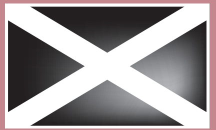

Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 3rd Report – Infancy

Health and Community Care

social research

EVALUATION OF THE FAMILY NURSE PARTNERSHIP PROGRAMME IN NHS LOTHIAN, SCOTLAND: 3RD REPORT – INFANCY

Rachel Ormston & Susan McConville
ScotCen Social Research

Scottish Government Social Research
2012

This report is available on the Scottish Government Social Research website (www.scotland.gov.uk/socialresearch) only.

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

© Crown copyright 2012
You may re-use this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit http://www.nationalarchives.gov.uk/doc/open-government-licence/ or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or e-mail: psi@nationalarchives.gsi.gov.uk

ACKNOWLEDGEMENTS

First and foremost, we would like to thank all the FNP clients, Family Nurses and stakeholders who gave up their time to take part in interviews for this evaluation, and especially to Val Alexander and her team for their help with recruitment of clients and for their ongoing participation in the study.

We would like to also thank everyone involved in contributing to and supporting the evaluation: Jacki Gordon, for leading the development of the Monitoring and Evaluation Framework and for her ongoing advice and input; Vanessa Strong (NHS Lothian) and Dr Jamie Reid (NHS Education for Scotland) for their work on preparing the FNP Edinburgh monitoring data included in this report; Victoria Milne (Scottish Government), for her advice throughout the evaluation process; and the rest of the Evaluation Advisory Group (Jonathan Wright, Carolyn Wilson and Gail Trotter, Scottish Government; Val Alexander and Sally Egan, NHS Lothian; Lynn Porteous, City of Edinburgh Council; and Ann Kerr, NHS Health Scotland) for their ongoing advice and support.

Thanks are also due to Irene Miller for her help with interviewing clients and nurses; and to Louise Marryat, Martine Miller, Claudia Martin and Fiona Dobbie for their input at earlier stages of the evaluation.

Responsibility for this report, and for all interpretation of the data, lies solely with the authors.

Rachel Ormston & Susan McConville

Table of Contents

EXECUTIVE SUMMARY I

Is the programme being implemented as intended? i
How does the programme work in NHS Lothian, Edinburgh? i
How do Nurses, clients and wider services respond to the programme? i
What factors support or inhibit delivery of the programme? ii
What are the implications for future nursing practice? iv
What is the potential for FNP to impact on short, medium and long-term outcomes relevant to Scotland? iv

1 BACKGROUND AND INTRODUCTION 1

About this report 1
The Family Nurse Partnership (FNP) programme 1
Testing FNP in Scotland 2
FNP in NHS Lothian, Edinburgh 2

2 SUMMARY OF EVALUATION AIMS AND METHODS 4

Evaluation aims and objectives 4
Monitoring and evaluation framework 4
Overview of methods and data included in this report 4
Reporting conventions 5

3 RELATIONSHIPS 7

Key questions 7
Key findings 7
Introduction 8
Client retention and attrition 8
Level of contact between clients and Family Nurses 9
Nature and impact of the client-Family Nurse relationship 11
Relationship between FNP and the client's wider family 13

4 OVERALL DELIVERY AND VIEWS OF PROGRAMME CONTENT DURING THE INFANCY PHASE 16

Key questions 16
Key findings 16
Introduction 16
Visit content figures 16
Overall views of programme content during infancy 17
Challenging topics 18

5 PARENTING, CHILD HEALTH AND DEVELOPMENT 20

Key questions 20
Key findings 20
Introduction 20
Bonding, attachment and parenting practice 21
Bonding and attachment 21
Routines 22
Infant feeding 22
Breastfeeding 22
Weaning 23
Baby health and safety 24
Immunisations 24
Safety in the home environment 25
Baby development 26

6 MATERNAL HEALTH, WELLBEING AND FUTURE PLANS 27

Key questions 27
Key findings 27
Maternal health and wellbeing 27
Health behaviours 28
Mental and emotional health 28
Second pregnancies 29
Contraception 30
Future plans around work and education 30

7 SERVICES, RESOURCES AND REFERRALS 33

Key questions and outcomes 33
Key findings 33
Introduction 33
Referrals to other services during infancy 33
Perceived impact of FNP referrals on clients 34

8 PROFESSIONAL VIEWS AND EXPERIENCES OF DELIVERING FNP 37

Key questions 37
Key findings 37
Introduction 37
Achievements 38
Challenges 39
Workload 39
Other challenges 40
Training and supervision 41

9 IMPLEMENTING FNP IN LOTHIAN 43

Key findings 43
Introduction 43
Stakeholder perceptions of FNP 44
General perceptions 44
Stakeholder views on how FNP compares with other services 46
Communication between FNP and other stakeholders 47
Learning from FNP in Lothian 48

REFERENCES 50

EXECUTIVE SUMMARY

1. The Family Nurse Partnership (FNP) programme is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old.

2. The evaluation of FNP in Scotland focuses on learning from the experience of implementing FNP in the first Scottish test site, based in NHS Lothian, Edinburgh. It is not an experimental impact evaluation, but rather focuses on learning around how the programme works in a Scottish context.

3. This summary outlines the key findings from the third of four evaluation reports. It focuses on learning from the delivery of the programme in NHS Lothian, Edinburgh in the infancy phase (specifically, the period from when clients' babies were 6 weeks old to their first birthdays). The report draws on quantitative data collected for all FNP clients and qualitative interviews with the initial NHS Lothian, Edinburgh FNP team, the FNP National Lead for Scotland, a sub-sample of FNP clients, and local stakeholders from Midwifery, General Practice and Social Work.

Is the programme being implemented as intended?

4. FNP continued to be implemented in NHS Lothian, Edinburgh with a high degree of fidelity to the Core Model Elements and fidelity 'stretch' goals.

    - Attrition during infancy remained well below the fidelity 'stretch' goal (12%, compared with the 20% maximum suggested for that period).
    - The fidelity 'stretch' goal for delivering at least 65% of expected visits to clients during infancy was met for 55% of clients.
    - The average time Family Nurses recorded spending on different topics during infancy came very close to the division suggested in the 'stretch' goals.
    - Family Nurses continue to engage with the intensive supervision required by the programme, which was viewed by the team as '*invaluable*'.

How does the programme work in NHS Lothian, Edinburgh?

How do Nurses, clients and wider services respond to the programme?

5. Both Family Nurses and clients viewed the programme as matching well with client needs during infancy, reporting that individual client requirements could be incorporated by 'agenda-matching' within the broad programme framework. Clients appreciated the dual focus of the programme, on both their child's needs and their own.

6. The NHS Lothian, Edinburgh Family Nurse Partnership team praised the training, supervision and materials associated with the programme. However, they identified a few areas where they felt materials, training or support might require some further development for the Scottish/UK context. These included materials around new relationships and support for Nurses around working with clients when they have a second pregnancy, in addition to materials for working with clients when their baby is being looked-after and materials around binge drinking (discussed in the second evaluation report).

7. Stakeholders from Midwifery, General Practice and Social Work described good working relations between their services and the NHS Lothian, Edinburgh FNP team. Factors that supported this included: initial and ongoing regular and open communication between the FNP team and other services, including attending team meetings of other services; shared electronic records (between Midwifery and FNP); new Family Nurses shadowing Midwives; the quality of Family Nurses' work around shared clients (for example, the quality of their written reports in Child Protection cases); and building on pre-existing working relationships.

8. Suggestions for further improving communication between FNP and other services included: more and/or earlier sharing of the theoretical and research base for the programme and how it would work with particular services, and more regular meetings between Family Nurses and GP practices. The FNP National Unit (Scotland) are currently considering issues around organisational preparation for delivering FNP, including how sites can best engage with GPs and other stakeholders.

9. Local stakeholders were also very positive about what they had seen of the impact of FNP on individual client outcomes. However, some reservations were apparent around:

   - *eligibility criteria for the programm*e - in particular, whether these were too strict
   - *sharing learning* - which was believed to be difficult because of the FNP license, and
   - *The resources associated with FNP* - particularly against a background of resource challenges in mainstream services.

What factors support or inhibit delivery of the programme?

10. The key factor identified by Family Nurses and clients as supporting both delivery of and client engagement with the programme was the strength and nature of the therapeutic relationships Nurses develop with clients. They reported that these relationships had continued to grow during infancy, enabling Family Nurses to provide more effective support as clients became more willing to share issues and feelings with them – particularly around mental health and emotional wellbeing. Family Nurses noted that this therapeutic relationship could be particularly valuable in cases where there was a child protection issue. Although these situations could also challenge Nurse-client relationships, the consistency of Family Nurses' contact with clients was seen as a central factor in keeping clients engaged with both FNP and with wider services.

11. The Partners in Parenting Education (PIPE) and DANCE tools were described by Family Nurses as particularly valuable in supporting delivery of content around parenting and parent-child interactions during infancy. They suggested that refresher training around these tools would be helpful to ensure Family Nurses are able to make the most effective use of them in visits.

12. Supervision continued to be viewed as '*invaluable'* in supporting Family Nurses to deliver FNP: one Family Nurse view was that *'You couldn't do it without supervision or the level of supervision.*

13. Managing workload to deliver scheduled visits and meet other requirements of the job remained a key challenge for the NHS Lothian, Edinburgh Family Nurse team. Delivery of the programme was described as presenting many challenges in terms of working patterns. While one view was that there was an improving trend, another was that difficulties containing the work without working additional hours persisted.

14. As in previous reports, factors identified by the NHS Lothian, Edinburgh Family Nurse team as contributing to high workloads included a combination of different kinds of issues. Additional hours at this stage of the programme related to:

    - The fact that the team is embedded within the NHS and has to adapt to changing demands and processes within the wider service.
    - Administrative changes within the team and the implementation of an improved system of electronic record keeping. The loss of the data administrator post compounded pressure on the team during this period. During the three month gap before the post was re-filled, there was recognition by the team of how essential this role is for sites. An additional nurse was also funded at this time to support the development of an new team Supervisor and increased responsibilities of national lead Supervisor.
    - The fact that NHS Lothian, Edinburgh was the first Scottish FNP site, so was called on for advice and support more than may be the case in the future as FNP becomes more established in other areas.

15. In relation to barriers to meeting the fidelity 'stretch' goal around the number of visits, the team also noted that fitting in 'missed' visits could be particularly challenging during infancy. Family Nurses have full case loads and are seeing most clients weekly or fortnightly during this period. A high degree of flexibility around appointment times is also required as clients (re)start work or education. The FNP Supervisor has worked closely with the nurses to develop strategies for addressing these challenges. One Family Nurse suggestion was that additional training around capacity planning and different electronic tools that could be used to support this might be helpful.

16. Additional challenges the NHS Lothian, Edinburgh Family Nurse Team identified in relation to delivery of the programme during infancy included:

    - *'Intergenerational influences'* on clients' beliefs about parenting, particularly in relation to weaning. Family Nurses reported addressing this by exploring family cultures around weaning with clients and explaining the changing nature of research and advice in this area to both clients and their wider families.
    - *The availability of appropriate local services.* FNP aims to ensure young mothers feel more supported by linking them with appropriate local services. However, while Family Nurses in NHS Lothian, Edinburgh were referring clients to a very wide range of services, they also reported some concerns around the both the availability and suitability of generic services for teenage parents (for example, in relation to mother and baby groups or domestic violence support).
    - *Balancing the requirements of child protection supervisions with supervision of other FNP clients*. Increased face-to-face supervision using a tri-partite process which includes the FNP Supervisor and local Child Protection Advisor has now been implemented across all FNP sites in Scotland. The increase in frequency of Child Protection supervisions since the start of the programme in NHS Lothian was felt to be impacting on the time available for focusing on other clients within the Supervisor-Family Nurse supervision schedule. It was recognised, however, that this issue may need to be considered at a Scotland-wide level.

What are the implications for future nursing practice?

17. Some potential implications for future nursing practice were discussed in the second FNP Scotland evaluation report. FNP continues to contribute to formal discussions around supporting Public Health nurses and Health Visitors through links with the Chief Nursing Officer. NHS Tayside (the second FNP site in Scotland) has begun work on a programme of development for Health Visitors, building on some of the principles of FNP – around motivational interviewing and the nature of leadership and supervision, for example. It was also felt that FNP has the potential to contribute to learning around co-production with service users – including older people and others beyond FNP's own client group.

What is the potential for FNP to impact on short, medium and long-term outcomes relevant to Scotland?

18. As noted above, the Evaluation of FNP in NHS Lothian, Scotland, is not a formal impact evaluation and cannot conclusively establish causal links between FNP and particular outcomes. The 'Building Blocks' Randomised Controlled Trial in England will provide this evidence within a UK context. However, interviews with Family Nurses and clients in NHS Lothian, Edinburgh continue to highlight a wide range of areas where participation in FNP was perceived to have a positive impact. In particular, there was evidence that it has the potential to support young mothers to:

    - Develop skills as competent, confident parents

- Engage in activities to support attachment with their child
- Delay weaning
- Assess their home for safety from the perspective of their child, and access practical home safety equipment
- Become more physically active
- Access contraception when they might not otherwise have pursued this
- Feel better supported in relation to their own mental and emotional health and wellbeing
- Link with appropriate community support to help them feel less isolated
- Resolve or manage relationship conflicts
- Navigate and access housing and benefit services and grants, and
- Broaden the options they consider around education or work, formulate goals and overcome barriers.

