



EVALUATION OF THE FAMILY NURSE PARTNERSHIP PROGRAMME IN NHS Lothian, SCOTLAND: SUMMARY OF KEY LEARNING AND IMPLICATIONS

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

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1 Introduction and background

1.1 Overview

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. Its key goals are to improve pregnancy outcomes, improve the health, development and well-being of first time parents and their children, and to support families' economic self-sufficiency.

This report follows four detailed evaluation reports which explored the experience of delivering FNP in the first Scottish test site in NHS Lothian, Edinburgh to a first cohort of clients over the period January 2010 to April 2013. These longer reports explored each phase of the programme – from early pregnancy to toddlerhood – from the perspective of clients, family nurses and others (see Martin et al, 2011; Ormston et al, 2012; Ormston & McConville, 2012; Ormston & McConville, 2013).

Given the level of detail in these reports, they were of most direct relevance to an FNP audience – for example, Family Nurse teams and others involved in decisions about implementing FNP in Scotland or elsewhere. As the final report in that series is published, this document aims to synthesise the key themes and learning from across the earlier reports, and to reflect on the implications of these for the planning, implementation, and evaluation of FNP in Scotland in the future.

As will be discussed in the following sections, the evaluation included a strong formative component. Thus, early challenges identified via this evaluation – and indeed learning from England – have already been used to refine implementation.

1.2 About the Family Nurse Partnership (FNP) programme

1.2.1 Defining features of FNP

Originally developed in the United States by Professor David Olds (University of Colorado, Denver), FNP is a licensed evidence based programme. This means that new sites are only permitted to run the programme and access the materials and programme of learning associated with it if they sign up to an agreement to implement it according to specific 'fidelity' requirements set by Professor Olds and his colleagues. Based on 30 years of evidence from delivering the programme in the US (where it is called the Nurse Family Partnership (NFP)), these requirements cover areas including client eligibility, staffing requirements, the content and frequency of the visiting schedule, and organisational structures and processes (training, supervision, record keeping, use of programme reports, etc.) There is an expectation that if the programme is faithfully replicated then the improved outcomes for mothers and children that have been observed in the US will be replicated in new sites.

The programme follows a core set of requirements with detailed materials (including facilitators to guide the conversation between the Family Nurse and client) which are used at appropriate stages. Family Nurses are also strongly encouraged to 'agenda match' their visit content to individual clients' specific needs and goals. FNP places considerable emphasis on developing a therapeutic relationship between the Family Nurse and their client as a key mechanism for ensuring positive client engagement and intended client/child outcomes. Nurses are also trained in techniques such as 'motivational interviewing' and in 'strengths-based' approaches, which aim to work with clients' existing motivations and strengths to achieve positive outcomes for clients and their babies.

1.2.2 The evidence informing FNP

The format and delivery of FNP has been informed by the research of Professor Olds and his colleagues in the USA over 30 years (Olds, 2006). In particular, its current specification has been informed by findings from three US-based Randomised Controlled Trials (RCTs) (see Olds, 2006 and Barnes, 2010 for further details). The precise outcomes observed differed

somewhat between trials, but key positive outcomes from FNP (identified in two or more trials) included:

- Better pregnancy outcomes:
 - Reduction in smoking in pregnancy
 - Reduced neonatal risk factors (e.g. birth weight and gestational age of infants)
- Improved child health and development:
 - Parents engage in child health-enhancing behaviours (e.g. increased initiation and engagement with breastfeeding and engagement and increased immunisation rates).
 - Reduced number of Accident and Emergency visits and hospitalisations for injuries and ingestions for children from birth to 2 years old.
 - Use of other programmes (e.g. breastfeeding support, children's centres etc).
 - Better emotional and language development in early years.
- Improved parental life course:
 - Greater interval between pregnancies and second births and fewer unplanned pregnancies.
 - Greater workforce participation.
 - Lower welfare dependency.
 - Involvement of fathers and other family members in the programme.

A key finding from the US was that 'the impact of the program was greater for those segments of the population at greater risk' (Olds, 2006). The evidence from the three trials suggested that it is more effective for specific client groups, including teenage mothers, lower income mothers, and mothers with fewer 'psychological resources' (defined as mental health problems, low intelligence and low self-efficacy – see discussion in Ball et al, 2012).

1.2.3 FNP in the UK

FNP was first introduced in the UK in 2007, across 10 pilot sites in England. The programme has subsequently been expanded in England, and by mid-2012 was operating across 80 local areas, (see Ball et al, 2012) while Northern Ireland began offering FNP in late 2010. In 2013 a new UK government target of delivery to 16,000 families by 2015 was announced¹

¹ See <https://www.gov.uk/government/news/family-nurse-partnership-programme-to-be-extended>

Within the UK, there was a strong interest in whether it would be possible to implement FNP according to all the fidelity requirements established for the programme within universal service provision. An implementation evaluation of the first 10 sites in England explored this within the English context (see Barnes et al, 2008, 2009 and 2011).

The English pilot evaluation also examined the potential for FNP to impact on child and maternal outcomes. While the US evidence strongly indicates the potential for FNP to have such positive impacts, there remain questions in a UK context about the *added* value FNP delivers over and above universal services available to all mothers. In other words, within the UK, where the National Health Service offers midwifery and health visiting support to all expectant and new mothers does the FNP achieve *improved* outcomes for young mothers and their children? This question is currently being addressed via a large-scale randomised controlled trial (RCT) 'the Building Blocks trial' involving 18 FNP sites in England and due to report in 2014 (see Sanders et al, 2011).

1.2.4 FNP in Scotland

In Scotland, the first FNP test site was established in NHS Lothian, Edinburgh Community Health Partnership (CHP) area, with client enrolment commencing from January 2010. Subsequently, the Scottish programme has also expanded, with additional sites in Tayside (from 2011) and in Greater Glasgow and Clyde, Fife, Ayrshire and Arran, Highland and Lanarkshire (from 2012-13). NHS Lothian have also expanded the programme locally. The first team of Family Nurses began recruiting a second cohort of clients in September 2012, while a second team was appointed in August 2013. The current capacity to support clients in Scotland has increased more than ten times, since initial implementation, to 1,970. There are currently 11 supervisors and 67 family nurses in place to support them.

1.3 The Evaluation of FNP in NHS Lothian, Edinburgh

1.3.1 Aims and objectives

In October 2009, prior to client enrolment in the test site, the Scottish Government commissioned an independent evaluation. In view of the fact that an RCT of FNP was already underway in the UK to assess causal links between FNP and outcomes, the purpose of the evaluation of FNP in NHS Lothian, Edinburgh

was '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 was intended to assess:

- Whether the programme is being implemented as intended (and if not, why not)
- How the programme operates 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
- The plausibility of the FNP to impact on short, medium and long-term outcomes, in particular, outcomes of relevance to Scotland.

1.3.2 Methods, scope and limitations

The evaluation was structured around a 'theory of change' developed and agreed by key organisational stakeholders (in the Scottish Government, NHS and Local Authorities), the FNP team and ScotCen – in other words, a clear and consensual view of how FNP was intended to operate, what it was expected to achieve and how.

