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Evaluation of the Family Nurse
Partnership Programme in
NHS Lothian, Scotland:
4th Report – Toddlerhood

Health and Community Care



**EVALUATION OF THE FAMILY NURSE
PARTNERSHIP PROGRAMME IN NHS Lothian,
SCOTLAND:
4TH REPORT – TODDLERHOOD**

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

Rachel Ormston & Susan McConville

Table of Contents

EXECUTIVE SUMMARY	I
Is the programme being implemented as intended?	i
How does the programme work in NHS Lothian, Edinburgh?	i
How do Nurses, clients and wider services respond to the programme?	i
What factors support or inhibit delivery of the programme?	ii
What are the implications for future community nursing practice?	iii
What is the potential for FNP to impact on short, medium and long-term outcomes relevant to Scotland?	iv
1 BACKGROUND AND INTRODUCTION	1
About this report	1
The Family Nurse Partnership (FNP) programme	1
Testing FNP in Scotland	2
FNP in NHS Lothian, Edinburgh	2
2 SUMMARY OF EVALUATION AIMS AND METHODS	4
Evaluation aims and objectives	4
Monitoring and evaluation framework	4
Overview of methods and data included in this report	4
Reporting conventions	5
3 RELATIONSHIPS	7
Key questions	7
Key findings	7
Introduction	7
Client retention and attrition	8
Level of contact between clients and Family Nurses	9
Nature and impact of the client-Family Nurse relationship	10
Perceived impact of client-Family Nurse relationship in child protection cases	11
Graduation	12
How FNP prepares clients for graduation	12
Family Nurse and client perceptions of graduation	13
Relationship between FNP and the client's wider family	15
4 OVERALL DELIVERY AND VIEWS OF PROGRAMME CONTENT DURING THE TODDLERHOOD PHASE	17
Key questions	17
Key findings	17
Introduction	17
Visit content figures	18
Overall views of programme content in Toddlerhood	18
Challenging topics	19
5 PARENTING, CHILD HEALTH AND DEVELOPMENT	22
Key questions	22
Key findings	22
Introduction	22
Parenting practice in toddlerhood	23
Bonding and attachment	23
Toddler Behaviour	24
Routines	24
Diet and nutrition	25
Breastfeeding	26

Child Health and Safety	27
Child dental health	27
Immunisations	27
Safety in the home (and wider) environment	28
Child development	28
Potty training	29
Speech and language development	29
Socialisation	29
6 MATERNAL HEALTH, WELLBEING AND FUTURE PLANS	30
Key questions	30
Key findings	30
Introduction	30
Maternal health and wellbeing	31
Mental and emotional health	31
Subsequent pregnancies, second births and contraception	31
Subsequent pregnancies and second births	31
Contraception and planning for subsequent pregnancies	32
Future plans around work and education	33
7 REFERRALS AND TRANSITIONS	35
Key questions and outcomes	35
Key findings	35
Introduction	36
Referrals to other services during toddlerhood	36
Perceived impact of FNP referrals on clients	38
Transitions to universal services	39
Perceptions of working with Health Visiting around transition	39
Joint working with other services	41
Key learning around joint working	42
8 PROFESSIONAL VIEWS AND EXPERIENCES OF DELIVERING FNP	43
Key questions	43
Key findings	43
Introduction	43
Achievements	44
Challenges	45
Workloads	45
Database	48
Training	48
Supervision	49
9 LEARNING FROM IMPLEMENTING FNP IN LOTHIAN	51
Key findings	51
Introduction	51
Learning for FNP roll-out in Scotland	51
Supporting sites with introducing and expanding FNP	51
Recruiting and developing staff	52
Potential learning for wider services	53
REFERENCES	54

EXECUTIVE SUMMARY

1. The Family Nurse Partnership (FNP) programme is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old.
2. The FNP programme was developed in the USA (where it is called the 'Nurse Family Partnership' programme) by Professor David Olds (University of Colorado, Denver). Based around a structured programme of home visits to the mother (and, after birth, the mother and child) delivered by trained Family Nurses, it is a preventative programme, aimed at first time mothers and their babies. The programme's goals are to improve pregnancy outcomes, the health, development and well-being of first time parents and their children, and families' economic self-sufficiency.
3. The evaluation of FNP in Scotland focuses on learning from the experience of implementing FNP in the first Scottish test site, based in NHS Lothian, Edinburgh in which 148 clients were initially recruited. It is not an experimental impact evaluation, but rather focuses on learning around how the programme works in a Scottish context.
4. This summary outlines the key findings from the fourth of four evaluation reports on the individual 'phases' of FNP. It focuses on learning from the delivery of the programme in NHS Lothian, Edinburgh in the **toddlerhood phase** (the period when clients' children are 12 to 24 months old). The report draws on quantitative data collected for all FNP clients and qualitative interviews with the initial NHS Lothian, Edinburgh FNP team, the FNP National Lead for Scotland, and a sub-sample of FNP clients and their nominated 'significant others'.

Is the programme being implemented as intended?

5. Throughout the toddlerhood phase 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 toddlerhood remained below the fidelity 'stretch' goal (5%, compared with the 10% maximum suggested for that period).
 - The fidelity 'stretch' goal of delivering at least 60% of selected visits to clients during toddlerhood was met for 83% of clients.
 - The average time Family Nurses spent on different topics during toddlerhood came close to the division suggested in the 'stretch' goals.
 - As in previous evaluation reports, Family Nurses were highly engaged with supervision which continued to be viewed as 'absolutely pivotal' to delivery of the programme.

How does the programme work in NHS Lothian, Edinburgh?

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

6. Both clients and Family Nurses continued to respond very positively to the programme during the toddlerhood period. Comments from both indicated that Family Nurses were able to deliver materials that were well-matched to client expectations and needs during that phase, while also 'agenda matching' successfully to clients' specific circumstances.
7. Varying views were expressed about individual client 'readiness' to graduate from FNP when the programme ends (shortly after the client's child turns two years-old). However, overall, Family Nurses reported that the way the programme had built on clients' strengths and prepared them for graduating meant that clients had been more confident about the programme ending than Family Nurses had anticipated at the outset.
8. Clients' views about graduating from FNP fell into three main categories: those who felt completely ready to leave and move on with their lives; those who had some reservations about graduating, but understood why the programme had to end; and those who reported not feeling quite ready to leave or who still thought they needed support.
9. The views of stakeholders outside FNP were discussed in the third evaluation report. The NHS Lothian, Edinburgh FNP team felt that by the time their first cohort of clients were graduating from the programme, working relationships with other services in general had improved as these services became more familiar with FNP and their ways of working.

What factors support or inhibit delivery of the programme?

10. As in previous reports, the therapeutic relationship between clients and Family Nurses was identified by both clients and Family Nurses as key to the success of the programme in general, to Nurses' ability to meet fidelity around numbers of visits, and to both clients' and Nurses' ability to raise and discuss 'difficult' topics (including child protection concerns) in a frank and honest manner.
11. The NHS Lothian, Edinburgh FNP team identified various factors they believed had supported successful client transitions from FNP to universal services. In particular, they commented on:
 - The structure of the programme itself and the fact that graduation is discussed from very early on and supported by more specific materials and activities during the toddlerhood phase, and
 - Joint visits with Public Health Nurses/Health Visitors prior to clients graduating from the programme (which were seen as important in supporting ongoing engagement with universal services after FNP comes to an end).
12. Where clients were experiencing a crisis of some kind at the time they needed to graduate, some Family Nurses reported wishing they could keep them in the programme a little longer, although accepted that this was not how FNP works. The NHS Lothian, Edinburgh FNP Team also reported some challenges around working with Public Health Nurses/Health Visitors at transition, particularly relating to client perceptions that Public Health Nurses/Health Visitors were

making critical comments at joint visits that might make it hard for clients to engage with Health Visiting subsequently. The team had agreed to meet with Public Health Nurses/Health Visitors in advance of the joint visit to discuss the client's background in order to try and avoid such issues arising.

13. Early and ongoing communication with wider services about what FNP is and what it does was considered essential in supporting FNP delivery and expansion in a site. FNP's engagement with other services was also viewed as key to supporting clients' successful transitions from the programme. As noted above, the NHS Lothian, Edinburgh FNP team felt that working relations with other services had improved since the start of the programme. However, they also reported some ongoing challenges relating to differences in philosophy between FNP and other services, particularly around what it means to implement a 'strengths-based' approach to working with young parents. There was also a view that, while the team and other services had worked hard to put services in place for clients as they moved out of FNP, there was something of a gap around formal services in Edinburgh for young parents of two year-olds.
14. As noted above, supervision continued to be viewed as key to supporting nurses to deliver the programme (though views on whether child protection supervisions were as useful as they could be and whether their frequency was appropriate remained mixed). The quality of FNP training also continued to be praised. However, the team's experiences of applying their formal training also suggest that greater consideration may need to be given to the timing of training for later phases of the programme (e.g. there was a suggestion that the toddlerhood and DANCE training components may have been delivered too early). In future, there may also be a need to consider whether and what kinds of refresher training might be required, particularly where there are long gaps between the initial delivery of a particular phase of FNP and when it is next delivered by a team.
15. At the time the NHS Lothian, Edinburgh, FNP team were interviewed for this report, workloads were generally viewed as more manageable, largely because team members had smaller caseloads. At the time, they were moving from the testing stage of the programme to small scale expansion and were in the process of building up again to a full caseload of second cohort clients. The more staggered approach taken to recruiting this second cohort was felt to have avoided some of the workload pressures experienced as a result of 'front-loading' recruitment of the first cohort. However, views within the team around how manageable FNP workloads are more generally remained mixed.

What are the implications for future community nursing practice?

16. Family Nurses and other stakeholders interviewed for this report recognised that developing future community nursing practice in general involves complex issues and that FNP can only contribute to discussions about future direction if considered alongside other services. However, similar themes to those discussed in earlier reports were raised in relation to potential shared learning with wider services, including:

- Learning about how to support nurses working in intensive roles, particularly through developing models of supervision that facilitate effective reflection and help nurses feel supported when stretched
- How different models of education might help nurses feel equipped for their roles or for working with specific client groups, and
- Learning about how to manage risk but within a client-focused, strength-based framework.

17. The NHS Lothian, Edinburgh FNP team also suggested that there may be a need for further investigation of how FNP can help support other nursing colleagues, particularly Public Health Nurses/Health Visitors who were perceived to have a difficult job which was not always fully recognised.

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

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

- Become more confident parents
- Manage their child's behaviour and routines more effectively
- Manage routine development activities – like potty training – more confidently
- Improve their toddler's diets
- Keep their child safe as they grow
- Manage their own mental and emotional health
- Broaden their horizons in relation to work and education.

19. However, FNP works alongside existing services and the evaluation also identified various external factors that might impact on FNP's ability to deliver these outcomes – such as the availability and perceived suitability of services specifically for young parents, or client concerns about affordable childcare to enable them to work. Thus while FNP appears to have the potential to have a range of positive impacts on short, medium and long-term outcomes, its ability to impact on these in practice will depend not only on the delivery of FNP itself, but also how it interacts with and is supported by the wider service landscape.

1 BACKGROUND AND INTRODUCTION

About this report

- 1.1 The Family Nurse Partnership (FNP) programme is a licensed preventative programme which aims to improve outcomes for young first time mothers and their children. It does this through a structured programme of home visits delivered by specially trained Family Nurses from pregnancy until the child is two years old.
- 1.2 The evaluation of FNP in Scotland focuses on learning from the experience of implementing FNP in the first Scottish FNP test site, based in NHS Lothian, Edinburgh. It focuses on process and understanding how the programme works in a Scottish context.
- 1.3 This fourth evaluation report focuses on the delivery of the programme in the **toddlerhood period** (the period when clients' children are 12 to 24 months old, at the end of which clients 'graduate' from the programme and stop receiving Family Nurse visits). Three earlier reports (Martin et al, 2011, Ormston et al, 2012, Ormston and McConville, 2012) focused on (a) early implementation and early pregnancy, (b) late pregnancy to around six weeks post-partum, and (c) infancy (six weeks to 12 months). This report focuses explicitly on new findings emerging from the data collected for the toddlerhood period. A final evaluation report, due for publication Autumn 2013, will summarise key learning from across all four of the more detailed reports on individual 'phases' of FNP.
- 1.4 The remainder of this introductory chapter describes the FNP programme and its implementation in Scotland in more detail. Chapter 2 briefly outlines the evaluation methods and aims, while chapters 3 to 9 discuss the main findings from this phase of the evaluation.

The Family Nurse Partnership (FNP) programme

- 1.5 The FNP programme was developed in the USA (where it is called the 'Nurse Family Partnership' (NFP) programme) by Professor David Olds (University of Colorado, Denver). Based around a structured programme of home visits to the mother (and, after birth, the mother and child) delivered by trained Family Nurses, it is a preventative programme, aimed at first time mothers and their babies. The programme's goals are to improve pregnancy outcomes, the health, development and well-being of first time parents and their children, and families' economic self-sufficiency. For a summary of the key theoretical approaches underpinning FNP, see Olds (2006).
- 1.6 FNP is a licensed programme, which ensures that the original research conditions under which improved outcomes for mothers and children have been observed are replicated in new sites. As such, new sites may only 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. Developed by the University of Colorado (whom the licensing relationship is with) and referred to in the FNP Management Manual (Department of Health

FNP National Unit, adapted for Scottish FNP sites, November 2010) as '**Core Model Elements**', these licensing requirements cover:

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

1.7 In addition, the FNP Management Manual sets out various fidelity goals – described as 'stretch goals'¹. The **fidelity 'stretch' goals** cover client retention, visit 'dosage' (in terms of the numbers and length of visits to clients at different stages of their participation in the programme), and coverage of different 'domains' or topics during visits. A full list of the FNP Core Model Elements and Fidelity 'stretch' goals can be found in the annexes of the first evaluation report on the pregnancy phase (see Martin et al, 2011).

