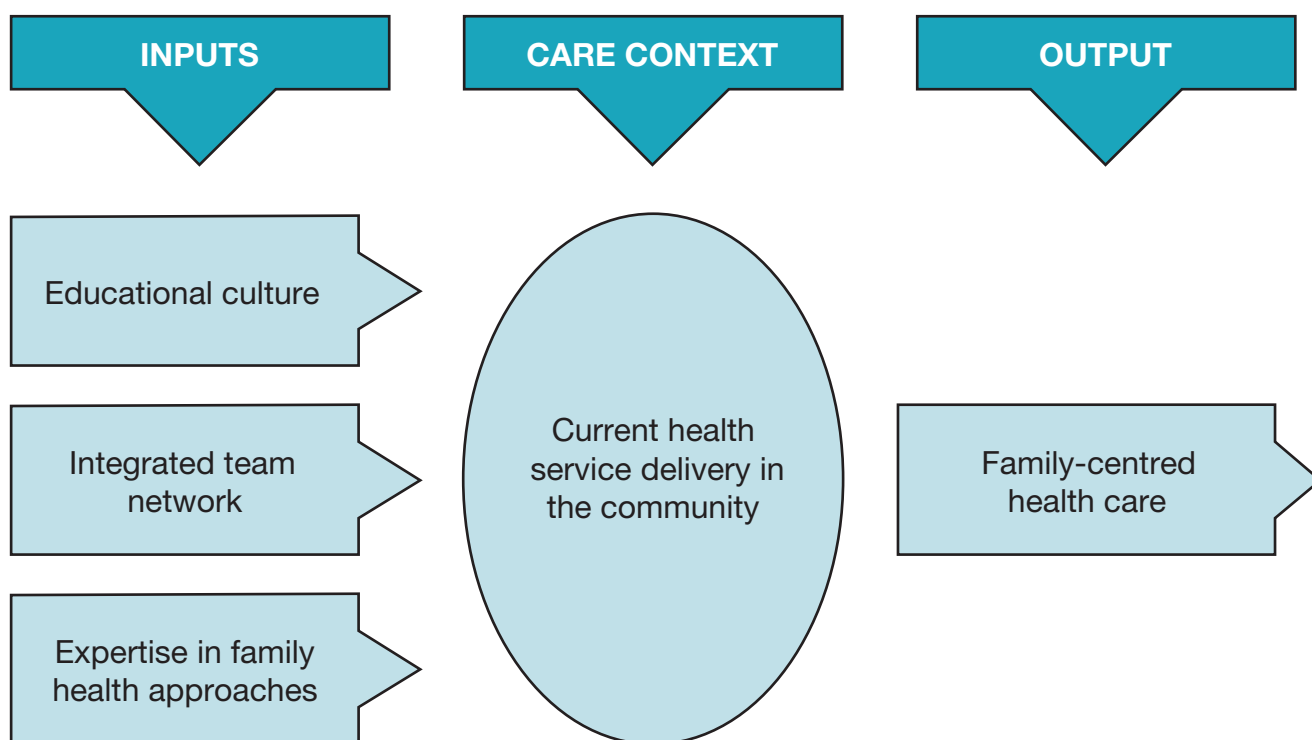


Figure 2.2 Conceptual model for family-centred health care (Parfitt et al, 2006).

The process depicted in this model is the transformation of the current mode of service delivery in the community into a family-focused system of health care, in which Family Health Nurses play a full role.

This model is built on a systems approach where three crucial inputs are required:

- professional expertise underpinned by a portfolio of skills and knowledge on family health approaches that include assessment and health planning
- integrated team working comprising specialist and generalist roles from within nursing and across other professional groups and agencies
- educational culture that takes account of formalised programmes of education and a team ethos of shared learning that embraces the family health approach to care.

These 3 interlocking *inputs* interact with, build upon, and transform the current mode of health service delivery in the community, in order to produce the *output* of family-centred care.

The successful implementation of this model requires a process of dynamic change that includes the whole team. If that process does not take place then family-centred health care will not emerge as a distinct way of working. When all parts of the system (3 inputs) are present, Family Health Nurses are enabled to:

- apply knowledge and skills on family health approaches to benefit the service users
- receive and make referrals through a system of clearly defined boundaries of agreed responsibility
- achieve positive outcomes through:
 - undertaking clinical care and public health activities with families, with the aim of long term health improvement for all members

- targeting those who do not fall within the remit of a specialist nursing services or acting as the lynchpin for those with multiple needs
- working in collaboration with other nurses and agencies to set up local community initiatives.

