Partnering in primary care in New Zealand: clients' and nurses' experience of the Flinders Program™ in the management of long-term conditions

Dianne Elizabeth Roy RN, PhD, FCNA(NZ)

Senior Lecturer, Department of Nursing, Faculty of Health Sciences, Unitec New Zealand

Faith Mahony RN, MPH

Research Fellow, Centre for Health Services Research and Policy, University of Auckland

Margaret Horsburgh RN, EdD, MA (Hons), Dip Ed, FCNA(NZ)

Associate Professor, School of Nursing, University of Auckland

Janine Bycroft MB ChB, Dip Obs, Dip Paeds, MPH (Hons), FRNZGP

Honorary Senior Lecturer, Department of General Practice and Primary Care, University of Auckland

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Aim and Objectives. To explore clients' and nurses' experience of the Flinders Program™ of self-management within a study assessing the feasibility for a trial gauging the effectiveness of the Flinders Program™ in New Zealand (NZ).

Background. The Flinders Program™ has been adopted in NZ as a useful and appropriate approach for improving long-term condition management; approximately 500 health professionals have been trained in its use. Evidence for the effectiveness of self-management is inconclusive and support for introduction of new and complex interventions in primary care inconsistent.

Design. The feasibility study used mixed methods with simultaneous qualitative and quantitative components, including a web-based survey. The qualitative component, reported here, used interpretive description.

Method. In 2009, two focus groups were conducted with nurses participating in the intervention group of the feasibility study together with interviews of 11 clients with long-term conditions who had completed Flinders assessments and four nurses who partnered with these clients. Free-text responses from survey participants (n = 355) who had completed 'Flinders' training in NZ since 2005 were included in the interpretative analysis.

Findings. Three themes describe the experience of clients and nurses: 'enablers and benefits' with sub-themes of process, relationships and time; 'challenges' with sub-themes of motivation, resistance to change, primary care structure and time. 'A catalyst for change' is the third theme.

Conclusion. While implementation of the Flinders Program™ in NZ is limited, there are benefits of the approach for clients and nurses in terms of greater understanding of self-management, collaborative care and effective strategies to support client behaviour change. There are, however, challenges in facilitating such programs in primary care.

Relevance to clinical practice. Understanding the experience of the Flinders Program™ in primary care illustrates the value of supported self-management for clients with long-term conditions, while highlighting the challenges of implementing new and complex interventions.

Introduction

Management of long-term conditions accounts for 78% of all healthcare spending in New Zealand (NZ) and for approximately 70% of all encounters in primary care (National Health Committee 2007) and imposes an increasing burden to the state-funded healthcare system. The 2006/ 07 NZ Health Survey found one-third of children and two-thirds of adults had been diagnosed with a long-term condition (Ministry of Health 2008). A critical role for primary care is to respond to the challenges imposed by the increasing prevalence of long-term conditions; supporting people to effectively manage their condition is fundamental to this.

Empirical knowledge and conceptualisation of self-management in long-term conditions are at an early stage (Battersby et al. 2010a) with contested understanding of the term. What cannot be contested is that people with long-term conditions self-manage their illness. 'Each day, clients decide what they are going to eat, whether they will exercise and to what extent they will consume prescribed medicines' (Bodenheimer et al. 2002a, p. 2470). The question then is not whether people manage their illness, but how? The NZ report 'Meeting the needs of people with chronic conditions' (National Health Committee 2007) recognised supporting self-management as a key component of chronic care and recommends incorporating self-management approaches; with the Flinders Model of Self-Management (now the Flinders Program™) (Flinders Human Behaviour & Health Research Unit) (FHBHRU) a model for consideration. Within the Flinders Program™ self-management support is defined as the 'process of providing multi-level resources in health-care systems (and the community) to facilitate a person's self-management. It includes the social, physical and emotional support given by health professionals, significant others and/ or carers and other supports to assist a person in managing their chronic condition. Self-management support is what health professionals and the health system do to assist the person with a chronic condition manage their condition(s)' (Battersby et al. 2010a, p. 103).