Testing FNP in Scotland

1.8 The background to and history of FNP's introduction in the UK is described in Martin et al (2011). The first FNP test site in Scotland commenced in NHS Lothian, Edinburgh, with the first clients enrolled from January 2010. Since then, additional Scottish FNP sites have been introduced in NHS Tayside (from July 2011) and in Greater Glasgow and Clyde, Ayrshire and Arran, Fife, Lanarkshire and Highland (in 2012-2013). FNP in Scotland is coordinated by the FNP National Unit (Scotland). Formerly based in the Scottish Government, this Unit has now moved to NHS Education for Scotland (NES), although the licence for the programme remains with the Scottish Government.

FNP in NHS Lothian, Edinburgh

1.9 The first NHS Lothian, Edinburgh FNP test site is based in Edinburgh Community Health Partnership (CHP) and delivered by NHS Lothian. The NHS Lothian FNP Edinburgh delivery team was initially comprised of a Supervisor, six Family Nurses, and an Administrator/Data Manager, supported by a local FNP Lead in Lothian. The team has subsequently undergone a number of changes reflecting staff departures, expansion, and new responsibilities among the existing team.²

¹ 'Stretch goals' are goals which the programme aspires to achieve. Based on the US research evidence, these are the optimum goals for ensuring the success of the programme. However, they may be difficult to achieve when first implementing the programme.

² These changes were discussed in previous evaluation reports. However since the infancy report, one of the original team has now left FNP and been replaced. The team's original Supervisor remains in place but, at the time of writing, was seconded two days a week to the Scottish Government as the National Lead Supervisor for Scotland. One of the original Family Nurses who had been acting up as Supervisor for two days a week is now a full-time supervisor as the team has expanded. A second

- 1.10 FNP was offered to all eligible women within Edinburgh CHP during the recruitment and enrolment period. Of those, 148 women who met the key criteria for participation (living within Edinburgh CHP, first time mothers, aged 19 or under at Last Menstrual Period, and under 28 weeks gestation) were enrolled with FNP in NHS Lothian, Edinburgh over a nine month period in 2010. The first clients delivered their babies in April 2010, so the first cohort of clients started to 'graduate' from April 2012 (when their children turned two years-old), with the full first cohort completing the programme by the end of April 2013.
- 1.11 The first NHS Lothian Family Nurse team started recruiting a second cohort of clients from 25th September 2012, with a full second cohort expected to be on board within 12 months. Matched funding (Scottish Government and NHS Lothian) has also now been secured to enable NHS Lothian to expand their programme, with an aspiration to move to small scale expansion (i.e. being able to offer the programme on an ongoing basis to every eligible client in the area, without a break in enrolment).

team of eight Family Nurses and a new supervisor have also been recruited in NHS Lothian and at the time of writing were due to start in June 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
 - What factors support or inhibit the delivery of the programme, and
 - Implications for future nursing practice
 - What the potential is for FNP to impact on short, medium and long-term outcomes relevant to Scotland.
- 2.2 The evaluation focuses on the experience of delivering FNP in the first Scottish site in NHS Lothian, Edinburgh to the first cohort of clients, with the expectation that the learning from this will help inform decisions and practice relating to further roll-out of FNP in Scotland.
- 2.3 This evaluation is **not** an experimental impact evaluation and cannot, therefore, conclusively establish causal links between FNP and particular outcomes. However, where possible, it reports on the evidence for the potential for FNP to impact on key outcomes for parents, children and services, drawing primarily on the accounts of clients and Family Nurses. The current 'Building Blocks' Randomised Controlled Trial in England (described in Sanders et al, 2011 and due to report final results in 2014) will be able to provide causal evidence, and is therefore likely to be of considerable importance for those with an interest in FNP in Scotland too. Further details about the remit for the evaluation are provided in Martin et al (2011).

Monitoring and evaluation framework

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

Overview of methods and data included in this report

- 2.5 The evaluation addresses the aims set out above using a range of quantitative and qualitative methods. These are described in full in Martin et al (2011). This fourth report draws on:
- **Quantitative data** collected and collated by the NHS Lothian, Edinburgh FNP team for all clients covering the **toddlerhood period**. This data is routinely collected by Family Nurses and collated and provided to the

ScotCen evaluation team as anonymised, aggregate figures.³ Quantitative data provides information about the extent to which FNP in NHS Lothian, Edinburgh have met the fidelity requirements of the programme with their first cohort, and provides wider context for the more qualitative findings which comprise the bulk of this report.

- **Qualitative data** from:
 - A smaller sub-sample of **FNP clients**, interviewed around **22-24 months** after their babies were born. This was the fourth occasion on which this longitudinal client 'panel' was interviewed for the evaluation. Of the original panel of 15 clients recruited to the evaluation, 13 were re-interviewed at 22-24 months.⁴
 - **Clients' 'significant others'** – clients were asked to nominate a 'significant other' who could speak to the research team about their views of FNP. Seven interviews with significant others (including two with the baby's father, four with the client's mother and one with a friend of the client) were carried out around 24 months after clients joined FNP.⁵
 - The NHS Lothian, Edinburgh **Family Nurse team** (including the Nurse Supervisors), interviewed in early 2013.⁶ Again, this was the fourth round of interviews with the team.
 - Ongoing interviews with the **FNP National Lead** for Scotland.

2.6 Qualitative data explores experiences of the programme in depth, including aspects that are difficult to quantify.

2.7 The evaluation team had also planned to conduct three focus groups over the course of the evaluation with NHS Lothian, Edinburgh FNP clients who were not selected for the longitudinal panel interviews. However, the first two of these groups were not successful, with a high level of non-attendance on the day. The evaluation team attended a graduation event in March 2013 in order to gather informal feedback from a wider group of clients and to check the findings included in these reports for face validity.

Reporting conventions

2.8 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

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

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

⁵ Three of the nominated significant others declined to take part. Two were unavailable or not contactable during the interviewing period.

⁶ Note that although the NHS Lothian, Edinburgh Family Nurse team has expanded since the second evaluation interviews (with three new Family Nurses), the evaluation interviews are with the original team, recruited in 2009, since the purpose of the evaluation is to capture learning from the first test phase of FNP in Scotland and to explore any changes in Family Nurses' experiences and views over this period.

the qualitative data about the prevalence of particular views or experiences of FNP. Given this, where possible quantifying language, such as 'all', 'most' or 'a few', is avoided when discussing qualitative findings.

- 2.9 It is also worth noting that interviews with clients, significant others, Family Nurses and key stakeholders focused on their perceptions of FNP. These perceptions may not necessarily always agree with each other, or with the views of others on how the programme works. However, they each provide valuable information about how the programme is experienced from the point of view of different stakeholders.
- 2.10 In order to protect the anonymity of clients and Family Nurses, participants are referred to by numbers only. Where participants were in unique or identifiable roles, they were given the opportunity to review their transcripts and/or any sections of the report that summarised their views in a way that might be identifiable or which quoted them directly. Any requests to remove a quote or potentially identifiable summary were always respected.
- 2.11 Finally, this report does not include any explicit comparisons with findings from the implementation evaluation of FNP in England (Barnes et al, 2008, 2009 and 2011). This is because the implementation of FNP in Scotland has been informed by the experiences of FNP in England. Any comparisons may not, therefore, be entirely comparing like with like.

3 RELATIONSHIPS

Key questions

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

Key findings

- Client retention for the first NHS Lothian, Edinburgh FNP cohort was very high – cumulative retention by the end of the toddlerhood phase was 81%. Attrition during toddlerhood, (5%) was below the 10% maximum suggested by the fidelity 'stretch' goal.
- The fidelity 'stretch' goal for delivering at least 60% of the expected number of visits during toddlerhood was met for 83% of clients. The average (mean) proportion of expected visits delivered across all clients was 75%.
- While feelings about individual clients graduating from the programme varied, one Family Nurse view was that overall clients had been more confident about leaving the programme than Family Nurses had anticipated at the outset. This was attributed to the systematic way in which FNP prepares clients for graduation and the ways in which the programme builds and affirms clients' strengths.
- Clients' views about graduating from FNP fell into three main categories: those who felt completely ready to leave and move on with their lives; those who had some reservations about graduating, but understood why the programme had to end; and those who reported not feeling quite ready to leave or who still thought they needed support.
- The therapeutic relationship they had with clients was believed by Family Nurses to have contributed to more positive experiences and in some cases outcomes for those clients involved in child protection processes.
- The data collected for FNP makes it difficult to distinguish how involved fathers in particular are in the FNP process/visits. In general, significant others interviewed for the evaluation reported that they attended fewer visits as the programme progressed. However, those significant others interviewed for the evaluation gave examples where they felt FNP had been beneficial both for themselves and for clients.

Introduction

- 3.1 As described in Olds (2006), an 'empathetic and trusting relationship with the mother and other family members' is key to FNP's approach. Family Nurses aim to build 'therapeutic relationships' with their clients, both to model the

positive relationships they hope clients will build with their children and to support clients' ongoing engagement with the programme. The holistic focus of FNP – exploring the social, emotional and economic context of clients' lives – also means that Family Nurses may seek to involve other family members, with the aim of enhancing the wider support available to both mother and baby. This Chapter explores how these relationships develop during toddlerhood and how they might promote positive outcomes for clients. However, first it summarises quantitative data on client retention and attrition and the level of contact between Family Nurses and clients in NHS Lothian, Edinburgh.

Client retention and attrition

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

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

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

3.4 Table 3.1 shows attrition and retention during the toddlerhood phases of FNP in NHS Lothian, Edinburgh. Programme attrition during toddlerhood was 5%. Cumulative retention for the first Scottish FNP cohort across the whole programme was 81%.

Table 3.1: Attrition and retention, NHS Lothian, Edinburgh FNP test site⁷

	Pregnancy phase	Infancy phase	Toddlerhood phase
Total number of clients receiving this phase	148	145	128
Fidelity 'stretch' goal for maximum attrition for phase	10%	20%	10%
Attrition during phase	3% (4/148)	11% (17/148)	5% (8/148)
Cumulative attrition by end of phase	3% (4/148)	14% (20/148)	19% (28/148)
Cumulative retention at end of phase	97% (144/148)	86% (128/148)	81% (120/148)

3.5 The attrition figures presented for infancy in Table 3.1 have been corrected since the third evaluation report (Ormston and McConville 2012), which stated that infancy attrition was 12%. The correct attrition rate for infancy is 11%.⁸

⁷ Of the four clients who left the programme during pregnancy, one rejoined during infancy. This client is therefore included in the bases for infancy and toddlerhood attrition and explains why the cumulative total of clients leaving/inactive by the end of infancy and toddlerhood are less than the sum of the individual attrition figures for pregnancy, infancy and toddlerhood.

- 3.6 The second and third evaluation reports (Ormston et al, 2012, Ormston and McConville 2012) included discussion of the perceived reasons for the low attrition rates during pregnancy and infancy, as well as reasons for leaving or becoming inactive where this had occurred. An additional (or more common) potential trigger for becoming inactive during toddlerhood related to the challenges of fitting in FNP visits alongside more numerous changes in a clients life.

New job, new house, new everything and it was just too much ...
it was just that. It wasn't right for her, which was fine.
(Family Nurse 4)

Level of contact between clients and Family Nurses

- 3.7 The Core Model Elements for FNP include a visit schedule, which specifies the frequency and timing of home visits. The fidelity 'stretch' goals then include goals for the proportion of 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.

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

- 3.9 The NHS Lothian, Edinburgh FNP site met the fidelity 'stretch' goal (60% or more of scheduled visits) during toddlerhood for 83% (106/128) of clients who were still participating at the start of that phase. During pregnancy the fidelity 'stretch' goal (80% or more of schedule visits) was met for 52% of clients and during infancy (65% or more of scheduled visits) it was met for 55%.

- 3.10 The average (mean) dosage during toddlerhood was 75%, compared to 79% in pregnancy and 65% in infancy⁹.

⁸ The figure in the third report was calculated using the total number of clients that received each phase of the programme (e.g. in infancy this was 145) as the denominator to calculate attrition. This is no longer the accepted method to calculate attrition. Instead, the denominator should be the number of clients who were ever enrolled in FNP (e.g. for infancy this would be 148).

⁹ Average dosage is the total number of visits completed divided by the expected number of visits completed.

- 3.11 Family Nurses reported that they had expected to find meeting fidelity around the visit schedule in toddlerhood more challenging than it had been in practice. By this stage, clients often had a lot more going on, for example getting a job or continuing with their education. In fact, where FNP was successful in helping clients to meet goals around work and education, this often meant that Family Nurses found it more challenging to fit their visits into clients' busy schedules.

