

Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England

Pregnancy and the Post-partum Period

Professor Jacqueline Barnes, Mog Ball, Pamela Meadows,
Jenny McLeish, Professor Jay Belsky and the FNP
Implementation Research Team

Institute for the Study of Children, Families and
Social Issues

Birkbeck, University of London



**Research Report No
DCSF-RW051**

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ISBN 978 1 84775 165 2

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KEY MESSAGES

1. The Family Nurse Partnership (FNP) programme can be delivered effectively in England, in a variety of different areas, but further work needs to be done to understand and address the reasons for not meeting the fidelity targets for early recruitment, dosage, attrition and data collection. The findings of the evaluation highlight the following factors:
 - The conditions of being a test site, learning the programme and demands of the tight set up timetable i.e. birth clustered around same time;
 - There were wider demands on Family Nurses' time from organisation and multi-agency working;
 - There were challenges in providing this service within the UK context, with national healthcare, compared to the USA; and
 - There was a lack of integration between maternity and child health services.
2. The FNP reached those who are likely to benefit most and the current eligibility criteria of all 19 years and under first time births should continue. Any further testing of the FNP with non-teenage mothers should focus on 20 to 22 year olds. Recruitment systems and processes have not always worked well and the evaluation indicates the following success factors:
 - Establishing clear, simple and consistent recruitment pathways and criteria;
 - Engaging midwifery leaders from the beginning and keeping them informed;
 - Family Nurses (FNs) are best placed to 'sell' the FNP to at risk clients; and
 - Better data collection is needed at recruitment to understand the relationship between potential eligibility, referrals, eligibility and uptake.
3. The FNP is acceptable to first-time, young mothers but attrition during pregnancy exceeded the fidelity target in some sites. Further work is needed to understand why clients refuse or leave the programme and to factors associated with attrition such as dosage or client demographic characteristics. The evaluation found that:
 - Enrolment rates were high, on average 87% of those offered the FNP;
 - Enrolment was higher for under 20s (88%) than 20 to 23 year olds (81%);
 - Clients had very high regard for their Family Nurses;
 - Clients appreciated the difference between the FNP and other services;
 - Clients identified universal services as being judgemental;
 - Clients valued the learning aspects of the programme;
 - Some found the programme too demanding and did not wish to make a long term commitment; and
 - Attrition rates were variable, with high mobility in some areas meaning that clients were known to have moved, or were not locatable.
4. The FNP seems acceptable to fathers. The evaluation found that fathers:
 - Participated in visits;
 - Used programme activities;
 - Valued the learning on prenatal development, diet and smoking, and preparation for labour and delivery; and
 - FNs reported that many clients requested materials for fathers who could not be present, and conveyed questions that fathers had asked about the FNP programme.

5. The FNP is acceptable to the practitioners delivering the programme who, on the whole:
 - Valued the learning;
 - Considered that it differed substantially from their previous roles (as health visitors and midwives) with the emphasis on developing a supportive relationship with the client and her family;
 - Recognised the value of the FNP and the potential benefits for at risk clients; and
 - Nonetheless they find the work demanding both emotionally and professionally and the workload heavy with significant levels of overtime.

6. Supervision is a core function of the FNP and vital to successful delivery to families but establishing this particular style of supervision was a challenge:
 - It proved difficult for first wave supervisors who were learning the programme at the same time as FNs;
 - Meeting the requirements for one-to-one supervision and group supervision added to perceived workload problems for the FNs;
 - On the whole supervisors were valued by the FNs but team functioning issues could get in the way of supervision; and
 - Further work needs to be done to develop supervision in existing and future sites.

7. The evaluation identified best practice and barriers to effective working. FNs recognised the benefits of using a structured programme, developing a different kind of relationship with clients, using new skills and reaching real need. Barriers to effective working for further exploration are:
 - Caseload size;
 - Cancellation of visits by clients;
 - Lack of planning time;
 - Strategies for keeping clients engaged;
 - Wider family involvement;
 - Specific client needs (e.g. literacy, language); and
 - Travel time and isolation from the team, particularly in rural areas.

8. Organisational infrastructure and support impacts on successful delivery of the FNP. Project Leads and Project Managers had key roles in setting up the FNP in the sites. Findings suggest that:
 - Midwifery leads need to be involved from the beginning;
 - There was a lack of clarity about responsibilities of supervisor and Project Manager; and
 - The Project Manager and supervisor need to work collaboratively.

9. The integration of the FNP with wider services indicated that health colleagues were more familiar with the FNP but the evaluation identified concerns:
- Some other professionals think that FNP teams are elitist and that they may take over existing roles;
 - Local Authorities had a lower level of understanding of the FNP;
 - Children's Centres in particular were not well informed and many did not understand the potential contribution of the FNP; and
 - More needs to be done to promote and explain the FNP and raise its profile in Local Authorities.
10. The evaluation has looked at short term programme objectives, including:
- Client views on their learning, changes in parenting and understanding of their infant. Many reported that they had gained confidence as parents and described aspirations for the future;
 - Most Family Nurses thought that clients were coping better with pregnancy, labour and becoming a parent;
 - Smoking in pregnancy showed a 17% relative reduction from 41% to 34%;
 - Breastfeeding rates appear better for this age group than national rates indicate, with more than two thirds initiating breastfeeding compared to just over half in a comparable national sample;
 - Engagement of fathers was good, with more than half attending visits; and
 - There are limitations to these data such as the possibility that clients did not disclose alcohol and substance use, and some had not been questioned at two time points. In addition there is a lack of comparative data for this particular client group. However these early findings are promising.
11. Strengthening programme delivery. The evaluation has identified factors that support or hinder high quality programme delivery that require further discussion:
- Should the FNP be protected at this early stage as a discrete programme or integrated within multi-agency children's services?
 - Clarity is needed about what the FNP is for parents. Much of the content is educational but presented with clinical expertise;
 - Appropriate caseload size, workloads and the feasibility of meeting fidelity requirements within English context need to be determined;
 - Time spent by FNs on non-programme activities needs better documentation
 - The nature of the therapeutic relationship is integral to the FNP and what this means for professional practice needs examination;
 - Family Nurses need guidance on dealing with scrutiny and data collection, which are inherent in the FNP, not only when it is piloted;
 - The level of central support has facilitated coping with local difficulties and allowed for shared learning between sites. The role of central team in the future will need to be discussed; and
 - To determine the impact of the FNP for clients, their children and their families it is essential to conduct an RCT.

EXECUTIVE SUMMARY

1. Background

The Nurse-Family Partnership (NFP), developed in the USA by Professor David Olds, is an evidence-based nurse home-visiting programme designed to improve the health, well-being and self-sufficiency of young first-time parents and their children. It involves weekly or fortnightly structured home visits by a specially trained nurse from early pregnancy until children are 24 months old. The curriculum is well specified and detailed with a plan for the number, timing and content of visits. Supervision is ongoing and careful records of visits are maintained. The programme has strong theoretical underpinnings, with the formation of a strong therapeutic relationship between nurse and mother at its heart. The programme is designed for low-income mothers who have had no previous live births and starts in the second trimester of pregnancy.

The main goals are to improve the outcomes of pregnancy by helping women improve their prenatal health; to improve the child's health and development by helping parents to provide more sensitive and competent care of the child; to improve parental life course by helping parents plan future pregnancies, complete their education and find work. Research evidence from three randomised control trials in the USA has shown it to have positive effects from pregnancy through to the time children are 15 years old. The most pervasive effects are those relating to maternal life course (such as fewer and more widely spaced pregnancies) and better financial status. The likelihood of child abuse and accidents is reduced, the children are likely to have improved developmental outcomes as they reach school age and there is clear evidence for a reduction in antisocial behaviour in children when they reach their teens.

2. The evaluation of 10 pilot sites in England

In 2006 the UK government announced that 10 demonstration sites would test the NFP in England, where it is called the Family Nurse Partnership (FNP). Applications were invited from PCTs and local authorities, who were to be funded for one year; PCTs/LAs agreed to continue to support the service until the children involved were 24 months old. Selected sites, one from each Government Office region with two in London, provided some contrast in size and geography: County Durham and Darlington, Manchester, Barnsley, Derby City, Walsall, South East Essex, Slough, Somerset, Southwark and Tower Hamlets. The majority of those recruited to offer the FNP were extremely experienced. Most teams consisted of four Family Nurses and a supervisor, but some teams were a little larger.

The aims of the evaluation were: to document, analyse and interpret the feasibility of implementing the Nurse-Family Partnership (NFP) model of home visiting in 10 demonstration sites in England; to determine the most effective method of presenting the model; to estimate the cost of presenting the NFP model; to determine the short-term impact on practitioners, the wider service community and the children and families; and to set the groundwork for a possible longer term experimental assessment of the programme and its impacts.

The findings in this report are based on a number of information sources: forms completed by Family Nurses as part of the FNP programme; semi-structured interviews with approximately a 10% sample of the clients enrolled on the programme and with some of their partners or other family members - at two points in time, during pregnancy and in the first month or two after their baby was born; semi-structured interviews with all the Family Nurses and supervisors, team administrators, local

managers, stakeholders from other agencies in the areas, and members of the central government team responsible for establishing the programme. In addition, researchers made visits to all the sites and observed some of the group supervision meetings. Training events were attended and their ratings of the different training experiences were analysed. Family Nurses and supervisors who wished to also contributed unstructured reflective thoughts on an ongoing basis.

It must be noted that this report contains early findings from test sites that were established with a tight, perhaps too tight time-scale. Setting up a new and very different programme such as FNP within the context of much larger systems of service provision is a complex task and the difficulties encountered would need to be addressed for the service to be delivered successfully.

3. Can the FNP be implemented with fidelity in England?

A number of fidelity targets are incorporated into FNP to allow the programme to be adjusted when used in new settings, and to promote ongoing performance, based on what has been shown to work in the USA. Collectively, the fidelity targets cover recruitment, attrition, and delivery of the programme and were assessed using forms completed by FNs after each home visit.

Recruitment targets

- 75% of eligible referrals are enrolled on the programme;
- 100% of enrolled women are first time mothers;
- 60% of pregnant women are enrolled by 16 weeks gestation; and
- All full-time nurses have a caseload of 25 within 8-9 months.

The first two targets were achieved, the third was not achieved with recruitment taking place on average at 17 or 18 weeks and the fourth was close to being achieved.

Attrition target

- Attrition of 10% or less for pregnancy phase.

This was not achieved across the sites: one site attained less than 10% but others ranged from 11- 24%. Attrition statistics include not only those clients who decide to stop receiving the service but also those who experience miscarriage or infant death, and those who move out of the area.

Delivery targets

- Percentage of visits completed is 80% of expected visits or greater in pregnancy;
- On average length of home visits with participants is 60 minutes; and
- Content of home visits reflects variation in developmental needs of participants across programme phases. (Visit content is divided into domains, with a specification of the average time to be spent on each: personal health, 35-40%; maternal role 23-25%; life course development 10-15%; environmental health 5-7%).

The first of these was not achieved, it proved a challenge for most sites - the average proportion of expected visits received was 53%, and just over one in five clients (21%) received at least 80% of the expected number of visits. This fidelity target will be monitored closely so that future performance can be enhanced. The second was achieved with an average visit time of 73 minutes; the complex third target was close to being achieved.

Overall, while there were complications in sites in terms of identifying eligible pregnant women, once Family Nurses met with mothers there was a high rate of acceptance of the service. This suggests that the Family Nurses were well-prepared by their training to offer the service and that young first time mothers in England were open to the idea of this kind of help. The dosage being provided to clients is below that recommended by the USA, which may impact on expected outcomes. However attainment of this target was influenced by a number of external factors such as difficulties in establishing efficient recruitment pathways; the requirement to attend training during the period that recruitment took place; and a concentration of new clients, who require more frequent visits. These can be taken into account in future implementation plans.

Information collection

There is a substantial amount of record keeping integrated into the programme, using specially developed data forms from the USA. These cover a range of topics including demographic information about clients and document health related behaviour and relationships. Completion of the forms allows for monitoring of fidelity so that performance can be enhanced, and is also essential for the reflective learning aspect of the programme to operate. Teams were more successful in collecting forms about maternal health, less for forms about smoking, alcohol and drug use and changes in relationships.

4. Are the right people being reached?

Two categories of recruitment criteria were used in the ten sites. All sites offered the programme to first-time mothers under the age of twenty. Some sites also recruited mothers aged 20 to 23 if they had risk criteria relating to lack of income, education and/or employment or absence of a partner.

Using these inclusion criteria, the clients have many characteristics that make them potentially vulnerable to poor outcomes for themselves or their children. The majority are becoming parents at a young age, have low incomes, do not live with their partners and have few educational qualifications or steady employment. In addition they have identifiable vulnerabilities including physical health difficulties, mental health problems, experience of domestic violence and homelessness. They reflect the characteristics of the population in the US that has been shown to benefit most from this programme.

This suggests that a simple selection on the basis of being a first-time parent under the age of 20 will identify a group similar to those who were found to benefit most from the programme in the USA trials.

5. Is the FNP acceptable in England?

To young pregnant women, fathers and members of the extended family?

Clients and their families were positive about the programme and about the FNs. While it took a while for them to understand the full extent of the programme, they liked it in comparison with other services. They noted in particular the different way they were perceived by FNP staff, not judged and undermined but supported and strengthened. Some were not sure about it when they accepted, but most found the programme better than they had expected, particularly some of the young men interviewed. They felt more involved as fathers to be. Grandmothers were generally happy to let the Family Nurse provide up-to-date information to their daughters.

“I thought she was going to be really nose-y and look down at me because I’m a teenage mum. But no she was really, really nice. Nothing like I expected her to be. I expected it to be really bad. I get on really well with her.”

“Every week she leaves stuff for me to read, to keep, so it’s nice to look back on them and go through them.”

To Family Nurses?

Many reported enjoying the job and the challenges it offered. On the whole they are very loyal to the programme, enthusiastic about its potential and have a sense of achievement. They feel satisfaction that their clients are well prepared for labour and have support from them when their babies are born. Many say it is the best job they have ever had. But a common theme throughout their interviews was the strain of seeing 25 clients and the number of visits required to them, relevant to the finding about dosage shortfall.

As well as the workload difficulties some Family Nurses had issues about the supervision, management or leadership of their team, and the majority made some comments about the burden of paperwork, which was exacerbated by additional requirements from their PCT to enter data in more than one place. However, they valued the high quality, extensive training and support they had received, and found working with a structured, prescribed programme more interesting and satisfying than they had expected. The descriptions of their growing familiarity with the programme and the materials indicated that Family Nurses’ understanding of both increased as they used them.

