The Implementation and Evaluation of the World Health Organisation (WHO) Europe Family Health Nurse Role —The Scottish Pilot

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I. Introduction

This paper describes Phase 2 of the Scottish pilot study of WHO Europe multinational Family Health Nurse (FHN) project (Scottish Executive, 2006). The project involved the development, implementation and evaluation of a new model of community-based nursing. Scotland was one of eight countries within the WHO Europe region that participated in the project. The countries that participated in the multi-national study were diverse, geographically, politically, culturally, and in terms of health and nurse education infrastructures. Each country faced a different set of challenges— for Scotland that was about integrating a different way of working into a well established specialist community nursing system. For others it was developing a family nursing service as part of a radical reform of primary care provision.

II. Policy Context

The worldwide community is being faced with many health challenges—an ageing population, rising incidence of chronic health problems, and alcohol and drug related diseases and injuries. Within Europe the response to these emerging health challenges was Health 21, the health for all policy adopted by WHO European Member States (WHO Europe, 1998). This policy, based on an analysis of health problems of people in the region, identified strategies that countries can adapt to reduce the incidence of diseases and injuries, and promote health. Furthermore, it identified nurses and midwives as being central to these aims. With a strong emphasis on primary care, a recommendation was made that the role of a family health nurse, who would provide a broad range of lifestyle counselling, family support and home care clinical services, should be piloted. In 2000, the Munich declaration called for the enhancement of the role of nurses and midwives to promote the establishment and support of public health and family focused community education programmes and services.

The concept of family is both complex and open to several interpretations. Within Scotland, the Family Health Nursing concept was based on the idea of the ‘family unit’, which 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.’

This quote emphasises the dual needs of families, firstly for clinical care in response to a medical need, and secondly as a vehicle through which health improvement can be addressed to reduce familial risk factors which may contribute to disease and illness. Within this context, there is a need to look at models of practice that could respond to these different needs. The FHN role was seen as a model which could contribute to addressing different health challenges across Europe while also offering an alternative way of working with families.

III. The Family Health Nurse Role

Table 1. WHO Europe definition of the Family Health Nurse Role

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<tr>
<th>The Family Health Nurse role:</th>
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| "Contains elements which may already be a part of the role of several different types of nurses working in primary care. What is new is the particular combination of various elements, the focus on families and on the home where family members should jointly take up their own health problems and create a healthy family."

WHO Europe described the role as having 4 key elements:

- an understanding of the socio-economic factors in family health
- acting as a substitute for the doctor as required
- being a care provider, decision-maker, communicator
- being a leader in community

This suggests that the Family Health Nurse is working at an advanced level. A nurse who understands the determinants of health, can substitute for the family doctor if required, can provide care to the family and is able to demonstrate a high level of decision-making in their practice. In addition, they would be expected take a lead role in the community and contribute to the public health agenda creating a culture of ‘enabling others to do’.

Within Scotland, the FHN role was based on a generalist model underpinned by 3 underlying principles:

- a focus on the family using family nursing approaches
- a commitment to health by helping individual and families to make lifestyle changes to help reduce risk factors
- advanced nursing skills to deliver care to members of the family with illness or disability

This is a role therefore that requires a breadth of knowledge and multiple skills related to family dynamics and relationships, public health and disease management. This is different from other commu-
nity nursing roles within Scotland where specialist nurses usually focus on one of these underlying principles.

IV. The Scottish Pilot

Scotland has some of the highest death rates from cancer and cardio-respiratory disease. A key piece of recent legislation has resulted in a ban on smoking in all public places. There are also unacceptable health inequalities within communities with high levels of social deprivation. The Minister for Health is committed to tackling these problems through encouraging health and social organisations to work together and through encouraging people to change their lifestyle and to care about their own health. The family health nurse pilot is one of many initiatives that are currently being tested to look at sustainable ways to deliver health care in the future.

The Scottish project was managed using an integrated approach that included policy makers from the government, nurse educators, nurses and researchers working together. The role in Scotland is based on a generalist model in a similar way to that of the Family Doctor (general medical practitioner) who has advanced generalist skills, recognises their professional limitations and knows when to refer onto specialist services. The FHN would be involved in all stages of the person’s life span—with the support of a specialist nursing system. Within the United Kingdom, there is a system of different specialist nurses who work in the community (Table 2). These are registered nurses who have undertaken a post-graduate 1 year education programme.