And it was quite interesting where you know you are in a situation where (...) pretty much the programme has allowed them to help meet their outcomes, yet you're struggling to meet your fidelity because they've met their outcomes
(Family Nurse 1)

- 3.12 However, in spite of these challenges, Family Nurses thought they had either met or were close to meeting fidelity on visit numbers with most clients during toddlerhood. The quality of the relationship between the Family Nurse and clients was again viewed as a key factor in whether or not Family Nurses met fidelity (see discussion in previous evaluation reports). Other enablers and barriers to meeting the visiting schedule during toddlerhood were also similar to those discussed in the infancy and pregnancy reports. Key enablers included Nurse flexibility around appointment times and client motivation. Challenges again divided into client-related factors – like availability, occasionally forgetting, other issues in their lives making keeping appointments difficult – and programme or nurse-related factors, such as Nurses taking on additional responsibilities involving delivering or attending additional training.
- 3.13 Family Nurses also noted that cancelled or missed visits in the final months can lead to prolonging the programme and Family Nurses having to deliver 'last visits' after the 24 month mark. A suggestion for the future was that when clients drop down to monthly visits, Family Nurses should start to arrange final visits with clients further in advance in order to provide some leeway if there is a need to re-schedule.
- 3.14 Clients graduate from the FNP programme when their child is 24 months old (plus or minus two weeks). While contact between Family Nurses and clients can occur post graduation, this is part of clients' transition to universal services rather than a continuation of the programme. Family Nurses in NHS Lothian, Edinburgh reported that in general their contact with clients post graduation has been limited to the occasional text message, with clients updating their Family Nurse on how they are doing. There had also been some contact when clients were unsure who to speak to when their Public Health Nurses/Health Visitor was off sick or had left the Health Visiting team. Instances of Family Nurses meeting up with their client post graduation were reported to be rare and one-off. These instances were sometime initiated by the client - for example, inviting the Family Nurse round to see a new house.

Nature and impact of the client-Family Nurse relationship

- 3.15 In general, Family Nurses reported that their therapeutic relationships with clients had grown and strengthened further during toddlerhood. Again, the factors Family Nurses and clients associated with developing effective

relationships were very similar to each other, and echoed those discussed in previous reports - trust, level of contact, a non-judgmental approach, and consistency of having the same Family Nurse throughout. Where contact was less regular, Family Nurses tended to view the therapeutic relationship as less strong.

...the relationship seemed very effective and very deep [with some clients, but with others - who I (...) struggled... with contact - it was less so.
(Family Nurse 5)

Perceived impact of client-Family Nurse relationship in child protection cases

3.16 Perceptions of the ways in which the client-Family Nurse relationship could help when dealing with clients where there is a child protection concern were discussed in the previous evaluation report (Ormston and McConville, 2012). In their fourth evaluation interviews, the NHS Lothian, Edinburgh FNP team again reflected on this area. They felt that their therapeutic relationship with clients could help improve client experiences of the child protection process, general perceptions of Social Work involvement (and sometimes the results of this process) by:

- Ensuring that initial concerns are raised by someone who knows them rather than another professional they may not have met before
- Making it possible to discuss concerns in a way that might be perceived by the client as less judgmental
- Being able to explain the process to clients and help to break down any resistance to Social Work involvement, and
- Being able to draw on their depth of knowledge of the client's circumstances to give a wider context in meetings with other professionals, highlighting the client's strengths while also acknowledging and discussing concerns. In some cases, this was felt by the FNP team to have led to better outcomes for the client.

I think FNP has allowed them to see a lot of this as support, and I have one family who very much felt that, "... these people have helped me", and began to work along with the children's panel and eventually came off the register.
(Family Nurse 3)

3.17 However, as discussed in earlier evaluation reports, the child protection process can also sometimes pose a challenge to Family Nurses' relationships with clients. In some instances, this may relate to additional roles Family Nurses might have in the process. For example, one Family Nurse recounted what happened when she became the chair of a planning meeting.

That became quite difficult because I was in the role of the family nurse at the same point chairing this quite formal child planning meeting, and I think one of my clients struggled with that. (...) I think my relationship with her improved

(subsequently) (...) because I could go back to being her Family Nurse.
(Family Nurse 5)

This suggests a need to consider carefully how Family Nurses can best contribute to child protection proceedings, and how specific roles might impact on the client-Family Nurse relationship (which could, in turn, have consequences for client engagement with both FNP and child protection proceedings).

Graduation

3.18 The client-Family Nurse therapeutic relationship exists for a fixed period of time. As previously stated, clients graduate from the programme when their child is 24 months old (plus or minus two weeks). Withdrawing support of any kind can often be experienced as challenging for both professionals and service users. This section explores the experience of preparing for and managing graduation from the Family Nurse and client perspective.

How FNP prepares clients for graduation

3.19 Family Nurses reported that they start preparing their clients for graduation from the outset of FNP.

You start disengaging them from the moment you engage them, kind of thing. “You know we’re working with you ‘til your child is two”, we say to them on the very first time you meet them, before they’ve even said yes to the programme (...)
(Family Nurse 6)

3.20 Graduation is then mentioned on a regular basis throughout the programme. However, from around six months prior to graduation, the programme materials begin to focus on graduation in a more structured way. Sessions focus on feelings around ‘endings’. During this time, Family Nurses also report doing a lot of ‘agenda matching’ with clients about what they would like to cover in the last few months of the programme. Visits become less frequent, moving to monthly in the last three months, so that clients become accustomed to seeing their Family Nurses less often.

The facilitators start six months beforehand, and actually start off very, very generic about ... What's it like to ... say goodbye to someone, full stop, regardless of who that is? How does that process work? How does that make them feel?' ... Gradually, you just build upon that, right up until ... the day of it. Getting to 21 months however, going down to the monthly, it's a gradual process, so you're not just saying, “Right. OK. I've seen you fortnightly, and then it stops.” It's that kind of gradual build.
(Family Nurse 3)

3.21 With every client, Family Nurses produce a ‘testimonial’ – covering where the Family Nurse feels they were when they first met and what the client has achieved since, highlighting all the future things they would like to achieve, and

indicating how, using the strengths they have built, they can now go on and achieve these goals.

- 3.22 Clients and Family Nurses also start to plan what they will do for their 'last visit'. The idea behind the last visit is for the Family Nurse, client and child to do something as a way of celebrating their time together. Last visits usually take place within two weeks either side of the child's second birthday, although this can vary due to individual circumstances. Examples of last visits included going to soft play or a play park, baking together or bringing over a cake, finger painting, making child hand/foot prints, or going to a farm or zoo. Clients also attend a graduation event with their Family Nurses, other clients and children who have finished the programme at a similar time.
- 3.23 FNP clients have their Family Nurse instead of a Public Health Nurse/Health Visitor for the first two years of their child's life. However, as they get closer to graduation, Family Nurses liaise with the Public Health Nurses/Health Visitors to whom clients are being transferred. In NHS Lothian, the FNP team and Health Visiting service agreed to arrange a joint visit with the client's new Public Health Nurse/Health Visitor, to give the client an opportunity to meet the Public Health Nurse/Health Visitor and vice versa. Family Nurse perceptions of joint working with Public Health Nurses/Health Visitors around graduation from FNP are discussed in more detail in Chapter 7.

Family Nurse and client perceptions of graduation

- 3.24 In their final evaluation interviews, clients and Family Nurses were asked about their feelings about graduation. It is worth keeping in mind here that clients' final interviews took place before they had fully graduated from FNP, and therefore reflect how they anticipated graduating might be. As FNP develops in Scotland, further qualitative and quantitative work may be required to follow-up clients post-graduation and explore how the transition to universal services has actually worked in practice over the medium to longer-term.
- 3.25 The NHS Lothian, Edinburgh Family Nurse team expressed a range of emotions and views about their first cohort of clients graduating. Perhaps unsurprisingly, there was some sadness about these intense therapeutic relationships coming to an end. However, at the same time graduation was viewed as a celebration of what clients have achieved. One view was that the team were surprised at how confident clients had been about graduating, a fact they attributed at least in part to the work that the team had put in to building clients' strengths and preparing them for that point.

I think they've handled it very well. I'm not sure that I had expected (...) most of them to be as confident about it. I'm delighted that that's happened (...) But in saying that, it's possibly come because of all the work that we did put in.
(Family Nurse 3)

- 3.26 The team reported that preparation for graduation was 'woven through the relationship from day one' by the FNP programme. By talking about graduation from very early in the programme, Family Nurses believed that clients

understood the boundaries of the relationship and the fact it was time limited. One Family Nurse recalled one of her clients demonstrating the benefits of this approach, reporting that the client had told her:

“I’m under no illusion that you’re leaving and this relationship has been very positive, because the good thing is that whenever we started working together you told me very specifically you would be leaving me at two, so the boundaries were set”.
(Family Nurse 1)

3.27 The joint visit with Public Health Nurses/Health Visitors was also believed by Family Nurses to have helped make graduation a positive process (discussed in more detail in Chapter 7).

3.28 However, the team also cited examples where they felt clients had been less ready for graduation from FNP. In particular, where the client was experiencing some kind of crisis at the time they needed to graduate, Family Nurses reported wishing they could keep them in the programme for a little longer, although they accepted that was not how FNP worked. Similarly, they also cited cases where clients appeared to have been less accepting of graduating. This could manifest in cancelled final visits, in order to postpone the end of their contact with their Family Nurse. Finally, Family Nurses noted that they could not always predict in advance how individual clients would react to the end of the programme.

There are some clients who absolutely, without a shadow of a doubt, are ready to go hop, skip and a jump into the next phase of their life and their child's life. But others ... there are occasions where you think, “Oh. It would be nice if I could just have another couple of months”

(Family Nurse 3)

(Client) was supposed to go to soft play and cancelled, and then we arranged to do something else and (she) texted to say her wee one wasn't well, and I eventually just had to go around to her house anyway. So it wasn't...it wasn't the ending that we had planned, and I think that's because (client) didn't want the relationship to end.

(Family Nurse 1)

Some clients I maybe thought it would be particularly challenging ending the relationship, they seem to have coped with it really well. And others I thought would be absolutely fine...I mean I had one girl recently just dissolved in front of me!
(Family Nurse 5)

3.29 Clients' own feelings about graduating from FNP paralleled those described by the Family Nurses above. Their views fell into three main categories: those who felt completely ready to leave and move on with their lives; those who had some reservations about graduating, but who understood why the programme

had to end; and those who reported not feeling quite ready to leave or who still thought they needed support.

I'm going to miss it because it's quite good having it there but...I think its time to move on. It's been two years (...) I think I'm fine now.

(Client 11)

I wish I could keep her forever, just put her in my pocket. She was like my wee doll of advice. I can understand why it's had to come to an end 'cause (child) is two and everything like that (...) I think it's time to let (Family Nurse) go and for her to do, do her magic on her other people that are having their kids. But it is upsetting. I know I do miss her.

(Client 1)

I'm panicking! I'll probably not get used to it and I'll end up texting her. I'll not be able to will I? I'll need to delete her number.

(Client 12)

- 3.30 Clients were also asked how they thought their Public Health Nurse/Health Visitor might differ from their Family Nurse. It should be kept in mind here that by the fourth evaluation interview most clients were either still to meet their Public Health Nurse/Health Visitor, or had only just met them (usually at the joint visit with their Family Nurse). Client views are therefore based on what they anticipated the difference between FNP and the Health Visiting service would be. However, the dominant view among clients was that while FNP had a dual focus on the mother and child, they believed that Public Health Nurses/Health Visitors would focus only on their child. Clients also thought there would be less time to get to know their Public Health Nurse/Health Visitor. As a result, they felt they would be less likely to build a trusting relationship, within which they could share their problems.

(My Family Nurse is) secure, safer, easier to go to with my problems, 'cos I knew she wouldn't judge me for it, 'cos she respected me as a person. Whereas people like... you know, other people – for example Health Visitors, midwives – they only know you for a limited amount of time, and they're just there to do their job, and then, as soon as the job's done, they leave. Whereas, with (Family Nurse)... she actually cared about me and my state of mind, as well as my children's.

(Client 8)

Relationship between FNP and the client's wider family

- 3.31 FNP is underpinned by 'human ecological theory', which highlights the importance of mothers' social, community and family context in influencing their decisions and the ways they care for their children. This is reflected both in the focus of the programme as delivered to clients (exploring their relationships

with others and their support networks, for example) and in attempts by Family Nurses to involve other family members in visits where possible and appropriate. During the toddlerhood phase, clients' own parents were involved at some level in 10% of FNP visits; the client's partner, husband or the baby's father¹⁰ were involved in 20% of visits; and clients' friends or other family members in 3% of visits.

3.32 Family Nurses reported varying levels of involvement from clients' wider family with FNP. Some family members dipped in and out of the programme, 'they got sound bites'. With other families, Family Nurses delivered the programme to everyone in the house. In other cases, clients reported that their wider family was not involved in visits at all.

3.33 In general, significant others interviewed for the evaluation reported attending fewer visits as the programme progressed. They suggested that they felt it was important for the client and Family Nurse to have some time alone to allow the client to discuss things she might not feel comfortable talking about in front of family or friends.

I was normally here when (Family Nurse) came, and I would sit for 5, 10 minutes, then I would sort o' just disappear upstairs or into the kitchen (...) I think it was good for her as well, 'cos it gave her a chance to talk without anyone else here.
(Significant other 8, client's mother)

3.34 Where significant others had spoken to the Family Nurse, they reported feeling similarly comfortable to clients in discussing relationship issues or things to do with the child. Fathers interviewed for the evaluation gave examples where they felt the Family Nurse had helped improve their relationship with the client, while there were examples where clients felt FNP had helped their partner or the baby's father be more involved with looking after the child.

We got on a lot better, 'cos at the start we werenae really communicating on what we were doing, and we would just snap at each other. So we explained to (Family Nurse) about it and then she gave us... She was obviously a counsellor in a way if you want to say it like that, you know? (...) I realised what I was doing wrong, so I obviously corrected all that as well.
(Significant other 6, child's father)

3.35 Clients also reported that Family Nurses had encouraged them to rely more on close family and friends, while also helping clients stand up to any conflicting or unwanted advice from family (see examples discussed in earlier evaluation reports).

¹⁰ Note that the form does not distinguish between these people.