To stakeholders?

Representatives of other services working with young parents in the pilot sites were aware of the programme but only superficially conversant with its approach and method. Some attended local boards or groups to oversee the development. In some areas Project Leads and Managers had been more successful in explaining the FNP than others, usually because they were personally well embedded in the area. The response to the FNP from health services was more welcoming and knowledgeable than that from other services. Here the idea that families were being offered intensive support was welcomed, but staff were afraid of overlap with their own work, felt they were already offering the support. They wanted FNs to be more involved with them on a multi-agency basis and to take clients who they felt would benefit from support. They worried about what would happen to the families once the children were two. It was clear that these stakeholders would have benefited from clearer information about the FNP and regular local feedback from it.

6. Management, existing structures and central team

The ten sites had Project Leads, in all but one based in the PCT, who mustered support for the programme from senior officers in the PCT, local authority and relevant agencies (including the midwifery service in acute trusts). A part-time Project Manager worked under the Lead, dealing with the practical needs of teams in order that they could operate in the English context and concentrate on delivering the programme. This meant looking after matters like accommodation, technology and communication, running steering and other support groups and explaining the programme locally.

Midwifery

The midwifery service was particularly important in this first year because midwives were central to the process of recruiting mothers to the programme. Midwifery managers had had some involvement in the original bid, but reported that they had ceased to have ongoing involvement and wished they could have more feedback about the local progress of the programme. In four sites midwives had not been targeted for recruitment as FNs, which had resulted in some resentment, and the programme could be seen as a threat by existing specialist workers like teenage pregnancy midwives.

To maintain partnership working between midwifery and FNP, midwifery managers needed to be involved in the planning of FNP services, and to be part of the strategic board guiding the programme. Referral systems needed to minimise additional work for midwives, and the latter needed to understand the programme its specific remit and its goals. Referrals needed to be written into the antenatal care pathway. FNP needed to make sure that the midwifery service knew whether clients had been accepted onto the programme. Guidance from the central team was required for all areas where FNP is operating, to clarify issues of consent and confidentiality for referrals.

Children's Centres

The plans for FNP in England had included integration of the programme into Children's Centres. Interviews with Children's Centre managers showed a low level of understanding of the precise nature of the FNP. It was difficult to see how managers could plan the integration of this programme with other services without that understanding. Family Nurses have been able to get some young clients to use Children's Centre services, often by accompanying them there. However this report deals primarily with FNP clients during early and late pregnancy and links between the FNP and Children's Centres may strengthen once infant are born.

Wider service structure

The implementation of the programme was managed by a central team based within the DCSF and in partnership with the DH. Their role initially focussed on learning in detail about NFP in the USA, and on managing programme implementation through the provision of training and support for FNs and supervisors, regular meetings with local leads and managers, troubleshooting when difficulties arose, such as in the establishment of effective recruitment pathways, and monitoring fidelity information. The open and full exchange between FNs, supervisors and managers and the central team is a strength in that it has allowed for ongoing support for the sites in this early phase, and has allowed for early difficulties to be addressed in a timely manner. The central team also have a wider role of linking FNP with the Every Child Matters and Child Health Promotion agendas and structures. They noted in interviews the tension between this new, innovative way of working and longstanding professional attitudes evident in some commissioners and local managers. However, the profile of FNP is high and it has been noted as an important element in the new Child Health Promotion Programme.

7. Cost issues

An examination of how Family Nurses apportion their time, based on detailed diary-keeping by all but one of the FNP staff over a two week period, showed that in all sites Family Nurses were not able to deliver the requirements of the programme within their normal working hours; they were working 20% more than their standard hours. And this was happening at a time when many did not have a full caseload. Family Nurses who work part-time found it hard to keep their non-working days free of programme commitments. However, it was also the case that, at the same time as they were seeing clients, the FNs were also attending ongoing training sessions requiring substantial time-commitment. In addition the fast rate of recruitment meant that they had many new clients at one time, all requiring a high frequency of visits (weekly in the first month) making it a challenge to reach the dosage target. If recruitment had been phased more slowly this would not have been the case.

At present the babies born to clients of the FNs are only a few weeks or months old, so that lifetime outcomes are unknown. This means that it is not yet possible to compare the benefits of the programme with the costs. Further work will be done on this in year 2 of the evaluation.

8. Nature of the work and best practice

All those directly involved in the FNP in the pilot sites and centrally point out that while it may appear to be an intensive version of existing UK early years health services, the actual experience is of a very new way of doing things. FNs feel they are reaching real need, using their skills, standing shoulder to shoulder with clients and seeing change in them. They note how different it is to work in a structured programme, but found it extremely helpful in comparison with the professional approaches they had been used to (in health visiting and midwifery).

They valued the close relationship within the FNP team, the high quality of the training and the chance to work with the whole family.

Barriers to good practice included managing the workload, last minute cancellations of visits by clients, and insufficient planning time for visits. Evidence from a series of case studies with clients, some of whom presented with extra needs, showed that FNs were considered good listeners who gain access to clients because they are approachable and seen as different from other professionals - non-judgemental, non-threatening and able to spend time with clients. Once engaged the Family Nurse builds trust with the client, reinforcing confidentiality on every visit. FNs have had to be flexible in gaining and keeping clients interested in the programme, and have learnt to adapt programme content while trying to keep fidelity. FNs have liaised with other agencies on the client's behalf, and supported clients in tackling crises that occur in their lives, based on self-efficacy principles.

Clients prefer help which is seen as practical and which can quickly be proven to be effective. They appreciate the professional background of the FNs and want to take advantage of their health expertise. FNs have managed to engage and maintain relationships with clients with whom other professionals have not managed to engage. They have done so even where child safeguarding procedures has been put in place at the instigation of the FN. FNs have emphasised the strength of clients and encouraged them to re-engage with agencies they had previously stopped using or refused to use. They have been able to engage fathers, and have worked flexibly to

keep fathers involved. FNs have found it difficult to maintain the engagement of some families where interpreters have been required and cultural perceptions have affected communication.

The skills of the Family Nurse and good practice in approaching clients can result in effective engagement, but progress can be strongly influenced by factors relating to the client, both current and historic.

9. Sites, teams and supervision

The organisation of FNs into dedicated teams is central to programme operations, with support from within the team and between team members acting as a consideration when FNs are finding the work difficult. The way FNP teams work is more intimate and mutually dependent than FNs had experienced in team-working in previous roles, where, for example, one of the prime functions of the team is to allow practitioners to cover for one another.

Team cohesion

Training has reinforced relationships within teams, partly because FNs have had to travel together to undertake training, and trainers have treated them as a group and also because they underwent team building exercises (though many disliked these at the time). Those who are not based with other members of their team feel isolated and can often lose some sense of the Family Nurse identity. Teams did not necessarily cohere from the outset, but relationships have improved over time, and are aided by the supervision process. It is therefore extremely important that group supervision is protected and experienced regularly.

Supervision

Supervisors help to make teams work, but at times their role is undermined, by local infrastructure deficits for instance. Ideally the team coheres and the supervisor helps this to happen. Supervisors, like the Family Nurses, feel frustrated that they do not have enough time to complete all elements of the job - but value the fact that they are visiting families and thus getting an insight into the day-to-day experience of team members. In the future it should be possible to ensure that a supervisor already has experience as a Family Nurse.

Support for supervisors from the central team psychologist and from the Implementation Lead has been helpful to them. They liked the direct link to the central team, and the opportunity to help one another. If the FNP develops in a wide number of sites, a system to allow links between supervisors, perhaps on a regional basis, would be helpful.

Supervisors have had a more extended local promotional role than might have been expected from their job descriptions. This may be because their insights into the FNP, based on their own visiting experience, have made them able to communicate what the programme is about in ways that are not open to Project Managers. Although most have enjoyed this part of the work, it can add considerably to their workload.

10. Can the FNP make a difference?

This implementation evaluation cannot say whether the clients who receive the programme changed in ways that are different to those who are not being supported in this manner. To answer that question a randomised trial is required but many of these clients believe that it is helping them. On a scale from 1 to 10, their average rating of the difference that the FNP was making to them was 8, with very few ratings below 6, suggesting that they think it has made a difference; both during pregnancy and once their infants had been born.

“She gives you that bit of extra support, confidence that you are doing things right with your child. She makes you feel better.”

Client substance use

At the start of support 40% had smoked in the previous two days and this was reduced to 34% by 36 weeks gestation, with an average reduction in the number of cigarettes per day, for those who smoked, of 1.3 cigarettes per day. The reduction for those who smoked 5 or more cigarettes per day was 2.4 cigarettes.

Few clients reported any alcohol use at intake (14%) and at 36 weeks even fewer (8%) reported any alcohol consumption in the previous two weeks. A comparison of the daily consumption for those who had reported any use of alcohol at intake indicated a significant reduction (down to 0.4 units) but this is based on a small number of clients. There were not sufficient clients using other drugs to make any sensible comparisons. It is likely that some clients were reluctant to disclose alcohol or other drug use to the Family Nurses and other methods may be required in a trial to gain accurate data.

Infant and maternal nutrition

At intake more than 50% of clients were either under or over-weight according to their BMI, estimated on the basis of their reported weight prior to pregnancy. Many recalled in interviews that Family Nurses had given them a lot of information about eating appropriately, with the use of diaries and information sheets, and this was said to have helped them to think about eating more fresh fruit and vegetables, and fewer fattening foods, which should contribute both to maternal and then infant health.

Many clients recalled that their Family Nurse had given them a great deal of support to enable them to think about breastfeeding, including knowledge about its benefits and practical activities such as using a special doll for practice. Two thirds had told their Family Nurse that they were planning to breastfeed and of those who had given birth two thirds had initiated breastfeeding, higher than the rate for mothers of that age in a national sample (52%). Data were available for 200 clients whose infants had reached 6 weeks and 21% were still breastfeeding, again higher than the national rate of 14%.

Father involvement

Many studies have shown that children do better academically and emotionally if their father is involved in their life, and families also gain financially if fathers, including non-resident ones, contribute financially. This study provides evidence about the involvement of fathers in the FNP programme, which should lead to closer involvement in their children's lives. The interviews with fathers revealed that many were interested

in the FNP materials and activities, and that these had given them confidence, for example finding out how to communicate with the new baby.

Almost half the fathers and partners (49%) had been present for at least one FNP visit and for those who had attended at least one the average number of visits attended was 3.3, representing overall 23% of the visits made. Family Nurses judged that when they were present fathers were almost as involved as the mothers in the activities and that they appeared to understand and accept the materials. Family Nurses also reported that over half (58%) of clients asked for materials to be left so that they could be shown to partners. These were then shared with the Family Nurse, even if the fathers could not be present themselves, through work commitments or for other reasons.

Strengthening parenting

During interviews mothers and fathers indicated that they felt more confident about becoming parents. They also appreciated the positive approach of the Family Nurses who, instead of making them feel that they should not be having a child, gave them skills to be able to cope with the difficulties of the labour and delivery and then with their new infants. They were, in some instances, empowered in the hospital in the face of staff who were at times less than supportive, to ask the right questions or make requests related to pain relief or the progress of the labour.

They were also empowered in their interactions with their infants, expressing amazement and enjoyment in their learning and understanding about the complex ways that infants use to communicate. This should enable them to deal more effectively with stressful infant behaviour such as crying or sleeplessness.

11. Implications for the future

Cycles of disadvantage and social exclusion

Previous UK research has found that mothers who give birth for the first time before the age of 20 are later in their lives more likely to live in social housing, receive benefits, have no qualifications, a low household income, poor health, mental health problems and a low satisfaction with life. Explanations of the adverse consequences of early motherhood often make associations with low educational attainment, which limits later employment options available to women, and low income. Their children are also more likely to have children while still in their teens.

The FNP programme has the potential to mitigate against the adverse outcomes found in the past to be associated with young parenthood. Research from the USA has shown that in all three trials of the programme there was wider spacing between the first and subsequent births, less reliance on welfare, more take-up of education and more paid employment. There was also more paid employment of partners. Although recruited for the most part with a simple age criterion, the English client group reflects the earlier UK findings in that they are disproportionately from households with low income, they have few educational qualifications, and many vulnerabilities including mental health problems. Thus it is possible to offer a service that is not presented as stigmatizing with a simple age criterion, but that reached some of the most disadvantaged first-time mothers, likely to become even more disadvantaged in later life.

Selection based on additional risks for mothers giving birth aged 20 to 23 was less successful. Refusal of FNP was greater for the 23 and 24 year olds, and only small numbers were identified. Thus future sites may want either to recruit only under 20s - the simplest option since it requires less of the other services in terms of information sharing - or to offer routinely to under 20s and selectively from 20 to 22 years. Going above that age group may not be a good use of resources.

Many of the young parents reported that they feel and are excluded, judged or demeaned by many professionals that they come into contact with. The FNP programme could provide a way for this psychological aspect of their exclusion to be reduced. The FNs behaved in ways that were contrary to this, they accepted, supported and strengthened their clients. This can allow these young people to approach the rest of their lives with a sense or potential to be achieved rather than failure to be accepted.

Fitting the FNP into existing services for children and families

The FNP is best viewed as a discrete intervention: focussed, complete in itself and not so much a partner in a multi-agency approach as a prelude to it, with the potential to link clients efficiently with a wider range of services when this is warranted. When respondents referred to newly trained FNs as an 'elite group' in a concerned way, there may be no cause for concern.

This will not mean that the FNP should operate in a vacuum, divorced from other support services. There is every reason to suppose that helping clients participate in other services, introducing them to Children's Centres, even helping Children's Centres to set up services for them will work well, both for the clients and for the Children's Centres. But there are risks in seeing FNs as new members of the Children's Centre team, sharing family support work between them. Rather, this is a small focused resource, working with a small group of families in a very specific way, and FNs need to be able to concentrate on this.

FNs describe themselves as being in a changed alignment with their clients. They have reached this position as a result of the FNP training, the new skills they have developed like motivational interviewing, and by the experience of using the programme, the contents of which have succeeded in re-orienting them. This new position can be precarious, and the greater level of scrutiny and feedback about progress can start to feel intrusive and critical. Their time needs to be protected so that they can devote as much as possible to FNP activities, which is sometimes problematic when they are working within statutory agencies.

