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The Evaluation of the Family Nurse Partnership Programme in Scotland: Phase 1 Report – Intake and Early Pregnancy

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THE EVALUATION OF THE FAMILY NURSE PARTNERSHIP PROGRAMME IN SCOTLAND: PHASE 1 REPORT – INTAKE AND EARLY PREGNANCY

Claudia Martin, Louise Marryat, Martine Miller and Rachel Ormston (Scottish Centre for Social Research) and **Jacki Gordon** (Jacki Gordon & Associates)

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Louise Marryat, Claudia Martin, Martine Miller, Rachel Ormston and Jacki Gordon

1 SUMMARY OF KEY FINDINGS

This section summarises the key findings from the first year of the evaluation of the Family Nurse Partnership (FNP) programme in Scotland. It focuses on the early implementation and pregnancy[1] period of the programme. Future reports will include findings on the birth and postpartum, infancy and toddler periods of the programme.

1.1 Summary of progress towards Core Model Elements and fidelity 'stretch' goals

Table 1-A summarises the progress of the first Scottish FNP test site in Edinburgh towards the Core Model Elements during the first year of the programme. Fidelity 'stretch' goals for which data was available for this report are also shown in italics. Core Model Elements and fidelity 'stretch' goals for which final data is not yet available will be reported on in subsequent reports.

[1] The report includes monitoring data from the nine-month recruitment phase, when clients were engaged and enrolled in the programme, and data from in-depth qualitative interviews with clients during their pregnancies, which took place up to the 40th week of pregnancy.

Table 1-A Progress towards Core Model Elements and fidelity 'stretch' goals in the first year of FNP Edinburgh

	Progress in year 1	Commentary
Clients		
Enrolment and participation is voluntary	Achieved	Family Nurses engaged with potential clients to introduce the programme and allowed them time to make a decision about whether or not to enrol.
Eligible clients include first-time mothers only	Achieved	
Eligible clients include high risk mothers only	Achieved	For the test site, this was defined as mothers aged 19 and under at LMP. All enrolled clients were in this age range.
60% of clients enrolled by 16th week of pregnancy	Not achieved	Several main factors appear to have created challenges to meeting this CME: first, the decision to offer the programme to all eligible women during the recruitment period, rather than focusing engagement on those under 16 weeks; second, the decision to approach all eligible women on Maternity Trak at the start of the recruitment period, which meant the average gestational age at enrolment was higher in the early months (since Maternity Trak included women already further along with their pregnancies); and third, the time taken to engage some women with the programme and to support them to make a voluntary decisions, which sometimes meant that while they were engaged prior to 16 weeks, they did not enrol until after this point.
100% of clients enrolled no later than the 28th week	Achieved	

	Progress in year 1	Commentary
Family Nurses		
Each client enrolled is visited by the same FN throughout her pregnancy and the first 2 years of her child's life	TO BE ASSESSED IN SUBSEQUENT REPORTS	This CME appears to have been met to date, but it is too early to assess whether it has been fully achieved.
75% of eligible clients who are offered the programme are enrolled	*Achieved*	*80% of those offered the programme enrolled with it.*
Family Nurses are registered with the NMC, educated to degree level and meet the person specification	Achieved	
Family Nurses follow the FNP learning programme and attend all FNP specific essential training	Achieved	
Follow the FNP Home Visit Guidelines	TO BE ASSESSED IN SUBSEQUENT REPORTS	Data on 'dosage' and fidelity to the Home Visit Guidelines are not included in this report, given the focus on the early pregnancy period.
Apportion home visit time among content domains within the ranges specified	TO BE ASSESSED IN SUBSEQUENT REPORTS	Data on 'dosage' and fidelity to the Home Visit Guidelines are not included in this report, given the focus on the early pregnancy period.
Actively participate in FNP supervision as specified	Achieved (to date)	
Be trained in specified approaches for establishing therapeutic relationship and motivating clients for positive behaviour change	Achieved	Nurses were trained in both the use of strengths-based approaches and in motivational interviewing.
Carry a caseload of no more than 25 families per full-time employee	Achieved	Each full-time Family Nurse had a caseload of 25

	Progress in year 1	Commentary
Family Nurses cont.		
Each nurse enrols 25 families (or pro rata adjusted) within 9 months of recruitment commencing	*Achieved*	*Recruitment commenced at the end of January 2010 and was complete by the end of October 2010 (9 months).*
Work at least 3 days a week on the programme.	Achieved to date	
Collect data about activity, visit content, mothers and children according to the schedule and procedures specified by the international partner's data management team and approved by David Olds.	TO BE ASSESSED IN SUBSEQUENT REPORTS	Although evidence to date suggests that Nurses were collecting all the data as required, further monitoring data and evidence will be required to assess whether this has been fully achieved.
Work exclusively in this programme	Achieved	Family Nurses were recruited specifically to work on the FNP Edinburgh programme.

	Progress in year 1	Commentary
Programme supervisors		
Be registered with NMC, at least equivalent in education and training to the family nurses, preferably educated to masters level and meet the person specifications	Achieved	
Follow the FNP learning programme and attend all FNP essential training, as well as supervisor training and action learning sets	Achieved	
Carry a supervisory load of no more than 8 family nurses	Achieved	The Edinburgh Supervisor is responsible for 6 Family Nurses.
Carry a small clinical caseload	Achieved to date	The Edinburgh FNP Supervisor has a caseload of 2 families
Work at least 3 days a week on the programme	Achieved to date	
Use programme reports to assess and manage areas where systems, organisational or operational changes are needed in order to enhance the overall quality of the programme operations and to inform reflective supervision with each family nurse	Partially achieved	The lack of a tailored database designed for extracting data for use in supervisions created some obstacles to running programme reports that were as up to date or useful as ideally required to inform reflective supervision. Although the local FNP Lead in NHS Lothian worked with the Supervisor to provide working solutions to support supervision, this was nonetheless viewed as falling short of the ideal.
Meet one-to-one with each family nurse at least weekly to provide supervision	Achieved to date	

	Progress in year 1	Commentary
Programme Supervisors cont.		
Conduct at least 4 team meetings per month: 2 to discuss programme implementation and 2 case discussions to identify client problems and solutions	TO BE ASSESSED IN SUBSEQUENT REPORTS	The accounts of Family Nurses and the supervisor suggest that group supervisions were happening regularly and were highly valued. Subsequent reports will clarify the extent to which it has been possible to stick to the group supervision schedule in different phases of the programme.
Develop opportunities for learning within the team and invite experts from other disciplines to participate in case discussions whenever cases require such consultation	TO BE ASSESSED IN SUBSEQUENT REPORTS	A clinical psychologist and child protection advisor were involved in group supervisions with the FNP team in Edinburgh. The role played by these and other experts will be explored in more detail in subsequent reports.
Make a minimum of one home visit every 4 months with each family nurse	Achieved to date	Family Nurses reported being accompanied by their supervisor on two client visits every 16 weeks.
Administrative support		
Each site will employ someone to provide support to the family nurses, including ensuring that data about family nurse activity, visit content, mothers and children are submitted completely and accurately on a timely basis and providing general administrative support	Achieved	The administrator has played a central role in supporting the delivery team and in managing inputting data from Nurse visits. It's perhaps worth noting though that although the FNP administrator inputs the initial data from Nurse Home Visit forms, this work has needed to be verified by either the Supervisor or local FNP Lead in NHS Lothian, due to the lack of automated verification and checking functions on the temporary database.

1.2 Eligibility and enrolment

1.2.1 The acceptability of the programme

The programme fidelity requirements for enrolment in FNP were achieved in all respects but one. One hundred and forty-eight young women were successfully enrolled with FNP in Edinburgh. As well as achieving the fidelity 'stretch' goal of enrolling 25 families per Nurse (plus 2 families for the supervisor) within nine months of recruitment commencing, this figure also represents 80% of all eligible clients who were offered the programme, surpassing the 75% fidelity 'stretch' goal for programme acceptance. Fidelity was also achieved in the following respects: all of those enrolled were aged 19 years or less at conception, all lived within Edinburgh CHP, all were first-time mothers and all were enrolled before the 28th week of pregnancy.

Fidelity was not achieved for the proportion of mothers who were enrolled at less than 16 weeks gestation - 32% of clients were enrolled by this stage in the pregnancy, short of the 60% specified in the Core Model Elements. Sixty per cent of clients were recruited by 18.5 weeks of pregnancy, however. It is worth noting that a number of the first 10 pilot sites in England were also unable to achieve the 60% target (Barnes et al, 2008). The overall proportion of clients recruited by 16 weeks across the first year of the English pilot sites was 51%, ranging from 28% to 73% across different sites. In the first Scottish FNP pilot site, several factors appeared to have influenced ability to recruit 60% of clients prior to 16 weeks. First, the programme was offered to *all* eligible women who became known to the delivery team during the recruitment period – both in order to meet the required number of participants and because of the test site's philosophy of providing an equitable service. Second, the front-loading of client engagement and enrolment using Maternity Trak data for all women eligible for FNP at the start of the recruitment phase (including those closer to 28 weeks at that time) meant that the average gestational age of clients recruited at the start of the programme was somewhat higher than it might otherwise have been. Third, the time required to engage with clients and support them in making an informed decisions meant that for some clients, although Family Nurses were engaging with them prior to 16 weeks of pregnancy, they did not make a final decision about enrolment until after this point.

A key reason clients gave for enrolling with FNP was the frequency and timing of visits – clients appreciated being offered a number of visits before as well as after the birth, and this was contrasted with the more limited (and primarily post-natal) support available from Health Visitors.

Only two clients left the programme during the early pregnancy phase (final figures for the pregnancy period will be available in the next report).

1.2.2 Identifying eligible women

Eligible women were identified using the NHS Lothian database "Maternity Trak", which records information about all pregnancies to women in Lothian as soon as they are known to health professionals. As a result, there was a group of potentially eligible women, who were already known to services and who could be offered a Family Nurse very quickly at the start of the recruitment phase. The use of Maternity Trak also meant that the team would not have to rely solely on midwives to access potentially eligible young women. This, in turn, allowed the Family Nurses to present the programme to women without the filter of other professionals who, however supportive of FNP, may not (yet) have the same investment and commitment to the programme.

However, while there were clear advantages to using Maternity Trak, it also became clear that the information recorded on this database was not always completely accurate. First, as pregnancies might be included on the database before the due date was confirmed by ultrasound, young women may be further advanced in their pregnancies than initially assumed and, hence, may not be eligible for FNP or were enrolled at a later stage in their pregnancy. Second, pregnancies may have been included on the database which were then subject to maternity loss through miscarriage or termination.

1.3 Experiences of the (early) pregnancy phase of the programme

1.3.1 Establishing the client-nurse working relationship

The visiting schedule can include up to 14 contact visits during pregnancy, each intended to last approximately 60-90 minutes. Clients' accounts suggest that there were times when visits were longer and, moreover, that there were often contacts between Nurse and client by telephone (calls and text) between visits. Clients appreciated the frequency of contacts during pregnancy and the time that their Family Nurse spent with them; they valued the relationship of trust that evolved between them and felt respected and acknowledged by their Family Nurse. This was based on a strong sense that their Family Nurse talked with them in a non-judgemental way, respected their confidentiality and supported them to make their own decisions – highlighting the benefits of using a strengths-based approach in working with potentially vulnerable young women. While clients initially found some topics – such as sexual health – difficult to discuss, the Nurses' own level of comfort in raising these issues encouraged clients to participate on potentially sensitive topics. Clients clearly recognised that, although there was a structured programme being delivered, there was also flexibility. Although they did not use the term "agenda matching", they experienced the process in a positive way and perceived the Family Nurses as willing to be guided by the clients' needs and interests. In other words, clients' accounts suggest they experienced the programme in ways that reflected the FNP values and approach and pointed to a growing 'therapeutic alliance' with their Family Nurses.

Not only did clients value and appreciate their Family Nurses' time and approach to them, there was evidence of shifts in clients' knowledge, attitudes and some behaviours which they attributed to their involvement in the programme. Clients interviewed for the evaluation all reported that they had discussed health behaviours with their Family Nurse and that they had become aware of risks that they had not hitherto known about. Further, they indicated that their Family Nurse had supported their access to and understanding of ante-natal services. Clients particularly appreciated referrals to classes designed specifically for younger mothers. The support Family Nurses provided with non-health issues – for example, housing and benefits – was also appreciated, particularly since one view was that obtaining housing benefits could cause more problems in pregnancy than anything else. Clients reported that discussions with their Family Nurses had impacted on their thinking about spending and saving money, which they might not previously have considered.

1.3.2 Involving others

There was evidence from clients and Family Nurses of fathers' involvement in FNP visits, although the extent to which this happened varied widely among those clients interviewed for the evaluation. Postpartum interviews with a client's "significant other" will include a number of fathers. As such, the next report will be able to explore this issue in greater detail and from the fathers' perspectives. Suffice to say, from the clients' perspectives, their partners were included by the Family Nurse and were given opportunities to participate in visits, or through materials left for them after visits. There were accounts too of other family members feeling that they had gained from the programme in terms of their own knowledge and understanding of – for example – the risks of passive smoking in pregnancy.

1.4 Recruitment, training and supervision of Family Nurses

1.4.1 Recruitment of the Family Nurse team

Programme fidelity includes closely specified requirements in relation to Family Nurse recruitment, training, supervision, and the collection of monitoring data. The team of six Family Nurses, all of whom met the requirements set out in the Core Model Elements, was appointed following a national recruitment initiative. It was very clear that the programme attracted highly motivated and skilled health professionals, who are committed to the FNP and who met the programme specifications. Those involved in the recruitment process commented that it was an enormous advantage to be in a position to recruit an entire team at the same time: this allowed the selection of Family Nurses with a range of complementary skills, and attributes, reflecting extensive and varied professional experience.

Potential service users, including teenage mothers or mothers-to-be, their partners and families, were invited to be involved in the recruitment of the Family Nurse team. This innovation was embraced by the service users who worked with FNP lead and the Psychologist to define questions to ask of the candidates

and was perceived by stakeholders as a very positive experience. The user-recruiters identified the same preferred candidates as the professionals involved in the recruitment process.

1.4.2 Training

Training of the Family Nurses and Supervisor was delivered by the DH FNP National Unit via a consultancy agreement with Scottish Government. The Family Nurse team were, without fail, enthusiastic about the range and quality of the training that they had received. There was great respect for the "excellent" training provided by DH FNP National Unit, even if the team found the travelling to attend training to be an additional pressure. It was acknowledged by all that would not currently be feasible to provide the training without the expertise and resources in England. Moreover, there were perceived benefits for the team beyond the actual training itself in terms of peer support and networking. It was very clear, for everyone involved, that the training provided not only formal inputs, but also provided opportunities for informal peer learning and exchange, which were seen as being of almost equal importance to the formal learning opportunities. The need to travel to England for peer learning and exchange may, of course, change as more sites are developed in Scotland.

However, while the training was clearly very highly valued, it was also clear that the Family Nurses felt, at times, overwhelmed by the need to complete the training while enrolling clients at - what they perceived to be - a fast rate. Not only did this place pressure on them, with an additional burden of having to travel to England to receive the training, but it was felt that it gave them little or no time to consolidate their learning within the FNP Edinburgh team - a finding that closely reflects the experiences of the pilot sites in England in their first year (Barnes et al, 2008). Finding ways to make space for consolidation was viewed as a key way in which training and learning would be enhanced. There was also a view that some elements were delivered too soon and that, in hindsight, the training programme did not necessarily need to be as compressed into a 12 month period. It was suggested that certain master classes, and DANCE training, would have been better delivered at a time when they were ready to use those specific skills.

1.4.3 Supervision

Supervision is integral to FNP. It was clear that the Family Nurses greatly valued the supervision model and felt themselves to be well supported by both the Supervisor within one-to-one weekly sessions and the group sessions with the Team Psychologist. Individual supervision sessions gave Nurses the opportunity to focus on specific clients, and to work through challenges they experience from a client-based perspective. Although there were concerns that these sessions might have been better informed if more detailed monitoring data had been available, there was a very clear view among the Family Nurses that they had never been so supported in their professional work.

1.5 Challenges in implementing FNP in Scotland

1.5.1 Factors affecting Nurse workloads

The Family Nurses' commitment to the programme was evidenced by their attendance at all training, their preparation for client visits, their ability and willingness to embrace the programme in all its complexity, their availability to their clients and their faithful delivery of the programme. Initial anxieties about delivering the programme appear to have been successfully overcome through training and support. The monitoring data also show that fidelity was achieved in key respects in relation to client enrolment and programme delivery. The Family Nurses, supported by the Supervisor, worked hard to deliver the programme in terms of the intended number of visits and – insofar as we can ascertain at this stage - in terms of delivering the required "dosages".

However, although fidelity was achieved for most elements, the first test site in Scotland nonetheless experienced some significant challenges relating to workloads in the first year of the programme. These included front-loading of enrolment in the early stages in combination with staff sickness which resulted in Family Nurses having larger than originally anticipated caseloads at an earlier stage of delivery, geographical challenges, and the need to combine the already heavy workload with travel to training. The fact that clients enrolled early on were further on in their pregnancies on average also meant that the first births occurred sooner in the programme than anticipated, at a point when the Nurses had only just completed the infancy training.

While the Family Nurses' clinical contacts did not usually exceed the normal working week or usual working hours, it was clear that travel to training and preparation time for client contacts could not necessarily be contained within normal working hours. It was also the case that the long hours cited by Family Nurses reflected, to some extent, personal decisions on their part to manage their travel to England for training in particular ways or to work after returning from training. This, in turn, was again a reflection of their commitment to their clients.

However, these findings reflect evidence from evaluation of the first 10 pilot sites in England which strongly indicated that Family Nurses are not able to deliver the early stages of the programme within their normal working hours. Indeed, on the basis of a specified recording of their hours, it appeared to be the case that Nurses in the first 10 pilot sites in England were working 20% above their standard hours (Barnes et al, 2008). Future sites may wish to consider how this issue is addressed - for example, by extending the recruitment period beyond 9 months, considering carefully how any front-loading of recruitment is managed, and perhaps examining the timetable for some aspects of training.

1.5.2 Management issues

There are distinct and clear line management and professional supervision structures within NHS Lothian for programme delivery. However, stakeholders in all sectors voiced the opinion that the management structure for the programme was confusing at times due to the number and the relatively high status of those involved in the Edinburgh site. This had led to some stakeholders perceiving the management structures to be top heavy.

1.5.3 FNP Database

It became clear at a relatively early stage – before the first clients were enrolled - that Scotland would not be able to use the database developed for the FNP sites in England. Although a database was commissioned at the end of 2010 with options hopefully available by April/May 2011, the lack of a National FNP database created some significant challenges for the FNP Edinburgh team during the first year of the programme. These challenges related particularly to the time and complexity involved in extracting data from a database initially set up as a short-term measure simply to store the data until a more tailored database became available. The lack of a user-friendly interface also limited the usefulness of the database in individual and group supervision meetings. While the local FNP Lead in NHS Lothian was able to extract some data for the Nurse supervisor, there was a strong perception that this was neither as easy to do, as up to date, nor as useful as it should be (and as it hopefully will be once the National database is available). There was also a strong perception that the significance and importance of the database for supporting the work of the FNP team was perhaps not fully recognised at the beginning.

Moving forward, it is hoped that the new National database will be available for all new FNP sites from the start, in order to avoid these difficulties and additional work for the implementation teams. The national solution must allow for the existing data from Edinburgh CHP to be imported, to ensure that all data collected since implementation can be drawn on for site monitoring and analysis.

2 BACKGROUND AND INTRODUCTION

2.1 The pregnancy report

This is the first interim report for the evaluation of the Family Nurse Partnership (FNP) programme in Scotland. The focus of this report is on the early implementation and pregnancy[2] period and presents data relating to:

- The early implementation of the programme
- Recruitment, training and supervision of the Family Nurse team
- Engagement of clients with the programme
- Enrolment and characteristics of clients
- The relationship between clients and the programme
- Visiting schedules, content of contacts and workload
- Programme management and inter-agency relationships.

The sources for the report include:

- Routine monitoring data
- In depth interviews with
  - clients
  - members of the FNP delivery team
  - Family Nurses, and
  - key stakeholders in Scottish Government, NHS Lothian, City of Edinburgh Council and the Department of Health (England).

2.2 The Family Nurse Partnership (FNP) programme

The Family Nurse Partnership Programme (FNP) is a preventive programme, developed in the USA by Professor David Olds at the University of Colorado (UCD) and based on the research of Professor Olds and his colleagues over the last three decades (Olds et al, 1986). The programme's goals are to improve pregnancy outcomes, the health and well-being of vulnerable first time parents and their children, child development and families' economic self-sufficiency. It aims to achieve these outcomes via an intensive, Nurse-led home visiting programme, beginning during pregnancy and continuing until the child is two years old. This visiting programme is aimed at helping first-time mothers to engage in good preventative health practices, supporting parents in providing responsible and competent care and positive parenting, and helping them to have a more coherent vision for their future. It focuses on vulnerable (particularly young) first-time mothers who are more likely to have low uptake of prenatal care and services, are at higher risk of engaging in unhealthy behaviours during pregnancy, are more likely to have poorer obstetric outcomes, and whose

[2] The report includes monitoring data from the nine-month recruitment phase, when clients were engaged and enrolled in the programme, and data from in-depth qualitative interviews with clients during their pregnancies, which took place up to the 40th week of pregnancy.

children may have poorer developmental outcomes than more advantaged mothers.

The programme involves the development of a one-to-one "therapeutic relationship" or “alliance” between a highly trained Family Nurse and the client. This support also extends to fathers and other family members. Three key theories underpin the programme: ecological theory (highlighting the importance of understanding the context in which people live their lives); attachment theory (in particular in relation to the formation of the bonds between parent and child as a basis for subsequent healthy child development); and self-efficacy theory (i.e. engendering a belief that individuals can take control of their lives in order to achieve certain outcomes).

2.2.1 The FNP evidence base

The evidence base for FNP from the USA suggests that it is likely to be most valuable for single women of low socioeconomic status and/or teenage mothers (who are often – though not always – from relatively deprived socio-economic backgrounds, Olds et al, 1986). Positive outcomes have been noted in relation to diet, aspects of child safety and maternal well-being and support. FNP has been subject to three randomised controlled trials (RCTs) in the USA (Olds et al, 1986; Kitzman et al, 1997; Olds et al, 2002).

Barnes et al (2008) summarised the short and long-term outcomes for FNP, evidenced by these RCTs in the USA. These, in the short-term (that is, during pregnancy and up to 24 months postpartum[3]) include: greater service use, fewer pregnancy-related complications, enhanced maternal health behaviours, improved status of newborns, improved child behaviour and development, more responsive parenting, more attempted breast-feeding, fewer subsequent pregnancies, less welfare dependency, enhanced cognitive development for the children, improvements in child health and less maltreatment. Longer-term outcomes include more positive parenting, less welfare dependency, greater pregnancy spacing, enhanced behavioural and cognitive development and, in the much longer-term, evidence for the FNP children of reduced offending behaviour.

2.2.2 FNP Core Model Elements and fidelity ‘stretch’ goals

FNP is a licensed programme, based on over 30 years of development and research in the USA. There are 2 main systems for ensuring that the programme is implemented with fidelity to the original research. First, there are various **‘Core Model Elements’** which are a requirement of the licensing conditions. The Core Model Elements cover:

- the visiting regime (a closely specified frequency of Family Nurse visits to clients throughout pregnancy until the child is two)

[3] ‘Postpartum’ means after the birth

- staffing requirements (for example, the professional and personal characteristics of Family Nurses)
- client eligibility (for example, relating to the point in pregnancy by which mothers should be enrolled), and
- the supporting organisational structures and processes needed to support the programme (for example, requirements relating to training, supervision and administrative support).