The Flinders Program™ (Flinders) was developed by the FHBHRU, following the Coordinated Care Trials (1997– 1999) in Australia (Battersby 2005, Battersby et al. 2007). Flinders is based on cognitive behaviour therapy and motivational interviewing techniques to support positive behaviour change. It uses a generic set of evidence-based tools and processes that enables clinicians and clients to undertake a structured process of assessment of self-management behaviours, collaborative identification of problems, and goal setting leading to the development of individualised care-plans (FHBHRU 2011).

Successful client-reported outcomes of the Flinders Program have been found in different client groups including Aboriginal people with type-2 diabetes (Battersby et al. 2008) and people with mental illness (Lawn et al. 2007). The Program has yet to be evaluated using rigorous controlled trial designs, although a study is underway (Battersby et al. 2010b).

Flinders has gained prominence in NZ as a useful and appropriate approach in primary care for supporting self-management in clients with long-term conditions. Since 2005

approximately 500 NZ health professionals have participated in 'Flinders training'. Most of them are primary care nurses; including 298 who completed the training within a postgraduate certificate course focusing on long-term conditions. Flinders has not been evaluated in NZ (Horsburgh et al. 2010a) nor client and practitioner experiences reported.

This paper reports findings from the qualitative component of a study undertaken in 2009 to assess feasibility for a trial to determine the effectiveness of Flinders in improving health outcomes for NZ populations with long-term conditions. The challenges of undertaking this research within NZ primary care settings are reported separately (Horsburgh et al. 2010c), as is the outcome of the feasibility study (Horsburgh et al. 2010a) and findings from a survey of health professionals who completed training in the use of the Flinders Program (Horsburgh et al. 2010b).

Methods

Aim

To understand the experience of Flinders for clients with long-term conditions and their nurses in the context of a study to assess the feasibility for a trial to determine the effectiveness of primary care nurses using the Program to improve health outcomes for NZ populations.

Design

We designed a mixed-method feasibility study with simultaneous qualitative and quantitative components (Whitehead & Elliott 2007). A quasi-experimental non-equivalent control group design was used. The qualitative component, reported here, was informed by interpretive description (Thorne et al. 1997, 2004, Thorne 2008b). A web-based survey of Flinders trained health practitioners in NZ was undertaken in parallel.

Study population

Following ethics approval we recruited 20 primary care practices; ten for selection of intervention group participants (n = 50) and ten for control group participants (n = 50). Letters of invitation were sent to clients identified from practice databases who were over 18 years of age with one or more long-term condition. Detailed description of sampling strategies and recruitment processes is reported elsewhere (Horsburgh et al. 2010a).

Intervention group participants were people with long-term conditions who received a Flinders assessment and management over a six-month period with primary care nurses who had completed Flinders training. These clients and their nurses were invited to participate in semi-structured face-to-face interviews on completion of the intervention (26 weeks). Flinders-trained primary care nurses were also invited to participate in two focus groups pre-and post-intervention.

The intervention

Following base-line assessment by research assistants, participants in the intervention group were contacted by their primary care nurse and an appointment scheduled for a Flinders assessment and care-plan development. Flinders involves the client first completing the Partners-in-Health Scale© (PIH); a 13-question self-assessment of their self-management capacity. This is followed by a motivational interview (Cue and Response©) during which the health professional uses cue questions to enable a shared understanding of barriers, strength

and impact from the client's perspective. Client priorities are identified and specific, measureable, action oriented, realistic, timely (SMART) goals developed (Problem and Goals assessment) (Lawn & Schoo 2010). A care-plan is collaboratively constructed by the health professional and client, which includes issues identified from the Cue and Response© as well as other key medical, psychosocial or carer issues. The care-plan also notes who is responsible for actions and review dates; a copy is given to the client. Follow-up was 'as appropriate' for client needs; at a minimum of three and six months in accord with Flinders and the study protocol.

Data collection

Eleven clients aged between 25–74 years and four primary care nurses who partnered with these clients were interviewed. Clients lived with a range of long-term conditions, singularly or in combination, including asthma, diabetes, coronary heart disease, bipolar disorder and osteoarthritis. Clients were interviewed in their homes; nurses at their workplace. Prior to commencement of the interviews ongoing consent was verified. Eight nurses from the intervention practices participated in the first focus group; five in the second. Interviews and focus groups, guided by open-ended questions (Table 1), were recorded. During the intervention phase nurses were asked to record reflection notes following client visits. Nurse reflection notes from the nurse/client dyads who participated in face-to-face interviews were included in the data set as were free-text responses from participants (n = 355) in the web-based survey (Horsburgh et al. 2010b).