The evaluation also had a number of other key features. First, it was intended to be both *formative* (feeding back into the work of the FNP site as it developed) and *summative* (drawing conclusions at the end). Secondly, it was *longitudinal* in character, following the experiences of a group of young mothers – and the staff working with them – over a period of time and through the various stages of the programme. Finally, it drew on two main types of information: *quantitative monitoring data* collected from (or about) all clients at key stages in the delivery of the programme, and *qualitative interviews* with clients, FNP staff and others with an interest in the programme. The scope and limitations of each of these methods – and of the project as a whole - are discussed further below.

In addition to routine monitoring data about the fidelity with which the programme was implemented (for example, whether the number and content of visits was consistent with the FNP Model), data were also routinely collected about client and child outcomes around breastfeeding, health behaviours (smoking, drinking and drug use), domestic abuse, child development, etc. While these are important for understanding whether desired

outcomes were achieved, and provide important contextual information for exploring whether such outcomes might plausibly have arisen as a consequence of the FNP, they do not (and were not intended to) answer the specific question of whether the Lothian FNP led to better outcomes than would have been achieved through the provision of 'universal care' (see discussion in Chapter Five). To answer such a question, a different – and more complex and ambitious – research design would be necessary, involving an experimental evaluation or randomised controlled trial (RCT).

At the heart of the evaluation was a series of repeat qualitative interviews with a sub-sample (or 'panel') of FNP clients, interviewed on four occasions (during pregnancy, when their child was aged around 3-4 months, around their first birthday, and just before their second birthday). Fifteen clients were originally recruited to the evaluation, with 13 taking part in all four interviews.

Others interviewed as part of the evaluation included:

- The NHS Lothian, Edinburgh Family Nurse team (including the Nurse Supervisors), also interviewed on four occasions
- Clients' 'significant others' (as nominated by panel clients)
- National and local strategic and operational stakeholders
- Local partners from Social Work, Midwifery and General Practice.

The aim of this element of the evaluation was to capture a diverse range of circumstances, characteristics, views and experiences and to generate insight and understanding about how the programme operated on the ground. It was not, however, intended to ensure 'representativeness' in a statistical sense. The number of interviews with stakeholders outwith FNP (see Ormston and McConville, 2012) was especially limited and particular caution is warranted in generalising too widely on the basis of their views.

In considering the extent to which it is possible to generalise from the findings of the evaluation, it is also worth emphasising the specific context and circumstances in which the programme was implemented in NHS Lothian. As the first test site for FNP in Scotland, it was likely to face particular (pathfinder) challenges, including heightened demands due to the high level of external interest. Such demands, and their associated impact on staff time, are unlikely to be experienced by subsequent sites (and, indeed, by subsequent cohorts within NHS Lothian itself).

While we hope that the report will provide useful learning for FNP as it is implemented more widely in Scotland, we are also conscious that there may already be important learning from subsequent sites that is not captured here. Additionally, much of the learning from the first test site has contributed to further implementation of FNP in Scotland. The evaluation is, therefore, best seen as a contribution to a wider evidence base about the implementation and effectiveness of FNP both in Scotland and beyond.

1.4 Report structure

The report has the following broad structure. In Chapter 2, we examine the issue of 'fidelity' and whether it has proved possible to implement FNP as intended within the specific social and institutional context of the NHS in Scotland. Chapter 3 discusses those factors that appear to have supported or inhibited delivery of the programme, while Chapter 4 examines the extent to which the evaluation provides evidence that FNP can actually impact on key client outcomes. The final chapter summarises some of the key findings and considers possible implications for future roll-out, monitoring and evaluation.



Family Nurse home visits – Using models of babies to represent the foetus and development.



2 Was FNP implemented as intended in NHS Lothian?

As discussed in the introduction to this report, FNP is a licensed programme. In order to ensure that the elements of the programme most strongly correlated with success (as evidenced by the US RCTs to date) are replicated, Professor Olds and his team have specified detailed core model elements which new sites must follow in order to implement the programme. A key aim of the evaluation of FNP in NHS Lothian, Edinburgh was to explore whether or not it was possible to implement the programme according to these core model elements within a Scottish context. It also explored barriers and enablers to implementing the FNP model in Scotland, to inform policy and practice around its future development. We discuss the first of these (whether FNP was implemented with fidelity) in this chapter, and the second (barriers and enablers to implementation) in Chapter Three.

Implementing with fidelity means adhering to the **‘Core Model Elements’ (CMEs)** of the programme. These are requirements of the FNP license that ensure that the original research conditions are replicated in order for the benefits to children and families to be realised (FNP Management Manual, 2010).

Fidelity ‘stretch’ goals relate to the delivery of the programme to clients. They are based on the US research and are believed to be optimum delivery goals for maximising the success of the programme. However, in contrast to the CMEs, the fidelity goals are design to be “stretch goals” as it is recognised that they may be challenging to achieve when first implementing the programme (FNP Management Manual, 2010). They cover four main areas and sometimes overlap with the core model elements (recruitment, retention of clients, amount of programme received and appropriateness of programme content).

Here, we summarise key aspects of performance against the quality of fidelity for the NHS Lothian, Edinburgh site during the period of delivery to their first cohort of clients.

2.1 Core Model Elements

The FNP CMEs include various criteria relating to client eligibility and recruitment, including that:

- enrolment and participation is voluntary

The full CMEs and fidelity ‘stretch goals’ are listed in Appendix E of the first evaluation report (Martin *et al*, 2011) <http://www.scotland.gov.uk/Resource/Doc/355013/0119868.pdf>

- only first time-mothers are eligible
- only high risk mothers are eligible – in Scotland, the decision has been to offer the programme to all first time young mothers (19 or under at conception), as age at first pregnancy is considered a risk factor for poor outcomes regardless of the presence of other risks
- sites enrol 100% of clients no later than the 28th week of pregnancy, and
- sites enrol at least 60% of clients during pregnancy by 16 weeks and 6 days² (in order to maximise the chances of being able to deliver pregnancy content and establish a relationship before the birth of the child).

NHS Lothian, Edinburgh achieved all of these goals with their first cohort of clients except the final one. Forty two per cent of clients were enrolled by 16 weeks and 6 days gestation, short of the 60% specified in the CMEs.

2.2 Fidelity ‘Stretch’ goals

2.2.1 Enrolment

The programme met the ‘stretch’ goal around enrolling 75% of clients to whom the programme is offered – 80% of all eligible clients offered the programme in NHS Lothian agreed to enrol.

2.2.2 Client retention and attrition

Client retention and attrition are key issues for evaluating the success of any publicly-funded programme – clearly if many clients leave before the end of a programme like FNP, the scope for it to deliver its target outcomes, in particular - its population level impact, will be severely constrained. Evidence from the US has informed fidelity ‘stretch’ goals relating to attrition across the programme as a whole (no more than 40%) and within specific phases of delivery:

- No more than 10% during pregnancy
- No more than 20% during infancy (when the child is 0-12 months old), and

² Since the first evaluation report this criteria has been amended. Previously it was believed that sites were to enrol at least 60% of clients by 16 weeks gestation. Using those criteria the first evaluation report (Martin et al, 2011) stated that 32% of clients had been enrolled by that time. This report has used the amended criteria (16 weeks and 6 days) in order to calculate the proportion of clients enrolled by that time.