1 BACKGROUND AND INTRODUCTION

About this report

1.1 The Family Nurse Partnership (FNP) programme is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old.

1.2 The evaluation of FNP in Scotland focuses on learning from the experience of implementing FNP in the first Scottish FNP test site, based in NHS Lothian, Edinburgh. It focuses on process and understanding how the programme works in a Scottish context.

1.3 This third evaluation report focuses on the delivery of the programme in the infancy period (specifically, the period from when clients' babies were 6 weeks old to their first birthdays). Two earlier reports (Martin et al, 2011 and Ormston et al, 2012) focused, first, on the early implementation and early pregnancy period and second, on late pregnancy to around 6 weeks post-partum. The next report (due spring 2013) will discuss learning from delivering the programme in toddlerhood (12-24 months). This report focuses explicitly on *new* findings emerging from the data collected for the infancy period. Findings already discussed in Martin et al (2011) and Ormston et al (2012) are not revisited in any detail here.

1.4 The remainder of this introductory chapter describes the FNP programme and its implementation in Scotland in more detail. Chapter 2 briefly outlines the evaluation methods and aims, while chapters 3 to 9 discuss the main findings from this phase of the evaluation, covering:

- **Relationships** between clients and their Family Nurses (chapter 3)
- Delivering **programme content** and its potential impact on client outcomes during infancy (chapters 4 to 6)
- **Services, resources and referrals** (including perceptions of working relations between FNP and other services) (chapter 7)
- **Professional views** of the main achievements and challenges of delivering the programme in the period since the last evaluation report, and their experience of training and supervision (chapter 8)
- Additional **strategic learning** from the experience of implementing FNP in Lothian (chapter 9).

The Family Nurse Partnership (FNP) programme

1.5 The FNP programme was developed in the USA (where it is called the 'Nurse Family Partnership' (NFP) programme) by Professor David Olds (University of Colorado, Denver). Based around a structured programme of home visits to the mother (and, after birth, the mother and child) delivered by trained Family Nurses, it is a preventative programme, aimed at first time mothers and their babies. The programme's goals are to improve pregnancy outcomes, the

health, development and well-being of first time parents and their children, and families' economic self-sufficiency. For a summary of the key theoretical approaches underpinning FNP, see Olds, 2006.

1.6 FNP is a licensed programme, such that new sites are only permitted to run the programme and access the materials and training associated with it if they sign up to an agreement to implement it according to specified fidelity requirements. Referred to in the FNP Management Manual (Department of Health FNP National Unit, adapted for Scottish FNP sites, November 2010) as '**Core Model Elements'**, these licensing requirements cover:

- the visiting schedule (specifying the frequency of Family Nurse visits to clients throughout pregnancy until the child is two)
- staffing requirements (for example, the professional and personal characteristics of Family Nurses)
- client eligibility (for example, the point in pregnancy by which mothers should be enrolled), and
- the organisational structures and processes needed to support the programme (including training, supervision and administrative support).

1.7 In addition, the FNP Management Manual sets out various fidelity goals – described as 'stretch goals'[1]. 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.

Testing FNP in Scotland

1.8 The background to and history of FNP's introduction in the UK is described in Martin et al (2011). The first FNP test site in Scotland commenced in NHS Lothian, Edinburgh, with the first clients enrolled from January 2010. Since then, additional Scottish FNP sites have been introduced in NHS Tayside (from July 2011), with further sites in Greater Glasgow and Clyde, Ayrshire and Arran, Fife, Lanarkshire and Highland preparing to start enrolling clients in 2012-2013. Matched funding has also been secured to enable NHS Lothian to move to small scale permanency (i.e. being able to offer the programme on an ongoing basis to every eligible client in the area, without a break in enrolment) starting from Autumn 2012.

FNP in NHS Lothian, Edinburgh

1.9 The NHS Lothian, Edinburgh FNP test site is based in Edinburgh Community Health Partnership (CHP) and delivered by NHS Lothian. The NHS Lothian FNP Edinburgh delivery team was initially comprised of a Supervisor, 6 Family Nurses, and an Administrator/Data Manager, supported by a local FNP Lead in

[1] 'Stretch goals' are goals which the programme aspires to achieve. Based on the US research evidence, these are the optimum goals for ensuring the success of the programme. However, they may be difficult to achieve when first implementing the programme. See Annexes to Martin et al (2011) for a full list of the FNP Core Model Elements and Fidelity 'stretch' goals.

Lothian. The team has subsequently undergone a number of changes reflecting staff departures, expansion, and new responsibilities among the existing team.[2]

1.10 FNP was offered to all eligible women within Edinburgh CHP during the recruitment and enrolment period. 148 women who met the key criteria for participation (living within Edinburgh CHP, first time mothers, aged 19 or under at LMP, and under 28 weeks gestation) were enrolled with FNP in NHS Lothian, Edinburgh over a nine month period in 2010. The first clients delivered their babies in April 2010, so the first cohort of clients started to 'graduate' from April 2012 (when their children turned two years-old), with the full cohort due to complete the programme by the end of April 2013.

[2] Three new Family Nurses started with the team in the first half of 2012. These new Nurses were recruited in part to enable one of the existing team to act up to Supervisor 2 days a week, and in part to prepare the team for offering the programme to all eligible clients on an ongoing basis in the future. The team's original Supervisor remains in place but, at the time of writing, was seconded one day a week to the Scottish Government as the National Lead Supervisor for Scotland. The local FNP Lead for Lothian left at the end of their contract in spring 2012. The team Administrator also left in early 2012 and was replaced after a four month gap. There are also now plans to recruit a second team of 8 Family Nurses in NHS Lothian.

2 SUMMARY OF EVALUATION AIMS AND METHODS

Evaluation aims and objectives

2.1 The overall aim of the evaluation of FNP in Scotland is 'to evaluate the implementation of the programme in Scotland (Lothian), focusing on process and understanding how the programme works in the Scottish context'. In particular, it is intended to assess:

- Whether the programme is being implemented as intended (and if not, why not)
- How the programme works in Scotland (Lothian), looking in particular at:
  - How Nurses, clients and wider services respond to the programme
  - What factors support or inhibit the delivery of the programme, and
  - Implications for future nursing practice
- What the potential is for FNP to impact on short, medium and long-term outcomes relevant to Scotland.

2.2 The evaluation focuses on the experience of delivering FNP in the first Scottish site in NHS Lothian, Edinburgh, with the expectation that the learning from this will help inform decisions and practice relating to further roll-out of FNP in Scotland.

2.3 This evaluation is **not** an experimental impact evaluation and cannot, therefore, conclusively establish causal links between FNP and particular outcomes. However, where possible, it reports on the evidence for the *potential* for FNP to impact on key outcomes for parents, children and services. The current 'Building Blocks' Randomised Controlled Trial in England (described in Sanders et al, 2011 and due to report final results in 2014) will be able to provide causal evidence, and is therefore likely to be of considerable importance for those with an interest in FNP in Scotland too. Further details about the remit for the evaluation are provided in Martin et al (2011).

Monitoring and evaluation framework

2.4 The evaluation of FNP in NHS Lothian, Edinburgh is informed by a monitoring and evaluation framework, developed by Jacki Gordon in discussion with key stakeholders from Scottish Government, NHS Lothian and City of Edinburgh Council. The key questions set out at the start of the findings chapters in this report are taken from this framework (see Martin et al, 2011 for full details).

Overview of methods and data included in this report

2.5 The evaluation is addressing the aims set out above using a range of quantitative and qualitative methods. These are described in full in Martin et al (2011). This third report draws on:

- **Quantitative data** collected and collated by the NHS Lothian, Edinburgh FNP team for <u>all</u> clients covering the **infancy period** (including data at 6 and 12 months). This data is routinely collected by Family Nurses and

collated and provided to the external evaluation team as anonymised, aggregate figures.[3]

- **Qualitative data** from:
  - A smaller sub-sample of **FNP clients**, interviewed around **12 months** after their babies were born. This was the third occasion on which this longitudinal client 'panel' was interviewed for the evaluation. Of the original panel of 15 clients recruited to the evaluation, 13 were re-interviewed at 12 months.[4]
  - The NHS Lothian, Edinburgh **Family Nurse team** (including the Nurse Supervisors), interviewed in spring/summer 2012.[5] Again, this was the third round of interviews with the team.
  - 6 telephone interviews with key operational and strategic stakeholders from **Midwifery, General Practice and Social Work** in the NHS Lothian area
  - Ongoing interviews with the **FNP National Lead** for Scotland.

2.6 Qualitative data compliments the quantitative data collected for all clients by exploring experiences of the programme in more depth, including aspects that are difficult to quantify. Interviews with local stakeholders are included at this stage in order to explore external views of FNP and its links with wider services. Although the number of stakeholder interviews was small (one strategic and one operational stakeholder from each of Midwifery, General Practice and Social Work), they nonetheless give an indication of how FNP has been received in NHS Lothian and some of the potential challenges and facilitators in communicating with key stakeholders about the programme. Clients' 'significant others' – as nominated by clients themselves – were interviewed for the second evaluation report to explore perceptions of FNP among the wider family. Their views will be included again in the fourth report.

2.7 The evaluation team had also planned to conduct three focus groups over the course of the evaluation with NHS Lothian, Edinburgh FNP clients who were not selected for the longitudinal panel interviews. However, the first two of these groups were not successful, with a high level of non-attendance on the day. Given this, the evaluation team is currently reviewing its strategy for capturing the views of a wider client group beyond the panel.

Reporting conventions

2.8 As discussed above, detailed information from FNP clients, Family Nurses and key stakeholders were collected using a qualitative approach. Qualitative samples are generally small, and are designed to ensure a range of different

[3] Initially by the NHS Lothian Local FNP Lead, and from March 2012 by the newly appointed FNP Research and Information officer, based in NHS Education for Scotland (NES).

[4] One dropped out after their first evaluation interview and another after their second interview.

[5] Note that although the NHS Lothian, Edinburgh Family Nurse team has expanded since the second evaluation interviews (with three new Family Nurses recruited to allow for expansion and cover for existing members of the team who have taken on additional responsibilities), the evaluation interviews are with the original cohort of 6 Family Nurses and the Nurse Supervisor, since the purpose of the evaluation is to capture learning from the first test phase of FNP in Scotland and to explore any changes in Family Nurses' experiences and views over this period.

views and experiences are captured. It is not appropriate given the number of interviews conducted to draw conclusions based solely on the qualitative data about the prevalence of particular views or experiences of FNP. Given this, where possible quantifying language, such as ‘all’, ‘most’ or ‘a few’, is avoided when discussing qualitative findings.

2.9 It is also worth noting that interviews with clients, Family Nurses and stakeholders focused on their *perceptions* of FNP. These perceptions may not necessarily always agree with each other, or with the views of others on how the programme works. However, they each provide valuable information about how the programme is experienced from the point of view of different stakeholders.

2.10 In order to protect the anonymity of clients and Family Nurses, participants are referred to by numbers only. Where participants were in unique or identifiable roles, they were given the opportunity to review their transcripts and/or any sections of the report that summarised their views in a way that might be identifiable or which quoted them directly. Any requests to remove a quote or potentially identifiable summary were always respected.

2.11 Finally, this report does not include any explicit comparisons with quantitative findings from the implementation evaluation of FNP in England (Barnes et al, 2008, 2009 and 2011). This is because the implementation of FNP in Scotland has been informed by the experiences of FNP in England. Any comparisons may not, therefore, be entirely comparing like with like.

3 RELATIONSHIPS

Key questions

- Does the programme meet the fidelity targets for attrition?
- Do the Family Nurses carry out the intended number of visits?
- How feasible is the visiting schedule?
- How involved are fathers in the FNP process/visits?
- Is the FNP seen to engender fathers' involvement?

Key findings

- Client retention remains very high for the first NHS Lothian, Edinburgh FNP cohort – cumulative retention by the end of the infancy phase was 86%. Attrition during infancy (12%) was well below the 20% maximum suggested by the fidelity 'stretch' goal.

- The fidelity 'stretch' goal for delivering at least 65% of expected number of visits during infancy was met for 55% of clients. The average (mean) proportion of expected visits delivered across all clients was 65%.

- Similar facilitators and barriers to meeting the visiting schedule in infancy were identified to those discussed in previous reports. However, it was also noted that fitting in 'missed' visits could be particularly challenging during infancy compared with other periods of the programme, as Family Nurses have full caseloads and are seeing most clients weekly or fortnightly. Flexibility around appointment times was viewed as particularly important in infancy as clients (re)started work or education.

- Both client retention and Family Nurses' ability to meet the visiting schedule are supported by the therapeutic relationship between clients and Family Nurses. Clients and Family Nurses reported that these relationships continued to grow during infancy, enabling Family Nurses to provide more effective support as clients became more willing to share issues and feelings with them.

- The therapeutic relationship was seen as particularly valuable in cases where there was a child protection issue. Although these situations could also challenge client-Nurse relationships, the consistency of Family Nurses' contact with clients could be central in keeping clients engaged with both FNP and wider services.

- 'Relationships with others' was viewed as a key topic for FNP during the infancy period. Clients valued FNP's support in this area highly, reporting that it was helping them achieve goals around parenting and education, resolve relationship conflicts, and feel less isolated.

- The involvement of fathers and/or clients' partners specifically will be considered in more detail in the next evaluation report.

Introduction

3.1 As described in Olds (2006), an 'empathetic and trusting relationship with the mother and other family members' is key to FNP's approach. Family Nurses aim to build 'therapeutic relationships' with their clients, both to model the positive relationships they hope clients will build with their children (drawing on the existing research base for FNP which shows the positive impacts of doing so), and to create trust that will support clients' ongoing engagement with the programme. The holistic focus of FNP – exploring the social, emotional and economic context of clients' lives – also means that Family Nurses often seek to involve other family members, with the aim of enhancing the wider support available to both mother and baby. This Chapter explores how these relationships develop during infancy and how they might promote positive outcomes for clients. However, first it summarises quantitative data on client retention and attrition and the level of contact between Family Nurses and clients in NHS Lothian, Edinburgh.

