

Evaluation of The Family Nurse
Partnership Programme In NHS
Lothian, Scotland: 2nd Report –
Late Pregnancy And Postpartum

**EVALUATION OF THE FAMILY NURSE
PARTNERSHIP PROGRAMME IN NHS Lothian,
SCOTLAND:
2ND REPORT – LATE PREGNANCY AND
POSTPARTUM**

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

Rachel Ormston & Susan McConville

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EXECUTIVE SUMMARY

Background

1. This summary presents the key findings from the second report of the evaluation of the Family Nurse Partnership (FNP) programme in NHS Lothian, Scotland. FNP is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a programme of structured home visits delivered by specially trained Family Nurses during early pregnancy and continuing until the child is two years old.
2. The evaluation focuses on learning from the experiences 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, drawing on quantitative data collected and collated by the NHS Lothian, Edinburgh FNP team, and on qualitative interviews with clients, Family Nurses and key stakeholders. This second report focuses on experiences of the programme in the late pregnancy and post-partum period (first 6 weeks following birth).

Relationships

3. By the end of the pregnancy phase, 93% of clients remained engaged with the NHS Lothian, Edinburgh FNP programme. The percentage of clients leaving the programme or 'inactive' (no contact for 6 months) during the pregnancy phase ('attrition') was 6.8% - well below the 10% or less attrition target in the fidelity 'stretch' goal. The NHS Lothian, Edinburgh Family Nurse team attributed this very low attrition rate primarily to the strength and continuity of the relationships established between clients and Family Nurses during pregnancy. Where challenges or difficulties were reported in Family Nurse-client relationships, these tended to be seen as related to lower levels of contact and/or specific challenging circumstances (like a baby being taken into care).
4. The NHS Lothian, Edinburgh FNP test site achieved the fidelity 'stretch' goal for the proportion of expected visits delivered during pregnancy (80%) for 52% of clients. Factors that helped Family Nurses meet the visiting schedule during pregnancy included: being able to be flexible about appointments; establishing strong client relationships (with clients motivated to keep appointments); and the level of motivation clients had to discuss the birth and beyond with their Family Nurse. Challenges to delivering the target number of visits for some clients during pregnancy included:
 - *Client related factors*: client mobility and/or geographical spread; challenges making appointments with clients who were working or who had chaotic lives; and fitting around client appointments with other services.
 - *Nurse or programme-related factors*: the amount of training Family Nurses attended during the pregnancy phase; nurse annual leave; and challenges delivering weekly visits at the same time as engaging and enrolling clients.
 - *External factors*: an extended period of bad weather (resulting in cancelled visits) and changes in clients' delivery dates.

- Partners were present for 32.8% of visits during the pregnancy phase. Where clients' partners were involved in FNP, there was evidence that participation helped support their involvement in the birth.

FNP programme content in the late pregnancy to post-partum phase

- The average time Family Nurses in NHS Lothian, Edinburgh recorded spending on different topics during pregnancy was very close to the division suggested by the fidelity 'stretch' goals. In general, Family Nurses felt that the suggested programme content during pregnancy was well matched to clients' needs. The content for the post-partum period was viewed as very full, however. It was suggested that a degree of flexibility was required to create space to deliver other relevant activities and to agenda match.
- In cases where a baby is taken into care, it was suggested that (where a final outcome has not yet been determined) the programme materials may not always lend themselves particularly well to supporting Family Nurse visits to mothers, since they focus on issues like attachment which can be very sensitive in this situation. Other aspects of the programme materials that Family Nurses felt could be improved or enhanced related to labour and delivery, sexual health and binge drinking.
- Clients appeared to be very happy with the overall content of the programme and with their ability to raise additional issues with their Family Nurses as required. In terms of the perceived impacts of the programme in the late pregnancy and post-partum period:
 - Both clients and their partners gave examples of the ways in which they felt more knowledgeable and confident about labour and delivery, including feeling clearer about the stages of labour, feeling better able to assert their views during delivery and feeling more confident when the delivery did not go completely to plan.
 - Examples of positive health behaviours and knowledge clients' attributed to FNP in the late pregnancy/post-partum period included: breastfeeding for longer; resisting pressure to wean early; greater awareness of the risks of smoking and drinking during and after pregnancy; changes to eating habits during or after pregnancy; and awareness of a greater range of contraceptive options.
 - In relation to bonding with their new baby, while one view was that clients and partners would have engaged in bonding activities without their Family Nurse, clients and partners also reported discovering or gaining confidence to try new activities to support attachment in the post-partum period.
 - Similarly, while clients did not necessarily feel that the information they received from FNP around safety and hazards was new to them, there were also examples where they felt they had changed their approach because of their Family Nurse – for example, in relation to safe sleeping positions or sterilising dummies.

- Clients in the qualitative panel who had experienced issues around their emotional or mental health around the birth and post-partum period were positive about the support they had received from their Family Nurse, ranging from general advice about coping with stress to assessments and referrals to GPs for treatment for post-natal depression.
9. Exceptions to this generally very positive picture of the support received around the birth/post-partum period included comments that clients had not received elements of support they had expected or wanted (including specific information relating to birth) or that they preferred to go to other people for advice.
 10. Quantitative evidence of outcomes was available for all FNP clients in relation to breastfeeding, gestation and birthweight. Some caution should be applied in interpreting these figures, given the lack of a control group. However, they nonetheless provide useful data on the experiences of the first FNP cohort in Scotland. Overall, 46% of NHS Lothian, Edinburgh FNP clients breastfed at least once. Among FNP clients who were hostile to or ambivalent about breastfeeding when they joined the programme, 28% went on to breastfeed at least once. There was some evidence that both clients and Family Nurses felt they were not always receiving either enough or appropriate support with breastfeeding in hospital, and that in some cases this might undermine clients' intentions to breastfeed. Average gestation of babies born to the first FNP cohort in Scotland was 40 weeks (well above the 37 week threshold for a birth to be considered full term). Average birthweight was 3,291g, with 7.2% having a low birthweight. None had a very low birthweight.

Services, resources and referrals

11. Family Nurses referred clients to a wide range of services during pregnancy. Referrals from Family Nurses for both maternal and child health issues were clearly appreciated by clients and significant others. It was suggested that without the support of the Family Nurse, maternal health issues might have gone undiagnosed or untreated for longer. Family Nurses also appeared to play an important role in giving clients confidence in their own judgement about when to contact their GP about their baby's health. The information and support Family Nurses provided in relation to accessing housing and benefits were highly valued. The nature of this support varied in terms of how involved Family Nurses were in actually liaising with other services on clients' behalf, or whether they adopted more of a sign-posting role. More active involvement in linking clients with services was sometimes considered necessary where clients lacked confidence or motivation to engage with other services, or where they were in particularly challenging situations.
12. In terms of perceived differences in the support received from FNP and other antenatal services, while some FNP clients reported good relationships with both their midwife and their Family Nurse, others reported more mixed relationships with their midwife. One client view was that they 'got a lot more' information from their Family Nurse. Another was that midwives were not always best placed to support young mothers in particular. FNP may play an important role in providing antenatal education for young mothers who may not otherwise engage with antenatal classes – perceived by clients and significant others as being more

suited to older women. At the same time, there may be a need for more antenatal and postnatal groups aimed more specifically at young women.

13. Delivering FNP city-wide was seen as advantageous in terms of getting to know the range of services clients might be able to access, although at the same time gaining familiarity with all the services available across the whole city could be challenging. From the perspective of the NHS Lothian, Edinburgh Family Nurse team, working relationships between FNP and key services like midwifery, health visiting, social work and housing had all improved since the start of the programme as they had become familiar with each other and with FNP's ways of working. However, Family Nurses noted some initial challenges in communicating to social work what working with a 'strength-based approach' means. They commented that a lot of 'open communication' had been required to reassure social work that this did not mean ignoring risk. The number of social work teams across Edinburgh also meant it took time to build relationships with them all.
14. It was noted that FNP has had relatively less contact with public health nursing colleagues (health visitors) to date. Meanwhile, it was suggested that benefits services had been less helpful and that both Family Nurses and clients had often found them more difficult to deal with., .

Professional views and experiences of delivering the programme in the late pregnancy to post-partum period

15. Family Nurses' views of the training they received remained extremely positive. The ongoing opportunities FNP provides for learning and sharing practice across the UK were appreciated by the team. The quality and level of supervision provided to the FNP team was also viewed as 'invaluable', with the fact that supervision was part of the license enabling the team to prioritise it.
16. In terms of challenges in delivering the programme as a whole, including meeting the visiting schedule, workload continued to be viewed as a significant issue, although it was also suggested that this had eased a little since the first evaluation interviews. Issues contributing to high workloads in the late pregnancy and post-partum period included factors relating to FNP specifically (for example, the requirement to visit clients weekly in the 6 weeks post-partum) and factors stemming from the fact that the team is part of the wider NHS (for example, the move to an electronic child health record keeping system in Lothian in late 2011).
17. The lack of a user-friendly database, while not preventing effective supervision, continued to be viewed as a limitation on the team's ability to creatively engage with FNP monitoring data to support 'reflective supervision'.

Implementing FNP in Lothian

18. Perceptions of key learning from the experience of delivering FNP in NHS Lothian, Edinburgh for other FNP sites include:
 - The importance of early engagement with local stakeholders and services
 - Learning that 'the programme will sell itself' as people see the changes it can effect, and

- Building in time for consolidating learning from FNP training from the start.

19. Perceptions of the potential influence the NHS Lothian, Edinburgh FNP programme may have had on the wider NHS and other services focused on learning about:

- How to work with those less likely to access universal services
- How to support Nurses working in high pressure roles
- Specific approaches to assessing clients, and
- Thinking about services for teenage parents who are not eligible for FNP.

1 BACKGROUND AND INTRODUCTION

About this report

- 1.1 FNP is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a programme of structured home visits delivered by specially trained Family Nurses during early pregnancy and continuing until the child is two years old.
- 1.2 The evaluation of the Family Nurse Partnership (FNP) programme in Scotland focuses on learning from the experiences 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 second evaluation report focuses on the delivery of the programme in the late pregnancy and post-partum period.¹ It follows a first report (Martin et al, 2011) about the early implementation of FNP in NHS Lothian, Edinburgh and its delivery in early pregnancy. Subsequent reports (due late 2012 and spring 2013) will discuss learning from the experiences of FNP in NHS Lothian, Edinburgh in delivering the programme in infancy and toddlerhood.
- 1.4 The remainder of this introductory chapter describes the FNP programme and its implementation in Scotland in more detail. Chapter 2 briefly presents the evaluation methods and aims, while chapters 3 to 7 discuss the main findings from this phase of the evaluation on:
 - **Relationships** – Chapter 3 focuses on: the developing relationship between clients and Family Nurses; the relationship between Family Nurses and other family members; and the potential impact of participation in FNP on the relationships between clients and their family and friends.
 - **Programme content** – Chapter 4 explores: the amount of time Family Nurses spend on different topics in the late pregnancy and post-partum period; client and Family Nurse perceptions of the appropriateness of the programme content; and their views of specific topics covered.
 - **Services, resources and referrals** – Chapter 5 covers: the number and nature of referrals of FNP clients to other services; and client and professional views of how FNP compares to and works with other services.
 - **Professional experiences of delivering the project** – Chapter 6 focuses on views of the key achievements and challenges in delivering the programme to clients during late pregnancy and in the weeks after birth, as well as Family Nurse views on workload and the training and supervision they receive.

¹ The client and Family Nurse interviews conducted for this report focused particularly on preparing for the birth, the birth itself and the support received in the weeks immediately after the birth. This report also includes quantitative monitoring data collected and collated by the FNP team in Edinburgh for the pregnancy period and the period up to 6 weeks post-partum.

- **Implementing FNP in Lothian** – Chapter 7 summarises perceptions of key learning, both for and from the Lothian site.

1.5 Finally, Chapter 8 summarises the conclusions and key learning from the report.

The Family Nurse Partnership (FNP) programme

1.6 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 and well-being of first time parents and their children, child development and families’ economic self-sufficiency.

1.7 FNP is informed by three key theoretical approaches to supporting mothers and their infants:

- **Attachment** theory acknowledges the critical importance of new born babies developing secure attachments to their mothers in their subsequent development and the equally critical importance of mothers initiating a strong relationship with their baby to become ‘good mothers’ (Karl et al, 2006). Family Nurses aim to parallel the mother-infant relationship in the relationships they build with clients, and to provide opportunities for activities that maximise contact between mothers and babies and help mothers become more responsive to their newborn babies’ cues.
- **Self-efficacy** theory provides a framework for Family Nurses to understand how women make decisions for themselves and their child by suggesting that people are most likely to choose behaviours not only on the basis that they will lead to a particular outcome, but also on the basis that they think they themselves can successfully carry out the behaviour (Olds, 2006). Family Nurses use techniques like motivational interviewing (Houston Miller, 2010) to improve participants’ sense of ‘self-efficacy’ and their feelings of control over their lives and relationships.
- **Human Ecological** theory highlights the importance of mothers’ social, community and family context in influencing their decisions and behaviour and the ways they care for their children. Family Nurses therefore work to involve other family members in visits and to link families with wider services in the local community.

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

1.9 In addition, the FNP Management Manual sets out various fidelity goals – described as 'stretch goals'². These are goals based on the research evidence which, if met, may help maximise the likelihood of the programme achieving the same results as the US sites. 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 (see Annexes to Martin et al (2011) for a full list of the FNP Core Model Elements and Fidelity 'stretch' goals).

Testing FNP in the UK

1.10 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 25 January 2010. Since then, Scottish FNP sites have been introduced in NHS Tayside in July 2011. At the time of writing, the Scottish Government was planning to increase FNP capacity to reach three times as many clients as now and recruiting five new Health Boards by the end of 2013. Boards have been invited to submit expressions of interest and self-assessments by one of three phased deadlines³ for assessing applications for participation in FNP roll-out. Regional information days are being delivered to assist Boards in considering whether or not they are ready to deliver FNP.⁴ Matched funding has also been secured to enable NHS Lothian to move to small scale permanency starting in summer 2012.

FNP in NHS Lothian, Edinburgh

1.11 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:

² 'Stretch goals' are goals which the programme aspires to achieve. These are the optimum goals for ensuring the success of the programme. However, they may be difficult to achieve when first implementing the programme.

³ 10 February 2012, 13 April 2012 and 15 June 2012.

⁴ For further information, see <http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership/training> (accessed 10 February 2012).

- One Supervisor
- 6 Family Nurses, and
- An Administrator/Data Manager.

1.12 Since the first evaluation report, key changes to this team include: the appointment of the Nurse Supervisor to a new role of Scottish National Lead Supervisor for one day a week, with an existing team member acting up to supervisor; the local FNP Lead in Lothian leaving at the end of their contract; and the departure of the team Administrator.

1.13 148 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, from February to October 2010. The first clients delivered their babies in April 2010, so the first cohort of clients will start to 'graduate' from April 2012 (when their child turns two years-old), with the full cohort due to complete the programme by the end of April 2013.

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
 - Implications for future nursing practice, and
 - What factors support or inhibit the delivery of the programme
- 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. It is hoped that many of the findings in this second evaluation report will be relevant to new FNP sites in both Scotland and further afield, and to Health Boards considering whether or not to apply to deliver FNP locally.

2.3 The evaluation is **not** a formal impact evaluation. Where possible, it reports on the evidence for the *potential* for FNP to impact on key outcomes for parents, children and services. However, it does not have an experimental or quasi-experimental design and it is not, therefore, possible to conclusively establish causal links between FNP and particular outcomes. The current 'Building Blocks' RCT in England (described in Sanders et al, 2011) will be able to provide such causal evidence, and is therefore likely to be of considerable importance for those with an interest in FNP in Scotland too.