See the fourth evaluation report (Ormston and McConville, 2013) for a table illustrating client retention and attrition in, NHS Lothian, Edinburgh FNP test site.
<http://www.scotland.gov.uk/Resource/0043/00435628.pdf>

- No more than 10% during the toddlerhood phase (when the child is 12-24 months old).

The NHS Lothian, Edinburgh FNP team experienced attrition rates considerably below these levels with their first cohort of clients. Just 3% of clients left the programme during pregnancy, 12% during infancy and 6% during toddlerhood. Cumulative attrition by the time all clients were due to graduate was 19%.

2.2.3 Delivery of expected number of visits

Delivering the programme according to the visit schedule is associated with stronger outcomes. The fidelity 'stretch' goals therefore include targets for the proportion of scheduled visits to be achieved for clients at different stages of the programme:

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

The 'stretch' goals do not include further guidance on what proportion of clients a site might expect to meet these goals for, but the expectation is that it applies to all clients. In NHS Lothian, they were met for 52% of clients during pregnancy, 55% during infancy and 83% in toddlerhood. The mean proportion of expected visits delivered was 79% in pregnancy, 65% in infancy and 75% in toddlerhood.

2.2.4 Time spent on key topics

FNP also has fidelity 'stretch' goals around the proportion of time spent with clients which is dedicated to different topics. The programme covers five broad topic 'domains' – personal health, environmental health, life course development, maternal role and family and friends. The suggested balance between these domains varies depending on the stage of the programme – for example, Family Nurses spend more time talking about the client's personal health during pregnancy, and more on life course development in toddlerhood. Overall, the time the NHS Lothian, Edinburgh FNP team recorded spending on these domains was very close to the stretch goals.

2.3 Family Nurse recruitment, training and supervision

The CMEs for FNP specify a variety of requirements around Family Nurse qualifications, recruitment, caseload, contracted

See the Second:

<http://www.scotland.gov.uk/Resource/0039/00396377.pdf>

Third:

<http://www.scotland.gov.uk/Resource/0041/00411535.pdf>

And Fourth:

<http://www.scotland.gov.uk/Resource/0043/00435628.pdf>

Evaluation reports for tables illustrating the time spend on key topics across all phases of FNP.

hours, training and supervision. These are intended to ensure not only that Family Nurses are qualified and prepared for the role, but also that they are able to dedicate sufficient time to delivering the programme to individual clients.

The NHS Lothian, Edinburgh site reported meeting all requirements around the qualifications, recruitment and caseload of nurses – all were registered with the Nursing and Midwifery Council, educated to degree level, worked for at least 3 days a week, worked exclusively in FNP, and carried a caseload of no more than 25 clients. The team attended all the training required, and while the evaluation did not monitor detailed compliance with the supervision regime, they all reported actively participating in the different elements of supervision (group, one-to-one, and shadowed home visits – see further discussion in Chapter Three).

2.4 Recording and using FNP data

As an evidence based programme, FNP as a whole is informed by ongoing research and evaluation, and the work of individual FNP teams is also informed by a systematic process of reflecting on data about clients and Family Nurses' contacts with them. The CMEs require Family Nurses to collect data about activity, visit content, mothers and children according to the original visit schedule. Each team's supervisor is then required to 'use programme reports to assess and manage areas where systems, organisational, or operational changes are needed in order to enhance the overall quality of programme operations and to inform reflective supervision with each Family Nurse'.

The interviews with the NHS Lothian, Edinburgh FNP team (i.e. self-reported data) suggested that the team had complied with all data collection requirements³. However, due to the delay to the delivery of a national database for FNP in Scotland, 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, for effective supervision and gave the FNP team the opportunity to apply an early intervention to improve client and child outcomes.

Overall, it appears possible to implement the FNP model with a high degree of fidelity to the core model elements in a Scottish

³ Aggregate figures derived from the data have been provided to the evaluation team by the NHS Lothian Local FNP Lead and, from March 2012, FNP Scotland's Research and Information officer.

context. In the next chapter, we discuss barriers to meeting these two goals, as part of a wider discussion of barriers and enablers to implementing FNP in NHS Lothian more generally.



Parents with their newborn baby



Family Nurse home visit – Playing with baby

3 What factors supported or inhibited delivery of FNP in NHS Lothian?

Factors that have impacted – either positively or negatively – on the delivery of FNP in the first Scottish test site have been discussed extensively in the four previous evaluation reports. Rather than revisiting each individual factor that supported or inhibited delivery here, we instead explore the broad areas that appear key to successful implementation and which may influence outcomes. These areas are likely to be significant for other FNP sites in Scotland, and include: 3.1) Adapting to the wider policy context, 3.2) Working with key stakeholders, 3.3) Developing and supporting nurses to work with young parents and their children, and 3.4) Building successful therapeutic relationships.

3.1 Adapting to the wider policy context

FNP is not delivered in isolation. The reception it receives and the impact it is likely to have will be influenced by a range of wider contextual factors. For the NHS Lothian, Edinburgh test site, the current focus within the **wider strategic and policy context** in Scotland on (a) the early years (b) co-production and (c) reducing inequalities, assets-based approaches and person-centred working may well have helped to ensure that FNP found a receptive audience at a strategic level. FNP was introduced in Lothian shortly after the publication of Getting it Right for Every Child (GIRFEC – the Scottish Government’s strategy for ensuring that every child in Scotland is supported to have the best possible start in life)⁴ and the Early Years Framework.⁵ As such, its focus on supporting young parents and their children in the early years was clearly timely. The use of a ‘strengths-based’ approach in this way (i.e. in a one-to-one relationship) was ‘new’ and diverged from the traditional ‘deficits-based’ approach. This new approach reflected wider interest in rethinking public services within Scotland using more ‘assets-based’ approaches, which seek to involve clients and

⁴ See <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright>

⁵ <http://www.scotland.gov.uk/Publications/2009/01/13095148/0>

communities in promoting their own health (see Burns, 2009 for example discussion⁶).

The Family Nurse Team reflected on the ways in which they felt the first FNP test site in NHS Lothian, Edinburgh might have influenced thinking in the wider NHS and in other services. It was suggested that it may have had an influence in the following key areas:

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

In terms of the **wider economic context**, the FNP programme was implemented in Edinburgh against a backdrop of the UK-wide economic downturn. The Family Nurse team felt this had required them to think more creatively about how to support clients towards becoming more financially self-reliant in a context where there were fewer jobs available – perhaps by looking at voluntary work or education as alternative options to paid employment.

Finally, in relation to **wider cultural factors** that may impact on delivery and outcomes, the NHS Lothian, Edinburgh FNP team noted the potentially significant influence of clients' own parents' views on their parenting. Family Nurses described involving fathers and family members in visits and explaining changing advice about areas like infant feeding. However, comments from clients indicated that they might nonetheless find it difficult to favour/follow advice from their Family Nurses against these 'intergenerational influences'.