Client retention and attrition

3.2 Evidence from the US indicates that to deliver FNP with fidelity and to obtain the expected outcomes, cumulative attrition from the programme should not be greater than 40% through to the child's second birthday. In addition, attrition should not be greater than:

- 10% during pregnancy
- 20% during infancy and
- 10% during the toddler phase.

3.3 These are fidelity 'stretch' goals (see Chapter 1 for definition).

3.4 Table 3.1 shows attrition and retention during the pregnancy and infancy phases of FNP in NHS Lothian, Edinburgh. Programme attrition during infancy was 12% - well below the 20% maximum specified in the fidelity 'stretch' goal for this stage. This figure comprises 6 clients who left the programme through moving out of the area or relinquishing their child into long-term care, and 11 clients who became inactive (because they had not had any Family Nurse visits) for 6 months or more by the end of the infancy phase.

Table 3.1: Attrition and retention, NHS Lothian, Edinburgh FNP test site

	Pregnancy phase	Infancy phase[6]
Total number of clients receiving this phase	148	145
Fidelity 'stretch' goal for maximum attrition for phase	10%	20%
Attrition during phase	3% (4/148)	12% (17/145)
Cumulative attrition by end of phase	3% (4/148)	14% (20/148)
Cumulative retention at end of phase	97% (144/148)	86% (128/148)

3.5 The attrition figures presented for pregnancy in Table 3.1 have been corrected since the second evaluation report (Ormston et al, 2012), which stated that pregnancy attrition was 7%. The correct client attrition rate for pregnancy is 3%.[7]

3.6 The second evaluation report (Ormston et al, 2012) included discussion of the perceived reasons for the very low attrition rate during pregnancy and reasons for leaving or becoming inactive where this had occurred. An additional potential trigger for leaving or becoming inactive during infancy related to challenges fitting in FNP visits as clients started work or college. Although Family Nurses reported offering a high degree of flexibility around appointment times to accommodate changes in clients' schedules, the team reported that in a small number of such cases clients felt the programme involved too great a time commitment.

Level of contact between clients and Family Nurses

3.7 The Core Model Elements for FNP include a visit schedule, which specifies the frequency and timing of home visits. The fidelity 'stretch' goals then include goals for the proportion of the scheduled visits to be achieved for all clients at different stages of the programme (referred to in the FNP Management manual as 'dosage') as follows:

- 80% or more of expected visits during pregnancy
- 65% or more of expected visits during infancy
- 60% or more of expected visits during toddlerhood.

[6] Of the 4 clients who left the programme during pregnancy, 1 rejoined during infancy. This client is therefore included in the bases for infancy attrition and explains why the cumulative total of clients leaving/inactive by the end of infancy is less than the sum of the individual attrition figures for pregnancy and infancy.

[7] The figure in the second report was based on client status at the fixed point when all clients had reached the end of the pregnancy period (that is, the end of April 2011). It therefore erroneously included several clients who actually became inactive after their own babies were born (i.e. during the infancy period). The figures presented in Table 3.1 are based on the status of each individual client when they reach the end of the relevant stage of the programme (i.e. when their own baby was born (end of pregnancy) or turned one (end of infancy)).

3.8 The visit schedule varies depending on the stage of the programme. The aim is for clients to receive weekly visits for the first 4 weeks after enrolment, and then fortnightly visits until the baby is born. After the birth, clients are visited weekly for the first 6 weeks, then fortnightly until the child is aged 21 months and monthly for the last 3 months of the programme. Family Nurses complete a 'Home Visit Encounter Form' after each visit, which sites use to monitor the number, length and content of visits.

3.9 The NHS Lothian, Edinburgh FNP site met the fidelity 'stretch' goal (65% or more of scheduled visits) during infancy for 55% (80/145) clients who were still participating at the start of infancy. The average (mean) dosage during infancy was 65%.

3.10 Family Nurses identified similar facilitators and barriers to meeting the visiting schedule during infancy to those discussed in the pregnancy report (Ormston et al, 2012). Key facilitators included Nurse flexibility around appointment times – which, as noted above, became particularly important in infancy as clients started returning to work or education – and client motivation. Challenges again divided into client-related factors – like availability, mobility and/or geographic location – and programme or nurse-related factors, such as additional compulsory training.

3.11 One Family Nurse view was that maintaining the visiting schedule for all their clients was a struggle across the entire programme:

> *I mean, I think the entire programme we struggle with time. We really do. And annual leave always makes it difficult to keep up the fortnightly contact. And I mean just time in general – managing the conflicting priorities of … of all our clients and the different programme components can make it a challenge to fit the schedule.*
> (Family Nurse 5)

3.12 However, the NHS Lothian, Edinburgh Family Nurse team also commented that fitting in 'missed' visits was particularly challenging during the infancy period, when Family Nurses have full caseloads and are typically seeing some of their clients weekly (in the six weeks after birth) and others fortnightly. It was noted that if the baby was not present when the Family Nurse arrived, this multiplied the number of visits required from infancy onwards (since although the mother is the client, Family Nurses are the professionals responsible for delivering Hall 4[8] to the baby and therefore need to see the child at each visit). Meanwhile, the impact of the programme on increasing clients' confidence was also cited by the team as something that, on occasion, could result in reduced engagement with the visiting schedule in infancy:

> *I think there were elements of their belief in themselves, that they were doing OK and they were doing a good job and they were being good parents, even though they valued the project*

[8] 'Health for All Children', child health screening and surveillance requirements – see http://www.scotland.gov.uk/Publications/2005/04/15161325/13269

> *… and they wanted the contact they didn't see them as necessary as they had in pregnancy and the early on in infancy. That makes sense … as they grew in confidence, they felt they needed us less which is good!*
> (Family Nurse 1)

3.13 For discussion of ways in which Family Nurses had tried to manage their visiting schedule and other workload, see chapter 8.

Nature and impact of the client-Family Nurse relationship

3.14 As discussed in the last evaluation report, the client-Family Nurse relationship was seen as key in supporting client retention and the feasibility of meeting the visiting schedule (with this therapeutic relationship motivating clients to keep appointments).

3.15 Clients and Family Nurses interviewed for the evaluation reflected on the ways in which their relationships with each other had developed during the infancy period. In general, Family Nurses felt therapeutic relationships with clients had become '*deeper'* and more trusting during infancy. Consequently, they thought clients had become more open in discussing the issues affecting them, enabling Family Nurses to provide more effective support to clients. The continuity of the Family Nurse-client relationship and the regular contact provided by the visiting schedule were seen as key by Family Nurses in underpinning the effectiveness of the therapeutic relationship in this respect.

> *You're not just dipping in and saying, "Well, I've given somebody a list of places to potentially go to", and not seeing them again, or seeing them again in 2 months. (…) You're building on stuff all the time … but also, people are more likely to tell you what's actually happening for them (…) Sometimes they don't, but ... over time, they tend to get to a point where they're more trusting of you and then actually saying ... what's going on.*
> (Family Nurse 2)

3.16 Conversely, Family Nurses noted that where contact was less frequent, the therapeutic relationship with clients was not as deep.

3.17 Family Nurses suggested that the therapeutic relationship they developed with their clients was a particular help when dealing with cases where there was a child protection issue. The NHS Lothian, Edinburgh FNP team acknowledged that these situations can challenge their therapeutic relationship with clients, particularly where the child protection referral came from the Family Nurse. However, the strength of the relationship and the consistency of their contact with clients were nonetheless seen as crucial in helping keep clients engaged with FNP during these difficult periods. This view was echoed in that of a social worker interviewed for the evaluation, who suggested that the strong therapeutic relationships Family Nurses have with clients can help multi-agency child protection groups keep clients engaged when they might otherwise have struggled because of some clients' '*fear'* of social services. Family Nurses also

reported that the client-Family Nurse relationship can help support challenging conversations around child protection:

> *… certainly in my experience (…) I can reflect on how difficult these conversations could be, and I would suggest that they were probably far easier with this client group because of the long term relationship that we had already established with them.*
> (Family Nurse 1)

3.18 Family Nurses' views of the ongoing development of therapeutic relationships were mirrored in those of clients interviewed for the evaluation. While some clients reported feeling very comfortable with their Family Nurses from the outset, others reported feeling more comfortable with their Family Nurses by their second or third evaluation interviews. Clients' accounts again indicate that the reliability and continuity of this relationship underpinned their willingness to seek support from their Family Nurse, whether about their child's health and development or about their own issues.

> *I know that she would give me advice straight away so it's a good relationship, and I think it makes it good because I know she's there.*
> (Client 1)

3.19 While one client view was that their Family Nurse was like a *'friend'*, clients also emphasised the fact that Family Nurses were professionals and that they were *not* a family member or friend as something they valued. Their professional status meant that clients could discuss problems with them in the knowledge that they would treat them confidentially and non-judgementally and that they would provide a valuable 'outside' and 'professional' perspective on issues or problems:

> *I know if I speak to (Family Nurse) it isn't going no further. Like if I speak to my mum and dad then it'll go back … within my family.*
> (Client 15)

> *(not) having just to rely on other people … who might not have brought up their kids in the best way … Whereas with (Family Nurse) … whatever she tells you, you can just sort of take it on board if you want to. You can take it on board and just use it to, like, your advantage with your child.*
> (Client 3)

3.20 Box 3.1 illustrates the ways in which the Family Nurse – Client relationship can develop over time through the account of the same client across three evaluation interviews, from pregnancy to 12 months after the birth of her child. In one sense, this client's relationship with her Family Nurse differed from that of other panel members, in that she was less happy with their relationship at the time of her second evaluation interview (3 or 4 months after the birth).

However, it also illustrates several recurrent themes from client and Family Nurse interviews around the importance of continuity and reliability of contact on clients' willingness to stay engaged with FNP and to seek support around sensitive or complex issues.

Box 3.1 – The developing therapeutic relationship

This client was very positive about her Family Nurse when interviewed during her pregnancy, describing her as easier to talk to than her midwife, because of the relationship she had with her Family Nurse and the trust she felt in her. She also said that her Family Nurse was flexible about making appointments to fit around the client's schedule.

In her second evaluation interview, around 3 months after her baby was born, this client was somewhat less positive about their relationship. Although she still felt they got on '*quite well'*, they had missed some appointments and she reported that her Family Nurse was sometimes late. She thought this might be because her Family Nurse felt she was better supported by her family than some of her other clients, but she did worry about what it would be like if she experienced a crisis. She had considered stopping FNP, but because she had worked with her Family Nurse for a while by that point she had decided to keep going to see how it went.

By her third evaluation interview, when her baby was around 12 months old, she reported that their relationship was *'a lot better'*. She had experienced a significant crisis in her life since her previous interview, and felt her Family Nurse had been really supportive and had helped her through this. The fact the client had known her Family Nurse from pregnancy and that her Family Nurse knew all the things that had happened to her since this period appeared to be key to her ease in discussing this crisis with her. She felt able to discuss issues with her Family Nurse that she said she would not be able to talk to others about, because she knew her Family Nurse would not tell anyone else unless she had to and because she felt she would not judge her.

Relationship between FNP and the client's wider family

3.21 FNP is underpinned by 'human ecological theory', which highlights the importance of mothers' social, community and family context in influencing their decisions and the ways they care for their children. This is reflected both in the focus of the programme as delivered to clients (exploring their relationships with others and their support networks, for example) and in attempts by Family Nurses to involve other family members in visits where possible and appropriate. During the infancy phase, clients' own parents were involved at some level in 17% of FNP visits; the client's partner, husband or the baby's father[9] were involved in 29% of visits; and clients' friends or other family members in 5% of visits.

[9] Note that the form does not distinguish between these people.

3.22 The second evaluation report discussed Family Nurses', clients' and clients' 'significant others' views on the impact of and barriers to involving the wider family with FNP. This topic was discussed in less detail in infancy evaluation interviews, in part because clients' 'significant others' were not being interviewed at this stage.[10]

3.23 One view among Family Nurses was that other family members were less involved with FNP during infancy, though it was also suggested that family members' involvement remained similar in pregnancy and infancy. However, Family Nurses also commented that even if they were less involved with FNP, other family members were no less influential on clients during infancy – a view reinforced by the fact that, other than their Family Nurse, their own family was identified as a main source of advice about child rearing by panel clients. The fact that clients may find it challenging to weigh conflicting information or advice is illustrated by the following quote from a client, who reported following information from her Family Nurses on some issues, but advice from her mother on others:

> *… it's not like I ken what tae do because obviously (Family Nurse)'s obviously a nurse and my mum's brought kids up herself so it's, it's just tricky. But it's all of it is different, how like (Family Nurse) would tell it to me and my mum would tell me, it's a lot different.*
> (Client 11)

3.24 Family Nurses reflected on the ways in which they supported clients to negotiate situations in which they were receiving conflicting information from their Family Nurse and their own family by involving family members in visits and explaining the research behind changing advice around issues like weaning or immunisations.