2.4 Further details about the remit for the evaluation are provided in Martin et al (2011).

Monitoring and evaluation framework

2.5 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 each findings chapter in this report are taken from this framework. For further details, see Martin et al (2011).

Overview of research methods

2.6 The evaluation is addressing the aims set out in Chapter 1 using a range of quantitative and qualitative methods, comprising:

- **Analysis of quantitative data collected by the FNP team in NHS Lothian, Edinburgh for all clients** in the first FNP cohort in Scotland. A large volume of data is collected on all clients by Family Nurses and collated and provided to the external evaluation team as anonymised, aggregate figures.⁵
- **Qualitative research with a smaller sub-sample of FNP families.** Qualitative data compliment the quantitative data collected for all clients by providing a more nuanced account of experiences of programme, including aspects of the programme that are difficult to quantify. A panel of mothers from the first FNP cohort in NHS Lothian, Edinburgh are being interviewed at four points as they move through the programme. 15 clients were initially recruited to this panel, with the expectation that at least 10 would be willing to be re-interviewed on all four occasions. In addition, participants 'significant others' are being interviewed at around 3-6 months and around 21-24 months after joining the programme. Finally, the evaluation team plans to conduct three focus groups with clients not included in the qualitative panel over the course of the evaluation.
- **Qualitative interviews with the NHS Lothian Edinburgh Family Nurse team.** Family Nurses (including the Nurse Supervisor) in Edinburgh are also being interviewed on four occasions during the evaluation, roughly mirroring the timing of the client panel interviews.
- **Qualitative interviews with national and local stakeholders.** A series of key national (Scotland and England) and local (Lothian) stakeholders were interviewed to inform the first evaluation report (Martin et al, 2011). The National FNP Lead for Scotland is being interviewed throughout the evaluation, while it is expected that the views of more local stakeholders, probably drawn from midwifery and General Practice, will be included in the next evaluation report, in order to explore their views of FNP and its relationship with wider services.

2.7 Further detail about the research methods used by the evaluation, and the purpose and contribution of each component, are included in Martin et al (2011).

Data included in this report

2.8 This second report of the evaluation of FNP in Scotland focuses on the experience of delivering and receiving FNP in the pregnancy and post-partum period. It uses data drawn from:

- **Quantitative data** collected and collated by the NHS Lothian Edinburgh FNP team for all clients covering the **pregnancy period** and the period up to **6 weeks post-partum**, and
- **Qualitative data** from:

⁵ Initially by the NHS Lothian local FNP lead, and from March 2012 by the newly appointed FNP Research and Information officer, based in NES.

- **panel clients**, interviewed around **3 months** after their babies were born
- **clients' 'significant others'**, interviewed after the clients' 3 month interviews
- the NHS Lothian, Edinburgh **Family Nurse team**, interviewed in October/November 2011.

2.9 The report is also informed by an additional paired depth discussion with two further FNP clients (not included in the longitudinal panel) and ongoing interviews with the FNP National Lead for Scotland.

2.10 Of the original panel of 15 clients recruited to the evaluation, 14 were re-interviewed around 3 months after their babies were born, while one dropped out of the evaluation. The evaluation team received contact details for 13 potential 'significant others', 6 of whom were interviewed (including a combination of participants' partners and their mothers). Two of those nominated declined to participate, while five were not contactable during the fieldwork period.⁶

2.11 As discussed above, the evaluation team planned to conduct three focus groups with NHS Lothian, Edinburgh FNP clients who were not selected for the longitudinal panel interviews. The first group was scheduled for October 2011. However, although 7 clients had indicated that they would attend, on the day only two clients attended. In light of this, the evaluation team is reviewing its strategy in advance of the next group (planned for summer 2012). The two clients who were interviewed nonetheless had valuable insights about their experiences of FNP, which are included in this report alongside those of panel clients.

Reporting conventions

2.12 As discussed above, detailed information from FNP clients, their 'significant others', 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 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 about or experiences of FNP. Given this, where possible quantifying language, such as 'all', 'most' or 'a few', is avoided when discussing qualitative findings.

2.13 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 completely 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.

⁶ The evaluation team plans to revisit their strategy for interviewing significant others in advance of the next round of interviews (21-24 months) to consider how the evaluation might more successfully engage with significant others.

- 2.14 In order to protect the anonymity of clients and Family Nurses, participants are referred to by numbers only. Where there are small number of participants in particular roles, it can be more difficult to guarantee confidentiality in reporting their views. In light of this consideration, where participants were in unique or identifiable roles, they were given the opportunity to review their transcripts and any sections of the report that summarised their views in a way that might potentially be identifiable or which quoted them directly. Any requests to remove a quote or potentially identifiable summary were always respected.
- 2.15 Finally, this report does not include any explicit comparisons with 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

- 3.1 The 'therapeutic relationship' between client and Family Nurse is at the heart of FNP's approach. The key aims of the programme – building clients' skills, self-efficacy and confidence as parents – underpin this client-Family Nurse relationship. The holistic focus of the programme – exploring the social, emotional and economic context of clients' lives – also means that Family Nurses often seek to involve other family members in the programme, with the aim of enhancing the wider support available to both mother and baby. This Chapter draws on both quantitative and qualitative data to explore the nature and quality of the relationships between, first, clients and Family Nurses and second, Family Nurses and other members of clients' families..
- 3.2 Key questions from the monitoring and evaluation framework addressed in this chapter include:
- Does the programme meet the fidelity targets for attrition?
 - Do the Family Nurses carry out the intended number of visits?
 - How feasible/appropriate is the visiting schedule?
 - How involved are fathers in the FNP process/visits?
 - Is the FNP seen to engender fathers' involvement?
 - Do clients mobilise support within personal networks?

Relationships between clients and Family Nurses

Client retention and engagement

- 3.3 As Barnes (2010) notes, 'In a programme extending over 30 months, attrition will always be a major concern'. Evidence from the delivery of the programme in 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, and should not be greater than:
- 10% during pregnancy
 - 20% during infancy and
 - 10% during the toddler phase.
- 3.4 These are fidelity 'stretch' goals (see Chapter 1 for definition).
- 3.5 Programme attrition during the pregnancy phase of FNP in NHS Lothian, Edinburgh was 6.8% - well below the 10% maximum attrition fidelity 'stretch goal' suggested for this phase. This figure is comprised of 2.7% (4 clients) who left the programme during pregnancy, and 4.1% (6 clients) who were 'inactive' (disengaged) for over 6 months by the end of pregnancy.
- 3.6 In all 4 cases where clients left the programme, withdrawal was either because they had moved out of the area covered by FNP in Edinburgh, or because of pregnancy loss – factors which in fact mean they are no longer eligible to participate. In fact, one of these 4 clients had subsequently moved back into the FNP catchment area, and re-joined the programme in the infancy phase.

No clients left the programme during the pregnancy phase because they no longer wished to take part.

- 3.7 FNP sites also monitor clients who have not left the programme, but are currently 'disengaged' (having not received a visit from their Family Nurse for more than 6 weeks) or 'inactive' (disengaged for 6 months or more – see Table 3.1). At the end of the pregnancy phase, 12 clients (8.1%) were classed as 'disengaged' – that is, they had not left the programme, but had not seen their Family Nurse for more than 6 weeks. Of these, 6 had not had any contact for more than 6 months.
- 3.8 The next evaluation report will include final attrition figures for the infancy phase. However, as of the end of November 2011, cumulative programme attrition was 11.5% (17/148), with 88.5% of clients remaining on the programme.⁷

Table 3.1: Attrition and disengagement (pregnancy phase), NHS Lothian, Edinburgh FNP test site

	Pregnancy phase
Left programme	2.7% (4/148)
Inactive (no contact for more than 6 months)*	6.8% (10/148)
Disengaged (no contact for more than 6 weeks)	8.1% (12/148)

* Inactive comprises those who have had no face-to-face contact for 6 months or more.

- 3.9 Clients who are disengaged or inactive can re-engage with the programme, and do not therefore count towards the attrition rate. The NHS Lothian, Edinburgh Family Nurse team commented on the fact that some clients' level of engagement does fluctuate. They cited examples of clients who appeared to be disengaging but subsequently fully re-engaged with the programme, either because '*their head has cleared*', or perhaps because they were experiencing some kind of adversity and were looking for support from FNP. Where clients either cancelled visits or were out of the area for several weeks on holiday or visiting family, there was a perception that 6 weeks might easily pass without face-to-face contact. However, the team reported making considerable effort to keep in touch with clients who had disengaged by text and phone. In fact, one view was that the figures for clients who are 'disengaged' might be an overestimate as they may not include these non face-to-face contacts within the 6 week window before a client is classed as 'disengaged'.
- 3.10 The NHS Lothian, Edinburgh Family Nurse team attributed the very low attrition rate during pregnancy primarily to the strength and continuity of the relationships between clients and Family Nurses, discussed in more detail below. Levels of disengagement were also low and, as discussed, may not necessarily lead to attrition. However, the team did reflect on the reasons why some clients had disengaged (and in some cases subsequently left the programme during infancy) and on approaches that, with hindsight, might have

⁷ Cumulative attrition by November 2011 comprised 7 clients who had moved out of the area during pregnancy or infancy, or who were otherwise no longer eligible to participate, and 10 clients who had been inactive (no contact with FNP) for 6 months or more as of November 2011.

helped prevent disengagement. Two main reasons why clients disengaged from FNP were identified by the NHS Lothian, Edinburgh Family Nurse Team:

- a belief on the client's part that they did not need the programme, and
- a perception that the nature of the programme had been difficult for the client to cope with at that point in time, for example because they found the programme too intense in terms of the time commitment or the topics covered, or (more exceptionally) because they found the strengths-based approach 'overwhelming' (because it was so unfamiliar to them).

3.11 Family Nurses reflected on things they might have done differently to keep these clients engaged. Their suggestions focused on agenda matching⁸ the programme to the clients' specific needs from an earlier stage, including:

- using a reduced visiting schedule for a period of time if the client appeared to be finding the programme too demanding and there was a concern they might disengage
- keeping the programme 'lighter' in the earlier stages and delving less deeply into emotional issues where clients appear to be struggling with this, and
- moderating use of 'strengths-based' language in the case where the client seemed to be reacting against this.

3.12 In part, these comments may reflect the fact that Family Nurses in Edinburgh were still at a relatively early stage of delivering the programme during the pregnancy period. As discussed in Chapter 4, Family Nurses felt that their ability to agenda match their approach to the needs of different clients was improving with time and experience. Family Nurses' suggestions also indicate that for the most vulnerable clients, a highly flexible approach to meeting their needs may be the best way of keeping them engaged. This reflects findings from the US research on the programme, which shows that nurses with the highest retention rates tended to emphasise tailoring and adapting the programme to the needs and interests of clients, while those with lower retention rates had a more directive approach, emphasising the programme's 'perks' and the positive outcomes of completion (Ingoldsby et al, 2009, discussed in Barnes, 2010).

3.13 A final suggestion from the Family Nurse interviews in relation to engagement and retention was that Family Nurses should avoid enrolling new clients in the week before they go on annual leave, as visits in the immediate weeks after enrolment were considered particularly important in terms of both establishing a relationship and addressing any concerns clients might have about participation.

Level of contact between clients and Family Nurses

3.14 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

⁸ 'Agenda matching' describes how Family Nurses aim to work with clients; respecting and addressing the clients agenda while balancing the implementation of a manualised programme.

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.

3.15 The fidelity 'stretch' goals also specify the content of the programme to be delivered in each phase of the programme.

3.16 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. In the post-partum period, clients are visited weekly for the first 6 weeks after the birth and 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.

3.17 The NHS Lothian, Edinburgh FNP site met the fidelity 'stretch' goal (80% of expected visits) during pregnancy for 52% (77/148) of all clients who enrolled in the programme. The average dosage during pregnancy was very close to 80% (79%). The average number of visits delivered during pregnancy was 9.6 for all clients.⁹

3.18 The Family Nurse team in NHS Lothian, Edinburgh identified a number of factors that they felt helped with meeting the visiting schedule during pregnancy, including: flexibility in terms of allowing clients to change appointments and being contactable by them by phone or text; the relationships they had with their clients which meant clients were motivated to keep to appointments; and the level of motivation they felt clients had during pregnancy to engage with the programme and to discuss the birth and beyond. However, Family Nurses also identified a number of issues they felt had been barriers to delivering the target number of visits for more clients during the pregnancy phase. These issues can be divided between client-related factors, programme or nurse-related factors and external factors, outwith the control of nurse or client. Client-related factors identified by Family Nurses included:

- Client mobility and/or geographical location – the fact that Family Nurses had clients across NHS Lothian and that clients tended to move frequently was seen as presenting practical challenges in getting round all the visits they needed to carry out within a particular week.

⁹ Note that the exact visiting schedule for pregnancy will depend on the stage of pregnancy at which clients were recruited to the programme (which obviously affects the time available for visits prior to the birth of the baby). The actual number of visits deliverable during pregnancy will also be affected by the date of the baby's delivery – for babies born early, fewer visits will be possible, and vice versa for late deliveries. Once all clients had delivered their babies, the NHS Lothian, Edinburgh FNP site re-calculated the expected number of visits for each client and compared this with the actual number of visits delivered during pregnancy to give an achieved 'dosage' (the proportion of expected visits actually delivered) for each client.

- Challenges around making/keeping appointments for clients who were working and whose time might be more limited as a result.
- Client life course – where clients were perceived to have relatively chaotic lives, this was sometimes viewed as mitigating against keeping regular appointments with them.
- Clients' appointments with other services, which were sometimes perceived to take up a lot of time and/or mean that clients had to cancel appointments with their Family Nurse.

3.19 Programme/nurse-related factors included:

- Nurse annual leave also sometimes preventing the team delivering weekly or fortnightly visits. Although clients have the option of contacting another member of the team when their Family Nurse is not available, the NHS Lothian Family Nurse team noted that in practice clients rarely did so. This preference for only contacting their own Family Nurse is reflected in client comments too:

I would prefer to speak to my nurse that I have. Like if there was a problem, I probably would feel a bit uncomfortable phoning someone else and asking them to come out 'cos I've been dealing with the same person, so I'd probably just look somewhere else instead of getting someone I don't know out.

(Client 9)

- Challenges around the recruitment window and around balancing the need to learn the programme and attend training with caseloads (discussed in Martin et al, 2011).

3.20 Finally, external factors affecting the team's ability to deliver planned visits included:

- The bad weather experienced towards the end of 2010 and early 2011, which had resulted in a large number of cancelled visits (82 in total).
- Changes in clients' delivery dates, which sometimes created difficulties in delivering the last few weeks of planned content for the pregnancy phase (though this would not be reflected in lower dosage figures, since these take account of the eventual delivery date).

3.21 The clients interviewed for the evaluation appeared aware of some of the barriers Family Nurses experienced in meeting every scheduled visit, mentioning the snow and their Family Nurse being on holiday or ill as reasons for gaps in visits. Client views on the duration and frequency of visits were generally positive though, with clients describing the level of contact during pregnancy and the post-partum period as '*just enough*' and stating that they were able to get in touch with their Family Nurse between appointments by text or phone in any case if they needed additional support. More negative comments, however, included a view that home visits were sometimes too long and took up too much of the client's time and complaints about Family Nurses being late or cancelling appointments with short notice.