There is a tendency, as social programmes are rolled out from their early testing, to give the development and support role to regional and local agencies, which are already dealing with training and support for family services. The FNP does not lend itself to this approach. It may benefit, in the long-term, from being supported by a central unit, which is positioned outside the statutory sector and which acts as a contractor to those wishing to implement the intervention.

It has been suggested that one of the most important outcomes of the Head Start initiative in the USA or the Perry Preschool Project (Schweinhart et al., 1993) was not that they 'boosted child IQ' since this often faded over time, but the programmes gave the families an expectation that formal services could be helpful for their children, and that is what made the difference in the long term. The FNP has the potential to achieve this for young vulnerable parents and their children in England.

Chapter 1 - The Nurse-Family Partnership (NFP) programme

“What works in the early years is high-quality social support alongside antenatal clinical care. Health visitors and midwives can play a pivotal role, as they provide a universally available service at a time when parents are typically highly receptive to external advice and support. ... Internationally we have identified a number of practical approaches that are truly outstanding in terms of outcomes and long-term cost-effectiveness. From pre-birth to age 2, the Nurse-Family Partnership model shows sustained impacts and has been found to be highly cost-effective... Home visits focus on three major activities: promoting improvements in women’s behaviour thought to affect pregnancy outcomes, the health and development of the child, and the parent’s life course; helping women to build supportive relationships; and linking women and family members to the services they need.” (Cabinet Office, 2006, pp. 51-2).

1. Background

The Nurse-Family Partnership (NFP) model, developed in the USA by Professor David Olds, is an evidence-based nurse home visiting programme designed to improve the health, well-being and self-sufficiency of first-time parents and their children. It involves structured home visits by a nurse from pregnancy until 24 months postpartum. David Olds recognized that the best *window of opportunity* to change the ubiquitous patterns of poverty, violence, school failure and crime occurs very early in life. Nurse-Family Partnership is the result of three decades of extensive research, conducted through three randomized, controlled trials. It has, in the USA, proven particularly beneficial for young and /or single women of low socioeconomic status (Olds et al., 1986).

The NFP programme follows a curriculum that is well specified and clearly detailed, with a plan for the number and timing of visits. It provides visit-by-visit guidelines, supervision is ongoing and a careful record is maintained of the visits. The programme has strong theoretical underpinnings, based on knowledge of the risk and protective factors, developmental pathways and mechanisms through which change may be produced (Olds & Kitzman, 1993; Olds et al., 1997). Specifically it draws from Ecological theory (Bronfenbrenner, 1979), Self-efficacy theory (Bandura, 1977) and Attachment theory (Bowlby, 1969). Ecological theory emphasises the importance of social contexts and interactions between the characteristics of individuals and the contexts that surround them; self-efficacy theory concentrates on an individual’s beliefs that they can successfully carry out the behaviour required for certain outcomes; and attachment theory highlights the importance of both the mother-infant relationships and that between the mother and the nurse. The formation of a therapeutic alliance is central to the NFP work.

The nurse home visitor’s attention is focused on the social, emotional and economic context of her client’s life, and her activities are based on understanding human interactions. The cornerstone of the NFP home visit and the distinguishing characteristic of the NFP model is the therapeutic relationship that develops between the nurse and the client. Home visitors build clients’ skills, confidence and hope in a paradigm that values the clients’ ability to determine their own futures.

Nurses in the USA receive more than 60 hours of instruction over a 12- to 16-month period of time. In addition to instruction that is specific to the NFP home visiting intervention, nurses also receive education in N-CAST feeding and teaching scales (Barnard, 1978) designed to assess parent-child interactions and in the Partners in

Parenting Education (PIPE) curriculum, designed to increase the emotional availability and relationship building skills of parents with their babies and toddlers.

In the USA each full-time nurse has up to 25 clients, and there is a half-time supervisor for each team of four full-time nurses. Nurses meet regularly with their supervisors to develop a reflective practice and continuously assess their clinical skills, identifying areas that need special attention. Teams meet regularly for case conferences, where they get help from colleagues so they can deliver the best possible care to their clients. Team meetings also help individual nurses cope with the stress inherent in working with clients who may have numerous personal and health-related crises and may be at high-risk for violence in their homes and neighbourhoods

2. Programme structure

The programme is designed for low-income mothers who have had no previous live births (thought to be the most responsive to support and guidance), starting during the second trimester of pregnancy. The home visiting has three major goals (Olds, 2006):

- To improve the outcomes of pregnancy by helping women improve their prenatal health;
- To improve the child's health and development by helping parents to provide more sensitive and competent care of the child; and
- To improve parental life course by helping parents plan future pregnancies, complete their education and find work.

Ideally, visits begin early in the second trimester (14-16 weeks gestation). Nurses visit weekly for the first month after enrolment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through to the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old.

During pregnancy the programme addresses modifiable risks for poor birth outcomes and child neurodevelopment impairment such as prenatal exposure to tobacco, alcohol, illicit substances, inadequate maternal diet and low take-up of antenatal care that might address obstetric complications. Following the birth the focus is more on developing sensitive, competent care of the child to avoid abuse and neglect or injuries, while fostering secure attachment bonds. Parents are shown ways to sensitively read their infant's signals and to avoid punitive or rejecting behaviour. During the first and second year mothers are given support to gain educational qualifications, to avoid closely spaced successive pregnancies, and to plan for workforce participation. There is also an emphasis on encouraging paternal involvement in the children's lives, both financial and behavioural, the latter by engaging in joint father-child activities.

3. USA research evidence

There is a range of strong evidence from randomised trials, where information is available about a control group not receiving the service, for beneficial impacts of NFP. The first randomised controlled trial (Elmira 1977), involved 400 low-income primarily white families in upstate New York (Olds et al., 1986). The second trial took place in Memphis, Tennessee (1988) with a larger sample (1,138), this time of low-income African-American families (Kitzman et al., 1997). The third trial in Denver, Colorado (1994) involved 735 low-income, primarily Hispanic families (Olds et al., 2002). Thus,

the programme has been demonstrated to be relevant to families spanning a range of cultural backgrounds typically found in the USA.

The results of the three trials are summarised below. All have followed children beyond the end of the programme (2 years of age) but have not all reported follow-up for similar ages. There is consistent evidence that some detected beneficial effects were restricted to select sub-populations, most notably mothers with limited psychological resources and/or poor unmarried teens. Maternal psychological resources were defined as a combination of general intellectual functioning, maternal mental health and self-efficacy. Mothers in the Memphis and Denver trials were grouped into high or low on this composite.

Short-term effects of the NFP

In the main, longer-term effects are more pronounced than shorter-term ones, and this appeared to be the case within the short-term period (pregnancy to 2 years) itself. Pregnancy (Elmira, Memphis, Denver):

- Greater service use (e.g., childbirth class attendance, doctor visits, preventative services) and more support received (e.g., father interested in pregnancy, woman accompanied in labour).
- Fewer pregnancy-related health complications (e.g., kidney infections, hypertension) by NFP mothers and enhanced maternal health behaviour was evident also (e.g., improved diet, reduced smoking).

Birth (Elmira)

- Some positive effects, with some evidence of enhanced newborn birth status (i.e., birthweight, gestational age), and typically for a sub-population (i.e., very young mothers and/or smokers).

First Year (Elmira, Denver)

- Some effects emerged in terms of child behaviour/development (e.g., positive mood, eating difficulties), parenting (responsive parenting, avoids restriction, provides more play materials) and maternal life course outcomes (e.g., in school) and applied to poor unmarried teens.
- In the Memphis trial more attempted breastfeeding.

Second Year (Elmira, Memphis, Denver)

- The most pronounced effects were for improvements in maternal life course, with fewer subsequent pregnancies and live births and evidence of less welfare dependency, these effects were restricted to poor unmarried teens and those young women with greater psychological resources.
- There is some evidence for improved child cognitive and behavioural functioning (e.g., less language delay, child responsivity), but only for mothers scoring low in psychological resources.
- Improvements in child health were notable, as reflected in fewer injuries, accidents, poisoning and, especially, contact with health care system for these conditions.
- Parenting appeared positively affected, with mothers (principally those who are poor, young and unmarried or those with low psychological resources) having less risky childrearing, engaging in less maltreatment and providing a more stimulating home environment (e.g. play materials).

Longer-term effects of the NFP

Third Year (Elmira)

- Parenting was broadly affected in a positive manner, with homes being safer and mothers being more stimulating of their child's development and/or involved with them. Again some impacts were most evident for poor unmarried teens or those where maltreatment was identified.

Fourth Year (Elmira, Memphis, Denver)

- In all three trials pregnancy spacing was greater for those receiving NFP and there was greater maternal employment, less welfare dependency and greater probability of mother living with a partner.
- Evidence in Elmira and Denver showing enhanced cognitive functioning and fewer behaviour problems on the part of children, principally where the mothers had limited psychological resources.
- In Elmira children of mothers supported by NFP had fewer doctor visits for injuries and/or ingestions.
- In Elmira and Denver mothers provided safer homes and more stimulating parenting, particularly in the case of mothers with low psychological resources and/or in the case of poor unmarried teenagers.

Sixth and ninth year (Memphis)

- At six and nine there is ongoing evidence of fewer pregnancies and live births and greater spacing between births, less welfare dependency, more months living with a partner, more employment and a greater sense of mastery.
- At six, lower levels of behaviour problems and enhanced cognitive and language development and math achievement, and at nine increased reading and math skill and achievement for children whose mothers were low in psychological resources

15th Year (Elmira)

- Elmira is the only trial for which reports are available concerning the NFP supported families when the children reach 15 years. Maternal life course was still positively affected, with NFP mothers having fewer births and, greater birth spacing, less welfare dependency and fewer arrests or substance-abuse impairment, all these beneficial effects applied to women who were poor and unmarried when originally enrolled in the programme.
- Mothers themselves were less likely to maltreat their children, an effect that was more pronounced for those who had been poor and unmarried when pregnant and/or experienced low levels of domestic violence.
- Children at age 15 had fewer sexual partners, fewer arrests, convictions and parole violations and were less likely to run away from home; some of these effects applied to children born originally to poor unmarried mothers.

4. Conclusions

The NFP is a model of intensive and structured home visiting, beneficial to vulnerable first time mothers and their children with a number of positive effects that have been identified in the USA from pregnancy through to the time when the children are 15 years old. The most pervasive are those findings relating to maternal life course (such as fewer and more widely spaced pregnancies) and better financial status, in terms of less reliance on state benefits. There is also evidence that child abuse and child injuries are less likely to be identified and that parenting is improved. The children are likely to have improved developmental outcomes as they reach school age and there appears to be the potential for reducing antisocial behaviour in children as they reach their mid teens.

Chapter 2 - The evaluation of NFP implementation in 10 pilot sites in England

“ACTION 16: The Government will establish 10 health-led parenting support demonstration projects from pre-birth to age 2, building in a rigorous evaluation of targeted support. ... The demonstration sites will help to build the English evidence based on health-led parenting support in the early years, trailblazing practical approaches to achieving the vision for health visiting and community midwifery that is set out in the National Service Framework for Children, Young People and Maternity Services.” (Cabinet Office, 2006, p.53)

1. Background, site selection

In late 2006 the UK government announced as part of the “Reaching Out” programme of the “Action Plan on Social Exclusion” 10 demonstration sites to test the Nurse-Family Partnership (NFP) model of home-visiting (Cabinet Office, 2006, pp. 51-52). Potential sites were asked to bid in late 2006 and were selected in early 2007 so that they could be operational from March, and starting to enrol clients by April 2007. Sites were asked to demonstrate: strong partnership working and a high degree of NHS/Local Authority service integration; community engagement; commitment to progressive universalism; workforce capacity and capability; effective local leadership; a relevant demographic profile and capacity to identify families; IT capacity; a record of successful innovation; and a plan that demonstrated the capacity to deliver according to the proposed timetable. Sites were offered funding for one year provided the PCTs/Local Authorities continued to support the service until the clients’ children were 24 months old.

Following 63 applications 10 were selected; two sites were established in London and one in each of the remaining Government Office regions (see Annex 1 for descriptions of the sites). Each was selected on the basis that it would be feasible to recruit 100 first-time young pregnant women in the six months between April and September 2007. Depending on the size of the population and the birth rate, in some areas they were all to be under 20 at the time of conception, while in sites with smaller populations and birth-rates mothers-to-be aged 20 to 23 were also to be recruited using the following additional criteria, decided upon after a systematic review of the literature by David Hall (Hall & Hall, 2007):

Any woman who fulfils the criteria of being a first-time parent and living in the area where recruitment is taking place and who is was 20 or older but less than 24 at the time of conception is automatically eligible if *any one* of the following three rules apply:

- She is NEET² *and* has never been in regular paid employment *OR*
- Is NEET *and* has no qualifications *OR*
- She does not have a stable supportive relationship with the baby’s father.

2. The FNP staff

The staff recruited to the 10 sites were very experienced. Almost all the nurse home visitors (42/44, 96%) - referred to as Family Nurses in the UK, and all the supervisors had a Registered General Nursing (RGN) qualification. All are registered with the Nursing and Midwifery Council. More than three quarters of the FNs (34, 77%) and nine of the ten supervisors had a first degree. Of the 34 with a degree, 19 Family

² Not in education, employment or training

Nurses and one supervisor specified a Health Visitor qualification. Six of the ten supervisors had a midwifery qualification, as did 18 of the Family Nurses (41%). Five of the 10 supervisors had worked as both a Midwife and a Health Visitor, as had 14 of the 47 Family Nurses. The Family Nurses and supervisors all had a range of additional training experiences. For instance, almost all were trained in safeguarding and child protection (51, 94%). About two thirds had received training in breast feeding (47, 87%), domestic abuse (45, 83%), smoking cessation (37, 69%) and perinatal mental health (34, 63%). Just under half (23, 43%) had received counselling training.

All the staff recruited had a number of years of work in different types of job or with different populations (Table 2.1). The most long-standing type of experience was working with families (average 12.3 years) though four described no work with families. Following that, child health care with infants (10.8 years), home visiting (9.3 years), work with diverse populations (9.3 years) and with teenage mothers (9.1 years) were the most frequent, with the maximum amount of experience for each of these of 25 years or more. Fewer than half the group had any experience of midwifery, labour and delivery, general nursing of children or mental health nursing.