Second, the FNP Management Manual (DH FNP National Unit, amended for Scottish FNP sites, November 2010) sets out various **fidelity goals** – described as '**stretch goals'**. These are goals based on the research evidence which, if met, may help maximise the likelihood of the programme achieving the same results as the US sites where the programme has been comprehensively evaluated. The fidelity 'stretch' goals cover client retention, visit 'dosage' (in terms of the numbers and length of visits to clients at different stages of their participation in the programme), and coverage of different 'domains' or topics during visits. The FNP Management Manual notes that achieving these fidelity 'stretch' goals can be challenging in the testing phase, but that they can be used by the Supervisor and the Family Nurses to monitor progress towards meeting them (see Appendix E for a full list of the Core Model Elements and Fidelity 'stretch' goals).

2.2.3 Testing FNP in the UK

The FNP programme is currently being tested in over 50 sites in England, with a planned expansion to double the number of families able to receive FNP at any one time, to at least 13,000 by 2015. An RCT is being conducted in 18 sites. In 2009, the first Scottish FNP programme was established in Edinburgh, to test FNP in a Scottish context. The Scottish Government commissioned formative and summative evaluation of the implementation of FNP in Edinburgh that would:

- develop a monitoring and evaluation framework
- work with the implementation team[4] to identify appropriate process and outcome measures, using monitoring and routinely collected data
- assess programme fidelity
- explore levers and barriers to implementation
- assess the acceptability and perceived value of the programme for service users, programme practitioners and key stakeholders, and
- distil key considerations for any future implementation in Scotland.

More recently, an FNP programme has been established in NHS Tayside and plans have been announced to look at FNP extension in NHS Greater Glasgow &

[4] The implementation team included representatives of the Scottish Government, NHS Lothian, Edinburgh City Council among others.

Clyde region. However, this evaluation is focused solely on the first Scottish FNP test site in Edinburgh.

2.3 The policy context in Scotland

There is now clear recognition that the earliest experiences, even pre-birth, can have long-lasting effects on children's development. It is also recognised that inequalities can appear early and that by age 3, differences in child development can be clearly related to socio-economic and emotional deprivation. The testing of FNP in Scotland reflects the Scottish Government's strong interest in early years, child and maternal health and has the potential to contribute to a number of key Scottish Government policies and targets.

The Early Years Framework, published in 2009 and developed in partnership between the Scottish Government, the Convention of Scottish Local Authorities (COSLA) and other partners, provides an overarching strategy for policy in relation to early years in Scotland (while providing local flexibility in implementing the framework, reflecting the 2007 concordat between the Scottish Government and COSLA). This long-term strategy addresses the needs of families with children from pre-birth to age 8. A central theme of the Framework is the reduction of inequalities, particularly health inequalities. Its broad strategic approach towards achieving better outcomes for Scotland's children includes not just development of specific support services for children and families (ante-natal and post-natal care, childcare, early education, health and family support) but also consideration of how other key determinants of health and well being (e.g. housing, deprivation) impact on outcomes for children.

The Framework is based on the key principles set out in the United Convention on the Rights of the Child (UNCRC) and seeks to promote and uphold children's rights. The Framework also sets out parental responsibilities. It embeds the principles and values set out in Getting it Right for Every Child (GIRFEC). GIRFEC aims to 'help practitioners and organisations to remove the obstacles that can block children's paths on their journey from birth to adulthood'. Of particular relevance to the Family Nurse Partnership, GIRFEC's core components include:

- A focus on improving outcomes for children, young people and their families based on a shared understanding of well-being
- Streamlined planning, assessment and decision-making processes that lead to the right help at the right time
- A lead professional to co-ordinate and monitor multi-agency activity where necessary
- Maximising the skilled workforce within universal services to address needs and risks at the earliest possible time.

In relation to health inequalities more generally, the report of the ministerial task force on health inequalities, *Equally Well*, (Scottish Government 2008) was

followed by the *Equally Well Implementation Plan* (December 2008). This brought together thinking on poverty, lack of employment, children's lives and support for families and physical and social environments, as well as on health and wellbeing and on the need to develop appropriate and timely interventions to produce better outcomes for children and families.

The Scottish Government Health Directorate has established a core set of ministerial objectives, targets and measures for the NHS. The targets for Health improvement, Efficiency, Access and Treatment, known as the HEAT targets, include three specific targets relating to maternal and child heath improvement:

- At least 60% of three and four year olds in each Scottish Index of Multiple Deprivation (SIMD) quintile to have fluoride varnishing twice a year by March 2014.
- Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.
- Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.

The Family Nurse Partnership has the potential to contribute to achieving these HEAT targets through an improvement in ante-natal and post-natal health, nutrition and support.

2.4 The Family Nurse Partnership in Edinburgh

The development of FNP in Scotland followed extensive discussion with David Olds at the University of Colorado and with the DH FNP National Unit. The license to implement the programme is held by Scottish Government and is under-pinned by a Consultancy agreement with the DH FNP National Unit, which provides training, access to expertise and support.

The first Scottish FNP programme is based in Edinburgh Community Health Partnership (CHP). It is wholly funded by Scottish Government and is delivered by NHS Lothian. The choice of Edinburgh was due, in part, to a view that it would be preferable to locate the test site in one city with relatively high teenage pregnancy rates and which was contained within one local authority area (that is, with co-terminus boundaries). It was also considered that the extensive joint working already in place in Edinburgh between health and local sector agencies would facilitate the venture. This included City of Edinburgh Council's work on parenting support strategies and the fact that Edinburgh tested "Getting It Right For Every Child" (GIRFEC) in two areas before rolling it out citywide from April 2010.

Chapter 8 provides a fuller description of the management and funding structures.

The NHS Lothian FNP delivery team is comprised of:

- The Supervisor
- 6 Family Nurses
- An Administrator/Data Manager

The Supervisor and Family Nurses collectively have experience drawn from previous roles in acute and community nursing.

The delivery team is supported by a local FNP Lead, based with the delivery team in NHS Lothian. The local FNP Lead role was established at the request of NHS Lothian to implement the programme at a local level and to ensure that it integrates with other services within Lothian as a whole and within NHS Lothian in particular. In addition, the local FNP Lead within NHS Lothian is responsible for providing anonymised, aggregated reports on FNP data relevant to outcomes of interest to the FNP evaluation. The local FNP Lead role in NHS Lothian incorporates elements similar to the Project Manager role in the English FNP test sites, but while in England the Project Manager role is a short-term role to set-up infrastructure for the local team, the local FNP Lead in NHS Lothian was a full-time secondment for 2 years.

The National FNP Implementation Lead Scotland – whose role is distinct from that of the local FNP Lead for Edinburgh based in NHS Lothian – was appointed in April 2009 to support the implementation of this programme across Scotland.

In order to meet the programme's Core Model Elements and fidelity 'stretch' goals, 148 clients who met the key criteria for participation were recruited over a nine month period[5]. The Core Model Elements also required clients to be first time mothers and planning to continue with the pregnancy, less than 28 weeks gestation at the point of enrolment, and to opt in to the programme voluntarily. More specific client eligibility criteria are not set out in the Core Model Elements, but were agreed with the National Unit at the Department of Health (England) based on evidence from their own research, their experience of implementing the programme in England and on evidence from the USA. The eligibility criteria for the Edinburgh test site were: age 19 or younger at conception (based on age at last menstrual period (LMP)) and living within Edinburgh CHP.

The process of engaging clients with the programme began on 25th January 2010 and the first client was enrolled on 1st February 2010. Enrolment was completed in October 2010.

[5] The Core Model Elements require each full-time Family Nurse to have a caseload of no more than 25, while the fidelity 'stretch' goals required them to recruit a caseload of 25 per full-time nurse within 9 months of recruitment commencing. In Lothian, 3 nurses recruited 26 clients (as there were a small number of early drop outs from the programme), 2 recruited 25 and 1 part-time nurse recruited 18. The supervisor also had 2 clients, as required by the Core Model Elements (see Appendix E for full list of Core Model Elements). They also co-visited one of the Family Nurse's clients for a period. The requirement to recruit clients over a 9 month period was a fidelity 'stretch' goal for the programme.

2.5 Report structure

The structure of the remainder of this report is as follows:

Chapter 3 presents a summary of the research methods used to evaluate the implementation of FNP in Scotland. A fuller description of the methods, including the development of the monitoring and evaluation framework and logic models can be found in Appendix B, C and D.

Chapter 4 explores early engagement with and enrolment of clients. It draws on the monitoring data for the recruitment phase in relation to programme fidelity and on interviews with clients and Family Nurses.

Chapter 5 considers the early pregnancy phase, particularly from the perspective of clients and Family Nurses and explores their views and experiences of programme delivery.

Chapter 6 presents clients' views of the impact of the programme in relation to their health behaviours, use of services and infant feeding intentions.

Chapter 7 considers the FNP team's experiences of recruitment, training and supervision.

Chapter 8 describes the views of the key stakeholders in relation to management, funding and links with the National Unit at the Department of Health, England.

Chapter 9 summarises and discusses the emergent findings and key learning from this report.

3 THE EVALUATION OF FNP IN SCOTLAND

3.1 Aims and objectives of the evaluation

The overall aim of the evaluation is to assess the implementation of the FNP programme in Edinburgh, and to use the learning from this to assess whether the programme can be implemented in other areas of the country.

The evaluation focuses on three broad questions:

- Is the programme being implemented as intended? If not, why not?
- How does the programme work in Scotland (Lothian)?
  - How do Nurses, clients and the wider services respond to the programme?
  - What are the implications for future nursing practice?
  - What factors support or inhibit the delivery of the programme?
- What is the potential for FNP to impact on short, medium and long term outcomes relevant to Scotland?

3.2 Monitoring and evaluation framework

The evaluation combines analysis of quantitative monitoring data collected by NHS Lothian on the experiences of all 148 FNP clients, and qualitative data collected by ScotCen (the external evaluation team) on a smaller sub-sample of clients interviewed at regular intervals as they progress through the programme.

Following three logic modelling events, which involved key stakeholders from Scottish Government, NHS Lothian and City of Edinburgh Council, it was agreed that the internal monitoring and external evaluation of the test site in Edinburgh for FNP would:

- distil learning on FNP delivery in Edinburgh, including the barriers faced
- explore views on the skills, systems and infrastructure believed to be necessary to implement the programme, and challenges faced in achieving these; and
- contribute to national learning on how the programme (or aspects of it) might be used in the future.

A full description of how the monitoring and evaluation framework was agreed and of the three logic models that informed this is available in Appendices C and D.

3.3 Overview of research methods

The evaluation research is addressing the objectives set out above using a range of formative and summative approaches, including:

- A review of published and grey literature to inform the evaluation (on-going)
- The development of a monitoring and evaluation framework using a logic modeling approach based around Theories of Change
- Analysis of data collected for all clients using the measures developed for routine monitoring, to assess the implementation of the programme
- Longitudinal qualitative research (case study approach) involving repeat in-depth matched interviews with a panel of up to 15 clients (4 interviews – during pregnancy, 3 months after birth, when their baby is 12 months old, and when their baby is 24 months old), a nominated significant other (2 interviews) and the clients' Family Nurses (2 interviews), at key points during the client's pregnancy and the first two years of her child's life
- Key stakeholder and FNP Edinburgh team interviews at key points to inform and reflect their understandings of the implementation of the programme.

This report focuses on the client recruitment and pregnancy phases of FNP and, hence, on the first interviews with clients, Family Nurses and with key stakeholders. It also draws on monitoring data relating primarily to the client recruitment phase. By the end of the evaluation, however, the following longitudinal data will be available:

- Monitoring information for all clients, from initial engagement to leaving the programme
- Repeat interviews with key stakeholders
- Case studies for 15 clients which will bring together:
  - clients' views and experiences of the programme, from their initial engagement with FNP until their child is 24 months old (4 interviews)
  - their Family Nurses' views of these clients' involvement with the programme, and of the role the Family Nurses have played with respect to these clients (2 interviews)
  - the views and experiences of clients' "significant others" (2 interviews).

3.4 Ethical and NHS approval

Application for ethical approval was submitted to the South-East Scotland Research Ethics Committee. The study was approved May 2010. Application was simultaneously sought for local NHS access and this was received June 2010. Recruitment of clients to the evaluation therefore began after all approvals had been received. This meant that clients who enrolled with FNP in the earliest months of the FNP recruitment phase were not able to be recruited to the evaluation qualitative panel.

4 ENGAGING AND ENROLLING CLIENTS

4.1 Introduction

This chapter presents information about the **recruitment phase** of the first Scottish FNP test site in Edinburgh – the nine months of the programme from late January to late October 2010 during which clients were identified, engaged and enrolled with the programme. For individual clients, recruitment to FNP involves several stages. First, potentially eligible clients need to be **identified**. Next, once their eligibility is confirmed, Family Nurses **engage** with clients to introduce and explain the programme, and to support them in making a decision about whether or not they wish to participate in FNP. Finally, after this initial engagement clients make a decision on whether or not to opt-in and actually **enrol** with the programme.

The first section of the chapter (4.2) focuses on analyses of the monitoring data collected by the FNP team, including data about clients' characteristics at enrolment and the extent to which programme fidelity with respect to enrolment was achieved.

The following section (4.3) explores views and experiences of the engagement and enrolment processes from the perspectives of clients and the delivery team, including the Family Nurses, the Supervisor and local FNP Lead in NHS Lothian. The data for clients and the delivery team are drawn from in-depth qualitative interviews. As such, they include the respondents' *perceptions* of the engagement and enrolment processes. This means that their accounts reflect *their* experiences and interpretations of events and situations – different respondents' accounts may not always accord with each other, or with what is formally meant to happen. These accounts provide a window on the programme and allow insights into the process of engaging and enrolling clients from the perspectives of those most closely involved in delivering or receiving the programme.

4.2 Monitoring data relating to the recruitment phase

4.2.1 Core Model Elements and fidelity 'stretch' goals

The FNP is designed to be offered to vulnerable first-time mothers-to-be. The USA National Service Office has determined, based on the USA research evidence and on ongoing USA practice, that maximum impact can be obtained if clients are enrolled early in their pregnancy. To be acceptable, particularly in the British context where there are universal services for all expectant mothers, children and families, it is important that most of those who are offered the service, after being deemed suitable, actually take up the offer. The USA team has also determined the most efficient case-load for a nurse working on this programme. The Core Model Elements for FNP specify a number of requirements relating to client engagement and enrolment, as follows:

- Enrolment and participation in FNP is voluntary
- Eligible clients are first-time mothers only
- Eligible clients include high risk mothers only (during the testing phase, only mothers 19 years and under were eligible – as described above (section 2.4), this specific eligibility criteria was not part of the Core Model Elements, but was agreed with the National Unit at the Department of Health (England), based on the research evidence)
- At least 60% of clients are enrolled by 16 weeks gestation or earlier and 100% no later than 28 weeks
- Each client enrolled is visited by the same Family Nurse throughout her pregnancy and the first 2 years of her child's life.

There are also fidelity 'stretch' goals to:

- enrol 25 families per nurse within 9 months of recruitment commencing, and
- to enrol 75% of eligible clients who are offered the programme.

In addition, the Core Model Elements specify that each full-time Family Nurse should have a caseload of no more than 25 families, and that the Supervisor should have a small caseload of 2 or 3 families.

4.2.2 *Identifying eligible clients*

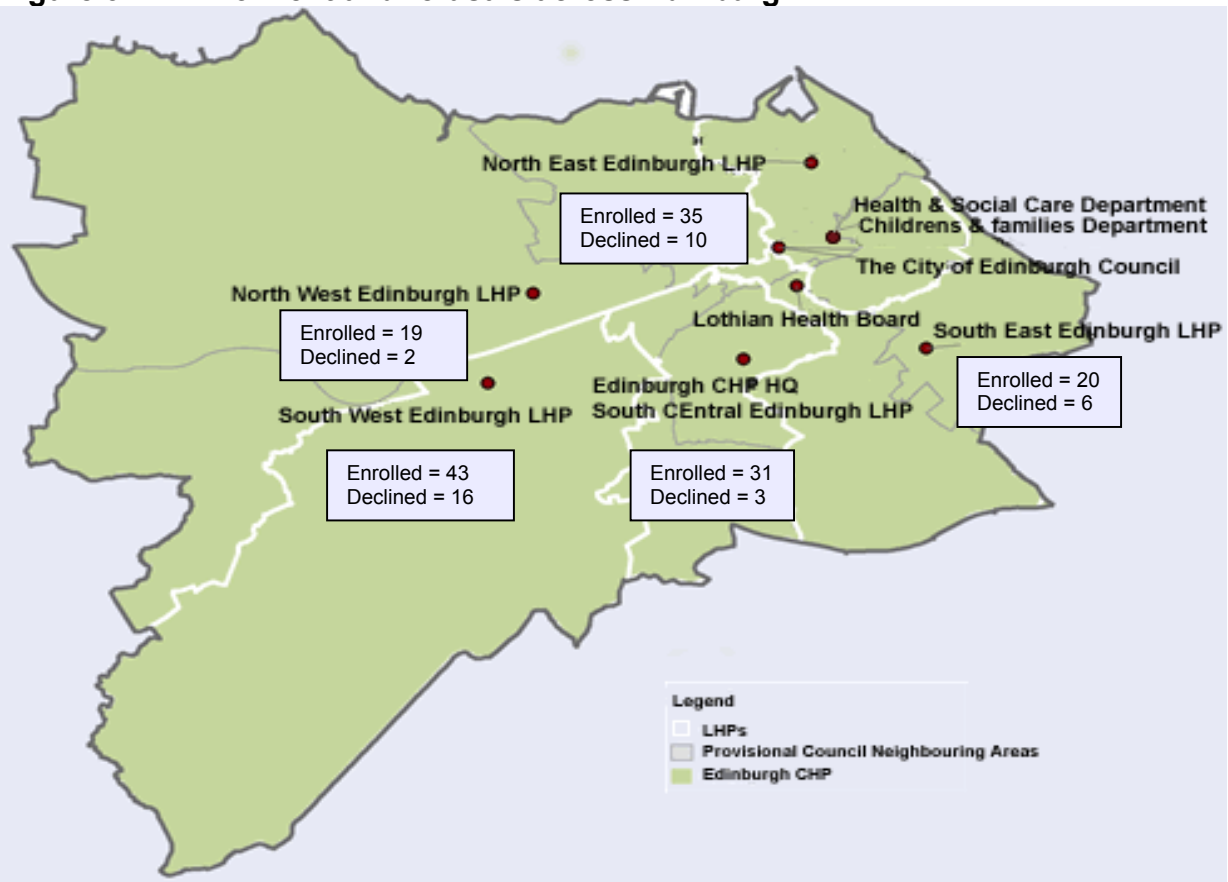
Eligible women were identified using a NHS Lothian database "Maternity Trak", which records information about all pregnancies to women in Lothian as soon as they become known to the health service. This meant that there was a group of potentially eligible women, who could be offered a Family Nurse very quickly at the start of the recruitment phase, without necessarily having to rely on other health professionals with whom the potential client may have contact. This approach differs from that used in England, where FNP projects were reliant on referrals from other professionals (primarily midwives and GPs).

In total, 396 potentially eligible women were identified using the Maternity Trak system between 25th January 2010 and the end of October 2010. Of these, 144 women did not - in the end - meet the eligibility criteria, primarily because they had experienced pregnancy loss (miscarriage and termination) after their name was included on the Maternity Trak database, or because they had already had one or more child. In addition, the Family Nurses were unable to contact 13 potential clients, while 26 clients who had been identified as potentially eligible were not in the end offered the programme, because all caseloads were at a maximum (and the recruitment phase was therefore ended). In one case, a potentially eligible client was not offered the programme because her estimated delivery data placed her delivery in a month where all nurses already had 4 clients with due dates.

Of the 185 eligible clients who were offered the programme, just 37 eligible women declined to be part of the programme, giving an acceptance rate of 80% - comfortably above the fidelity 'stretch' goal of 75%. The main reason given for refusal was that the woman already had enough support from friends and family (n = 21). Other reasons given were that they did not want the programme (n = 7) or, for a very small number (n = 2), that they were too busy working full-time. A further seven women gave no reason for declining. The final enrolled number of clients was 148 (See Appendix A for enrolment diagram).

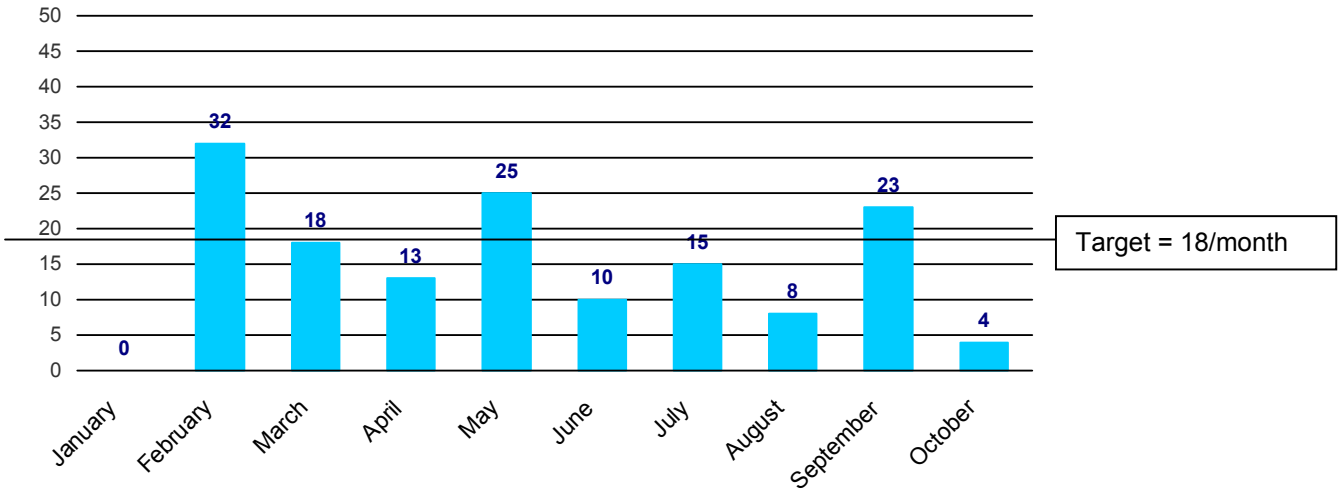
Enrolment varied by area (see Figure 3-A), with South Central and North West Edinburgh having the highest acceptance rates (91% and 90% respectively), and South West Edinburgh having the lowest (73%).

Figure 3-A Enrolment and refusals across Edinburgh CHP



The suggested target for enrolment was 17 women per month. As Figure 3-B shows, 32 women (22% of all clients) were enrolled within the first full month of the recruitment phase. May and September 2010 also saw high rates of enrolment, though both were followed by months of lower enrolment.

Figure 3-B Number of clients enrolled per month (25th Jan – Oct 2010)



Note: Clients enrolled *n* = 148

In line with the Core Model Elements, all clients were enrolled by 28 weeks of pregnancy and all were first-time mothers. Almost a third (48 women, 32%) were enrolled by 16 weeks gestation. However, this fell short of the 60% specified in the Core Model Elements and was lower than the figure of 51% achieved for the first 10 pilot sites in England (Barnes et al, 2008).