3.2 Working with key stakeholders

3.2.1 Embedding FNP as part of wider services

The NHS Lothian FNP team and FNP National Lead for Scotland were very keen to emphasise the importance of investing time in relationships with key stakeholders from universal and other specialist services with which FNP clients

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

(Family Nurse 3)

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

(Client 6)

⁶ Burns, H (2009) *Health in Scotland: Time for a change – the Annual Report of the Chief Medical Officer*, NHS Scotland, available at <http://www.scdc.org.uk/media/resources/assets-alliance/CMO%20Annual%20Report%202009.pdf>

might come into contact (e.g. Social Work, Children's services, Housing, Benefits, Voluntary organisations etc.). These relationships were considered essential to the successful implementation and delivery of the programme. While stakeholder relationships matter throughout FNP, they were perhaps particularly important at the outset of the programme in ensuring that other services were able and willing to work with FNP, and at the end of the programme in terms of ensuring that clients made a smooth transition to universal services.

Factors that were believed to have supported good working relations between FNP and other services in the NHS Lothian, Edinburgh area included:

- Building on pre-existing working relationships
- Continuous and open communication by the FNP team, including attending meetings of other services
- Shared electronic records (between Midwifery and FNP)
- The quality of Family Nurses' work around shared clients
- Joint visits with Health Visitors prior to clients transitioning back to universal services at the end of FNP.

Key barriers (from the perspective of the FNP team) to building and maintaining these relationships related to:

- Communicating the underlying philosophy of FNP – in particular, conveying the rationale for and practice of a strengths-based approach and reassuring other services that this does not mean ignoring risk.
- The time demands involved when other services undergo staff changes or when new services/geographical areas need to be visited (e.g. when clients move to other areas)

I think by the time our later clients were giving birth I think the midwives were beginning to come on board with understanding what it was we were trying to achieve and were able to see ... the girls ... were gaining knowledge etc. and were preparing well for their babies.
(Family Nurse 5)

Early learning point

Finding ways of optimising the relationship between FNP and wider services is clearly critical to the success of the programme. Some of the suggestions for further improving communication between FNP and other services included: more and/or earlier sharing of the theoretical and research base for the programme and how it would work with particular services, and more regular meetings between Family Nurses and GP practices.

3.2.2 Linking to appropriate wider services

Referrals and signposting from Family Nurses to other services for both maternal and child health issues were clearly appreciated by clients and their significant others. It was suggested that without the support of the Family Nurse, maternal health issues might have gone undiagnosed or untreated for longer.

Clients also reported finding it helpful to have support with various aspects of housing, benefits and money management, particularly as for some obtaining housing benefit was perceived as causing more problems during pregnancy than anything else. Clients appreciated advice about benefits as they were often uncertain about what they were entitled to, where to go for help and what forms to complete.

However, the availability and appropriateness of additional services for young mothers, or indeed families in general, may impact on FNP outcomes. Examples discussed in the evaluation reports include:

- Clients feeling that the breastfeeding support while they were still in hospital was insufficient for their needs. In some cases, this was believed to have contributed to clients giving up breastfeeding before their first postnatal FNP visit.
- A lack of antenatal classes that cater specifically for young mothers. Clients reported being reluctant to attend universally available antenatal classes, which were viewed as being more for older women.
- Some clients reported a reluctance to attend postnatal mother and baby/toddler groups for similar reasons. Meanwhile, the NHS Lothian, Edinburgh FNP team felt that there was something of a gap in the provision of general services for young parents of two year-olds.
- The perceived affordability and appropriateness of available childcare options was cited by clients as a key barrier to realising their ultimate goals around work and education.

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

(Significant other 3)

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

(Client 3)

Early learning point

While FNP is able to play a role in filling some important information and support gaps – for example, providing antenatal education to young mothers who may not otherwise engage with classes – it might be easier to achieve FNP outcomes (e.g. around behaviour change and improved health etc.) if there was a greater range of services catering effectively for mothers in its target age group. The FNP team in NHS Lothian has shown how it can inform the development of such services in Edinburgh by supporting a number of FNP clients to train as ‘peer supporters’ as part of a ‘best buddy’ scheme (which includes breastfeeding) run by NHS Lothian’s Infant Feeding team.

3.2.3 Managing risks within a strengths based approach (Child Protection)

Working relationships between FNP and key services like midwifery, health visiting, social work and housing had all improved since the start of the programme as they had become familiar with each other and with FNP’s ways of working. However, as discussed in Chapter Two, some initial challenges were noted in communicating the FNP approach.

3.3 Developing and supporting nurses to work with young parents and their children

3.3.1 Recruitment of nurses

FNP attracted highly motivated and skilled health professionals, who are committed to the client group, and met the programme requirements as set out in the CMEs.

In addition to a formal interview process with a professional panel, potential service users – young mothers (under 20), and mothers to be, their partners and families – were invited to be involved in the recruitment of the FNP Team. This innovative approach was embraced by the service users who worked with the FNP lead and the Psychologist to define questions to ask of the candidates and was perceived by those involved as a very positive experience. It was a measure of the success of the

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

(Family Nurse 5)

approach that the service user-recruiters identified the same Nurses as the professional recruiters and in the same order of preference.

3.3.2 The Learning Programme

FNP involves extensive core mandatory training and ongoing learning. Before Nurses are permitted to deliver the programme to clients they must complete the pregnancy training. They attend three residential courses between 3-5 days duration covering each 'phase' of FNP (pregnancy, infancy and toddlerhood). They also attend 'master classes' covering specific tools and approaches used in FNP, like communication skills training or the Partnership in Parenting Education (PIPE) materials.⁷

Family Nurses suggested that refresher training around these tools would be helpful to ensure Family Nurses are able to make the most effective use of them in visits. The NHS Lothian, Edinburgh FNP team were extremely enthusiastic about the training they had received for their role. They described it as '*phenomenal*' in terms of quality and suggested that it was superior to any training they had previously received as nurses. Their experience indicates the value of investing in high quality training in order to ensure that nurses are prepared for working with key groups of patients like young families.

Moreover, there were perceived benefits for the team beyond the actual training itself in terms of peer support and networking. It was very clear, for everyone involved, that the training provided not only formal inputs, but also provided opportunities for informal peer learning and exchange, which were seen as being of almost equal importance to the formal learning opportunities.

⁷ PIPE focuses on practical approaches to supporting parent-child relationships.

Early learning point

While the learning programme for FNP as a whole was highly praised, the majority of the core mandatory training (which takes place after the pregnancy phase training) is delivered over the next 18 months, commencing during the period (9 months) in which Family Nurses were trying to recruit the first cohort. As a result, there was a perception among the NHS Lothian FNP team that some elements – such as the toddlerhood training and some of the masterclasses (like DANCE⁸ training) – were delivered at a point at which it was difficult to apply the learning because of the age and stage of the children. While some time lag is perhaps always likely, according to Family Nurses, building in the opportunities to enable structured on site learning to consolidate training during the earlier stages of the programme would be useful. In order for the FNP learning programme in Scotland to continue to develop, the experiences of Family Nurses in the first site in NHS Lothian need to be considered alongside the experiences of those in subsequent sites⁹.

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

(Family Nurse 4)

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

(Family Nurse 3)

And [Psychologist] is also quite good at helping us think about 'Where are we as a team? What are the challenges? ... How's everybody kind of managing with those challenges?'