3.22 A specific issue also emerged from interviews with clients and the NHS Lothian, Edinburgh Family Nurse team about the level of support clients receive when a baby is taken into care. As long as the mother is engaged, the mother continues to receive visits from their Family Nurse. At the same time, unless there has been a clear decision that the baby will not be reunited with the mother, Family Nurses also continue to visit the baby, sometimes separately from visits with the mother when they are living apart. Interviews highlighted the continuing desire of mothers in this situation to receive support from their Family Nurse, but also the challenges for Family Nurses in delivering the programme in this scenario, which could lead to a client perception that the Family Nurse was supporting the baby more than the mother. The process for working with clients where a baby is taken into care is complex and the level of contact between Family Nurse and client may depend on a large number of variables including: whether the baby was taken into care with the mother's consent or whether he or she was removed; whether the arrangement is temporary or permanent (in most cases babies will be taken into care on a temporary basis initially, and this arrangement may or may not become permanent); the reasons for the baby being taken into care (which in some cases might create safety issues for Family Nurses around continuing with home visits – for example, if there were concerns violence in the home – as well as issues around criminal proceedings); the amount of time the mother has available for Family Nurse visits alongside supervised visits to the baby; and the mother's reaction to any involvement of the Family Nurse in the decision to take the baby into care. Interviews with the NHS Lothian, Edinburgh Family Nurse team also identified some challenges around delivering the *content* of the programme when a baby is taken into care (discussed further in Chapter 4).

Nature of the relationship between clients and Family Nurses

3.23 As discussed above, the nature and strength of the relationship between client and Family Nurse was considered key to maintaining engagement with the programme and to being able to agenda match the content effectively (see Chapter 4 for further discussion of this). In the second wave of evaluation interviews, conducted around 3 months after clients had delivered their babies, both clients and Family Nurses reflected on the ways in which their relationships with each other had developed during the pregnancy and post-partum period. While some relationships had taken longer to establish than others, Family Nurses suggested that in general their relationships with their clients were now deeper and that the 'therapeutic' aspect had become more prominent. These views were echoed in comments from clients, who described feeling more comfortable talking to their Family Nurses about a wide range of issues once they had got to know them better.

I think now I'm getting to know her better, we're getting on a lot better ... I feel ... more comfortable like speaking about anything, so I just let it all go basically. Just talk about anything!

(Client 12)

- 3.24 Clients also clearly valued both their Family Nurse's professional knowledge, while the ways in which they acknowledged and recognised clients' own knowledge and strengths could have a significant impact on client confidence.

She's someone easy to talk to ... She's like a friend to talk to, and then she's like ... a professional as well.

(Client 3)

There is a lot of folk actually out there that are like, 'Right, you're a young mum. You're not very good. How are you meant to cope with a child when you're basically a child yourself?' And it kinda does put you down and that. And ... they do build you up 'No you're not. You're a brilliant mum. You're doing fabulous.' ... So it just makes you feel like 'Maybe I'm not, ken, a young mum. Maybe I'm not daft and can't bring him up ... Maybe I'm actually a good mum and I can do this.'

(Client 16, paired interview)

- 3.25 Where clients and Family Nurses reported challenges or difficulties in their relationship, this tended to relate to lower levels of contact between them at particular points (reasons for which are discussed above) and/or to specific challenging circumstances (such as a baby being taken into care, discussed above).

Relationships between Family Nurses and the client's wider family

- 3.26 FNP is underpinned by 'human ecological theory', which highlights the importance of mothers' social, community and family context in influencing their decisions and behaviour and the ways in which they care for their children. Family Nurses therefore attempt to involve the wider family in visits where it is possible and appropriate to do so. The NHS Lothian, Edinburgh FNP site recorded that clients' husbands or partners were present for 32.8% of visits during the pregnancy phase.

- 3.27 Family Nurses reported that they encouraged clients to involve their partner and/or the baby's father with FNP. However, Family Nurse's and client's accounts of the level of involvement fathers/partners have in practice reflects a wide range, from little or no contact, to dipping in and out of sessions, to fathers who are very engaged and attend most sessions. Clients reported that where partners did not attend sessions, they nonetheless sometimes completed worksheets or read information left by the Family Nurse. Family Nurses' views on the relationship between the stage of the programme and fathers' levels of involvement varied – one view was that they saw more of them antenatally, while another was that fathers often became more engaged after the baby was born when they wanted to get more involved in the baby's care.

- 3.28 Barriers to involving fathers/partners included:

- Practical barriers around arranging visits to suit both client and father/partner, particularly where fathers/partners were working or studying full time. Family Nurses noted that they sometimes arrange later visits so that fathers/partners can attend.

- Client-related barriers – for example, Family Nurses reported that clients sometimes did not want their partner to be very involved as they felt their Family Nurse was ‘theirs’.
- Father/partner-related barriers – both Family Nurses and clients reported that sometimes partners just elected not to be involved.

3.29 Clients’ and partners’ accounts of the impact of involving partners in FNP in the pregnancy and post-partum phase tended to focus on the benefits of their Family Nurses advice for their relationships (discussed below) and on their partners’ confidence about the birth, rather than on practical childcare skills. Comments from Family Nurses, clients and partners suggested that Family Nurses could help give partners a better understanding of the birth itself and help them to feel more comfortable and confident about their role in this.

Certainly one of them was delighted to share with me that he actually managed to cut the cord in the end, because that was something he hadn’t been sure about and we’d spoke about it beforehand, that he wasn’t under pressure but if he wanted to this is what it would look like, this is what it would feel like and ... he was quite delighted that he had been able to do that.

(Family Nurse 5)

3.30 Although only a small number of partners were interviewed for this evaluation, and these are likely to be among those who were more involved with FNP, their comments nonetheless highlight the value they placed on their involvement and on being able to use the Family Nurse as a source of information when they had questions and concerns.

(Family Nurse) has answered my questions and queries just as ... as if I was the main sort of focus as client as well. I don’t feel like the second person. I feel like we’re together so (Family Nurse) sees us together.

(Significant Other 1)

3.31 While figures on the involvement of other family members in visits are not collected as part of FNP monitoring data, Family Nurses report that clients’ mothers are often present for visits. While the involvement of clients’ wider support network was welcomed, on occasion it could also be challenging, particularly where grandmothers appeared to consider that they knew as much or more about childcare compared with the Family Nurse. Family Nurses again described using a strength-based approach to address any potential conflict with other family members – by acknowledging their experience and wisdom and the support they can offer to the baby’s parents, but at the same time recognising that good practice and advice about looking after babies might have moved on since they had their children. Where their Family Nurse had met either their mother or their wider family, clients reported that they got on well and that their family appreciated having someone to ask questions of.

Impact of FNP on clients' wider relationships

3.32 'Family and friends' is one of the key topic domains for FNP, which aims to support clients in identifying and building or maintaining strong networks to support them as parents. The explicit focus of the programme on clients' wider relationships, as well as the immediate health needs of mothers and their babies, is something that arguably distinguishes it from universal health services. Family Nurses noted that discussing clients' relationships could be challenging, particularly where the client was experiencing problems. Examples of strategies for encouraging clients to open up about their relationships included asking them to reflect on other relationships (not their current one) as a way of helping them to put their current relationship into perspective, and asking clients to reflect on why they thought a partner or family member was reacting in a particular way.

3.33 Clients interviewed for the evaluation gave a range of examples of positive impacts they felt their Family Nurse had on their relationships with others, including:

- **Improved communication.** Clients described their Family Nurse doing practical communication exercises with them, giving them ideas for ways of framing concerns without escalating conflict, and helping them think about how their actions or words might affect others. These kinds of activities and discussions were viewed as having helped them communicate in a more helpful, mature fashion and to share feelings more openly. Clients suggested that this help had improved (or even saved) relationships with partners, as well as helping diffuse conflicts within their wider family:

It did actually help. Like sometimes if we were having an argument, I'd try and, like, say stuff she had told me ... and most of the time it did actually work. Like it calmed the situation down.

(Client 13)

- **Improved self-efficacy/confidence.** Where clients were experiencing difficulties with other family members giving unwelcome advice about looking after their baby, they described their Family Nurse helping them with strategies for disagreeing with them while avoiding major conflict. This advice was seen as having both practical impacts – for example, being able to resist pressure from other family members to wean early – and emotional impacts in terms of improving their confidence in their ability and rights as parents.

3.34 More generally, clients also reported their Family Nurses checking in with them regularly to make sure that they do have enough support – for example, by helping them map their support network, checking that they are getting to see their friends, and asking about their relationships with wider family. In some cases, clients reported feeling quite isolated after they became pregnant – highlighting the importance of their social networks for young mothers.

Key points

Does the programme meet the fidelity targets for attrition?

- The percentage of clients leaving the NHS Lothian, Edinburgh FNP programme or 'inactive' (no contact for 6 months) during the pregnancy phase ('attrition') was 6.8% - well below the 10% maximum attrition target in the fidelity 'stretch' goal.
- The NHS Lothian, Edinburgh Family Nurse team attributed this very low attrition rate primarily to the strength and continuity of the relationships established between clients and Family Nurses during pregnancy. Both clients and Family Nurses felt their relationships had developed and strengthened during the pregnancy and post-partum periods.
- Reflecting on approaches that might have prevented a minority of clients from disengaging during pregnancy, Family Nurses' comments suggest that, for the most vulnerable clients a highly flexible approach to meeting their needs might be required.

Do the Family Nurses carry out the intended number of visits? How feasible/appropriate is the visiting schedule?

- The NHS Lothian, Edinburgh FNP test site achieved the fidelity 'stretch' goal for the proportion of expected visits delivered during pregnancy (80%) for 52% of clients.
- Factors that helped Family Nurses meet the visiting schedule during pregnancy included: being able to be flexible about appointments; establishing strong client relationships (with clients motivated to keep appointments); and the level of motivation clients had to discuss the birth and beyond with their Family Nurse.
- Challenges to delivering the target number of visits for some clients during pregnancy included:
 - *Client related factors*: client mobility and/or geographical spread; challenges making appointments with clients who were working or who had chaotic lives; and fitting around client appointments with other services.
 - *Nurse or programme-related factors*: the amount of training Family Nurses attended during the pregnancy phase; nurse annual leave; and challenges delivering weekly visits at the same time as engaging and enrolling clients.
 - *External factors*: an extended period of bad weather (resulting in cancelled visits) and changes in clients' delivery dates

How involved are fathers in the FNP process/visits? Is the FNP seen to engender fathers' involvement?

- Partners were present for 32.8% of visits during the pregnancy phase
- Where clients' partners were involved in FNP, there was evidence that participation helped support their involvement in the birth.

Do clients mobilise support within personal networks?

- Clients reported that their Family Nurses had supported them to communicate more effectively and to feel more confident about disagreeing (where appropriate)

with their partners and wider family, with a positive impact on both their relationships and on their sense of control as parents.

Other findings

- Challenges or difficulties in Family Nurse-client relationships tended to be seen as related to lower levels of contact and/or specific challenging circumstances (like a baby being taken into care).

4 FNP PROGRAMME CONTENT IN THE LATE PREGNANCY TO POST-PARTUM PHASE

Introduction

- 4.1 This chapter presents findings on perceptions of the appropriateness and impact of the FNP programme content in the period from late pregnancy to the first few months after birth, drawn primarily from qualitative interviews with FNP clients and the NHS Lothian, Edinburgh Family Nurse team. It also briefly summarises data from analysis of the monitoring forms returned by Family Nurses on coverage of specific topic domains during visits.
- 4.2 Key questions from the monitoring and evaluation framework addressed in this chapter include:
- Do family nurses conduct their consultations in line with the fidelity criteria?
 - Is the FNP structure useful/appropriate?
 - Is there any evidence that clients feel better prepared for birth?
 - Is there evidence that the FNP results in improved knowledge/health behaviours in clients prior to/following birth of baby?
 - How good are the pregnancy outcomes of those enrolled on the programme?
 - Is there any evidence that the FNP engenders positive parenting practices and bonding?
 - Is there evidence that the client knows about key hazards and engages in practices to keep child safe?
 - Is there any evidence that mums feel more supported and less anxious/depressed because of the programme?

Visit content figures

- 4.3 The fidelity 'stretch' goals for FNP set out the suggested division of topic coverage during Family Nurse visits at different stages of the programme (pregnancy, infancy and toddlerhood). These figures are intended to reflect variation in the developmental needs of parents and infants at different stages – for example, the amount of time allocated to personal maternal health is highest during pregnancy, while after the birth more time is allocated to maternal role. As shown in Table 4.1, the actual average time Family Nurses in NHS Lothian, Edinburgh recorded spending on different topics during pregnancy came very close to the division suggested by the fidelity 'stretch' goals. The time recorded against personal health and life course development were both within the suggested range, while the amount of time spent on maternal role, relationships with family and friends and environmental health were all less than 2 percentage point outside of this range.

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

Average Time Devoted to Content Domains during Pregnancy	Fidelity 'stretch' goal	NHS Lothian, Edinburgh site average
Personal Health	35-40%	38.3%
Environmental Health	05-07%	9.4%
Life Course Development	10-15%	11.4%
Maternal Role	23-25%	25.4%
Family and Friends	10-15%	15.5%

Perceived fit of the programme

4.4 The Family Nurse Partnership programme combines a manualised programme, containing detailed information materials, worksheets, etc. for each visit, with an approach that allows Family Nurses to use the programme flexibly to 'agenda match' with clients' needs at particular points in time. During the late pregnancy and immediate post-partum period, key topics covered in the programme include:

- Preparing for the labour and birth
- Infant feeding
- Parenting (including bonding and attachment, reading babies' 'cues', and sleeping and feeding routines), and
- Maternal health (including contraception, recovery from pregnancy, and Post Natal Depression).

4.5 In general, Family Nurses in NHS Lothian, Edinburgh felt the suggested programme content was well-matched to their clients' needs in late pregnancy, but that in the initial post-partum period (particularly the first 6 weeks after birth) it could be more difficult to deliver. In particular, it was felt that the programme content was very full in the post-partum period, and that, if delivered in its entirety, it might not leave room for other activities that Nurses felt might be of more value at that point (for example, use of the Partners in Parenting Education (PIPE) activities around parenting and 'reading' your baby). This was not, however, necessarily perceived to be a major problem, as by the post-partum period Family Nurses were more used to 'agenda matching' their delivery to the clients' specific needs at that point in time. One view was that in the first 6 weeks after birth, in particular, this agenda matching was particularly key and that the programme needed to be more 'mum-led'.

I will say that some of the stuff in the early infancy ... just trying to fit everything in ... was a problem, and sometimes things seemed to re-occur: 'Your baby's now a week old. Your baby's now 4 weeks old. Your baby's now 6 weeks old', you know? ... So ... often I would just leave facilitators and touch on the other things that were going on there.

(Family Nurse 4)

I think towards the end of pregnancy it's fine ... the emphasis is fine and where it should be in terms of practical and emotional ... preparation for the baby. ... I think for the first six weeks it's got to be quite mum-led ... and ... less amount of facilitators I think.

(Family Nurse 6)

- 4.6 Family Nurses also observed that while the suggested programme content matches clients' needs well when they are in more settled circumstances, where an unexpected crisis occurs, it could be more difficult to cover the recommended content while also addressing this crisis. In these circumstances, agenda matching was again seen as essential, as it was for those clients who were more difficult to engage with the programme in general.

Yes, following the programme, but you know agenda-matching what these young women actually need or want from the programme, because in that case then you've got more chance of getting them to give you the commitment that the project needs.