Table 2.1: Work experiences of Family Nurses and supervisors

	Family Nurse Average N=44	Range	N with 0 years	Supervisor Average N=10	Range	N with 0 years
Work with Families	9.4	0-30	11	12.7	0-25	3
Home visiting	8.3	0-26	9	10.2	0-20	1
Child health care, infant	8.3	0-30	12	11.7	0-20	2
Diverse populations	8.4	0-25	12	7.9	0-20	3
Community work	7.2	0-25	14	7.9	0-20	3
Teenage mothers	7.1	0-26	14	9.7	0-25	1
Public health nursing	7.1	0-26	9	9.5	0-20	1
Antenatal care	5.9	0-26	18	8.2	0-20	3
Midwifery	3.1	0-25	28	6.6	0-25	5
General nursing, children	2.5	0-22	29	2.5	0-15	7

3. Aims of the evaluation and methods

The aims of the evaluation were: to document, analyse and interpret the feasibility of implementing the Nurse-Family Partnership (NFP) model of home visiting in 10 demonstration sites in England; to determine the most effective method of presenting the model; to estimate the cost of presenting the NFP model; to determine the short-term impact on practitioners, the wider service community and the children and families; and to set the groundwork for a possible longer term experimental assessment of the programme and its impacts.

A range of methods were used:

1. Face to face recorded semi-structured interviews that were subsequently transcribed and subject to thematic analysis (see Annex B for the number per site):
 - With all Family Nurses (N=47) and all supervisors (N=10) on two occasions, one early on in the year and the second about 6 months later, when caseloads were close to being full;

- With all members of the central team (N=5, two were interviewed twice), and with other members of the DCSF, DH and the Social Exclusion Unit including senior management (N=5);
- With all Project Leads (N=11), Project Managers (N=10) and FNP administrators (N=10);
- With an approximate 10% sample of enrolled clients during pregnancy (N=106) and then again once their infant was about one month old, though not all had given birth by the time the interviews had to be completed (N=82);
- With relatives of clients (N=44), most of whom were partners (N=30) and were only interviewed on one occasion, the remainder were mothers of the clients;
- With some who had declined the FNP, or left the programme (N=20); and
- With local stakeholders: 11 Midwifery managers, 11 Children's Centre managers, 6 teenage pregnancy midwives, 1 teenage pregnancy advisor, 5 Health Visitor leads, 3 Connexions staff, 2 local health visitors, 3 local midwives, 2 social workers, and 10 other professionals.

2. Analysis of feedback at all the training events.

3. Ongoing collection of confidential reflective notes from Family Nurses and supervisors, sent either as e-mail attachments or handwritten and sent by post.

4. Analysis of web-based discussion groups (open only to the central team, the research team and each site).

5. Observations of at least 2 group observation sessions per site.

6. Case studies of 10 clients selected to represent a range of different issues for FNP staff which involved interviews with the clients, the partner if appropriate, the Family Nurse, the supervisors, and any other relevant professionals (e.g. drug counsellor, social worker) analysed to identify best practice and barriers to best practice.

7. Analysis of data forms collected by Family Nurses as part of the ongoing provision of FNP, covering: numbers of referrals and their sources, demographic details of the clients, maternal health, relationships, details of every home visit made or attempted, contact to discuss FNP materials by telephone, any change of status (such as leaving or infant being born). Forms submitted between 1 April 2007 and 8th February 2008 were analysed.

8. Over a two-week period in November 2007 all FNP staff kept a detailed diary of their activities throughout the day.

4. Conclusions

The teams are situated in diverse locations, reflecting a mix of urban and rural areas and both large cities and small or medium sized towns but all with substantial disadvantaged populations. Some have larger teams of Family Nurses than others, and their situations vary, occupying either NHS space or placed in Children's Centres. All these variations in the nature of the areas, the teams and their management will be highlighted in the subsequent chapters.

The teams contained experienced, well qualified nurses, most of whom had worked extensively with disadvantaged populations and had done a great deal of home visiting and other community-based work. Thus they were well placed to be the first in England to be trained and then to offer the NFP programme.

The evaluation was a mix of qualitative semi-structured interviews with all those involved in offering the FNP, a selection of those receiving the FNP and a range of stakeholders from each of the sites. In addition a large amount of quantitative information collected by the Family Nurses as they trained for and provided the programme was also analysed.

Chapter 3 - Can the FNP be implemented with fidelity in England?

The NFP (known in England as the Family Nurse Partnership; FNP) is a programme that can only be used under license. The USA National Service Office in Colorado state that “The *NFP Visit Guidelines* specify the structure of the home visit and content to be covered. The USA guidance regarding fidelity has been developed on the basis of the three RCTs and subsequent monitoring of work in the USA, where the programme is being offered in 23 states. Adherence to this structure, content and process is essential to achieving fidelity to the model” (<http://www.nursefamilypartnership.org/>).

There are a number of fidelity measures to monitor progress and, if necessary, allow the programme to be adjusted when it is used in new settings. There are also a number of fidelity targets, designed to promote performance. Collectively, the fidelity measures and targets cover recruitment, attrition, delivery of the programme and outcomes. This chapter gives details of the fidelity that can be ascertained during the first year of implementing NFP in England, for the pregnancy phase (some of the objectives refer to the infancy and toddlerhood phases or to completion of the full NFP programme at 24 months). Outcome objectives are discussed in Chapter 10. The 10 English FNP pilot sites started recruiting clients in April 2007, though in most of the sites their main recruitment did not start until May, and the deadline for data reported here was February 8th 2008, reflecting the first 10 months of operation. It must also be noted that these data reflect the first stage of attaining fidelity during a time when the programme was new to all the staff concerned and they were involved in a rapid set-up process.

1. Fidelity in recruiting clients

The NFP programme is designed to be offered to first-time mothers, thought to be the most receptive to this kind of intervention. It is also a programme that involves substantial input during pregnancy. The USA National Service Office has determined, based on the USA research evidence and on ongoing USA practice, that maximum impact can be obtained if clients are enrolled early. To be acceptable, particularly in the English context where it will be part of a service for all children and families based on ‘progressive universalism’ (support for all, but those in greatest need get the greatest support’; Billingham, 2007; HM Treasury 2007a) it is important that most of those who are offered the service, after being deemed suitable, actually take up the offer. The USA team has also determined the most efficient case-load for a nurse working on this programme. Thus a number of objectives have been developed relating to recruitment.

Recruitment objectives:

- **75% of eligible referrals are enrolled in the programme;**
- **100% of enrolled women are first-time mothers;**
- **60% of pregnant women are enrolled by 16 weeks gestation or earlier; and**
- **A caseload of 25 for all full-time nurses within 8-9 months of programme operation.**

Determining eligibility

The first objective mentions 'eligible referrals'. The expectation prior to the beginning of the implementation evaluation study was that there would be two potential stages in identifying women who were eligible to be offered FNP. It was hoped that the total potentially eligible population could be identified by midwives at the time that booking-in of the pregnancy took place. Then the number referred and subsequently enrolled could be compared with the total eligible population. It would also enable those who were not interested in the service to be interviewed about their reasons. At booking-in of a new pregnancy, midwives in all sites would be asked to summarise for the FNP team a limited amount of information about each first-time pregnant woman below the age of 20: name, address with postcode, date of birth, expected date of delivery (EDD), home phone, and mobile number. The midwife would then complete with the young woman a 'Booking Consent Form' indicating one of four options:

- Willing to meet the Family Nurse to hear more about FNP;
- Not willing to meet the Family Nurse but willing for background information to be shared and also willing to be interviewed by the evaluation team about their views on services;
- Not willing to meet the Family Nurse but willing to answer some screening questions and have this information shared with the evaluation; or
- Not willing to collaborate in any way.

In addition, in sites where women aged 20 to 23 were being recruited, a short interview would be conducted by the midwife, recorded on an 'Information summary form' designed by Professor Sir David Hall (Hall & Hall, 2007), to determine their level of education, employment status, partner status, mental state and housing. If these two procedures had been conducted then it would have been possible to know what proportion of *all* eligible women were recruited to receive FNP and also to interview a substantial number of those who decided not to receive FNP. However this did not occur. While the majority of referrals did come from the community midwife (67%) or the hospital booking clinic (16%), some came from other sources (e.g. health visitor, Connexions, teen pregnancy service, directly from the hospital system at the time of scans). Thus it was not possible to gain any preliminary consent at the referral stage.

In consequence a more limited set of information is available about the referral process and take-up based on:

- An estimate of the number of eligible pregnant women under 20 in the area, derived from ONS and HES data;
- The number of names that were passed to the FNP team (total referred);
- The number referred who were identified as definitely *not* eligible;
- The number referred that were approached directly and told about FNP; and
- The proportion of those approached who agreed to the programme; and
- The short time-frame for recruitment.

Rate of take-up

The first fidelity objective was achieved. Of those definitely eligible (referred and in contact with FNP so that details such as whether they were first-time parents could be confirmed), 87% were enrolled in the programme (see Table 3.1) with a range across sites of 78% to 94%. The rate was slightly higher for under-20 year olds (88%, range 78% to 95%; see Table 3.2) than those aged 20 to 23 (81%, range 56% to 91%).

The capacity in each site was, nevertheless, not sufficient to be able to contact all those who were referred. Thus a substantial number were never contacted, some were not recruited due to language differences. Delays related to location of suitable interpreters and to the advice from the USA that it might not be effective to offer the programme through an interpreter. The central team decided that the number of families who required an interpreter should be restricted. Other referrals were not recruited because the number that could be managed for that month was complete, or the Family Nurses had their total caseload.

Table 3.1: Referrals and their disposition in total and by age group

	Total	Under 20 years³	20 – 23 years
Total number of referrals	3363	2196	1116
<i>Dispositions</i>	N (% of total)	N (% of total)	N (% of total)
1. None given	158 (5)	126 (6)	24 (1)
2. Unable to locate	230 (7)	126 (6)	96 (9)
3. Not eligible - wrong geographical area	213 (6)	111 (5)	98 (9)
4. Not eligible - >28 weeks pregnant	179 (5)	130 (6)	47 (4)
5. Not eligible - miscarried/fetal death	114 (3)	94 (4)	19 (2)
6. Not eligible - employment/qualifications	214 (6)	11	202 (18)
7. Not eligible - adoption planned	1	1	0
8. Not eligible - multiple problems	1	1	0
9. Not eligible - other, no details	481 (14)	146 (7)	332 (30)
10. Not recruited - Language issues	39 (1)	27 (1)	12 (1)
11. Not recruited - Monthly quota full	262 (8)	196 (9)	65 (6)
12. Not recruited - Programme full	66 (2)	25 (1)	16 (1)
13. Refused participation	188 (6)	148 (7)	38 (3)
14. Enrolled	1217 (36)	1054 (48)	167 (15)
Total possibly eligible ⁴	2160 (64)	1702 (77)	454 (41)
Enrolled as percent of possibly eligible	56%	62%	40%
Total definitely eligible ⁵	1405 (42)	1201 (55)	205 (18)
Enrolled as percent of definitely eligible	87%	88%	81%

The majority of referrals that were not enrolled due to the programme being full for the month (226/262, 86%) were in two sites (2 and 3) where it can be seen from Table 3.2 that the number of referrals of women under 20 far exceeded the prediction based on existing data. In addition Site 2 was also recruiting women aged 20 to 23. Since this decision was made when it was thought that there would not be sufficient under-20 first-time mothers presumably the local information was also inaccurate at the time that the bid was made.

Out of all those referred, just over half (55%) of the under 20s were found to be definitely eligible (see Tables 3.1 and 3.2) while only 18% of the 20-23 year olds were found to be definitely eligible. The total number enrolled represents just over half of those who may have been eligible (62% of under 20s, 40% of 20 to 23 year olds; see Table 3.1).

The low number of 20 to 23 year olds enrolled in comparison with the number of referrals reflects to a certain extent the additional eligibility requirements beyond this being their first child. Many did have employment, educational qualifications or a

³ Numbers broken down by age are not equal to the total, age not given for 51 referrals.

⁴ Total possibly eligible calculated as: total referrals minus not eligible (all reasons).

⁵ Total definitely eligible calculated as: total referrals minus: not eligible (all reasons); language issues; monthly quota full; programme full; unable to locate; no disposition given.

supportive partner. It also reflects the larger number of pregnancies to this age group and it is possible that many of the remaining referrals were eligible. If the FNP team could not make contact with them it was usually impossible to determine their eligibility on the basis of the information provided by the referral source.

Comparison of the estimated number of births based on ONS figures for 2006 and the actual number of referrals of under 20 year olds expecting their first child indicate that in many cases the number of referrals is greater than the estimate, suggesting that the recruitment method was effective. Only in two sites were the numbers of names received substantially lower than the predicted number. However, several of the sites did experience difficulties in gaining the involvement of local midwives and in some it was necessary for extended negotiations to take place before a good referral system could be implemented. This is discussed in more detail in Chapter 6.

Table 3.2: Referrals and enrolment of under-20 year olds in relation to eligible births per site

Site ⁶	Estimated number first time births to < 20s ⁷	Referrals to FNP Under 20s	% of ONS estimated number of total eligible births	Definitely eligible referrals < 20s ⁸	% of total referrals	< 20s Enrolled in FNP	% of Definitely eligible referrals
1	189	119	63%	104	87%	91	87%
2	185	222	120%	119	54%	107	90%
3	402	452	112%	227	50%	187	82%
4	419	230	55%	159	69%	139	87%
5	147	144	98%	75	52%	67	89%
6	233	184	79%	100	54%	91	91%
7	149	114	77%	79	69%	75	94%
8	150	279	186%	106	37%	99	93%
9	137	156	114%	99	63%	93	94%
10	252	293	116%	134	46%	105	78%
All	2263	2192	97%	1202	55%	1054	88%

Reasons for ineligibility for recruitment

At the start of the year the reasons for ineligibility were not given in detail, so it is not possible to tell why 14% of the referrals were not eligible (see Table 3.1). Where a reason for not attempting to recruit was given the most frequent was that the programme was full (8%), or that it was not possible to locate the referred young woman and talk to her (7%). The fact that it was not possible to locate 7% of the referrals relates partly to the paucity of information provided to the FNP teams by

⁶ The site numbers used in this and subsequent tables do not reflect the order in which the sites are described in Annex 1.

⁷ ONS 2006 data on births broken down by age and HES data indicating the percentage of births that are to first time mothers were combined to create estimates of first time births to women under 20 in each PCT. These annual figures were then reduced to represent births in an 8-month period. Thus the figures are liable to error and are only an indication of the total eligible population. They are also liable to error in the sites where the recruitment area does not represent the entire PCT.