The short-fall in the number enrolled prior to 16 weeks of pregnancy appears to reflect several issues. First, the programme was offered to all eligible clients who became known to the delivery team – there was no 'cherry picking' of clients under 16 weeks. This decision was in part driven by the need to recruit sufficient numbers within 9 months, but it also reflected a commitment to providing an equitable service and not excluding any women who were eligible to participate. A second, related challenge was associated with the decision taken early in the implementation of FNP in Edinburgh to try and recruit as many eligible women recorded on Maternity Trak at the start of the recruitment phase as possible, rather than simply offering the programme to those who became known to the team at that date. This decision was taken because of concern that the number of women eligible for FNP in Edinburgh over the nine-month recruitment phase might in fact be lower than initially anticipated, because of challenges around estimating numbers of first births to mothers under 20.[6] As the Maternity Trak database included those already at a later stage in pregnancy as at 25th January, this meant that early on more clients were enrolled further into their pregnancies. Analysis of the monitoring data confirms that average gestation of clients enrolled

[6] Early on in the set-up of the Edinburgh FNP test site, it was realised that the data used in the planning stages to estimate the likely number of births to women under 20 in a nine month period had been based on numbers of teenage *pregnancies* in Edinburgh, rather than the number of *births* to teenage mothers. As a result, there was some concern that it might have overestimated the likely numbers of women who would be eligible for FNP (since not all would continue with their pregnancy). A further complication arose from a lack of clarity in the birth data over whether these were women's were first or subsequent births (FNP is restricted to women expecting their first child).

in February was 130 days (18.5 weeks) and in March was 143 days (20.4 weeks), in contrast to 121 days (17.2 weeks) in April and 118 days (16.8 weeks) in May (there was also a peak in gestation in August due to Nurse holidays in the month before). There were also some inaccuracies in Maternity Trak data (resulting from, for example, pregnancies being more advanced than the client initially thought at their booking in appointment, rather than reflecting any errors in data entry), which again affected the point in the pregnancy at which clients were enrolled. Finally, an additional factor which may have impacted the ease of enrolling women prior to their 16th week of gestation was the time involved in engaging with clients and introducing the programme to them prior to enrolment. Family Nurses reported that engaging with clients, explaining the programme to them, and ensuring they were able to make an informed decision about whether to not to enrol could take some weeks, particularly where the potential client was unsure about either participating in FNP or about continuing with their pregnancy (see more detailed discussion in Sections 4.3.2 and 4.3.3, below). The need to allow clients to decide in their own time whether or not to enrol was thus viewed as another challenge to recruiting 60% of clients prior to 16 weeks gestation.

Further analysis of the monitoring data showed that 60% of clients were enrolled by 18 weeks and 3 days, which should allow sufficient time to deliver the full programme content for the pregnancy phase before the birth of the baby.

4.2.3 The demographic profile of enrolled clients

The mean age of clients at conception (based on the date of their last menstrual period) was 17.4 years. The mean age of clients at enrolment was 18.3 years (range 14 – 20 years[7]).

Ethnic identity of the enrolled clients was overwhelmingly White (93% were classed a “White British” with a further 3.5% classed as “White Other”). Less than 1 in 20 (3.5%) had a different ethnic background - this is very closely in line with the known ethnic profile for Scotland as a whole (Scottish Government, 2010). The vast majority of clients spoke English as their primary language, with other languages spoken being Arabic and Eastern European languages.

Almost nine in 10 of the clients (88%) had left school, with an average school leaving age of 15 years 10 months (range 14 – 17 years old). The year of leaving school ranged from S3 to S6. Four in five (80%) of the enrolled clients had achieved at least one Standard Grade or equivalent, with over half (57%) achieving five or more Standard Grades. In addition, more than a quarter (29%) of clients had achieved a Grade ‘2’ or above in at least one examination.[8] Clients were, therefore, relatively heterogeneous in terms of their educational attainment at the point of enrolment.

[7] A client may have conceived at age 19, but be 20 by the time they engage with the programme

[8] The base for education data is 143, with the remaining respondents declining to give this information to their family Nurse.

The majority of respondents currently had a partner (79%), although this was not necessarily the biological father of their baby Thirty-five per cent of clients were married, cohabiting or in a civil partnership. Eighty-one percent of respondents said that their current partner[9], husband, or ex-husband was the baby's biological father[10].

4.3 Clients' and the delivery team's experiences of the recruitment phase

4.3.1 Finding out about FNP

As described above, in the England FNP sites, potentially eligible clients are primarily identified by midwives at the booking-in visit, with a Booking Consent Form used to indicate their willingness to meet with a Family Nurse. In Edinburgh, the Maternity Trak database offered a more direct route to engaging clients, which would not necessarily involve midwives.

Clients were asked how they had first heard about the programme. Two routes were mentioned: either through their midwife, who asked if they would like to be "transferred" to the programme and to have their names passed to the Family Nurses, or they were contacted directly by a Family Nurse, either by telephone or a visit. Where the midwife had been the initial source, clients reported that they were given limited information by the midwife about the programme (in line with the agreed protocols)[11].

However clients first heard about the FNP, they all reported that the Family Nurse arranged an appointment to meet with them at home or work to explain the programme. Clients reported that there was a time lag of between 2 and 12 weeks between finding out they were pregnant and first hearing from their Family Nurse, in which time all of the young women in our qualitative panel had seen either their GP or a midwife.

At their first meeting with a Family Nurse, clients said that they were provided with a general explanation of the FNP and what a Family Nurse might do: they recalled being told that they would get help throughout pregnancy and up to when their child was aged two, and that the programme would be similar to having a Health Visitor, but that the Family Nurse would visit more regularly and they would talk about different things. All clients in the panel felt that they had enough information at this first meeting to enable them to make a decision - there was nothing else they would have liked to have known at that stage:

> *I thought that she told me everything like. I think I was quite aware o' what it was going to be. Like the first day, she told me loads.*
>
> [Pregnancy Interview, Client 13]

[9] Note – clients were not necessarily living with their current partner.

[10] This is higher than the 79% of clients who had a current partner because it includes ex-husbands.

[11] This is to save further pressure on Midwives explaining about a programme they may not be necessarily familiar with and a lesson learned from English FNP sites as being good practice.

Whatever stage of pregnancy they were at when they first heard about FNP, clients appeared to feel that this had been the right time for them. Finding out early in the pregnancy was felt to be helpful because the pregnancy hadn't "sunk in" yet, so it was good to have the Family Nurse there to explain each stage of the pregnancy. Finding out early was also viewed as giving the Family Nurse and client time to build up a relationship during the pregnancy. Those clients who had been enrolled early in their pregnancy felt that it might have been difficult or - as one client expressed it "quite weird" - to meet the Family Nurse at a later point. However, clients who had met their Family Nurse slightly later on in their pregnancy were equally likely to think this was the right time for them, either because it gave them time to settle into their pregnancy first or because, at that later point of the pregnancy, it was seen as a good time to start talking to someone outwith the family.

4.3.2 The engagement process

Family Nurses were understandably anxious about their initial engagement with clients and were anxious that clients would not want to enrol with the programme. In reality, however, the Family Nurses had a very different experience and found that vast majority of the clients they approached decided to take part in the programme, even if the process of engagement was lengthy for some clients. Among the clients in the evaluation's qualitative panel, the amount of time taken to decide whether to accept the programme ranged from an immediate decision to a longer process of hours, days or even weeks to think things through. The decision to sign up was made either alone or in consultation with a parent, partner or midwife.

Family Nurses reported that while some clients were immediately enthusiastic about the programme and signed-up without any hesitations, others – and particularly the more vulnerable young women (for example, those who were in precarious relationships or used drugs) - needed more time. Family Nurses described how they had to 'tread carefully' during their initial engagement with these clients in order to build up a degree of trust. In addition to providing clients with as much information as possible about the programme, the Nurses also talked with clients' families – particularly their mothers and in some cases partners – and provided them with information. Nurses described the importance of taking time to include the mother or partner in the engagement process to answer any questions they may have had. It was suggested that that this helped develop a level of trust and acceptance of the programme among families.

The Family Nurses reported that, in those cases where potential clients did not wish to proceed with the programme, they invariably thanked the Family Nurses for offering it to them. As discussed above, when eligible women declined the programme, a range of reasons were provided. Family Nurses reported that in some instances, the young women who had declined FNP felt that they had enough support structures around them in the form of partners, family and friends

or were – as the Family Nurses described them - 'high resource'. These young women may be in full-time employment and were in committed relationships.

In the small number of cases to date where clients withdrew from the programme after enrolling (by the end of October 2010, 2 clients had dropped out during their pregnancy and 2 after giving birth – see Appendix A), reasons cited by the Nurses included clients who felt that the programme was "not for them" or they were young women who did not want any professional involvement. In other cases, clients simply moved out of Edinburgh and could no longer be involved with the programme.

4.3.3 Deciding to sign up to FNP

Clients were asked about their reasons for enrolling with the programme. On the one hand, there were clients who simply thought the programme "sounded good", that FNP was the best option or that there was no point in saying 'no'. On the other hand, there were clients who provided more clearly defined reasons for enrolling: that it would be good to get practical and emotional support and, in particular, to have someone to talk to who was outside their family and who would keep anything they discussed confidential:

> *… it's, ken, confidential and that, and just somebody away from the family tae talk tae and just if you needed any information she was always there. I'd just phone her or she was just always there every time I need her.*
>
> [Pregnancy interview, Client 11]

A key reason for signing up to the FNP, however, was to obtain information from someone – the Family Nurse - who clients believed would be both informative and responsive. As one client said *"I didn't have a clue about anything"* [Client 9, Pregnancy Interview]. There was a perception among clients that Family Nurses would be able to provided balanced information which would help clients to decide for themselves what was best for them and their baby. The timing of the programme was an additional reason for enrolling: clients signed up because they would be visited many times *before* as well as after the birth, whereas a health visitor's support would be more limited and may largely be confined to the post-natal period.

Clients expressed few major concerns about enrolling with the FNP, although there were some initial worries that the Family Nurse *"sounded like a social worker"* and that enrolling might lead to information being passed to other agencies. Further comments from clients (discussed in section 5.4 below) suggest that this may in part have reflected an underlying fear that their baby might be removed –a concern associated with their young and vulnerable status.

In terms of the topics and issues that might be addressed by the Nurses, clients expected their Family Nurse to provide information, advice and support about the physical aspects of pregnancy and childbirth, ante-natal care and ante-natal

classes. There was also an expectation that the Nurse would provide advice and support after the baby was born, including information about their role as a parent - how to be a good mother (or father) and how to take care of a baby. Clients expected that they would gain confidence about being a mother through participating in the programme. More widely, clients hoped that their Family Nurse would have an impact on other aspects of their life, including – for example, providing help with college applications or employment after the birth. Their expectations were, therefore, consistent with what the programme is designed to deliver.

As discussed above, there were suggestions from FNP delivery team members that some potential clients appeared ambivalent about participating in the programme and that this uncertainty may have resulted in their taking longer to make a decision. It was suggested that before 16 weeks, a pregnant teenager may not yet know if she wants to continue her pregnancy and, additionally, may also be unsure or suspicious of the programme that is being offered.

> *They just haven't made up their mind. They don't know. It's the first time. They don't know what Health Visiting is. They don't know what FNP is. They're testing out the relationship [ ] Teenagers do that, don't they? So it's just teenage behaviour, but it is ... it's as a result of, you know, people always letting them down in life. So I think that maybe that bit of it you can't change either, so you can't make these girls any less ambivalent*
>
> [Family Nurse 7]

The critical factor, which Family Nurses and others reiterated, was that every potential client was given time to make their decision about enrolling or not – if necessary, the Family Nurse might revisit them on several occasions, giving the young women time to reflect, to find out more about the programme and to decide if they wished to have a Family Nurse. As indicated in Section 4.2, the net results of this engagement process was that there was a high acceptance rate, but with final enrolment happening beyond the 16th week of pregnancy for a greater proportion of clients than required to meet this aspect of the Core Model Elements.

4.3.4 The recruitment schedule

In the early stages of the programme, the Family Nurses felt themselves to be under pressure to enrol clients. It was suggested that this was not a pressure applied by the Supervisor, but was in part a self-imposed demand the Family Nurses placed on themselves. To some extent, this sense of pressure reflected Family Nurses' and others' acute awareness of the need to meet the Core Model Elements and the knowledge that there was a spotlight on their activities.

Nevertheless, there were suggestions that the recruitment phase of FNP could perhaps have been managed differently to ease the pressure on the Family Nurses in the early stages of the programme. The front-loading of engagement

and enrolment, described above (section 4.2), in combination with staff sickness leaving the team a nurse down in the first full month of recruitment, meant that the Family Nurses had rather larger caseloads than they might otherwise have had at an earlier stage in the implementation of the programme in Lothian. The requirement for more frequent visits to clients during the ante-natal period, the time involved in engaging with clients prior to enrolment, and the fact that the Family Nurses were new to the programme and were still attending training sessions all meant that this relatively large early caseload impacted on initial workloads, as well as on the number of clients enrolled before 16 weeks gestation. The Nurses suggested that in hindsight it might have been better to engage with and enrol a cluster of clients, deliver the programme materials to those early clients, consolidate their learning and then engage with and enrol another cluster of clients. There was acknowledgement that there was inevitably a learning phase however enrolment was staggered, but nevertheless there was a view that a somewhat slower pace might have eased the initial sense of pressure and stress that Nurses experienced.

> *…I think we recruited very, very quickly. That was difficult. I think had the recruitment time been slightly longer then that may not have felt quite so difficult. And it is starting to settle down now, the workload is easing slightly but just a little, but … I think were all beginning to see maybe the light at the end of the tunnel, that things may now start settling as all of our babies are born and things.*
>
> [Family Nurse 3]

5 PREGNANCY

This chapter describes the contacts between clients and their Family Nurse during the pregnancy phase of the programme. The findings reported here are primarily based on the first qualitative interviews with Family Nurses and clients (interviewed during their pregnancies, prior to the 40th week), as well as some monitoring data on visits completed by late October 2010. As discussed in chapter 4, the qualitative interviews reflect clients' and family Nurses' perceptions and understandings of these contacts and may not necessarily always agree with each other.

5.1 The visiting schedule

5.1.1 Core Model Elements and fidelity 'stretch' goals

FNP has a clearly defined schedule of home visits to clients. The frequency, structure and content of visits required in order to implement the programme according to the Core Model Elements and fidelity 'stretch' goals are closely specified in the FNP Home Visit Guidelines. The aim is to ensure that clients receive the guideline "dosage" overall *and* in relation to specific key domains (see below), both during pregnancy and after the child is born (see Appendix E for a full list of the Core Model Elements and fidelity 'stretch' goals). Again, these specifications are based on 30 years of research in the USA on the most effective way of structuring the home visiting programme.

> *Adherence to this structure, content and process is essential to achieving fidelity to the model.*
>
> http://www.Nursefamilypartnership.org/

At every visit, a *Home Visit Encounter Form* is completed by the Family Nurse. This includes the date, time and length of the visit. It also records the client's reaction to the materials used in the session, the topics covered and any referrals to other agencies. The schedule of visits is intended to be weekly for the first four weeks and fortnightly thereafter until the baby is born. The materials which the Family Nurses use in their visits cover 14 visits. However, this is based on enrolment by 16 weeks and a full term birth, but could not be achieved for enrolment at 28 weeks. The fidelity 'stretch' goal for pregnancy is all clients receive at least 80% or more of expected visits.

There are clear guidelines in relation to the topics to be covered during the pregnancy period visits. The fidelity 'stretch' goals also specify what proportion of time should be spent on each of five programme domains in this period.[12] The five domains covered by the fidelity 'stretch' goals are: personal health, maternal

[12] A sixth programme domain is health and human services. This relates to linking families with other community services necessary to meet the needs identified across the other five domains, and for which family resources are not available.

role, life course development, family and friends and, finally, environmental health. For each domain, there is a guideline in relation to "dosage". For example, during pregnancy approximately a third to two-fifths of time is meant to be devoted to personal health and a quarter to maternal role. Within each domain, there are numerous separate topics and associated material, which are delivered at the relevant point in the pregnancy, although this may vary for individual clients.

Final measures for the pregnancy period relating to adherence to the recommended 'dosage' of visits (see Appendix E) are not included in this report, but will be included in the late pregnancy/early infancy report. However, we are able to report on client and Family Nurse perceptions of the visiting schedule and its acceptability in the early stages of clients' involvement with the programme.

5.1.2 Clients' perceptions of the visiting schedule

Clients regarded the initial weekly contacts at the start of the visiting schedule as a way getting to know the Family Nurse – the shift to fortnightly visits thereafter was felt to be appropriate. The fortnightly visits clients were experiencing at the time of their first qualitative interviews were described as *"just right, it's not too much, just perfect"* [Pregnancy Interview, Client 9] and were seen to give clients time to think about any questions or worries they may have which they might want to discuss with their Nurse at the next scheduled visit. The visiting schedule seems, therefore, to match clients' shifting needs over the course of their pregnancy.

Clients reported that visits generally lasted between one and two hours, but this varied depending on the topic that were being discussed and the stage in their pregnancy. All of the clients interviewed felt they had enough time with their Family Nurse. They also felt that if they needed more time to talk about something they could ask and the Nurse would, if possible, stay longer. Although there were clients who reported initial concerns that they may not have any questions for the Nurse, this fear seems to have dissipated once the Nurse started to talk to them and they became involved in the discussion. This may be an example of how the Family Nurses' use of motivational interviewing techniques[13] helped clients to participate meaningfully in the programme.

Appointments for the subsequent visit were made at the end of a contact. Clients reported that they found it helpful to have a note on their folder both of the time of the next appointment and of topics they wanted to discuss. Family Nurses were reported as being very flexible, particularly for clients who were in employment, arranging appointments first thing in the morning or last thing in the afternoon. A further indicator of the developing relationship between clients and their Family

[13] An evidence based method for helping people engage with and maintain behavioural change. Originally developed to help people with substance misuse problems, motivational interviewing focuses on using an empathetic, person-centred style to elicit and strengthen people's own motivations to change (see Miller & Rose, 2009).

Nurse was clients' expression of a clear preference to see their own Family Nurse rather than someone who they "did not know and who did not know them", even if this meant there was a gap between visits because of a Nurse's illness or annual leave.

5.1.3 Contact between visits

All clients reported that they had mobile telephone contact details for their Family Nurse or for the Supervisor. The extent to which clients had contacted their Nurse outwith the visits varied greatly. Some clients had never contacted their Nurse by telephone, although they stressed that they felt they could if necessary, but had simply not needed to do this. Some had contacted their Family Nurse once or twice, while still others indicated that they had contacted their Nurse by telephone or text frequently. These clients expressed concern that the Nurses "must get quite annoyed" about frequent or untimely contacts, but also commented that they may not get an immediate response from the Nurse. They appreciated that their Family Nurse would always respond, even if it was not immediate and they valued the between-session reassurance that a conversation with their Nurse provided if they had a question or were worried.

> *If I was ever worried I would always ask her and she's always there.*
>
> [Pregnancy Interview, Client 1]

5.1.4 Nurses' experiences of programme delivery during the pregnancy period

The Family Nurses found certain aspects of the pregnancy programme easier to deliver than others. In particular, they described the challenges they faced in relation to helping clients achieve their life goals. They described a "facilitator" (these are materials on a wide range of topics that Family Nurses can use in their discussions with clients to promote discussion) early in pregnancy that allows clients to establish their future goals, but the discussions were not necessarily ones that happened every week. The Family Nurses described delivering the programme in the early stages of clients' pregnancies in very positive terms – they felt that clients particularly looked forward to their visits early on:

> *I think the weekly visits at the beginning are ... are fantastic. …They really like it. They're looking forward to you coming (...) because they're excited about their pregnancy, and, at the beginning, they often don't really feel that pregnant, and also they've got very few midwife appointments and things at that point.*
>
> [Family Nurse 3]

In terms of the delivery of the pregnancy materials, Nurses felt that those clients enrolled early in the recruitment phase would have experienced a very different style of delivery to those clients enrolled later. It was recognised that as they became increasingly familiar with the materials, the Nurses became more confident with their delivery:

> *…the sort of 21st, 23rd, 22nd, 23rd, 24th client have a very different experience of me delivering the programme than the, you know, girls 1 to 4, 1 to 10…because you're increasingly familiar with the material and how best to deliver said material, or I don't know 'how best', but hopefully you get better at it.*
>
> [Family Nurse 6]

Certainly, over time, the Family Nurses appear to have become increasingly confident in their delivery of the pregnancy materials (reflecting similar findings from Barnes et al's evaluation of the first 10 pilot sites in England). There were a number of reasons why they felt that this could be the case: growing familiarity with programme material; greater feeling of competence in delivering the material; and a greater knowledge of 'what is coming next' in the programme.

At the time of the Nurse interviews, some clients had already given birth and the Family Nurses were experiencing again the anxiety and lack of confidence associated with the delivery of new materials relating to the infancy phase of FNP. Additional training was not seen as a solution, but rather gaining familiarity with the materials through practice and discussions with colleagues. The support provided by the Family Nurse supervisor – including the joint client visits where the Supervisor accompanies each nurse – also appeared to be highly valued (see further discussion in Chapter 7). However, there were suggestions that the opportunity to observe materials being delivered by an experienced practitioner might have been helpful. Moreover, while they acknowledged that experience of the programme enhanced their confidence, the Family Nurses suggested that lack of time inhibited opportunities to share learning within the team in relation to specific elements of programme implementation.

Nurses felt that the frequency of client visits was appropriate – as indicated earlier, they felt clients appreciated the weekly visits, and the Family Nurses also viewed these as helpful in building relationships with clients early on in their involvement in the programme. However, as discussed in section 4.3.4, there was a feeling that the speed with which clients were engaged with and enrolled to the programme in the recruitment phase added considerable pressure to their workloads at the beginning of the programme.

Family Nurses suggested that in order to keep up with the programme during the early phase of delivery, they had to make contact, on average, with four or five clients per day. In addition to time spent directly with clients, home visits also involved travel and preparation time. Nurses commented that the programme's Edinburgh City-wide catchment area meant they spent a considerable amount of time travelling between clients. While the Supervisor attempted to match clients and Nurses within geographic locations and the Nurses themselves attempted to cluster their client visits, this could easily break down: clients might cancel appointments or request alternative dates and times, which sometimes resulted in travelling from one end of the city to the other in order to achieve the required client contacts. Moreover, clients did not necessarily stay in the same area and

might re-locate to a different part of the city – so the geographic spread of each Nurse's caseload did not necessarily remain the same throughout the programme.

Nurses also reported spending time preparing for each client visit. Early on, given that the Nurses were all new to the programme, this was perhaps inevitably time consuming. As they became more experienced, preparation time may start to feel less onerous. However, where Nurses had a high proportion of particularly vulnerable clients they reported that this involved considerable additional work in terms of liaising with external agencies, including case discussions with the Supervisor and, in some cases, a child protection advisor.

The final layer impacting on Family Nurses' workloads was the paperwork to be completed for each client visit – the *Home Visit Encounter Form* - plus any other assessments that might have been carried out in the course of a visit. In addition to the demands on their time outlined above the family Nurses also had weekly, fortnightly and monthly supervision sessions. As a result, although the Family Nurses understood the reasons FNP had been established around tightly specified fidelity criteria, they also described delivery of the early months of the programme as feeling at times like an "impossible task" in terms of the level of work required to deliver the programme with fidelity to the original model. Thus while Family Nurses attempted to keep their clinical contacts within working hours, it was clear that preparation and travel time for visits (and training) extended their hours beyond the standard working day.

Family Nurses stressed that they were well looked after by the Supervisor and they reiterated that they were strongly encouraged to take time back and to be mindful of the amount of hours that worked. They acknowledged that they had contributed to their own work pressures, but this was perceived to be because of their dedication and commitment to support their clients.