Data analysis

Data analysis was informed by interpretive description (Thorne et al. 1997, 2004, Thorne 2008b). The focus group recordings and individual interviews were transcribed verbatim. Following previously developed analytical processes (Giddings et al. 2007) a broad interpretive analysis was completed after the first focus group to inform the interview guide for the individual interviews and second group. Combined data were analysed using thematic interpretive processes (Thorne et al. 1997, 2004, Thorne 2008b) by two researchers, independently and collectively. Guiding questions were, 'What is happening here?' and 'What is this telling us about effectiveness and acceptability of Flinders?' We resisted early conceptualisation through challenging and clarifying relationships within data and emerging themes.

Rigour

Our processes and analysis were reviewed by others in the research team, which included primary care clinicians and, on completion of the study, nurses from the intervention practices. Their feedback affirmed the robustness of our approach and opened interpretations to critique. This 'thoughtful clinician test' (Thorne et al. 2004, p. 17) supported the credibility of our interpretation. Questions and discussions from audiences following presentation of initial findings at national and international conferences provided further critique of our findings. Our processes and reflexive account provide the necessary audit trail for evaluation of the plausibility (rigour) of the findings (Koch & Harrington 1998).

Table 1 Interview and focus groups – question guides

Focus Group discussion points – general guide (pre and post-intervention) – primary Care Nurses

- Nurse participants' experience of Flinders (when trained, how often used etc.) and context of their primary care practice. Post-intervention participants were asked to specifically discuss their experience during the six-month intervention period
- What (if anything) they liked about using Flinders (tools and processes)
- What (if anything) they found difficult in using Flinders (tools and processes)
- The nurses' opinions of the clients' response to Flinders

Facilitators used prompt and clarifying questions as required. For example, 'Can you give me a little more detail about that?' and 'A few minutes ago you mentioned …'

Interview trigger questions – client participants

- Can you please tell me what it was like for you to do/participate in the Flinders Program?
- What was it like sitting down with the nurse to complete the assessment? (Type of questions, time involved etc.)
- What sort of things did you identify as important to you (your goals)?
- Has there been any change in your health as a result of being involved with Flinders?
- Has there been any change in the way you manage your health condition?
- Can you please tell me about the relationship you have with your nurse and doctor? Has this changed at all since beginning with the program?
- Can you please tell me about the follow-up you have had with the nurse since your first Flinders assessment

Questions were not necessarily asked sequentially as interviews were 'conversational' and often participants in their response to the first general question answered subsequent ones. Pauses, prompt and clarifying questions were used as required.

Findings

Three themes were identified that describe the experiences of clients and nurses using Flinders in primary care in NZ; 'enablers and benefits', 'challenges' and 'a catalyst for change' (Table 2).

Table 2 Themes

Theme 1: Enablers and benefits
Sub-theme: The process
Sub-theme: Relationships
Sub-theme: Time
Theme 2: Challenges
Sub-theme: Motivation
Sub-theme: Resistance to change
Sub-theme: Primary care structures
Sub-theme: Time
Theme 3: A catalyst for change

Enablers and benefits

Participants described particular aspects of Flinders that enhanced self-management capacity and were important for successful outcomes.

The process

The process of assessment, collaborative identification of problems and goal setting over a sustained period of time that is fundamental to Flinders was identified by clients and nurses as an important enabler. Goal setting was pivotal to the clients' success, providing focus and something 'concrete to aim for': *Setting the goals gave me something concrete to aim for*. The goals were not necessarily based on new knowledge or understanding of their condition, but because they were client-focused there was a sense of ownership and commitment not previously present: *No-one forced me or tied my arm behind my back or anything; I just decided to do it properly.* Having the goals incorporated into a written care-plan and receiving a copy was an important enabler for clients: *I set some goals, putting it in writing gave me those goals to work to.* The ongoing collaborative nature of the process assisted clients in achieving their goals and having follow-up appointments with the nurse was motivation for change: *She doesn't get on my case about it, but just a nudge every now and then keeps me going.*

The nurses liked the fact that Flinders was client-centred and recognised that using the whole program was important:

> I like Flinders because it's so patient-centred. It's actually all about them. My experience of using the tools is that they show us we can get it completely wrong when we think about the patient's issues. Often what I think and what the clients identify are at opposite ends of the spectrum. The value comes from following the whole process despite the time it takes.