(Family Nurse 1)

- 4.7 A specific scenario where the programme materials were perceived to be less appropriate related to cases where a baby is taken into care as a result of child protection proceedings. In this situation (where it is uncertain whether the mother and baby will be reunited), it was suggested by the NHS Lothian, Edinburgh Family Nurse Team that the current FNP materials do not always lend themselves well to supporting Family Nurses with visits to mothers. For example, the materials might involve asking the client about what their baby did last night, or exploring attachment, both of which could be difficult and sensitive topics when the mother and baby were not living together.¹⁰ As this is the first cohort of FNP clients in Scotland, the confidence of Family Nurses to adapt the materials to fit this specific circumstance may improve as they become more familiar with the programme and materials and are working with a second cohort of families. However, participants' comments around the challenges of delivering the programme in the specific context where a baby has been taken into care may suggest that this is an area of programme design worthy of further exploration locally (possibly with social work or other colleagues, to develop an integrated approach to supporting mothers at this very sensitive time) or nationally. The new role of National Lead Supervisor also incorporates a remit to review educational materials used in the programme and, where required, to develop them to reflect the Scottish and national setting (in line with University Colorado Denver copyright agreements). The opportunity for FNP in Scotland to shape educational materials for FNP nationally is also offered via the FNP National Unit (DoH). NHS Lothian FNP team is represented by a Family Nurse to attend and contribute to this workstream.
- 4.8 Other suggestions from Family Nurses and key stakeholders about aspects of the programme content or materials that they felt could be improved included:

- Simplifying some of the materials relating to labour and delivery.

¹⁰ Where a clear decision is made that the baby will be permanently removed, the focus of FNP delivery changes to supporting the mother to move on.

- Revising some of the sexual health materials to make them more appropriate to a UK context (topics like douching and use of diaphragms were seen as reflecting the US origins of the programme and as less appropriate for British teenagers).
- Reducing and simplifying the suggested content for the immediate post-partum period generally.
- Moving some of the data collection included in the immediate post-partum period (e.g. domestic violence) to later in the programme.
- Facilitators and educational materials around binge drinking, which was seen as an issue for some clients which was not fully reflected in the current materials developed for FNP in the UK.

4.9 As noted above, FNP in Scotland has the opportunity to shape educational materials for FNP via input to the FNP National Unit (DoH) materials workstream and via the new National Lead Supervisor role .

4.10 Clients interviewed around 3 months after their babies were born appeared to be very happy with the overall content of the programme. They reported that the balance of different topics seemed about right and commented positively on the dual focus on both the mother and baby in the post-partum period. Clients' comments also illustrate that they are aware that Family Nurses have to deliver particular content. However, they felt both that the topics covered by FNP generally matched their key concerns at particular points, and that there was sufficient flexibility for them to raise other issues where necessary.

She asks me that at the end of every session like, if there's anything else that we need to cover. But everything she covers or talks about, like, is what I need to know or what I want to know.

(Client 11)

4.11 In reflecting on 'who decides' what they talk about in their meetings, clients described different means of 'agenda matching':

- their Family Nurse brings things she would like to talk about but also asks them what else they would like to discuss
- the Family Nurse asks clients whether the topics she has in mind are OK with them, or
- the Family Nurse raises topics, but the client feels confident enough to raise their own questions and concerns and their Nurse will adjust sessions to address these

4.12 There were, however, a few examples of exceptions to this generally positive picture, where clients suggested that they had not received elements of help or support they had wanted from their Family Nurse or that they preferred to go to other people for advice. These included:

- Family Nurses not following up on requests to provide information about other services, and

- A perception that Family Nurses did not always appear to clients to be as knowledgeable as friends or family members in relation to looking after a new born.

4.13 In part, these views appeared to be linked with either clients already being well supported (and therefore tending to rely on family and friends more) and/or with a lower level of contact with their Family Nurse during the post-partum period, which meant they tended to rely on them less. In fact, these two factors were explicitly linked by a client who was less happy with the amount and nature of support she had received in the post-partum period. She speculated that perhaps she had not seen as much of her Family Nurse in the post-partum period because she had good support from her family, while her Family Nurse might have other clients in different situations who needed more support:

... she knows I've got everybody here anyway, so I don't know if she's looking at it that way; that I've got everybody here. And some o' her folk have got nobody, so ...

(Client 6)

4.14 In this scenario, the fact she had good support was seen (by the client) to be the cause of lower levels of contact with her Family Nurse, which in turn lead to her relying less on her Family Nurse and more on her family for advice and support.

I've spoke to my mum, and took him to the doctor's. I've never really phoned her about anything since he's been born. Or I've spoke to the Health Visitor when I've took him for his jags and stuff because I just dinnae think she (Family Nurse) knows what's going on fae when he's been born.

(Client 6)

Specific topics covered in the late pregnancy to post-partum period

Preparedness for birth

4.15 Preparing for labour and birth is, unsurprisingly, a key focus of the FNP programme in late pregnancy. In terms of the perceived impact of FNP in preparing participants for the birth, clients mentioned:

- Feeling clearer about the different stages of labour. Clients were able to describe these in interviews and discussed, for example, how they had learned to count the spacing of their contractions in order to work out when to go to hospital. If in doubt, they were able to contact their Family Nurse for reassurance that they were 'reading' their contractions correctly.
- Feeling better able to assert their views with hospital staff during the delivery as a result of discussions with their Family Nurse.

So then she (Family Nurse) said to me, 'If they say like "Don't you push just now" then just say "Well d'you want to give me another vaginal examination, because I'm really feeling the need to push?'. So then I said that to the woman. I was like "Look, I

really need to push". I was like, "You can even check." ... And then (I) started pushing and then (Baby) came out!

(Client 12)

- Feeling more confident when the delivery does not go completely to plan as a result of information received from their Family Nurse about the different things that might happen in the delivery room (e.g. use of forceps).

4.16 There was also evidence of FNP helping partners to prepare for the birth, as illustrated by the following quote. The client in this case had not felt she needed much information from her Family Nurse about the birth, as she felt she already knew a lot about this. However, both the client and her partner felt FNP had helped him to prepare for the delivery.

Just telling me what happens at childbirth that was a big help, because I had not a clue what was happening or anything like that. Just ... (client) was calm and her mum was calm but they never really told me what to expect.

(Significant Other 2)

4.17 Family Nurses themselves suggested that discussions about roles in the labour room were among the most valuable sessions in the pregnancy period in terms of ensuring that any tensions and concerns are aired and addressed in advance, and in terms of helping fathers feel more comfortable and confident about their role.

4.18 Although one view among clients was that there was nothing else they either needed or wanted to know about the birth, there were a few suggestions of areas they would have liked to know more about, including:

- specific sorts of pain relief (e.g. spinal blocks)
- potential problems that might arise during labour or immediately after the birth (e.g. treatment if the baby is jaundiced, or the possibility that the baby would need help with breathing, as well as more information about tearing and stitches after delivery)
- information on particular labour symptoms (e.g. labour pains occurring mainly in the back)
- more detailed advice on what to take with them to the hospital, and
- more discussion around how the client might feel physically and emotionally immediately after the birth.

4.19 These areas are all covered in the FNP guidelines. However, those clients who mentioned them nonetheless felt they would have benefited from further information or discussion.

4.20 Birth outcomes are recorded for all FNP clients. 139 babies were born to 138 clients from the first NHS Lothian, Edinburgh FNP cohort who were still engaged at the time of the birth.¹¹

- Average gestation at delivery was 40 weeks (delivery is considered 'full term' at or after 37 weeks gestation).
- The average birth weight was 3291g
- 7.2% (10/139) of babies having a low birth weight (below 2500g). None were very low birth weight (less than 1500g). According to ISD figures for 2010, 5.1% of all babies born in Scottish hospitals had a low birth weight (below 2500g), with 0.7% having a very low birth weight (<1500g).¹² The Scotland-wide figures for 2010 are not broken down by maternal age, but as age is associated with low birth weight (with younger and older mothers more likely to have low birth weight babies – ISD 2011), these figures are likely to be higher for mothers under 20.
- 13% (18/139) of FNP babies were admitted to a Special Care Baby Unit.

Infant feeding

4.21 As discussed in the first report from the Scotland evaluation, FNP is a strengths-based programme. Rather than only advocating one approach to infant feeding, it emphasises working with clients' own feelings about and potential resistance to behaviours like breastfeeding. Feeding their baby was clearly an area clients felt anxious about in the early weeks after the birth - were they feeding their baby enough? Were they feeding them often enough or too often? Were they sterilising bottles correctly? What positions are best for breast feeding? Clients interviewed for the evaluation described seeking out their Family Nurse's advice on all these issues. Table 4.2 shows the kinds of information and support they identified as particularly helpful.

Table 4.2: Support with feeding

Breast feeding	Bottle feeding	Weaning	General
<ul style="list-style-type: none"> - Demonstrating feeding positions - Information about supplements to help with milk flow 	<ul style="list-style-type: none"> - Information about sterilising bottles - Advice about how much to feed their baby - Demonstrating how to hold the baby during feeding 	<ul style="list-style-type: none"> - Information about recommended guidance on weaning and reasons for leaving it to 6 months - Support in dealing with family pressure to wean early 	<ul style="list-style-type: none"> - Reassurance that their baby is putting on the right amount of weight - Information about feeding routines

¹¹ As discussed in Chapter 3, 4 clients had left the programme and 6 had been disengaged for 6 months or more by the end of the pregnancy period.

¹² See <http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/data-tables.asp>

- 4.22 This support was clearly believed to have made a difference – for example, information about supplements was seen by a client as having helped them to breastfeed for longer, while her Family Nurse’s support in dealing with family pressure to wean early was viewed as having helped another mother both to hold off on weaning and to feel more confident in her own parenting skills and parental role.
- 4.23 Increasing breastfeeding has been a particular focus of health promotion in Scotland and the rest of the UK for a number of years now. Scotland has relatively low breastfeeding rates compared with other countries in the UK, while young mothers have much lower rates of breastfeeding than the population as a whole. A review of the research literature on young mothers and breastfeeding by the Department of Health, Social Security and Public Safety in Northern Ireland (2004) suggested that many young people have no knowledge of breastfeeding, lack access to key sources of information (from antenatal classes to support from friends and family) and lack assertiveness around asking for advice on breastfeeding. Embarrassment, a lack of role models, fear of pain and misconceptions about babies being able to gain enough weight through breastfeeding were also identified as potential barriers for young mothers.
- 4.24 FNP routinely collects data on clients’ intentions regarding breastfeeding as well as whether or not they actually go on to initiate and sustain breastfeeding. Analysis of the data for the first NHS Lothian, Edinburgh FNP cohort shows that:
- 46% ever breastfed or expressed milk
 - 13% were still breastfeeding at 6 weeks, and
 - 7% were exclusively breastfeeding at 6 weeks.
- 4.25 Considerable caution should be applied in drawing any conclusions from comparisons between these figures and those for other mothers aged under 20 in Scotland. Differences in methodologies for assessing breastfeeding rates and potential differences in the profile of FNP clients in Edinburgh compared with all those aged under 20 in Scotland mean that any such comparisons can at best be tentative. However, for information, the proportion of mothers under 20 initiating breastfeeding was 33% according to the 2005 Growing Up in Scotland survey (Skafida, 2008) and 39% among the Scottish sample for the Infant Feeding Survey (NHS Information Centre/IFF Research, 2011). NHS Information and Statistics Division (ISD) figures for 2010/11 show that 8.0% of Scottish mothers under 20 were still breastfeeding at their 6-8 week health visiting review, while 4.7% were exclusively breastfeeding (ISD, 2011). The Building Blocks trial in England (Sanders et al, 2011) will provide more robust data on the impact of FNP on breastfeeding rates.
- 4.26 Family Nurses use motivational interviewing techniques to support clients over time in considering and making healthy decisions for themselves and their babies. There is interest in the potential for this kind of approach to encourage clients who are initially ambivalent or hostile to the idea of breastfeeding to at least try it after the birth. When they first joined FNP, 32% of clients in the first

NHS Lothian, Edinburgh cohort definitely intended to breastfeed, while 42% were undecided and 26% said they definitely would not breastfeed. Among those who definitely intended to breastfeed, most (83%) went on to do so at least once. However, so too did 43% of those who were originally undecided and 8% of those who did not originally want to breastfeed – a ‘conversion’ rate of 28% of those who were initially ambivalent about or hostile to breastfeeding.

4.27 Family Nurses reflected on the ways in which FNP might help encourage clients to try breastfeeding. They thought that the structure of FNP was helpful – in particular, the fact that Family Nurses have repeat contact with clients during pregnancy allowed them to introduce information about feeding and revisit it later on. The approach of FNP in supporting clients to make their own decisions was also contrasted with the perceived approach of universal services:

So it wasn't about "Because I really want you to breastfeed", 'cos I think that that was a message that a lot of the girls felt was coming from other universal services, you know? ... it was very much about giving all the information ... And some girls that I thought that were definitely going to breastfeed didn't, and other girls that I thought weren't even going to think about it at least gave it a bash. So I don't know if I got it right, but I was listening to where they were, their starting point, and trying to fit in with that.

(Family Nurse 4)

4.28 While this evidence suggests that FNP may have the potential to support more young women to at least try breastfeeding, the overall figures cited above indicate that while almost half clients attempted breastfeeding, there remain significant barriers to encouraging young mothers to continue breastfeeding for a longer period. The panel of clients interviewed in-depth for the evaluation included clients who had never breastfed, clients who initiated breastfeeding but stopped shortly after the birth, clients who breastfed for a week or more but were bottle feeding by the time of the interview (3 months after the birth) and clients who were still breastfeeding, either exclusively or in combination with bottle-feeding. Among those who were not breastfeeding at the time of their second evaluation interview (around 3 months after the birth), familiar barriers were identified, including:

- Feeling uncomfortable breastfeeding outside
- Soreness, and
- The baby not latching on.

4.29 In addition, there was some evidence that both clients and Family Nurses felt FNP mothers were not getting enough support, or not getting appropriate support with breastfeeding before they left the hospital. Family Nurses recognised that midwives in hospital were often very stretched and might not always have enough time to fully support tired new mothers to breastfeed. However, in some cases Family Nurses felt this may have undermined clients' intentions to breastfeed, and that some clients were later disappointed not to have either tried or persisted with breastfeeding.

I would say that some people said ... they did but a lot of them said they didn't feel supported, and that would be one of the reasons why they didn't continue. (...) By the time I was coming in to see them, they'd stopped.

(Family Nurse 2)

- 4.30 This was also reflected in comments from clients. Experiences of support with breastfeeding in hospital varied, with some positive comments about the support received from midwives in showing clients how to initiate breastfeeding or helping them express milk. However, there were also examples where clients described finding it too difficult and giving up before they were discharged, or where they were deterred from continuing by inappropriate support:

Well I found it quite embarrassing, but they kept on grabbing me and then like forcing it into (baby's) mouth and everything.

(Client 14)

I had actually tried breastfeeding him at first in the hospital, but I found I didn't really get very much help in the hospital trying to do it ... He never took to it, so it was scary for me ... He's been bottle-fed since about the second day.

(Client 16, paired interview)

- 4.31 One Family Nurse suggestion was that a volunteer breastfeeding scheme, where mothers are paired with other mothers who are breastfeeding or have breastfed prior to the birth, might be more effective in helping them with feeding immediately after the birth. It is also worth noting that the recently refreshed framework for maternity care in Scotland (Scottish Government, 2011) includes an emphasis on critically appraising breastfeeding rates and planning improvement measures for women in particular need of support.
- 4.32 Where clients had not initiated or maintained breastfeeding this time, one view among Family Nurses was that clients might be more likely to try it with subsequent babies as a result of the information received from FNP. Finally, both clients and Family Nurses commented on the fact that where young mothers had not continued breastfeeding, they sometimes needed additional support to avoid feeling a 'failure' and losing confidence in their parenting ability.