(Family Nurse 5)

3.3.3 Supervision (supporting intensive interventions)

Supervision was viewed by Family Nurses as '*invaluable*' in supporting them to manage a challenging caseload and giving them the '*headspace*' to reflect on and improve their practice. Making supervision mandatory (i.e. part of the licence) was viewed as key to ensuring that the team committed to attending sessions, and that it did not drop out of people's busy working week, instead it enabled the team to prioritise it.

Nurses felt that the supervision they received mirrored what they offered to their clients – reflecting the focus on 'parallel processing' as a key component of the FNP model.

The Family Nurses had various other forms of group support, including monthly clinical supervision with the team psychologist. The team psychologist provides both group

⁸ A tool for evaluating caregiver-child interactions.

⁹ The learning programme has been adapted since the Lothian team attended in 2010. The recruitment timeline has also been extended to 12 months.

supervision to encourage reflective practice among the FNP team, and individual supervision to the FNP supervisor.

3.3.4 Developing the FNP materials

The FNP materials themselves were viewed by the NHS Lothian FNP team (and by clients) as high quality and very helpful in supporting them to discuss sometimes challenging topics. This is one area where there is perhaps less scope for sharing learning between FNP and other services, since all FNP materials are under license and cannot be shared out with FNP teams.

There may perhaps be shared learning about the kinds of topics in which professionals working with families might find it particularly useful to have high quality supporting materials.

In terms of the future development materials for FNP in Scotland, the evaluation highlighted some areas that might need to be considered, including:

- Development of additional/alternative materials for use when a client's child is temporarily taken into care - FNP materials focusing on interactions with your child were viewed as sometimes inappropriate during this particularly sensitive period for clients.
- Development/tailoring of materials appropriate for the age and stage of the baby and mother. For example, depending on the needs of the client, this may include alcohol, new relationships and contraception.

Early learning point

Although the Family Nurses praised the training, supervision and materials associated with the programme, they identified a few areas which may require some further development depending on the age and stage of the child/mother and the needs and interests of the client. These include:

- Labour and delivery
- Sexual health
- New relationships
- Working with clients when they have a second pregnancy
- Working with clients when their baby is being looked after
- Binge drinking

3.3.5 Managing challenging workloads

The role of Family Nurses is undoubtedly challenging. Although their caseload is lower than that of most Public Health Nurses-Health Visitors (FNP caseloads are capped at 25 clients per full time equivalent Family Nurse), the frequency of client contacts specified by the visiting schedule, the intensity of the relationships that develop, and the fact that their clients' young age can sometimes (though not always) be associated with particular vulnerabilities all contribute to a workload that can be heavy in terms of hours, as well as being emotionally challenging.

Workload was the key challenge discussed by the NHS Lothian, Edinburgh FNP team over the two and a half years of the evaluation. Heavy workload was believed to be a key factor impacting on the team's ability to deliver the required number of visits to all clients, particularly in the pregnancy and early infancy phases of the programme (see Chapter Two for figures on the proportion of expected visits actually achieved).

However, views and experiences of workloads shifted over the course of the evaluation, both in terms of the degree to which workload was believed to be a major issue for the team, and the factors thought to contribute to higher workloads. There remained divergent views on whether the Family Nurse workload as a whole was manageable within contracted hours. Meanwhile, the Supervisor workload was viewed as having been very challenging throughout the programme to date. The FNP Supervisor has worked closely with the nurses to develop strategies for addressing challenges. It was suggested that additional training around capacity planning and different electronic tools that could be used to support this might be helpful.

The factors believed to have contributed to high workloads and/or to difficulties achieving the target number of visits for every client can be divided into:

- **Issues associated with being a test site** – in particular, the need to complete the majority of the core mandatory training at the same time as recruiting clients. The NHS Lothian, Edinburgh FNP team also appeared to experience additional pressures as a result of being the first test site in Scotland, reporting large volumes of enquiries or requests for support from other sites, prospective Family Nurses, and the FNP National Unit (Scotland).
- **FNP programme-related factors** – the requirement for the NHS Lothian, Edinburgh team to recruit the first cohort of clients within nine months was believed to have caused

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

(Family Nurse 5)

considerable workload pressure. In addition, delivering the required weekly visits in the six weeks post-partum was viewed as particularly difficult to accommodate within normal working hours, during that period.

- **Issues associated with being part of a wider service (the NHS)** – in addition to attending mandatory FNP training, Family Nurses in the UK also need to attend mandatory NHS training. Moreover, local changes within the NHS and the number of cases which require more intensive support can contribute to workloads – for example, the introduction of a new system of record keeping in NHS Lothian was believed to have caused some initial additional work for the team.
- **Client-related factors** – the team reported that their clients were often highly mobile, moving frequently over the course of the programme. This created challenges in terms of being able to ‘zone’ clients geographically to enable visits to be carried out in a time-efficient manner.
- **External factors** – finally, external factors like an extended period of very poor weather and staff illness had also created additional workload pressures at specific points in time.

Early learning point

Some factors associated with being a test site should dissipate over time, and the recruitment period for further FNP sites (and for the second cohort of clients in Lothian) has already been extended to 12 months. However, other factors – like the requirements placed on teams as part of a wider service, client mobility, and the requirement to deliver weekly visits to all clients during the first six weeks post-partum – will not automatically change over time. While the NHS Lothian, Edinburgh FNP team reported feeling well supported in attempts to manage their workload, wider issues around the longer-term sustainability of the hours involved in delivering FNP in Scotland may need to be considered as the programme develops (see further discussion in Chapter Five).

3.4 Building successful therapeutic relationships

Perhaps the key factor believed – by clients and Family Nurses – to have supported effective delivery of the programme was the quality of the therapeutic relationships that developed between Family Nurses and their clients. Low attrition, client engagement with the visiting schedule, and positive client outcomes were all attributed by the Family Nurse team to these relationships. The development of these relationships was in turn supported by:

- **The consistency of the Family Nurse’s involvement with clients** – clients indicated that the reliability and continuity of this relationship, and fact they had got to know their Family Nurse over an extended period of time (from pregnancy) was key to their feeling able to open up to them about any difficulties with which they needed help. This was contrasted with clients’ views of other professionals, whose infrequent and time-limited involvement in their lives was seen as a barrier to building up the same level of trust.
- **The use of strengths-based approaches** – a key way in which clients felt their Family Nurses differed from other professionals they had encountered was the fact that they did not ‘judge’ them and that they offered them information that they could ‘take .. on board if you want to’. In addition to underpinning client trust in their Family Nurses, the fact that the programme emphasises recognising clients’ own strengths and knowledge appeared to have a significant impact on client confidence in their own capacity to be good parents.
- **The visiting schedule** – where Family Nurses had been able to see clients regularly, they generally reported a ‘deepening’ therapeutic relationship with them over time. In contrast, where contact with clients was less frequent, they tended to view the therapeutic relationship with clients as not as deep.
- **The use of agenda-matching** – the fact that Family Nurses are trained to ‘flex’ the programme to meet the clients’ specific needs clearly contributed to clients’ positive experiences of their relationship with their nurse: clients reported that they were always able to bring any issues or concerns they had to their meetings with their Family Nurse. Meanwhile, Family Nurses noted that if a particular topic was initially met with client resistance, the structure of FNP meant that they were able to reintroduce it and address it at a more appropriate point in time for that client.
- **The team’s commitment to their clients** – finally, while the structure of the programme supports the development of therapeutic relationships, the high level of commitment the team had to their clients was also very evident throughout

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

(Client 1)

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

(Client 1)

the evaluation. Building such strong relationships between a professional and client might be thought likely to lead to dependency difficulties at the point clients need to leave a programme. However, the experiences of the NHS Lothian, Edinburgh FNP team and their clients suggests that, by introducing transition from the programme to on-going support right from the start of the programme and by working in a structured way to prepare clients for this, it is possible to support effective transitions out of intensive services like FNP.