The FHN role is based on a generalist model that combines elements of public health with disease management rather than the above current system where the specialist community nurse may focus on either disease management, home nursing care or public health.

V. Pilot Aims

Scotland had a two phase project with the initial phase focussing on 4 remote and rural National Health Service (NHS) Board areas (Scottish Executive Health Department 2003 a, Scottish Executive Health Department 2003 b). The second phase included an urban site and also introduced a programme of practice development for existing FHNs in remote and rural areas (Scottish Executive 2006). Both phases included an education programme and research evaluation, and were project managed by a network of national and local implementation groups.

Importantly when we first started the project the FHN was a hypothetical role i.e. it had never been implemented or tested in a real health care system. The aims therefore were to:

- test the FHN model as a way of delivering community nursing services to remote and rural areas (phase 1) and urban areas (phase 2)
- develop and test the educational preparation of FHN

The population of Scotland has diverse cultural differences. Within the urban sites nurses are required to deliver services to an increasing multi-

<table>
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<tr>
<th>Table 2</th>
<th>Example of different community nurse specialists</th>
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<tbody>
<tr>
<td>District Nurse</td>
<td>cares for people with physical health problems</td>
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<tr>
<td>Community Psychiatric Nurse</td>
<td>responsible for adults with mental health problems</td>
</tr>
<tr>
<td>Community Children’s Nurse</td>
<td>looks after children with specialist physical needs</td>
</tr>
<tr>
<td>Learning disability nurse</td>
<td>supports those with special needs</td>
</tr>
<tr>
<td>Occupational Health Nurse</td>
<td>manages the health of the workforce within an organisation</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>assists the family doctor for example in immunisation clinics, women’s health and chronic disease management</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>is responsible for child health and development, school children and the health of community members</td>
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cultural population in densely populated and often socially deprived areas. Across remote and rural sites the challenge is to make services accessible to small communities across a large geographical area.

VI. Research Evaluation

1. Methodology

An action research approach was used in Phase 2 which included the implementation of an 18 month practice development programme to support new FHNs in practice (Scottish Executive 2006). The major aim of this study was to evaluate the role of the Family Health Nurse in an urban pilot area. Specifically, it aimed to identify the impact of the FHN role, from the perspectives of FHNs, their colleagues and individuals and families. In the remote and rural areas, the study aimed to assess the impact of the FHN role after 3-4 years of practice. In both settings, the study identified factors that have helped or hindered the implementation process.

2. Data collection from FHNs

Postal questionnaires were distributed to all FHNs (32 rural; 15 urban), which asked details about the nature of their work, and the process of implementation. The questionnaire was mainly qualitative, with open-ended questions, to which participants responded in great detail. A 60% response rate was achieved, with 10 urban FHNs and 18 rural FHNs participating in the research. Thematic analysis sought to identify the major features of the FHN role.

3. Data collection from FHNs’ professional colleagues

A validated questionnaire developed for previous research (Scottish Executive Health Department, 2003 b) was used to assess urban-based FHNs’ nursing and medical colleagues’ attitudes to the role. Out of 60 questionnaires sent out, 31 were completed (52% response rate). Likert-type attitudinal items sought colleagues’ views on the impact and degree of success of the role.

4. Data collection from service users (patients and families)

Semi-structured interviews were carried out with service users (n = 20) who had received input from a FHN to assess their experience of the role. Thematic analysis identified the particular impacts that the FHN role had on clients.

VII. Education Programme

The education programme was developed from a multi-national curriculum created by WHO Europe (2000). This was adapted to fit with the United Kingdom nurse education regulation system. The programme was delivered over 1 academic year at post-registration level i.e. all students were registered nurses with experience of working in the community. The competency-based programme comprised 50% theoretical learning in the University and 50% practice based learning in their clinical placement area. The units of study covered the following subjects:

- Research, decision-making and evaluation
Advanced communication
Working with families
Principles and practice of family health nursing

Forty-nine students graduated from the programme as Family Health Nurses and are now working in pilot areas across Scotland.