⁸ Total definitely eligible referrals calculated as (total enrolled + total refused).

referring midwives or hospitals and to the mobility of this age group. Generally if no mobile telephone number was available it was very difficult for contact to be made. It is important to note that a substantial proportion (5% overall) were past the stage at which it is considered appropriate to start FNP (28 weeks gestation) suggesting that there were some late bookings and also that in some cases information may not have been transferred to the FNP teams in a timely manner. It is known that women are often late in booking in their pregnancy. For instance analysis of the Hospital Episode Statistics by the Department of Health found that 16% book their first appointment after 20 weeks and 4.8% after 36 weeks.⁹ A more efficient system may in some cases have enabled them to receive the support that they may have needed.

Almost one in five (18%) of the 20 to 23s were ineligible due to their level of educational qualifications or being in employment. If this kind of information were collected in booking clinics it would make the identification of mothers-to-be to be offered FNP in this age group more efficient. Details were not provided for almost a third of the 20 to 23 year olds deemed ineligible. In some cases it is likely that this option was selected when the young woman had a supportive partner since no specific option on the form was given for that reason, an amendment that would be useful for future FNP teams to consider.

Reasons for refusal

Most who declined to be told about the FNP were not asked to give consent for research contact, but it was possible to interview a small number (21) of those initially agreed to the support but who had subsequently stopped receiving FNP. Typically, those who left after one or two visits indicated that they were not sure why they had been selected but that they were well supported by their family and the family of the baby's father replying with comments such as *"I just did not think it was for me, I have support from my family and friends."* Some were also wary about being involved with a service for such a long time. For example one 18 year old, who lived with her mother in good housing replied that the family were all pleased about the pregnancy and that her health was good. Her boyfriend lived nearby with his family. When the Family Nurse telephoned her she said that the FN seemed nice but that she did not want *"anyone butting in for such a long period of time."*

The second objective, recruiting all first time mothers, was achieved. None of the clients had a child. For the majority (78%) it was also their first pregnancy, and for most of the remainder it was their second pregnancy (16%) or their third (4%). A small number had been pregnant three or four times, one client reported five previous pregnancies and one reported six.

The third objective, recruiting at least 60% of clients by the 16th week of gestation, and all by the 28th week, was close to being achieved. The overall proportion of clients who were recruited by the 16th week of gestation was 51% (565/1116; missing information for 101), with four sites achieving the target and a range between sites from 28% to 73% (see Table 3.3). The rate was the same for the two age groups (under 20 486/962, 51%; 20 to 23 79/154, 51%). Six clients were recruited after 28 weeks.

⁹ Maternity Matters: Choice, access and continuity of care in a safe service. DH-073576. www.dh.gov.uk [accessed online 18.04.08]

The average gestational age at recruitment was 17.5 weeks (minimum 3 weeks, maximum 31 weeks), with means ranging between sites from 13.8 to 20.5 weeks (see Table 3.3). It can be seen in Table 3.3 that the earliest week of gestation for any recruitment varied from 3 to 10 weeks, suggesting that in some sites the process of receiving names from midwives was slower than in others (this is discussed more in Chapter 6).

Table 3.3: Mean weeks gestation at enrolment and numbers enrolled by 16 weeks (percentages in brackets)

Site	N	Mean weeks gestation	Enrolled by 16 weeks	Range
1	89	13.8	65(73)	3-27
2	108	16.0	72 (67)	5-28
3	184	16.0	118 (64)	6-29
4	119	19.7	39 (33)	10-31
5	109	17.8	53(49)	8-29
6	74	16.7	44 (60)	5-28
7	101	17.8	55 (55)	9-28
8	113	20.5	32(28)	6-28
9	112	19.1	37 (33)	11-29
10	107	17.5	50 (47)	9-28
All	1116	17.5	565 (51)	3-31

Family Nurse case-load

The fourth objective was close to being achieved. Not all the Family Nurses are full time so the expected number to allocate is 15 (3 days per week), 20 (4 days per week) or 25 (full time). All four of the three-day-per-week Family Nurses had been allocated at least 15 clients (range 15 to 19), six of the nine four-day-per-week FNs had been allocated at least 20 clients (range 16 to 25), and 24 of the 34 full-time FNs had been allocated at least 25 clients (range 19 to 32). However the total allocation includes clients who have left so the number of current clients is a better indication of fidelity (see Table 3.4). Overall, with the attrition of 212 clients, the majority of the Family Nurses had at the end of February 2008 (10 months after the start) caseloads that are smaller than the fidelity objective. However, in some sites, this may be because decisions regarding on-going recruitment had not been made.

Table 3.4: Number of current clients per Family Nurse

	N	Mean number of clients	Range	Target	Number at or Above target
Full time	34	21.5	19 to 26	25	3
4 days	9	17.6	14 to 22	20	3
3 days	4	13.8	13 to 14	15	0

2. Fidelity in retaining clients

There are four fidelity objectives for limiting the proportion of clients who leave the programme before their child is 24 months old, the time that the FNP support is designed to finish, but in the current study only attrition during pregnancy can be evaluated (others refer to later phases and to the entire programme). The target is **attrition of 10% or less for pregnancy phase.**

The USA National Service Office note, however, that attrition rates may exceed the target objectives defined above when Family Nurses are first learning the programme model. They further report that in the USA there has been considerable variability among sites, with an average of 15% attrition during pregnancy.

The attrition objective was not achieved. The overall attrition rate during pregnancy in England was above the target at 15.8 % (see Table 3.5) with only one site attaining the objective of 10% or less with a range across sites of 8% to 24%. However two of the reasons for leaving the programme ('miscarriage/fetal death' and 'moved out of the area'; see Table 3.6)) relate to the client no longer being eligible for FNP rather than their reaction to the programme so could be considered separately, although they are obviously relevant for commissioners if it is known that an area has, for instance, a particularly mobile population. These two reasons account for more than one quarter (28%) of all attrition. Removing those two categories from the calculations, overall attrition is 11.3%, with a range across sites from 4% to 19% and half the sites below 10% (see Table 3.5). Attrition rates during pregnancy did not differ substantially when comparing the younger and older clients (see Table 3.6).

Table 3.5: Attrition during pregnancy per site (percentages in brackets)

Site	Total enrolled	Left FNP	Miscarriage / foetal death	Moved	Left minus miscarriage & moving
1	117	18 (15)	3	4	11 (9)
2	109	12 (11)	0	2	10 (9)
3	192	46 (24)	3	7	36 (19)
4	144	21 (15)	1	1	19 (13)
5	111	15 (14)	3	6	6 (5)
6	101	19 (19)	0	5	14 (14)
7	101	12 (12)	1	3	8 (8)
8	120	10 (8)	2	3	5 (4)
9	113	16 (14)	1	3	12 (11)
10	109	23 (21)	1	5	17 (16)
All	1217	192 (16)	15	39	138 (11)

Table 3.6: Reasons for leaving FNP in pregnancy in total and by age group (percentages in brackets)

Reason for leaving the programme	All enrolled N=1217	<20 years N=1054	20-23 years N=163
Moved out of service area	39 (3.2)	31 (3.0)	8 (4.9)
Miscarried/fetal death	15 (1.2)	1(1.0)	4 (2.4)
Clients needs satisfied	26(2.1)	25 (2.4)	1 (0.6)
Excessive missed appointments	25 (2.1)	22 (2.1)	3 (1.8)
Unable to locate	16 (1.3)	14 (1.3)	2 (1.2)
Pressure from family members	11 (0.9)	11 (1.0)	0
Client dissatisfied with programme	7 (0.6)	6 (0.6)	1 (0.6)
Returned to work or school	6 (0.5)	4 (0.4)	2 (1.2)
Services from another programme	3 (0.2)	2 (0.2)	1 (0.6)
Refused new Family Nurse	3 (0.2)	3 (0.3)	0
Other reasons, miscellaneous	41 (3.4)	35 (3.3)	6 (3.7)
Total	192 (15.6)	164 (15.6)	28 (17.2)

3. Fidelity in delivery of the programme

Each time a visit is made the FN completes a 'Home Visit Encounter Form' which includes not only the date, time and length of the visit but also the reaction of the client and any other individuals present to the materials, the types of topic covered (from specified domains, as described in the next section), and any referrals made to other agencies.

The expected number of visits during pregnancy is weekly for the first four weeks and then every fortnight until the infant's birth. There are materials for 14 separate visits, which would be possible if recruitment took place at 16 weeks and the birth was not early. The objective for pregnancy is set at 80% of expected visits. Lower percentages are set for infancy (65%) and for the toddler phase (60%) recognising that the intense involvement with FNP may be reduced once the anxiety of the pregnancy phase is complete, and that mothers with young children may be out and about visiting or may take up employment or education so be less easy to reach. The infancy and toddler phases are not reported on here. There is also a guideline for the expected length of visits, a time that should be sufficient to enable all the materials to be covered.

The guidelines for conducting visits cover a wealth of topics and these are grouped under five headings reflecting the aims of the programme, as shown above (a different balance of percentages is required for infancy and toddlerhood). During pregnancy more than a third of the time is expected to be taken up with the mother's personal health, so that she can be prepared to give birth to a healthy infant. A quarter of the time is expected to be spent on discussing the maternal role so that she can work through expectations, worries and concerns, and change her self-perception to include the new role of being a parent. Smaller proportions of the time are spent on activities designed to help her think about her life course (e.g. thinking about education in the

future); on family and friends (e.g. thinking about relationships, any possible conflict about methods of childrearing, who might support them); and on environmental health (e.g. home safety, housing conditions). After each visit the FN estimates what proportion of time she spent in that visit on each of the domains and these have been totalled, for all visits during pregnancy in all sites.

Programme delivery targets:

- Percentage of expected visits completed is 80% or greater for the pregnancy phase;
- On average, length of home visits with participants is ≥ 60 minutes; and
- Content of home visits reflects variation in developmental needs of participants across programme phases: Average time devoted to content domains during pregnancy is as follows:
 - Personal Health 35-40%;
 - Maternal Role 23-25%;
 - Life Course Development 10-15%;
 - Family and Friends 10-15%;
 - Environmental Health 5-7%.

The 'dosage' target of 80% or more was not achieved. Attainment of the expected visits is based on the number of weeks of enrolment rather than whether or not 14 visits took place for each client, so that the Family Nurses would not be penalised in their fidelity with clients who were recruited later than 16 weeks (almost half the clients enrolled). The calculations include those who have left the programme during pregnancy. Despite taking date of enrolment into account, this target proved to be a challenge for most of the sites and overall the percent of clients receiving 80% or more of their expected visits during pregnancy was 21%, with values for each site ranging from 10% up to 31% (see Table 3.7). The average number of visits during pregnancy was 6.2, the average expected was 12.1 and the average proportion of expected visits received was 52.9% (range 41.3% to 62.2%). Some clients had not received any visits in pregnancy. This may be because they are newly enrolled, so one or two visits may have been completed but the documentation had not yet been processed by the local administrator and submitted to the central database. Alternatively they may have been elusive following enrolment, but their Family Nurse was reluctant to consider that they should be identified as someone who had left the programme, if they had appeared initially enthusiastic about the FNP support, or they may have left or moved away but this information had not yet been given to the FNP team. Family Nurses are also able to record situations when they go to a visit but the client is not home. The average number of attempted visits was just under 1 overall (range 0 to 10) and the average per site ranged from 0.4 attempts per client to 1.2 (see Table 3.7).

Table 3.7: Completed and attempted visits during pregnancy (percentages in brackets)

Site	N	Mean visits	Range visits	Mean expected visits	Mean % of expected visits	80% + expected visits	Mean visit attempts	Range attempts
1	117	5.8	0 - 17	13.7	47.8	22 (19)	0.4	0 - 5
2	109	7.5	0 - 21	12.3	62.2	31(28)	1.2	0 - 8
3	192	8.1	0 - 17	13.6	61.3	60 (31)	0.7	0 - 9
4	144	5.4	0 - 15	11.8	48.4	22 (15)	1.0	0 - 7
5	111	6.7	0 - 14	11.8	58.7	29 (26)	1.1	0 -10
6	101	6.6	0 - 14	12.6	53.9	17 (17)	1.1	0 - 7
7	101	6.5	0 - 17	12.4	53.0	17 (17)	1.2	0 - 6
8	120	4.4	0 - 15	9.8	47.1	18 (15)	0.8	0 - 5
9	113	5.4	0 - 12	10.8	51.7	25 (22)	0.6	0 - 4
10	109	4.6	0 - 14	11.6	41.3	11 (10)	1.1	0 - 5
All	1217	6.2	0 - 21	12.1	52.9	252 (21)	0.9	0 - 10

Table 3.8: Completed and attempted visits for those whose pregnancy is complete, based on EDD at intake or infant birth form (percentages in brackets)

Site	N	Mean visits	Range visits	Mean expected visits	Mean % of expected visits	80% + expected visits	Mean visit attempts	Range attempts
1	32	8.1	1 - 15	11.5	73.4	13 (41)	0.4	0 - 3
2	65	8.4	0- 21	11.8	71.9	28 (43)	1.2	0 - 7
3	103	9.0	0 - 17	12.9	71.9	53 (52)	0.7	0 - 9
4	77	6.6	0 - 15	10.7	62.6	21 (27)	1.2	0 - 7
5	64	7.9	1 - 14	10.8	74.0	28 (44)	1.2	0 - 4
6	63	7.3	0 - 14	11.9	61.8	15 (24)	1.2	0 - 7
7	64	6.5	0 - 17	11.5	58.1	13 (20)	1.3	0 - 6
8	69	5.2	0 - 15	8.3	59.7	16 (23)	0.6	0 - 4
9	62	6.8	0 - 12	10.1	68.7	24 (39)	0.6	0 - 4
10	55	6.0	1 - 14	11.0	55.5	11 (20)	1.1	0 - 5
All	654	7.2	0 - 21	11.1	65.8	222 (34)	1.0	0 - 9

A second set of analyses was done including only those clients who had completed their pregnancy, based either on their expected delivery date (EDD) at recruitment or on the infant birth form (N = 654). Their average number of visits completed during pregnancy again falls short of the target with a mean of 7.2 (mean expected 11.1) but their average percentage of expected visits completed is slightly higher at 65.5%, with a range between sites from 55.5% to 74.0% and a slightly higher proportion (34%) had received 80% or more of the expected visits (see Table 3.8). They had a similar number of attempted visits as the whole group (mean 1.0, range 0 to 9).