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

Key questions

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

Key findings

- The average time Family Nurses in NHS Lothian, Edinburgh, spent on different topics during toddlerhood came very close to the breakdown of coverage of different content domains suggested in the fidelity 'stretch' goals.
- Family Nurses and clients reported that the programme covered issues of relevance to clients during the toddlerhood phase, while also enabling clients and Nurses to 'agenda match' visits to address clients' specific needs.
- By toddlerhood, the strength of client and Family Nurse relationships meant that clients were more comfortable raising 'difficult' topics and that Nurses felt more able to be frank and direct in addressing these issues. However, some clients continued to find it difficult to discuss their own feelings and mental health, even two years into the programme.
- The FNP materials were viewed as particularly helpful in supporting discussion around graduation (by introducing it as a theme from early on) and relationships (both by providing different ways into raising this topic, and by 'normalising' its discussion as part of the programme).

Introduction

- 4.1 FNP combines a detailed manualised programme, including worksheets and materials for each visit, with an active focus on 'agenda matching' to clients' particular needs. Thus while each stage of the programme includes 'stretch goals' around the balance of coverage of specific topics, Family Nurses are also expected to 'flex' the programme to fit individual clients.
- 4.2 This is the first of three chapters that focus on programme content during toddlerhood. This chapter briefly reviews the overall delivery of FNP content to the first cohort of clients in NHS Lothian, Edinburgh during the toddlerhood phase of the programme. In addition to comparing the balance of time Family Nurses spent on different topics with FNP fidelity criteria and highlighting the topics that clients considered to be of most use to them in toddlerhood, it summarises Family Nurses' and clients' overall views of programme content in this period, and their perceptions of any topics they found particularly

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

challenging to address. This chapter also sets the scene for and introduces some of the topics that will be covered in the next two chapters.

Visit content figures

4.3 Fidelity ‘stretch’ goals around the suggested division of topic coverage within FNP 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 health is highest during pregnancy, while during toddlerhood (12-24 months), more time is allocated to life course development, as parents are supported to plan for their and their child’s future. As shown in Table 4.1, the average time Family Nurses in NHS Lothian, Edinburgh, recorded spending on different topics during toddlerhood came very close to the fidelity ‘stretch’ goals for this period. The times recorded for each content domain were all within one to three percentage points of the suggested range.

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

Average Time Devoted to Content Domains	Toddlerhood	
	Fidelity ‘stretch’ goal	NHS Lothian, Edinburgh site average
Personal Health	10-15%	17%
Environmental Health	7-10%	13%
Life Course Development	18-20%	15%
Maternal Role	40-45%	39%
Family and Friends	10-15%	16%

Overall views of programme content in Toddlerhood

4.4 FNP topics in toddlerhood were similarly wide ranging to those covered in earlier phases of the programme, reflecting the variation across and within the FNP domains listed in Table 4.1, above. Within these domains, new topics were covered as they became relevant during toddlerhood – for example, potty training, moving from bottle to cup, and child dental health – while other topics were revisited or expanded upon. Family Nurses commented that the toddlerhood period provided greater opportunities for reflection on clients’ development as parents, which served to further increase clients’ confidence in their own abilities as young parents. Client and Family Nurse views relating to these topics will be discussed in more detail in Chapter 5 which focuses on delivery of programme content relating to parenting, child health and development.

4.5 As discussed in Chapter 3, discussion of graduation is threaded throughout the programme, but becomes a more specific focus from around six months into toddlerhood. While in general the structure of the FNP programme and many of the materials were viewed by Family Nurses as extremely effective in supporting graduation, however there was some feeling that the materials might slightly overplay the difficulty of ‘endings’. It was suggested that the team

might benefit from some further group reflection on how to use these materials in future.

- 4.6 As noted above, there is a greater focus on life course during the toddlerhood phase. In chapter 6 of the report, we will discuss in more details client and Family Nurse experiences of the programme content relating to maternal health, wellbeing and future plans. Family Nurses suggested that by Year Two of the programme, clients themselves often felt more confident about topics around parenting and child development and more able to look at themselves and what they want from life. However, the exact focus of the programme continued to depend heavily on the needs of individual clients.

That's the beauty of the Family Nurse Partnership, is you have the ability to agenda match, so for some in that stage there was a much greater focus on employment, or education, and moving that forward. But others...they're not at that stage yet so...for some there is a continued emphasis on parenting.
(Family Nurse 5)

- 4.7 Family Nurses commented that by this stage they felt much more adept at tailoring the FNP materials to clients' needs. The programme was seen to work best when Family Nurses were able to combine agenda matching with creative use of the materials – for example, using a facilitator around the client-nurse relationship to broach issues around a client's relationship with their partner, or using a facilitator on diet to prompt wider discussion of a client's health.
- 4.8 Clients' views on the topics they found most useful in toddlerhood were again diverse, including: potty training; how to deal with their child's behaviour; money issues and benefits; managing their relationships with others; (re)establishing sleeping routines; child diet and nutrition; their own mental health and stress; support around the client or their partner moving into education or employment; and help arranging nursery places. However, clients reported that they were always able to cover any issues they particularly wanted to discuss, suggesting that the NHS Lothian, Edinburgh FNP team were continuing to successfully agenda match during toddlerhood.

Challenging topics

- 4.9 As discussed in the Infancy phase report (Ormston and McConville, 2012), clients' and Family Nurses' perceptions of 'difficult' topics and the ease with which they were able to discuss these changed over time as their relationships developed. By the end of the programme, three main client experiences in relation to discussing 'challenging topics' with their Family Nurse were apparent:
- Some clients reported finding it easy to speak to their Family Nurses from very early on (during pregnancy) and continued to feel comfortable talking to their Family Nurse about any topic.

She was just really like...really friendly and easy to get on with from the start so it's probably just been good the whole time.

(Client 13)

- Others reported that their confidence in discussing 'challenging' topics – in particular their own feelings and mental health – had improved over the course of the programme as their relationship with their Family Nurse developed:

I think just at the beginning I was quite shy, but then once I personally know someone for so long, I kinda build up my .. don't know what you call it .. my trust maybe? (...) But now she comes in and we just chat. I just tell her everything, so I think it's actually really good now than it was at the beginning!

(Client 2)

- Finally, other clients reported that they continued to find it difficult to talk about specific topics, notably their own feelings. However, where they had felt able to broach these issues with their Family Nurse, they reported that it had helped them.

Client: I just don't really talk to anybody about that.

(...)

Interviewer: OK. So have you ever talked about any of your own feelings or worries with (Family Nurse)?

Client: Yeah. (...) like I had anxiety and stuff, so I spoke to her about that, but that's the only thing. (...) She gave me kinda some stress relief things to do, and it has actually helped.

(Client 10)

4.10 Family Nurses similarly reflected on the ways in which their deepening relationships with clients had impacted on their ability to raise 'difficult' issues during visits. One view was that by toddlerhood, the strength of this relationship made it easier both for clients to feel comfortable raising issues and for Family Nurses to be more frank and direct with them about 'challenging' areas. As discussed in Chapter 3 and in earlier reports, there was a clear view among the Family Nurse team that the therapeutic relationship made it both easier to raise issues around child protection and possible to sustain clients' involvement with FNP during ongoing child protection processes.

4.11 Family Nurses also noted that the FNP materials were extremely helpful in supporting the introduction of topics that might be perceived as 'challenging', either by the Nurse or the client. Being able to show the client a facilitator and say that the issue is being covered with everyone on FNP was viewed as making it 'so much easier' to discuss areas like domestic abuse, relationships and finances – all areas that Family Nurses felt clients could find 'emotionally' challenging to talk about. It was reported that it could be difficult to find an

appropriate time to talk about clients' relationships with others if a partner or family member regularly attended sessions with the client. One Family Nurse suggested that with their second cohort of clients, they would be clearer from the start that they needed to see clients at least once on their own during each phase of the programme, to ensure they had space to discuss such issues.

5 PARENTING, CHILD HEALTH AND DEVELOPMENT

Key questions

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

Key findings

- In toddlerhood, Family Nurses reported focusing particularly on how clients communicate with their child and how that impacts on both bonding and attachment. One Family Nurse reported that a key success for FNP for one of her clients was in supporting strong attachment with her child despite the adversity the client had faced in her own life.
- Family Nurses believed they had helped their clients become more confident parents by supporting them to make their own decisions. Clients felt that the advice they received from Family Nurses had helped them better manage their toddler's behaviour (e.g. children were having fewer tantrums or were in a better sleeping routine).
- Diet and nutrition was not an issue for all clients, but for those who were having trouble getting their children to eat new foods, clients believed the tips Family Nurses gave them had a positive effect on their child's diet.
- While not all clients reported FNP having a big impact on child development during toddlerhood, those clients who reported concerns about, for example, potty training or speech and language development gave examples of advice and information their Family Nurses had provided in this area.
- Safety continued to be an important theme in toddlerhood. Clients engaged in practices to keep their child safe by 'child-proofing' their property and teaching their children about, for example, the dangers of fire.

Introduction

- 5.1 The previous chapter looked at the overall delivery of programme content to clients during toddlerhood. In this and the following chapter, we focus on specific topics relating to parenting practices in toddlerhood, diet and nutrition, child health and safety and child development (Chapter 5) and maternal health, wellbeing and future plans around work and education (Chapter 6). In addition to examining the perceived impact of the programme, these chapters also

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

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

Parenting practice in toddlerhood

- 5.3 Parenting practice remained a key topic for FNP during the toddlerhood period. In general, Family Nurses believed that they had helped their clients become more confident as parents during toddlerhood, citing examples where they felt that clients were more self-reliant (relying less on their family and making more decisions for themselves) and better able to interact with their child as a result. However, while Family Nurses expressed positive views on clients' parenting skills during toddlerhood, they also felt that some clients needed ongoing support around 'parenting' as their child's needs changed over time.

As her child's stage of development changed, her parenting needed to change and she required support throughout that process
(Family Nurse 5)

- 5.4 Specific areas of parenting practice discussed by Family Nurses and clients related to bonding and attachment, dealing with toddler behaviour, and establishing and maintaining routines.

Bonding and attachment

- 5.5 Bonding and attachment is a key topic throughout FNP. Approaches to and perceived impacts of promoting bonding have been discussed in earlier evaluation reports (Ormston et al, 2012, Ormston and McConville, 2012). In toddlerhood, Family Nurses reported focusing particularly on how clients communicate with their child, which impacts on both bonding and attachment and on the child's own communication skills (discussed below).
- 5.6 In an attempt to sum up how the relationship between mother and child develops over time, one Family Nurse recounted the ongoing conversations clients and Family Nurses have been having since the very beginning about "regulation". She described this as starting with parents and babies getting "in sync" with each other, and then moving on to discuss other things such as play, behaviour management, and building a trusting relationship so that children can then feel confident that they are loved and cared for.
- 5.7 For one Family Nurse, a key success for FNP for one of her younger clients was in supporting good attachment and enabling her to maintain her relationship with her child despite all the adversity the client had faced in her life.

That's credit to her, so, you know, success comes in all forms, and, as I said before, I think every one o' my clients is in a different place from when they started. And perhaps some of that would o' happened anyway, but I think the programme supported that I think as well.
(Family Nurse 4)

Toddler Behaviour

- 5.8 Both Family Nurses and clients identified dealing with toddler behaviour as a key issue during the toddlerhood phase. Family Nurses commented on the challenges parents can experience when moving from a compliant baby to a toddler who can express their own wishes and demands - "it's a very different parenting task".
- 5.9 Family Nurses reported discussing a combination of strategies clients could use to help their toddler learn appropriate behaviour. They discussed ways to help clients resist the temptation to say 'no' all the time (so that when they really need to say 'no' it will be more effective) and instead to guide their children in a more positive way. For example, one Nurse recalled that one of her client's children kept trying to "fiddle around behind the TV and pull out the wires" despite the client telling him 'no'. The Family Nurse encouraged the client to first think about why their child kept doing this, and what kinds of things she could do instead of telling him 'no'. She suggested the client try some preventative strategies (distraction, play, getting down on the floor) and, as the child's language develops, saying simple things to explain why he should not engage in that behaviour. She felt that these suggestions had a positive impact on how her client dealt with the situation.
- 5.10 Clients also reported finding speaking to their Family Nurses about their child's behaviour useful. Examples of FNP information and advice that clients felt had helped them effectively manage their child's behaviour included:
- Telling children what you want him/her to do and expecting them to do it, rather than telling them what not to do
 - Leaving children (when they are having a tantrum) as they will soon get bored
 - To help clients not lose their temper when their child is misbehaving, counting to ten and then speaking to them, and
 - Demonstrating how clients could use the "naughty chair" technique.
- 5.11 Clients gave examples where they felt that, as a result of following this advice, their children were having fewer tantrums and when they did have a tantrum they were now better able to deal with it. On the other hand, some clients reported that despite trying all the things the Family Nurses advised they were still finding managing their toddler's behaviour difficult.

Routines

- 5.12 Routines were also discussed in the Infancy phase report (Ormston and McConville, 2012) and continued to be a key theme for FNP Nurses and clients

in toddlerhood. As noted in Ormston and McConville (2012) one view held by clients was that advice on sleeping had been the most helpful part of FNP. During toddlerhood, Family Nurses provided further advice about sleeping routines, including, for example, reducing the number of naps the child has during the day, or reading a book instead of letting him/her fall asleep in the front of the television. Again, clients reported positive impacts from this advice:

I would'nae have known to do that, I dinnae ken if I'd been able to do it myself, if I leave him for that long...she said keep having a wee peak, making sure he's alright. He's no' hurt himself, walk away, if he gets up say "mum loves you - night night! Bed time!" Put him back in. And that's what I done.
(Client 11)

5.13 In some instances when clients' children were not in established sleeping routines at the time of their toddlerhood interview, clients suggested that it was their own fault for being too "soft" with their children and not sticking with the techniques their Family Nurse had given them.