> *We want to be there for the girls, so therefore yes I am doing a huge amount of hours, but it's through my own pressure"*
>
> [Family Nurse 3]

5.2 The content of contacts

As discussed above, the content of each FNP visit at each stage of the programme is carefully defined, with a range of supporting materials that can be used with the client. However, while there is an imperative to deliver the programme with fidelity in terms of visit structure and content, the Family Nurses do not disregard immediate or pressing concerns a client may have which may not necessarily be on the agenda for that visit. Similarly, at an early stage in the programme, Nurses work with each client to "agenda match" the programme's goals with the client's own life goals.

5.2.1 Clients' perceptions

Clients' perspectives were very much that their Family Nurse worked with them to decide what was talked about and regarded their Nurse as flexible. In some cases, clients felt that the visits were very much set, but were happy to "stick" with that if they did not have any specific topics, questions or worries or simply felt that the programme reflected their needs at any given time. Others believed that *they* always decided what they wanted to talk about. This might be something that they had been discussing with their partner between visits, or something that been concerning them (see section 5.2.2 for Family Nurses' accounts of their attempts to match the programme's and their clients agendas). Clients commented that that if they had a lot of questions or worries about a particular topic that was not necessarily scheduled for that visit, this would be brought forward by the Nurse so that the client's questions or concerns could be answered. Clients were aware of their Family Nurse looking at the list of topics and commenting 'I don't think this is for us'. The clients' perception was that Family Nurses were able and willing to be guided by them, tailoring their input to the client's needs.

Clients felt they had enough time for each topic and that if they wanted to talk more about something or still were not sure about a topic, they could ask to talk more at the next visit or, if necessary, request an additional visit. Clients felt they had been told everything at the right time and reported that they knew everything they felt they needed to at the time of their first qualitative interview.

> *[Topics covered are] fab. They're all stuff like I had in my mind, like that I was going to ask her. They're great. They cover everything I need to know.*
>
> [Pregnancy Interview, Client 13].

5.2.2 Family Nurses' perceptions

The Family Nurses' accounts of their contacts with clients corroborate the clients' in terms of agenda matching. This is an area in which the Family Nurses, by their own accounts, have become more adept at over time as their familiarity with FNP materials has improved. For example, Family Nurses described the ways in which they worked with each client to ensure that the programme's and the clients' goals were aligned in ways that reflected the programme's central philosophies.

Nurses discussed occasions where they found that they had to focus on issues they had not intended to address at that point - for example, if a client was experiencing a particular crisis which required them to adapt or change the intended content of the contact. However, for the most part, Family Nurses found that they were able to use and manipulate the programme materials in ways that made each session relevant for their client. With increasing knowledge and experience of the programme, they felt their ability to draw creatively on the materials to meet clients' needs had also increased.

…it's only now, with clients that are still pregnant, that I'm doing more of actually agenda-matching, and I couldn't have done it at the beginning. I couldn't have gone 'jump, jump, jump. Bring this. Bring that'. I think as you become more familiar with the programme, you're able to agenda-match with the clients' needs whilst covering the content that should be delivered, and that's only come with time, familiarity with the material, and hopefully some increased skill on my part.

[Family Nurse 6]

Delivery of a programme that was relevant and appropriate for each client and a structure that enabled them to work flexibly with clients was regarded by the Family Nurses as a critical factor underlying the success of the FNP programme. For example, early in the pregnancy phase of the programme, clients were provided with the opportunity to prioritise topics in terms of their own particular interests. Nurses felt that this process of agenda-matching enabled them to tailor the programme around each individual client.

It's got to be what they're wanting, what's going on in their life at that time, and let it flow from that.

[Family Nurse 3]

5.3 The involvement of others

5.3.1 *Involvement of partners*

Monitoring data shows that a third (34%) of visits were attended by the client's partner or the baby's father, while almost half (46%) were attended by at least one other person, usually a family member. In the next report, we will be able to include data from interviews with a client's nominated "significant other" (usually the partner or parent of the client). At this stage, however, we only have data from the Family Nurses and clients themselves on how others in their life have participated in the programme.

Clients reported that the Family Nurse had told them at the start that it was acceptable for a parent or partner to be involved in visits, but reported different levels of actual involvement in visits from their significant others. Some partners/fathers had not met the Family Nurse at all, either because of work commitments or because they were not at the client's house at the time of the visits. Another group of partner/fathers had met the Family Nurse once or twice, sometimes by chance because they happened to be at the client's house when the Nurse visited, or sometimes by design. Clients' reasons for the more limited involvement of their partners included work commitments, shyness on the part of their partner, or because the partner just did not want to get involved. Indeed, in some cases, clients reported that their partner would go out when he knew the Family Nurse was coming. Finally, there was a group of fathers who were very

much involved and had attended several meetings with the Family Nurse, even if their actual participation in those meetings was sometimes limited.

Clients and Family Nurses commented that, even for fathers who were not particularly involved in visits, there were attempts to involve them in the programme as a whole. Clients reported that a copy of every sheet the Nurse gave them was left for their partner and that their partner would complete them, or do so together with the client. This was seen as "a nice thing" for the Nurse to do. Clients reported that they also fed back to their partner what the Nurse had said and, if there was a concern that topics might make the father or client self-conscious, the Nurses gave clients leaflets to give to their partner.

Clients valued their partner's involvement with FNP: it allowed him to receive new information, enabled them to do both their family trees and there was a view that it was helpful that the Nurse then knew both of them. Clients' perceptions were that the fathers liked having the Family Nurse as well.

5.3.2 Family Involvement

Family Nurses reported that they had met a wide range of their clients' family and friends - including parents, siblings, grandparents and friends – although there were also some clients for whom the Family Nurse had not met any family members or friends. The actual extent of involvement in visits of all these family members was generally limited, with family members being "around" during meetings but not actively participating. Family Nurses were described as being accepting of and sensitive to other family members, but would always ensure that the client was comfortable with their presence. There were times though when the whole family would get involved. An example reported by a client was her family's excitement when a life-sized doll was brought in by the Family Nurse. Family members appeared to glean information as well, through being around while the Family Nurse was talking or through the client telling them what had been talked about:

> *"…everybody's sort o' learned bits and bobs like from her"*
> [Pregnancy Interview, Client 13].

In some cases, clients' mothers were very much involved with visits and would join in discussions. Those clients valued this, feeling that it made their mother feel more involved. Good relationships between the family Nurse and clients' mothers were reported. Indeed, one client reported that their mother had *"taken a real shine to her"* [Pregnancy Interview, Client 3]. There was also a view among clients that their mother's involvement in the FNP had brought them closer together.

5.4 Relationships between clients and Family Nurses

It was clear that clients experienced the programme via their relationship with their Nurse and that those experiences reflected the approaches and values

which define FNP. It was evident from the client interviews how much they liked their respective Family Nurses, who were described as “really nice”, “a good laugh”, “funny”, “friendly” and “great”. It was suggested that talking to the Family Nurse was more like talking to a “pal” than a nurse or a midwife. In their pregnancy interviews, the qualitative panel of clients did not make any negative comments about their Family Nurses, with clients’ accounts indicating that they got on “quite” or “really” well with their Nurse. Family Nurses were said to listen and help, both in terms of practical support, and in terms of helping to explain and clarify issues. Nurses were seen always to “add extra” [Pregnancy Interview, Client, 13].

Respondents reported that they found it easy to be open and honest with their Family Nurse and felt comfortable with them because they had built up a relationship and now trusted them. Confidentiality was key here, with clients reporting they were able to talk to their Family Nurse about anything because they knew it would be kept between the two of them, unless there were safety concerns. There was a view that Family Nurses gave balanced opinions and would never tell a respondent ‘this is bad, this is good’. The Family Nurses were not seen as judgemental, but rather as being there to help.

Family Nurses were felt to be easy to talk to: they were perceived to have the time to sit and talk to clients in a way that midwives did not and to be open to any questions, even if they were not necessarily able to provide an immediate answer. The clients also felt that their Family Nurse did not make them talk about something if they did not want to. The sharing of experiences was valued.

> *Just sitting here with a cup of tea and a chit chat about anything and everything, just seems good.*
>
> [Pregnancy Interview, Client 14]

> *I feel quite comfortable telling her like pretty much anything, I’ve told her everything like, so it’s like you’re just speaking to a friend.*
>
> [Pregnancy Interview, Client 9]

While the clients in the qualitative panel reported good relationships with their Family Nurse at the time of their first interview for the evaluation, some clients reported that when they first enrolled with the programme they were not accustomed to opening up to other people and found this difficult to begin with. There was also a concern for some clients, at the start of the programme, that the Family Nurse might take their baby away if the client told them too much about their lives. Reassurances from Family Nurses about their role played an important part in allowing clients to build trust with their Nurse and also ensured that any disagreements or clashes of opinion could be addressed in a spirit of perceived compromise. Clients’ accounts thus provide evidence of the developing therapeutic alliance with their Family Nurse.

Family Nurses expressed very similar views and experiences of this developing relationship as their clients. The frequency of visits during pregnancy was felt appropriate to building a relationship with clients. Also central to this was clients being able to trust their Nurse and know that she would visit as agreed. Nurses acknowledged that they did, on occasion, find it difficult to ask what might be deemed sensitive or intrusive questions - about issues such as income and domestic abuse - early in the client-Family Nurse relationship. There was a view that there was "a fine line" between gathering important but sensitive data and ruining the relationship. There was also a view that clients found some topics, such as sexual health, difficult to discuss at first, but that their own (that is, the Nurses') degree of comfort raising certain issues influenced clients' willingness to participate in discussions on potentially difficult topics.

The Nurses suggested that there was a balance too to be made between conveying information in visits and sounding like a teacher. Nurses were clear that the programme would not work if they came in and said – as one Nurse put it - '*right, this is what we're doing today'*. The strengths-based approach of the programme – which recognises that clients have existing strengths and are capable of drawing on these to solve problems – may have helped convey that this was a different sort of relationship. Nurses also commented that a degree of humility was necessary on their part, whereby they would always acknowledge to clients if they could not answer a question.

6 EARLY CLIENT IMPACTS

This chapter explores information from the monitoring data about clients' knowledge and behaviours at (or shortly after) enrolment.[14] It also uses the qualitative interviews to consider clients' and Nurses' perceptions of the early impacts of the Family Nurse on specific health behaviours, knowledge and understanding and on clients' wide social and economic situation.

6.1 Smoking, alcohol and drug use

Data about smoking, alcohol and drug use were collected at the third or fourth visit after clients enrolled with the programme. Almost two-thirds (62%) of clients in the FNP Edinburgh programme had smoked at some point in their pregnancy. This was somewhat higher than the figure at enrolment into the programme reported for the first 10 pilot sites in England of those reporting smoking in past 48 hours at intake to the programme (40%) and those reporting at intake to the programme that they had ever smoked in pregnancy which was 45% (Barnes et al, 2008). This figure is also considerably higher than the rates for smoking in pregnancy in Scotland. Although, as the FNP clients are specifically a group of younger pregnant women, this may reflect the evidence that smoking amongst young women is much higher than in the population as a whole, hence one of the explanations for much higher levels. Provisional figures for 2009 indicate that less than 1 in 5 (18%) pregnant women smoked during pregnancy in Scotland (Scottish Government, 2011). However, several studies have identified a tendency for women in general to underreport smoking during pregnancy, perhaps due to the social stigma associated with smoking while pregnant (e.g. Boyd et al, 1998). It is therefore possible that the higher reported smoking rates among FNP clients in part reflect a greater willingness to acknowledge smoking to their Family Nurses than might be the case where they asked by another health professional (see discussion in section 5.4). Of the clients that had smoked at some point during pregnancy, 69% had smoked at least one cigarette in the previous 48 hours, with a mean of 15.5 cigarettes for that period. Of those who reported smoking during pregnancy, approximately a third had not yet been referred to a smoking cessation service, a third had accepted smoking cessation support and the remaining third had declined a referral.

Six percent of clients reported to their Family Nurse that they had consumed alcohol in the previous 14 days – a much lower figure than the 14% reported for the first 10 pilot sites in England (Barnes et al, 2008). The number of days range from one to two, and the number of units consumed on any day ranged from one to six, with a mean of two units.

Recorded use of illicit drugs was low: five clients (3.4%) had used marijuana in the previous 14 days, using this drug on between 1 and 14 days. In addition,

[14] The data reported in this chapter were collected at either the first or the third or fourth client visits after enrolment.

fewer than five clients reported using any other form of street drugs. These figures are very similar to those reported by Barnes et al for England.

All clients interviewed as part of the qualitative panel reported that they had spoken to their Family Nurse at some point during their pregnancy and to varying degrees about smoking, alcohol and drugs, although this obviously varied according to their current use of any of these substances. Where substance use had been discussed in more detail, clients said that they had learned from their Family Nurse about the effects of the substances during pregnancy and on the baby after birth.

> *I probably knew some bits from school, but, apart from that, I never really thought about the after effects after the baby's born. I just thought the effects obviously during pregnancy. I never really thought after … when the baby's born what kinda effects it would have.*
>
> [Pregnancy Interview, Client 1]

> *Well I, to be honest I already knew about like drinking alcohol and taking drugs but I never knew about the smoking thing because my gran smoked with all her three kids while she was pregnant and my gran keeps on saying that later on they were fine.*
>
> [Pregnancy Interview, Client 13]

Clients reported that talking to Family Nurses had had an impact on their and their family's behaviour. Although clients may have tried to cut down smoking before speaking to the Family Nurse, they reported that they tried to cut down even more afterwards. There were reports of family members who had also tried to stop smoking around the client after she filled in a form about how much smoke she was exposed to. Family members would now leave the room when smoking, open a window or limit smoking to one room in the house.

> *I smoke maybe about two or three a day but it's because of what I got told fae the Family Nurse that I tried tae cut doon.*
>
> [Pregnancy Interview, Client 11]

Clients reported that they had not started drinking again after the first trimester as they had planned. The Family Nurses' advice that they needed to make a good home for the baby and that the baby was depending on them appears to have had an impact on clients.

Clients were happy to discuss these issues with their Nurse, reporting that they felt comfortable doing so as she never judged them and did not ask direct personal questions, such as "do you take drugs? How much do you take? Do you drink loads?" From the clients' perspective, everything they talked about with their Nurse was relevant.

6.2 Maternal mental health

Maternal mental health was measured at enrolment using the Hospital Anxiety and Depression Score (HADS). HADS was used alongside the Edinburgh Post-natal Depression Scale (EPDS) which is routinely administered in Scotland to all mothers in the postpartum period. Although higher scores are associated with low mood and potential depression or stress and adjustment disorder, there is no agreed cut-off score for HADS (Walker et al, 2006, Herrmann, 1997). However, the tests authors suggest scores of 8-10 suggest mild cases of anxiety and depression, scores of 11-15 moderate cases, and 16+ severe cases (see discussion Crawford et al, 2001). A systematic review of studies assessing depression during pregnancy which had used a range of assessment tools found that rates of depression ranged from 7.4% in the first trimester to 12.8% and 12% in the second and third trimesters of pregnancy (Bennett et al, 2004). A quarter (26%) of FNP clients were reported to have scores of 15+, with a further 18% scoring 11-14. Thus if HADS scores of 11 or more are taken as indicating moderate to severe anxiety and depression, then the HADS data for FNP appear to indicate that the enrolled clients had higher rates than other populations of pregnant women.

Percentage of clients scoring in each HADS score category

HADS Score	Clients at Intake (%)
Below 8	32
8-10	24
11-14	18
15+	26
Base	*136*

Clients who spoke to their Family Nurse early on about negative emotions could find this difficult at first, primarily because they did not want to speak to anyone about how they were feeling. However, those clients who had spoken to the Family Nurse about such feelings said that acknowledging their stress or distress to the Nurse who they trusted was helpful and reassuring. Clients contrasted the Nurses' concern with their emotions with midwives and GPs, who were perceived to have little regard for their feelings. Clients who had more serious emotional health difficulties reported that they were referred by their Family Nurse (or were offered a referral) to counselling services and were given advice about how to "get into a routine" and "give yourself something to do in order to feel better". This was appreciated by these clients.

6.3 Domestic abuse

Data on domestic abuse is derived from the FNP monitoring data gathered shortly after their enrolment (base=134[15]). It was agreed that this topic should not be included in the first evaluation interview, but will be explored in future interviews.

Almost a third (31%) of clients reported having experienced emotional or physical abuse at some point in their lives, including almost 1 in 4 (23%) who had been abused by a partner or someone important to them. 1 in 5 (19%) clients reported being physically abused in the year prior to enrolment, of whom almost half (46%) were abused by their current/ex-partner, more than a third (39%) by a friend/acquaintance/family member and almost a quarter (23%) by a stranger[16]. The majority of these clients (69%) had been physically abused once or twice, with the remainder having been abused more often. The forms of abuse reported were a slap or push (73%), a kick or cut (54%), a burn, bruise or broken bone (31%), a head, internal or permanent injury, or being abused with a weapon[17]. In addition, a small minority of clients reported being forced by either an ex-partner or a stranger to have sexual relations in the last year.

Since becoming pregnant, 1 in 20 (5%) of all clients reported being hit, slapped, kicked or otherwise physically hurt by someone else. There were no new events of physical abuse against clients who had not already experienced abuse before becoming pregnant and, apart from one incident, the perpetrators appeared to be the same people (reported as same category of perpetrator). Fourteen percent of clients reported being afraid of a current or previous partner, of which around a third were afraid of their current partner.

These figures are similar to those reported for the pregnancy period in the first 10 pilot sites in England - although the reported abuse rate for the previous 12 month period appears to be slightly lower for Scotland (19% in Scotland vs. 24% in England), this difference is not statistically significant. The figure for abuse since becoming pregnant was, however, slightly but significantly lower in Scotland than that reported for England (5% vs. 11%).[18]

6.4 Accessing ante-natal care

All clients in the qualitative panel had seen their midwife during their pregnancy, but had also talked to their Family Nurse about aspects of their ante-natal care. This included asking for advice if there was anything concerning them or if they

[15] This figure is lower than the 148 initially enrolled due to client disengagement before data collection and cancelled appointments, which meant that a small number of clients had not completed the relevant form at the time of data analysis. Data on domestic abuse was collected at the third or fourth visit post-enrolment.
[16] Note: clients could be abused by people in more than one category.
[17] Numbers in the last two categories are too small to report on. More than one type of injury could be reported. Base: Clients who were physically abused in the year prior to enrolment= 26.
[18] The English figures are based on those reported in Barnes et al (2008). The difference in the 2 figures was tested using a standard z-test for testing the difference between 2 percentages from independent samples.

had forgotten to ask the midwife something. They might also ask the Family Nurse to explain their notes to them if they did not understand the "lingo" or to explain blood tests and scans. The Family Nurse was able to explain the purpose of tests and – on occasion - prepare the client for potentially bad news. Clients valued this support.

Clients reported mixed relationships with their midwife, either saying they felt pretty lucky to have a really nice midwife as well as a Family Nurse or reporting that they did not know their midwife and did not have enough time with them to get to know them as well as the Family Nurse. Where clients felt that they did not have a relationship with their midwife, they were reluctant to ask her questions and felt that they were "shooed back out" as soon as the check up was over [Pregnancy Interview, Client 3]. This was contrasted with the Family Nurse, who they perceived would sit and talk to them and answer questions for as long as needed.

All clients were made aware of possible ante-natal classes they might attend through their Family Nurse, midwife or both. There were clients who did not want to attend ante-natal classes, either because they felt that they lacked of confidence or the times of classes were not convenient. Of those clients who did in fact attend classes, there was a view that the information given was similar to that which they received from their Nurse, but that the information received from the Family Nurse was much more detailed. Clients particularly praised classes they were referred to for young mothers, as they felt they "fitted right in", because they were designed for younger women. However, it is worth noting that the FNP team in Lothian had some reservations about the content of the ante-natal support provided through some classes geared specifically at teenagers. While they recognised the benefit clients may have gained from the social aspects of attending such services, there were some concerns that the messages clients received about breastfeeding, for example, did not always chime with the messages the FNP team were hoping to convey. Moreover, these classes were not available to all FNP clients, as the main service offering ante-natal services specifically geared to young expectant mothers in Edinburgh stopped delivering relatively early in the recruitment period of FNP.

6.5 Intentions to breastfeed

Monitoring data from shortly after enrolment[19] shows that a third (32%) of the clients definitely intended to breastfeed, 42% said that they would possibly breastfeed but were not certain, and a quarter (26%) were definitely not intending to breastfeed.

The Growing Up in Scotland data (Sweep 1) indicate that 40% of mothers aged under 20 had intended to breast feed and that 75% (30% of all teen mothers) of those went on to breastfeed at all (Scottish Executive, 2007). At this point, the intended breast feeding rates (combining definite plus possible breast feeders)

[19] Gathered at the first pregnancy visit.

for the FNP clients appears to be higher than the figure for GUS.[20] Once the post-natal data are available, it will be possible to assess whether the FNP clients have elevated breast feeding rates compared with all teen mothers in Scotland.

Unless clients expressed a strong preference for one feeding method and requested not to talk about alternatives, Family Nurses were praised by clients for being unbiased and non- judgemental about infant feeding. Clients' perceptions were that their Nurse explained the advantages and disadvantages of each feeding method, but would never say that one method was bad. This was contrasted with a view of midwives, who were perceived as putting pressure on clients to breastfeed:

> *…[the Midwife] just keep going on and on about breastfeeding and how good it was, but with [Family Nurse] she was just like 'I'm not going to say you should be doing this, it's totally up to you, I'm never going to judge you in any way and I'm not going to pressure you and say breastfeeding's got all these benefits'. We sat and went over like the pros and cons of bottle-feeding and breastfeeding, so I dinnae feel like the pressure that normally got from my midwife about it, so it was really good.*
>
> [Pregnancy Interview, Client 9]

Clients reported being told everything they needed to know, including making up bottles and sterilising bottles, attaching the baby, and how to know if the baby has had enough breast milk. There was a view that it was useful to know the benefits of each method. In terms of breastfeeding, clients found it helpful to talk about it with the Family Nurse as there were a lot of things they found that they had not known and hoped that having had all the information beforehand, they knew what to expect. Clients were reassured that bottle feeding would not be detrimental to their baby and nor would it affect bonding with the baby. After speaking to their Family Nurses, qualitative panel clients were almost equally split between those who intended to breast feed and those who intended to bottle feed.

The fact that clients' reported that their Nurses gave balanced advice and did not say one method of feeding was good and one bad should not necessarily be interpreted as implying that Family Nurses were not working with clients to encourage them to breastfeed. Rather, the specific approach FNP takes to working with clients may mean that, particularly at the stage at which the evaluation interviewed clients during pregnancy, clients do not recognise this directly. FNP emphasises working with clients' own feelings and potential resistance to behaviour change, but using motivational interviewing to try and support them over time to make healthier choices for themselves and their babies. Subsequent evaluation reports will provide further evidence on the impact

[20] Note that the two figures are not completely comparable, however. GUS asks mothers *retrospectively* after their baby is born whether or not they had intended to breastfeed and does not distinguish between 'definite' and 'possible' intentions to breastfeed.

which this approach appears to have had on eventual breastfeeding rates among clients.

6.6 Housing and finance

Monitoring data shows that at enrolment, a fifth (21%) of clients lived with their husband or partner only and 1 in 10 (11%) lived alone. The remainder lived with some combination or husband/partner, family and friends/others. In addition, 10% of clients were classed as homeless.