3.4.1 Working with the family (Involvement of fathers and family members)

Clients' family members gained new knowledge, confidence and skills from FNP. They appreciated the information Family Nurses gave them, and recognised this could be more up to date than their own knowledge.

Clients' and partners' accounts of the impact of involving partners in FNP focused on the benefits of their Family Nurses advice for their relationships and on their partner confidence about the birth, rather than practical childcare skills.

Early learning point

While, overall, the depth and strength of the relationships that developed between Family Nurses and clients was a key facilitator of successful delivery, it was also associated with some challenges in relation to the continuity of programme delivery. For example, comments from both Family Nurses and clients indicated the strong preference clients have for seeing their own Family Nurse – which meant that attempts to cover individual nurses' visits during any periods of leave were rarely successful. Meanwhile, attempts to 'hand over' clients of a Family Nurse to allow her to act up to supervisor on a part-time basis were met with similar resistance. Future implementation of FNP will need to acknowledge and anticipate this issue in terms of managing both staffing and client expectations.

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

(Family Nurse 3)

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

(Significant Other 1)

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

(Client 13)



Family Nurse home visits – covering topics such as child’s brain development, reading and stimulation through play



4 What is the potential for FNP to impact on client outcomes relevant to Scotland?

As discussed in Chapter One, this evaluation was not designed to provide decisive evidence about the impacts FNP can have in a Scottish context in comparison to universal care. However, through interviews with clients, their significant others, and their Family Nurses, this evaluation has explored perceptions of the impacts FNP has for the young mothers who participate in it, and for their children. Although such accounts cannot be taken as conclusive evidence of FNP impacts (we cannot be sure that these outcomes would not have occurred in the absence of FNP), they nonetheless provide evidence of the *potential* or plausibility for FNP to achieve its target outcomes.

FNP aims to improve outcomes in three main areas – pregnancy outcomes, child health and development, and maternal health and self-efficacy. We address each of these in turn below.

4.1 Improved pregnancy outcomes

4.1.1 Improved knowledge of health behaviours and impact on child

The early stages of the programme also focus strongly on client health behaviours around smoking, drinking, diet and exercise. However, in some cases clients reported having made decisions around giving up smoking when pregnant, for example, in advance of joining FNP. Nevertheless, there were also clear examples where clients reported a better understanding of the impact of their own health behaviours (e.g. the risks of smoking and drinking) on their developing baby as a result of information received from FNP, and of clients changing their behaviour as a result.

Breastfeeding has been a particular focus of infant health promotion in Scotland and the UK for some years now. The experiences of delivering FNP to the first FNP cohort in Scotland highlighted the challenges involved in promoting breastfeeding to young mothers, whose rates of breastfeeding are known to be lower than those of mothers in general. There were examples of clients reporting positive impacts on

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

I used to think that, 'oh, as soon as I'm not pregnant, I can have a wee drink'... but I've just like not anyway, I've just left it because I know it can make the baby more sleepy.
(Client 3)
Describing the perceived impact of information from her Family Nurse about drinking while still breast feeding.

... [the Midwife] just keep going on and on about breastfeeding and how good it was, but with [Family Nurse] [...] We sat and went over like the pros and cons of bottle feeding and breastfeeding, so I dinnae feel like the pressure that normally got from my midwife about it, so it was really good.
(Client 9)

breastfeeding decisions as a result of information received from FNP – for example, a client who reported being able to breastfeed longer because of information from her Family Nurse about supplements to help with milk flow. Based on quantitative figures collected by the NHS Lothian, Edinburgh FNP team, overall 46% of clients breast fed at least once, while 28% of those clients who were initially either undecided or did not intend to breastfeed when they joined the programme, went on to breastfeed at least once. However, clients interviewed for the evaluation who were not breastfeeding by their second evaluation interview (around 3 months after the birth of their child) identified familiar barriers to doing so, including feeling uncomfortable breastfeeding outside the home, soreness, and the baby not latching on well. As discussed in Chapter Three, there was also some evidence that FNP’s outcomes may also be influenced by the support clients receive from other services at key points.

...it was very much about giving all the information ... And some girls that I thought that were definitely going to breastfeed didn't, and other girls that I thought weren't even going to think about it at least gave it a bash. So I don't know if I got it right, but I was listening to where they were, their starting point, and trying to fit in with that.

(Family Nurse 4)

4.1.2 More knowledgeable and confident about labour and delivery

Preparing for labour and birth is a key focus of FNP during the pregnancy phase. Clients interviewed for this evaluation described feeling better prepared for the birth itself as a result of discussion with their Family Nurse in terms of:

- Feeling clearer about the different stages of labour
- Feeling more confident when the delivery did not go completely to plan, and
- Feeling better able to assert their views with hospital staff during delivery.

There was also evidence that FNP had helped fathers feel better prepared for the birth by giving them information about what would happen and by discussing roles in the labour room with the family in advance.

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

... And then (I) started pushing and then (Baby) came out!

(Client 12)

4.2 Improved child health and development

4.2.1 Positive parenting practices including good parent-child bonding and attachment

'Attachment theory' is one of the key theories underpinning FNP. It acknowledges the critical importance of new born babies developing secure attachments to their mothers for their subsequent development (Karl et al, 2006). Clients interviewed for this evaluation had discussed a range of activities to support attachment with their Family Nurse, including: skin-to-skin contact; the benefits of breastfeeding and the best feeding positions to encourage bonding; and the benefits of hugging, playing with, talking and singing to babies. While one view among clients was that they would have done all these things anyway, another was that clients and their partners discovered or gained the confidence to try new things with their child as a result of discussions with their Family Nurse.

I found it good that she was advising me to do skin-to-skin. I knew about skin-to-skin and I was planning on doing it anyway, but I needed that wee bit of confidence boost for me to do skin-to-skin and stuff like that.
(Client 4)

4.2.2 Clients understand how to keep their child safe and create a safe home environment

The FNP supported clients to assess their home for safety from the perspective of their child, and to access practical home safety equipment. Topics relating to child safety are threaded throughout FNP. Family Nurses reported that clients were often already very knowledgeable about child safety – which may mean that the impact of FNP on their behaviour in this area was sometimes limited. However, clients gave various examples of gaining new information from FNP and changing their approach as a result, including: adopting safe sleeping positions (positioning babies at the bottom of the cot); sterilising dummies; and being more aware of the changes to the home environment that were needed to keep their children safe as they start to crawl and walk. Clients also reported that without the support they received from their Family Nurses in accessing financial grants, they would not have been able to purchase essential safety equipment, like fire guards or safety gates.