Diet and nutrition

5.14 Clients reported talking to their Family Nurses about a range of issues related to their child's diet and nutrition during toddlerhood. The kinds of information and advice they recalled receiving from FNP included:

- Lots of information about the types of foods their child should be eating
- Advice about cooking and eating together
- Suggestions that clients eat the same things as their children.
- (To encourage children to try new foods) introducing new foods more than once so that children can get used to them and to disguise 'healthy foods' that their toddler initially rejects in sauces
- Giving clients a 'nutrition plate' that illustrated the different types of food children should be eating and the correct portion size for their age.

5.15 Diet and nutrition was not viewed as an issue by all panel clients, with some reporting feeling confident about the different kinds of foods their child should be eating. However, others reported that these suggestions from their Family Nurses had a positive effect on their child's diet.

(Family Nurse) suggested maybe the things that she doesn't like putting it in with like a sauce, 'cos it was things like tuna and things, so maybe like putting it in with some sauce. Or egg, maybe try and making it a different way. Or just little things like that.

I: Great. And (...) did that help in any way?

F: Yeah it did, she now eats it. She'll eat anything now.
(Client 9)

...we've been trying loads of different foods with her, healthy options, and things, because before I was bad for just a quick meal, like shove it in the oven – let it cook! But like she said “well why do you not cook things fresh, freeze it, and then defrost it and heat it up?” And I'm like “I'll need to start trying that”. I did start; (child)'s eating a lot better with it to be honest. (Client 12)

- 5.16 Another client view was that the advice from the Family Nurse had not helped yet, but the client was still trying and hoping for a “breakthrough” with their child's diet.

Breastfeeding

- 5.17 Breastfeeding among the first cohort of FNP clients in Lothian with their first babies is discussed in the second and third evaluation reports (Ormston et al, 2012, Ormston and McConville, 2012). One possibility raised by Family Nurses in report two (pregnancy and early infancy) was that where clients had not initiated or continued breastfeeding with their first child, they might do so with their second child as a result of the support and information they had received from FNP around this issue. Only a very small number of clients (two) interviewed for this evaluation were either pregnant or had gone on to have second babies by their toddlerhood interview (c. 22-24 months after their first baby was born). However, within this very small group, there was an example both of a client who reported deciding not to speak to their Family Nurse about breastfeeding their second child because they had already made the decision not to breastfeed, and a client who had breastfed their second baby for longer than their first child, attributing this at least in part to the support they had received from FNP (see case study below).

Case study – Breastfeeding second babies

In her earlier evaluation interviews, this client talked about her feelings of disappointment at stopping breastfeeding her first child at 12 weeks. She had wanted to breastfeed her baby for longer (upto six months) and did not feel she had been as successful as she wanted to be. Her Family Nurse had helped her work through her negative feelings about this.

With the client's second baby, she reported that her Family Nurse knew how much breastfeeding meant to her and had supported her with this – for example, helping her when she was having issues getting her second baby to latch on. At the time of her fourth evaluation interview (c.22-24 months after her first child was born), the client had been breastfeeding her second child for 14 weeks and intended to continue with this.

In relation to both her first and second babies, client also commented that she did not think that there was much support in hospitals when it came to breastfeeding. The client said she had been lucky to have her Family Nurse as when things did not go according to plan, the Family Nurse could teach her what to do.

As a result of her experiences with breastfeeding, the client (after being signposted to it by her Family Nurse) had been trained as a peer supporter as part of a programme being run by NHS Lothian's Infant Feeding Team to support mothers with breastfeeding.

Child Health and Safety

5.18 Clients continued to state that their Family Nurse was usually their first port of call when they had questions about their child's health. Health and safety topics covered during the toddlerhood period included: dental health, immunisations, and safety in the home and wider environment.

Child dental health

5.19 Clients reported that they would not have known when to register or take their child to the Dentist if it had not been for their Family Nurses, who recommended registering for the dentist as soon as the child's first tooth came in.

Immunisations

5.20 Scotland's routine Childhood Immunisation Schedule¹² recommends children should receive three doses of diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) vaccine (the 'five-in-one' vaccine) at two, three and four months of age, one dose of Meningitis C (MenC) vaccine at three months of age, two doses of Pneumococcal (PCV) at two and four months of age, and two doses of Rotavirus vaccine at two and three months of age. Children should then receive a further dose of Hib and MenC (given as the Hib/MenC booster vaccine), the PCV booster, and one dose of Measles, Mumps and Rubella (MMR) at 12 to 13 months of age.

5.21 Of the 110 children in the first NHS Lothian, Edinburgh FNP cohort for whom data was recorded, 97% (n = 107) were up to date with all their child's immunisations at 24 months.¹³ Comparison figures for all children of young mothers across Scotland were not available. The target of the national immunisation programme in Scotland is for 95% of children to complete courses of the following childhood immunisations by 24 months of age (Health Protection Scotland).¹⁴

5.22 As reported in Ormston and McConville (2012), clients who were apprehensive or unsure about vaccinations described their Family Nurse providing reassurance. Other clients reported that they did not need to speak to the Family Nurse about immunisations, as their children were already up to date with them. In one case, a client who had very definitely decided (for reasons connected with her family history) not to get her child immunised described discussing this with her Family Nurse and her Family Nurse liaising with midwifery to explain the client's views on this issue. The client also felt her Family Nurse had supported her in discussions with the baby's father about immunisation, pointing out that he could get the child immunised if he wanted,

¹² See <http://www.immunisationscotland.org.uk/when-to-immunise/immunisation-schedule.aspx>

¹³ Of the 120 clients that remained active until the end of the programme, 115 infant health care forms were completed. Additionally in 5 of these forms it was not stated whether or not the child was up to date with their immunisations. Of those clients for whom information was recorded, 67% of records were based on the client's self-report that their child's immunisations were up to date, 21% were based on a written record of immunisations and for 12% no basis for this information was stated.

¹⁴ See <http://www.hps.scot.nhs.uk/immvax/vaccineuptake.aspx>

which had reduced conflict between the client and the baby's father. This example illustrates how FNP gives clients information but ultimately supports them in their decisions, even where these may not be the decisions Family Nurses would prefer them to take. It also shows the role FNP can play in mediating conflict over parenting within the family.

Safety in the home (and wider) environment

5.23 As in the previous stages of the programme, safety continued to be a major theme for FNP. During toddlerhood, the focus expanded to encompass not only safety in the home, but also safety in the wider environment.

Here we've got a little person becoming more autonomous and more mobile. (...) (We're) thinking about, you know, all aspects of safety - indoors, outdoors, wherever you are. Dogs. Everything. Safety is a... a big issue.
(Family Nurse 4)

5.24 Clients' continuing discussions with their Family Nurses about keeping their child safe at home appeared to be reflected in their awareness of key hazards. For example, clients knew only to give their child toys that are suitable for their age, they recognised hazards associated with normal household items ("even a mop and bucket can be dangerous to a toddler"), and, as their children grew, they discussed how they had again reassessed the hazards at home. Examples of client engaging in practices to keep their children safe included: child proofing the house with cupboard clips, baby gates, plug covers, cushion corners; moving the television to a safer position; keeping household items like washing tablets out of reach; and teaching children about fire and hot drinks.

5.25 As discussed in the Infancy phase report, clients indicated that they might not have been able to purchase safety equipment without support from their Family Nurses in accessing grants. However, one client view was that information from Family Nurses around safety, although useful, was not new to them (it was all 'common sense').

Child development

5.26 Again, child development is a theme throughout FNP but the precise focus changes with the growth and stage of the child. During toddlerhood, key topics include potty training, speech and language development, and socialisation.

5.27 Where clients described their child developing normally during toddlerhood, it was not always clear whether or not they felt their Family Nurse had made a difference in this area or not. However, where clients had experienced concerns about their child's development, they were able to give examples of Family Nurses providing advice that they had found helpful, as described under the more specific headings below.

Potty training

5.28 Potty training was an issue that clearly caused anxiety for some FNP clients. They reported that their Family Nurses provided them with:

- Leaflets to see what techniques would work best for them
- Advice about when to start potty training and the signs to look for to indicate their child was ready. This included reassuring clients that they did not have to rush into potty training and that it is better to wait until the child understands what she or he is being told.
- Advice on how to go about potty training including role modelling (i.e. taking the child to the toilet with them to see the different stages)
- Advice that they could go straight to the toilet rather than using a potty first.

5.29 Clients felt they could open up to their Family nurses about their anxieties around potty training in a way they did not always feel able to do with others. They reported feeling reassured and supported by their Family Nurses.

Like when (Family Nurse) was here I was just like...I do not have a clue what I'm doing with potty training, I'm actually scared to start, but I probably wouldn't have said to anybody else I'm scared to start this. I probably would have just kept it to myself.

(Client 13)

Speech and language development

5.30 According to those clients who voiced concerns about their children's speech and language development, Family Nurses had provided them with various kinds of advice about how to help with this, including:

- Speaking properly to the child (don't speak 'silly')
- Reading books and singing songs to aid development
- Avoiding using bad language because the child will copy you
- Encouraging clients to take child to the library, and
- Giving examples of or worksheets on developmental activities.

Socialisation

5.31 Clients also talked about the impact that taking part in FNP had on their willingness to take their child out more, citing for example Family Nurse advice about encouraging outdoor play, like jumping in puddles, to engage their senses.

I kinda take him out a lot more than I probably would have initially done.

(Client 10)

5.32 However, one Family Nurse view was that while many of clients understood the need to increase their child's experiences and socialisation, supporting clients to engage with community groups was nonetheless challenging.

6 MATERNAL HEALTH, WELLBEING AND FUTURE PLANS

Key questions

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

Key findings

- Family Nurses supported clients' emotional and mental health both by being someone they could trust to talk to about their feelings, and by providing advice and helping them to access additional support where required.
- Based on the currently available evidence for Scotland, it is not possible to establish whether FNP is leading to fewer unplanned pregnancies.
- The NHS Lothian, Edinburgh FNP team had reflected on why some first cohort clients had second babies relatively soon and had concluded that there may be a need for more directive input around contraception early after birth. They had put in place a system to enable their second cohort of clients to access contraception more quickly and easily.
- Clients and significant others gave examples where they believed FNP had a significant impact on clients' decisions in relation to work and education. However, for some clients other areas of their lives were more of a priority, while childcare remained a barrier to work or education for others.

Introduction

6.1 FNP has a dual focus on the health and wellbeing of young mothers as well as their children. Family Nurses in NHS Lothian, Edinburgh reported that during toddlerhood there is a lot of revision of maternal health and wellbeing topics covered earlier on in the programme, including coping with stress, contraception, sexual health, diet and nutrition, and exercise. However, over the course of toddlerhood the balance in topics covered does change with more focus on, for example, life course development. The potential impact of FNP on all these areas has been discussed in some detail in previous evaluation reports. This chapter therefore focuses on giving any new potential impacts reported during the toddlerhood period.

Maternal health and wellbeing

Mental and emotional health

6.2 As reported in Chapter 4, as clients progress through FNP they felt more able to talk to their Family Nurse about their emotional and mental health, including any stresses or worries they were feeling. Clients described Family Nurses supporting them in this area through:

- Being someone they could trust to talk to about their feelings
- Providing advice about stress reduction, and
- Encouraging and helping them to access additional support where necessary – e.g. GPs and anger management classes.

CASE STUDY – Mental Health

This client reported having experienced depression since prior to enrolling with FNP. She felt unsupported by her family and, because she had not told anyone else about her feelings, initially found it hard to talk to her Family Nurse about them too. She reported ‘testing’ her Family Nurse by telling her a small amount to see how she reacted. It took until at least half way through the infancy period of the programme before she trusted her Family Nurse enough to disclose her depression more fully.

After the client disclosed her mental health issues, her Family Nurse supported her in accessing further help, including accompanying her to a GP appointment. The client had been able to avoid taking medication (which she had not liked because of the side effects) and had started to attend therapy. She viewed her Family Nurse as ‘a rock’ and considered the support she had provided in accessing help with her depression to be the most useful thing FNP had done for her.

In her fourth interview, the client reported that her Family Nurse had made sure she had appropriate support in place post-FNP, including a key worker and a Health Visitor. She felt very thankful to her Family Nurse, saying ‘it scares me to think what my life would have been without her’.

Subsequent pregnancies, second births and contraception

6.3 Family Nurse and client discussions and feelings in relation to subsequent pregnancies, second births and contraception were discussed in the previous evaluation report (Ormston and McConville, 2012).

Subsequent pregnancies and second births

6.4 In NHS Lothian, Edinburgh, 41 of the first cohort of clients had become pregnant (at least once) in the 24 months since the birth of their first child¹⁵,

¹⁵ A small number of clients had two or more subsequent pregnancies in the 24 months since the birth of their first child.

with 27 clients continuing with their pregnancy (13 had a second birth). Only two of the clients being interviewed for the evaluation were either pregnant or had second children by the time of their fourth interviews. It is not possible to say based on this data alone whether FNP is either increasing the gap between first and second pregnancies or resulting in fewer unplanned subsequent pregnancies; data from controlled trials is required to assess both these outcomes. Fewer closely spaced subsequent pregnancies were observed in two of the three US trials (Olds, 2006¹⁶). Further evidence on the impact of FNP in this respect in a UK context will be provided by the Building Blocks trial in England.