Relationships

Clients and nurses reported a benefit of using Flinders was the change in their relationship. Changes occurred in the dynamics of relationships through Flinders processes:

> It's quite a different way of communication with health professionals to talk about goals and to have the contact and follow through. We were able to find ways to work on my goals. The two of us just kept working together. I think between the two of us

> we are on a fairly even level now. (client)

The relationship became a partnership as client and nurse worked together to enhance the client's management of their long-term condition and improve health outcomes. Improved communication and increased awareness of what was important to the client were benefits of the changed relationships.

> The interaction is better. She knows me better. Nobody asked me these things before. (client)

> It made a difference that I listened to [client] and found out what was important for her. Then we worked with that. (nurse)

Nurses came to know more about the clients' lives through the prolonged engagement with them and the nature of the assessment process.

> Doing the 'partners-in-health' was quite amazing. Listening to her, she actually told me more about the family. It gave me a picture of family life that I hadn't had the opportunity to hear before. (nurse)

Being listened to and having time to listen were significant benefits of participating in Flinders for clients and nurses and contributed to the changed relationships:

> Here's somebody listening to me. (client)

> The clients say that they feel for the first time really listened to. Often it's the first time that person has been allowed to tell their whole story without being interrupted, without us jumping in there and fixing things straight away. (nurse)

Time

Time was an important factor leading to improved relationships and it was also pivotal to successful outcomes of Flinders. The clients reported having the longer period of time for the assessment phase contributed to their success with the program: *them taking that extra time helped*. Nurses also described the benefits of time:

> The time that you have to do an assessment is important. I would never have delved into the depths previously because there has never been time allocated. It took that time to sit down and really work out why she was feeling so lousy.

The time taken for the Flinders assessment enabled clients to reflect and identify their most important problems and issues. One nurse recalled:

> It's the time that you spend with somebody. Most people want to elaborate. It's the fact that they're listened to for that time. They have time to stop and think about what their major problem is; it's actually the self thought and self analysis.

One client, with a long history of asthma, described her reaction when the nurse discussed smoking cessation:

> I looked at her and said, 'No I'm not giving up smoking.' I said it exactly like that. But then later-on I decided. I thought, 'I wonder if I can reduce my smoking.' And so I tried.

Time for self-reflection following the initial Flinders assessment lead the woman to set and

achieve goals towards smoking cessation.

For many of the clients being part of Flinders (and the study) presented the 'right-time' for making changes in their self-management strategies. This was the serendipitous time when the client was ready to change; they were open to understanding more, deciding which goals they wanted to focus on and more effectively manage their long-term conditions.

> They were things that I should have done anyway but I just hadn't got around to it. It was the right time for me, everything just gelled.

Nurses too recognised there was a 'right-time' for change: *I think it was the right time for her. Asthma was her biggest problem, but she was able to look at other things and was ready to do something about it.* What is not clear in the data is whether being enrolled in Flinders triggered the 'right-time' or if clients agreed to participate because they were ready to initiate change.

Challenges

Motivation

Few clients discussed issues that could be interpreted as challenges, however, becoming and staying motivated was identified. It seemed that motivation was linked to the 'right-time' for change. Nurses recognised the challenge of motivation and a readiness for change:

> Motivation is important. Some clients are not ready, like with [client] she sees all her problems, can tell me all her problems, knows what's right to do and what she needs to do, but she doesn't do it.

Resistance to change

Some nurses, while recognising the potential benefits of using Flinders in practice, were reluctant to do so. This was primarily related to time constraints:

> Time is the greatest factor in general practice setting; there is not enough! When you're busy it is just easier to keep doing what you are doing, rather than change it.

Some nurses experienced resistance from their colleagues. They were seen as not 'pulling their weight' and spending too much time with clients. One nurse described her experience:

> I need undisturbed time. But people knock on my office door and say, ''It's really busy out here''. It's hard not to get that distraction. I know I'm spending longer than other people, but I'm there for the patient. But it makes me feel as if I'm not pulling my weight.