She showed me how to play and everything with her, the way that she would respond when she's old enough, and then she started responding.
(Significant other 2)

4.2.3 Improved infant feeding practices

Clients and Family Nurses discussed the perceived influence of FNP on decisions and practices relating to weaning and their child's diet. Again, there were examples of clients reporting holding off weaning for longer as a result of the support they received from their Family Nurse (current NHS advice is not to begin weaning children until they are six months old in order to

With the Family Nurse, she's given us confidence to do ... to do things that we wouldn't normally think of doing ... Yeah, some of them are scary. Some of them aren't so scary. But at the same time then we know that, if it happens, this is how you deal with it.
(Significant Other 1)

give their digestive system time to develop). However, there were also examples where clients appeared to follow family members' advice about when to wean (see discussion of 'intergenerational influences' in Chapter Three).

Clients reported receiving lots of information from their Family Nurses about toddler diet and nutrition. While some panel clients said they already felt confident about what to feed their child, others cited positive impacts from the advice received, in terms of helping them introduce new foods or putting into practice ideas for how to make their toddler's diets more healthy.


4.2.4 Enabling parenting practices to support child development

Supporting children's cognitive and physical development is another key topic for FNP throughout the programme. Again, while one client view was that they would have undertaken the kinds of development activities their Family Nurses suggested anyway, others reported learning new things or doing things differently because of the support their Family Nurse gave them. For example, clients reported:

- Talking to their child more to support their speech development
- Reading to their child
- Adapting play for their child to make it more stimulating to support cognitive and physical development, and
- Being encouraged to take their child to the library and to read and sing to them to aid speech and language development.

4.3 Improved maternal health and self-efficacy

Clients interviewed for the evaluation were very positive about the dual focus of FNP on both mother and baby. This was sometimes contrasted with the support clients believed other services would offer them.



It's not just your baby as well. She'll look after you.

(Client 3)

4.3.1 Clients feel better supported in relation to their own mental and emotional health and wellbeing

There was evidence of the potential for FNP to support young mothers to feel better supported in relation their own mental health and wellbeing as well as, where needed, support in coping with stress to help assessing treatment.

In addition to promoting positive health outcomes for their children, FNP has a strong focus on maternal health and self-efficacy. It aims to ensure that young mothers (and their partners) feel better supported in relation to their own **physical and mental health**, are better equipped to address any issues they have in their key personal relationships, and make plans for the future.

4.3.2 Clients making decisions about contraception (when they might not otherwise have pursued this)

In NHS Lothian, there were some examples of clients reporting making earlier decisions about contraception as a result of advice received from their Family Nurse. However, the NHS Lothian, Edinburgh FNP team felt that some of their first cohort of clients had been at a relatively early stage in their journey towards becoming 'self-efficacious' in relation to their health behaviours in the period after birth, and that they might have needed more directive input around contraception at this point. As a result of these discussions, the team put in place a 'passport' system for their second cohort of clients, so that they could access contraception more quickly and easily.¹⁰

4.3.3 Resolve or manage relationship conflicts

FNP aims to support clients in building and maintaining strong networks to support them as parents. As such, 'Family and friends' is a key topic for the programme. Clients and their significant others interviewed for the evaluation identified various examples of positive impacts they felt their involvement with FNP had on their **relationships with others**, including:

It was helpful yeah but I already had my mind made up anyway

(Client 7)

I probably would have left it (...) And probably have been pregnant again if I did.

(Client 1)

¹⁰ 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).

- Improved communication - clients suggested that the help received from their Family Nurse around raising concerns without escalating conflict had improved (or even saved) relationships with partners, as well as helping to diffuse conflicts with their wider family.
- Improved confidence in dealing with disagreements with family members over how to raise their child – for example, resisting family pressure to wean early.

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

4.3.4 Greater access and use of community support/resources

There was evidence that FNP had the potential to support young mothers to link with appropriate community support to help them feel less isolated as well as navigate and access housing and benefit services and grants. Clients' comments indicated the scope for their Family Nurses to play an important role in supporting them to become more independent and self-reliant. Clients mentioned their Family Nurses helping them identify who to contact for housing or benefits advice, contacting other services (e.g. Housing) on their behalf, supporting them in setting up or attending meetings and, providing information about different housing and benefits options. For some clients, this help around housing or benefits was viewed as the most useful element of FNP. Clients also reported that discussions with their Family Nurse had impacted on their thinking about spending and saving money, which they might not previously have considered.

4.3.5 Broadening the options clients considered around education or work

Finally, clients also discussed the impact FNP had in helping them to make decisions about their own **future plans for work or education** by supporting them to formulate goals and overcome barriers – for example, deciding to go back to college in the face of a lack of family support for that decision. Client, significant other and Family Nurse accounts indicated the potential for FNP to:

- help them to identify goals
- broaden the options clients consider in relation to work, training and education – for example, broadening the list of colleges they considered applying to, and
- support them to overcome barriers – for example, by providing information about the childcare and funding options available to them if they do decide to return to work or study.

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

(Client 12)



Clients and their children attending a Parenting Strategy Event



Clients and their children at a Family Nurse Partnership Graduation Event

5 Issues for future roll-out, monitoring and evaluation

The first four chapters focused on summarising key findings and learning from the evaluation of the first FNP test site in NHS Lothian, Scotland, looking back over the past two and a half years. In this final chapter, we look forward to the future development and roll-out of FNP in Scotland. Drawing on learning from the evaluation of FNP to date and on the views and suggestions of those interviewed for this evaluation, we suggest some areas that are likely to require further consideration, monitoring and/or evaluation as decisions are made about the future implementation of FNP in Scotland.

5.1 Monitoring and understanding implementation within FNP in Scotland

This evaluation was deliberately limited in scope – it was intended to assess implementation, explore the potential for FNP to contribute to key outcomes and identify lessons learned from the very first FNP cohort in Scotland. As FNP expands across Scotland it is essential that the information being generated by FNP teams, FNP sites and at a national level is collated and interrogated on an ongoing basis. This will ensure that the programme is implemented and delivered as intended and that it continues to develop and respond to local context. A national monitoring and evaluation strategy which supports shared learning and continuous improvement at national and local level for FNP would help ensure that this happens in a regular and systematic fashion. The monitoring and evaluation framework generated for this evaluation would provide an obvious starting point for development of any future national strategy. Such a strategy would be able to draw on the evidence routinely collected by sites about all client visits, once the national FNP database is fully functional. Additionally, the framework would provide a useful basis to consider where evidence is weakest, and therefore the outcomes (and assumed mechanisms to achieve these) that should be prioritised in future evaluation activity.