Family Nurses talked to clients about various aspects of housing, benefits and money management. In terms of housing, Family Nurses were perceived to have helped clients in several different ways: they talked through situations and scenarios, they helped clients through the process of securing new accommodation, they told clients how to get and fill in forms for housing benefit and council tax benefit, answering questions and writing letters in support of applications to the council. Clients reported being grateful and finding it helpful to have this support, particularly as for some obtaining housing benefits was perceived as causing more problems during pregnancy than anything else.

There were clients who had not yet discussed money management with their Family Nurse. For those who had, Nurses gave information about the benefits clients may be entitled to and clients were given a money management sheet on which they could fill in their incomings and outgoings. While there were clients who found this “silly” at first, the idea was deemed more helpful with time. Until their Family Nurse asked how they were going to manage, clients had not necessarily thought about money, just about the pregnancy and baby. Certainly, clients were aware of the impact of the Family Nurse on their spending and saving. There was also appreciation of advice about benefits with clients not always knowing what they might be entitled to, where to go for help and what forms to complete.

At this early stage, the impact of the programme on the clients in the qualitative panel’s lives as a whole varied. While there were clients who could not identify specific impacts, others felt that the Family Nurse had made things more manageable in different ways. Family Nurses provided advice and information about a wide range of topics – infant feeding, smoking and alcohol and their impact on the unborn and newborn baby, money management, benefits and how to seek help with housing. Family Nurses were thought to have made clients’ lives more manageable by being there if the client needed to talk, was worried or required extra support or information.

7 RECRUITMENT, TRAINING AND SUPERVISION OF NURSES

This chapter considers the programme start-up from the perspective of stakeholders, Family Nurses and others involved in the implementation of the first FNP programme in Scotland. The focus is on the recruitment of the Family Nurses, and on their training and supervision, all of which are key elements of the FNP programme approach.

7.1 Recruitment of the Family Nurse team

In order to adhere to the Core Model Elements for FNP, Family Nurses are required to be registered with the Nursing and Midwifery Council (NMC), be educated to degree level and to meet the person specification for a Family Nurse. The Family Nurse supervisor, who is also required to be registered with the NMC, and to be at least equivalent in education and training to Family Nurses, preferably educated to masters level, was recruited in advance of the Family Nurses. This was in order to allow time for their own training and development, for building the local infrastructure, and so that they could be involved in recruiting the rest of the FNP Edinburgh team.

The Family Nurse job description was agreed nationally and the Family Nurses in Scotland were recruited through a national advertising campaign.[21] The selected Family Nurses were all qualified and experienced nurses, with professional backgrounds which included health visiting/public health nursing, midwifery and sexual health nursing. Individually and as a group the Nurses reflected extensive and varied professional experience.

The articulation of the necessary qualities for Family Nurses was shared by all of those involved in the programme. Namely, beyond their formal qualifications and experience, a good Family Nurse was seen as someone who is: committed to the client group, flexible, willing to work with a manualised programme, has a good understanding of the complex needs of the client age group, is clinically competent and understands their own deficits, has a capacity for learning and is enthusiastic about working in a different way. Those involved in the recruitment process commented that it was an enormous advantage to be in a position to recruit an entire team at the same time: this allowed the selection of Family Nurses with a range of complementary skills, experience and attributes.

> *….we were in a privileged position to be recruiting six people at once [ ] your recruitment process is very tight, and you are not allowed to cherry pick in anyway, shape of form. [ ] … at the end of the process we managed from the criteria that we had, from the applicants that we got, to get a very good mix of staff. So I feel…that we have successfully recruited*

[21] The jobs were advertised in the Scotsman and other newspapers and on the SHOW website and NHS intranet.

a team with a vast array of strengths between them, that are complimentary to one another.

[Stakeholder interviewee]

In addition to a formal interview process with a professional panel, service users – teen mothers or mothers-to-be, their partners and families - were invited to be involved in the recruitment process. This was an innovative step, but one which was deemed to be very successful with the users able to ask candidates a series of questions that tapped into their own perceptions of the necessary Family Nurse characteristics. The user group were provided with brief training on the process by the FNP Nurse Supervisor and were supported by the recruitment team (including a Clinical Psychologist), to identify appropriate questions on a range of matters salient to potential clients (see Section 7.3.4 for further discussion of the Clinical Psychologist role on FNP). It was a measure of the success of the approach that that the user-recruiters identified the same Nurses as the professional recruiters and in the same order of preference.

7.2 Training

We explored with the Nurses the range of training courses that they had received throughout their first year in post (a summary of the FNP National Learning Programme is included in Appendix F). There were three main categories of training received: first was the mandatory NHS Lothian training that included a number of study days, covering issues such as 'Child Protection', 'Adults that are at Risk' and 'Maternity Trak'. Second, there was the programme-specific training delivered by the DH FNP National Unit, which covered the three main phases of the programme - the pregnancy, infancy and toddler stages. Within these blocks of programme-specific training, Family Nurses received training on the programme manuals, materials and facilitators. Third, there was training was in the form of master classes: Nurses undertook a variety of courses such as 'Motivational Interviewing', 'DANCE' (Dyadic and Naturalistic Caregiver Experiences), 'PIPE' (Partnership in Parenting Education), 'Perinatal Mental Health' and 'Compassionate Minds'.

Family Nurses came into post at the end of November 2009. Following team building and local learning, they attended an intensive, mandatory, residential 5 day course in England in mid-January 2010 focused on the pregnancy phase of the programme, using the facilitators and learning about strengths-based approaches and motivational interviewing. In the following months, Family Nurses participated in a range of training courses and master classes relating to, for example, perinatal mental health and motivational interviewing, while the 5 day mandatory residential infancy training course fell around half way through the nine-month recruitment phase (4 months after the pregnancy training).

In addition to training for the Family Nurses, the supervisor (who, as noted above, was recruited in advance of the Family Nurses) has to undergo specific training for their role, including a 3 day residential course two months prior to the 5 day pregnancy training course (which the supervisor also attended). The supervisor

also has regular monthly support meetings and 'learn and change' sets to support her development, facilitated by the Department of Health.

7.2.1 Nurses' experiences of training

Family Nurses were unequivocal that the content and delivery of their training was outstanding and, indeed, of a higher quality than they had ever expected. It was felt that training had been delivered by dynamic individuals who lived and breathed FNP. Experienced Family Nurse practitioners were also on-hand throughout training sessions, which gave the Family Nurses access to advice and information. Nurses said that they felt privileged to have received such high quality training and, in turn, felt that they would in all likelihood be disappointed with the delivery and course content of any training outwith FNP that they may receive in the future.

> *I'd say [FNP training's] been very very good. Very good; so much so that when I've gone on local training … this is gonna sound terrible ... when I've gone then on local training - not FNP - it's been really disappointing … Really disappointing. There is such a vast difference in quality of training that we've had.*
>
> [Family Nurse 5]

It was, nevertheless, clear that the Family Nurses experienced the sheer volume of training as considerable and sometimes onerous in the first year of the programme. As a result, Nurses felt, at times, overwhelmed in terms of their ability to absorb and retain information while simultaneously engaging and enrolling clients and adapting into their new roles. However, Nurses also felt that the training they have received had stimulated and stretched them and allowed them to adopt a very different approach to working with clients. In particular, adopting motivational interviewing techniques and working from a strengths-based approach were very new skills which the training supported.

7.2.2 Ready for practice

Family Nurses' accounts indicate that they were exceptionally motivated and eager to start working with clients, but had understandable concerns about how well prepared they felt themselves to be after their initial pregnancy training. Family Nurses described three main anxieties that they experienced in the initial stages of the programme. First, there were concerns about their ability to deliver the programme which stemmed from their move from being highly skilled and experienced in their previous roles, to "novices" in their new capacity as a Family Nurse.

> *… you think to yourself, "Oh, I'll never be able to pull that off"*
>
> [Family Nurse 3]

> *…you've got this kind of conscious incompetence and unconscious incompetence … and the idea behind training is that you're learning things*

and then you have to apply them, and it's … hard in a way to go back to being kind of almost a novice at something…

[Family Nurse 2]

Second, Nurses described anxiety about engaging clients. As discussed in Chapter 4, Family Nurses mentioned their initial fears that clients would not want to take part in the programme.

Finally, Nurses described anxiety about their ability to digest the wealth of information that they had received. There was a general feeling of being overwhelmed by the amount and number of new materials, while also feeling under pressure to perform as well as other FNP sites. They commented that there were some aspects of the programme that they had felt more comfortable with from the start than others. For example, they described feeling more familiar with materials on personal health or maternal role as opposed to environmental health and life course development, possibly reflecting their prior professional roles.

However, the Nurses also recognised that while they may have felt overwhelmed or daunted to begin with, over time, there would be a process of consolidation and learning through practice. Certainly, the Family Nurses suggested that throwing themselves into practice was the only way to consolidate their initial learning. On-the-job learning and shared learning among the team was highly valued and something that could not be taught within the classroom setting. Nurses also acknowledged that they had to allow themselves a degree of professional patience. There was the view that becoming familiar and comfortable with the programme and its contents would be a gradual process and that they had to accept that consolidation of learning would take time and that they should not doubt their professional skills. That said, there were also some suggestions that the timing of some elements of the training and the structuring of the recruitment phase could be improved for future sites to ensure that Family Nurses have more time to consolidate their learning in this way. This is discussed in more detail in the following sections.

7.2.3 *Travel and timing of training*

Nurses were aware when they came into post that there would be a substantial amount of travelling involved for the mandatory training. While the mandatory 5 day pregnancy training course commenced prior to the client recruitment phase, as noted above the Nurses attended a range of training courses and master classes in the following months (see Appendix F for a summary of content and timings of the National Learning Programme for FNP). The fact that training took place in England had advantages and disadvantages from the Family Nurses' perspective: on the one hand, the fact that training involved FNP teams in England afforded the positive and motivating chance to meet other site teams, while in the other hand, the time involved in travelling to training impacted on their busy working schedules and/or their personal lives.

The travelling for training was described as “exhausting”. There was consensus that it would be preferable to hold training further north, but this was tempered by recognition that, at that time, they were still the only Scottish site[22]. There was optimism, however, that when there were other Scottish sites the issue may be resolved via the provision of training in Scotland or the north of England.

In relation to timing of the training elements, the Nurses generally felt that these had been well spaced and delivered at an appropriate point in relation to the delivery of the programme with, for example, infancy training occurring just before the birth of any babies. The delivery of training in stage-specific blocks was seen as helpful, enabling retention of the information.

However, because of the actual and perceived pressures experienced by the Nurses during the recruitment phase in terms of engaging and enrolling clients and delivering the programme to their current caseload while simultaneously undergoing training, there was a view that aspects of the training programme could have been delivered at a later stage. While the initial pregnancy training was not viewed as problematic as, at that point, Family Nurses did not yet have any clients, pressures were seen as mounting when they became involved in engaging clients, delivering the programme with fidelity, receiving supervision *and* attending training.

> *The issue for the team at the moment is the capacity of them to carry on recruiting when they are struggling to meet the dosage of the people that they’ve actually got on board.*
>
> [Stakeholder interviewee]

Nurses reported that they often found it difficult to take time out from their caseloads in order to ‘clear their headspace’ to then fully engage with the training. It was also suggested that in some cases they felt they had little opportunity to consolidate learning before having to put training into practice. Given these considerations, it was felt that certain master classes, and DANCE training, would have been better delivered at a time when they were ready to use those newly acquired skills. Moreover, there was also a view that it may not have been necessary to deliver the training programme over a 12 month period and that a longer timeframe of, for example, 18 months may have been preferable and less pressured.

However, there was also an expectation that overall workloads should become more manageable once the mandatory training was complete. This expectation does appear to reflect the experiences of the first 10 pilot sites in England – Barnes et al (2009) noted that the diaries kept by a sample of Family Nurses included fewer comments about excessive hours and stress in the second year of

[22] Since the interviews were conducted, it has been announced that FNP sites in NHS Tayside will be funded.

the programme in comparison with the first (though they attribute this to relationships with clients settling down and nurses becoming more expert in managing their time, rather than the completion of training).

7.2.4 Family Nurses' suggestions for improvements to the training

While the Nurses praised the training that they had received in relation to FNP, there were three key areas where they felt it could be improved.

First, the Nurses felt that they would benefit enormously from observing experienced practitioners delivering the programme. There was a view that they did not have the opportunity to observe the programme being delivered before they started their clinical practice. Observing a mock session or pairing up with an experienced practitioner to observe them delivering the programme materials were two ways in which the Nurses felt they could have benefited. In particular, it was felt that this would have provided an opportunity observe ways in which they could apply the theoretical content of the programme to their clinical practice.

Second, while the Nurses welcomed the opportunity to meet colleagues from other sites, training held further north would reduce the amount of time that they had to take out of both their clinical practice and their own free-time to travel to courses.

Third, although in general the timing of training was seen as appropriate, as discussed above, due to the pressures of work, it was suggested that certain aspects of the programme might better be placed later on in the programme.

In addition to suggestions for improving the training itself, the Nurses felt that the speed with which clients were enrolled onto the programme had an impact on them in terms of the consolidation of their training and learning. There was a view that there might have been benefits to enrolling a small number of clients to whom they could then deliver the programme in terms of allowing the Family Nurses to consolidate their learning before continuing with the engagement and enrolment process. However, as a result of front-loading in the recruitment phase (described in Chapter 4) the Nurses felt themselves to be under huge pressure to enrol clients while simultaneously learning and delivering the programme materials. Moreover, the fact that clients enrolled early on were further on in their pregnancies on average (as a result of the decision to engage with eligible women already registered on Maternity Trak in early 2010, rather than engaging with women as they registered) also meant that the first births occurred sooner in the programme than anticipated (and this was compounded by the premature birth of the first FNP baby) at a point when the Nurses had only just completed the infancy training. Although dates for consolidation of learning were scheduled, these were sometimes removed from diaries due to competing priorities. Finding ways to make space for that consolidation of learning was viewed as a key way in which training and learning would be enhanced.

7.3 Supervision

Supervision is an integral function of FNP and is intended to be delivered within a structured format. Supervision was experienced in a number of ways:

- Individual supervision on a weekly basis
- Four group supervisions per month (two clinical and two operational)
- Supervision visit with one client every 16 weeks
- Group supervision clinical meeting attended monthly by psychologist
- Group supervision clinical meeting attended by Child Protection Advisor quarterly

Nurses perceived two key functions for supervision. Firstly, supervision was seen as providing a space for them to think through their caseloads and was an opportunity for them and their supervisor to 'bounce ideas' off of one another. Secondly, supervision was seen as providing an opportunity for Nurses to ask questions and to seek advice. It was suggested that having the opportunity to work through challenging caseloads with their supervisor enabled them to deepen their understandings of their clients and their clients' situations. Overall, Family Nurses were very positive about the supervision they received on FNP – they said that they had never before, in their professional careers, felt so supported. Indeed, although the support and supervision structures in place reflect the Core Model Elements of the programme, the Family Nurses nevertheless considered that this professional support and supervision felt like "a luxury", especially compared with their prior professional experiences.

7.3.1 Individual supervision

Family Nurses, together with the Supervisor, determined the content of weekly individual supervision sessions. Discussions focus on issues that are particularly relevant or currently salient for the individual Family Nurse at that point in time. Initially, individual supervisions were driven by a fairly structured format whereby the Nurses were encouraged to discuss their challenges, their achievements, their progress plans and their clients. However, it became apparent that this approach led to difficulties moving discussions beyond individuals' challenges and this led to a shift of approach to a more of a client-based focus. Nurses felt they were better able to work through their challenges using a client-based perspective.

The opportunity to focus on specific clients and, in turn, Nurses' approach to working with clients was highly valued by the Family Nurses. There was a feeling that without supervision, they would have struggled with their caseloads, particularly where they had a high proportion of clients with particular vulnerabilities and/or child protection issues. There was a view, therefore, that the role of the Supervisor was to help Nurses prioritise and manage their caseloads as well as individual client needs. Essentially, Nurses felt that the supervision that they received mirrored what they offered to their clients –

reflecting the focus on 'parallel processing' as a key component of the FNP model:

> *…it's a … definitely a parallel to what we're giving to the clients. It's our space to clear our head. It's our space to think things through. It's our place to be able to ask a few questions and say, 'What do you think o' this? (…) Can you help me with this problem?' (...) but mainly a support person, but very much is somebody you can bounce ideas off of and say, 'What do you think of ..?' or 'Listen. I'm stumped. Can you help me out here?'*
>
> [Family Nurse 3]

In addition to discussing clients, Nurses felt that they were able to bring any issue to their supervisor session and further felt that, if required, they would be able to arrange extra support from their supervisor.

7.3.2 *Group supervision*

Group supervision sessions took place every two weeks and mostly focused on clinical or operational practice. Sessions lasted around 2.5 hours and were seen as an opportunity to bring a case study to the group in order to discuss potential challenges. The group, therefore, provided a means to work through how best to approach client-specific issues. Group sessions also provided an opportunity to discuss programme implementation issues.

Family Nurses found group supervision sessions to be a great form of support and an opportunity for them to talk about any worries or concerns and how they were managing generally. It was commented that it was only by talking their worries through that Family Nurses realised that they shared similar concerns.

> *… individually, each of us have got challenges or worries or concerns, and you think, I'm the only one thinking this, and then somebody'll mention it in the office, and "Oh right. Oh. So you find the same. Oh, you're worried about the same things".*
>
> [Family Nurse 5]

Within group sessions, Family Nurses shared learning and discussed their approach to delivering the programme materials with clients. This was another aspect of the group sessions that was highly valued, particularly as they felt that they had not had the opportunity to observe programme materials being delivered by other Nurses in advance of delivering them themselves.

Nonetheless, despite the opportunity to share learning within group supervisions, there was a feeling that, as a team, they did not have enough opportunities to share learning or discuss styles of delivery. There was the concern that due to the nature of their work, they were often out the office visiting clients, which

meant that the opportunity to discuss general issues with colleagues was often missed.

7.3.3 Supervision visits

In addition to individual supervision sessions, Family Nurses were also accompanied by their Supervisor to client visits (two clients every 16 weeks). It was hoped that by the end of the programme, the Supervisor would have observed each Family Nurse with all of their clients. Supervision visits were felt to be somewhat 'anxiety provoking' but, nevertheless extremely useful in terms of obtaining feedback on their style of delivery and use of specific techniques with clients.

7.3.4 Other support

Various other forms of group support were experienced by the Family Nurses. These included monthly clinical supervision with the team psychologist, clinical supervision with the team's child protection advisor every six months and, last but not least, peer support both within the FNP team and from Family Nurse colleagues across other sites.

The Team Psychologist provides both group supervision to encourage reflective practice among the Family Nurse team and individual supervision to the FNP supervisor. Initially, Nurses described feeling nervous about supervision sessions with the Team Psychologist. However, over time, these concerns dissipated and they valued her role in helping them to think through client issues from a different perspective. The Team Psychologist was also said to help the Nurses think about how they were performing as a team. They were encouraged to think through their challenges and discuss how each of them as individuals were managing those challenges.

> *[Psychologist] helps us kind of just think about how … how things are from other people's perspectives, how the … kind of how our approach differs from other people's and, you know, it helps us understand other people's approaches as well…Also helps us kind of think about where the girl had come in from, what their challenges are …*
>
> *And [Psychologist] is also quite good at helping us think about 'Where are we as a team? What are the challenges? … How's everybody kind of managing with those challenges?*
>
> [Family Nurse 5]

Clinical sessions with the team's Child Protection Advisor were also viewed as an essential component of the supervision "package". Nurses brought cases to the sessions that had been identified as being vulnerable or 'families in need' and found that this forum also provided an opportunity to manage and identify methods of working with those often complex families.

Informal support was derived from peers within the Edinburgh team and also from colleagues in the English sites. Within the Edinburgh team, Nurses discussed their ability as a team to provide support, advice and encouragement for one another. Where they had been in contact with Nurses at other sites, their experiences were overwhelmingly positive. There was a sense of colleagues going out of their way to help.

7.3.5 Availability of data to support supervision sessions

Individual supervision sessions are intended to be based on information about each Family Nurse's casework for the previous week. This allows the Supervisor to review clients in a timely fashion with the Nurse, but also to seek comparable or relevant information for other sites which might help them to understand if there are – for example – comparisons which might throw light on a particular case or situation. This information should be accessible from the FNP database, which contains a record of all the data that Family Nurses gather about their contacts with clients for the purposes of both assessing fidelity requirements, and informing weekly supervisions.

However, a number of challenges have meant that, at the time of writing, a user-friendly database for FNP in Scotland was not yet available. It became apparent at a relatively early stage – before the first clients were enrolled - that Scotland would not be able to use the database developed for the FNP sites in England, due to the complex technical infrastructure used. This meant that a bespoke database would have to be developed for Scotland. A number of solutions were considered: first, an in-house solution with Scottish Government (not possible due to the data protocols around NHS data); next a bespoke solution, built by Scottish Government but housed within NHS Lothian; then a local solution, within NHS Lothian, using an existing application. Finally, following issues relating to capacity and access, it was agreed to nationally commission an FNP database through e-Health. This work was commissioned in December 2010 with options available in April/May 2011.

In the absence of a national FNP database at the start of the programme, an interim database was developed by the FNP implementation team in NHS Lothian. This was a fairly basic, DOS-base system, initially designed as a short-term measure to 'store' data from the forms Family Nurses fill in for each client contact until a more sophisticated database became available.

> *That database was never set up to do any data analysis. [ ] at the time of setting that up, it was a holding database [ ] it's easy enough to put it all in, but (…) it was never designed to pull it all out*
>
> [Stakeholder interviewee]

Although as noted in the quote it was not originally designed to be used for analysis purposes, it has been possible, although not straightforward, for the local FNP Lead in NHS Lothian to extract some data in advance for use in

supervision sessions. As the local FNP Lead has acquired greater proficiency accessing and downloading information from the interim database, this has provided a working solution. However, it was apparent that this was not ideal – it is not, for example, possible at present for the Supervisor to use the database to explore the data for an individual nurse or client during a supervision session. As the data for supervisions needs to be extracted in advance, it is not always completely up to date in terms of very recent visits. Moreover, the basic nature of the database has created barriers to extracting detailed information on whether nurses are achieving fidelity in terms of dosage for the purposes of weekly supervisions. Finally, extracting data has proved both complicated and time consuming, and has meant that the local FNP Lead in NHS Lothian in particular has had to devote much of their time not only to the maintenance and management of the database but also to the analysis and reporting of the data. Given the limited functionality of the temporary database as regards 'validation checks', this has also included double-checking data entry for accuracy, while the nurse supervisor and administrator have also had to check paper forms for errors in advance of data entry.

As a result of these limitations, an element of supervision that, at the time of their initial interviews, Family Nurses felt was missing from supervision sessions was regular, detailed, formal feedback on their performance in terms of fidelity of dosage and how this related to performance of the group or of other nurses, including nurses in England. The nurses thus felt a slight sense of frustration due to the fact that collecting the data was a requirement of their post but they felt they were missing out on the opportunity to monitor or compare their progress:

> *I've seen it, and how it's used elsewhere yeah (…) I think from a team point of view it's a bit of a miss (SIC), you know, because we could have used the data to say, 'Well, you know, some of you seem to be delivering more of this. Some are less. What .. what are people finding easy? What are people finding difficult?' Given the ... the data, not only individually, but from a team perspective. You know? Some people are managing fidelity. Some people aren't, you know? How is that? How are they doing it? You know? Is it because some people are working more hours? Is it some people are managing their time more effectively in the visits? What can we learn from each other? ...So ... yeah. I think it's a bit of a gap.*
>
> [Family Nurse 5]

There was a feeling that if they were to receive more structured fidelity feedback on frequency, length of visits and dosage, the Nurses and their Supervisor would be able to disentangle reasons why certain aspects of the programme may be easier to deliver than others. This learning was perceived as an important potential mechanism for individual and group learning.