3.25 Reflecting more broadly on the impact of FNP on clients' relationships with others, one Family Nurse view was that during the infancy period, relationship counselling and communication work were key client needs. This view was reflected in clients' accounts of the ways in which their Family Nurses had supported them to negotiate relationships with others during infancy, including:

- Supporting them to be more confident when making decisions, whether about their child or their own future (for example, the decision to go to college). One client described how her Family Nurse's support had encouraged her to go to college (which she had now started and was '*loving*') against a lack of family support for this decision:

> *But then she kept saying, "Well, remember that you're doing it for her. You're doing it for your daughter.", and I was like, "Well, aye. I am, but I'm just not feeling much love and support right*

[10] 'Significant others' nominated by clients participating in the evaluation are being interviewed in the fourth round of interviews when clients' children are around 21-24 months old. Their views will therefore be included in the next (fourth) evaluation report.

now!". I was like, "Everyone is expecting me to give up". She was like, "Well, prove them wrong".
(Client 12)

- Support with relationship difficulties – examples included sign-posting to couple's counselling, communication coaching, and information about access arrangements. Clients attributed improved relationships with partners and other family members to the support their Family Nurse had provided in this respect:

  I spoke to (Family Nurse) about it and she obviously gave me like some ideas to try … and it's helped us. Now we're talking and we're getting on a bit better and it's thanks to the nurse that we are.
  (Client 11)

- Putting clients in touch with other young mothers – which was much appreciated where clients had reported feeling 'isolated' in previous interviews.

4 OVERALL DELIVERY AND VIEWS OF PROGRAMME CONTENT DURING THE INFANCY PHASE

Key questions

- Do Family Nurses conduct visits in line with fidelity criteria?
- How is the FNP structure experienced by clients and Family Nurses?[11]

Key findings

- The average time Family Nurses in NHS Lothian, Edinburgh recorded spending on different topics during infancy was very close to the breakdown of coverage of different content domains suggested in the fidelity 'stretch' goals.

- Family Nurses and clients viewed the programme as matching well with client needs during infancy. Both were happy that individual client needs were being met by agenda-matching within the broad programme framework.

- The Partners in Parenting Education (PIPE) and DANCE tools were described by Family Nurses as particularly valuable in facilitating delivery of content around parenting and parent-child interactions.

- Family Nurses comments suggested that it may be worth considering whether materials around new relationships need any further development for the Scottish or UK context.

Introduction

4.1 FNP combines a manualised programme, containing detailed information materials and worksheets for each visit, with an approach that encourages Family Nurses to 'agenda match' to clients' needs at particular points in time. Thus while FNP includes fidelity 'stretch' goals around topic coverage in visits at different stages of the programme, within this Family Nurses are expected to 'flex' the programme to clients' specific needs.

4.2 This chapter briefly reviews the overall delivery of programme content during the infancy phase in NHS Lothian, Edinburgh. In addition to examining whether Family Nurses undertake visits in line with fidelity criteria, it also briefly considers clients' and Family Nurses' overall views of the programme content during this phase, and their perceptions of any topics that were particularly challenging.

Visit content figures

4.3 Fidelity 'stretch' goals around the suggested division of topic coverage are intended to reflect variation in the developmental needs of parents and infants

[11] Note: the Monitoring and Evaluation Framework originally asked 'Is the FNP structure useful/appropriate?'. However, as the evaluation is focusing on the process of implementing FNP in NHS Lothian, Edinburgh, it was felt that it was more appropriate to reframe this in terms of how the structure was experienced in that site.

at different stages. For example, the amount of time allocated to personal health is highest during pregnancy, while after the birth more time is allocated to maternal role. As shown in Table 4.1, the average time Family Nurses in NHS Lothian, Edinburgh recorded spending on different topics during infancy came very close to the fidelity 'stretch' goals for this period. The time recorded for personal health and life course development were within this range, while the amount of time spent on environmental health, maternal role and relationships with family and friends were all within 2 percentage points of the suggested range.

Table 4.1: Visit content figures, NHS Lothian, Edinburgh FNP site, infancy

	Infancy	
Average Time Devoted to Content Domains	**Fidelity 'stretch' goal**	**NHS Lothian, Edinburgh site average**
Personal Health	14-20%	18.5%
Environmental Health	7-10%	11.5%
Life Course Development	10-15%	11.0%
Maternal Role	45-50%	43.1%
Family and Friends	10-15%	15.9%

Overall views of programme content during infancy

4.4 The FNP programme content during infancy is extremely wide ranging. Key topics Family Nurses mentioned covering included:

- Maternal role, child health and development (including how clients interact with their children, how they understand and meet their needs, developmental stages, weaning/feeding, routines, toilet training)
- Client health (including diet, exercise, smoking, drugs, family planning, post-natal depression)
- Environmental health (including safety within and outwith the home, which was described as an ongoing theme given the focus within the programme on preventing accidents)
- Health and other services (including accessing universal services, local groups, immunisations)
- Family and friends (including relationship dynamics and, where applicable, domestic violence)
- Life course (clients' goals around work and education and their goals for their children).

4.5 The variation in clients' individual needs over the course of infancy is underlined by their views on what aspects of the support provided by FNP they found most helpful over this period. Across the 13 clients interviewed for the evaluation, responses were wide-ranging, including: weaning/feeding; child health; safety; information about playing and interacting with their child;

information about child development; support establishing routines with their child; support with applying to college; support dealing with relationship breakdown; and help around financial issues. However, in spite of this diversity, both Family Nurses and clients viewed the programme as matching well with client needs during infancy. Family Nurses described '*tweaking'* or *'mixing and matching'* the content to meet specific needs at the times they arose, while clients appeared happy that their own agendas could be incorporated within the broad programme framework for infancy:

> *Obviously she's got a pack to work to, but she has said to me before like, "is there anything you would like to work on first?" So she just gives me like the option, but it's usually what I want to talk about.*
> (Client 10)

4.6 Family Nurses also noted the benefits of the structured, long-term approach of FNP in terms of engaging clients with issues they might not feel ready to discuss at the start:

> *There's a lot of repetition in quite subtle ways in FNP that really work. So for example you can bring up - as the child's beginning to move around / become more independent - the idea of them going out to a mother and baby group, and they said, "No. No. No. No. I don't want to do that". And it comes up again in terms of looking at other resources, looking at how they spend their time (…) – and they still don't want to do it. (…) And then it comes up again, and then, hey presto, the child's 13, 14 months, running around, and they say, "You know, I think … I really think we should be getting out somewhere and going to something."*
> (Family Nurse 2)

4.7 In terms of tools Family Nurses felt had particularly facilitated delivery of the programme content during infancy, the Partners in Parenting Education (PIPE) activities were described as *'like gold dust'* (Family Nurse 2) in terms of being able to show clients how to '*play, interact, support, balance, love their child*' (Family Nurse 6). The DANCE tool for evaluating caregiver-child interactions was also praised by Family Nurses. While DANCE is only licensed for use within FNP, it is possible for other services to purchase PIPE. It may, therefore, be worth considering whether health or other professionals working with young mothers outwith FNP might benefit from PIPE training and materials.

Challenging topics

4.8 As in the second evaluation report, one view among clients and Family Nurses was that there were no topics that they found particularly difficult to discuss with each other. If anything, this view appeared even more dominant by the time clients were interviewed 12 months after their babies were born. In particular, where clients had previously indicated finding feelings of stress or depression difficult to discuss with their Family Nurse, they suggested they were now less

uncomfortable with these issues. As discussed in Chapter 3, this appeared to reflect the further development of their relationship with their Family Nurse:

> *Probably at the start like when I started telling her I feel right down and depressed and everything like that, I probably felt like out of my comfort zone. Because she's here to … she's here to help and everything like that but I just … she's not family. And like I know I can trust her, but like that was really personal, so there was a doubt in the back of my head "what happens if she runs and then goes and tells somebody that's not meant to…like I dinnae want them to know." There was always that doubt. But I know I can trust her now. I've always been able to trust her, but like I know not to feel self conscious about it.*
> (Client 1)

4.9 Family Nurses did, however, identify a few topics they felt remained challenging to discuss with some clients, including:

- **Relationships with partners** – in particular, the impact that new relationships might have on clients' children. Although it was recognised that the FNP materials do cover relationships with new partners, one Family Nurse view was that they were insufficiently detailed. Family Nurses reported trying to approach the topic from the child's point of view, encouraging the client to think about what their baby experiences when a new partner enters their lives. As noted in Ormston et al (2012), the FNP National Unit (Scotland) has a remit to consider (in collaboration with colleagues in England and now Northern Ireland) where materials may require expanding or developing to meet specific local needs. Relationships with new patterns may be a topic worth further examination, alongside binge drinking and the content to be delivered when a child is being looked after, which were both identified as potential areas for further development in the second evaluation report (Ormston et al, 2012).
- **Contraception** – Although there was some evidence of discussions about contraception impacting on client behaviour (see Chapter 6), Family Nurses also described some clients reacting with '*ambivalence'* to this topic – *'they don't want another baby, but they don't want to do anything else'* (Family Nurse 6) – which could make it a challenging issue to tackle.

4.10 Family Nurses also commented on the fact that it could be challenging to encourage clients to '*focus'* on goals around work or education during infancy, because they tended to be very focused on their child and their maternal role at that stage. They suggested that these 'life course development' issues became easier to engage clients with during the toddlerhood phase of the programme.

5 PARENTING, CHILD HEALTH AND DEVELOPMENT

Key questions

- Is there any evidence that FNP
    - Engenders positive parenting practices and bonding?
    - Improves knowledge on how infant health can be promoted and that any such knowledge is translated into behaviour?
    - Leads to improved child health and development?
- Is there any evidence that the client knows about key hazards and engages in practices to keep child safe?
- Is there any evidence to indicate that infants meet developmental milestones?

Key findings

- Family Nurses believed that the programme continued to have a positive impact on clients; that they had developed skills as competent, confident parents.

- Clients felt their Family Nurses had supported both bonding and child development by sharing practical ideas and materials for activities they could do with their child to support this.

- Although clients did not always hold off weaning until the recommended 6 months, client and Family Nurse accounts indicate that some were delaying weaning for longer as a result of input from FNP.

- '*Intergenerational influences'* on clients' behaviour, particularly in relation to weaning, were cited as a potential challenge by Family Nurses. Approaches to addressing this included exploring family cultures around weaning with clients and explaining the changing nature of research and advice in this area to both clients and their wider families.

- Ninety percent of clients engaged with FNP at the end of the infancy phase were up to date with their child's vaccinations at 12 months. Qualitative interviews indicated that Family Nurses could play a role in reassuring clients about getting their child immunised.

- Clients reported that FNP had helped them to assess their home for safety from the perspective of their child and had provided practical support in accessing grants to buy safety equipment that they might not otherwise have purchased.

Introduction

5.1 The previous chapter reviewed the overall delivery of programme content to clients during infancy. In this and the following chapter, we focus on specific topics relating to parenting, child health and development (Chapter 5) and maternal health, wellbeing and future plans (Chapter 6). In addition to examining the perceived impact of the programme, these chapters also explore

Family Nurse and client perspectives on what has worked well or less well in delivering content on these topics.

5.2 It is important to keep in mind when reading these chapters that the evaluation is not a formal impact evaluation. Further research (such as the Building Blocks RCT referred to in Chapter 2) is required to establish the nature and scale of the impacts FNP is having in a UK context. However, the findings discussed here indicate the potential for FNP in Scotland to impact on client outcomes, based on participants' accounts.

Bonding, attachment and parenting practice

5.3 Family Nurses believed that the programme continued to have a positive impact on parenting practice in the infancy period, acting as a support mechanism through the '*minefield'* of parenting. They reported seeing their clients develop skills, self-belief and confidence as parents over the course of infancy. They felt clients had become more reflective about parenting, better able to consider the challenges as well as recognising what they were doing well. As noted in Chapter 4, Family Nurses mentioned specific tools (PIPE and DANCE) they had found particularly useful in helping them to explore parenting practice and the relationship between parent and child.

Bonding and attachment

5.4 Promoting parent-child bonding and attachment is a key aim of FNP. Clients again mentioned discussing a range of activities to support attachment with their Family Nurse, including hugging, talking, singing to their child, and playing with them.

5.5 As described in the second evaluation report (Ormston et al, 2012), it was not always clear whether clients felt they had a stronger bond with their child as a result of the support received from FNP. Indeed, one client view was that the information they had received around bonding and attachment was unnecessary as they already had a good bond with their child. However, clients did mention their Family Nurses providing them with additional ideas (for games) and materials (e.g. play mats) to facilitate parent-child play, which they recognised as a good way of bonding with their child. There was also evidence that they felt they had a better understanding of what their child is communicating to them as a result of information their Family Nurse had given them.

> *I'd like to think I was close to (baby) anyway, but, you know, my desire was always to be a mum, and she knew that, so like she knew that there was no problems with bonding.*
> (Client 8)

> *She does show me a couple o' things to do. … She was showing me ... how to sort o' ... like play with the toys that he's playing with, so that you can do it together and sort o' let him explore sort o' thing.*
> (Client 2)

> *She gave me like a leaflet on about how to recognise what cries (are) for what and things, so that was helpful.*
> (Client 9)

Routines

5.6 'Routines' was a recurrent theme throughout the infancy stage. Clients reported having detailed discussions with their Family Nurses around bedtime and sleeping routines in particular. They described positive impacts from these conversations in helping them establish sleeping routines, which they saw as benefiting both themselves (*'(I) get a better sleep myself'*) and their babies. One view was that discussions around routines were the most useful aspect of FNP during infancy. Even where clients felt that information from their Family Nurses had not been the central factor in establishing a routine, they were nonetheless pleased to have had options to try when they were struggling with this.