Contraception and planning for subsequent pregnancies

- 6.5 Of the 113 FNP clients for whom data was available at 24 months 85%¹⁷ had used some form of birth control in the last six months to plan subsequent pregnancies, while 15% were not using any contraception.
- 6.6 Clients reported that they currently had no (immediate) plans for more children. The main reasons for this were that they wanted to focus on other things first, such as finishing their exams or building a career.
- 6.7 In relation to contraception, as reported in Ormston and McConville (2012) one client view was that they might not have sorted this out without their Family Nurses' advice. Another view was that while they might have made the same decision about contraception, it would have taken them longer to arrive at this decision without advice and information from FNP.
- 6.8 The Family Nurse team reported that they had been working together to reflect on why some clients in the first cohort had subsequent pregnancies relatively soon. One explanation was that FNP tries to engage clients in a journey towards becoming self-efficacious, but many clients were relatively early on in that journey immediately after the birth of their child. As such, there might be a need for Family Nurses to use a more directive and facilitative approach around contraception after birth. As a result of these discussions, the team had put in place a 'passport' system for their second cohort of clients, so that they can access contraception more quickly and easily.¹⁸ It was suggested that subsequent pregnancies may be an area for further work within FNP more widely, for example, working with a site to see what could be developed about how to work with the client group on this sensitive topic.

¹⁶ See also <http://www.nursefamilypartnership.org/proven-results/Changes-in-mother-s-life-course> for a summary of results. The increase in intervals between first and second babies for FNP clients compared with control groups was 3.7, 4.1 and 12.5 months across the three US trials of the programme.

¹⁷ This represents 96 out of 113 clients. Of the 120 clients that remained active until the end of the programme, 114 forms were completed. Additionally in 1 of these forms it was not stated whether or not the client had used some form of birth control in the last 6 months to prevent pregnancy.

¹⁸ This system meant that clients could present at a sexual health clinic and be seen more quickly without needing to have their contraceptive needs re-assessed (as the passport indicates that they have already been assessed by a Family Nurse).

Future plans around work and education

6.9 Of the 113 clients in the first NHS Lothian, Edinburgh FNP cohort for whom 24 month data was available, 10% (n = 11) were enrolled in an educational programme at the time, while 28% (n = 32) reported having worked in paid employment at some point since their child was born¹⁹.

6.10 Supporting clients' economic self-sufficiency is a key aim of FNP. Family Nurses believed that the toddlerhood stage allowed clients to focus on changes in their own life in relation to education and employment and to appreciate the value of this to their family in the long term. They felt there was a large shift in clients' thought processes around life course development during this period.

(Clients are) looking to become not just mum or partner, but actually look back to themselves, and thinking about themselves again as well.

(Family Nurse 3)

6.11 Clients commented that Family Nurses had helped them to figure out what they wanted to do in terms of future employment. For example, watching her Family Nurse do her job made one client think that she would like to do something similar. After support from her Family Nurse, the client has a job in a pharmacy and an interview for a Nursing course.

Interviewer: ...Was that just something you'd always wanted to do?

Client: Not always (...), I think just seeing like (Family Nurse) doing it and you can do lots of different things with nursing, you can go on and do midwifery or could be a health visitor, you can do loads of things.

(Client 9)

6.12 Significant others also commented on the direct impact FNP had in terms of encouraging clients to broaden their horizons in relation to education.

These kind of things that she would never have done (...) she would never have went for that if I'd said to her "you should join the college", she'd never have done it. So these things are brilliant.

(Significant other 3, client's mother)

6.13 However, although work and education were often a major focus in the toddlerhood period, both Family Nurses and clients commented that in some cases clients were more focused on other aspects of their lives during that phase, whether second pregnancies, housing issues, or getting their child into nursery.

¹⁹ Of the 120 clients that remained active until the end of the programme, 114 forms were completed. Additionally one form did not include responses to these questions.

I mean work and the future and stuff, we've not done much talk on that – what I'm gonna do in the future – because my plans changed when I decided I was gonna have another baby, so we've not really spoke about (it).

(Client 8)

- 6.14 For some clients, childcare also remained a barrier to pursuing education or work plans. One client who had yet to discuss this with her Family Nurse reported that she was thinking about college but believed that childcare was too expensive and therefore thought it did not make sense financially. Another was holding off leaving her job to go to college and re-train because her current job was able to accommodate her in terms of childcare. This highlights the fact that FNP does not influence outcomes in a vacuum and that the availability of other services to support young parents, like affordable childcare, is key to the impacts it can achieve.

7 REFERRALS AND TRANSITIONS

Key questions and outcomes

- 7.1 Specific outcomes from the monitoring and evaluation framework of relevance to this chapter include:
- Referrals to other services, and
 - Use of community resources and supports.
- 7.2 Both of these are intended to support the higher level outcome of mothers feeling more supported and less anxious or depressed. As noted in earlier evaluation reports, the relationship between FNP and other services is also of wider interest in terms of understanding how the programme is being implemented in a Scottish context and what issues other FNP sites may encounter in relation to joint working practices.

Key findings

- Family Nurses referred clients to a range of services in toddlerhood. Once again, clients appreciated the support from their Family Nurses in linking them in with housing services and in helping them access financial support.
- As noted in previous evaluation reports, the availability and perceived suitability of services for young mothers can be an issue - for example, a lack of formal services for young parents of two year-olds, alongside a lack of confidence among clients about attending group-based sessions on their own.
- The NHS Lothian, Edinburgh FNP team identified various challenges and enablers to working with Health Visiting around client transition to universal services.
- Challenges included: Public Health Nurse/Health Visitor concerns about client expectations of their service; specific Public Health Nurses/Health Visitor expectations of FNP clients (expecting them either to be very vulnerable or that FNP will have resolved any difficulties they may face); and practical issues around handing over large paper files.
- Enablers included: joint visits with the Family Nurse (including meeting in advance of visiting the client's home); early and ongoing communication with Health Visiting colleagues; work within Lothian to increase understanding of strengths-based approaches; and the reintroduction of the 27 month child health check.
- Family Nurses felt there were still some challenges in working relations between FNP and other services due to differences in their ways of working and a lack of understanding of what FNP does. However, they also felt that over time this was changing. The team reported using some of the communication skills learned as part of FNP to help convey the programme and its philosophy and to address any concerns among colleagues in other services.

Introduction

- 7.3 'Human ecological theory' (one of the key theories underpinning FNP) highlights the importance of the social and community, as well as family context, in influencing parenting. As such, a key role for FNP is in linking clients with other services and resources that may be able to support them. In a UK and Scottish context, this role clearly becomes particularly important during toddlerhood towards the point of transition from FNP to universal services when the client's child turns two years-old. Although Family Nurses work with a range of existing services, which may continue after graduation, the client will be referred to Public Health Nursing/Health Visiting services for ongoing support following graduation. Links to Health Visiting are therefore of particular interest in this context.
- 7.4 This chapter summarises the number and types of referrals made by Family Nurses during the toddlerhood phase of the programme, discusses client and Family Nurse perspectives on the impact of those referrals, explores views of the transition to universal services, and summarises views within the NHS Lothian, Edinburgh Family Nurse team on working relations between FNP and other services and what they have learned about supporting these.

Referrals to other services during toddlerhood

- 7.5 During toddlerhood Family Nurses made 240 referrals. This is fewer than the number of referrals in infancy (where there were more than 400) and greater than the number in pregnancy (166 referrals). In comparison to the infancy phase, while there were fewer referrals to health care services for clients and for their children in toddlerhood, there were more referrals to community support and social care. There were also a greater number of referrals to 'other' organisations. These included children and family centres (Family Nurses were probably making sure support was in place for clients once they had graduated from the programme). Compared to infancy, more referrals were also made to a number of organisations which provide assistance in accessing furniture (this was due to a new initiative through Save the Children).

Table 7.1: Numbers of clients referred to services

	Pregnancy phase	Infancy phase	Toddlerhood phase
Health-related services			
Smoking cessation	17	<5	5
Mental health services	7	9	<5
Sexual health services	-	8	<5
Antenatal classes	24	NA	NA
Health care services (client)	84	70	42
Injury prevention	NA	6	<5
Health care services (child)	NA	53	33
Other services			
Financial assistance	15	34	13
Social care (including child protection/child in need and adult disability services)	10	20	23
Community Support	<5	11	20
Job training	-	14	<5
Housing services	9	12	6
Legal Services	<5	<5	<5
Childcare	-	<5	<5
Breastfeeding support	NA	<5	0
Educational programmes	-	<5	0
Development referral	-	<5	<5
Other *	13	48	70

* In toddlerhood, 'other' services included: Avenil Trust, Best Buddies Volunteer, Buttle Trust, Child and Family Centre, Children's Centre, Community Group, DALO Support, Early Years Centre, Eat Learn Sleep, ESD, EVOT, FAB Pad, Fire Brigade, General Benefits Advice, 'Get On', Greengables Family Centre, Healthcare Academy, Lifeline Charity, Link Living, Mum & Toddler Group, Parenting Support, Police, Police Check, Prince's Trust, Rathbone, Save the Children, Tax Credits, Working for Families.

7.6 The NHS Lothian, Edinburgh Family Nurse team commented on the need to plan ahead during toddlerhood to identify the kinds of services clients might require on transition from FNP. However, they also suggested that there were not many general projects for young mums in the local area to support clients after graduation. One view was that in England, more additional programmes had been developed partly in response to FNP and that there was more of a 'supported landscape' for clients to graduate into. In Edinburgh, there was perceived to be something of a gap in the landscape around formal services for young parents of two year-olds. However, the team reported that they had successfully worked with children's services, who had worked hard to ensure that services were in place to meet identified needs at the time of transition. They reported that, before graduation, Family Nurses were thinking about (and making contact with, where needed) the sorts of projects that were available and suitable for their clients' needs - for example, considering whether individual clients felt isolated, needed to get into normal play groups, etc.

[Family Nurse] was very helpful in making sure that I wasn't just left and forgotten about, she made sure that I had everything that I needed before and I had that support (Client 63)

Perceived impact of FNP referrals on clients

7.7 Clients' narratives about the impacts of referrals made for them by FNP during toddlerhood echoed those discussed in earlier evaluation reports. They reported FNP linking them to community groups or services they were unaware of and to services they were not sure how to access or may not have accessed on their own. Examples of the kinds of referrals clients mentioned during toddlerhood included:

- 'Rhymetime' (library sessions for parents/carers and children aged 0-4)
- Mother and Toddler Groups.
- Financial grants
- Referrals to agencies that would help them get furniture
- Services offering advice on housing. Again, the support that Family Nurses provided in accessing and communicating with Housing services – including help with writing and/or responding to letters from the council, making phonecalls on their behalf, and putting them in touch with Housing Officers, was praised by clients.

7.8 As in earlier reports, clients gave examples where they felt that they would not have been able to access resources without these referrals from FNP.

She set me up with, it was Save the Children charity, which got me help with vouchers to get help with kitchen things, because I went in to a new house, and I got toys for (child) and vouchers and things. (...) So she was really helpful. I wouldn't have got any of that if it wasn't for (Family Nurse).
(Client 9)

7.9 However, as reported in Ormston and McConville (2012), accounts of clients and Family Nurses suggested that the impact of some referrals could be limited by both service and client-related barriers to taking up these referrals. For example, while some clients said that Mother and Toddler groups provided valuable social and emotional support for them as well as their child, other clients did not take up referrals to these groups. While one client view was that they simply did not have time to attend such groups because they already had busy social lives, others cited more problematic barriers: feeling uncomfortable around people they did not know; feeling excluded by the other mums; a dislike of crowds/groups; and a lack of confidence to attend groups alone. Family Nurses reported accompanying clients to attend community groups where they felt they lacked the confidence to attend alone. However, they also reflected that accompanying a client to a group once might not always be enough, and suggested this was something they might try and do more of in the future – though clearly doing so would have time implications for FNP teams.

Transitions to universal services

- 7.10 As discussed in chapter 3, FNP is a time-limited programme. Both clients and Family Nurses are made aware from the outset that their involvement will stop once the child turns two years-old. At this point, clients are 'transitioned' to universal services. In particular, Public Health Nurses/Health Visitors become the 'named person' (first point of contact for children and families) and takes over delivery of Hall 4 ('Health for All Children' - the Royal College of Paediatrics and Child Health recommended programme of routine health checks and health promotion activities) for the child until they start primary school.
- 7.11 Chapter 3 of this report has already discussed client and Family Nurse perspectives on graduation and transition from FNP. Here, we focus on Family Nurse views of working relations with Public Health Nurses/Health Visitors and other key services around the graduation period. As the evaluation did not involve interviews with other services around the graduation phase, this report can only comment on perceptions of working relations between FNP and other services around this period from the point of view of the NHS Lothian, Edinburgh FNP team.

Perceptions of working with Health Visiting around transition

- 7.12 The NHS Lothian, Edinburgh FNP team identified various challenges and enablers in working with Public Health Nursing/Health Visiting colleagues around client transition. In terms of challenges, the team had carried out an audit of 10% of transferred clients which involved seeking feedback directly from Public Health Nurses/Health Visitors about the transition process. The team noted that while most of this feedback was very positive, Health Visiting colleagues were also asked about any problems or anxieties they had about receiving FNP clients. These had included:
- Their capacity to deal with FNP paper files (as these are often large and Public Health Nurses/Health Visitors have limited storage for their own notes)
 - Concerns about clients having expectations of very regular contact. The team felt that this generally would not be the case, however, as FNP does reduce contact over the toddlerhood period (to monthly in the last three months).
 - Worries about not being able to get hold of FNP clients easily.
- 7.13 There was a perception among the NHS Lothian, Edinburgh FNP team that sometimes Public Health Nurses/Health Visitors tended towards a view of FNP clients being at one end or other of a spectrum - either expecting all clients to be very vulnerable at transition or expecting clients to graduate with all of their problems fully resolved. According to the FNP team, this view was not seen to capture the full complexity of the programme.
- 7.14 These kinds of expectations were viewed as requiring active management by the FNP team. The joint visit with the client's new Public Health Nurse/Health Visitor (discussed in Chapter 3) was viewed by the FNP team as a key factor

that helped facilitate good joint working around client transition. Prior to client graduation, the NHS Lothian, Edinburgh FNP Supervisor had elicited the views of the Health Visiting Service by questionnaire to inform the transition process. Eighty-six per cent of Public Health Nurses/Health Visitors agreed that a joint visit with the client would be helpful. From the perspective of the FNP team these visits were key to ensuring clients' engagement with universal services. The FNP team did, however, report some early challenges around joint visits, relating to Public Health Nurses/Health Visitors making comments that clients perceived as critical, for example about clients' living environments. They gave examples where such comments lead to clients indicating they would find it hard to engage with the Public Health Nurses/Health Visitor subsequently. This prompted to a decision that Edinburgh Family Nurses would meet with Public Health Nurses/Health Visitors in advance of going to visit the client, in order to talk through the client's background, to try and avoid such situations in the future.