Explanation of each component of the model

Introduction

Family-centred health care is the intended result. This is a generalist-based approach, which begins with families and communities as a whole, to identify the health care needs of the collective members of the community, rather than beginning with a set of specialists who work selectively with particular client groups according to age or underlying disease.

To put this into practice requires 3 interlocking key components – (1) a change in education and shared learning to support a generalist-based family oriented approach (2) an organisational change towards more integrated teamwork within and across disciplines, including a clear referral system for generalists, specialists and support staff and (3) expertise in family health approaches.

1. Educational culture

This model requires a culture change for those delivering health services and for those developing programmes of education. It involves a portfolio of skills and knowledge that include - in addition to clinical and public health skills - counselling, negotiation, facilitation, family development, dynamics and interaction, and change management. However for systems change to take effect, learning and behaviour change at different levels within the health service and from *all* members of the primary care team is needed. In order to

support and grow such change, modifications to education at pre and post-registration level, and programmes of continuing professional development (CPD) for existing team members that incorporate the ethos of family-centred care, are required.

2. Integrated team network

The main *conceptual shift* to take place is away from thinking in terms of each practitioner having their caseload of individual clients, and towards thinking of the *community as the client*. This is a 'bottom-up' rather than 'top-down' model of healthcare delivery. This means that the planning, design and delivery of services is driven by community need, rather than by specialists with their individual caseloads. In this way all members of the team have responsibility for the whole community.

For this model to work depends upon an *organisational development* towards integrated teamwork. Generalists – including the Family Health Nurse and the General Medical Practitioner (GP) – are the first point of contact for families, and have a thorough understanding of individual families' needs and the resources available to support them. The Family Health Nurse works together with colleagues to plan and deliver community-wide initiatives that address the particular health needs of local families. The success of an integrated team approach depends upon generalist practitioners being supported by a network of specialists and support workers.

Integrated teamwork requires clearly defined boundaries of responsibility. This includes a referral system where individuals and families are allocated to the most appropriate member of the team. This recognises the different skills and talents of all members. The Family Health Nurse as the first point of contact would make a professional judgement on whether they have

the required knowledge and skills to deal with the issue themselves, or whether to refer the person on to an appropriate specialist. Family Health Nurses may also receive referrals for families with complex needs or where there is a requirement for clinical intervention and lifestyle change.

3. Expertise in family health approach

Family-centred care requires a high level of expertise in family health approaches. The Family Health Nurse has a portfolio of knowledge and skills to equip them to support families with complex needs. These added skills build on their existing knowledge base. Expertise grows through experience of working with families at different stages in their development. A key aim of this approach to care is moving families away from dependence on health care professionals towards independence within a supportive community.

The expertise of the Family Health Nurse enables them to contribute to the primary care team's 'planning of service' strategy which includes locally developed practice profiles. These profiles detail the health priorities for that community and guide service delivery. The Family Health Nurse can contribute by undertaking risk assessment using their skills of family health assessment to identify health and disease trends. The third area of expertise is their intergenerational approach, working with all generations within family units and using tools such as genograms (family health trees) to help the members identify and respond to health risk factors.

Appendix 3

EXECUTIVE SUMMARY

Family Centred Health Care: The Contribution of Family Health Nurses. An Evaluation of the Family Health Nurse Role, Phase 2

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According to current WHO Europe and Scottish health policy, the delivery of health care must shift away from an acute, hospital-focused service, and towards a community-based service. Family Health Nursing offers one possible new model for the delivery of community nursing services. Family Health Nurses work to a generalist model, delivering clinical care, promoting families' health, and organising community health initiatives. Family Health Nursing has been piloted in Scotland, since 2001 in remote and rural areas, and in 2005 in an urban area. This small-scale study evaluated the implementation of Family Health Nursing after 6 months in an urban area, and followed up the implementation after 3-4 years in remote and rural areas. The study aimed to understand the impact of the Family Health Nurse role, and the factors that have helped or hindered the implementation of the role.

Key findings

- Family Health Nurses were working to a generalist model, covering clinical care, health promotion, and community health initiatives. Many were working across the generations in a family
- the generalist model enabled the Family Health Nurses to pick up health issues and individuals who otherwise may have 'fallen through the cracks' of more specialist services
- Family Health Nurses were particularly effective in working with families with multiple needs

- both Family Health Nurses and service users had very positive attitudes to the Family Health Nurse role
- while service users and carers were positive about other nursing services, they particularly valued the Family Health Nurses' accessibility and their holistic perspective which included all members of the family
- service users and carers valued the Family Health Nurses as a first point of contact
- building relationships with families required significant time, which was not always easy in a context of large client caseloads
- the Family Health Nurse model may risk creating a relationship of dependency between vulnerable families and the nurse. To foster self-care and empowerment, Family Health Nurses should identify and develop family and community strengths
- professional colleagues' responses were key to successful implementation. While some colleagues felt that the Family Health Nurse role had much to offer and supported it, others resisted the role, feeling that it was a duplication of existing nursing roles
- the twin challenges of Family Health Nurse' time and colleagues' 'buy in' were effectively addressed when teams collaborated to plan a new way of working together based on identification of community need and the expertise of each team member.