8 IMPLEMENTATION OF FNP IN SCOTLAND

Among the key aims of the evaluation as set out in the research brief are:

- to identify factors that support or inhibit the delivery of the programme, and
- to report family nurse, client and programme management views and experiences of the programme.

It is largely a process evaluation, with an emphasis placed on evaluating the implementation of the programme in Scotland and understanding how it works in a Scottish context.

This chapter describes the early implementation of the programme, drawing largely on the perspectives of key informants within Scottish Government, NHS Lothian (including members of the FNP implementation team), City of Edinburgh Council and the DH FNP National Unit, England. Key informants held a mix of high-level, strategic posts and implementation roles in relation to FNP. Interviews explored their perceptions of the funding, management and organisational structures and perceptions of the factors that had either facilitated or impeded the implementation process (from their perspective). The focus, therefore, is on the infrastructure of the programme as it was implemented in the first test site in Scotland in order to distil any implications should the programme be rolled out to other areas.

8.1 The funding model

The funding model for the Edinburgh site is different from the mechanisms in place in England, where sites are only wholly DH FNP National Unit funded if they are part of the RCT. The other sites are funded locally, with a central DH part-funding contribution in the first year, some jointly funded by Primary Care Trust and local authority. The decision to part fund was based, partly on the basis that full government funding might inhibit local ownership and sustainability of the programme.

> *We took the view from the beginning that we would only half fund the first year because if Government funds something altogether, by the time it ends … when it ends, they won't pick up funding locally, and there isn't that sense of ownership, and these are their vulnerable babies.*
>
> [Stakeholder interviewee]

The decision by the Scottish Government to fully fund the Edinburgh programme was based on the uncertainty in the current economic climate and the potential risk posed by this for the programme to be completed in its entirety..

8.2 The links with the National Unit at the Department of Health, England

FNP cannot be delivered without a licence from the University of Colorado, Denver (UCD) where David Olds, the programme's developer and Professor of Paediatrics, Psychiatry and Preventive Medicine is based. There is a licensing agreement between Scottish Government and UCD and a consultancy

agreement (in the form of a Memorandum of Understanding) between DH FNP National Unit and the Scottish Government for the DH FNP National Unit to provide training and consultancy support:[23]

> *It operates (…) reasonably formally at one level in that [DH FNP National Unit] is responsible for training and providing the materials, sharing learning, providing advice as needed, and that's essentially ... that's what [DH FNP National Unit] do.*
>
> [Stakeholder interviewee]

In addition, the National Implementation Lead for Scotland has been able to undergo all FNP training that both Family Nurses and Family Nurse Supervisors undertake. This was described this as a quid pro quo arrangement which has allowed a member of the Scottish Government FNP team to 'immerse ' themselves totally into the FNP education programme via the process of experiential learning and, where appropriate, to contribute to the UK FNP training programme delivery including facilitation of FNP 'Learn and Change' sets.

The relationship with the DH FNP National Unit was seen as crucial in a number of respects. First, it was acknowledged that the English RCT will provide the evidence relating to outcomes and that this, in turn, allows the Scottish Government to focus on local implementation processes. Second, the learning that has accumulated in England is being shared with Scotland and, at a strategic and operational level, is seen as invaluable. Third, the training that the Family Nurses and the Supervisor undertake is largely provided by the DH FNP National Unit. Not only does this provide very "high quality training" for the team, but also ensures that the Family Nurses (and the Supervisor) can be part of wider groups with whom they can share experiences and learning. This was deemed by Nurses and other stakeholders to be of great value to the programme in Scotland.

> *Well I think there is absolutely no way we could have done it without the Department of Health. Nobody to my knowledge in Scotland has the experience of the Family Nurse Partnership because it hasn't ever been tested here.*
>
> [Stakeholder interviewee]

It was notable that the consultancy agreement was a new model for FNP, since UCD ordinarily provides the consultancy support. The Licensing agreement with UCD was also a new arrangement to both the DH FNP National Unit and the Scottish Government. In the absence of such a precedent, it remains to be seen whether the form of the current consultancy arrangement between DH FNP National Unit and the Scottish Government has been the most productive mechanism for supporting implementation. Specifically, concerns were raised

[23] This arrangement between DH FNP National Unit and the Scottish Government was made a requirement of the license by UCD.

that distances from London can inhibit meaningful participation with the National Unit at the DH FNP National Unit. It was also suggested that a more clear-cut financial exchange might have been useful and beneficial for both parties for which their costs are reimbursed after training and consultancy support. Moreover, if there are to be more sites in Scotland (and indeed, at this point in time, the programme is due to commence operation in NHS Tayside and plans have been announced to begin looking at FNP extension in NHS Greater Glasgow & Clyde region) a position may ultimately be reached where consideration might be given to the feasibility of developing FNP consultancy and training expertise within Scotland.

> *I think …we have got to make a decision in the future, if this is a programme that's extended anywhere else, do we develop a home grown Family Nurse Partnership Central Team in Scotland?*
>
> *I think in the long term, we need to think through ... what it would look like. You know, if Scotland goes for 10 sites, what would that then look like in terms of who's going to do what [DH FNP National Unit] do – a national unit – because you do need a national unit doing this ... doing what [DH FNP National Unit] do really.*
>
> [Stakeholder interviewee]

8.3 Management and governance

Management and governance were raised spontaneously by stakeholder informants (in every setting) as issues that they felt had impacted on ease of programme implementation.

The FNP National Project Board meets once every three months and includes representation of the key agencies. The National Board was described as providing an "overarching perspective" and is intended to be the vehicle for ensuring that the various arms of the programme can be co-ordinated. There is also a small NHS Lothian Steering Group and a larger multi-agency Edinburgh CHP group that focuses on operational issues and does not include government representatives.

There is a clear line management and professional supervision structure within NHS Lothian for programme delivery. However, there was a perception among stakeholders that management roles can – at times – become blurred between sectors and that this can affect the ease of implementation of the programme. Both strategic and operational stakeholders suggested that the number and the relatively high status of those involved in the Edinburgh site had led to management structures that appeared to them top-heavy – described by one stakeholder as *"a lot of chiefs for six Indians"* - when compared with those in place in England, where there are many more sites.

I think the issue for Scotland is when you've got one site … you've got a supervisor and you've got a local leader, and you've got a lead in the Government. [ ] …but it feels slightly people falling over each other, and actually the person who gets squeezed out will be the supervisor, and that's the person who needs to grow into the lead role.

[Stakeholder interviewee]

The distinctive roles of the Supervisor and the local FNP Lead in NHS Lothian (whose role is to implement the programme at a local level, and to ensure that it fits with and integrates well with other services) were well demarcated. However, in the early days, at least, it was suggested that there was some blurring of roles within Scottish Government and between SG and NHS Lothian, with a lack of clarity about who was responsible for different elements of the implementation process. The range of interests across sectors represented within the programme's strategic management may also reflect rather different perspectives which, in turn, may influence day-to-day management and delivery.

We've come to the view that the most stable person in a system in turmoil is the supervisor, so we're investing more and more in … and helping supervisors; recognising that they're going to have to take on selling it to commissioners and GPs, and the strategic bit as well as the clinical and the team.

[Stakeholder interviewee]

Nevertheless, the importance of the Scottish Government's commitment to the programme cannot be over-estimated: it ensured that funding was guaranteed until all clients' children are two years old and, further, it is well established that "buy-in" from the wider organisation can be a critical factor influencing successful implementation. In times of economic constraint, this financial commitment was welcomed.

9 DISCUSSION

9.1 Introduction

In the previous chapters we have outlined the views and experiences of clients, Family Nurses and key stakeholders in relation to the early implementation, client recruitment and pregnancy phases of the programme. In this chapter, we discuss the key learning points for the wider implementation of the FNP in Scotland. We also briefly discuss some issues around transfer of learning from FNP to wider nursing and professional practice in Scotland.

9.2 Conclusions and key learning points

The early stages of the FNP programme in Edinburgh appear to have been particularly successful in terms of:

- The high degree of fidelity achieved in relation to both the Core Model Elements and fidelity 'stretch' goals. The Family Nurse recruitment process, the engagement and enrolment of eligible clients, training, supervision and programme delivery were all achieved with a high level of programme fidelity. The recruitment process attracted a team of Nurses reflecting extensive and varied professional experience.
- The level of acceptance of the programme by clients – with the proportion of eligible clients who agreed to participate exceeding the fidelity 'stretch' goal for acceptance.
- The development of good, trusting relationships between Family Nurses and clients, with their descriptions of 'agenda matching' in meetings and their views of their therapeutic relationships closely reflecting the central values and principles of the programme. The degree of trust and respect between clients and Family Nurses also highlights the benefits of the strengths-based approach which underpins FNP in working with vulnerable young women.
- The value clients placed on having support during, as well as after, the birth of their first child.
- The influence of the Family Nurses' own degree of comfort in discussing sensitive issues on clients' willingness to discuss topics like sexual health.
- The value clients placed on referrals to services specifically targeting younger women, and on the advice and help they received from their Family Nurse on issues beyond maternal and infant health – like housing benefits and money management.
- The involvement of user-recruiters in the recruitment process for Family Nurses – with users identifying the same preferred candidates as the panel.
- The value Family Nurses placed on the training delivered by the National Unit at the DH FNP National Unit – perceived to be of a higher quality than any previous professional training that they had received.

- The value Family Nurses placed on the individual and group supervision received.

In addition to these substantial successes, the early phase of the evaluation also identified a number of challenges experienced in implementing FNP in the first Scottish pilot site, which can be learned from as the programme is extended to other areas of Scotland (or, indeed, elsewhere). Key learning from these challenges includes:

- Giving careful consideration to any decision to front-load client engagement during the recruitment phase. Any front-loading will require careful management to ensure that Family Nurses have time to become familiar with the programme and to consolidate their learning before their number of cases increases significantly.
- The decision to front load using existing Maternity Trak cases also appeared to increase the proportion of clients who were already 16 weeks at enrolment (the one Core Model Element the programme appears to have missed during the recruitment phase). However, this also reflects the decision to offer FNP to all eligible women identified during the recruitment period. Given that most pregnant young women will be in contact with health professionals in advance of 16 weeks gestation, perhaps this element of FNP is less crucial to its success in the Scottish context – providing that clients are still enrolled sufficiently early in their pregnancy to allow for the full 'dosage' of FNP home visits to be delivered.
- The early stages of the programme appear particularly challenging to deliver within normal working hours. This highlights the central importance of ensuring that workloads are monitored on a continual and transparent basis, with supports in place to address excessive workloads, as well as the potential need to consider more formal ways of alleviating pressures on workloads early in the implementation of FNP.
- Considering the timing of master classes and additional training, to ensure that it is delivered close to the time when the Family Nurses are ready to use the skills covered.
- Ensuring there are sufficient opportunities for paced learning and consolidation of that learning can be challenging, particularly in the early stages of delivery. However, this is clearly viewed as extremely important to Family Nurses' development and should be considered and reviewed regularly.
- Having an appropriate and fully functional database in operation at inception is very important in terms of supporting effective supervision and avoiding unnecessary additional work for the Supervisor and local FNP Lead.
- The management structures for FNP were viewed as sometimes confusing for the professionals involved. Where multiple organisations are involved in managing and delivering FNP, management roles and lines of reporting need to be very clearly agreed and articulated to all those involved.

Subsequent reports will provide more detailed information about the entire pregnancy and infancy periods of the FNP programme in Edinburgh, and will consider the experiences of the programme through the eyes of the panel of 15 clients, their Family Nurses and members of their families.

9.3 Wider learning

In terms of learning beyond the FNP programme itself, strategic stakeholders and others suggested that the programme is in a position to inform the community nursing agenda and to influence practice in Scotland more widely. Indeed, the Scottish Government FNP team are contributing to the Modernising Nursing in the Community Programme. The key ways in which the FNP programme was perceived to be potentially influential included lessons relating to the implementation of change within the health service, engaging and supporting service users and, specifically, and offering a different approach to interacting with service users, particularly via the use of motivational interview techniques and a 'strength based approach' (reflected in an increasing interest in 'assets-based' approaches in health interventions more generally – see for example Assets Alliance Scotland, 2010).[24]

However, whilst taking into account that the FNP it still at a very early stage in Scotland, there would appear at this early stage to be some barriers to ensuring learning transfer of this kind. Stakeholder informants were very clear that a critical aspect of FNP (if not *the* critical aspect) is that it is a carefully prescribed, manualised programme with defined inputs (the Family Nurses, the training, supervision etc) and outputs (the prescribed number of visits, specified content of contacts, albeit within a context of agenda matching, and the materials that the Nurses use during the contacts with clients etc).

The dilemma for learning transfer is two-fold. First, those involved in the development and delivery of the programme were clear that, for example, motivational interviewing and strength-based approaches are elements of the evolving "therapeutic relationship" between clients and Family Nurses which could be learned from. However, the evidenced outcomes for FNP depend on meeting the stringent Core Model Elements and fidelity 'stretch' goals which extend beyond the use of specific techniques. The success of the programme is, put simply, more than the sum of its individual components. Second, the licensing agreement and copyright restrictions do not allow the materials to be used outwith the programme. So, however useful those materials are deemed to be (and the team did regard them highly), they cannot for Intellectual Property Right reasons (intended to prevent inappropriate or poor replication of the programme) be shared with, for example, community nurse colleagues. , There are, therefore, some challenges relating to the extent to which experience of FNP can be effectively embraced more widely in the light of these dilemmas in relation to learning transfer.

[24] It should be noted that these are only early findings from the FNP pilot in Scotland, and full recommendations will not be available until the whole programme has been implemented.

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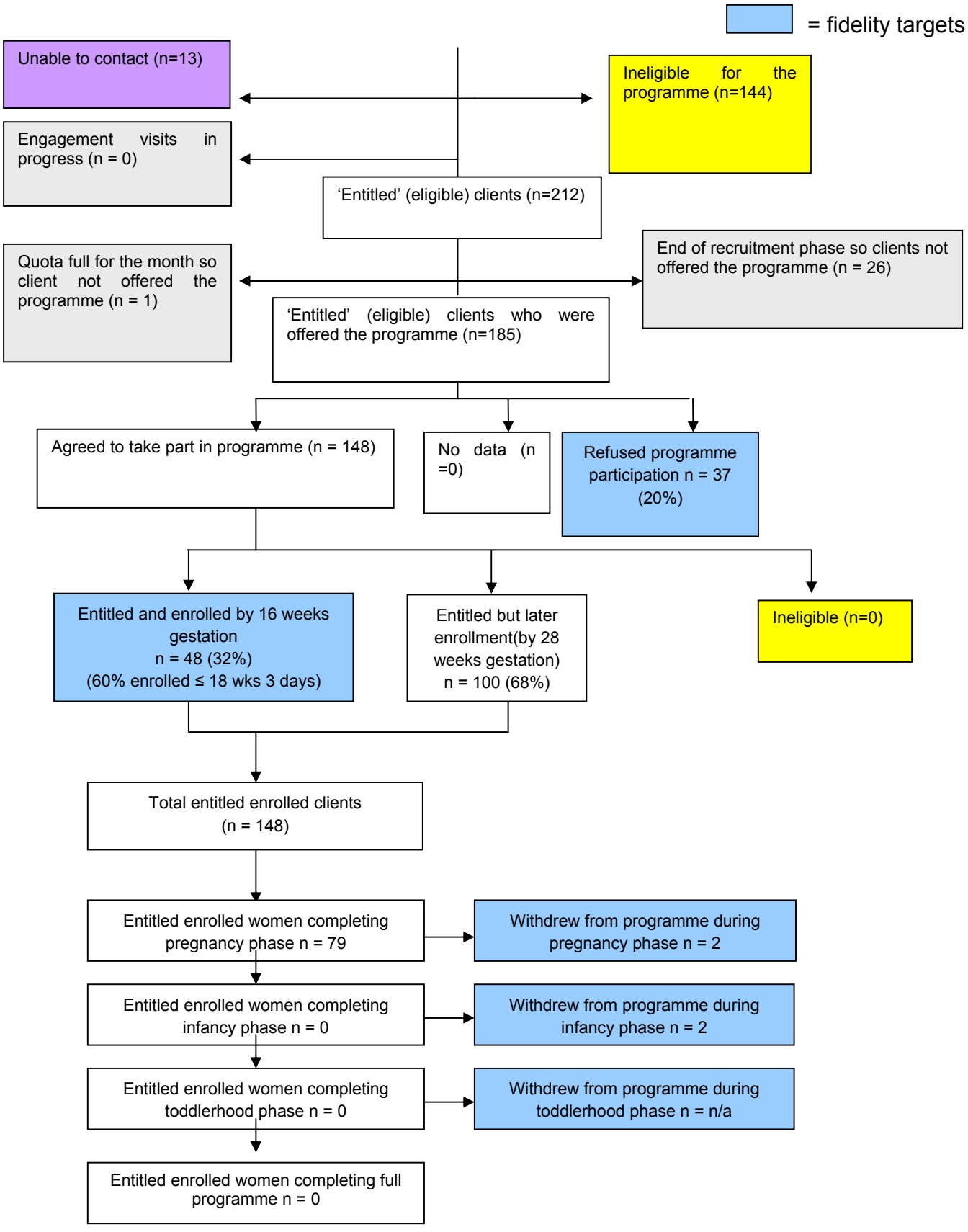
Appendix A: FNP programme recruitment (at month 9)



Appendix B: Evaluation methods

1.1 The evaluation team

In October 2009, the Scottish Centre for Social Research with Jacki Gordon & Associates was commissioned to carry out an evaluation of FNP in Scotland.

At an early stage, it was agreed that the evaluation group would be comprised of the external evaluation team (ScotCen with Jacki Gordon) and an internal monitoring team (represented by the NHS Lothian FNP Lead) which would be responsible for the collection and collation of the routine monitoring data. Jacki Gordon would take the lead role in terms of facilitating and developing the monitoring and evaluation framework which would inform the evaluation throughout, while ScotCen would be responsible for qualitative data collection with stakeholders, clients, family respondents and members of the FNP team and would also be responsible for reporting.

1.2 Aims and objectives of the evaluation

The overall aim of the evaluation is to assess the implementation of the programme in Edinburgh, and then to use the learning from the experience to assess whether the programme can be implemented in other areas of the country.

The specific objectives of the research are to:

1. Review existing evidence of the Family Nurse Partnership Programme
   - identify evaluations of the programme in the USA and elsewhere
   - identify different approaches to evaluation that have been used elsewhere with a view to replicating methods where appropriate
   - take note of the evaluation carried out in England
   - assess implications for programme implementation and evaluation development.

2. Work with the FNP programme to develop a monitoring and evaluation framework
   - identify a minimum/essential dataset
   - identify acceptable levels for delivery and outcomes of interest
   - define an expected timeframe which would identify how well the programme is being delivered and its impact on participants.

3. Assess the implementation of the FNP programme using the monitoring and evaluation framework:
   - establish a baseline
   - identify the factors which support or inhibit the delivery of the programme.

- report family nurse experience of implementing the programme, clients' and programme management views and experiences of the programme
- Identify programme alerts
- Identify the impacts the programme has on associated community services and on the community nurse workforce in Edinburgh.
- *Identify the cost/benefits of implementing the programme.*
- Reflect on contribution of the programme to the wider policy context.

4. Identify the wider implications should the FNP programme be extended:
   - Make recommendations for implementing the programme
   - Identify refinements to the monitoring and evaluation framework for use elsewhere.

1.3 Overview of research methods

The evaluation research is addressing the objectives using a range of formative and summative approaches, including:

- A review of published and grey literature to inform the evaluation (on-going)
- The development of a monitoring and evaluation framework using a logic modeling approach based around Theories of Change
- The development of appropriate and informed instruments for routine monitoring and agreed indicators and measures
- Analysis of data collected for all clients using the measures developed for routine monitoring, to assess the implementation of the programme (Objective 3)
- Longitudinal qualitative research (case study approach) involving repeat in-depth matched interviews with a panel of up to 15 clients, a nominated significant other and the clients' family nurses, interviewed at key points during the client's pregnancy and the first two years of her child's life (See Chart 1)
- Key informant and team interviews at key points to inform, assess and reflect on the implementation of the programme

1.4 The recruitment of clients to the longitudinal panel

Clients were asked to participate in the research on a strictly opt-in basis. Family nurses were asked to give a leaflet explaining the evaluation to all of their clients. The leaflet described what would be involved and how the research would contribute to our understanding of FNP in Scotland. At that stage, all that was requested of clients was that they indicate a willingness to be contacted about the research and to consent to their contact details being passed to the research team. The information was entered onto a form which the FNP Supervisor reviewed and then passed to us.

The panel of 15 clients was recruited to the evaluation on the basis of their expected date of delivery (EDD), their age at conception of the FNP baby (LMP) and who was their family nurse. The aim was to interview clients at the rate of 5 per month over a period of three month, to ensure that there was a range of ages and that the clients of all family nurses were, as far as possible, equally represented. This was to ensure that, if possible, no one nurse would have to be interviewed about more than 3 clients.

The Supervisor was asked to review the names of clients who had consented and to remove anyone who she felt might be harmed in any way through participation in the evaluation.

Of the 148 initially recruited to FNP, 82 (55%) agreed to share their contact details with the research team. Two clients were excluded by the Supervisor and a further 25 were ineligible because they had already had their baby. We then contacted by letter and then by telephone 27 of the remaining 55 eligible clients who would provide the spread of characteristics we wanted to include and, of these, 15 were successfully interviewed. The interviews were conducted over a somewhat longer period than initially for a variety of reasons, but largely because of our need to spread the panel across all family nurses and have a range in relation to the clients' ages.

The research team gave a presentation to the family nurses which described the evaluation and what would be required of them personally. It was a agreed that interviews with the family nurses would, as far as possible, cover both their own experiences of the programme and their experiences in relation to the specific clients included in the panel. Access to the nurses would be via the FNP Supervisor who would co-ordinate interview times.

1.5 The content of interviews

The interviews with key stakeholder informants within Scottish Government, NHS Lothian, Edinburgh City Council and the Department of Health (England) focused on:

- understandings of the programme (and changes over time)
- perceptions of desirable and achievable outcomes
- views of the training and support
- personal experiences
- perceptions of the barriers and facilitators to implementation
- reflections on the success (or otherwise) of the project

The interviews with clients were informed by the monitoring and evaluation framework (see example below) and included:

- understanding of FNP
- recruitment process
- reasons for participation
- visiting schedule, content of contacts
- perceptions of usefulness and appropriateness of schedule and contacts
- use of antenatal services
- impact of FNP on health knowledge and behaviours
- preparedness for the birth
- use of community resources
- well-being
- self-efficacy
- relationship with family nurse and with FNP
- relationships with partner, family members and friends

Family nurses were only interviewed about specific clients if they client herself had given us signed consent to speak with her nurse about her. The interviews with clients' family nurses focused on the following generic/ general topics:

- background information about the family nurse
- perceptions of their FNP training
- assessments and record keeping
- supervision
- perceptions of the aims and value of the programme

In addition, the interviews asked family nurses to reflect on their experiences with specific clients who had consented to the researchers approaching their family nurse. This element of the interviews with family nurses addressed the topics included in the client interview, but from the family nurses' perspectives, including their perceptions of their influence on the client's knowledge and behaviour.