7.15 The team also cited other work initiated by NHS Lothian to support understanding of FNP and of strengths-based approaches²⁰ to working with clients among Public Health Nurses/Health Visitors and others. This included a new package of training for Health Visiting teams focusing on strengths-based approaches, and ongoing communications from the FNP team around the broader principles of FNP, both through their every day contact with Public Health Nurses/Health Visitors and via the team's involvement in delivering training to other NHS staff. The team commented on the importance of building good links with Health Visiting from as early on in the programme as possible to underpin successful joint working around transition. They also noted the importance of reinforcing to fellow professionals that although the relationship with the client ends at the point of transition, the Family Nurse was still contactable for professionals.

7.16 Other enablers to successful joint working with Health Visiting around transition included:

- Public Health Nurses/Health Visitors being flexible about communication options with clients - one Family Nurse gave an example of a Public Health Nurses/Health Visitor offering the client her mobile number in order to keep in touch.
- The reintroduction (from 2012) of the 27-30 month child health review for children in Scotland. The team felt that this came in at the right time for FNP in terms of ensuring that there is a scheduled meeting with Public Health Nurses/Health Visitors three months after client involvement with FNP ends. Moreover, in Lothian this check uses ASQ (Ages and Stages Questionnaire), which clients are familiar with from FNP, ensuring a more 'joined-up' experience for clients.

²⁰ That is, approaches which recognise that clients have existing strengths and are capable of drawing on these to solve problems.

Joint working with other services

7.17 The NHS Lothian, Edinburgh FNP team were keen to emphasise that transition is not just about working with Health Visiting colleagues. Depending on the client's needs, transition could also involve considerable joint working with other services, like social work, children's centres, third sector key workers, and General Practice. Where clients' cases were more complex, the team highlighted the need to ensure that everyone involved is aware when FNP finishes.

7.18 From the NHS Lothian, Edinburgh FNP team's perspective, a common challenge around joint working with other services is communicating the strengths-based approach of FNP. This has been discussed in more detail – particularly in relation to Social Work – in previous evaluation reports (Ormston et al, 2012, Ormston and McConville, 2012). By the end of toddlerhood, the FNP team believed that their training in motivational interviewing and experience of delivering the programme was enabling them to use FNP approaches in communications with professionals as well as clients – listening, thinking through the issue, and working with them to address any concerns. The team reported seeing strengths-based approaches reflected (at least to an extent) in the language of other colleagues in meetings:

I've seen that change over the time and, you know, in that our strength based approach has been, if not adopted by some of our social work colleagues, certainly a bit more mirroring anyway.

(Family Nurse 6)

7.19 However, there remained a view among the NHS Lothian, Edinburgh FNP team that while the language of 'strengths-based' approaches had become more common over the last three years, there were still some gaps between how other services approached working with young parents and FNP's philosophy. For example, while the team felt that understanding of FNP was now much stronger among Edinburgh social work teams, they nonetheless felt that social work remained generally more reactive, and less likely to work with clients' existing strengths.

7.20 The team also reported that, by the later toddlerhood period, their working relationships with other services were improving in general because people had more knowledge about how FNP works, "most people have actually embraced FNP". At the same time it was noted that working relations varied across the services they worked with – for example, in relation to children's centres while one Family Nurse view was that these centres had 'really embraced' FNP, another was that 'there's still work to do, particularly with some centres'. Expanding the programme to new areas of Lothian also meant that the team were starting again in addressing concerns and communicating the nature and purpose of FNP to services in those areas. Nonetheless, their experience of delivering FNP to the first cohort meant that the team found such networking more straightforward than last time (since they could anticipate questions and concerns), if not any less time consuming.

Key learning around joint working

7.21 Family Nurses discussed what they would share with new FNP teams about how FNP engages with other services (particularly around child protection). They suggested that considerable preparatory work was needed with other agencies to talk about what FNP is and does. An ongoing need for engagement and communication with other services, particularly as sites expand, is also apparent from the experiences of the NHS Lothian, Edinburgh FNP team. The discussion above suggests that using some of the communication skills teams learn for their work with clients with other professionals can help support understanding of the programme. Meanwhile, joint visits with Public Health Nurses/Health Visitors appear useful in supporting successful transition from the perspective of FNP teams. However, further work may be needed to explore in more detail how Public Health Nurses/Health Visitors and clients view these joint visits (as noted in Chapter 3, by their fourth evaluation interviews, most clients had yet to receive a joint visit).

8 PROFESSIONAL VIEWS AND EXPERIENCES OF DELIVERING FNP

Key questions

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

Key findings

- Family Nurses' perceptions of the training they received to support them in their role remained highly positive. However, there were some ongoing queries about timing – in particular, whether the toddlerhood and DANCE training were delivered too early.
- Family Nurse comments on delivering the pregnancy phase of the programme to a second cohort suggested that there may be a need for some refresher training – particularly when Nurses are delivering the programme to one cohort at a time, with large gaps between when they first deliver a phase and when they next deliver it.
- Supervision continued to be viewed as 'absolutely pivotal'. Family Nurses commented on the role supervision had played in supporting and preparing them for graduating their first cohort of clients from the programme.
- Views on whether child protection supervisions were as useful as they could be and whether their frequency was appropriate remained mixed. The FNP National Unit (Scotland) was commissioning a review of child protection support requirements within FNP at the time of writing.
- At the time they were interviewed for this report, Family Nurses in the first NHS Lothian, Edinburgh FNP team had smaller caseloads due to their first cohort of clients starting to graduate, while recruitment of their second cohort was ongoing. While workloads were generally viewed as more manageable as a result, views of how manageable FNP workloads are more generally varied.
- The more staggered approach to recruitment adopted for the second cohort of clients in Lothian was felt to have avoided some of the workload pressures experienced as a result of 'front-loading' recruitment of the first cohort.

Introduction

8.1 This chapter moves from discussing views on the delivery of specific elements of the FNP programme to clients, to professional perspectives on those programme components intended to support FNP delivery more generally. In particular, it looks at views of Family Nurse training and of supervision – both of which are mandatory elements of FNP set out in the manual. It starts, however, with a broader discussion of the main achievements and challenges of the NHS Lothian, Edinburgh Family Nurse team in delivering the programme over the

period from spring/summer 2012 (the time of their third evaluation interviews) to early 2013 (the time of their fourth and final evaluation interviews).

- 8.2 During this period, the first FNP team in NHS Lothian saw a majority of its first cohort of clients graduate from the programme and, from September 2012, began to recruit a new cohort. Although the focus of this evaluation is on delivery to the first cohort of FNP clients in Scotland, a key element of the team's experience of delivering the programme from late 2012 to early 2013 was recruiting the second cohort. Moreover, given NHS Lothian is the first Health Board in Scotland to recruit a second cohort, there may be learning from the team's experience of this for other sites who are considering, 'scaling up' their FNP service. This chapter therefore also explores the NHS Lothian, Edinburgh FNP team's perceptions of working with a new cohort, focusing particularly on areas where they feel they have learned from their experiences of delivering FNP to the first cohort of clients.

Achievements

- 8.3 As in previous evaluation reports, the NHS Lothian, Edinburgh Family Nurse team's perceptions of their key achievements over the period from mid-2012 to early 2013 focused on, first, clients' achievements within FNP and, second, perceived improvements in their own professional practice. Family Nurses' accounts of clients' achievements were sometimes framed with reference to graduation, which provided a focus and opportunity for reflecting on clients' 'journeys' and how far they had come since enrolling:

I think one of the nice bits has been ... to reflect back on what their assessment of their parenting journey has been like and that's been really lovely. They themselves are able to see their own achievements, its not just all about "this is what you've done and haven't you done well?" They're able to look back and they recognise that themselves - how their child has grown, how they've grown - and that's probably been the nicest bit about it to be honest.

(Family Nurse 5)

- 8.4 Family Nurses in the first NHS Lothian, Edinburgh FNP team were unanimous in their view that delivering FNP had positively impacted on their own professional practice, from learning specific techniques (like motivational interviewing) to developing a more sophisticated understanding of 'respectful' ways of working with their client group. Nurses' reflections on their own developing professional practice were often discussed in the context of how they were able to approach the programme slightly differently with the second cohort of clients compared with the first cohort. For example, Family Nurses reported feeling more confident about 'agenda matching' with second cohort clients from a much earlier stage, even from the enrolment visit, as well as finding it easier to give prospective clients the information they need to make an informed decision about enrolling

I think it's easier to say what the programme's about, the successes of it, ... to be honest about what the commitment is

to the client, so that they know what they're getting themselves into. And in terms of the actual materials in early pregnancy, I don't feel as bound to do every single bit of every single session. I can mix and match in terms of where individual clients are at, and what I'll do more .. much much more of what we call the agenda-matching.

(Family Nurse 2)

8.5 The FNP National Lead for Scotland also commented on what she saw as the key achievements of the NHS Lothian, Edinburgh FNP team, which included:

- Maintaining a high level of fidelity to the Core Model Elements and 'stretch' goals of FNP
- Low levels of staff turnover (only one of the original team of Family Nurses has left since the start of the programme. In addition, the team also recruited a new Administrator after their original administrator left.)
- The level of involvement the NHS Lothian, Edinburgh FNP team have had in contributing to Scotland and UK-wide initiatives – including, for example, their supervisor acting as National Lead Supervisor for Scotland two days a week, one of their team leading training on DANCE (a tool for evaluating caregiver-child interactions) in Scotland, the team's contributions to UK-wide development of FNP materials, and the wider team's contributions to national conferences and events.
- Involving clients in "telling their story" – for example, through clients' attendance at FNP events and/or media involvement

Challenges

Workloads

8.6 As in all three previous evaluation reports, workload remained the main challenge to delivering FNP discussed by the NHS Lothian, Edinburgh FNP team. However, in general, views of Family Nurse workloads at the point in time at which they were interviewed for this fourth evaluation report were less negative than those previously discussed. It was suggested that although it remained 'quite a heavy workload' it had 'reduced greatly from what it was in the beginning', in part this was due to having fewer clients, less training to attend and greater familiarisation with the materials.

8.7 At the point of their fourth evaluation interviews (in early 2013), none of the Family Nurses in the original NHS Lothian team had a full caseload (25 clients per full-time equivalent Family Nurse is specified as the maximum permissible caseload within FNP). Their first cohort of clients had begun to graduate from FNP in April 2012, while recruitment of the second cohort began in September 2012 and runs for 12 months²¹. While the NHS Lothian, Edinburgh FNP team remained busy (e.g. taking on an additional training role), they were also in a transitional phase where many of their first cohort clients had graduated but they were still in the process of recruiting a full new caseload.

²¹ This longer recruitment time 12 months compared to 9) was informed by the experiences of recruiting the first cohort, see Martin et al, 2011).

- 8.8 However, although perceptions of workload were generally less negative, there nonetheless remained a range of opinions among the team about how manageable FNP workloads are in general. One view was that, whether or not the workload was more manageable in early 2013 than it had been at the start of the programme, there remained a mismatch within FNP between the volume of work it entails and the hours available in which to deliver it. Another, as described above, was that the workload had been heavier at the start of the programme but had eased gradually as training reduced and nurses became more familiar with delivering the programme. Finally, a third view was that workload on FNP simply fluctuated, from very busy to more manageable.
- 8.9 As discussed in the previous evaluation reports, Family Nurses reported a range of factors that either increased or helped to reduce or manage workloads at different points of the programme. Similar challenges were raised again in the team's final interviews, including:
- Requests for input and support from both other Scottish FNP sites and from the FNP National Unit (Scotland) – for example, it was estimated that around 100 potential Family Nurses who were thinking of applying for posts in NHS Lanarkshire had contacted the NHS Lothian, Edinburgh FNP team for advice.
 - Travel time between clients – it was noted that because FNP clients often move during the two and a half years of the programme, by the time they reach the toddlerhood phase, any positive impact on travel time from initial 'zoning' of clients had significantly reduced.
 - A perception that there was a 'huge amount' of record keeping required between FNP and other requirements (like GIRFEC²² reporting and additional reports for meetings like Child Protection case conferences).
 - The balance of different kinds of cases within individual Family Nurse's caseloads, with Family Nurses who reported high numbers of clients with social work involvement continuing to report that this was associated with considerable additional work.
- 8.10 In addition, it was noted that managing clients' transition out of FNP is time consuming. One view was that this had probably involved more work than the team initially anticipated – including carrying out handover meetings and joint visits with Public Health Nurses/Health Visitors, and making sure all the paperwork was tied together. Finally, it was noted that the NHS Lothian, Edinburgh FNP team set themselves very high standards and goals, and that sometimes they might need reminding to 'take their foot off the accelerator' in order to avoid consistently high workloads. Supervisor workloads within FNP were discussed in the previous evaluation report (Ormston and McConville, 2012).
- 8.11 The key factor that had helped reduce workloads since the previous evaluation interviews was the smaller caseloads resulting from the fact that the team were still in the process of recruiting their second cohort. The team were also adopting a slightly different strategy for recruiting the second cohort. As

²² Getting It Right for Every Child

reported in Martin et al (2011), recruitment of the first FNP cohort took place over nine months and was 'front-loaded'. Every woman registered with NHS Lothian's system for tracking women through pregnancy (Maternity Trak) who was eligible (i.e. under 20, under 28 weeks pregnant and living in Edinburgh CHP) at the start of the recruitment period was offered FNP. As discussed in the first evaluation report, this was believed to have caused unsustainable workload pressures early on in delivery of FNP. For the second cohort, NHS Lothian had adopted a more staggered approach over a longer (12 month) period. The programme was offered to women who met eligibility criteria and became known to maternity services from the start of the recruitment period (rather than to all eligible women already registered at a set start point). The team felt this had meant that the start of recruitment to cohort two was more manageable – if anything, it was reported that there was something of a 'lag' at the start, where eligible women were becoming known to maternity services but were too early on in their pregnancy to approach about FNP. One view among the team was that there was a possibility this 'lag' at the start would mean that recruitment needed to accelerate towards the end of the twelve months to meet the target caseload. Given the various different paces and approaches to FNP recruitment now being employed across FNP sites, there may be a need for the FNP National Unit (Scotland) to review the impact of different strategies in terms of their impact on client take-up patterns and Nurse workloads.