Bonding and attachment

- 4.33 Promoting parent and child bonding and attachment is a key aim of FNP. As discussed in the introduction to this report, attachment theory acknowledges the critical importance of bonding both in the child's subsequent development and in the mother's (and father's) ability to be responsive parents to their babies. It was suggested that discussing attachment in pregnancy was particularly valuable in terms of preparing FNP clients for parenthood:

I would say that ... they've got much more ... readiness of parenting ... I think that's very clear whenever the babies are first born that they're

much more in tune with their babies because that's been raised throughout the whole of the pregnancy.

(Family Nurse 3)

- 4.34 Clients mentioned discussing a range of activities that can help support attachment with their Family Nurses, including skin to skin contact when the baby is first born, the best feeding positions to encourage bonding, the benefits of breastfeeding for bonding, hugging, playing with, talking and singing to their baby, and in general making sure they spent time together as a family and avoided having too many visitors in the immediate post-natal period. One view among clients was that they felt they would have done all these things anyway, either because they were already aware of them before their Family Nurse mentioned them, or because they thought it was a matter of instinct. However, clients and significant others did also report discovering or gaining confidence to try new things through their Family Nurse.

Well I already got to know – 'cos he's my baby, obviously – got to know his cries and his facial expressions and what they mean, but there were some ones, like extraordinary ones on there, like, you know, if a baby's in an active sleep or a quiet sleep, and, you know, you can tell the difference now.

(Client 8)

I found it good that she was advising me to do skin-to-skin. I knew about skin-to-skin and I was planning on doing it anyway, but I needed that wee bit of confidence boost for me to do skin-to-skin and stuff like that.

(Client 4)

She showed me how to play and everything with her, the way that she would respond when she's old enough, and then she started responding.

(Significant other 2)

Baby health and safety and baby development

- 4.35 Baby and child health, safety and development is unsurprisingly a theme Family Nurses return to repeatedly throughout the FNP programme. Clients were generally perceived by Nurses to be both receptive to these topics and already very knowledgeable about some areas, particularly in relation to hazards. This was reflected in comments from clients that they did not necessarily feel the information they received from FNP around safety and hazards in particular was new to them. However, again there were examples of clients gaining new information and changing their approach because of their Family Nurse, including adopting safe sleeping positions, having 'tummy time', and sterilising dummies.

Just like things that I wouldnae have had a clue (about). Like ... I thought that you would have them at the top of the cot ... I was like, 'the cot's so big, surely her feet cannae go at the bottom', but she was

like 'That is the safest way to do it because she canne wriggle down and go under the covers'.

(Client 13)

- 4.36 Clients also suggested that even where they did already know about aspects of how to keep their baby safe and well, they valued being able to show professionals what they knew. The strengths-based approach of FNP and the ways in which this can improve clients' confidence was reflected in clients' accounts of the status of the information they received from their Family Nurse around baby health and safety, which was seen as one source (albeit a particularly respected one) of advice to help them make their own decisions.

I said that to (Family Nurse) and she was like 'well, it's up to you, whatever you feel most comfortable with.' ... 'Cos then ... I've got ... two people's opinions so it's really up to me. So I just like to get the advice.

(Client 1)

- 4.37 Clients reported the ways in which their Family Nurse encouraged them to trust in their own judgement about what their babies need and helped support them in challenging the parenting advice of other family members where this was unwelcome and/or outdated.

- 4.38 The other family members interviewed for the evaluation also reported appreciating the information the Family Nurse gave them, and recognising that this could be more up to date than their own knowledge. In common with findings reported above about preparing for the birth, in some cases, even where the client did not feel they had found out anything new about baby health and safety from their Family Nurse, their family members nonetheless felt that they had gained new knowledge, confidence or skills from FNP.

With the Family Nurse, she's given us confidence to do ... to do things that we wouldn't normally think of doing ... Yeah, some of them are scary. Some of them aren't so scary. But at the same time then we know that, if it happens, this is how you deal with it.

(Significant Other 1)

Mother's health and wellbeing

- 4.39 Making space for the mother's own health and wellbeing in the weeks after birth was viewed by Family Nurses as extremely important, although sometimes challenging because clients are so focused on their new baby. Clients themselves valued being able to ask their Family Nurse for advice about their own health as well as their baby's both during the pregnancy and after the birth.

- 4.40 In addition to discussing their physical health (recovery from the birth, stitches and infections, and checking for breast lumps – something client comments suggest they might not otherwise have considered doing), mental and emotional health and wellbeing is clearly a key focus of FNP in the post-natal period. All clients are assessed for potential post-natal depression. Based on

data for 130 clients engaged with the programme at the time this data was recorded,¹³ the mean Edinburgh Postnatal Depression Score was 7.3 (with scores ranging from 0 to 26). The SIGN guidelines for Scotland note that a cut off of greater than 9 has been suggested for possible postnatal depression and a cut off of greater than 12 for probable postnatal depression (SIGN, 2002).¹⁴

4.41 Clients in the qualitative panel who had experienced issues around their emotional or mental health either during pregnancy or after the baby was born talked about the support their Family Nurses had given them in coping with this. This ranged from general advice about coping with stress and reassurance that their feelings were normal, to assessment and referral to their GP for treatment for post-natal depression. Family members interviewed for the evaluation also described having contacted the client's Family Nurse with concerns about potential post-natal depression, and the Family Nurse being able to raise this with the client and support them in getting either professional help or help from their families.

It was that night (after the Family Nurse's visit) that (client) said to me, 'I need help', kinda thing ... It was the first time she's actually asked for help properly, you know?

(Significant other 3)

4.42 Maternal health behaviours – drinking, smoking, drugs, diet, exercise and sexual health – are also threaded throughout the FNP programme, including the late pregnancy and post-partum period. FNP collects information about smoking, alcohol consumption and drug use at a number of time points. Table 4.3, below, shows the proportion of clients who were smoking, drinking or using drugs at intake, 36 weeks gestation and 6 weeks after the birth.

Table 4.3: Maternal smoking, drinking and drug use

Time point	Current smoker (last 48 hours)	Current drinker (past 14 days)	Drug use (past 14 days)
Intake to FNP	43% (61/141)	6% (9/141)	4% (5/141)
36 weeks gestation	38% (40/133)	2% (3/133)	3% (4/133)
6 weeks post-natal	43% (58/134)	N/A	N/A

4.43 The smoking patterns in Table 4.3 do not fully reflect the level of change in clients' smoking behaviour, however. Of the 130 clients in the first NHS Lothian, Edinburgh cohort for whom information about smoking at both intake and 36 weeks gestation was collected,¹⁵ 58 (45%) reported that they smoked at intake.¹⁶ By 36 weeks gestation:

¹⁴ Although others have noted that use of recommended thresholds on EPDS varies considerably (Matthey et al, 2006).

¹⁵ Reasons for missing data were: client disengagement or moving prior to data collection, pregnancy loss, the form not being completed as it was not a clinical priority at that point (n = 1) and missing forms with no specified reason (n = 2).

¹⁶ Note this is somewhat lower than the figure for all those who smoked at some point during pregnancy - 62% - reported in the first evaluation report. The higher figure in the earlier report is

- 14 of these had not changed their smoking behaviour at all
- 10 reported smoking more
- 24 reported smoking less, and
- 10 had stopped smoking.

4.44 Among clients who had not reported smoking at intake, 2 had started smoking during pregnancy. Comparison of 36 week data with that collected 6 weeks post-natally shows that:

- 70 out of 130 remained non-smokers
- 4 were smoking in late pregnancy but had stopped by 6 weeks after the birth
- 15 had decreased their smoking
- 11 were smoking the same amount
- 19 had increased their smoking since late pregnancy
- 9 had stopped smoking during pregnancy but resumed smoking since, and
- 2 former non-smokers had started smoking by 6 weeks after the birth.

4.45 Among the small number of clients (n = 9) who drank alcohol at intake, most (n = 7) had stopped drinking by 36 weeks gestation, while one client who did not drink at intake had started drinking by this point.

4.46 Without a control group, it is not possible to establish what proportions of these changes in client's smoking and drinking behaviour result from participating in FNP. Qualitative interviews with both Family Nurses and clients suggest that they did not always attribute any such changes wholly to FNP – for example, clients described having made decisions about stopping or changing their smoking habits in advance of joining FNP, while Nurses suggested that in some cases clients had already decided to cut down on drinking before joining and FNP was just supporting them in '*continuing along that path*'. However, there was also evidence of the potential for FNP to raise clients' awareness of the risks of smoking and drinking during and after pregnancy, which could lead to changes in behaviour.

Just obviously being pregnant I thought 'Oh, I'm not gonna smoke as much', but I was still smoking about maybe 6 a day. But with the Family Nurse telling me the risks it could have caused, I cut right down to about maybe 2 a day ... Sometimes I didnae even have a fag during the day.

(Client 19)

I used to think that, 'oh, as soon as I'm not pregnant, I can have a wee drink'... but I've just like not anyway, I've just left it because I know it can make the baby more sleepy

(Client 3, describing perceived impact of information from Family Nurse about drinking while still breast feeding)

based on having smoked at any point during pregnancy, while the figure reported in Table 4.3, above, is based on smoking in the previous 48 hours.

- 4.47 There were also examples of clients attributing changes in their eating habits during or after pregnancy to the information they had received from their Family Nurse – for instance, reporting drinking more water and eating better because of information about the importance of this for their milk supply.
- 4.48 Finally, sexual health was another topic that Family Nurses felt needed to be introduced in late pregnancy, rather than after the birth when most mothers were too tired to give contraception any serious thought. The involvement of FNP before the birth was seen as a '*great advantage*' in this respect. Again, interviews with clients provide examples of Family Nurses raising their awareness of the range of contraceptive options available to them:

I would have thought about something, but I don't know if I would have went for the implant ... 'Cos I never knew there was so much stuff, but there obviously is!

(Client 2)

Future plans around work and education

- 4.49 Supporting parents to be financially independent and reducing reliance on benefits is a key aim of FNP. Work and education tend to be less of a focus of the programme around the late pregnancy and post-partum period, where preparing for the birth and caring for a newborn baby take precedence. However, clients mentioned having discussed work and education with their Family Nurses either before or after the birth. In addition to encouraging them to think about where they wanted to be in five years time, FNP had provided them with practical information about courses and about crèches and nurseries to allow them to attend work or college. Family Nurses also had offered help with filling in application forms.
- 4.50 Reflecting on their experiences of delivering FNP in general in the last 12 months, Family Nurses suggested that the recession had meant they had to think more creatively about how to support clients towards becoming more financially self-reliant in a context where there are fewer jobs available:

We're building these clients up to have ... the confidence and the ability to go out and try and get themselves jobs and move on in the world, and as the recession is biting that's becoming more and more difficult ... So we're trying to now think about ... 'OK, let's try and think about part-time work ... let's think about maybe doing some voluntary stuff, let's think about doing education and training' rather than ... going straight into full-time work.

(Family Nurse 3)

Challenging topics

- 4.51 Clients and Family Nurses interviewed for the evaluation were asked whether there were any particular topics they found difficult to discuss with each other. One view (expressed by both clients and Family Nurses) was that by late pregnancy or the early weeks after the birth, there were no such topics as they

had built such a strong relationship by then. However, various topics that had the potential to be uncomfortable or difficult were also identified, including:

- **Mental health and wellbeing.** Clients described feeling awkward discussing how they were feeling because they were not used to doing so. Similarly, there was a view among clients that it was easier to talk about their baby's health rather than how they themselves were feeling, although they also appreciated that it was part of the Family Nurse's job to assess them for post-natal depression. Family Nurses suggested that mental health usually became easier to discuss once they had established a relationship with their client. They also felt that the FNP facilitators and the fact that mental health is revisited at various points during pregnancy helped make it easier to raise it in the post-natal period. Where clients had missed visits during pregnancy, however, it was suggested that it could be more difficult for Nurses to discuss post-natal depression after birth, as they did not have this foundation (either in terms of the relationship or having already introduced it as a topic).
- **Maternal health behaviours.** Family Nurses noted that clients could be resistant to talking about issues like smoking. A non-judgemental approach, as well as knowing when to leave a topic and when to revisit it, were seen as key here.

I had a client who, at the beginning of pregnancy, the minute that smoking was mentioned in any shape or form clammed up ... I tried to raise it a couple of times after that and I really did think 'If I talk about this again, she's going to stop me from coming', so I didn't raise it for a good while, and then she then mentioned it to me ... and I went in very softly softly and she now has completely stopped.

(Family Nurse 3)

- **Domestic violence.** Family Nurses suggested that there was a particular need to be very flexible about when domestic violence is discussed, rather than rigidly following suggested dates for assessing it in the manual. Bringing it up in the third person, rather than asking clients about their experiences directly, was also seen as a useful strategy for encouraging clients to open up if domestic violence is suspected.

I would keep it until an opportune moment came up, and quite often with the domestic violence material you would wait until you got the client by themselves ... You choose your moment really ... I've had quite a few disclosures ...when I've said 'a lot of us in our lifetime will come across somebody who suffers from domestic violence' ... So bringing it up ... in that objective way ... seemed to make it easier for them.

(Family Nurse 5)

4.52 Family Nurses also described how the skills they had learned through FNP had helped them handle potentially challenging conversations or issues where they and the client had a different view of what was best for the baby. The non-

judgemental approach of FNP was also reflected in clients' observations about areas where they had differences of opinion with their Family Nurse – rather than feeling they had fallen out over this, it was described in terms of their Family Nurse providing them with information to make an informed decision but then supporting them with their choice.

Even something as simple as somebody choosing to take their baby into the bed with them ... I mean, it's not such a challenge now because I feel I now have the skills to explore that without being judgemental, without being directive ... I can introduce information and give them the place to make their own decisions on it.

(Family Nurse 5)

She's just advised me like on stuff ...so it's not that we've disagreed. We've just got different opinions ... She's very supportive ... I think it was leaflets she gave me ... what they're there for and all that, so she has gave me advice, and she knows that it is my choice.

(Client 1)

Key points

Do family nurses conduct their consultations in line with the fidelity criteria?

- The average time Family Nurses in NHS Lothian, Edinburgh recorded spending on different topics during pregnancy was very close to the division suggested by the fidelity 'stretch' goals.

Is the FNP structure useful/appropriate?

- In general, Family Nurses felt that the suggested programme content during pregnancy was well matched to clients' needs. The content for the post-partum period was viewed as very full, however. It was suggested that a degree of flexibility was required to create space to deliver other relevant activities and to agenda match.
- In cases where a baby is taken into care, it was suggested that (where a final outcome has not yet been determined) the programme materials may not always lend themselves particularly well to supporting Family Nurse visits to mothers, since they focus on issues like attachment which can be very sensitive in this situation.
- Other aspects of the programme materials that Family Nurses felt could be improved or enhanced related to labour and delivery, sexual health and binge drinking.
- Clients appeared to be very happy with the overall content of the programme and with their ability to raise additional issues with their Family Nurses as required.
- Challenging topics identified by clients and/or Family Nurses included mental health and wellbeing, maternal health behaviours and domestic violence. Factors that facilitated discussing these issues included an established relationship between client and Family Nurse, a non-judgemental approach, and flexibility around when these topics were introduced.

Is there any evidence that clients feel better prepared for birth?

- Both clients and their partners gave examples of the ways in which they felt more knowledgeable and confident about labour and delivery, including feeling clearer about the stages of labour, feeling better able to assert their views during delivery and feeling more confident when the delivery did not go completely to plan.