The required length of visit was achieved. A substantial amount of material is provided for each visit and it is expected that FNs will generally stay for at least one hour. This target was met overall, with the average length of all visits per client being 73 minutes (see Table 3.9) and was achieved in each of the 10 sites with averages ranging from 62 to 82 minutes. Out of the 1142 clients (four of whom only had infancy visits), 151 (13%) had an average visit length that was below 60 minutes. There was however a wide range across the sites, from 1% to 29% of clients.

Table 3.9: Average length of visit in pregnancy and early infancy (minutes), and clients with average visit length below 60 minutes (percentages in brackets)

Site	N	Average Pregnancy	< 60 minutes pregnancy	Average early infancy	< 60 minutes early infancy	Average all visits	<60 minutes all visits
1	102	62	28 (28)	63	8/31 (26)	62	30 (29)
2	108	74	7 (7)	75	5/59 (9)	73	7 (7)
3	188	66	53 (28)	69	15/80 (19)	66	55 (29)
4	136	78	11 (8)	74	8/67 (12)	77	13 (10)
5	106	73	13 (12)	72	8/54 (15)	72	15 (14)
6	98	79	1 (1)	76	3/56 (5)	78	1 (1)
7	97	79	11 (11)	79	7/52 (13)	79	12 (12)
8	110	73	8 (7)	72	4/57 (7)	72	9 (8)
9	99	78	7 (7)	85	7/52 (14)	79	6 (6)
10	94	81	3 (3)	84	1/39 (3)	82	3 (3)
All	1138¹⁰	74	142 (13)	75	66/547 (12)	73	151 (13)

The figures are also broken down so that visits during pregnancy can be examined separately from infancy. The average visit length during pregnancy was 74 minutes and the proportion of clients who did not have an average visit length of over 60 minutes was similar to the total (13%, 142/1138) ranging between sites from 1% to 28%. The average visit length was maintained for the smaller number of clients (547) who have received visits following their child's birth at 75 minutes, with only 12% (66) having an average below 60 minutes, ranging between sites from 3% to 26%.

Coverage of the domains was close to the fidelity target. The overall average time spent on 'Personal Health' during visits was at the recommended level (35-40%) at 36% and this was achieved in five sites with other sites mainly lower (4) (see Table 3.10). The overall mean for 'Maternal Role' was also within the recommended range (23-25%) at 25% with six sites attaining this target, three marginally over and one site just below the range. Nine of the ten sites attained the recommended percentage of time spent for 'Life Course' and the average for all sites was within the boundaries (10-15%) at 11%. With an average just above (16%) only two sites were within the

¹⁰ 75 of the 1217 enrolled clients had not yet had a visit and 4 had received visits in infancy but not pregnancy.

recommended range (10-15%) for 'Family and Friends', all other sites spending more than 15% of time on this domain. Similarly FNs in all sites spent on average more than the recommended time on 'Environmental Health' (5-7%) with an overall average twice the recommended level at 13% and a range from 10% to 15%.

Table 3.10: Average percentage of time spent on the five programme domains in pregnancy by site (target percentage in brackets)

Site	Personal Health (35-40)	Maternal Role (23-25)	Life Course (10-15)	Family and Friends (10-15)	Environmental Health (5-7)
1	40	23	10	17	11
2	30	28	12	17	13
3	33	23	13	16	15
4	36	24	11	15	14
5	40	26	10	14	10
6	35	24	10	17	13
7	34	22	11	18	14
8	31	27	13	16	14
9	36	25	11	17	12
10	41	24	9	16	11
All	36	25	11	16	13

Data completeness

In addition to the 'Home Visit Encounter' forms, completed after each visit or attempted visit, there are a number of other forms integral to the provision of the FNP programme. These cover a range of topics, including basic demographic information about clients and also documenting health related behaviour and relationships over time. Much of the information that follows in this report depends on these forms, thus it is important to know about their completeness. In some cases parts of forms have not been completed (e.g. information about household income) and in other cases entire forms are missing (e.g. relationship assessment).

As well as being important in the interpretation of the following chapters, completion of the forms represents another aspect of fidelity. The guidance manual for completing the forms notes that: *"In addition to maintaining records about the services provided, the Family Nurse collects information from clients that helps to describe risk characteristics of those served and their progress toward programme goals."* Family Nurses are encouraged to use them like research instruments, following the exact wording as much as possible so that the information is consistent, though it is acknowledged that some clients with literacy problems may need additional explanation of some of the questions. No specific target is set since the basic requirement is that all forms should be completed for all clients.

The first set of forms is intended to be completed over the first three of four home visits, to gain details about maternal health (during visit 1), their demographic characteristics (during visit 2), their use of cigarettes, alcohol and other drugs ('Health Habits at Intake', during visit 3 or 4), and any history of abusive relationships ('Relationships at Intake', during visit 3 or 4). The latter two forms are repeated towards the end of pregnancy (at 36 weeks) in order to document any change. By introducing these potentially sensitive topics (e.g. use of illicit drugs, history of abuse) with structured instruments it is hoped that clients will feel that they are not being judged in any way; FNs can introduce the questionnaire by saying "we ask everybody

about this.” If birth takes place prematurely then the Family Nurses are encouraged to collect the 36-week information as soon as possible after the birth, making sure that they introduce the questions so that the answers relate to pregnancy. For instance some women give up smoking during pregnancy but start after the birth. If the questions are asked at that time then some positive outcomes such as reduction of smoking during pregnancy would be missed.

To determine if any form was overdue a “to be done by date” was calculated based on the client’s first home visit encounter form. Intake forms not done within 6 weeks of the first visits are identified as ‘overdue’. A 4-week buffer zone was used for the forms due at 36 weeks gestation. **Three of the forms due at intake were completed successfully** with overall percentages of 92% (Demographics), 92% (Maternal Health) and 89% (Health Habits). However there was some variability between sites (see Table 3.11). For instance site 3 had completion rates of 100%, 96% and 93% respectively while site 10 had rates of 78%, 83% and 90%. Site 8 had similarly low rates. The rate of completion of the relationships form was lower than for the other forms completed in the first visits (82% overall) but again site 3 Family Nurses completed 96% while only 64% were completed in site 10.

Table 3.11: Forms expected and completed at intake by site (percentages in brackets)

Site	Maternal Health		Demographics		Health Habits		Relationships	
	N	Completed	N	Completed	N	Completed	N	Completed
1	88	72 (82)	88	79 (90)	88	74 (84)	87	74 (85)
2	96	96 (100)	95	91 (96)	95	88 (93)	96	74 (77)
3	142	137 (96)	142	141 (99)	141	134 (95)	141	136 (96)
4	112	100 (89)	111	97 (87)	106	84 (79)	107	73 (68)
5	83	79 (95)	85	82 (96)	82	72 (88)	81	71 (88)
6	80	75 (94)	79	67 (85)	80	76 (95)	80	62 (78)
7	86	84 (98)	86	85 (99)	86	85 (99)	86	84 (98)
8	103	88 (85)	103	90 (87)	100	70 (70)	100	69 (69)
9	86	83 (94)	87	79 (91)	85	81(95)	82	77 (94)
10	80	62 (78)	78	65 (83)	77	69 (90)	77	49 (64)
All	956	876 (92)	954	876 (92)	940	833 (89)	937	769 (82)

Forms due at 36 weeks were completed with less regularity; only three quarters of the expected ‘Health Habits’ forms and even fewer (62%) ‘Relationships’ forms were completed (see Table 3.12). Nevertheless site 3 again had good completion with rates (96%, 92%) suggesting that this aspect of programme performance can be enhanced, possibly with discussion about why certain forms may be challenging - especially those dealing with sensitive topics such as drug use or abusive relationships.

Table 3.12: Forms expected and completed at 36 weeks by site (percentages in brackets)

Site	Health Habits		Relationships	
	N	Completed	N	Completed
1	44	32 (73)	44	29 (66)
2	68	43 (63)	68	45 (66)
3	96	92 (96)	96	88 (92)
4	76	51 (67)	75	33 (44)
5	55	42 (76)	57	34 (60)
6	67	52 (78)	66	39 (59)
7	65	53 (82)	68	61(88)
8	75	40 (53)	71	3 (4)
9	60	54 (90)	59	54 (92)
10	55	39 (71)	54	25 (46)
All	661	498 (75)	658	411 (62)

4. Conclusions

Some fidelity targets have been easier to attain in England than others. While there were complications in many sites in terms of identifying the relevant pregnant women, particularly if those aged 20 to 23 were to be offered the programme, once FNP Family Nurses met with potential clients there was a very high rate of acceptance. This suggests two things. First FNs were confident after their initial training, even though they had not been able to use much of their training in practice at the outset, that they had something really useful to offer and conveyed this effectively to potential clients. Second, young first-time mothers in England were open to the idea of extra help. Both these topics are discussed in more detail in Chapter 4, drawing from open-ended interviews with the Family Nurses and with clients.

Where difficulties have been identified they are reaching prospective clients soon enough. The systems through which the FNP teams needed to collect information about first-time mothers enabled four sites to recruit at least 60% before they reached 16 weeks gestation, but this was not so for the other sites. In one site no one was recruited before 11 weeks and only one third by 16 weeks. The links with the midwifery services were important to this objective and this is discussed in more detail in Chapter 6.

The allotted case-loads of most of the Family Nurses were not at the recommended level after 10 months of operation, which is associated with failure to attain the target for attrition. While the USA team expect that attrition will not be above 10% during pregnancy it was more than twice that in two sites and close to twice that level in a third location. Some of the reasons for leaving were related either to clients moving away (perhaps more likely in England than in the USA) or to miscarriage or termination. However the remainder were related to clients either avoiding contact with their Family Nurse after initial enrolment or to their specifying that they did not need support any longer. Family Nurses' feelings about this loss of clients and their strategies are discussed in detail in the next chapter. Undoubtedly it added to the stress of learning a new role, with all the attendant enthusiasm, to find that some clients then dropped out before really finding out what the programme might be able to do for them.

A small number of those who left were interviewed and their comments are also discussed in Chapter 4. In general they got 'cold feet' about the length of involvement rather than having strong feelings about the content or structure of the programme. In one of the USA trials (Olds et al., 1986) some mothers to be were offered the support just for pregnancy. While this did not result in such substantial outcomes it might be something to consider within the context of progressive universalism. Nevertheless, to deliver with fidelity Family Nurses need to follow quite a detailed curriculum and this may not be to everyone's taste.

The guidelines provided to the 10 pilot sites state "Family Nurses need to deliver the programme as closely as possible to the prescribed model, in terms of method, content and quantity of the programme. Understanding and working within the theoretical and methodological framework of the programme and striving to achieve the optimum 'dosage' of the programme in terms of number and content of the visits are important aspects of fidelity" (Central FNP Team, 2007). The Family Nurses in England spent the recommended time on their visits. Comments in the next chapter reveal their enjoyment at having more time to spend with people than they had in their previous roles. Possibly related to their previous work, however, (most had at some stage in their career been health visitors) the balance of time spent on each of the five domains was not precisely as set out in the NFP model. They tended to focus more on environmental health and extended family and friends than is suggested by the USA National Office. In relation to this fidelity target there was very little variation between the 10 sites indicating that, rather than being related to administrative or logistic issues, this variation may be inherently related to the English workforce and their wide range of experience in home visiting.

Where all the sites did struggle was in attaining the desired 'dosage' by completing at least 80% of the expected visits. The average late gestation at enrolment could influence this if calculations had been based on determining whether clients received 14 visits before their child was born, but in fact the calculations made were based on the time that each client was enrolled, with the expectation that for the first four weeks after enrolment visits would be weekly and after that fortnightly. Calculation of the average number of visits made during pregnancy for those whose pregnancy was complete indicates most of the Family Nurses will have needed to cover the curriculum visit 'package' of 14 visits in less time than is optimal since on average they had made 7.2 visits per client. In all but three sites the maximum number of visits made was greater than 14, suggesting that some clients may be occupying much more of the FNs' time than others, although other clients recruited early and delivering past their due date would also be likely to receive more than this number of visits. Attainment of this target was of course influenced by the fact that many new referrals were received in a short time, all of whom required weekly visits. A more phased method of recruitment in the future may address this issue. Overall, calculating dosage is complex and needs further analysis and interpretation, in particular because of discrepancies around what nurses understand to be and have recorded as home visits. For example, some Family Nurses have recorded visits when they accompanied a client to a service such as an infant immunisation clinic, or to visit the hospital delivery room in preparation for the birth, while others have not.

A minority of clients were frequently not at home when the Family Nurse called, revealed by the numbers of attempted visits and it is reported anecdotally that many clients cancel by text message at the last minute so would not be recorded as visit attempts. However the FN will have made her arrangements and planning and may not easily be able to substitute another client in the time period. The client population in the USA may be less likely to cancel visits given that a home visiting service from a nurse is not likely to be received unless one is receiving this support. Data record

forms used in the UK have subsequently been modified so that last minute client cancellations can be monitored.

In addition to having a structured curriculum there is a substantial amount of record keeping involved with the programme. In most cases the forms that collect important information at intake about maternal health, about any behaviour that may adversely influence her own health or that of her baby, and her demographic background were completed although some teams were more successful than others. There was a shortfall in the forms that documented potentially abusive relationships, which is understandable given the sensitivity of this topic and the fact that some partners were present for most of the visits. Nevertheless, it could have implications for the potential of FNP to prevent such experiences. There was also a shortfall in the forms that recorded any change in health habits such as smoking, alcohol and drug use. The USA evidence indicates that the programme has the potential to reduce smoking so opportunities for documenting success may be being missed if these second forms are not completed. If the young women give birth before their due date it is important for the Family Nurses, who might have thought it was too late once the baby was born, to retrospectively collect the necessary information at the earliest opportunity after the birth. Undoubtedly some forms were also missed because Family Nurses had not been able to complete the expected number of visits - either because the client cancelled or because of competing demands on their time. The issue of workforce capacity is discussed in more detail in Chapter 7.

Chapter 4 - Are the right people reached?

In the USA all the trials examined the impact of NFP with women who had no previous live births, and each focused recruitment on women who were low income, unmarried, and adolescents. The primary change from the first (Elmira) trial, for which any woman bearing a first child was allowed to register, is that the subsequent Memphis and Denver trials focused recruitment more exclusively on those with overlapping risks i.e., being both unmarried and from a low-income family. As described in Chapter 1, the impacts identified in these trials were predominantly found in those women who had several risk factors, such as being low income, unmarried and teenager, or having 'low psychological resources' as indicated by a low score on IQ tests, low self-efficacy and/or the presence of mental health problems.