Background

Family Health Nursing has been implemented in Scotland in two phases. Phase 1 took place in

remote and rural areas, beginning in 2001, and evaluated after one year of practice by a team of researchers from The Robert Gordon University. Phase 2 was undertaken to:

- (i.) understand the impact of the Family Health Nurse role in an urban area during the first 6 months of practice from the perspectives of service users, Family Health Nurses and Family Health Nurses' professional colleagues
- (ii.) follow up Family Health Nurses' experience of the role after 3-4 years in remote and rural areas
- (iii.) understand the factors that have helped or hindered the implementation of the Family Health Nurse role.

Impact of the Family Health Nurse role

The Family Health Nurse role is particularly suited to providing services to families with multiple healthcare needs. The Family Health Nurses' generalist skills enable them to uncover unmet needs and to address a wide range of health issues, including disease treatment and health promotion, and to work with all generations of a family. Service users and carers had a positive attitude to the Family Health Nurse role. In a context where many service users felt that they should not 'bother' the doctor, they greatly appreciated having the Family Health Nurse as a first point of contact who could give the appropriate care or refer service users on to appropriate services. Key to service users' high levels of satisfaction was their feeling that the Family Health Nurses had sufficient time available to develop a holistic perspective on the full range of issues confronting the family.

Implementation of Family Health Nursing

Family Health Nurses' expertise in advanced communication, listening, family dynamics and relationships, creating networks in a community, liaising with the range of services available to

service users, risk analysis and family assessment were crucial to their success. The investment of time during the initial stages of building relationships with families and conducting family assessments was essential. The long-term benefits of this approach were perceived as helping families to develop and identify their own coping mechanisms. Time could be created for these activities when teams worked together to consider priorities and allocate work on the basis of each team member's particular skills and expertise. Full implementation of the Family Health Nurse role was hampered in some practices by resistance from professional colleagues, some of whom chose not to make referrals to Family Health Nurses.

Conclusions

The Family Health Nurse model is highly acceptable to service users, and is a role valued by the Family Health Nurses themselves. The generalist model enabled Family Health Nurses to pick up on health issues that would not otherwise have been addressed. Change management is crucial to the role's success, a finding also supported by the WHO multinational study of Family Health Nursing (WHO Europe 2006). Achieving the full potential of the Family Health Nurse role requires the transformation of the current model of service delivery to embrace a family-focused approach to care that is rooted in the needs of the community. It is anticipated that the findings from this report will contribute to the future policy development of nursing in the community.

Recommendations

- (i.) strategic leadership at Community Health Partnership (CHP) level is required to instigate the required systems change.
- (ii.) man power modelling research is required to explore the practical feasibility of the Family Health Nurse model.

(iii.) community nursing education programmes should be reviewed to ensure that all practitioners are familiarised with Family Health Nurse concepts.

Research methods

The research used mainly qualitative methods. Twenty-eight Family Health Nurses (10 urban; 18 remote & rural – 60% response rate) completed a postal questionnaire with open-ended questions asking them about their experiences in the Family Health Nurse role.

Twenty service users and carers in the urban area were interviewed about their experience of the Family Health Nurse. Thirty-one (52% response rate) professional colleagues of urban Family Health Nurses completed questionnaires about their attitudes to the Family Health Nurse role.

Appendix 4

Education programme⁸

Semester One

Research, Decision-Making and Evaluation in Clinical Practice (Practice Frameworks) (44 SCQF at Level 9)

Introduction

The Family Health Nurse, like other Specialist Practitioners, is required to practise within a number of broad overlapping frameworks. These frameworks include evidence-informed practice, decision-making, and governance in health and social care. The intention of this double-weighted module is to develop an understanding of these three frameworks by exploring the concepts relating to, and the reality of, working with families and communities. The core concepts explored within these frameworks will be revisited and further developed in subsequent modules.

This module forms the first in the series of modules that constitutes the Family Health Nurse Programme. It is a mixed theory and practice module spanning the fifteen week semester (including two weeks annual leave). The module is structured to enable students to gain core Specialist Practitioner knowledge about families and community, evidence, governance and decision-making, in order to explore and embed this knowledge within practice settings. It will also support students to develop skills to critically engage with knowledge underpinning practice.