> *He sleeps about 16 hours a night, but, like I said, he's always been wi' a good routine. But that's 'cos the Family Nurse Partnership showed me how to put him in a routine, like doing the same things every night – ... bath time, read a book, bottle, bed. And it's been the same since he was about 4 months old. And she taught me about that.*
> (Client 8)

> *It was just helpful to try things, 'cos I thought this is never going to be ending and it was just nice to have options to try them, so that was good.*
> (Client 13)

Infant feeding

Breastfeeding

5.7 Of the 130 babies whose mothers were still active in the programme at 6 months after birth, 9 (7%) were still being breastfed at 6 months. As reported in the second evaluation report (Ormston et al, 2012), 13% of NHS Lothian, Edinburgh FNP clients were still breastfeeding 6 weeks after birth (7% exclusively). It is inappropriate to draw conclusions about FNP breastfeeding rates from the small number of clients in the first Scottish cohort – the Building Blocks trial in England, alongside further data from Scottish sites, will be required before any robust conclusions can be drawn. However, the proportion of the first NHS Lothian, Edinburgh FNP cohort still breastfeeding at 6 months

(7%) was similar to that identified by the 2005 Growing Up in Scotland survey for mothers under 20 (8% - see Scottish Government, 2007).

5.8 Challenges around supporting young mothers to breastfeed were discussed in some detail in the second evaluation report (Ormston et al, 2012). One Family Nurse suggestion at the time was for a volunteer breastfeeding scheme to support young mothers by linking them with other mothers who had breastfed. Since the second evaluation interviews, the NHS Lothian, Edinburgh Family Nurse team had started working with NHS Lothian's Infancy Feeding Team to support a group of FNP clients who had breastfed to become 'breastfeeding buddies', able to support other younger (or older) mothers with breastfeeding. This highlights the potential for FNP to support both co-production of services with young parents, and capacity building for wider support to meet the needs of other young parents in their area.

Weaning

5.9 Clients reported that the Family Nurses provided them with lots of information about weaning. This included:

- Recognising the behaviours in your baby that can indicate it is time to start weaning
- Telling them about weaning classes
- Explaining how to introduce foods, using finger foods and letting them try little bits of different foods
- Advice about blending or mushing up foods rather than giving them 'baby food' as it is cheaper and generally healthier
- Providing recipe books, and
- Information on what food children should and should not eat at different ages.

5.10 Family Nurses reported bringing weaning up from early in infancy, providing factual information but also exploring clients' family cultures around weaning. One approach was to explain the history of weaning so that clients and their families understand why people have done it differently at certain points in history and how new research has influenced advice. As discussed in Chapter 3, this was seen as a particularly useful approach when family members might be giving clients different advice about when to wean. While weaning was not described as a challenging topic to raise with clients, one Family Nurse view was that the FNP materials on weaning could be expanded, for example by developing more visual tools to help clients better understand this stage.

5.11 Evidence for the impact of Family Nurses on the age at which clients weaned their children was mixed. Panel clients reported weaning their babies from 2½ months to 6 or 7 months. Where they had weaned their babies earlier than 6 months, their reasons centred around the belief that they had very hungry babies and concern that their child was not getting enough food. There were also examples where panel clients appeared to have followed advice around weaning from other family members rather than their Family Nurses.

'*Intergenerational influences'* were viewed by Family Nurses as a significant challenge in relation to this topic in particular.

> *She did advise me to wait till he was 6 months, but I couldnae do it. He was starving. (...) Like my mum said as well, me and my brother were on solids by about 3 months, so (…) There's nothing wrong with it.*
> (Client 6)

5.12 However, there were also examples where the discussions clients had with their Family Nurses' appeared to have made a difference – where clients had held off weaning for longer than they would have without FNP's input.

> *He's like a real hungry baby and I like thought he needed it about 4 months, and she was asking me you 'could try and hold off as long as possible and try like the hungry baby milk?' So I tried, sort of managed to hold off 'til about 5 and a half months, which was actually quite good I think.*
> (Client 10)

5.13 This was reflected in comments from Family Nurses that even if clients did not wait right up to 6 months to wean, they were able to '*stretch'* them to hold off for longer.

Baby health and safety

5.14 Baby and child health and safety is discussed regularly in FNP, from pregnancy onwards, and continued to feature heavily in client and Family Nurse accounts of the programme in infancy. In addition to general child health issues (such as minor ailments), key topics discussed in interviews were immunisations and safety in the home environment.

Immunisations

5.15 The UK Childhood Immunisation Schedule recommends children should receive three doses of diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib) vaccine (the 'five-in-one' vaccine) at two, three and four months of age, two doses of Meningitis C (MenC) vaccine at three and four months of age, and two doses of Pneumococcal (PCV) at two and four months of age. Children should then receive a further dose of Hib and MenC (given as the Hib/MenC booster vaccine), the PCV booster, and one dose of Measles, Mumps and Rubella (MMR) at 12 to 13 months of age.

5.16 Of the 125 babies in the first NHS Lothian, Edinburgh FNP cohort for whom data was recorded, 90% (113) were up to date with all their child's immunisations at 12 months.[12] Comparison figures for all children of young mothers across Scotland were not available. The target of the national

[12] NB of the 128 clients still in FNP at the end of the infancy phase, 3 were temporarily disengaged at the point their child turned 1, so this information was not collected at 12 months. Of those clients for whom information was recorded, 66% of records were based on the client's self-report that their child's immunisations were up to date and 34% were based on a written record of immunisations.

immunisation programme in Scotland is for 95% of children to complete courses of the following childhood immunisations by 24 months of age (Health Protection Scotland).[13]

5.17 Clients described Family Nurses providing them with information about what the injections were for and why they were important, as well as explaining the process so they knew what to expect (for example, that their child might cry or feel a little unwell afterwards). For clients who were apprehensive or unsure about getting their child immunised (for example, as a result of well-publicised but discredited claims about links between the MMR vaccination and autism), the Family Nurse was able to provide much needed reassurance.

> *She was just saying like, any research that's been done on it, it's like never really been proven, like, for what they're saying it can cause or something. So that made me feel better about that, 'cos I was quite scared about that actually.*
> (Client 13)

Safety in the home environment

5.18 As noted in the second evaluation report, some clients were perceived by Family Nurses to already be very knowledgeable about keeping their child safe and hazards. However, Nurses reported that clients continued to respond well to topics around the home environment and safety, exploring potential new dangers in infancy as their children reached different developmental stages. Both clients and Family Nurses commented on the usefulness of an activity where the client crawls on the floor to see their home from their child's point of view to try and spot potential hazards. Family Nurses had also helped their clients access financial support to buy safety equipment, without which clients indicated that they might not have been able to purchase equipment like safety gates, fire guards, wall socket covers, cupboard and drawer locks, door stoppers, protective corners for tables and radiator covers when they were needed. Clients' comments thus suggest that FNP has the potential to impact on keeping children safe in terms of both practical support and client knowledge and awareness.

> *I think the biggest thing that ... the Family Nurse Partnership's taught me was you need to change your surroundings for your child, especially when they're starting to walk and crawl. My living room was laid out differently when (baby) came. I didn't have the fireguard, didn't have the stair-gate up on my kitchen door. All that was a necessity and the Family Nurse Partnership were the ones that got me the stair-gate and the fireguard.*
> *(Client 6)*
>
> *I probably wouldn't have the safety gates by now, you know what I mean?*
> (Client 15)

[13] See http://www.hps.scot.nhs.uk/immvax/vaccineuptake.aspx

Baby development

5.19 In terms of the perceived impact of FNP on client understanding of child development, Family Nurses believed clients appreciated having someone with whom they had a strong relationship that they could regularly ask questions of, particularly as their children hit new developmental stages. They felt that clients had a better understanding of child development as a result.

> *… they've said to me that they've felt that they've had a greater understanding than they possibly would have had, had we not been there with them.*
>
> (Family Nurse 3)

5.20 Clients described their Family Nurses explaining how the brain develops and showing them different activities they could do with their child to help their brains *'grow better and better'*. For example:

- Talking to them to support speech development – although one client view was that they would have done this anyway, another was that they talked to their child more as a result of their Family Nurse's encouragement:

  > *I felt stupid. You know, like in the first couple o' weeks, I felt stupid for saying to (baby), "OK, darling. We're gonna go and get your nappy changed now", because (…) like she wasn't even smiling at me. (…) And then like I think for a little while I just sort of stopped talking to her, 'cos I was like, "Oh, she's not showing any like recognition of my voice, and she's not like showing me, you know, like any love back", and (Family Nurse)'s like, "No. Coz all this is gonna keep adding, and" (…) and then like .. like she sort of explained it a bit more to me, and .. so I just started blabbing away like anything I was doing: "OK. Mummy's just putting on her socks" and "Mummy's gonna make a cup o' tea now" (…) And I think that's what made her .. like she's such a vocal wee thing now. (…) I think that me just talking to her, like being told to talk to her, has really really helped.*
  >
  > (Client 3)

- Reading to their child – clients reported getting their child a library card at their Family Nurse's suggestion, and being given books by their Family Nurse to read with their child.

- Playing with their child - clients reported discovering how to change their children's toys around to ensure they remain stimulated and to support physical development(e.g. moving toys just out of reach to encourage babies to learn to crawl), and learning about the potentially negative effects of watching TV during infancy from their Family Nurses.

6 MATERNAL HEALTH, WELLBEING AND FUTURE PLANS

Key questions

- Is there evidence to indicate that
  - FNP results in improved knowledge/health behaviours in clients following birth of baby?
  - Mums feel more supported and less anxious/depressed because of the programme?
  - FNP leads to fewer unplanned pregnancies, and helps mums work out what they want to achieve and supports them in realising their plans?

Key findings

- In addition to evidence around FNP's potential role in raising awareness of the risks of some health behaviours, discussed in previous evaluation reports, there was some evidence of clients attributing changes in their physical activity levels after their child was born to information they had received from their Family Nurse.

- FNP has the potential to impact positively on the mental health and wellbeing of young mothers both via the direct support Family Nurses provide to clients as a trusted confidant, and by linking them with further services and support where needed.

- It is not possible to establish based on the available evidence for Scotland whether FNP is leading to fewer unplanned pregnancies. However, there was some evidence that Family Nurses were supporting clients to access contraception where they might not otherwise have pursued this.

- Working with clients who have second pregnancies during their involvement with FNP was seen as creating both challenges and opportunities for Family Nurse teams. It was suggested that this may be an area for further exploration within FNP.

- Client and Family Nurse accounts indicate the potential for FNP to support clients in broadening the options they consider in relation to education or work, formulating goals, and overcoming barriers around childcare or funding.

Maternal health and wellbeing

6.1 FNP explores the mother's health alongside that of their child throughout the programme. This dual focus of FNP was something clients particularly valued.

> *It's not just your baby as well. She'll look after you.*
> (Client 3)

Health behaviours

6.2 As discussed in the second evaluation report (Ormston et al, 2012) maternal health behaviours – drinking, smoking, drugs, diet, exercise and sexual health – are threaded throughout the FNP programme. These topics were discussed in more detail in the first two evaluation reports. However, during infancy there was further evidence of clients attributing changes in their physical activity levels in particular to information they had received from their Family Nurse. This included walking and swimming more than they used to.

Mental and emotional health

6.3 As discussed in Chapter 4, clients who had previously indicated finding it difficult to talk about their mental and emotional health reported feeling more comfortable raising these issues with their Family Nurse by the end of the infancy period. Clients indicated that they felt able to share their stresses, worries and *'stuff that is like way too much for me to cope, inside'* with their Family Nurses. Being able to trust that their Family Nurse would treat such information confidentially was central to clients' willingness to open up to them.

6.4 Clients' accounts indicate that FNP had a positive impact on their mental health and wellbeing both via the direct emotional support provided by Family Nurses and through referrals to further support. According to the clients, being able to talk to the Family Nurse meant that they had an outlet and were not keeping how they were feeling to themselves, which they acknowledged could add to their problems.

> *I actually feel a lot better once I have spoken to her because it feels like a weight has been lifted off my shoulders. Because a lot of the time I keep my feelings in. I don't tell anybody, and that's when all my problems start, so in a way it is good that she appears every 2 weeks because if a lot's happened… I know I can phone her and tell her*
> (Client 6)

> *At the end of it it's like…it takes a wee bit of the stress and worry away.*
> (Client 14)

6.5 Clients and Family Nurses also described examples where Family Nurses had referred clients to a GP, counselling or a psychiatrist for further support (in some cases, accompanying them to appointments), provided information about evening classes to support them with specific issues, and referred them to groups where they could meet other mums who have had similar experiences. Clients themselves also sought out emotional support from people outside FNP, such as a counsellor or friends and family.

Second pregnancies

6.6 In NHS Lothian, Edinburgh, 22 of the first cohort of clients had become pregnant in the 12 months since the birth of their first child, with 10 clients continuing with their pregnancy. It is not possible to say based on this data alone whether FNP is either increasing the gap between first and second pregnancies or resulting in fewer unplanned second pregnancies; data from controlled trials is required to assess both these outcomes. Fewer closely spaced subsequent pregnancies were observed in two of the three US trials (Olds, 2006[14]). Further evidence on the impact of FNP in this respect in a UK context will be provided by the Building Blocks trial in England.

6.7 In terms of approaches to discussing future pregnancies, Family Nurses recounted how they encouraged their clients to consider whether it was the right time to have a second baby and to weigh the pros and cons. The impact of these discussions was not necessarily to prevent second pregnancies (which is not the aim of FNP), but to help ensure that these were planned.