Chart 1: Schedule of repeat interviews with clients, family members and family nurses

Respondent	Pregnancy	Postpartum	12 months	21-24 months
Client	Interview 1	Interview 2	Interview 3	Interview 4
Family member		Interview 1		Interview 2
Family nurse	Interview 1	Interview 2		Interview 3

1.6 The analytical process

The analysis and integration of data collected from multiple sources was informed by linked stages, which comprised:

- development of the monitoring and evaluation framework which specified the data that was required in order to address the evaluation aims and objectives
- specification of monitoring data items for the evaluation
- identification of topics/issues for interviews with stakeholders, clients, nurses and family members
- development of topic guides
- development of thematic charts (themes and sub-themes) which summarise narrative qualitative data (see 1.6.4)
- descriptive analysis (see 1.6.4)
- interpretive analysis (see 1.6.4)
- integration of quantitative and qualitative data

1.6.1 Analysis of qualitative data

The interviews with stakeholders, clients, family members/significant others, family nurses and other members of the FNP implementation team are digitally recorded and transcribed verbatim (that is, word for word) and in the vernacular (that is, including slang words and local expressions).

The first step in the analysis process required the research team to read through all the transcripts. We then developed a coding frame which would allow us to apply a descriptive label to what people had said about different topics. The coding frame was made up of a number of broad themes and sub-themes.

The next step entailed testing the coding framework. This was achieved by members of the research team each coding the same transcripts, comparing the coding and then revising the coding framework to ensure that all responses could be meaningfully encapsulated.

The third step involved summarising all the interview data under an appropriate descriptive sub-theme. In this way, we were able to divide each interview transcript into comparable sections and bring together what different respondents had said about – for example – how they found out about the programme. The data can be displayed in a matrix which shows the summaries for every respondent by theme and sub-theme. The example below uses data collected as part of the evaluation, but not from the same three respondents. The nurse interviews were coded and summarised in two ways: first, in relation to generic topics (such as training or supervision) and, second, in relation to the specific clients about whom they were interviewed. This a is a complex approach, but one which will ultimately allow us to explore narratives from a range of perspectives over time.

These thematic data are then further summarised into briefer descriptions and, from these, categories are developed which group responses within and across

themes in meaningful ways which encapsulate the views and experiences all respondents.

The aim throughout is:

- to map the range and diversity of all responses within the interviews
- to capture that range, regardless of how many respondents gave particular responses *and*
- to explore patterns of responses – for example in relation to age or any other factor which helps us to explain and understand the data.

1.6.2 Reporting qualitative data

The samples were purposively selected and we cannot, therefore, express the data in a way that implies statistical representativeness. Our approach, however, ensures that all views and experiences are represented and contribute to grounded descriptions and interpretations of the data. In terms of reporting the interview data, that meant that we do not quantify responses. Nor could we say that one factor was more important than another as we simply do not know.

The task when reporting qualitative data is show the scope of views or experiences. There is rarely a single perspective which represents an entire group of respondents. It is also important to be aware that respondents' accounts reflected their perceptions of events or situations: they may or may not have been "factually" accurate or have accorded with other respondents' or stakeholders' perceptions or views, but they did nevertheless represent that person's reality and were therefore equally valid. While this may at times seem to be at odds with what is "known" about a situation or setting, the key issue is that it is these individual perceptions and meanings which help us to understand whether and how the programme is influencing clients and their families.

We use quotes throughout to illustrate our interpretation of the data, rather than as a tool to make a point about individual respondents. Finally, more information about our "Framework" approach to qualitative data management, analysis and reporting can be found in "Qualitative Research Practice" (Ritchie and Lewis, 2003) and while Woodfield et al (2001) discuss longitudinal qualitative research approaches. References are included in the main report.

In this first interim report, we have focused very much on giving as full a description possible of clients' and family nurses' views and experiences of the programme. Later reports will integrate client and nurse narratives over time.

1.7 Ethical and NHS approval

Application for ethical approval was submitted to the South-East Scotland Research Ethics Committee. The study was approved May 2010. Application was simultaneously sought for local NHS access and this was received June 2010.

Appendix C: The monitoring and evaluation framework

In this chapter, we describe the process that was used to develop the monitoring and evaluation framework for the FNP, and summarise the content of this.

1.1 Context for developing the monitoring and evaluation framework

Olds and colleagues believe that the effectiveness of the FNP model is contingent on it being implemented as intended. For this reason, delivery of the FNP is tightly-specified in many respects. Thus, for example, eligibility criteria, training requirements, case load size and the number, timing and to a large extent, the content of the visiting schedule, are all pre-defined. As such, these requirements are intended to provide a blueprint to guide implementation (thereby ensuring consistency with Olds' 'tried and tested' model).

To assist this, the FNP is accompanied by a series of fidelity requirements and 'stretch goals': the former are tightly specified criteria with which the project is expected to comply whereas the latter are more fluid and aspirational.

As part of our contract for the commissioned evaluation, we were to develop a monitoring and evaluation framework that would capture:

- data to provide ongoing feedback to the Project Board and project implementers on whether the programme is being implemented as intended, in particular whether it complies with the fidelity requirements as set out in the licensing agreement;
- system alerts in order that the Project Board and implementers are given advance warning of any actual or likely failure to meet these fidelity requirements; and
- data on outcomes of interest, in particular those that are considered to be particularly relevant to understanding the FNP's implementation in Scotland.

1.2 Our approach

We used logic modelling to establish stakeholder consensus on what the FNP in Scotland was intending to achieve and how, and in turn used this as the basis to develop its monitoring and evaluation framework.

1.2.1 About logic modelling

Logic modelling is being increasingly used as a tool to assist in the process of outcome focused planning, the implementation of projects and programmes, and in the development of associated monitoring and evaluation frameworks. Essentially a logic model is a convincing picture linking intended results with planned activities. Thus a logic model can be used to make explicit available inputs, the projected sequence and timescales of activities and associated outputs, and the connections of these to the intended outcomes.

The process of developing a logic model creates opportunities to highlight assumptions underpinning the successful implementation of a programme and its effectiveness in achieving the desired outcomes. This process of identifying underlying assumptions can help stakeholders consider whether there are any flaws in the logic of their model, and therefore whether and how these might be overcome.

The process also encourages stakeholders to identify external factors over which they have no control. In turn, this can prompt them to consider whether there are any contingency plans that they should put in place to limit any risk to programme implementation and/or effectiveness.

Furthermore, developing and agreeing a logic model can be useful:

- to engage stakeholders in the planning process; and
- to help them understand the contribution that they can make and for which they might reasonably be held accountable.

In addition, and most importantly, the process provides an opportunity to jointly consider whether stakeholders' plans are not only logical/*plausible*, but also *do-able* and *testable*.

1.2.2 How logic modelling can inform the development of a monitoring and evaluation framework

Setting out the projected sequence of activities, outputs and anticipated outcomes in a well specified manner provides a basis for testing whether a programme has been implemented as intended and achieved the changes that are envisaged. Thus it provides a basis for:

- monitoring process and progress;
- assessing effectiveness; and
- articulating assumptions that can or should be tested out via evaluation.

For these reasons, the development of a logic model provides a useful basis to guide the development of a monitoring and evaluation framework.

1.2.3 The development of logic models for implementing FNP in Scotland

We facilitated a series of discussions the purpose of which were to develop three logic models:

- a high level 'Google earth' model showing how the FNP is viewed to contribute to outcomes of national (Scottish) interest in the short, medium and long term;

- a detailed implementation logic model, explicating key outputs of the project including (but not restricted to) its fidelity requirements/stretch goals and for which the project is obliged to collect monitoring data; and
- an embedded implementation logic model that detailed the stakeholders' collective view on the short term outcomes that the project is expected to achieve i.e. the outcomes that the project is expected to achieve over the period of its implementation i.e. in supporting teenage mothers up until their children are two years old.

In the discussions surrounding the development of the logic models, we highlighted a number of issues that we suggested had implications for FNP implementation. These included the following:

- The absence of any contingency arrangements if any members of the FNP left their post/went off sick: as delivery relies on FNs attending bespoke training, we suggested that it might be useful to create a 'bank' of additional health visitors by training them in the FNP programme.

- FNs would be unlikely to have the capacity to cover others' caseloads: the English evaluation highlighted the excessive demands on family nurses resulting in them working more hours than they were contracted to do: this means that existing

- The recruitment requirements were ambitious and in view of this and the challenges involved in setting up any new programme, we suggested that it might be desirable to allow a longer 'lead in' period

- The absence of an FNP database together with the short/fixed term nature of the FNP (Lothian) Lead's contract (until August 2011) were seen as potential threats that might compromise the quality, interrogative potential and maintenance of implementation data that are in themselves, a requirement for the FNP licence

- The English evaluation highlighted that the quality of some of the data collected via the FNP paperwork are questionable e.g. the timing and phrasing of questions on domestic abuse data are such that not only may (early) disclosure be low, they do not allow an assessment of any change that has taken place during the programme. We suggested that the latter weakness is problematic if domestic abuse is an outcome of interest.

Furthermore, one of the stakeholders indicated that whereas the FNP uses the Hospital Anxiety and Depression Scale (HADS) to assess maternal mental health, it is routine practice in Lothian to use the Edinburgh Postnatal Depression Scale (EPDS) and that communication/referrals to service providers would require the use of this latter tool. This stakeholder therefore suggested that the FNP routinely use this tool either instead of the HADS, or in addition to it.

These three logic models, which reflect the consensual view of the stakeholders, are provided in Appendices. .

In turn, the latter two models (i.e. the implementation models) provided the basis for a paper in which we scoped out options for inclusion in the monitoring and evaluation of the project1.

Subsequently, stakeholders were asked to consider these options, and identify their priorities for inclusion in the final monitoring and evaluation framework. As such, it was agreed that decisions regarding priorities should be underpinned by a number of considerations, including:

- the feasibility of collecting data in a consistent and timely manner;
- the (anticipated) acceptability of the data collection measures for both the families and for the family nurses;
- the requirement for good quality data;
- the need for meaningful data (in particular, the availability of routinely collected data from across Scotland or Lothian that can be used for comparative purposes and thereby aid attribution of any improved outcomes to the FNP);
- learning from the English evaluation (i.e. conclusions regarding measures that were included in the English evaluation design, but subsequently were considered to be of limited value); and
- 'added value' i.e. the data that are collected should provide insights that are important to understanding the project's implementation in Scotland, and should not attempt to determine whether or not the project is effective in achieving those outcomes that are being assessed as part of the larger and more resource-intensive (RCT) evaluation of the English pilot sites.

In addition, and informed by the discussions regarding the alignment with and potential contribution to Scottish (national outcomes), a further consideration was whether the project might want to collect data that might evidence its contribution to relevant national outcomes e.g. HEAT 7 and its target to increase the proportion of babies exclusively breast fed at 6-8 weeks.

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[1] *Scoping options for monitoring and evaluating the FNP: a preliminary discussion paper. January 2010*

1.3 Terms of reference for the monitoring and evaluation framework

The monitoring and evaluation framework was developed to map out the information that stakeholders identified and agreed as priorities in relation to the FNP in Scotland.

Importantly, it was intended to indicate not only which data would be collected, but also by whom. As such, decisions on who would collect data were underpinned by the acknowledgement that:

- the FNP would collect information from all women who take part;
- the independent evaluation would collect depth information from a sample of up to 15 women and their family members (on four occasions: during pregnancy, early in the postnatal phase, and when the children are 12 months, and 18-24 months old), and from stakeholders who are key to the planning and delivery of the programme.

The implication of this was therefore that any decisions to collect data from all women would require that this be performed by the FNP team.

1.3.1 Roles and responsibilities

A vast array of documentation is integral to the FNP programme and a requirement under the licensing arrangements: in addition to the mandatory records of each visit, there are forms that are administered to guide family nurses' decisions and practice, including the support that the clients may need e.g. the maternal health assessment when clients' embark on the programme (UK005).

In addition to the requirement for the collection and data entry/management from these sources, it was agreed that the FNP team would be responsible for collecting all data necessary for routine (and regular) monitoring of the project's implementation.

It was agreed that this should include collecting the data necessary for establishing and supporting a system of implementation alerts. Furthermore, wherever there was an identified need for data on outcomes of interest, it was recognised that this would require that data be collected across the full cohort of women. The responsibility for this would therefore fall to the FNP (and not the external evaluation).

The implication of the above was that that the data collected by the FNP should:

- enable an assessment of the extent to which the project has been implemented as intended; and
- have the potential to provide some insights into the project's effectiveness. However, the extent to which these data would actually be able to demonstrate effectiveness would be dependent on factors such as the

utility/robustness of the data collection instruments, the availability of comparative data (e.g. from across Scotland), etc.

In contrast to the role of the FNP team, it was acknowledged that the data to be collected by the external evaluation would be qualitative in nature and focus on processes. It was agreed that its remit should include:

- testing out the assumptions on which the programme rests;
- exploring views on the feasibility/do-ability of the programme (and the fidelity requirements), particularly in view of the resources available and the timescale for implementation; and
- seeking to identify whether there is any qualitative evidence to indicate that outcomes may have (plausibly) arisen as a consequence of the programme.

This apparent division of roles belies the symbiotic relationship between the internal and evaluation however. In acknowledgement of the importance of this two-way relationship, it was agreed that the Lothian FNP implementation lead (who has lead responsibility for the internal evaluation) should participate in key meetings of the external evaluation team.

1.3.2 Key questions for the external evaluation

As indicated above, it was agreed that the external evaluation would concentrate on exploration of: some key assumptions; the programme's do-ability; and views on whether (and if so, how) FNP is effective.

Thus, in terms of exploring key assumptions, there was agreement that ones in the bulleted list below should be explored by the external evaluation team, i.e:

- the programme is reaching those whose babies are most likely to be at heightened risk[2];
- there will be a high uptake of the programme, and once enrolled, few will drop out;
- the programme will be valued/highly acceptable to families and will be felt to be non-stigmatising in nature;
- the family nurses will establish a therapeutic relationship with the families, and that this will engender open dialogue on matters concerning the mothers' and their babies' well-being and development;
- the service infrastructure is supportive and able to respond to referrals made by the family nurse for additional support; *and*
- the FNP is a better/more effective service than that routinely provided to the target group.

In terms of the feasibility considerations (i.e. the do-ability of the programme), there was agreement that the external evaluation team consider whether:

- the fidelity requirements are realistic (and compatible with the delivery of person-centred support);
- the allocated budget is sufficient to deliver the programme as intended;
- the training and support that family nurses receive is sufficient to equip them for their role; and
- the demands on the FNP are manageable, both in terms of the delivery of the model, and the collection of (good quality) data.

The third responsibility for the external evaluation is to explore whether there is any qualitative evidence that key outcomes have arisen *as a consequence of the programme*. Those outcomes that the stakeholder group (including the commissioner) indicated as being of particular interest were:

- parenting qualities and behaviours including responsiveness, warmth, and attachment;
- parental involvement in learning;
- protective health behaviours, such as smoking cessation in pregnancy;
- breastfeeding; and
- psychological resources, including self-esteem.

To address the stakeholders' interest in these outcomes, it was agreed that the external evaluation includes a focus on the plausibility/likelihood that the FNP has influenced these. Doing so was felt to require consideration of:

- data provided by FNP (i.e. from the extensive records that are integral to the delivery of the programme)
- routinely collected data sources, where available (e.g. breastfeeding rates for FNP mothers as compared with women living in areas of deprivation); and
- data collected by the external evaluation i.e. the panel interviews with families and the interviews with the family nurses.

1.3.3 Summary: what the monitoring evaluation will and will not do

It was agreed that the internal and external monitoring and evaluation would focus on:

- distilling learning on FNP delivery in Edinburgh, including the barriers faced;

- understanding and exploring views on the skills, systems and infrastructure believed to be necessary to implement the programme, and challenges faced in achieving these; and
- on the basis of these insights, contribute to national learning on how the programme (or aspects of it) might be used in the future.

There was agreement also on what the monitoring and evaluation would not tell us. Thus:

- while we will learn whether/how the FNP was implemented as intended and the reasons for this, the evaluation will not be able to demonstrate whether the model – if implemented according to the fidelity requirements – would result in improved outcomes in Scotland;
- while we will obtain some insights as to whether and if so how, the programme might have plausibly) influenced the mothers in some key areas (e.g. breastfeeding, parenting), we will not be able to conclude that it actually effected change that would otherwise not have happened; and
- while we will hope to develop some insights into factors associated with engaging teenage mums and working with them in a person-centred manner to address (and improve) outcomes for them and their children, the evaluation will not provide a blueprint for the future of community nursing in Scotland.

1.4 The monitoring and evaluation framework

The development of the monitoring and evaluation framework was underpinned by the implementation logic models together with the stakeholders' agreements about the particular elements/dimensions which they considered to be a priority for the Scottish evaluation.

This framework did not (and was not intended to) detail all the information that would be collected over the life of the FNP: it was acknowledged that the FNP would be collecting a wider set of data than those included in the framework, for example, to help the family nurses tailor their activities to the needs of individual families.

Furthermore, it was acknowledged that the external evaluation would also collect data on more issues than those detailed in the framework: as the project evolved, additional areas of interest were likely to emerge that ScotCen explores in more detail. This iterative approach is a common (and valuable) feature of qualitative evaluation methods.

The framework was built by going through each of the outputs and outcomes in the implementation logic models, and using these as a basis to formulate a list of key questions. The ones that were identified for inclusion within the framework were as follows:

- Does the team receive the training and support intended, and develop the knowledge and skills required?
- Are fidelity requirements met for recruitment?
- Does project meet the fidelity targets for attrition?
- Do the family nurses carry out the intended number of visits?
- How feasible/appropriate is the visiting schedule?
- Do family nurses conduct their consultations in line with the fidelity criteria?
- Is the FNP structure useful/appropriate?
- Are FNP data entered into the FNP database in a timely fashion?
- Is there any evidence that the FNP leads to use of screening/antenatal services and recommended antenatal practices (CEL 31)
- Is there any evidence that clients feel better prepared for birth?
- Is there evidence that the FNP results in improved knowledge /health behaviours in clients prior to/following birth of baby?
- How good are the pregnancy outcomes of those enrolled on the programme?
- Is there any evidence that the programme improves knowledge about how infant health can be promoted, and for any such knowledge to be translated into behaviour?
- Is there any evidence that the FNP engenders positive parenting practices and bonding?
- Is there evidence that the client knows about key hazards and engages in practices to keep child safe?
- Do clients mobilise support within personal networks?
- Is there any evidence that FNP reduces domestic abuse?
- How involved are fathers in the FNP process/visits?
- Is the FNP seen to engender fathers' involvement?
- Is there any evidence that mums feels more supported and less anxious/depressed because of the programme?
- Is there any evidence to indicate that FNP leads to fewer unplanned pregnancies, and help mums work out what they want to achieve, and supports them in realising their plans?
- Is there any evidence that the FNP programme leads to improved child health and development?

Using a unique code to enable cross referencing of each evaluation question to the outputs and outcomes in the implementation logic models, the framework detailed:

- the indicator(s) that would be used
- whether this output/indicator was a fidelity requirement or goal (and if so, defining the criteria for a 'programme alert' that would serve to provide a timely warning of any failure to achieve the programme's recommended inclusion criteria and/or intervention 'dosage')

- who would collect the data, how and when;
- who would analyse the data; and
- whether there were additional considerations that should be borne in mind.

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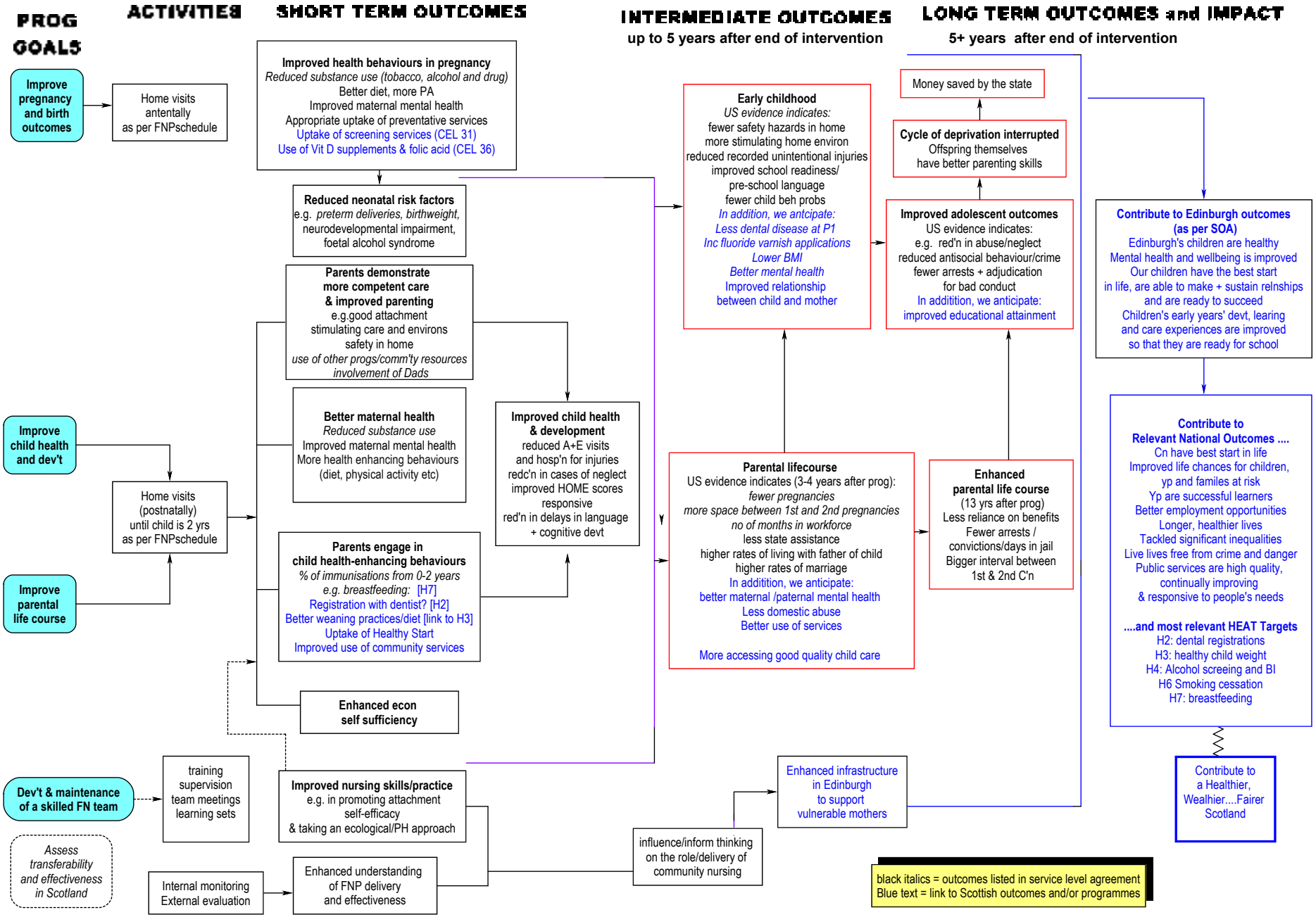
1.4.1 Identification of problematic data/data sources for evaluation purposes

There were a few outcomes (and associated questions) that were considered to be of interest, that, while included in the monitoring and evaluation framework, were (explicitly) identified as problematic either because of difficulties in collecting good data and/or of drawing conclusions that could enable attribution of any effect to the FNP. For example, the question is there any evidence that the infants in the programme are not being maltreated? will be monitored (routinely) but the associated question - can this be attributed to the FNP? cannot be answered as the 'expected' numbers of cases is likely to be very small (given the small cohort) making it difficult to draw any conclusions about FNP effectiveness in relation to this outcome. Furthermore, there is no obvious and useful proxy measure: for example, referrals to social services could be considered as a 'good' or as 'bad' thing. Similarly, the question -is there any evidence that the FNP results in fewer accidents? is problematic as those data that are routinely collected do not provide a meaningful basis for comparison because, for example, not all cases of unintentional injury result in admission to A&E departments, and not all admissions to A&E are for serious injury.