In the 10 English pilot sites slightly different recruitment criteria were used, based on a report by David Hall commissioned by the Department of Health (Hall & Hall, 2007). When first-time mothers were under the age of 20 no additional risk criteria relating to income, education, employment or their partner were required whereas when first time mothers aged 20 to 23 at conception were recruited some additional criteria were necessary for selection (see Chapter 2 for details). Due to concerns about the availability of income information (Hall & Hall, 2007) these criteria focused on absence of: educational qualifications and employment; qualifications and being in education/training; or a supportive partner. In the first instance five of the 10 sites intended to recruit 20 to 23 year olds, due to lower teenage birth rates and smaller populations (see Chapter 2 for details). Eventually two urban sites changed their criteria to include 20 to 23 year olds due to low numbers of referrals of under 20 year olds and all sites recruited at least a small number in this age group, mainly when young women were close to their 20th birthday at the time of conception and referral but who had reached 20 by the time they were enrolled.

Thus, since for most of the clients the main criterion was simply age, it is useful to determine the extent to which they compare with the USA populations offered the programme, in terms of risk factors such as low income and marital status.

1. Demographic characteristics of the FNP clients

Age

The average age of all clients enrolled was 17.9 with a range in age from 13 up to 24. All sites enrolled at least one client under the age of 16, but the majority (64%) were aged 17 to 19 (see Figure 4.1 and Table 4.1). The average age ranged from 17.2 up to 19.0 between sites.

The rate of refusal was greatest for those 19 or older (see Table 4.1). However pregnant first-time mothers aged 20 to 23 were only offered the FNP if they also had identified risk factors. It has been found in other studies that vulnerable families are less likely to accept support than those with fewer risk factors (Barlow et al., 2005; Barnes et al., 2006).

Figure 4.1: Distribution of ages (years) of clients enrolled in FNP (N=1217)

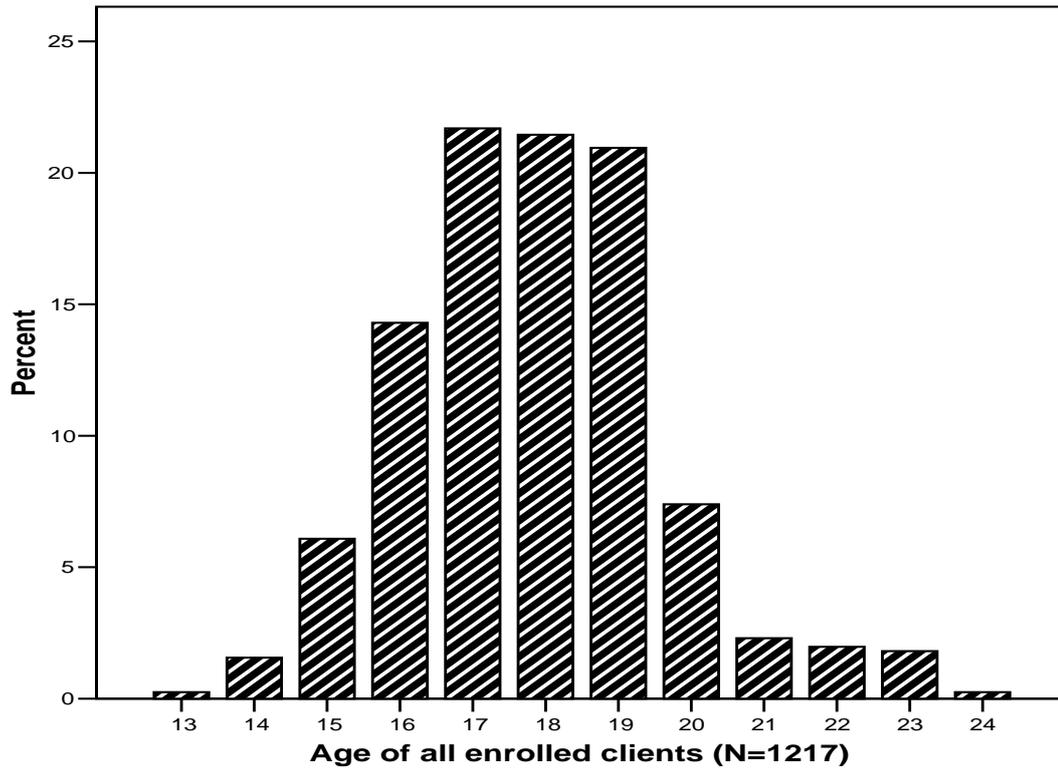


Table 4.1: Enrolled clients and those who refused by age group

Age (years)	Offered FNP (refused + enrolled)	Enrolled (% of total)	% of enrolled clients	Refused (% of total)	% of refusers
13	3	3 (100)	0%	0 (0)	0%
14	20	19 (95)	2%	1 (5)	1%
15	81	74 (91)	6%	7 (9)	4%
16	201	174 (87)	14%	27 (13)	15%
17	287	264 (91)	22%	23 (9)	12%
18	295	261 (88)	21%	34 (12)	18%
19	311	255 (82)	21%	56 (18)	30%
20	109	90 (83)	7%	19 (17)	10%
21	34	28 (82)	2%	6 (18)	3%
22	30	24 (80)	2%	6 (20)	3%
23	26	22 (85)	2%	4 (15)	2%
24	6	3 (50)	0%	3 (50)	2%
Total	1403	1217 (87)		186 (13)	

Ethnic group and language

Demographic forms were received for 994 of the 1217 clients so there is no information about ethnic background for the remainder. The majority (80%) of the clients are white with similar proportions of Black (8%), Asian (6%) and mixed race (5%) backgrounds. These are not distributed evenly across sites however (see Table 4.2). Sites 4 and 8 (both large urban centres) have the largest proportions of black clients while site 9 (also urban) and site 5 (small town) have the largest proportions of Asian clients. In the majority of sites all or nearly all clients had English as their primary language (average overall 92%). However it was markedly lower in sites 9 (67%), 5 (77%) and 8 (87%).

Table 4.2: Ethnic backgrounds of enrolled FNP clients by site (percentages in brackets)

Site	Total Clients	Forms	White	Asian	Black	Chinese	Mixed	Not recorded
1	117	88	87 (99)	0	0	0	0	1
2	109	98	86 (88)	1 (1)	5 (5)	0	6 (6)	0
3	192	172	172 (100)	0	0	0	0	0
4	144	112	84 (75)	0	18 (16)	1 (1)	7 (6)	2
5	111	95	68 (72)	15 (16)	3 (3)	0	7 (7)	2
6	101	78	77 (99)	0	0	0	1 (1)	0
7	101	92	88 (96)	2 (2)	0	1 (1)	0	1
8	120	97	37 (38)	2 (2)	40 (41)	1 (1)	13 (13)	4
9	113	89	32 (36)	38 (43)	7 (8)	0	9 (10)	3
10	109	73	65 (89)	1 (1)	2 (3)	0	5 (7)	0
All	1217	994	796 (80)	59 (6)	75 (8)	3 (0)	48 (5)	13 (1)

Partner / marital status

More than three quarters (78%) of clients reported at the time of their first visit having a partner with only moderate variation between sites (range from 70% to 84%) and similar rates for under 20 year olds and older clients (78% and 80%). Almost the same proportion (75%) indicated that their partner was the biological father of the expected infant (range 66% to 83%) indicating that, for most of those with a partner he was the biological father. Again there was little difference between the under 20s (74%) and the 20 to 23 year olds (77%). A much lower proportion overall lived with their partner or husband (34%), ranging from 25% to 44%. It was more likely that 20 to 23 year olds were living with their partner (41%) than the younger clients (31%). They were asked to indicate who they did live with and the largest proportion (42%) were living with their own mother or their mother and others, but not including their partner (see Table 4.3). This was the case for almost half (44%) of the under 20 year olds but only one quarter (26%) of the 20 to 23 year olds. One quarter of the 20 to 23 year olds and 14% of the younger clients lived with their partner, with no other adults present and a further 18%

of each age group lived with their partner and some other adults. A relatively small proportion (9%) live alone and a minority (7%) were either homeless or in a group home or shelter but this ranged across sites from as low as 2% to as high as 16%. However information subsequently provided by the Family Nurses (see Table 4.7) suggests that many had poor housing even if they were not officially described as homeless.

Table 4.3: Responses to “Who do you live with?” at the first / second visit (percentages in brackets)

Lives with:	Number	Number <20 years	Number 20-23 years
Husband / partner only	152 (15)	120 (14)	32 (25)
Own mother or mother and others, including husband / partner	92 (9)	88 (10)	4 (3)
Husband / partner and others (not including maternal mother)	91 (9)	72 (8)	19 (15)
Own mother or mother and others, not including husband / partner	417 (42)	384 (44)	33 (26)
Other adults (e.g. father, aunt, grandmother, older sibling, friend)	84 (8)	75 (9)	9 (7)
Alone	89 (9)	71 (8)	18 (14)
In a group home / shelter	53 (5)	41 (5)	12 (9)
Homeless	16 (2)	14 (2)	2 (2)
Total	994	865	129

Education, training and employment

The average number of years of school completed was 10.6, with similar values across sites (10.4 to 10.8). The final year in school ranged from year 6 to year 11, with 24% (230) not completing year 11. This suggests that a substantial proportion have dropped out of education prematurely since only 8% of these clients were not yet 16 years old, the usual age for completing year 11. One quarter of the clients were still in school or some kind of training at the time of intake, and this differed depending on the age group with 28% of under-20s still in school or training but only 11% of those aged 20 to 23 (see Table 4.4). In England and Wales on average the rate of completion of level 2 qualification has been increasing, from 49% of those aged 19 in 2004 to 59% of those who will be aged 19 in 2010 (DCSF, 2008).

The average number of GCSE passes was 4.2 (any passes) and 2.3 at Grade C or higher. One in five (197, 20%) had 5 or more GCSE passes at grade C or higher. In England more than 60% of school pupils attained 5 or more GCSE passes at Grade C or higher in 2007¹¹. In each of the sites the averages were similar and in each site the range in the number of GCSEs was considerable, from 0 up to 16. About half (56%) overall had ever been employed, representing 54% of the under-20 year olds and 71% of the 20 to 23 year olds. One in five of the older clients were currently employed full time with a further 10% employed part-time.

¹¹ Jim Knight praises schools for passing GCSE milestone on road to raising standards for all. http://www.dfes.gov.uk/pns/DisplayPN.cgi?pn_id=2007_0194

Table 4.4: Education, training and employment in total and by age group (percentages in brackets)

	All N = 966¹²	<20 N = 844	20-23 N = 122
Completed year 11	736 (76)	630 (60)	106 (89)
Any GCSEs	616 (64)	537 (64)	79 (65)
5 or more GCSEs at C or higher	197 (20)	177 (21)	20 (16)
In school or training	252 (25)	238 (28)	14 (11)
- School	84 (7)	84 (8)	0
- Training	137 (11)	129 (12)	8 (5)
- Access course / university	31 (3)	25 (3)	6 (5)
Ever worked	554 (56)	464 (54)	90 (71)
In work full time	99 (10)	74 (9)	25 (20)
In work, part time	116 (12)	104 (12)	12 (10)
Stopped work, pregnancy	95 (10)	83 (10)	12 (10)

Income

When completing the demographic intake form on the first or second visits clients are asked by the Family Nurse to estimate their total household income, from a list of possible ranges of weekly, monthly or annual income. Unfortunately there is no income information for almost half the clients (570, 47%; see Table 4.5). Some were said not to know (N=320) possibly due to the fact that they lived in households with other family members whose income was not known, and others (250) were not asked. Some FNs considered that it was intrusive to collect this kind of information. It may be useful in the future to give some training in how to help clients estimate their income, and to help them understand how useful this kind of information can be in understanding the impact of the programme (for instance in analysis of who decides to finish the support prematurely or who cancels more appointments).

For those who could provide information it can be seen that the majority (75%) were living at income levels that were below £10,400 per year, which equates to less than £200 per week. Of the 81 with reported household incomes of at least £15,600 per year, only 27 were above £26,000.

Table 4.5: Number and percent of enrolled clients by annual income band (N=647) (percentages are for those with data)

Site	Up to £3,099	£3,100 - £6,199	£6200 - £10,399	£10,400 - £15,599	£15,600 or more	No information
1	30 (39)	10 (13)	16 (21)	9 (12)	12 (16)	40
2	14 (37)	7 (18)	6 (16)	4 (11)	7 (18)	71
3	62 (50)	15 (14)	20 (19)	6 (6)	2 (2)	87
4	46 (52)	11 (13)	15 (17)	9 (10)	7 (8)	88
5	10 (21)	7 (15)	9 (19)	10 (21)	12 (25)	48
6	15 (23)	12 (19)	9 (14)	14 (22)	14 (22)	64
7	23 (32)	11 (16)	13 (18)	10 (14)	14 (20)	30
8	28 (53)	9 (17)	9 (17)	5 (9)	2 (4)	67
9	25 (41)	7 (12)	16 (26)	6 (10)	7 (12)	52
10	15 (36)	9 (21)	11 (26)	3 (7)	4 (10)	67
All	268 (41)	98 (15)	124 (19)	76 (12)	81 (13)	570

¹² Information from Demographics Form at intake, not received for all clients enrolled

2. Other vulnerabilities

A range of information is available about potential sources of vulnerability, from two main sources. First a number of forms are completed during the first few weeks after enrolment to cover: maternal health and well-being; use of cigarettes, alcohol and other drugs; and relationships. Secondly, FNs completed audit forms to describe additional factors such as housing problems, learning difficulties, current involvement with a social worker and a history of being in care.

Physical health problems

On the first visit the 'Maternal health assessment, pregnancy intake' form was completed by Family Nurses, asking clients about a range of possible health problems and about height and weight prior to pregnancy so that their Body Mass Index (BMI) could be calculated. Then two sets of structured questions were asked, to create two scales: 'well-being' (range 5 to 25) and 'mastery' (range 1 to 4). For both these scales a higher score indicates better functioning; thus vulnerability can be extrapolated by the proportion substantially below the mean.

The rates of chronic health problems were moderate apart from asthma, experienced by one in five and mental health problems (unspecified) reported for one in ten (see Table 4.6). In addition to chronic problems, a substantial proportion (212, 21%) had at least one UTI since becoming pregnant and 9% (92) had been diagnosed with at least one chronic vaginal infection since becoming pregnant indicating the importance of early booking so that testing can identify any asymptomatic infections such as Chlamydia.