Is there evidence that the FNP results in improved knowledge/health behaviours in clients prior to/following birth of baby?

- Examples of positive health behaviours and knowledge clients' attributed to FNP in the late pregnancy/post-partum period included: breastfeeding for longer; resisting pressure to wean early; greater awareness of the risks of smoking and drinking during and after pregnancy; changes to eating habits during or after pregnancy; and awareness of a greater range of contraceptive options.
- Overall, 46% of NHS Lothian, Edinburgh FNP clients breastfed at least once.
- Among FNP clients who were hostile to or ambivalent about breastfeeding when they joined the programme, 28% went on to breastfeed at least once.
- There was some evidence that both clients and Family Nurses felt they were not always receiving either enough or appropriate support with breastfeeding in hospital, and that in some cases this might undermine clients' intentions to breastfeed.

How good are the pregnancy outcomes of those enrolled on the programme?

- Average gestation of babies born to the first FNP cohort in Scotland was 40 weeks (well above the threshold for a birth to be considered full term).
- Average birthweight was 3,291g, with 7.2% having a low birthweight. None had a very low birthweight.

Is there any evidence that the FNP engenders positive parenting practices and bonding?

- In relation to bonding with their new baby, while one view was that clients and partners would have engaged in bonding activities without their Family Nurse, clients and partners also reported discovering or gaining confidence to try new activities to support attachment in the post-partum period.

Is there evidence that the client knows about key hazards and engages in practices to keep child safe?

- Family Nurses generally felt clients were very knowledgeable about hazards and safety. While clients did not necessarily feel that the information they received from FNP around safety and hazards was new to them, there were also examples where they felt they had changed their approach because of their Family Nurse – for example, in relation to safe sleeping positions or sterilising dummies.

Is there any evidence that mums feel more supported and less anxious/depressed because of the programme?

- It is not possible in this evaluation to compare how supported FNP clients feel in comparison with how they would have felt without the programme (since there is no control group who are not receiving the programme). However, clients in the qualitative panel who had experienced issues around their emotional or mental health around the birth and post-partum period were positive about the support

they had received from their Family Nurse, ranging from general advice about coping with stress to assessments and referrals to GPs for treatment for post-natal depression.

Other findings

- Exceptions to this generally very positive picture of the support received around the birth/post-partum period included comments that clients had not received elements of support they had expected or wanted (including specific information relating to birth) or that they preferred to go to other people for advice.

5 SERVICES, RESOURCES AND REFERRALS

- 5.1 FNP provides clients with information about other services throughout the programme. This Chapter presents data on the numbers and types of referrals made by Family Nurses during the pregnancy phase of the programme. It discusses clients' and Family Nurses' views about FNP's role in linking clients with services and their perceptions of the differences, if any, between the services provided by FNP and by others. It also explores the NHS Lothian, Edinburgh Family Nurse Team's perspective on establishing working relations between FNP and other services. It is hoped that subsequent reports will be able to explore these issues from the perspective of other stakeholders (particularly midwives, social workers and GPs).
- 5.2 While the monitoring and evaluation framework only includes one specific question relating to use of other services (Is there any evidence that the FNP leads to use of screening/antenatal services and recommended antenatal practices?), the use made of referrals clearly has the potential to contribute to other outcomes for clients, while the relationship between FNP and other services is of wider interest in terms of understanding how the programme operates in a Scottish context.

Referrals to other services

- 5.3 Routinely collected data shows that FNP recorded 148 referrals for 84 clients prior to 36 weeks gestation and 166 referrals for 87 clients during the pregnancy phase as a whole. As indicated in Table 5.1, Family Nurses referred clients to a very wide range of services.

Table 5.1: Numbers of clients referred to services

	36 weeks gestation	Pregnancy phase
Smoking cessation	16	17
Mental health services	7	7
Other health care services	72	84
Financial assistance	13	15
Housing services	9	9
Antenatal classes	24	24
Social care (including child protection/child in need and adult disability services)	9	10
Other (including Community Support, Legal Services, Citizen's Advice Bureau, Edinburgh Fun initiative, Granton Information Centre, Kids Love Clothes, Mehip, Relate, Stepping Stones, Young Mums Group, Children's Centre, Bethany Trust, Amethyst and EVOC)	12	15

- 5.4 In addition, FNP recorded that 96% of clients attended for a second trimester fetal ultrasound scan.¹⁷ Again, while it is not possible to say what proportion of clients would have attended for this scan in the absence of FNP, this figure shows that uptake of routine antenatal checks was very high among the first FNP cohort in Scotland.

Perceptions of Family Nurses' role in linking clients with other services

- 5.5 Family Nurses suggested that the fact the programme covers a whole city was very helpful in getting to know all the different services available for clients. However, covering a whole city can also pose challenges in terms of gaining familiarity with services in every area (and with ensuring that all those services are familiar with FNP). This was reflected in comments both from the NHS Lothian, Edinburgh Family Nurse team and from clients. While one client view was that where their Family Nurse did not know their area they were nonetheless '*doing their best*' to find local services they could use, another was that their Family Nurse needed '*to get familiar with this area*'.
- 5.6 The accounts of both clients and Family Nurses highlight variations in how involved Family Nurses are in actually liaising with other services on behalf of clients or whether they adopt more of a 'sign-posting' role. As FNP aims to foster self-efficacy, Family Nurses may sign-post clients to services but encourage them to actually contact them for themselves. However, sometimes additional support was viewed as necessary to ensure clients actually engage with other services, either because clients lacked the confidence or motivation to engage with other services on their own, or because they were in particularly difficult situations. This balance between encouraging self-efficacy (i.e. encouraging clients to contact and access services themselves) and providing support in accessing services may occasionally create some tensions and client resistance, as illustrated by following client account:

I just stop asking stuff because ... I dinnae think that there's any point because she doesnae ken the answer, so what's the point in me keeping asking her when she's just gonna keep telling me the same thing about 'just go to the JobCentre or just go to the Citizen's Advice and ask them, ... or check the internet' ... So I end up doing that myself.

(Client 6)

- 5.7 Although this client appeared frustrated by the fact that her Family Nurse did not just know or find out the answers to her questions, she did confirm that she eventually found the information she needed herself – so the Family Nurse's approach may actually have supported her to develop self-efficacy. Finally, Family Nurses also suggested that 'feeling judged' could act as a barrier to young mothers accessing other services.

A lot of these young women find it very difficult to take that first step and engage because they do fundamentally bring with them the

¹⁷ Note that by the 31st December 2009, all Health Boards in Scotland offered a second trimester fetal anomaly ultrasound scan, so all FNP clients in this cohort would have been offered a second scan.

baggage of always feeling judged, and feeling judged because, you know, they're very young and they've got a baby.

(Family Nurse 1)

Impact of FNP referrals on clients

- 5.8 As indicated by the figures in Table 5.1 above, many of the referrals FNP makes during pregnancy are for health services. These referrals were clearly appreciated. In particular, the comments of clients and significant others suggest without the advice of a Family Nurse they trusted, maternal health issues may have gone untreated for longer:

There's things that you would have let just go had you not known. ... She's pointed out something that I would never have known. It could have gone on for long enough without (client) knowing any better.

(Significant other 3)

- 5.9 Clients also reported regularly consulting their Family Nurses about their babies' health, both within and outwith their pre-arranged home visits. Family Nurses appeared to play a role in both spotting symptoms the client might have missed (like oral thrush) and helping them decide whether or not minor symptoms (like rashes or coughing) merited a trip to the doctors, as well as giving them confidence in their own judgement about when to contact their GP.

Yesterday I kinda phoned her up because for the past couple o' days like he hadn't been feeding. He'd been coughing and sneezing. Just didn't seem himself. And she was quite helpful, and said that I should just go with my instinct. Coz he does sound a bit poorly, phone up a doctor and see if I can get an appointment.

(Client 10)

- 5.10 As discussed in the first evaluation report, clients also discussed a range of ways in which they felt their Family Nurses had helped them with housing and benefits. This was echoed in the second round of client interviews. Clients mentioned their Family Nurses: writing to the Council to help them with getting their own accommodation; supporting them with setting up meetings with Housing (including actually attending meetings with them); giving the client (or their family, where they were living with others) lists of different Housing Associations; giving information about the pros and cons of different types of tenancies; giving them information about tax credits, grants and benefits they might be eligible for; and helping them work out what number to ring for benefits advice. Again, the information and support received from FNP in this area was clearly valued:

She's helped me obviously with all the major things. Like helped with like obviously housing and getting my money sorted and that kind of thing ... She's done a lot for me ... She's done enough, basically!

(Client 2)

Perceptions of differences between FNP and antenatal and postnatal services

5.11 Clients reflected on some of the differences they perceived between the support they received from FNP and support from other services. In particular, they reflected on the differences between Family Nurses, Midwives and Health Visitors, and on the differences between receiving advice and information through antenatal education and through their Family Nurse.

5.12 As discussed in Martin et al (2011), before the birth, clients reported mixed relationships with their midwives, either reporting that they were fortunate to have a good midwife as well as a Family Nurse, or that they did not really know their midwife and did not seem to get enough time with them to ask questions or raise concerns. It was suggested that clients were sometimes left with unanswered questions after seeing their midwife, and that they felt they 'got a lot more' information from their Family Nurse. One client view was that some midwives might not always be well equipped to support younger mothers in particular:

My midwife was really bad. She'd never dealt with anyone my age I don't think ... they were all like 30 plus, and she just ... me and her did not get on, so having my family nurse meant that somebody who like kinda understood me a lot more than my midwife.

(Client 17 – paired interview)

5.13 Client perceptions about the level of contact they had with their midwives were, to an extent, echoed in the views of Family Nurses, who suggested that while some clients were seeing their midwives regularly in late pregnancy for others it seemed they did not have a lot of contact with them other than for scans and check-ups in this period.

5.14 With respect to antenatal education, although all FNP clients were made aware of available antenatal classes, they differed in whether they intended to or wanted to attend such classes. When interviewed after the baby's birth, clients and significant others again commented on the fact that standard antenatal classes were seen as intimidating for young women. There was a perception that these were mainly attended by older women and that young mothers felt too shy or embarrassed to attend. As noted in the Martin et al (2011), the main service offering antenatal classes specifically geared towards younger women stopped delivering before the end of the recruitment period for the first FNP cohort in NHS Lothian, Edinburgh. While the NHS Lothian, Edinburgh Family Nurse Team had expressed some concerns about the content delivered by this service, at the same time they noted that clients did not appear as keen to attend routine antenatal services after this service ended. The finding that teenagers are less likely to engage with traditional antenatal support, including classes, is acknowledged in both the Better Health Better Care Action Plan (Scottish Government, 2008) and the refreshed Maternity Services Framework (Scottish Government, 2011).

5.15 Similar perceptions were also apparent among clients in relation to post-natal mother and baby groups. While some clients were very keen to attend these as

a way of meeting new people and getting out of the house after the birth, others were not comfortable attending a group with (older) strangers:

I think everybody at those groups would just be too old anyway. They'd be like twenty ... mid-twenties or something.

(Client 3)

5.16 FNP may thus play an important role in providing antenatal education for young mothers who might not otherwise engage with antenatal classes. At the same time, these findings suggest that young women may be better served if there were more antenatal and postnatal groups targeted specifically at their age group.

FNP perceptions of working relations with other services

5.17 In their second interviews for the evaluation, the NHS Lothian, Edinburgh Family Nurse team reflected on their working relationships with colleagues in health and other services and on how these relationships had developed since FNP was launched in NHS Lothian in 2009.¹⁸ It was suggested that both midwifery and public health nursing/health visiting were initially unclear about the role of FNP and perhaps worried that they would start taking over their jobs. However, by late 2011, the relationship between midwifery and the FNP team in NHS Lothian, Edinburgh appeared to be viewed positively by the FNP team as a result of midwives seeing the impact of the programme on clients.

I think by the time our later clients were giving birth I think the midwives were beginning to come on board with understanding what it was we were trying to achieve and were able to see ... the girls ... were gaining knowledge etc. and were preparing well for their babies.

(Family Nurse 5)

5.18 In comparison with midwifery there had been relatively less contact between FNP and Health Visiting in Lothian to date, since (as of late 2011) the first cohort of FNP clients had yet to make the transition back to universal Health Visiting services. Where Family Nurses did have contact with Health Visitors, however – for example, where there were child protection concerns – they were believed to view FNP positively and any initial concerns were seen to have reduced as contact with the programme increased.

5.19 Relationships and joint-working between FNP and social work were also believed to have improved since the start of the programme. Initial perceived barriers to building understanding of FNP among social workers included:

- The number of social work teams across Edinburgh, meaning it takes time to reach them all
- The fact that the programme in NHS Lothian, Edinburgh is still in a test phase and is therefore closed to new recruits - meaning you '*build up a level of understanding which then starts to erode again*'

¹⁸ FNP was launched in Lothian in 2009, with the first clients enrolled in February 2010.

- Challenges in communicating what working with a ‘strength-based’ approach means. Initially at least, Family Nurses felt that social workers were not clear about how risk was handled within a ‘strengths-based’ approach and that a lot of ‘open communication’ had been required to build understanding of the potential benefits of this approach.

I think sometimes it was just seen as ‘strengths-based approach, you don’t see any of the risks’. And it’s not that you don’t see the risks, you maybe just deal with them in a slightly different manner. ... so I think it was sometimes a challenge to just ... get over the .. perspective we were coming from. However, when people started to see the fruits of the labour, they actually then got the approach ... they really got behind us.

(Family Nurse 5)

5.20 It was also noted that in general social workers have sometimes expressed a desire to ‘stretch’ the eligibility criteria for FNP to include, for example, teenagers with concealed pregnancies who present after 28 weeks. However, in general this was seen as something that could be resolved by explaining the rationale for FNP and the fact that it is designed as an early intervention programme.

5.21 Finally, the NHS Lothian, Edinburgh Family Nurse team felt that after some initial challenges, the relationship between FNP and the Housing Team in Edinburgh was now good. Building relationships with key staff within Housing was seen as key to building understanding between the services. It was also suggested that the support that FNP clients receive from their Family Nurses was reassuring for Housing Workers who might otherwise have concerns about an unsupported young person taking on a tenancy. It was suggested, however, that benefits services had been less helpful and that both Family Nurses and clients had often found them more difficult to deal with.

Key points

- Family Nurses referred clients to a wide range of services during pregnancy. In addition to health and antenatal care, these included housing, social care, financial assistance and a variety of other public and voluntary sector services.
- Referrals from Family Nurses for both maternal and child health issues were clearly appreciated by clients and significant others. It was suggested that without the support of the Family Nurse, maternal health issues might have gone undiagnosed or untreated for longer. Family Nurses also appeared to play an important role in giving clients confidence in their own judgement about when to contact their doctor about their baby’s health.
- The information and support Family Nurses provided in relation to accessing housing and benefits were highly valued (as also discussed in the first report, Martin et al, 2011).
- Clients reported mixed relationships with their midwives. One client view was that they ‘got a lot more’ information from their Family Nurse. Another was that midwives were not always best placed to support young mothers in particular.