> *I mean that's a big discussion as well. We talk about family planning from the antenatal stage right through, and then it gets fitted in through the infancy stage. Kinda get them to really look at the pros and cons of having a second child, and helping them to make those decisions (…) I do now have quite a few that have got second children, but I would say (…) They were definitely planned babies.*

(Family Nurse 5)

6.8 The NHS Lothian, Edinburgh FNP team felt there were both challenges and opportunities around delivering FNP when clients have a second pregnancy. Challenges related to the practicalities of delivering infancy content while a client may be very focused on a new pregnancy. After the birth of the second baby, Family Nurses were also delivering mandatory health screening and surveillance for the new baby, although their FNP clients remained the mother and the first baby. Both these factors could mean visits were very full. There were also challenges and opportunities around observing how clients approach parenting with their second child. For example, the team reported seeing clients breastfeeding with their second children where they had not managed this with their first. However, where clients were perhaps not parenting their second children in a way that reflected their work with FNP, the team suggested this could be challenging for Family Nurses to respond to.

6.9 It was noted that Family Nurses themselves could experience feelings of anxiety and '*failure'* when their clients do have second pregnancies. A lack of guidance on what an 'expected' rate of second pregnancies might be for their clients was seen as potentially exacerbating such feelings. One view from the NHS Lothian, Edinburgh FNP team was that there was scope for further work

[14] See also http://www.nursefamilypartnership.org/proven-results/Changes-in-mother-s-life-course for a summary of results. The increase in intervals between first and second babies for FNP clients compared with control groups was 3.7, 4.1 and 12.5 months across the 3 US trials.

within FNP nationally (at UK or Scotland-level) around further pregnancies and the challenges and opportunities these bring for FNP teams.

Contraception

6.10 87% of FNP clients for whom data was available at 12 months had used some form of birth control in the last 6 months to prevent another pregnancy. 11% were not using any contraception, while the small number of remaining clients were either practising abstinence or their partner had undergone a vasectomy.

6.11 Family Nurses considered contraception to be one of the biggest topics to be addressed during infancy. They also reported that most clients were keen to find out about their contraception options, where to get them from and possible side effects. While one client view was that they had already decided on their contraception before discussing this with their Family Nurse, another was that without their Family Nurse's input, they might not have got round to sorting out contraception.

> *It was helpful yeah but I already had my mind made up anyway*
>
> (Client 7)

> *I probably would have left it (…) And probably have been pregnant again if I did.*
>
> (Client 1)

6.12 It is worth noting here that a further clinical trial is being undertaken in the US context looking at the impact on unintended pregnancies of enabling Family Nurses to provide contraceptives to clients rather than referring them to primary care to access these.[15]

Future plans around work and education

6.13 Supporting families' economic self-sufficiency is a key aim of FNP. Family Nurses look at goals and planning around work and education throughout the programme, supporting clients to revisit and reassess their own goals as their circumstances change.

6.14 Of the 125 clients in the first NHS Lothian, Edinburgh FNP cohort for whom 12 month data was available[16], 12% (n = 15) were enrolled in an educational programme at the time, while 26% (n = 33) reported having worked in paid employment at some point since their child was born. Clients interviewed for the evaluation included: some who were currently working, at school or college; some who had applied to or were about to start college or university; and some who had not yet made firm plans but indicated that they planned to get a job or continue their education in the longer-term.

---

[15] http://clinicaltrials.gov/ct2/show/NCT00928538

[16] 3 of the 128 clients still in FNP at the end of the infancy phase were temporarily disengaged at the point their child turned 1, so their demographic details were not updated at that point.

6.15 Family Nurses reported talking through their options and providing information and signposting to clients – for example, information about courses or signposting to Job Centre Plus. They had contacted colleges or other institutions for some clients and made them aware of possible funding for courses or for childcare to enable them to attend college. They also helped to build their clients' confidence for job interviews, for example by supporting them with designing or updating CVs: .

> *…there is a lot around communication as well because they're faced with interviews and then interview techniques and being able to actually sit down confidently and sell yourself um… is something that I think most teenagers actually find quite challenging.*

(Family Nurse 1)

6.16 Family Nurses felt the programme was having a positive impact in terms of clients being able to reflect on their life goals and, with support of the Family Nurse, work through a plan to achieve these. Clients also commented that their Family Nurses had helped them to think through their options, and cited impacts in terms of, for example, broadening the list of colleges they considered applying to. One client (who was currently working, but wanted to go back to education) commented that her Family Nurse had helped her work through her finances, comparing attending college with employment, which made her realise that she could afford to continue her education. This client did not think she would have been done this without her Family Nurse.

6.17 Where clients had decided to delay plans for work or education beyond the infancy period, concern about childcare was a recurrent factor, with some clients initially apprehensive about having anyone else look after their child. This was an area Family Nurses reported spending a lot of time on, discussing both the different childcare options (and funding options) available, and how clients can develop trust in others to look after their children to enable them to pursue their goals. These discussions could benefit clients both in terms of overcoming practical obstacles, and in reassuring them that using childcare will not be detrimental to their child.

> *She helped me out with the childcare as well, coz I didn't know they had nurseries or I'd get funding for it.*
> (Client 12)

> *I'm wanting to go to college next year and (Family Nurse) was like "well put her into a crèche or like a nursery" so she gets used to being away from me. And she'll get to meet other children and all that as well (…) That's what I've been scared to…I've not really fancied like going back to work or that because I'm like "she's too young" at times. And (Family Nurse) says "I know but you have to start them off young for them to learn" and I'm like "well that's true".*
> (Client 1)

6.18 The client case study in Box 6.1 illustrates the ways in which FNP can support clients to identify and achieve their future goals. Although clients clearly follow different paths in relation to work and education, this case study reflects some recurrent themes around the usefulness of being able to reflect on their options with their Family Nurses across the course of the programme and the importance of advice and support around childcare and finances in helping them to achieve their goals.

Box 6.1 – Working with clients to plan and achieve goals around work and education

When she joined FNP, this client was working in a very low paid job. She left this job (supported by her Family Nurse to ensure she accessed the benefits she was entitled to during this period) before her baby was born. When first interviewed for the evaluation, while she was still pregnant, she was thinking about starting college, perhaps a year after the baby was born. The client reported that because the Family Nurse brought up the future and where they would like to be in a few years time, *'it makes you think and plan out more'*.

By the time of her second interview, when her baby was around three and a half months old, she was thinking about what to do when her maternity allowance ran out. At this point, she felt torn over whether to get a job or go to college – *'I've basically got all these things in my head and I can't really decide'.* The client reported that her Family Nurse was helping her work out what she should do and had suggested that she apply to college anyway, so that if her job plans did not work out she had college '*to fall back on'*.

She followed this suggestion and had started a college course just before her baby turned one. The client reported that her Family Nurse had provided both practical and emotional support with getting into college – providing information about childcare and funding, encouraging her to broaden the range of colleges she applied to, and supporting her when she felt her family were being unsupportive of her desire to attend college. She felt that the support her Family Nurse had provided around getting in to college had been the most helpful thing she had discussed with her - *'she gave me all the advice and help that I could ever need.'* When asked how she was finding college, she said *'It's been great. I've loved it'.* She was planning to continue with her studies before getting a job.

7 SERVICES, RESOURCES AND REFERRALS

Key questions and outcomes

7.1 Specific outcomes from the monitoring and evaluation framework of relevance to this chapter include:

- Referrals to other services, and
- Use of community resources and supports.

7.2 Both of these are intended to support the higher level outcome of mothers feeling more supported and less anxious or depressed. As noted in Ormston et al (2012), the relationship between FNP and other services is also of wider interest in terms of understanding how the programme is being implemented in a Scottish context.

Key findings

- Family Nurses referred clients to a wide range of services during infancy. Clients reported benefiting particularly from FNP's support in linking them with housing and benefits services and in helping them access grants.

- The availability and perceived suitability of services for young mothers and their needs can be a barrier to clients either taking-up or benefiting fully from the services they are referred to by FNP. This was discussed specifically in relation to mother and baby groups and domestic abuse support. However, it was suggested there were often issues around the suitability of generic services for young mothers.

- Clients felt that their relationship with their Family Nurse made it easier to report problems to them and easier for Family Nurses to assess those problems accurately in comparison with other health professionals with whom they had a less 'personal' relationship.

Introduction

7.3 'Human ecological theory' highlights the importance of the social and community, as well as family context, in influencing parenting. As such, a key role for FNP is in linking clients with other services and resources that may be able to support them. This chapter summarises the number and types of referrals made by Family Nurses during the infancy phase of the programme and discusses client and Family Nurse perspectives on the impact of those referrals.

Referrals to other services during infancy

7.4 In comparison with the pregnancy phase, during which 166 referrals were made for 87 clients, Family Nurses made a greater number of referrals (more than 400) during infancy. Referrals were also made to a wider range of services, in part reflecting the greater number of services that are relevant once clients' babies arrive (e.g. childcare, breastfeeding support, injury prevention,

child health care services). There were also more referrals to financial assistance and job training support in infancy.

Table 7.1: Numbers of clients referred to services

	Pregnancy phase	**Infancy Phase**
Health-related services		
Smoking cessation	17	<5
Mental health services	7	9
Sexual health services	-	8
Antenatal classes	24	NA
Health care services (client)	84	70
Injury prevention	NA	6
Health care services (child)	NA	53
Other services		
Financial assistance	15	34
Social care (including child protection/child in need and adult disability services)	10	20
Community Support	<5	11
Job training	-	14
Housing services	9	12
Legal Services	<5	<5
Childcare	-	<5
Breastfeeding support	NA	<5
Educational programmes	-	<5
Development referral	-	<5
Other *	13	48

* Other services included: Adult learning, adult literacy, HPV Vaccine appointment, autism support, No.6, Avenil Trust Charity, baby massage, child benefit, child tax credit, children's clothes, Children's Reporter, couple counselling, Crossreach, EVOT, EVOT (grant), fire brigade (safety), fuel poverty advice, Healthcare Academy, Kids Love Clothes, Princes Trust, Sighthill Young Mums, other mother's groups, Sisters of Mercy, Stepping Stones, stop smoking (partner), Sure Start Parent Group, Tax Credits, Womens Aid, Working For Families.

Perceived impact of FNP referrals on clients

7.5 Clients' accounts of FNP referrals during infancy suggest the potential for these to have a positive impact on client outcomes via:

- Facilitating more rapid access to services (particularly health services) than might otherwise have occurred
- Linking clients to services they were unsure about how to access on their own, and
- Linking clients to services they were unaware of and may not have accessed on their own.

7.6 Linking clients with services they were unsure about how to access was discussed particularly in relation to housing and benefits. Clients described their Family Nurses playing a key role in explaining processes and what they

were entitled to, putting them in touch with the right people, and in some cases supporting them by attending meetings with them.

> *I wouldn't know where to start. I was phoning like everybody and they were just telling me there was nothing I could do. And then when she found out the place that I could go to, they were just, like, saying the people that I had been phoning weren't the right people anyway. So that was great, that was a good help.*
> (Client 13)

7.7 Clients identified benefits and financial grants as an area where their knowledge had been particularly limited prior to receiving information from their Family Nurse. Without the support their Family Nurses had provided, clients suggested that they might not have purchased essential safety equipment, applied to college, or accessed the money they needed to support themselves and their child.

> *That was one of the things that was holding me back from applying to college, because I wasn't sure about nurseries – like how much I would pay - … and (Family Nurse) said that you apply for the nursery fund and I was like 'oh right', so I didn't know about that.*
> (Client 9)

> *I had to give up my job and stuff and I just … I didn't know where to go from here. I didn't know what to apply for. I didn't have a clue what I was entitled to. So she kind of helped me out with that. And so I was quite pleased that I did have her, because if I didnae have her I'd probably still be sitting there twiddling my thumbs, with nae money, living off my mum and dad.*
> (Client 6)

7.8 Of course, it is not possible to say based solely on clients' accounts that they would not eventually have accessed these resources without support from FNP. However, their views provide evidence that FNP can facilitate timely engagement with services when they are needed.

7.9 Comments from both clients and Family Nurses also highlight that the impact of Family Nurse referrals may also sometimes be limited by the availability or perceived suitability of services to refer clients to. For example, clients who had not taken up Family Nurse referrals to mother and baby groups discussed the reasons for this, including: feeling shy; not liking groups or feeling the group was not welcoming; the timings being inconvenient (particularly where they were early morning, but also where clients worked and reported difficulty fitting them in); waiting lists for spaces; and feeling they did not need to attend a 'formal' group as they had enough contact with other parents.

> *She helped me find some baby groups about the area – not that I've went, but we did have a look. I'm quite a shy person, so I dinnae like going myself, and a lot o' the groups are like first*

thing in the morning, and it takes me a while to get organised and get myself moving, so I'm like, "Well .. Oh well. We'll just go to the soft play instead"
(Client 12)

7.10 As noted in Ormston et al (2012), there appeared to be a perception among clients that some mother and baby groups were more suited to older women, underlining the need for groups to cater specifically to younger mothers. However, even where such provision is available, these comments indicate that some younger mothers may still need considerable encouragement and support to attend group-based support.

7.11 One view among the NHS Lothian, Edinburgh Family Nurse team was that generic services often do not meet teenagers' needs particularly well. For example, the NHS Lothian, Edinburgh Family Nurse Team also identified a specific issue around the availability of appropriate domestic violence support services for their client group. While FNP was felt to cover domestic violence well, it was suggested that clients had *'found a lot of the support programmes are not for them*' and that because their approach is different to FNP they can be less effective. The team suggested that there may need to be some further work with other services around supporting young mothers.