Students will be encouraged to engage with theory and knowledge based practice relating to families and community and to explore, discuss and debate issues relating to theoretical and practice based frameworks that are utilised in the health and social care

systems and organisations. This module will enable the students through interaction with both peers and teachers to explore the variances that may exist with regard to rural and urban healthcare. Both formative and summative assessments require the application of these frameworks to students' practice experiences and assist students to meet a number of the core Family Health Nurse competencies.

Clinical practice

Students will undertake periods of clinical practice in which they will explore the influences on and features of the community in which they work, and begin to develop contacts with a number of families. This clinical practice will be supervised by an experienced practitioner who will be prepared for this role and act as Mentor to the student. Dedicated time will be set aside for clinical supervision during periods of clinical practice. Each week of practice includes a day of practice-related study time. Students will be able to use this time to develop their Evidence Base Portfolio through use of both structured and unstructured activities, towards achievement of the Family Health Nurse Competencies. As the period of practice continues and students gain knowledge and experience with a number of families and communities, students will be guided to critically analyse the implications for effective interventions and evaluation of their practice. This understanding and 'synthesis' is central to high level decision-making which is the hallmark of excellence in clinical practice.

Learning will be supported through:

- directly taught sessions
- group work
- self-directed study
- WebCT.

⁸ Information taken from: University of Stirling (2006) *Family Health Nurse (FHN) Project – Education Programme Report (February 2006)*. Stirling: University of Stirling.

Semester Two

Working with Families in the Community (22 SCQF at Level 9) runs concurrently with following module

Introduction

This module develops core SPQ principles and explores prior knowledge and experience in Community nursing and the rationale for change to Family Health Nursing. The identified conceptual framework of the Family Health Nurse will be critically analysed, compared and contrasted with other models of community care.

Emphasis will be placed on WHO Health 21 targets for health. This will encompass primary, secondary and tertiary prevention of illness aimed at the individual, the family and the community as a whole in an effort to reduce morbidity and set targets in collaboration with others for health improvement.

Building on content within semester one, local and national policies and recommendations will be analysed. An exploration of the management of change and inter-agency collaboration for the provision of health and social care will be facilitated. Reflective practice, ethical and legal matters will also be developed further in this module.

Recognising that the students undertaking the short course will join with those undertaking the long course students at this time, a number of supportive measures will again be made available to all students. Further computer training will be available, along with the use of library facilities, study skills, tutorial and mentor support to meet the learning needs of the students, as individually required.

This module provides the student with a strong grounding in the exploration of the Family Health Nurse role; issues surrounding

autonomous practice; and an examination of the need and dynamics of collaboration with families, liaison with peers and relevant others.

Clinical Practice

Clinical experience will enable the student to apply theory to practice with a limited number of families, and enable the student to carry out a three generational family assessment and identification of health needs.

Semester Three

Principles and Practice of Family Health Nursing (44 SCQF at Level 9)

Introduction

The intention of this double-weighted module is to develop an understanding of the phenomena and underlying dynamics within the family system that may be indicative of the dysfunctional or pathological processes, thus giving an indication regarding therapeutic interventions or referrals. It is also intended to develop in the student an understanding of the connectedness of the various theoretical underpinnings of the Family Health Nurse, initially introduced in previous semesters. Therefore semester three's main outcome is to effect an integration within each student which will help develop their competence to apply these constructs in day to day practice, within the context of an evidence-based framework.

The module provides the opportunity for a period of sustained study and practice of those therapeutic skills considered necessary for effective clinical practice with families and communities. The development has been influenced largely by qualified community nurses, with the support of academic staff and it therefore reflects practising nurses' expert understanding of the skills needed for Family Health Nursing practice. Students will be exposed to a wide range of interventions, some

of which are currently the province of other community nursing roles. The Family Health Nurse must possess a range of competencies, which cross traditional role boundaries in existing community nursing practice. A multidisciplinary focus in the Module provides richness and breadth of learning, together with an understanding of the various professional roles and agencies that affect families and communities. The module will be tailored to the specific needs of students - an arrangement which is important given the fact that qualified and unqualified community nurses will undertake the Programme. The campus-based learning will be facilitated via a series of focused workshops that alternate with practice throughout the semester. A life-course approach is adopted along with a clear focus on the key national and local health issues such as cardiovascular health, mental health, cancer care and child health.

Clinical Practice

Clinical practice is necessary within this module to utilise skills, consolidate learning and produce evidence of integrated understanding. Research based management of specific clinical issues and their application to the family will be examined. The student will be required to work independently at times to gather clinical information, analyse, discuss, evaluate and review it in relation to practice.

The three main sections: management, social/sociological understanding and therapeutic interventions will be subsumed within the overall semester heading of Principles and Practice of Family Health Nursing.



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