Primary care structure

Nurses identified that the time required to complete the Flinders assessment[1] did not easily fit existing appointment and funding structures within their primary care practices. One nurse said: *There's the time; your financial return to the surgery. Funding for the length of time involved becomes a cost*. In NZ most primary care practices are small businesses usually owned by a medical practitioner with a business management focus on profit and how costs

[1] Initial Flinders assessment may take 40 minutes to two hours depending on practitioner experience with Flinders and the complexity of client issues. Usual time for a nurse appointment in primary care is 15–30 minutes.

will be covered. Survey responses in particular revealed much about challenges faced by nurses in practice. One described her experience when trying to implement the program in her workplace following her successful completion of the Flinders training: *My workplace was not interested; they saw it as a waste of time and not financially worth their while.* Another noted: *To my knowledge not one GP [general practitioner][2] in our practice has shown any interest in supporting Flinders. GPs are about making a profit and seeing as many patients as they can in the day*. This was not the experience of all nurses; some practices found ways to fund Flinders from existing funding streams:

> Cost is covered by our PHO [Primary Health Organisation][3] for our high needs population, otherwise we try to cover it with Care Plus.[4] Funding becomes a problem if clients don't meet [Care Plus] criteria and are unable to pay for consultation time.

Flinders 'aligns with the internationally recognised chronic care model' (Lawn & Schoo 2010, p. 209), however, an acute care model underpins many aspects of primary care in NZ, challenging implementation. This was recognised by nurses, one of whom described feeling as if *she was working as a square peg in a round hole* when using Flinders.

Time

As much as time enabled successful implementation of Flinders it was also a major challenge. Clients reported finding *the time it takes to achieve goals* challenging. Some goals, such as increasing levels of physical exercise, were achievable in short timeframes. Long-term goals that had the potential for bringing the greatest health benefits took longer to achieve and required motivation and determination. This was particularly difficult for participants with multiple long-term conditions:

> I've changed my diet and I'm trying to find ways to exercise. I've found a few things that I'm in the process of organising. I've got quite a few problems; diabetes and bad arthritis. I can barely walk, so exercise is quite a problem. The long-term goal is to get the weight down. I've got to lose 60–70 kilos. Realistically I probably won't lose that, but even if I lose 10–20 kilos that's going to benefit my health and mobility but it will take a long time.

Nurses reported significant time challenges in using Flinders. Many reflected on the time it took to complete an assessment and provide follow-up: *the assessment takes about an hour and then additional time is required to write it up if using all of the tools properly.*

Nurses committed to Flinders shared strategies they used in an attempt to manage time challenges. These strategies related to scheduling and developing shortcuts with the tools used.

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[2] General practitioner (GP) is the term used in NZ for medical practitioners who provide primary care services.

[3] In NZ primary health organisations (PHOs) are government funded via District Health Boards to provide essential primary healthcare services to those people who are enrolled with the PHO. PHOs bring together doctors, nurses and other health professionals (such as Maaori health workers, health promotion workers, dietitians, pharmacists, physiotherapists, psychologists and midwives) in the community to serve the health needs of their enrolled populations Ministry of Health (2010b).

[4] Care Plus is a NZ primary healthcare initiative, funded by the Ministry of Health targeting people with high health need due to chronic and other conditions Ministry of Health (2010a).

> I try to cut down the time. I read through the patient history, then have a chat to them on the phone and send them the PIH to go through at home. When they come in they've already done the scale. After the assessment I write up the plan, it will take me about an hour, so it's about 2 hours really for that first visit with a lot of prep work. I've found it useful to 'roughly' set goals at the end of first visit; then get patients back a week later when we've both had time to think through the problems and goals and then adjust them to what the patient really wants/needs.

Despite the time constraints and other barriers encountered by nurses and clients, there were reports of significant changes in health and quality of life for many clients. These changes are encapsulated in the final theme; 'a catalyst for change'.

A catalyst for change

Flinders acted as a catalyst for change for many of the intervention group clients interviewed. It enhanced their self-management capacity and gave them the motivation and confidence to set goals and work to achieve them. As the final theme, 'a catalyst for change' can best be illustrated in a vignette.