8 PROFESSIONAL VIEWS AND EXPERIENCES OF DELIVERING FNP

Key questions

- Does the team receive the training and support intended and develop the knowledge and skills required?

Key findings

- Family Nurses continued to praise the quality of the training received through FNP. An additional potential training need was around capacity planning, given the challenge of managing FNP caseloads to meet fidelity criteria.

- Family Nurses felt they had further consolidated their skills over the last six months. In particular, they said they were making better use of some of the specific tools that support FNP delivery, like DANCE. At the same time, there was a desire for refresher training around some of these tools.

- Supervision continued to be viewed as '*invaluable'*. Additional suggestions for supervision included discussing experiences of using FNP materials in general (rather than with specific clients).

- There was some ongoing concern about the appropriate balance between child protection supervision and supervision of other clients. It was suggested this may need to be considered at a Scotland-wide level.

- Family Nurses viewed the changes they had seen in their clients' parenting skills, confidence and self-efficacy as the key achievements of the programme. A specific achievement was the team's support for a group of FNP clients to become 'breastfeeding buddies', who will support other mothers with breastfeeding.

- The team expressed divergent views on their current workload. One view was that it was more manageable than it had been earlier in the programme; another was that it continued to be difficult to contain without working additional hours.

- Factors that may have helped ease workloads included: increased familiarity with the programme; clients starting to graduate; and the completion of preparation work for this transition. On the other hand, issues around the record keeping process, additional meetings associated with child protection cases, tasks associated with being the first Scottish test site, and a temporary gap in administrative support were all cited as contributing to high workloads in the first half of 2012.

Introduction

8.1 Family Nurse's experiences of delivering FNP to clients in infancy have been discussed in some detail in the preceding chapters. The programme of client visits is supported by extensive training and structured supervision, specified in

the FNP manual. This chapter summarises the team's views on these aspects of the programme. It starts, however, with a more general discussion of the NHS Lothian, Edinburgh Family Nurse team's views of the main achievements and challenges associated with delivering the programme over the six months since the second round of evaluation interviews.

Achievements

8.2 Family Nurses' accounts of the team's key achievements in the period from late 2011 to mid-2012 reflected similar themes to those discussed in the second evaluation report (Ormston et al, 2012). Again, the impacts for and achievements of their clients featured strongly, as evidenced by their accounts of the changes they saw in clients' parenting skills, confidence and self-efficacy (discussed in earlier chapters). And again, the team took obvious pride in the strength of the relationships underpinning their work with clients, particularly where these had been more challenging to maintain.

> *Achievements? I think I'm just so proud o' my clients, d'you know? And in how .. how much they've come on.*
> (Family Nurse 3)
>
> *The girls that ... have had more going on in their life, and are more tricky to see, you know, the fact that you are still seeing them, and they do still, you know, want to see you, I think that's … a real achievement.*
> (Family Nurse 6)

8.3 More specifically, the development and training of a group of FNP clients to become 'breastfeeding buddies', able to support other young (and older) mothers with breastfeeding was viewed by the Team as a key achievement.

8.4 In terms of their own developing professional practice, the six months from late 2011 to mid-2012 appeared to be viewed by the Family Nurse team as primarily a period of '*consolidation'* rather than major change. Although there was a view that it can be *'hard to measure your own progress'*, Family Nurses reported feeling they were becoming more *'skilled delivers'* of the programme. They also believed they were becoming more experienced at agenda matching and making better use of some of the tools which support the delivery of FNP – for example, the DANCE tool that helps with assessing and offering feedback on parent-child interactions:

> *I think just having an awareness of that tool now helps me better assess the interaction that I see, and ... it allows me to offer positive feedback to parents (…) That's not to say that ... that there aren't areas that require further development, but it's .. it's much easier to pick out the positives in that parent/child than it would have been previously for me.*
> (Family Nurse 5)

Challenges

Workload

8.5 Workload was identified as a major challenge in delivering FNP in both the previous evaluation reports (Martin et al, 2011 and Ormston et al, 2012). It remained the key challenge discussed by the NHS Lothian, Edinburgh FNP team in mid-2012. However, at this point somewhat divergent views were expressed by the team in relation to their current workloads. One view was that the workload was in fact *'much more manageable now'* than it had been previously. Nurses' increased familiarity with the programme, the fact that clients were starting to graduate, and the fact that the team had finished their main preparation work for this transition were all seen as helping the job become *'more containable'* within standard working hours. However, at the same time there remained a strong view that the workload remained *'very, very heavy'* and that Family Nurses were still working additional hours to carry out their role.

8.6 The Family Nurse Supervisor in NHS Lothian also reported finding it extremely difficult to contain her role within a standard working week. While this in part reflected the challenge of balancing her role in NHS Lothian with her one-day a week role as National Lead Supervisor, she also felt that there were a lot of component parts to the Supervisor job alone that made it very challenging to deliver. She felt that workload within the Supervisor role needs to be contained *'because you couldn't continue to work at the pace*'.

8.7 Some of the factors to which the team attributed heavy workloads reflected those already listed in previous evaluation reports, including:

- The move to an electronic record keeping system within NHS Lothian. Although the team recognised the benefits of being able to access other health professionals' notes, there was an ongoing perception that electronic record-keeping took somewhat longer. It was suggested that if the system could be adapted for FNP, so that the fields better fit with their domains and the information they need to gather for FNP, this might help reduce the additional time taken. The team also noted that during infancy the volume of record-keeping required increases, as Family Nurses need to complete notes for both mother and baby.
- Family Nurses with cases involving a child protection issue again noted the additional time these added to their workload in terms of attendance at meetings and hearings, writing reports, etc.
- Additional work associated with being the first test site for FNP in Scotland. It was acknowledged that the Scottish Government had attempted to prevent the NHS Lothian, Edinburgh team from being over-burdened with requests as FNP was rolled out in Scotland. However, since the last evaluation interviews the team had regularly received requests for information or advice from other Health Boards and prospective Family Nurses from other areas.

8.8 Additional factors that the team viewed as adding to their workload in the first half of 2012 included:

- The need to produce reports for Getting it Right for Every Child (GIRFEC). It was suggested that GIRFEC was not yet fully incorporated within NHS Lothian's electronic record keeping system, necessitating further cutting and pasting between the two. There was also time associated with familiarisation with GIRFEC reporting templates and language.
- Changes within the team towards the start of 2012. In particular, the team's first administrator left in early 2012 and there was a three month gap before a new permanent administrator started. The team commented on the importance of administrative support and found this gap particularly challenging:

  > *I think that's been one of the hardest things that we've had to do in the whole ... since the team started. So the workload was horrific whilst ... when we didn't have our admin*
  > (Family Nurse 3)

8.9 Finally, the team also acknowledged that they sometimes put additional pressure on themselves because of the strength of their commitment to the programme and to their clients.

8.10 While one view among the team was that nothing had proved very effective in terms of managing their workloads, strategies that some team members had adopted and found helpful (to an extent) included:

- Developing an excel sheet to look at capacity and plan their own visits and other commitments across a month, with reference to fidelity targets, and
- Keeping sessions with clients more strictly to time.

8.11 As discussed in Ormston et al (2012), the Scottish Government has funded a 1:6 ratio of Family Nurse Supervisors to Nurses in NHS Lothian, rather than the maximum allowed within FNP of 1:8. Given that workload has consistently been reported as a major challenge by the team throughout this evaluation, it may be necessary to carry out further research and analysis around team workloads as FNP is rolled out in Scotland. This work could explore the extent to which the factors identified in this evaluation persist or dissipate over time, the extent to which any issues appear to be specific to a Lothian, Scotland or UK context, strategies for managing Family Nurse workloads, and whether Nurse and Supervisor workloads do become more manageable as the programme becomes more established.

Other challenges

8.12 As noted in chapter 1, there were a number of changes to the NHS Lothian, Edinburgh FNP team in the first half of 2012. While the team was very positive about the new Family Nurses who had joined them, there was also some discussion of the challenges associated with team changes mid-way through the FNP programme cycle. In particular, the experience of trying to move

clients from an existing Family Nurse who had been promoted to supervisor two-days a week had been *'really complicated'* because *'clients don't accept being swapped'.* The number of clients who had been successfully moved to a new Family Nurse was thus fewer than originally planned, which meant the acting Supervisor had not had as much capacity to support the lead Supervisor as hoped. Given the challenges they had experienced with moving clients between Nurses, it was suggested that although the model of having an existing Family Nurse 'act up' to Supervisor is a good one, it needs very careful planning and ideally should not be started when the Nurse has a full caseload.

Training and supervision

8.13 Team perceptions of the training and supervision received as part of FNP were described in detail in the previous evaluation reports. By mid-2012, Family Nurses in NHS Lothian, Edinburgh found it difficult to reflect back on the mandatory training they had received for the infancy period, as this was completed in 2010. However, they reiterated the view that the training offered by FNP was '*phenomenal'* in terms of its quality. In terms of additional training requirements, the team commented that it would be useful to have refresher days for some of the tools introduced to support FNP delivery. DANCE, PIPE, Smart Choices and Compassionate Minds were all mentioned in this context, as tools that Family Nurses valued highly but did not necessarily feel completely *'up to speed'* with.

> *I think we could have done with more training on PIPE, I think the days that we had were fine but I think its one of these things that it takes to go away and think about it, try and implement it, and then have a better grasp of concept yourself to then come back and then revisit it and look at it differently. For me I think that would have been helpful and possibly the same with DANCE and possibly the same with compassionate minds.*
> (Family Nurse 1)

8.14 It was also suggested that the team might benefit from some training around capacity planning and electronic tools to support this, given the challenges around managing workload identified above.

8.15 Supervision is an integral and mandatory component of FNP. It continued to be viewed extremely positively by the Family Nurse team in NHS Lothian, providing *'time, space, somewhere that you feel comfortable and you can actually just unload'*. Indeed, it was described as '*invaluable'*:

> *You couldn't do it without supervision or the level of supervision. You really need to have that reflective space just to look and analyse what you've actually done and what you've actually seen to plan ahead.*

(Family Nurse 4)

8.16 Although there had not been any major changes to supervision since the previous evaluation interviews, it was suggested that the process was becoming deeper and more '*refined'* over time. For example, it was commented

that one-to-one supervisions with the Supervisor were able to focus more in-depth on levels of engagement within visits and the reasons for this, rather than reflecting at a more general level on client-nurse relationships.

8.17 In terms of improving supervisions, Family Nurses again commented that it would be helpful if group supervisions were also used to look again at training on tools like PIPE and to discuss experiences of using FNP materials and facilitators in general. There was also a view that a more open discussion about hours within group supervisions might be beneficial.

8.18 Increased face-to-face supervision using a tri-partite process which includes the FNP Supervisor and local Child Protection Advisor has now been implemented across all FNP sites in Scotland. The increase in frequency of Child Protection supervisions, discussed in the previous evaluation report, was still felt by the NHS Lothian, Edinburgh FNP team to be impacting on the time available for supervision other clients in the programme who did not have child protection issues. It was reported that the Scottish Government Child Protection lead was reviewing this. One suggestion from the team for addressing this balance was that the number of Child Protection supervisions could vary across individual Family Nurses and their own level of child protection understanding or training. However, it was also felt that this issue needed to be addressed in a Scotland-wide context and take into account views outside the NHS Lothian, Edinburgh FNP team. Work has also commenced across FNP in the UK to examine what benefits this additional supervision brings to sites.

8.19 Finally, although at the time of writing a bespoke database for FNP in Scotland was still being developed, data was now being used somewhat differently by the NHS Lothian, Edinburgh FNP team. Each Family Nurse now received their own individual report once a month from the Supervisor. This meant that Family Nurses now lead the conversation in supervisions around their own data, which the Supervisor reported was working well. The Supervisor also reported an increased understanding of how to extract data herself, which she felt had been helpful in terms of being able to access specific data during supervisions.

9 IMPLEMENTING FNP IN LOTHIAN

Key findings

- Local stakeholders from other services were very positive about what they had seen of the impact of FNP on individual clients. However, some reservations were apparent around eligibility criteria, sharing learning and the resources associated with FNP.

- Working relations between the NHS Lothian, Edinburgh FNP team and other services were viewed as good by stakeholders from Midwifery, General Practice and Social Work. Factors supporting this included: initial and ongoing regular and open communication by the FNP team, including attending meetings of other services; shared electronic records (between Midwifery and FNP); new Family Nurses shadowing Midwives; the quality of Family Nurses' work around shared clients (for example, the quality of their written reports in Child Protection cases); and building on pre-existing working relationships.

- Stakeholder suggestions for improving communication between FNP and other services included: more and/or earlier sharing of the theoretical and research base for the programme and how it would work with particular services, and more regular meetings between Family Nurses and GP practices.

- FNP in Scotland was contributing to discussions around supporting Public Health nurses through, for example, links with the Chief Nursing Officer. NHS Tayside (the second FNP site in Scotland) had also begun work around a programme of development for Health Visitors, building on some of the principles of FNP – around motivational interviewing and the nature of leadership and supervision, for example.

- Additional strategic learning from the experience of implementing FNP in Lothian related to:

    - Appropriate handling of media activities involving FNP clients
    - The importance of considering sustainability and thinking widely about the potential benefits of FNP across organisations and divisions from the outset of planning a new site, and
    - The potential of FNP to contribute to learning around co-production with services users.

Introduction

9.1 Previous chapters in this report have focused on the detail and experience of delivering FNP in the first Scotland test site in NHS Lothian, Edinburgh. This final chapter explores broader, strategic-level learning from the experience of implementing FNP in NHS Lothian, Edinburgh. It starts by summarising views of FNP among local stakeholders (from Midwifery, General Practice and Social Work). It then summarises views on potential additional learning from the experience of implementing FNP in NHS Lothian, Edinburgh for both other FNP sites and wider services.