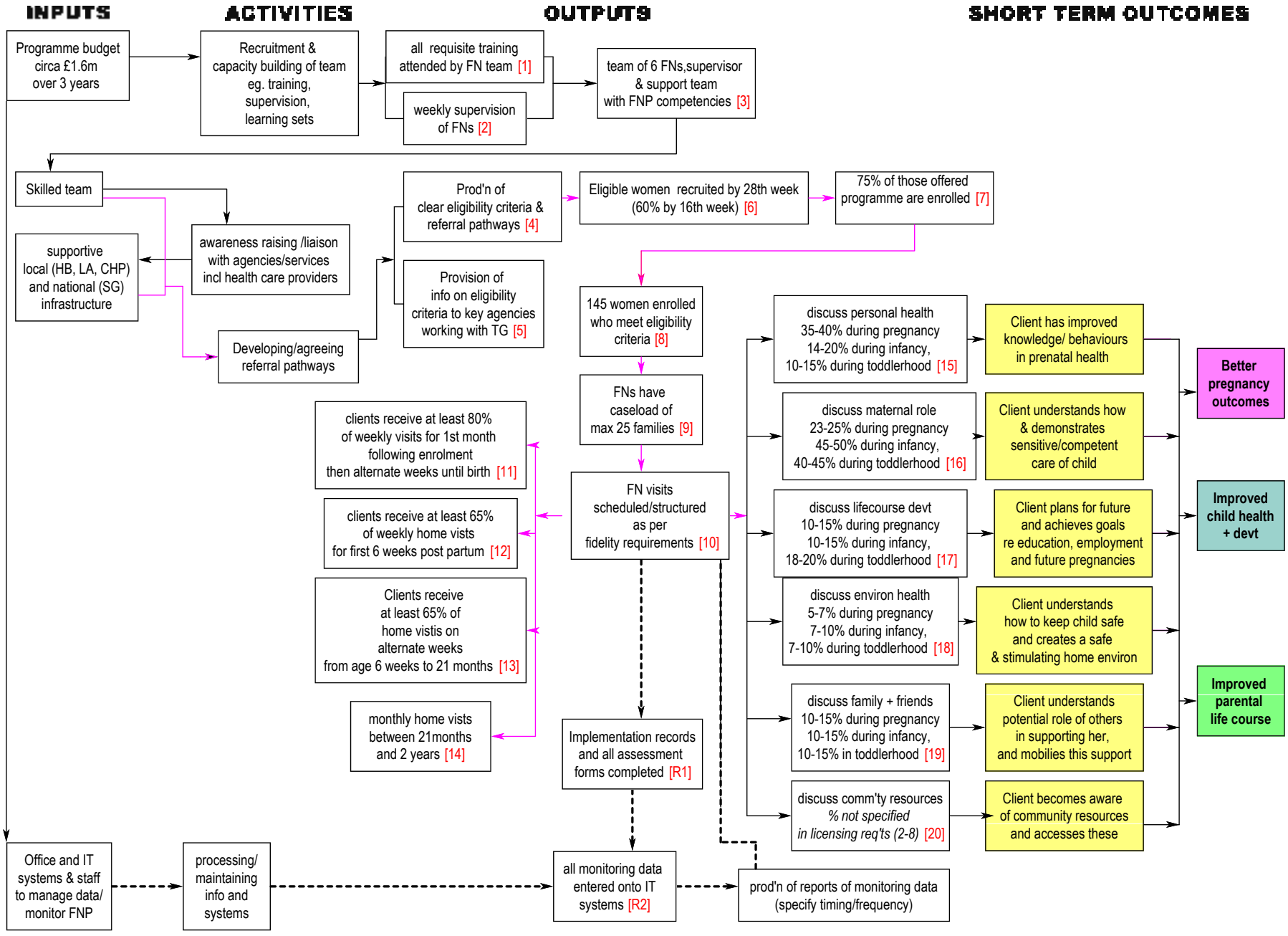
While the FNP is required to collect data across a number of measures (such as accidents, maltreatment etc.) in order to ensure it meets the needs of its clients, not all these measures are core to the evaluating whether the FNP has been implemented as intended or whether/how it has been effective. Rather they provide additional information to help us (simply) describe and profile those involved in the programme

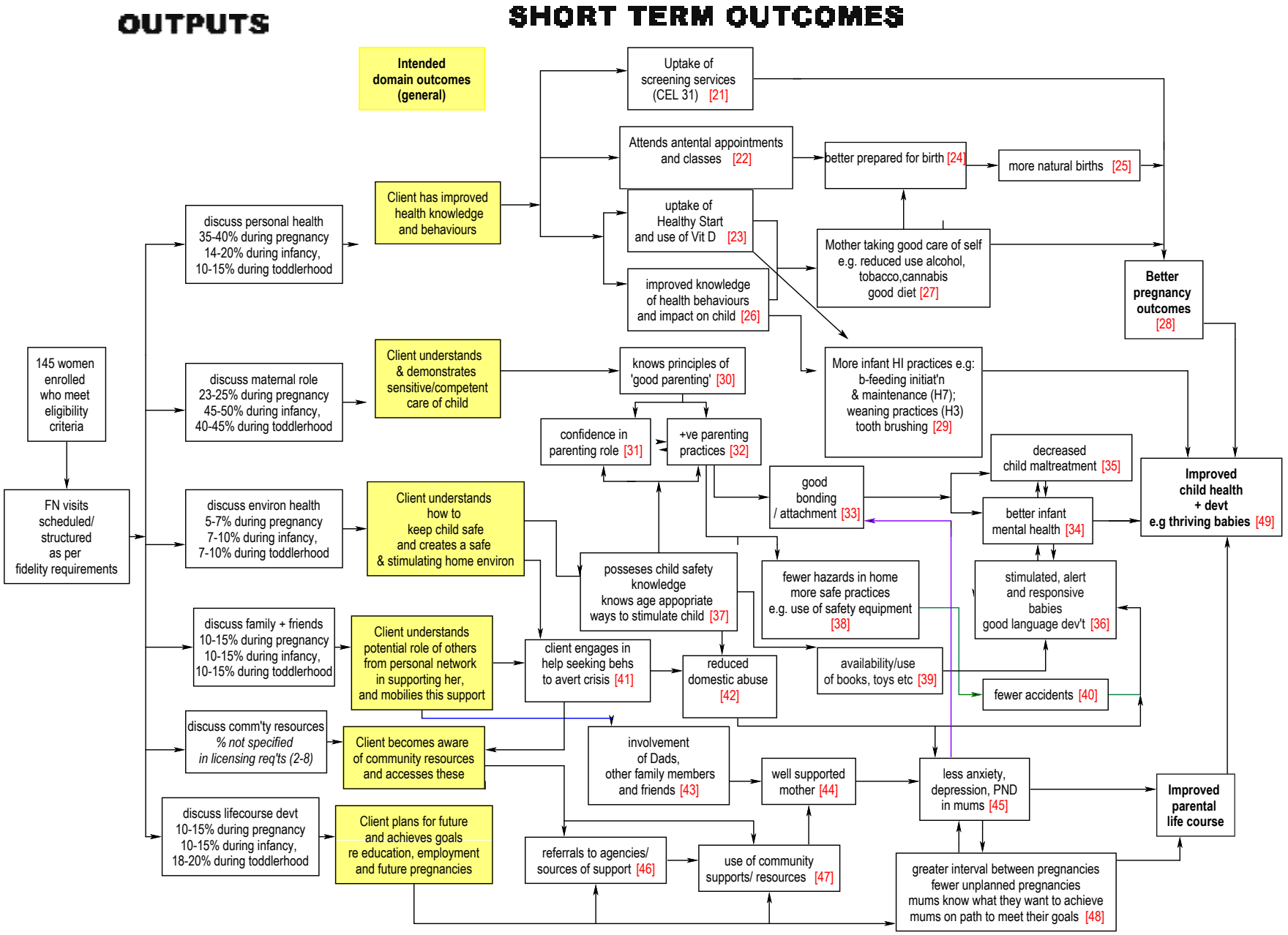
The monitoring and evaluation framework was agreed and 'signed off' in February 2010. Since then, it has provided the template for capturing the 'core data set' on which the commissioned evaluation is based.

Appendix D: Logic models to support FNP Monitoring & Evaluation Framework



Developed by Jacki Gordon/ScotCen for Scottish Government


INPUTS
ACTIVITIES
OUTPUTS
SHORT TERM OUTCOMES
Programme budget circa £1.6m over 3 years
Recruitment & capacity building of team eg. training, supervision, learning sets
all requisite training attended by FN team [1]
weekly supervision of FNs [2]
team of 6 FNs,supervisor & support team with FNP competencies [3]
Skilled team
supportive local (HB, LA, CHP) and national (SG) infrastructure
awareness raising /liaison with agencies/services incl health care providers
Developing/agreeing referral pathways
Prod'n of clear eligibility criteria & referral pathways [4]
Provision of info on eligibility criteria to key agencies working with TG [5]
Eligible women recruited by 28th week (60% by 16th week) [6]
75% of those offered programme are enrolled [7]
145 women enrolled who meet eligibility criteria [8]
FNs have caseload of max 25 families [9]
FN visits scheduled/structured as per fidelity requirements [10]
clients receive at least 80% of weekly visits for 1st month following enrolment then alternate weeks until birth [11]
clients receive at least 65% of weekly home vists for first 6 weeks post partum [12]
Clients receive at least 65% of home vistis on alternate weeks from age 6 weeks to 21 months [13]
monthly home vists between 21months and 2 years [14]
Implementation records and all assessment forms completed [R1]
discuss personal health 35-40% during pregnancy 14-20% during infancy, 10-15% during toddlerhood [15]
discuss maternal role 23-25% during pregnancy 45-50% during infancy, 40-45% during toddlerhood [16]
discuss lifecourse devt 10-15% during pregnancy 10-15% during infancy, 18-20% during toddlerhood [17]
discuss environ health 5-7% during pregnancy 7-10% during infancy, 7-10% during toddlerhood [18]
discuss family + friends 10-15% during pregnancy 10-15% during infancy, 10-15% in toddlerhood [19]
discuss comm'ty resources % not specified in licensing req'ts (2-8) [20]
Client has improved knowledge/ behaviours in prenatal health
Client understands how & demonstrates sensitive/competent care of child
Client plans for future and achieves goals re education, employment and future pregnancies
Client understands how to keep child safe and creates a safe & stimulating home environ
Client understands potential role of others in supporting her, and mobilies this support
Client becomes aware of community resources and accesses these
Better pregnancy outcomes
Improved child health + devt
Improved parental life course
Office and IT systems & staff to manage data/ monitor FNP
processing/ maintaining info and systems
all monitoring data entered onto IT systems [R2]
prod'n of reports of monitoring data (specify timing/frequency)


OUTPUTS
SHORT TERM OUTCOMES
Intended domain outcomes (general)
145 women enrolled who meet eligibility criteria
FN visits scheduled/ structured as per fidelity requirements
discuss personal health 35-40% during pregnancy 14-20% during infancy, 10-15% during toddlerhood
discuss maternal role 23-25% during pregnancy 45-50% during infancy, 40-45% during toddlerhood
discuss environ health 5-7% during pregnancy 7-10% during infancy, 7-10% during toddlerhood
discuss family + friends 10-15% during pregnancy 10-15% during infancy, 10-15% during toddlerhood
discuss comm'ty resources % not specified in licensing req'ts (2-8)
discuss lifecourse devt 10-15% during pregnancy 10-15% during infancy, 18-20% during toddlerhood
Client has improved health knowledge and behaviours
Client understands & demonstrates sensitive/competent care of child
Client understands how to keep child safe and creates a safe & stimulating home environ
Client understands potential role of others from personal network in supporting her, and mobilies this support
Client becomes aware of community resources and accesses these
Client plans for future and achieves goals re education, employment and future pregnancies
Uptake of screening services (CEL 31) [21]
Attends antental appointments and classes [22]
uptake of Healthy Start and use of Vit D [23]
improved knowledge of health behaviours and impact on child [26]
better prepared for birth [24]
more natural births [25]
Mother taking good care of self e.g. reduced use alcohol, tobacco,cannabis good diet [27]
Better pregnancy outcomes [28]
knows principles of 'good parenting' [30]
confidence in parenting role [31]
+ve parenting practices [32]
More infant HI practices e.g: b-feeding initiat'n & maintenance (H7); weaning practices (H3) tooth brushing [29]
good bonding / attachment [33]
decreased child maltreatment [35]
better infant mental health [34]
Improved child health + devt e.g thriving babies [49]
posseses child safety knowledge knows age appopriate ways to stimulate child [37]
fewer hazards in home more safe practices e.g. use of safety equipment [38]
stimulated, alert and responsive babies good language dev't [36]
client engages in help seeking behs to avert crisis [41]
reduced domestic abuse [42]
availability/use of books, toys etc [39]
fewer accidents [40]
involvement of Dads, other family members and friends [43]
well supported mother [44]
less anxiety, depression, PND in mums [45]
Improved parental life course
referrals to agencies/ sources of support [46]
use of community supports/ resources [47]
greater interval between pregnancies
fewer unplanned pregnancies
mums know what they want to achieve
mums on path to meet their goals [48]

Appendix E: FNP core model elements and fidelity ('stretch') goals

Taken from Family Nurse Partnership (FNP) Management Manual November 2010.

Section 2 - Licensing Requirements – Guidance

Introduction

The University of Colorado owns the intellectual property rights of the Nurse-Family Partnership (NFP). The Department of Health and SG, working jointly with the Department for Children Schools and Families (DCSF) and SG Early Years Team, have negotiated that sites will be able to test the programme, known as the Family Nurse Partnership in Scotland and England.

The programme is licensed to make sure that the original research conditions are replicated so that we can be confident that the benefits to children and families are realised. We are testing the FNP because of its strong evidence base so it is important not to dilute or change the programme. Any adaptations need to be agreed with the SG FNP Team who will in turn work with FNP National Unit.

Fidelity

The Nurse-Family Partnership (known as the FNP in and Scotland England) is a licensed programme that has been developed, researched and refined over 30 years in the USA. The FNP programme can only be used under license and fidelity measures are used to monitor implementation.

There are 2 main systems for ensuring fidelity to the original research:-

1. The **Core Model Elements** of the programme cover the visiting regime, staffing requirements, client eligibility and the supporting organisational structures and processes needed. These are the core requirement of the licensing conditions.

2. The **FNP Fidelity Goals** relate to the delivery of the programme to clients and cover client retention, visit dosage and coverage of domains. These are stretch goals and give sites and the SG FNP Team and FNP National Unit a benchmark against which to assess delivery. In the testing phase it can be challenging to achieve these goals so the supervisor and the team use them to monitor their progress towards meeting them.

The FNP Core Model Elements

Core model elements are prescribed for 5 aspects of the programme:-

i. Client enrolment and engagement
ii. Family nurse recruitment, training and working practices
iii. Supervisor recruitment, training and working practices
iv. Administrative support
v. Interpreter support

FNP leads, supervisors and family nurses should be familiar with these requirements and ensure that they adhere to them.

i. Clients:

- Enrolment and participation in the FNP is voluntary.
- Eligible clients include first-time mothers only.
- Eligible clients include high risk mothers only – during the testing phase this is 19 years and under at last LMP.
- Sites enrol at least 60% of clients by the 16th week of pregnancy and 100% no later than the 28th week.
- Each client enrolled is visited by the same family nurse throughout her pregnancy and the first 2 years of her child's life.

ii. Family Nurses:

- Are registered with the Nursing and Midwifery Council (NMC), are educated to degree level and meet the person specification for a family nurse.
- Follow the FNP learning programme and attend all FNP specific essential training.
- Follow the FNP Home Visit Guidelines 1) original visit schedule, which specifies the frequency and timing of home visits; and 2) the adapted programme guidelines, which specify the desired structure and content of each visit, and programme assessments and interventions to be used.
- Apportion home visit time among content domains within the ranges specified.
- Actively participate in FNP supervision as specified.
- Be trained in specified approaches for establishing therapeutic relationship and motivating clients for positive behaviour changes.
- Carry a caseload of no more than 25 families per full-time employee.
- Work at least 3 days a week (20 hours per week) on the programme. Collect data about activity, visit content, mothers, and children according to the schedule and procedures specified by the international partner's data management team and approved by Professor David Olds.
- Will work exclusively in this programme.

iii. Programme Supervisors:

Each programme supervisor will:-

- Be registered with the NMC, at least equivalent in education and training to family nurses, preferably educated to masters level, and meet the person specification requirements.
- Follow the FNP learning programme and attend all FNP essential training, as well as supervisor training and action learning sets.
- Carry a supervisory load of no more than 8 family nurses (per full-time programme supervisor).
- Carry a small clinical caseload (2-3 families).
- Work at least 3 days (hours per week) on the programme.
- Use programme reports to assess and manage areas where systems, organisational, or operational changes are needed in order to enhance the overall quality of programme operations and to inform reflective supervision with each family nurse.
- Meet one-on-one with each family nurse at least weekly to provide supervision, preferably in person but by telephone where travel constraints limit family nurse or programme supervisor mobility.
- Conduct at least 4 team meetings per month: 2 to discuss programme implementation and 2 case discussions to identify client problems and solutions.
- Develop opportunities for learning within the team and invite experts from other disciplines to participate in case discussions whenever cases require such consultation.
- Make a minimum of one home visit every 4 months with each family nurse.

iv. Administrative Support:

Each site will employ a person (at least 0.5 full-time equivalent per 100 mothers enrolled) to provide support to the family nurses and programme supervisor, including:-

- Ensuring that data about family nurse activity, visit content, mothers, and children are submitted completely and accurately on a timely basis.
- Providing general administrative support.

v. Interpreter Support:

In addition to the research-based core model elements, we have added a further element regarding requirements for working with non-English speaking clients within FNP. Sites may wish to offer eligible non-English

speaking families the programme. If so trained interpreters will be needed to work with family nurses.

Where local demography indicates a predominant second language in the local community, sites will ensure that a consistent interpreter is available to support the programme. Where a number of languages are used, sites will work with local interpreting providers to ensure that wherever possible consistency of interpreter is achieved for each client.

The supervisor will be responsible for ensuring that the interpreters are given adequate training in FNP and use of interpreters will follow the FNP guidance (Ref 3.14).

Supervisors should discuss with interpreting providers responsibility for supervision and support of interpreters both within and outside of FNP.

FNP Fidelity Goals

The FNP fidelity goals have been set using the achievements of the NFP teams in the US research trials. In contrast to the core model elements, the fidelity goals are designed to be "stretch goals" in recognition that achievement of these fidelity goals is not solely under the control of the family nurse. However, the US research indicates that reaching these goals, or being close to them, will maximise the site's likelihood of achieving the same results as those found in the research trial. Supervisors will be sent regular reports detailing their team and individual family nurse achievements against these goals and will use these to learn about and reflect on their progress.

The stretch goals cover 4 main areas and some of the measures overlap with the core model elements:-

A. Recruitment
B. Retention of clients (measured by attrition rates)
C. Amount of programme received ("dosage" as measured by visits)
D. Appropriateness of programme content received (measured by the time spent of each domain).

A. Recruitment and Enrolment

The programme attains enrolment goals of:-

- At least 60% enrolled before 16 weeks of pregnancy and 100% no later than the 28 weeks.
- 100% clients enrolled are first-time mothers, within the specified site age bracket.
- 75% of eligible clients who are offered the programme are enrolled.

- Each family nurse enrols 25 families (or pro rata adjusted) within 9 months of recruitment commencing.

B. Attrition

Clients leave the programme at no more than these rates:-

- Cumulative programme attrition is 40% or less through to the child's second birthday:-
  - ⇨ 10% or less during the pregnancy phase.
  - ⇨ 20% or less during infancy phase
  - ⇨ 10% or less during toddlerhood

C. Dosage

Clients receive:-

- 80% or more of expected visits during pregnancy
- 65% or more of expected visits during infancy
- 60% or more of expected visits during toddlerhood
- On average, length of home visits with participants is around 60 minutes.

D. Programme Content

It is expected that the content of home visits reflect variation in developmental needs of participants across the programme phases:-

Average Time Devoted to Content Domains during Pregnancy	
Personal Health	35-40%
Environmental Health	5-7%
Life Course Development	10-15%
Maternal Role	23-25%
Family and Friends	10-15%

Average Time Devoted to Content Domains during Infancy	
Personal Health	14-20%
Environmental Health	7-10%
Life Course Development	10-15%
Maternal Role	45-50%
Family and Friends	10-15%

Average Time Devoted to Content Domains during Toddlerhood	
Personal Health	10-15%
Environmental Health	7-10%
Life Course Development	18-20%
Maternal Role	40-45%
Family and Friends	10-15%

Appendix F: Summary of National Learning Programme

Taken from Family Nurse Partnership (FNP) Management Manual November 2010.

Family Nurses and Supervisors

CONTENT	WHEN?	WHO FOR?
Supervisors 3-day residential training	2 months before Pregnancy training	Supervisors
Supervisors facilitate team based learning prior to residential training	Just prior to Pregnancy training	Supervisors and family nurses
Supervisors Learning Set: monthly in London	Starts the month before the Pregnancy training	Supervisors
Pregnancy Training - 5 day residential		Supervisors and family nurses
FNP information system and data gathering	2 weeks after pregnancy training	Supervisors, administrators and one family nurse
Masterclass: Perinatal Mental Health – one day	Month after Pregnancy training	Supervisors and family nurses
Understanding Your Baby - one day	One or 2 months after Pregnancy training	Supervisors and family nurses
Motivational Interviewing (MI): 2 days residential (provided regionally)	2 months after Pregnancy training	Supervisors and family nurses
Motivational Interviewing for Supervisors - one day	3 months after Pregnancy training	Supervisors
Supervisors facilitate team based MI skills development and practice sessions	Between core MI training and MI skills development training	Supervisors and family nurses
Motivational Interviewing Skills Development - one day (provided regionally)	2 months after first MI training	Supervisors and family nurses
Extended Motivational Interviewing skills for supervisors	3 months after first MI training	Supervisors
Supervisors facilitate team based MI skills development and practice sessions	Following MI skills development training	
Masterclass: Compassionate Mind Training – one day	3 or 4 months after Pregnancy training	Supervisors and family nurses
Supervisors facilitate team based learning prior to Infancy training	One to 2 weeks prior to Infancy training	Supervisor and family nurses
Safeguarding Supervision – 2 + one day	3 months after Pregnancy training	Supervisors
Infancy Training – 5 days residential	4 months after Pregnancy training	Supervisors and family nurses

Supervisors facilitate team based learning “Getting started with observation of caregiver/child interactions”	8 weeks prior to Caregiver/child observation training	Supervisors and family nurses
Caregiver/Child Observation training – one day (regional)	2-3 months after Infancy training	Supervisors and family nurses
Supervisors facilitate team based learning using centrally provided materials	Following caregiver/child observation training	Supervisors and family nurses
Caregiver/Child observation training – 2 days (regionally provided)	6-8 weeks after first observation training	Supervisors and family nurses
Toddlerhood Training – 2 days residential	13 months after Pregnancy training	Supervisors and family nurses
Extending Practice Workshops x 2 per year	5 and 11 months after Pregnancy training	Supervisors and family nurses
Strength Based Leadership – up to 4 days	Anytime during first 12 months	FNP leads and other managers

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