During the Flinders assessment Kiri,[5] a 60-year-old Maori woman, identified that her main problem was she could no longer go out with friends and family. Her increasing social isolation was the result of severe, unstable asthma; everywhere she went she seemed to encounter triggers and was *constantly sucking on her inhalers.*

Prior to Flinders, Kiri was reluctant to monitor her peak flows or maintain an action plan: *I never acted until it was too late. I used to be so bad that by the time I got up to the clinic I'd be fighting for breath.* The nurse recognised there were self-management issues for Kiri but was unsure how to proceed in supporting her:

> She was up here quite a few times with acute asthma. She wasn't very approachable. It was very difficult because she would just shut off. I don't know how I got her onto the program, but she was on the list.[6] She had a barrier there which was very difficult to identify. When I talked to her, tried to educate her, she wasn't listening.

Completing the assessment was a revelation:

> With Flinders I started approaching it from her level, trying to understand why she had recurrent episodes. I found that the thing that was actually a problem was she was deaf, she couldn't hear. So that was the turning point of the whole thing.

Kiri has lived with asthma for more than 20 years and the assessment revealed she also had a hearing impairment. Discussion between nurse and client identified that Kiri did not have a good understanding of asthma, monitoring of symptoms or managing medications. She had attended education sessions in the past and had been told how to use her medications, but she had been unable to disclose that she could not hear well and had not heard everything.

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[5] Pseudonym. While not used for data excerpts elsewhere in the paper, a pseudonym is used here to enhance flow and readability.

[6] Recruitment list for the study.

> Because I was deaf I couldn't catch what they were saying, it was so frustrating. Because I couldn't hear them I couldn't understand what they were talking about.

Kiri and the nurse worked together to develop client-centred goals and a care-plan with interventions identified that were actioned by Kiri and the nurse. Goals set were: to be able to get out and about more and to sort out her hearing issues. Monitoring and review occurred at regular intervals; some phone contact and face-to-face visits at three and six months.

> I referred her for a hearing assessment. I taught her to use the peak flow and to record and act on the readings.

Kiri was motivated to make changes:

> I noticed my hearing was getting too much of an issue. I said, 'Hey I have to do something.' So I did that for myself.

At the time of the interview (six months after the initial Flinders assessment) Kiri had a working action plan, regularly monitored her peak flow and was using inhalers as prescribed:

> I record my peak flow, the picture is so logical. I see the picture and think, 'wow'. Before I wasn't recording the graphs, but now I understand what the picture means. I have 2 inhalers; I have a brown and a blue one. I didn't know the difference between them before, but now I do.

Kiri was also using a hearing aid:

> The challenge for me was trying to listen properly. Now for the first time I am not just going with the flow and not really knowing anything. It was really frustrating for me; and probably for the nurse too. The two of us kept working together despite the hearing problem. I kept saying, 'I can't hear you, you have to talk up' but now I say, 'Don't yell, I can hear you'. So communication was the biggest challenge for me. It is a lot easier now we are on the same wavelength.

Participation in Flinders changed Kiri's relationship with the nurse and GP and improved her health: *I haven't been back to the doctor for an emergency since I first started Flinders*. Staff were very pleased with her improved respiratory function (as was Kiri) but she was most excited about what this meant for her and her family. Now that she is no longer *constantly sucking on her inhalers* she is getting out meeting friends, exercising and helping care for grandchildren. She is also making korowai,[7] which she had been unable to do because the feathers constantly triggered her asthma: *I like swimming and I go walking. Making korowai is my new hobby. I have done about ten so far.*

What made the difference? Kiri suggested it was having the time to talk to the nurse and feeling listened to. This meant she felt safe to disclose her hearing impairment. She also said that she was surprised that the nurse was interested in things other than her asthma and inhalers. She was pleased to finally have some control over her condition:

> The nurse was always telling me, 'you have to do something', it was the nurse who put me on to Flinders. I've never been so grateful to have gone through that and learnt

[7] Korowai are cloaks based on traditional Maori designs, often with feathers woven into the garment.

> such a lot. Being part of Flinders gave me the chance to stop and think. I thought, 'there must be a reason for why they're putting me on this program.' Without it I would've just gone with the flow, got out of breath, run up to the medical centre and expected a miracle.

Participation in Flinders precipitated a change in the relationship between Kiri and the nurse. It enabled her, with the support of the nurse, to set goals and make changes in how she managed her long-term condition, which had significant impact on her physical health and the quality of her everyday life. Flinders worked as a catalyst for change.