- FNP may play an important role in providing antenatal education for young mothers who may not otherwise engage with antenatal classes – perceived by clients and significant others as being more suited to older women. At the same time, there may be a need for more antenatal and postnatal groups aimed more specifically at young women.
- Variations were apparent in whether Family Nurses liaised with other services on behalf of clients or acted primarily in a ‘sign-posting’ role. Client and Family Nurse comments suggest there is a (sometimes challenging) balance to maintain between encouraging self-efficacy and ensuring clients do actually access other services.
- Delivering FNP city-wide was seen as advantageous in terms of getting to know the range of services clients might be able to access, although at the same time gaining familiarity with all the services available across the whole city could be challenging.
- From the perspective of the NHS Lothian, Edinburgh Family Nurse team, working relationships between FNP and key services like midwifery, health visiting, social work and housing had all improved since the start of the programme as they had become familiar with each other and with FNP’s ways of working. However, Family Nurses noted some initial challenges in communicating to social work what working with a ‘strength-based approach’ means. They commented that a lot of ‘open communication’ had been required to reassure social work that this did not mean ignoring risk.
- It was noted that FNP has had relatively less contact with health visiting to date, while the number of social work teams across Edinburgh meant it took time to build relationships with them all. Relationships with benefits services were also reported to be more difficult.

6 PROFESSIONAL VIEWS AND EXPERIENCES OF DELIVERING THE PROGRAMME IN THE LATE PREGNANCY TO POST-PARTUM PERIOD

- 6.1 As the first FNP Team in Scotland, the experiences of the team in NHS Lothian, Edinburgh in delivering the programme are likely to be of substantial interest, particularly for newer FNP sites and Health Boards who may be considering establishing an FNP programme. Family Nurse views and experiences of delivering the programme to clients have already been discussed in some detail in Chapters 3 and 4. This chapter therefore focuses on other (non-client contact) aspects of the programme – particularly training and supervision. As both these issues were considered in some detail in the first Scotland evaluation report (Martin et al, 2011), discussion focuses on new issues or learning raised in interviews with the NHS Lothian, Edinburgh FNP team conducted in late 2011. The chapter starts, however, with a more general discussion of perceptions among the NHS Lothian, Edinburgh FNP team of their key achievements and of the key challenges associated with delivering the programme in the pregnancy and early post-partum period.
- 6.2 Key questions from the monitoring and evaluation framework relevant to this chapter include:
- Does the team receive the training and support intended, and develop the knowledge and skills required?
 - How feasible/appropriate is the visiting schedule?
 - Are FNP data entered into the FNP database in a timely fashion?

Key achievements

- 6.3 Family Nurses were asked what they viewed as the key achievements of FNP since they were first interviewed for the evaluation (in late 2010/early 2011). Unsurprisingly, **impacts for and achievements of clients** featured strongly. Family Nurses described themselves as *'walking alongside'* their clients and were enthusiastic about the changes they perceived in clients' confidence levels and parenting ability, particularly in relation to those clients who were seen to be most vulnerable.

She (Supervisor) met one of our really quite vulnerable wee girls a few months ago when her baby was little, and then this girl came along to an FNP event the other day at half nine in the morning which is not her idea of fun ... and she was really impressed with how this young woman presented, ... you know sort of good eye contact, the big cheesy grin and ... showing her baby off kind of thing.

(Family Nurse 6)

- 6.4 The **establishment of strong therapeutic relationships with clients** was (as described in Chapter 3 and in the first Scotland evaluation report) viewed as key to the delivery of FNP. These relationships were evidently something the

NHS Lothian, Edinburgh Family Nurse team were very proud of and (as discussed in Chapter 3) viewed as key to their high retention rates:

My personal achievement? ... I feel ... I've built up such a good strong therapeutic relationship with my clients that ... I've not had any one who has left the programme ... because of a breakdown in our relationship.

(Family Nurse 3)

6.5 Increasing familiarity with, and confidence in using, both the programme materials and FNP's approaches to delivering these was also viewed as a key area of achievement since the first evaluation report. It was suggested that the team's initial confidence levels in delivering different elements of the programme varied in part with their particular professional backgrounds – those with a health visiting background might feel more familiar with the detailed content of the programme in the post-partum period, while those with midwifery experience reported finding the late pregnancy and birth stage relatively easier. Family Nurses thus reported having expanded their knowledge of areas that may not have been part of their original professional background as well as having gained in confidence using the specific facilitators and materials associated with FNP. The use of motivational interviewing and strengths-based approaches to delivering these materials, as well as the holistic focus of the programme (tackling social issues alongside health), was viewed as having led to significant shifts in professional practice and interactions with clients.

This is the lovely thing about, I think, the programme, is as a nurse, you want to 'fix, do, make things better' ... Whereas what the programme has done is it's sort of freed that up a bit in the sense that, "OK. You've got a problem here. Let's look at it. What can you do to fix it? How can I help you find a solution to fix it?". And d'you know what? Most of the girls have got that now.

(Family Nurse 4)

FNP covered, you know, the whole spectrum. It's not just about health practice ... It's about social practice as well, and it's about where all these social things actually interlink with health, and how everything links together for a better future for everybody. ... So I guess it's probably the impact it's had on me is that, even if FNP didn't continue, or if .. if we chose to go back to our previous careers, I guess we would all ... professionally visit in a very different way.

(Family Nurse 1)

6.6 The potential achievements of FNP in terms of its perceived influence on wider services are covered in the next chapter.

Key challenges

Workload

- 6.7 The Scottish Government took a decision early on to fund a 1:6 ratio of Family Nurse Supervisors to Nurses, rather than the agreed maximum of 1:8. As this does increase the cost of the programme, it is important to monitor workload levels across sites. The findings below reflect the views of the NHS Lothian, Edinburgh Family Nurse team in late 2011, around half way through delivering the programme to their first cohort. Evidence from previous evaluations of FNP (e.g. Barnes et al, 2009, 2011) indicate that as Family Nurses' confidence and familiarity with the programme increase and the level of training reduces, workload pressures may reduce.
- 6.8 There was consensus among the Family Nurse team in NHS Lothian, Edinburgh that workloads remained a major challenge in delivering the programme. Issues around workloads were discussed in some detail in the first Scotland evaluation report (Martin et al, 2011). While workloads were believed to have eased somewhat since then, as of late 2011 delivering the programme within a standard working week (37.5 hours) was still seen as a significant challenge. The view that *'it's got marginally better, but it's not great'* summed up opinion within the team.
- 6.9 The factors contributing to high workloads were, however, seen as changing depending on the stage of the programme. As discussed in Martin et al (2011), coping with the high volume of training at the same time as enrolling clients created challenges in the initial stages of delivery. Later, as clients started to deliver their babies, the need to visit them weekly in the 6 weeks post-partum could be difficult to accommodate in the hours available. Workload was also affected by the complexity of each Nurse's caseload. For example, cases where there were child protection issues often took up considerably more time (for attending case conferences, making referrals, etc) than others. The fact that NHS Lothian, Edinburgh was the first FNP site in Scotland was also seen as creating some additional pressures, relating to the volume of visitors to the project and the number of events team members were asked to host or attend, for example. Finally, other factors that contributed to workload pressures were less connected with FNP specifically and more related to the fact that the team is part of the wider NHS. An issue which the team felt had a significant impact on their workload in late 2011 was the requirement for them to move to electronic record keeping. Prior to this, Family Nurses had maintained hand-written records only, which they tended to write-up between visits. Being able to write up notes on a timely basis between visits was initially more difficult when the new system was introduced, leading to some duplication of effort (e.g. making hand written notes to type up later). At the time of writing, this had been resolved by providing the NHS Lothian, Edinburgh Family Nurse team with NHS laptops so that they could enter their notes directly between visits. Another issue arising out of the team's location within the wider NHS was the amount of time the Supervisor needed to spend on liaison with other NHS and non-NHS services. In general it was suggested that the requirements for UK-based Family Nurses to link with wider services, undergo standard NHS

training, etc., might mean their workloads were heavier than those of their US counterparts.

6.10 In terms of strategies for managing workloads, as discussed in the first Scotland evaluation report, the Supervisor was viewed as being very supportive, including being firm about taking time back. In comparison with their first interviews, Family Nurses also reported putting more 'boundaries' themselves around their work to try and protect their work-life balance – for example, being stricter about the number of client visits they would try and fit into a single day and no longer trying to see every client in the week before annual leave. Other ways in which the NHS Lothian, Edinburgh team have tried to meet workload challenges include:

- Drawing on support from the Team Administrator in making up packs of materials, sending out client letters, setting up events, etc.
- Team discussions around ideas for time management
- Attempting to geographically 'cluster' visits, and
- Providing NHS laptops to facilitate record keeping in the field (as discussed above).

Other challenges

6.11 Other challenges to delivering the programme in 2011 included:

- **Assimilating learning/gaining familiarity with materials** – As reported above, the FNP Team felt they were becoming more familiar with FNP materials over time. However, the volume of materials associated with the programme was nonetheless seen as a lot to take in. It was suggested that they would feel much more confident about delivering the programme to the next cohort of clients.
- **Gaining confidence with new approaches** – Again, although using motivational interviewing and strengths-based approaches were areas where Family Nurses felt they had grown in confidence and skill, the move to using these approaches was viewed as involving a '*massive learning curve*'.
- **Challenges around keeping in touch with a mobile client group** – As discussed in Chapter 3, the fact that FNP clients move house frequently and that some may have relatively complex or chaotic lives posed some challenges to meeting fidelity around visit numbers in pregnancy. While Family Nurses reported being extremely flexible and accommodating in their approaches with these clients, keeping them engaged was obviously challenging:

For example today I went out to see somebody and she wasn't around. I did text her this morning to remind her, I didn't hear from her. Went out, I texted her again, went out, not there, texted her again, she's in a new house painting the house and having, then having to rearrange. There's a lot of that kind of stuff

- **Balancing necessary team changes with the requirements of a licensed programme.** As noted in Chapter 1, there were several changes to the NHS Lothian, Edinburgh team in the last year, including the appointment of a new Family Nurse and the promotion of an existing team member to act up to supervisor two days a week. While these changes were discussed positively, they did create some challenges, particularly around balancing the desire to keep clients with the same Family Nurse (listed as one of the Core Model Elements) and training requirements for the new supervisor with the workloads of different team members.

Training

6.12 As described in Martin et al (2011), the formal training provided to Family Nurses in NHS Lothian, Edinburgh falls into three main categories:

- **FNP programme specific training**, delivered by the DH FNP National Unit. This covers the three main phases of FNP – pregnancy, infancy and toddler. Within each block, Family Nurses are trained on programme manuals, materials and facilitators.
- **Master Classes** relevant to Family Nurses. These cover approaches to delivering FNP, such as Motivational Interviewing, as well as specific topics (e.g. 'Perinatal Mental Health') and approaches to discussing these (e.g. PIPE, Partnership in Parenting Education, which focuses on practical approaches to supporting parent-child relationships).
- **Mandatory NHS Lothian training**, covering issues such as child and adult protection and NHS Lothian IT and records systems.

6.13 The FNP NHS Lothian, Edinburgh Team had already completed the mandatory 5 day residential pregnancy and infancy training courses at the time of their first evaluation interviews. Their views on this are reported in detail in Martin et al (2011). Reflecting back on the pregnancy and infancy phase training, Family Nurses again described the training as having been '*second to none*', although challenges around finding time for absorbing and consolidating training (particularly for the infancy phase) were again noted. The only additional areas where, on reflection, Family Nurses suggested the National Learning Programme could have been improved were:

- **Including more practical workshops.** One view was that the programme was very focused on principles and delivery, and that it would have been helpful to spend more time on practical issues like understanding labour processes or on maternal mental health (also identified as a gap by Family Nurses interviewed in Barnes et al, 2008). Similarly, it was suggested that the PIPE training could have included more practical demonstrations. Understanding labour processes in more detail could be a particular issue for those who were not from a midwifery background. In Lothian, this was addressed by one of the team who did have a midwifery background running sessions on labour and delivery (described as '*hugely helpful*' by other team members).

- **Less reliance on self-directed learning for some topics.** The decision to use self-directed learning for some FNP topics was made to support teams learning together locally and in response to the finding that pre-course work was required to maximise the effectiveness of some training. However, one Family Nurse view was that the PIPE and Smart Choices courses should both rely less on self-directed learning. Both these courses were seen as very valuable, but workload pressures could prevent Family Nurses from completing self-study and fully incorporating them into their practice until later in the programme. Expanding these courses and/or relying less on self-study were seen as ways of ensuring that Family Nurses are equipped to use this learning at the earliest opportunity.

6.14 Since completion of the FNP National Learning Programme, ongoing learning and development has been facilitated within the team via scheduled learning and consolidation days, and through the NHS Lothian, Edinburgh team's continued engagement with activities, workshops and conferences organised by the DH FNP National Unit. These include:

- Regional Learning Sets – which bring FNP Supervisors together in different venues in England on the same day for training.
- Supervisor Buddy Groups – the FNP Supervisor is currently 'buddied' with supervisors in Sunderland and Durham. In addition to meeting for Supervisor peer support, these groups also organise joint learning sessions for their teams.
- Other workshops and events – for example a workshop on fathers' engagement with FNP.

6.15 Although the requirement to travel to England for these events was time consuming, there were perceived to be ongoing benefits to the NHS Lothian, Edinburgh team from being involved in learning activities with the English FNP sites, particularly from sites which are further on in implementing the programme than NHS Lothian, Edinburgh. There was therefore a concern that the NHS Lothian, Edinburgh team might miss out on valuable shared learning if these activities become more localised in the future (for example, Scotland-specific buddy groups once there are several FNP sites in Scotland).

6.16 Plans for further developing FNP training in Scotland include: the appointment of a new FNP Child Protection Lead within the FNP National Unit (Scotland) team; a new National Lead Psychologist; a National Lead Supervisor; and a DANCE trainer. The Child Protection Lead remit includes identifying specific learning needs relating to child protection in FNP in Scotland, and supporting the development of appropriate training to address these needs.

Supervision

6.17 Supervision is an integral part of the FNP programme. Perceptions of supervision among the NHS Lothian, Edinburgh Family Nurse Team were discussed in detail in the first Scotland evaluation report (Martin et al, 2011). The views and issues raised in Family Nurses' second interviews largely echoed those discussed there: Family Nurses commented on the priority

attached to supervision within FNP, viewing this as *'invaluable'* in supporting them with managing a challenging caseload and giving them the *'headspace'* to reflect on and improve their practice. The fact that supervision is specified as part of the licensing conditions for the programme was viewed as key to enabling the team to prioritise it – without this, it might drop out of people's *'busy working week'*. Additional points or developments in how supervision was approached raised in the second NHS Lothian, Edinburgh Family Nurse Team interviews included:

- The increase in frequency in Child Protection supervisions (from 6 monthly to quarterly). The Supervisor noted that this might mean that some cases that did not involve such issues received less attention in group sessions.
- The recent decision by the NHS Lothian, Edinburgh FNP Team to change their group supervision sessions from being completely *'open'* (where Family Nurses only discussed those cases they felt they needed to talk about that week) to a more structured programme, with set clients to discuss at each meeting. This may be one way of ensuring that teams are able to learn from all their cases as a group, and not only those which raise specific kinds of concerns.
- The increasing perceived usefulness of supervisions with the team Psychologist, as Family Nurses have become more familiar and comfortable with these sessions.

6.18 While supervision within FNP was generally viewed extremely positively, there were a few suggestions from NHS Lothian, Edinburgh Family Nurses for changes to the way supervision was structured locally. These primarily related to the focus of FNP supervisions on specific clients as a way of learning from practice. One view was that while this was useful, it might also be valuable to spend more time talking about general clinical issues, or looking at programme delivery in general – for example, looking at materials and sharing views on ways of delivering that worked particularly well.