Stakeholder perceptions of FNP

General perceptions

9.2 In Scotland and the UK, FNP is delivered within a wider context of universal and targeted services. Family Nurses need to work with colleagues in health and other services like social work, education, justice and the voluntary sector in order both to meet clients' needs and to comply with regulation around the monitoring and protection of child health and wellbeing. Here, we briefly summarise Midwifery, General Practice, and Social Work statekholders' overall views of FNP and how they would like to see it develop in the future. While it should be born in mind that the number of interviews on which this is based was small and limited to three specific services in one Health Board, it nonetheless gives an indication of the kinds of issues that may need to be considered in trying to develop stakeholder support for FNP in other sites.

9.3 Stakeholders were asked to reflect on what they had thought about FNP when they first heard about it (which in all cases was as a result of plans to introduce it in Lothian – no one reported having heard about it prior to this) and whether their views had changed over time. Those interviewed reported a good understanding of what FNP involved (intensive support for teenage mothers from pregnancy through the first two years of their child's life) and its approaches (early engagement and preventative support delivered via a therapeutic relationship between nurse and client). However, they reported some initial scepticism about specific aspects of the programme among either themselves or their colleagues, focusing on:

- Whether or not the programme would have the same impact when transferred from a US to a UK context
- The strictness of the enrolment criteria (only first-time mothers aged under 20 and identified before 28 weeks gestation are eligible)
- Perceived '*secrecy'* around FNP materials and concerns about whether it would be possible to share learning with Health Visitors and incorporate into core practice, and
- The intensity of resources required to sustain the programme within the NHS.

9.4 Some of the reported concern around the likely impact of the programme appeared to have been addressed for these stakeholders, at least in part, as a result of observing benefits for individual clients. They reported, for example, observing healthy outcomes for babies, children staying with mothers in cases where they thought they might otherwise have been removed, feeling the family was better supported in a case where the child was removed, and perceived impacts on the parenting skills and confidence of FNP clients.

> *In the case of this patient, she had a very, very good outcome, and I'm sure a lot of that was due to the family nurse. Certainly the family nurse was able to intervene on her behalf when there were a couple of controversies at Social Work meetings.*
> (GP)

I am kind of much more confident that … that the mum had the best chance that she could, and the Family Nurse Partnership played part of that.
(Social Worker)

It wasn't anything that was very measurable, but (…) the contact seemed to have given those parents a level of confidence that … that seemed different to what I would have expected.
(GP)

9.5 However, while these local stakeholders were generally very positive about FNP in terms of both working relationships and the client outcomes they were observing, they reported some ongoing reservations around eligibility criteria, sharing learning and resources.

9.6 Stakeholders indicated that they would like to see eligibility criteria extended, for example to clients aged over 19, fathers, clients who book their pregnancy late or clients who turned down the programme at the first pregnancy. This suggests an ongoing need for clarity and discussion with local stakeholders around eligibility.

9.7 Concern around sharing learning was associated with a belief that it was not possible to pick out key approaches from FNP that could be applied more universally. One view was that it might be preferable in terms of mainstreaming and sharing learning if Family Nurses could be embedded within local Health Visiting or practice Community Nursing teams, rather than being separate teams. It was also suggested that Health Visitors ought to be taught more about what Family Nurses do, even if they cannot spend as much time with clients as a Family Nurse would.

9.8 As discussed in the last evaluation report, Family Nurses and FNP stakeholders felt that in practice sharing learning from FNP had been less focused on what could not be shared from the manual and more focused around what can be learned in terms of, for example, approaches to engaging those less likely to access universal services. But that fact that concerns around sharing learning continue to be expressed by stakeholders may indicate an ongoing need for FNP sites to be clear about how learning can and is being shared with universal services.

9.9 Finally, stakeholders from Midwifery and General Practice reported some ongoing reservations about the financial sustainability and cost of FNP. One view was that if it was shown to make a major different to outcomes, the cost of the programme was worthwhile. Indeed, there were already suggestions from stakeholders that it should be expanded to cover more clients or a wider geographical area. However, at the same time they reported some ongoing tensions relating to the perceived resources spent on FNP in comparison with pressures on resources for mainstream services like Midwifery and Health Visiting.

9.10 This view was reflected in a related comment from those involved in implementing FNP Scotland, who suggested that the more other Public Health Nurses understood about FNP, the more they questioned the support available to them. The further development of support for Public Health nurses was described as a key area to which FNP nationally could contribute in the future. NHS Tayside (the second area in Scotland to deliver FNP) had already begun work on a programme of development for Health Visitors, building on some of the principles of FNP around motivational interviewing and the nature of leadership and supervision. The FNP National Unit (Scotland) had also issued guidance for FNP sites in Scotland around engaging local organisational and development leads in considering the change management implications of introducing FNP, particularly in relation to the Health Visiting and Midwifery workforces.

Stakeholder views on how FNP compares with other services

9.11 The views of stakeholders from Midwifery, General Practice and Social Work on how FNP compared to other services largely echoed those of both Family Nurses and clients (see Ormston et al, 2012; Martin et al, 2011).

9.12 In comparison with universal Midwifery services, FNP was seen as having a different approach to antenatal education, much more geared to teenagers. FNP's role in providing antenatal education was described as helping ease some of the challenges Midwifery experienced in trying to find space in parenting classes for everyone in their caseload. FNP was also seen as more '*intensive'* than Midwifery and able to provide more holistic support as a result. Similar comments were also made in relation to health visiting and social work.

9.13 Social Work and FNP were seen as sharing similar values around supporting families; trying to keep them together and helping them access resources. However, differences in their perspectives were also noted. In particular, it was suggested that FNP focused on strengths and on '*early intervention*', whereas social workers have to focus primarily on '*preventing risk'*.

9.14 In general, the role of different services in relation to clients appeared to be clearly understood by the local stakeholders interviewed for the evaluation. However, a stakeholder form General Practice commented that it could be confusing from their perspective having two services (Health Visiting and FNP) running alongside each other and that it would be helpful to have a list of all the clients FNP are working with in their practice to ensure they know who is looking after which family. A Social Work stakeholder also noted that there had been some lack of clarity around what role the Family Nurse and Health Visitor should play in a case where a child was being accommodated. This had been resolved at the time and had not been a major '*challenge'*, but it was reported that there had needed to be some debate about roles in relation to the child. In a related comment, the NHS Lothian, Family Nurse Supervisor noted that there had been some confusion around who was the 'named person' for the child for Getting it Right for Every Child purposes, with all the related standards currently stating that it is the Health Visitor. Again, this was not seen as creating major difficulties but was something that needed clarifying and was being looked into by the FNP National Unit (Scotland).

Communication between FNP and other stakeholders

9.15 The stakeholders interviewed for the evaluation had contact with the NHS Lothian, Edinburgh FNP team through a variety of routes: through discussions or meetings about individual clients; via direct contact from the FNP team to inform their service about the programme; through occasional sharing of workspaces; and through involvement in strategic discussions within NHS Lothian about FNP. The level of direct contact they had with the NHS Lothian, Edinburgh team varied across the stakeholders interviewed for the evaluation. However, all were able to comment on aspects of communication and working relations they felt had worked well and less well. Overall, communication and working relations between FNP and individual practitioners around clients was reported to have been good – suggestions for improvement tended to be more at the service to service level.

9.16 Social Work stakeholders reported that it was interesting and challenging to work with someone with an '*undiluted'* focus and approach. Even where social workers and Family Nurses disagreed over the best course of action for a client or their child, they reported that FNP's input was valued in ensuring that all views are considered and that they have done everything they can for the family. Stakeholders from General Practice and Midwifery similarly reported that their links with FNP over individual clients were good and that they were able to work together where needed.

9.17 Factors stakeholders identified that appeared to support good working relations and communication between FNP and their services included:

- Regular and open communication from the FNP team when FNP was first being set up
- Ongoing regular meetings and e-mail contact, including members of the FNP team attending meetings of other services to help them better understand what FNP is about and their approach
- The electronic record system within NHS Lothian, which meant that both Midwives and Family Nurses could see what was happening with shared clients
- New Family Nurses shadowing Midwives to get a feel for what is happening in Midwifery
- Family Nurses providing timely and detailed reports to other services (mentioned in relation to social work in particular)
- Individual staff already knowing individual members of the FNP team.

9.18 Midwifery stakeholders felt their service had become a bit more distant from FNP in the recent past. This underlines the need to re-establish links and re-introduce FNP to other services after a break in enrolment *'because these things get lost over time, or put at the bottom of a drawer'* (Midwife). In fact, this was already happening in NHS Lothian, with Midwifery reporting that the FNP team were re-visiting Midwifery team meetings and giving out information and contact details again.

9.19 Stakeholder suggestions for improving communication between FNP and other services included:

- **More and/or earlier sharing around the theoretical and research base of the programme, as well as how it will work with their service.** Both Social Work and General Practice stakeholders commented on this, suggesting that it would be helpful to find out more at the outset about the theoretical background to FNP, what the evidence is for its successes, and how it works with other agencies. A Social Worker commented on how useful a DVD that the NHS Lothian, Edinburgh team had shared with them had been in this respect, while a suggestion from General Practice was that all GPs should be sent summaries of the aims of FNP, what Family Nurses do, how they will communicate with GPs and what the evaluation evidence for FNP shows.
- **More regular meetings between Family Nurses and GP practices.** It was commented that in comparison with Health Visitors based within GP surgeries, there was less informal regular contact between GPs and Family Nurses. Given this, it was suggested that it would be helpful if Family Nurses could meet with GPs in practices where their clients were clustered to update them on how their clients are doing and how much contact they had with them. It is worth noting here that the FNP National Unit (Scotland) are currently considering issues around organisational preparation for delivering FNP, including how sites can best engage with GPs.

Learning from FNP in Lothian

9.20 The second evaluation report (Ormston et al, 2012) identified a variety of areas of potential strategic learning for other FNP sites and wider services from the experience of implementing FNP in NHS Lothian, Edinburgh. Additional learning points discussed in the third round of evaluation interviews focused on:

- **Learning around involving FNP clients in media and publicity around the programme.** It was suggested that while the media are very interested in FNP, this needs to be handled very carefully given the vulnerabilities of some clients. The FNP National Unit (Scotland) had worked with Communications colleagues on best practice in this area, drawing on the experience of working with the media around the NHS Lothian, Edinburgh site.
- **The importance of considering sustainability from the outset.** In terms of the long-term sustainability of FNP in Scotland, it was considered essential for Health Boards to think widely about the potential gains from FNP across organisations and divisions and to encourage connections with local authorities and others from the outset. It was noted that this had been built in to the Expression of Interest process for new FNP sites in Scotland.

- **Contributing to learning around co-production with service users**. FNP was believed to be contributing to the debate around co-production as an exemplar of an approach that supported people to make sense of their own situation and use their own strengths. It was suggested that there was considerable scope for FNP to work more with other areas – such as Community Nurses working with older people – in sharing learning around this theme.

REFERENCES

Barnes, J, Ball, M, Meadows, P, McLeish, J, Belsky, J and the FNP Implementation Research Team (2008) *Nurse-Family Partnership Programme: first year pilot sites implementation in England: pregnancy and the post-partum period*, London: Dept of Health/Dept of Children, Schools and Families

Barnes, J, Ball, M, Meadows, P, Belsky, J and the FNP Implementation Research Team (2009) *Nurse-Family Partnership Programme: second year pilot sites implementation in England: the infancy period,* London: Dept of Health/Dept of Children, Schools and Families

Barnes, J, Ball, M, Meadows, P, Howden, B, Jackson, A, Henderson, J and Niven, L (2011) *The Family-Nurse Partnership Programme in England: Wave 1 implementation in toddlerhood & a comparison between Waves 1 and 2a of implementation in pregnancy and infancy*, London: Dept of Health

Department of Health (November 2010) *FNP Management Manual* (amended for Scottish FNP sites)

ISD (2012) *Childhood Immunisation Statistics: Quarter and Year ending 31 December 2011*, available online at http://www.isdscotland.org/Health-Topics/Child-Health/Publications/2012-03-27/2012-03-27-Immunisation-Report.pdf?46152895690

Martin, C, Marryat, L, Miller, M, Ormston, R and Gordon, J (2011) *The evaluation of the Family Nurse Partnership programme in Scotland: phase 1 report – intake and early pregnancy*, Edinburgh: Scottish Government available online at http://www.scotland.gov.uk/Resource/Doc/355013/0119868.pdf

Olds, D (2006) 'The Nurse-Family Partnership: an evidence-based preventive intervention', *Infant Mental Health Journal* 27(1): 5-25

Ormston, R, McConville, S and Gordon, J (2012) *Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 2nd report – Late pregnancy and postpartum*, Scottish Government, available online at: http://www.scotland.gov.uk/Publications/2012/06/1551

Sanders, J, Owen-Jones, E and Robling, M (2011) 'Evaluating the Family Nurse Partnership in England: the Building Blocks trial', *The Practising Midwife*, 14(7): 13-15.

Scottish Government (2007) Growing Up in Scotland: Summary of findings from Year 1, available online at: http://www.scotland.gov.uk/Resource/Doc/162291/0044115.pdf

Social Research series
ISSN 2045-6964
ISBN 978-1-78256-312-9
web only publication

www.scotland.gov.uk/socialresearch

APS Group Scotland
DPPAS13752 (12/12)