Specific issues a national monitoring and evaluation strategy could cover include:

- Identifying any variations or wider implementation issues relating to the extent to which fidelity to the FNP model is

achieved across (or within) sites or any changes in adherence to fidelity over time

- Exploring the reasons for any such variations, how success can be replicated and how challenges can be/have been overcome (e.g. identifying areas for improvement and areas that are improving).
- Assessing any variations in the apparent feasibility of delivering FNP in areas where pregnancy rates among the target population of mothers are high or low (either of which could create challenges around workloads and sustainability)
- Research around barriers and enablers to delivery of FNP to specific client groups – for example, women from minority ethnic groups, or women with substance misuse problems.
- Understanding the particular circumstances associated with/ contributing to better (and worse) outcomes, using this evidence to inform future delivery.
- Further research in the wider NHS and with other key stakeholders in order to better understand how FNP has been received by other services, and how working relations might be further improved.

5.2 Monitoring and benchmarking key outcomes

As we have emphasised, without an RCT it is not possible to conclusively establish what, if any, impact FNP is having in Scotland over and above that which might be expected from delivery of routine antenatal and postnatal care to young families. The FNP National Unit (Scotland) will therefore need to identify appropriate benchmarks against which to interpret quantitative findings for Scottish FNP clients. In the short-term, it may be sensible to focus on a smaller-number of client outcomes, rather than attempting to benchmark every possible FNP outcome. These could be selected on the basis of those known to have been observed in RCTs of the programme (see Chapter One and Ball et al, 2012), and/or on the basis of outcomes that are considered particularly key to policy objectives in Scotland. Monitoring outcomes within and across Scottish sites against agreed benchmarks might then become a key element of any national monitoring and evaluation strategy (as described above).

Decisions about what constitutes an appropriate benchmark for specific outcomes will need to take account of a variety of issues including:

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- the feasibility and acceptability of FNP collecting (good) data in a systematic and timely manner
 - the appropriateness of the comparison data (Are they available for mothers under 20?)
 - the robustness of the comparison data (Are they based on the whole population or a sample? How reliable is it?)
 - the level at which comparison data are available (NHS Board? Scotland-wide? UK-wide?), and
 - comparability of data with that collected for FNP (How do the questions used to collect comparison data compare with those used within FNP? What issues might any differences in how they were collected create?).

In addition to monitoring and benchmarking key outcomes in the short-term, the FNP National Unit (Scotland) may wish to plan for monitoring and evaluating longer-term outcomes among FNP clients in Scotland. The evaluation on which this report is based only followed clients to the point just before their graduation from the programme. Further research is required to establish the potential for FNP to contribute to clients longer-term outcomes, beyond their involvement in the programme itself. While the FNP approaches are consistent with practices employed with health inequalities or 'youth employment' (e.g. asset-based approaches, use of motivational interviewing etc), there would seem to be a need to explore client and wider services' experiences of clients' transitions out of FNP, their ongoing contact with universal services and how such services can build on and sustain positive outcomes.

5.3 Understanding and future planning for FNP workloads

As discussed in Chapter Three, views and experiences of the workload associated with delivering FNP varied across the course of the first two and a half years of delivery, as well as varying within the NHS Lothian, Edinburgh FNP team. Assessing workloads during a pilot phase of a programme is difficult – any findings may not be completely representative in terms of likely future workloads once initial training is complete and Family Nurses are more familiar with the programme and their role.

In the evaluation conducted by Barnes et al (2011) of the first 10 sites in England, they found that the amount of additional time Family Nurses on average worked over their standard

hours decreased over time¹¹. This could possibly be due to Family Nurses being more efficient in delivery as they get to know the programme better. A recent study of the Family Nurse workforce in England found that two thirds of Family Nurses and nine in ten supervisors said they regularly worked longer hours than those indicated by their contracts (Robinson and Miller, 2013). Given these findings, and the divergent views and experiences reported by the NHS Lothian, Edinburgh FNP team, there is arguably a need for a more systematic review of FNP workloads and monitoring by local sites as the programme moves beyond a pilot phase in Scotland.

Findings from such a review could then feed in to further decisions and guidance on how to assess whether or not sites are ready to 'scale up' their FNP service to recruiting clients on a rolling basis (sometimes referred to as 'small scale expansion'). Decisions on this are likely to involve a number of complex issues, including:

- How well prepared the local area is in terms of leadership, and in terms of other services' responses to and understanding of FNP.
- How local information should be used to estimate the likely in- and out-flow of eligible women over an extended period of time
- How to move from client population estimates to a decision about how many Family Nurses and Supervisors may be needed to enable sites to offer the programme to all or most eligible women in their area
- Differences across Health Board/geographical areas – for example, delivering FNP to a client populations that are highly dispersed (e.g. in remote and rural areas), and/or that include women who are highly transient (e.g. gypsy travellers who are unlikely to stay in the area for the duration of the programme) or moderately so (e.g. due to availability of housing stock)
- How to balance the FNP fidelity requirement to ensure Family Nurse continuity with inevitable constraints around what is a feasible caseload for a Family Nurse when supporting dispersed or transient groups as described above
- What impact the recruitment of Family Nurses might have for the local Midwifery and Health Visiting workforce (an issue highlighted in both Robinson and Miller, 2013 and Ball et al, 2012)

¹¹ From 20% additional time in 2007 to 5% in 2010.

In order to ensure that decisions about ‘scaling up’ are being taken on a consistent and coherent basis, and the quality is maintained, further work at a national level to produce guidance on these specific areas may well be required.

5.4 Maintaining learning from the international evidence base

In taking decisions about the future development of FNP in Scotland, it is important that the programme continues to learn from the existing and emerging international evidence generated by FNP on what works, for which groups of clients, and with what outcomes.

As Ball et al (2012) note, the precise benefits shown in the US trials are often only apparent in the medium or longer term. Moreover, they note that while FNP is often reported as having ‘improved pregnancy outcomes’, in fact such improvements were not apparent across all of the outcomes measured by FNP. While FNP remains one of the few early years programmes internationally that shows well evidenced benefits, they therefore suggest that FNP commissioners and practitioners in the UK need to understand more of the detail of the FNP evidence to avoid disappointment or ‘over-promising’ about what the programme may achieve.

Further, in a Scottish context, while in the short term there will clearly be a focus on what the English RCT reveals about the scope for FNP to have short-term impacts in a UK context, it is also important not to lose sight of evidence from elsewhere. For example, FNP programmes are currently starting in Canada and Australia. Given their geographies, there may well be learning from these countries about how to structure and support Family Nurse teams in rural and remote areas which is particularly relevant to Scotland.

Finally, and consistent with FNP’s ethos and commitment to evidence based practice, it is recommended that attention be given to the *translation* of evidence: as such, to ensure that implementation is informed by emerging evidence, there will be an ongoing need to distil lessons learned, reflect on the implications of these for FNP in Scotland, and disseminate these in a manner that is not only targeted at key stakeholders and but also tailored to meet their information needs.

5.5 Conclusion

This evaluation has demonstrated that it is possible to implement the FNP programme with fidelity in a Scottish context. While it has been unable to measure or demonstrate impact over and above that which might have been achieved through existing services, it has also provided evidence that the programme may plausibly achieve its intended long-term outcomes – in other words, that many of the key mechanisms within its theory of change appear to be working as intended. Finally, and perhaps most importantly, it has highlighted a number of implementation issues that, if taken into account in the planning and delivery of future sites, will further improve the chances of success of the programme.



Family Nurse home visit during toddlerhood



Family Nurse Partnership Graduation Event

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