8.12 Other factors contributing to workloads feeling more manageable included:

- The fact that Nurses were not undergoing long periods of training at the same time as recruiting the second cohort (as had been the case with the first cohort – see Martin et al, 2011)
- Improvements in Family Nurses' own strategies for managing their workloads, including clustering visits with clients living in the same area for the same day; more organised to-do lists/filing systems; and arranging visits for lunchtimes or picking clients up and carrying out visits on clients' way to their work. Although this latter strategy sometimes involved carrying out contacts in the car, which it was recognised was not ideal, one view was that it was the only way of avoiding evening working once clients started returning to work or college.

8.13 Asking other Family Nurses to cover visits had also been tried within the team, but was reported not to work as clients tended not to accept being visited by another team member with whom they did not have the same therapeutic relationship.

8.14 Team suggestions for improvements that might further help them manage their workloads included:

- Family Nurse supervisors and sites to consider options for more flexible working patterns (for example, a nine day fortnight – which it was reported was being tried in some FNP teams in England)
- reviewing and attempting to reduce the volume of record keeping, particularly where there were perceived to be duplications/overlaps (for

example, in relation to the Public Health Nurses/Health Visitors handover report and GIRFEC reports), and

- further limiting the geographical spread of each Family Nurse's caseload (though as noted above, another view was that this would only be effective early on as the FNP client group tend to be highly mobile).

Database

8.15 Ultimately, a fully functional, user-friendly database will be key to the sustainability of the programme. As reported in previous evaluation reports (see Martin et al, 2011 and Ormston et al, 2012), there have been delays to the delivery of a database for FNP in Scotland which can both store data and, crucially, allow Supervisors easy access to reports that can inform reflective supervisions on both a team and one-to-one basis. For the first cohort, the NHS Lothian, Edinburgh FNP team used a database developed in-house to store data from their visits. While this was not viewed as a suitable long-term solution, because of the significant manual intervention required to develop meaningful reports, it did allow the data to be interrogated, used in supervision and to inform client outcomes. However, the perception of the NHS Lothian, Edinburgh FNP Team was that the time it took to get some of this information on client outcomes (e.g. on subsequent pregnancies) meant that potential issues were not always identified as early as they could have been.

8.16 Since the NHS Lothian, Edinburgh FNP team started recruiting the second cohort in September 2012, they have been using a new bespoke database. At the time of writing, however, it was not possible to generate system reports at local level, although detailed information could be extracted on their behalf by the FNP NU Information Team for static reports.

Training

The best training I've had in all my years of nursing has been the FNP training
(Family Nurse 4)

8.17 As discussed in previous evaluation reports, the NHS Lothian, Edinburgh FNP team's views of the training they had received to support them delivering FNP were extremely positive. However, at the time of their fourth interviews, the team found it very difficult to comment in any detail on the mandatory training received for the toddlerhood phase, as this had been completed more than two years previously. On further probing, recollection of the toddlerhood training content varied: some team members said they could not remember details, while others talked about specific elements, such as content around 'goodbyes' which they had found helpful when approaching graduation. One Family Nurse view was that there had been too big a gap between the toddlerhood training and when you deliver that part of the programme. However, another view was that by the time the team were delivering the toddlerhood phase they had more time to consolidate learning from across all the FNP training, so the fact the initial training was some time ago was less of an issue. Now the team were delivering the pregnancy phase of the programme to a new cohort, there was also a view that the team had forgotten some of their learning about that stage.

This may suggest a need for some additional refresher training, particularly when sites are delivering to one cohort at a time (if sites move to a continuous model of delivery they are more likely to have clients in different phases of the programme at the same time, which may help Family Nurses to maintain skills and knowledge about different phases more easily).

8.18 Other suggestions for further improving Family Nurses' training experience included.

- More training being provided in Scotland
- More training on additional materials and tools that support FNP, like PIPE (Partners in Parenting Education), DANCE and ASQ
- More training on child protection.

8.19 At the time of writing, the majority of compulsory FNP training (with the exception of Communication and DANCE training) was still being delivered in England, by the Tavistock and Portman NHS Foundation Trust.²³ However the FNP National Unit (Scotland) was working with Tavistock to develop capacity to deliver training in Scotland in the longer-term. In doing so, they were looking at models of FNP training outside the UK as well as the model adopted in England. For example, the US education programme involves more online learning and fewer face-to-face sessions. There was interest in understanding the international evidence on different models of training and how these support delivery of FNP in order to inform Scotland's own programme.

8.20 As noted above, further DANCE training is now being provided in Scotland (supported by a member of the NHS Lothian, Edinburgh FNP team). One view among the FNP team was that DANCE training had initially been provided too early in the programme. At that stage the children were too young for the Family Nurses to practice these skills and consolidate their learning. Appropriate timing for each of the elements of FNP training may be another issue for the FNP National Unit (Scotland) to consider as they move to delivering more training in Scotland.

Supervision

Supervision is absolutely pivotal in FNP ... all aspects of it. (...) I think we've got a fantastic team (...) who want to share, who want to learn, and are dead keen to share everything with each other. So ... it's not just the one-to-one. It's everything ... it's all-encompassing.
(Family Nurse 3)

8.21 Supervision is an integral and mandatory component of FNP. It continued to be highly valued by the NHS Lothian, Edinburgh FNP team, as illustrated by the quote above. The team discussed in particular the role that supervision had

²³ A specialist NHS Trust offering high quality mental health care and education. Tavistock are working with the Impetus Trust and the Social Research Unit at Dartington to support the delivery of FNP in England.

played in preparing them as nurses for their clients graduating from FNP. This was supported through team days and through sessions with both the Supervisor and the team Psychologist, where the team could talk about what graduation meant, their feelings about clients leaving FNP, and how they were going to manage the process in general and with individual clients.

- 8.22 Views of Child Protection supervisions, as discussed in previous evaluation reports (Ormston et al, 2012, Ormston and McConville, 2012), remained more mixed. One Family Nurse view was that they were less useful than other supervisions as they were mainly just checking what they had done in particular cases. Another was that they were useful but too frequent. At the time of writing, a national review of Child Protection support requirements within FNP was being commissioned, which will consider the most appropriate and robust model of supporting sites in this area.
- 8.23 Other suggestions for improvements to supervision again included a suggestion that it would be useful to look at programme materials in general rather than focusing on specific clients, in order to share learning about creative ways of using the materials.

9 LEARNING FROM IMPLEMENTING FNP IN LOTHIAN

Key findings

- Early involvement of key stakeholders from universal health services and wider services was viewed as key to successful implementation of FNP in a new area.
- In thinking about FNP expansion, Health Boards may need to consider not only quantitative data on site performance, but also qualitative evidence about team readiness, universal service responses, and senior stakeholder commitment to FNP.
- There may be a need for future work at a national level around supporting Health Boards to plan effectively for expansion. In particular, further guidance may be needed on how to estimate things like recruitment rates and likely numbers of clients at different stages of the programme for several years into the future.
- Expanding an FNP team brings both challenges and opportunities and requires careful planning – e.g. around timing of new team members starting and ensuring that new and existing team members integrate effectively.
- The successes of the NHS Lothian, Edinburgh FNP team suggest areas of potential learning to be shared with wider services – around supervision, nurse education, and managing risk within a strength-based framework. However, developing other services involves complex issues and FNP is only one contributor to discussions about this.

Introduction

9.1 Previous chapters have focused on the detail of delivery of FNP to the first Scottish cohort of clients, in NHS Lothian, Edinburgh and have shown that throughout the toddlerhood phase, FNP continued to be implemented with a high degree of fidelity to the Core Model Elements and Fidelity 'stretch' goals. This final chapter focuses on broader, more strategic level learning from the experience of implementing FNP in Lothian, both for other FNP sites and potential shared learning for wider services. Again, it focuses on new themes raised in interviews with the NHS Lothian, Edinburgh FNP team and the FNP National Lead for Scotland in the fourth round of interviews with these professionals.

Learning for FNP roll-out in Scotland

Supporting sites with introducing and expanding FNP

9.2 The experience of Lothian as the first site to introduce FNP had contributed to the FNP National Unit's (Scotland) considerations on what support new sites might need in terms of organisational readiness to start the programme. In particular, the National Unit was clear on the importance of involving key stakeholders from universal health services and wider services who might

come into contact with FNP clients at a very early stage of preparing for delivering the programme. Working with these stakeholders to develop understanding of a strengths-based approach was seen as key to successful implementation of FNP in a Scottish context.

- 9.3 In terms of supporting Health Boards with determining if and when they might wish to expand their delivery of FNP – to recruiting a second cohort, or to permanence, where every eligible woman in a given area is offered the programme – data on performance against fidelity was seen as only one criteria for judging organisational and team wellbeing. Open dialogue with the team, psychologist and (especially) the supervisor is also required, alongside reviewing how universal services are reacting to FNP and evidence of commitment to the programme at a senior level in terms of funding and leadership.
- 9.4 In relation to planning for permanence, it was noted that there is no simple formula for working out what size of FNP team is required to enable a Board to offer the programme to every eligible woman. One suggestion was that, as learning increases across Scotland, the National Unit provide guidance to sites (especially supervisors) drawing on experience across sites. This guidance would help sites to think through annual recruitment rates, how many clients the Board is likely to get month by month over a period of years, the different stages that different clients are likely to be at concurrently, and therefore how many Family Nurses and Supervisors are needed. Other factors that may need to be considered in planning expansion include how best to schedule recruitment and training in relation to each other and which stakeholders to involve in early discussions about the programme.
- 9.5 Finally, in terms of advice to other areas, it was suggested that if recruitment does close for a period (as it did in Lothian after the first nine-month recruitment of cohort one), it may be better to continue to collect local figures on the number of potentially, eligible mothers coming through maternity services month-by-month. It was suggested that it is then easier to review and monitor these figures when considering expansion, rather than trying to compile them retrospectively.

Recruiting and developing staff

- 9.6 The model of recruitment for Family Nurses and supervisors adopted initially in Lothian has now been used for recruiting other FNP teams in Scotland, and was viewed as a ‘tried and tested’ model – in particular, the involvement of clients in interviews.
- 9.7 The development model used with the second supervisor in the NHS Lothian, Edinburgh team, whereby a Family Nurse acted up to supervisor on a part-time basis initially and was mentored by the original supervisor, was also seen as an effective model that might be emulated by other UK sites.
- 9.8 The NHS Lothian, Edinburgh FNP team has expanded since the start of the programme from a team of one supervisor and six nurses to a team with two supervisors and eight nurses. The team reflected on both the opportunities and

challenges associated with expanding an FNP team. It was suggested that the new team members had been able to learn from the original team's expertise while the original team members were able to learn from the new team's more recent experiences of FNP mandatory training. At the same time, it was suggested that, where possible, having at least two new nurses start together worked better so that new team members had each other for moral support, since they could sometimes be daunted by the level of expertise of more experienced team members.

Potential learning for wider services

9.9 Earlier evaluation reports have discussed stakeholder perceptions of some of the areas in which FNP may be able to share learning with wider NHS and non-NHS services. Similar themes were raised again in the fourth wave of evaluation interviews, including:

- Learning about how to support nurses working in intensive roles, particularly through developing models of supervision that facilitate effective reflection and help nurses feel supported when stretched
- How different models of education might help nurses feel equipped for their roles or for working with specific client groups, and
- Learning about how to manage risk but within a client-focused, strength-based framework.

9.10 It was acknowledged that developing other services involves complex issues and FNP can only contribute to discussions about future direction, alongside others. Family Nurses in the first NHS Lothian, Edinburgh team suggested that there may be further ways of looking at how FNP can help support Public Health Nursing/Health Visiting colleagues in particular, as they face challenges which Family Nurses felt are not always recognised:

There's a lot of people, you know, working very hard in ... related areas and if we can work together in a way to structure that in a more focused way we'd probably find that we get a lot better outcomes for not just our clients but all babies and children across Lothian.
(Family Nurse 4)

REFERENCES

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

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

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

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

Ormston, R and McConville, S (2012) Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 3rd report – Infancy, Scottish Government, available online at: <http://www.scotland.gov.uk/Publications/2012/12/4237>

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

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