Discussion

Small changes within the care context of people with long-term conditions 'can exert a powerful influence upon the course of an illness and eventual outcomes for individuals' (Thorne 2008a, p. 296). Interpretive analysis showed life-changing responses for a number of participants. This was evident particularly in clients with asthma, where small changes achieved significant health benefits over the six-month study period. Other clients made progress in improving their quality of life through changes in self-management, but the nature of their conditions was such that short-term goals achieved did not immediately reflect in measureable health gains.

The Flinders Program™ can be a catalyst for change; providing nurses with a structured yet flexible process to support clients' shift from being passive recipients of care to people who understand their condition, can monitor symptoms and manage their condition within the context of their everyday life. Nurses who saw improvements in their client's self-management capacity identified the importance of using the whole Program rather than shortening the process by selecting components considered on the surface to be more useful. Some nurses adapted the way they used the Flinders tools, including spreading the assessment process across multiple client-contacts; the flexibility to do this is considered an advantage of the Flinders Program™ (Lawn & Schoo 2010). Spreading assessment processes may be beneficial in giving clients time to reflect on the information revealed and problems and goals identified. Client reports that follow-up by the nurse provided ongoing motivation when their resolve was decreasing draws attention to the benefits of sustained involvement inherent in the Flinders Program™.

Consistent with earlier research (Battersby et al. 2008) we found the Flinders Program™ facilitated change in the nurse/ client relationship; where both parties came to know and understand the others' perspective. Their interactions moved from the more traditional 'professionals know best' approach to a partnership where mutual expertise was recognised and valued (Bodenheimer et al. 2002a, Giddings et al. 2007). These relational changes reflected a shift in focus from an acute to chronic care model (Bodenheimer et al. 2002b). For effective implementation of self-management approaches change at interpersonal levels must be supported by similar changes within the practice and wider health system (Bodenheimer et al. 2002c, Lawn & Schoo 2010).

Time was a paradox; an enabler to improved assessments and relationships, yet a challenge to these improvements occurring. The usual 15–30 minutes scheduled for consultations did not easily allow nurses to understand clients' perspectives or give clients space to reflect; time

had to be found for the Flinders Program™. Nurses without dedicated 'chronic care' clinic time relied on the goodwill of colleagues to support the time for a Flinders assessment. Proficiency with the Flinders Program™ comes with experience; however, many nurses were deterred in gaining this proficiency by the time it took to complete assessments. Some clients became ready to change when given time; they were not necessarily the clients nurses would have identified as being motivated. Nurses initially considered several of the interviewed clients 'non-compliant' or 'never going to change' but proceeded because the client had been selected for participation in the study. Macdonald et al. (2008) similarly found practice nurses based care on initial assumptions about clients' self-management capacity rather than in-depth assessment. Nurses risk delivering ineffective care if they limit use of the Flinders Program™ to those clients they assume will benefit most. The FHBHRU indicates that the PIH can be used as a screening tool to determine who requires full care planning and case management, however, it is important to remain mindful that the Flinders process itself can be a catalyst for change. A question remains for future study as whether and how best to identify clients who are 'ready-to-change' and might most benefit from participation in the Flinders Program™.

Limitations

This study is limited by a small purposive sample and findings may not apply in other healthcare settings. Clients who volunteered to participate in the qualitative component were, on the whole, ones who achieved successful outcomes from Flinders participation; the voices of those who may have had more negative experiences remain unheard. The six-month intervention period was insufficient for many of the longer-term goals set by clients to be achieved.

Conclusion

Flinders provides an evidence-based generic set of tools to systematically assess self-management capacity and collaboratively identify issues, goals and a management plan for people with long-term conditions. In NZ while implementation is to date limited, benefits of the approach have been identified. As this study has shown, the Flinders Program™ can be a catalyst for change resulting in significant health benefits and improvement in quality of life for individuals with long-term conditions.

Relevance to practice

Clients with long-term conditions benefit from working collaboratively with nurses over a sustained period of time to enhance their self-management capacity. Nurses should provide client-centred self-management support that is mindful of the context of client's lives and utilising strategies underpinned by an approach such as the Flinders Program™ allows. The challenges of implementing new and complex intervention in primary care must be taken into account when introducing such approaches.

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