6.19 Finally, as discussed in the first Scotland evaluation report, the lack of a user-friendly database for FNP in Scotland, while not preventing effective supervision, nonetheless continued to be viewed as a significant limitation on the team's ability to creatively engage with the data Family Nurses collect within supervision meetings. It was also perceived as creating continued pressure on the Administrator's and Supervisor's workloads in relation to data checking and validation.

Key points

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

- Family Nurses' views of the training they received remained extremely positive. The only ways in which it was felt training might be improved were including more practical sessions and relying less on self-learning (which could be difficult to find the time for).
- The ongoing opportunities FNP provides for learning and sharing practice – including with FNP teams in England – were appreciated by the team.

- The quality and level of supervision provided to the FNP team was viewed as '*invaluable*', particularly in situations where the FNP manual materials were perhaps seen as relating less well to specific client needs. The fact that supervision was part of the license enabled the team to prioritise it.
- Supervisions with the team Psychologist were seen as increasing in value as the programme progressed and the team became more comfortable with these sessions.
- Suggestions for changes to supervision included spending more time talking about general clinical issues or looking at programme delivery in general.

How feasible/appropriate is the visiting schedule?

- General challenges in meeting the visiting schedule are discussed in Chapter 3. In terms of challenges in delivering the programme as a whole, including meeting the visiting schedule, workload continued to be viewed as a significant issue, although it was also suggested that this had eased a little since the first evaluation interviews.
- Issues contributing to high workloads in the late pregnancy and post-partum period included factors relating to FNP specifically (for example, the requirement to visit clients weekly in the 6 weeks post-partum and the volume of visits and events associated with being the first FNP test site in Scotland) and factors stemming from the fact that the team is part of the wider NHS (for example, the move to an electronic child health record keeping system in Lothian in late 2011).

Are FNP data entered into the FNP database in a timely fashion?

- Although there were no reports of issues around the timeliness of data entry from the forms completed by Family Nurses at each visit, the lack of a user-friendly database, while not preventing effective supervision, continued to be viewed as a limitation on the team's ability to creatively engage with FNP monitoring data to support 'reflective supervision'.

7 IMPLEMENTING FNP IN LoTHIAN

- 7.1 A key purpose of this evaluation is to help distil and disseminate key learning from the first Scotland FNP test site in NHS Lothian, Edinburgh. The following chapter draws together wider lessons and conclusions from this report as a whole, while this penultimate chapter focuses specifically on Family Nurse and stakeholder perspectives on key areas of potential learning from the experience of delivering FNP in NHS Lothian, Edinburgh in the last year. It is hoped that future reports will be able to consider this issue from the perspective of non-FNP professionals (particularly midwifery and General Practice).

Learning from FNP in Scotland

- 7.2 The first Scotland evaluation report (Martin et al, 2011) identified some initial concerns around how easy it would be to share learning from a licensed programme, which specifies that the detailed materials and manuals cannot be disseminated beyond trained FNP teams. While this report cannot comment on how the wider NHS and other services view this issue, the views of Family Nurses and FNP stakeholders interviewed for this evaluation suggest that in practice this has not been a major barrier to sharing learning. It was felt that discussions about shared learning had been less focused on what could not be shared in terms of details of the manual, and more focused around what can be learned in terms of, for example, different approaches to engaging those less likely to access universal services. Good practice was shared within Lothian via the local FNP lead and Nurse Supervisor's contact with wider NHS and non-NHS services (for example, via the CHP Clinical Nurse Manager structure) and by the Family Nurses themselves via day-to-day contact with other services. More widely, both the FNP team in Lothian (and now Tayside) and the FNP National Unit (Scotland) shared learning via their involvement in both FNP specific and more general conferences and away days. A recent example was an away day convened at the request of the Chief Nursing Officer to look at what the Modernising Nursing in the Community programme can learn from FNP and vice versa. At the same time, there was also a perceived need to balance sharing learning about what appears to be good practice, with a recognition that FNP is still being evaluated in the UK, and that it cannot be a panacea solution for all the problems teenage mothers might face.

Learning from Lothian for other FNP sites

- 7.3 The experience of introducing FNP in Lothian was seen as having highlighted the central importance for other sites of early engagement with other local stakeholders and services, particularly local authorities, maternity services and general practice. Building relations with Housing and the third sector was also seen as key. Scottish Government recognition of the importance of building these relationships has been reflected in the establishment of strengths-based leadership courses for key stakeholders working with FNP local teams in Scotland (including senior social workers, child protection leads and child health commissioners). The skill of the Nurse Supervisor and local lead and the close support of strategic leads within NHS Lothian were viewed as key factors that had facilitated good engagement with wider services in Lothian.

- 7.4 At the same time as recognising the importance of building these relationships to the success of FNP, however, it was also suggested that a key learning point from the experience of delivering it in Lothian was that *'the programme will sell itself'*. As people see changes *'in people they thought it wasn't possible to change'*, appreciation of FNP was seen as naturally increasing.
- 7.5 A final learning point for other sites related to the importance of building in time for consolidating learning from FNP training. This was identified as a key challenge in the early stages of the NHS Lothian, Edinburgh programme in the first Scotland evaluation report (Martin et al, 2011), and it was noted that more time for this was being built into Supervisor schedules for new sites in Scotland.

Learning from Lothian for wider services

- 7.6 Interviewees also reflected on the ways in which they felt the first FNP test site in NHS Lothian, Edinburgh might have influenced thinking in the wider NHS and in other services. It was suggested that FNP NHS Lothian, Edinburgh may have had an influence in three key areas:

- **Engaging clients.** It was noted that the strength-based philosophy of FNP chimed well with a number of other recent developments in the NHS (in particular, the renewed focus on an assets-based approach). However, although such approaches are not necessarily unique to FNP, Family Nurses in NHS Lothian, Edinburgh believed that they had seen changes in the way other NHS and non-NHS services speak to their clients as a result of their explaining and modelling a strengths-based approach.

I think (it) has had a rippling type of effect in many ways because ... you hear examples you know about how ... the way we might focus on strengths ... you hear other agencies maybe do more of that and they feel that that's probably come from us.

(Family Nurse 6)

Learning from FNP in this respect was not necessarily confined to young mothers and children – for example, FNP (Scotland) contributed to national conference on coproducing services for older people, illustrating how learning from FNP approach may be transferrable to other areas, with potential positive impacts for understanding how to bring about change within communities.

- **How to support Nurses working in high pressure roles.** There was a perception that the wider NHS was being encouraged to think about its own models of supervision, training and support for Nurses in the light of the positive experiences of the NHS Lothian, Edinburgh FNP team. The low levels of sickness and retention of Family Nurses within the NHS Lothian, Edinburgh FNP team, in spite of the demands of the Family Nurse role was seen as an indication of the benefits of the FNP supervision and support model. At the same time, it was suggested that the investment in Nurses' training and supervision associated with FNP might be boosting

the morale of the wider nursing community by conveying the importance the Scottish Government attaches to the profession.

- **Specific approaches to assessing clients.** While some of the tools used by FNP are covered by the license and cannot be shared more widely, the programme also makes use of standard tools and assessments that may be useful for other services. For example, dissemination by the FNP team in NHS Lothian, Edinburgh of their use of the Ages and Stages Questionnaire (ASQ) child development questionnaire had led to this potentially being trialled in universal services in Lothian.
- **Services for teenage parents who are not eligible for FNP.** The experience of delivering FNP was also viewed as having acted as a 'prompt' for NHS Lothian to think about services available to teenagers who are not eligible for FNP, and to start developing a 'pathway' for teenager's health.

Key points

- Perceptions of key learning from the experience of delivering FNP in NHS Lothian, Edinburgh for other FNP sites include:
 - The importance of early engagement with local stakeholders and services
 - Learning that 'the programme will sell itself' as people see the changes it can effect, and
 - Building in time for consolidating learning from FNP training from the start.
- Perceptions of the potential influence the NHS Lothian, Edinburgh FNP programme may have had on the wider NHS and other services focused on learning about:
 - How to work with those less likely to access universal services
 - How to support Nurses working in high pressure roles
 - Specific approaches to assessing clients, and
 - Thinking about services for teenage parents who are not eligible for FNP.

8 CONCLUSIONS AND KEY LEARNING

8.1 This final chapter summarises the key conclusions and learning from this report in relation to each of the evaluation aims (discussed in Chapter 2).

Is the programme being implemented as intended?

8.2 This second report indicates that 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 pregnancy was well below the fidelity 'stretch' goal, while the proportion of clients receiving the target level of expected visits (80% or more) during pregnancy was 52%. The amount of time Family Nurses spent on different topics during pregnancy also came very close to the division suggested by the fidelity 'stretch' goals. The NHS Lothian, Edinburgh Family Nurse team continued to actively participate in all the training and supervision required by the programme.

8.3 The Family Nurse team in NHS Lothian, Edinburgh suggested that their low attrition rate during pregnancy was primarily a result of the strength and continuity of the relationships established between clients and Family Nurses. For the minority of clients who had disengaged, in retrospect Family Nurses suggested that a more flexible approach to meeting their needs in the early stages of the programme, focused on agenda-matching rather than closely following the suggested content, might possibly have helped.

8.4 Key factors that facilitated Family Nurses being able to meet the visiting schedule during pregnancy included: being able to be flexible about appointments; establishing strong client relationships (with clients motivated to keep appointments); and the perceived level of motivation clients had to discuss the birth and beyond with their Family Nurse. However, Family Nurses also identified a number of barriers to delivering the target number of visits for some clients during pregnancy. Some of these were external factors (such as weather), outwith the team's (or clients') control. Other factors related specifically to the fact that NHS Lothian, Edinburgh is still in a test phase – for example, the team should not face the same pressures around delivering home visits at the same time as receiving intensive mandatory training when the next cohort of clients are recruited. Similarly, if the team moved to small-scale permanence, they should not face the same pressures around delivering weekly visits to many of their clients while still engaging and enrolling the remainder. However, factors like client mobility and clients' preferences for seeing their own Family Nurses, in combination with the higher level of annual leave nurses in the UK are entitled to in comparison with nurses in the US, may continue to mitigate against delivering 80% of home visits for some clients.

How does the programme work in Lothian?

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

- 8.5 Clients continued to praise the impact of the FNP programme in supporting them both practically and emotionally. As discussed below, they identified a wide range of perceived benefits from their participation and appeared very happy both with the overall content of the programme and the scope for 'agenda-matching' with their own concerns. Cases where the programme appeared to be somewhat less successful in meeting clients' needs or expectations generally appeared to feature a lower level of contact between client and Family Nurse and/or specific challenging circumstances, like a child being taken into care. The NHS Lothian, Edinburgh Family Nurse team highlighted the particular challenges associated with supporting clients if their baby is taken into care, suggesting that the programme materials were not always very helpful in this scenario.
- 8.6 Family Nurses highlighted the impact of FNP not only for clients but also for their own professional development and practice. The level and quality of training and supervision both continued to receive high praise. Family Nurses also reported feeling increasingly confident in delivering both the programme materials and the new ways of working associated with FNP. Suggestions for further improvements to training included more practical sessions and less reliance on self-learning, while it was felt that supervision sessions might benefit from more general discussion around clinical issues or programme delivery, rather than always being structured around particular clients. Finally, it was noted that the programme content for the post-partum period was very full and suggested that some of the materials might benefit from being reduced, simplified or, in relation to contraception, revised for the UK context.
- 8.7 The evaluation has not yet included interviews with stakeholders from other services. However, the FNP team suggested that working relationships between FNP and key services like midwifery, health visiting, social work and housing had all improved since the start of the programme as they had become familiar with each other and with FNP's ways of working. Family Nurses suggested that they had started to see aspects of their own practice – for example, the use of strengths-based language – reflected back by some of the other services they were working with. Relationships with benefits services were reported to be more difficult. Building on experiences of working with other services, this may perhaps be addressed in the future through identifying opportunities for joint-working and shared learning around strengths-based approaches. It was also suggested that the establishment of FNP had encouraged NHS Lothian to think about their services for other teenagers, who are not eligible for FNP. Future evaluation reports will hopefully include the views of other services on FNP.

What are the implications for future nursing practice?

- 8.8 As discussed in Chapter 7, it is important not to draw too many conclusions about the success of FNP at this early stage, before the results of the English RCT are available and before the learning from NHS Lothian, Edinburgh and

other test sites has been fully consolidated. However, the findings in this report nonetheless suggest a number of potential implications for wider nursing practice from the experience of delivering FNP in NHS Lothian, Edinburgh to date, including:

- The benefits of adopting a strengths-based approach in securing and maintaining the engagement of ‘hard to reach’ clients with services.
- The potential for motivational interviewing to encourage clients who are ambivalent or hostile to try or change particular behaviours, like breastfeeding or cutting down on smoking.
- Potential learning for midwifery and other services around young mothers’ anxieties and learning needs in relation to infant feeding.
- The importance of agenda-matching services to clients’ current needs and aspirations – particularly in relation to keeping the most vulnerable clients engaged.
- The potential for intensive, mandatory, structured supervision, which also reflects a strengths-based approach to staff management, to reduce turnover and maintain motivation and morale where nurses are working in high pressure roles.

What factors support or inhibit delivery of the programme?

8.9 Family Nurse and client accounts suggest that the key factor underpinning successful delivery of the programme is the quality of the client-Family Nurse relationship. The establishment of this therapeutic relationship was seen as having helped reduce attrition, motivated clients to keep appointments and facilitated the open discussion of potentially uncomfortable issues. The flip-side of this was that where Family Nurses and clients had less contact during pregnancy (for whatever reason), it could be more difficult and/or take longer to establish this therapeutic relationship, with consequences for engagement, clients’ level of comfort discussing particular issues and perceptions of the quality of support received. Training and supervision were also key factors underpinning Family Nurses’ ability to deliver the programme.

8.10 Workload remained a key challenge for the FNP team in delivering the programme. An important point here, which echoes findings from Barnes et al’s evaluation of the Wave 1 England FNP test sites, is that workload pressures do not only reflect FNP programme requirements. They also reflect the requirements of being part of the wider NHS – attending mandatory training, engaging with and commenting on new developments, networking with universal services, etc. As FNP is rolled out further in Scotland – particularly if it moves from test phase to permanency – it may be worth carrying out further research to review Family Nurse workloads and the balance between the FNP-specific and NHS-generic requirements of their role. Monitoring future workloads is also important in the light of the additional costs associated with the Scottish Government’s decision to support a lower Supervisor: Nurse ratio (1:6 rather than 1:8), which obviously has cost implications.

8.11 Finally, the lack of a user-friendly database, while not preventing effective supervision, continued to be viewed as a limitation on the team’s ability to

creatively engage with the monitoring data they collected as part of a 'reflective supervision' process.

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

8.12 As discussed in the introduction to this report, this evaluation is not a formal impact evaluation and cannot conclusively establish causal links between FNP and particular outcomes. The 'Building Blocks' RCT in England will provide this evidence. However, interviews with Family Nurses and clients conducted for this evaluation nonetheless highlight a wide range of areas where participation in FNP was perceived to have a positive impact, including:

- Young parents who are better prepared for labour and delivery, and feel more confident and in control.
- Improved parent-child attachment.
- Improved maternal health behaviours.
- Enhanced awareness of child health and safety issues.
- More confident parents.
- Mothers who feel better supported in dealing with mental health and emotional difficulties.

8.13 There was also some evidence of the potential for the approach used by FNP to have a positive impact on breastfeeding rates among younger mothers. However, this report also highlights the essential importance of the support mothers receive with breastfeeding in the first few days after birth, particularly in hospital. Without this support, positive intentions to breastfeed may easily be undermined, particularly where young mothers may have been ambivalent about this in the first place.

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