VIII. Practice Development Programme

The 18 month practice development work was designed to support newly qualified FHNs and their team members (other nurses and general medical practitioners) in order to grow the role to achieve its maximum potential. This was carried out through the appointment of facilitators in each site (total of 4) to create a facilitation team with varied skills and experience. Facilitators are people who assist the progress of a project. In Scotland, facilitators were nurses who had experience in leadership, change management, education and research. The facilitators met every 3 months for a 2 day workshop to develop skills such as project management, negotiation, and problem solving. Facilitators then shared these new skills with FHNs and team members.

Figure 2. shows the facilitators and the national co-ordinator creating team building activities to help FHNs share information on their role with other staff.

The facilitators found when they visited teams where FHNs were based that there was a mixed understanding and some misconceptions about the role. Some teams reported that traditional ways of working (in specialist roles) and poor communication between different members acted as barriers. However, there was also a sense that teams were making a contribution to family health through supporting carers and developing programmes of chronic disease management in areas such as respiratory disease and diabetes.

The facilitators encouraged FHN to develop their practice. Some examples on new initiatives led by FHNs are given below:

- Family nursing approaches have been continually refined. The genogram (family health tree) has been particularly important in helping families to understand risk factors and develop support and coping mechanisms. This approach has helped motivate families to take responsibility for their health and make decisions with FHNs about lifestyle change. The use of family health trees (genograms) can help the family to recognise risk factors associated for example with heart disease and diabetes. The FHN worked with them and agreed a health plan that can contribute to reduce these risks by introducing exercise, healthy diet and smoking cessation.

- Another FHN team worked with community members to determine what they wanted from the service. The nurses created a poster display and a suggestion box for ideas. The topics the community members suggested included an exercise class for people aged over 65 years,
promoting healthy ageing sessions in a residential care complex, a family carer’s support group, a team-led cardiac rehabilitation programme and setting up a local youth club.

Further information on the practice development work can be found in the national project report (Scottish Executive Health Department, 2006).

IX. Research Evaluation—Preliminary Findings

The evaluation (as described in the previous section) was conducted in the final 6 months of the project (Parfitt et al, 2006). Preliminary themes emerged in 3 key areas, these are summarised below.

1. The Family Health Nurse as the first point of contact

Families liked having one nurse they could contact to talk about health issues and to receive care when ill. They felt the FHN could help them find solutions to their problems.

2. Care enhancement

The FHN role is particularly suited to providing services to families with multiple healthcare needs. The FHNs’ generalist skills enabled 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. One FHN when visiting a member of the family with heart disease was also able to support another family member who was being physically abused by their partner.

3. Health systems change

The role was most successful when team members worked together to consider work priorities and allocate work on the basis of each team member’s particular skills and expertise. Full implementation of the FHN role was hampered in some practices by resistance from professional colleagues.

The success of the role was dependent on acceptance by other nurses and doctors, and where everyone had a shared aim of developing family-centred health care.

X. Conclusions

Findings from the Scottish pilot study offer potential solutions to developing a modernized health care system. However, in order to achieve the full potential of the role, transformation of the current model of service delivery to embrace a more family-focused approach to care is required. This includes combining elements from the FHN education curriculum with the strengths of existing nurse education programmes at pre and post-registration level.

The FHN model was found to be highly acceptable to patients and families, and is a role valued by the FHNs themselves. The generalist model enabled FHNs to pick up on health issues that would not otherwise have been addressed because they did not fit within the remit of existing specialist nurses.

An important feature of the project was changing professional attitudes towards family care. The following quote from a FHN illustrates her own professional and personal development.

1. “I thought I was working in a family-centred way, now I realise I wasn’t.”

This quote demonstrates how the nurse had changed the way in which she worked with families, and now felt as a FHN, that she was working in a different, more family-centred way.

The FHN 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. However, it is important that our experiences contribute to the international debate on models of practice, and that the worldwide community of nursing seek to learn from inter-country collaboration and the sharing of different approaches to family care.

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