Table 4.6: Chronic health conditions reported at intake (percentages in brackets)

Health condition	N =991
Asthma	196 (20)
Mental health problem	113 (11)
Chronic urinary tract infections	73 (7)
Chronic vaginal infections	42 (4)
Heart Problems	33 (3)
High blood pressure	31 (3)
Chronic gastrointestinal disease	15 (2)
Diabetes	14 (1)
Kidney disease	14 (1)
Genetic disease, congenital anomaly	11 (1)
Sickle cell disease	10 (1)
Epilepsy	0

The average BMI of clients, based on their reported weight before they became pregnant and reported at the time of their first visit so an approximation, was 22.8 (minimum 14, maximum 55). Nevertheless, fewer than half the enrolled clients (446, 47%) had in fact been within the recommended range of values indicating an appropriate weight for height (BMI 20 to 25). Just under a third had values below (BMI 18 to 19; 197, 20%) or substantially below (BMI <18; 86, 9%) the recommended weight. A slightly smaller proportion had values above (BMI 26 to 30; 138, 14%) or substantially above (BMI >30; 78, 8%) the range of BMIs indicating an appropriate weight (see Table 4.7).

Table 4.7: Vulnerability based on forms completed at intake

Factor	Source	N
Smoked during pregnancy	Health habits, N = 911	410 (45)
Smoked during previous 48 hours		355 (40)
Alcohol use during previous 14 days		126 (14)
Illicit drug use in previous 14 days		25 (3)
In smoking cessation programme	Demographics, N=991	24 (2)
In alcohol abuse programme		26 (3)
Receiving mental health service		60 (6)
Family member receiving mental health service		49 (5)
Lifetime, history of abuse	Relationships, N=838	266 (32)
Physical abuse, previous 12 months		202 (24)
Physical abuse during pregnancy		94 (11)
Sexual abuse, previous 12 months		36 (4)
Afraid of partner / significant adult		105 (13)
Low well-being	Maternal health, N=999	182 (18)
Low mastery		119 (12)
BMI below 20 prior to pregnancy		283 (28)
BMI 26 or above prior to pregnancy		216 (22)

Smoking, alcohol and drugs

At intake two fifths (366/911, 40%) of clients reported smoking at least one cigarette in the previous 48 hours (mean 12.6, range from 1 to 60) with a further 44 (5%) indicating that they had smoked at some time in the pregnancy (see Table 4.7). Only a small proportion of smokers (51, 14%; 4% of the sample) were receiving smoking cessation services. The number reporting any intake of alcohol in the previous 14 days was lower than the rate of smoking (126, 14%). A small proportion (25, 3%) reported using any illicit drugs in the previous 14 days. Their intake was marijuana in all but three cases, two reported using cocaine and marijuana and one reported use of other illicit 'street' drugs. A small proportion (24/991, 2%) was in a smoking cessation programme at the time of recruitment, a similar number were in an alcohol abuse programme (26/991, 2%) and 6 were in a drug abuse programme. To gain more accurate indications of substance use it may be useful to use biochemical testing rather than relying on client reporting to the Family Nurses, which may be influenced by social desirability.

Domestic violence

It must be noted that while demographic information was available for 966 clients, the relationship assessment form was completed for fewer (838/966, 87%). This was in the majority of cases due to the presence of the client's partner and/or other family members, making it inappropriate to ask sensitive questions. When asked about any history of abuse, just under one third (266/838, 32%) reported that they had experienced some emotional or physical abuse during their life. Almost a quarter (202/838, 24%) indicated that they had been physically abused in the last year - 7% (61) three or more times - and 13% (105) reported that they were afraid of a current or previous partner, or of someone else important to them (see Table 4.6). A small number (10, 1%) were currently receiving social services support for domestic violence. Types of physical abuse experienced during the previous year included being slapped or pushed (20%), punched or kicked (16%), burned, bruised or having a bone broken (8%), having a weapon used against them (4%) or receiving a head or internal

injury (3%). A smaller proportion (94, 11%) had been physically abused since becoming pregnant. A small proportion (36, 4%) reported that they had been forced to have sex in the past year, with about one third of these (10) indicating that this had taken place six or more times.

Mental well-being

The 'well-being' score based on responses to five questions indicates the absence of symptoms such as nervousness, being downhearted or down in the dumps. The total possible score is 25 and a low score would therefore suggest the presence of mental health problems. The average score at intake was 17.9, at which time 6% (60/991) reported that they were receiving mental health services and an additional 5% reported that a family member was receiving mental health services (see Table 4.7).

The 'mastery' score indicates confidence about being able to solve problems, control one's life and avoid being 'pushed around' on a scale from 1 to 4. The average was 3.0 (standard deviation 0.5), with some clients (42, 4%) gaining the maximum score. Only a small proportion (119, 12%) had mastery levels that were more than one standard deviation below the mean.

Other factors - FN audit

Family Nurses were asked at about the time that the majority of their clients had been recruited (at the end of 2007) to indicate whether or not each of their clients had mental health problems and they judged that this was the case for 21% (202/955; See Table 4.8). These clients had on average significantly lower mental well-being scores than the remainder (15.7 vs. 18.5, $F_{96.3}$, $p < 0.0001$). Family Nurses also indicated that 8% (80) clients had a learning difficulty or developmental delay.

They reported that 39% (376) of their clients were in poor housing or were homeless; that 13% of clients (126) had been or were still in care; 13% (125) had an assigned social worker; and Common Assessment Framework (CAF) forms had been completed for a small percentage (3%, 27). At that time only about one third of infants had been born (405) and of those 3% (12) had been taken into care.

**Table 4.8: Vulnerability factors according to FN audit information
(N= 960 clients, 405 infants, percentages in brackets)**

	N
Client homeless or in poor housing	376 (39)
Client has mental health problems	202 (21)
Client was / is in care	126 (13)
Client has an assigned social worker	125 (13)
Client has developmental delay / learning difficulty	80 (8)
CAF for completed	27 (3)
Infant born with health problems	38 (9)
Infant taken into care	12 (3)

3. Conclusions

The young mothers described in this chapter have many characteristics that make them potentially vulnerable, either to poor outcomes for themselves or to poor outcomes for their children. The majority of them are becoming parents at a young age, they have low incomes, do not live with their partners and have few educational qualifications or steady employment, all of which make it more likely that they will in the future face social exclusion. In addition, they have many identifiable vulnerabilities including physical health difficulties, mental health problems, experience of domestic violence and homelessness, reflected in the substantial proportion that are being supported by social work services. Thus they appear to reflect the characteristics of the population in the USA that has been shown to benefit most from this programme, those who have low socioeconomic status and who may not have the personal resources to cope effectively, without support, with the challenge of becoming a parent for the first time. Some of the data are less accurate than others, but where there is inaccuracy it will mainly indicate underreporting and thus more vulnerability if more complete data could be collected. For example the reporting of the use of alcohol or other drugs may be influenced by wanting to show the Family Nurses that they were acting appropriately. In addition, there may be an underestimate of domestic violence.

The FNP is being offered non-selectively to under-20s although the context in which it is being offered is selective to some degree in that the sites include substantial areas of high deprivation. But any non-selective system is likely to catch some people whose need may be less than others, whose children may not have poor outcomes. Nevertheless, on the basis of the information in this chapter the majority have substantial need. Also, as a preventive programme, there must be a degree of uncertainty about the actual significance of the need. The whole point of the intervention is to reach these young women and their partners before difficulties develop. That some may have less need is probably a reliable part of offering a non-stigmatising service (discussed in Chapter 5). In addition, FNs have mentioned (see Chapter 5) that they can cope with the caseload better if there is some mix in the clients, some with more need and others with less. To make it a more targeted service - though this may not be the best approach - the teams would need more sensitive screening mechanisms than they currently have available to them.

Chapter 5 - Is the NFP acceptable in England?

“The Government has announced that, over the next Comprehensive Spending Review period, it will invest a further £30 million in the expansion of the Family Nurse Partnership programme and embedding learning from this programme in universal child health services.” (Social Exclusion Task Force, 2008, p. 10.)

The NFP programme is a very specific intervention that has been developed and tested in the United States of America. The results of the testing have brought it international attention, because they have been largely positive, and have been shown to be so when the intervention is applied to differing populations. The context in England differs in demography, diversity, culture and social provision. This chapter looks at the way the introduction of this new approach has been experienced by personnel in ten sites in England who are delivering it, receiving it, observing it or working alongside it. To create a UK slant to the programme it was decided (after due democratic process) to call the programme the Family Nurse Partnership (FNP), and the practitioners chose to call themselves Family Nurses.

1. Acceptable to pregnant young women?

Accepting the service

As reported in Chapter 4, when potential clients were told about the FNP support the vast majority (87%) accepted. Acceptance is likely to be influenced by a number of factors such as the perception of the mother-to-be about why she has been selected for the service, how the service is offered, and the potential implications in terms of a commitment from the client. Previous research has indicated that potential recipients of services may decline if they feel that they are being targeted because of some perceived vulnerability in themselves. As Hall and Hall (2007) report “It would be stigmatising and therefore disastrous for the programme if it were to be perceived as aimed at potentially “bad” mothers. The presentation of the offer must be in positive terms of the services and support involved in the programme” (p. 14). In addition, the most vulnerable may be the most likely to turn down the offer of additional support (Barlow et al., 2005; Barnes et al., 2006)

Why offered and accepted

The great majority of the clients interviewed (a random 10% sample of those receiving FNP support) reported that they had been offered the support because of their age or because it was their first baby - *“Because I am under 20”, “Because I am young and single and needed help”, “Because I am a first-time mum”, “I need support because I am young”*. Some who were aged 20 to 23 understood that they had been referred because of additional problems *“Because I was getting headaches through stress because of my housing problems”*. None reported any negative feelings about being identified on this basis.

Acceptance was sometimes based on gaining extra information, for example one client reported looking up the programme on the Internet so she accepted because *“I knew there was nothing to worry about”*. Others agreed when they heard that the service was being offered only in some areas, with research to see how things went. One client remarked *“I agreed because it gives us more information and might help someone else as it’s research”*. Most saw the potential of the programme in positive ways and their remarks reflected a real need for support - *“Why shouldn’t I [have agreed to FNP]? I accept whatever help I can get in life”, “I was pleased, I needed*

someone to be there for me, to talk to”, “I think it is a good idea, my friend (age 18) had a baby and she never had this kind of help and she struggles to cope now.” It was particularly encouraging for mothers-to-be who felt unsupported, such as this young woman who was living with her own family but her husband was in Bangladesh “I remember, I was really excited because I thought ‘I don’t know anything about it and now somebody is going to come every two weeks or week and she’s going to go through the information that I don’t know’. That really made me happy.”

Having support from family members did not preclude being pleased about the offer of FNP as this 16 year old reported “It was funny because earlier on in the day my Mum and I had been talking about this and we were saying that we did not think I was getting much support as such and that it was just my midwife and that was it. And then the nurse rang up that day. So I was pleased for her to come and visit me.” Another client’s remarks identified the fact that the support families provide may sometimes be coercive, so it was good to have someone else to talk to: “It’s nice to have someone to talk to outside the family; the family are putting pressure on me to do things the way they say.” Similarly, sensitive feelings could be shared with a Family Nurse but not with the family “With Mum it’s different, with [FN], she is not involved emotionally and I can speak to her about anything.”

Some of the young women were more circumspect about the offer of FNP, not sure how it would turn out but willing to try, as indicated by this 18 year old, who had some mental health problems “From what my midwife explained to me, it didn’t sound very much, but I thought I’ll give it a go and I’ll see. If I don’t like it I’ll say so. And from the first visit we just clicked and got along, which I don’t normally”. Another noted, “I didn’t think I needed it but I thought it would be good to try, to see what it was like for a bit”. Some were wary of intrusion and worried that their home would be judged “At first I thought ‘They are going to check up on things, look round your house’, but when she comes it’s completely different”, “I was dead nervous, the house was spotless [for the first visit] but [FN] explained that she does not want the house spotless.” Thus these young pregnant women were open to something new, hoping for additional support and interested in being involved in something new even if some were somewhat cautious initially.

Why continue?

Having agreed to the Family Nurse visits, carrying on past the first couple of visits was influenced to a great extent by clients’ perceptions of the Family Nurses, which were overwhelmingly positive. The most frequently applied adjectives were “Nice”, “Friendly”, “Lovely” “Professional” and most importantly “Easy to talk to”. Many comments were made about the fact that the Family Nurses spent a good amount of time with them, sufficient for them to ask questions and go over information, much of which they had received via midwifery visits, but in a way that they could fully understand. For example one noted “She waits until you are ready for her to go, if I didn’t see [FN] I would be a lot more worried because the midwives don’t really tell you anything.” Another young woman, who had some learning difficulties, as did her partner, noted, “She doesn’t rush us and she makes sure we understand things.” Given the extra time, compared to a visit that they might have with their midwife, and the approachable way that Family Nurses interacted, problems could be raised “There are questions I have asked [FN] that I didn’t have the nerve to ask the Midwife, I felt embarrassed.”

The overall impression was that the Family Nurses interacted with clients in a different way to other professionals, particularly they were not judgemental about their being pregnant: *“I’ve just changed doctors and I think they’re really rude there. Because where I’m young and pregnant they pick at that all the time - they said to me last time that it’s like kids having kids, it made me low and made me feel upset. But (FN) she is a nice person and don’t treat me like a kid - she treats me like everyone else, she don’t treat me like I’m different.”*

“I was expecting someone to come and treat me like I was thick, because of my age, like I didn’t know nothing, but she was quite understanding about it really, you don’t get a lot of people like that. She let me ask the questions.”

“I thought she was going to be really nose-y and look down at me because I’m a teenage mum. But no she was really, really nice. Nothing like I expected her to be. I expected it to be really bad. I get on really well with her.” What is interesting is that this young woman and the others quoted, still accepted the offer of support even though they expected it to be “really bad”. It is unfortunate that other professionals gave them such negative feedback, likely to reduce the chance that they would use preventative services. One healthy 19 year old, who had expected the Family Nurse would say she should not have got pregnant, saw that on her midwifery notes someone had written ‘too young’.

This favourable comparison with other professionals was remarked upon in second interviews, when clients had given birth. From the hospital experience onwards the attitude and approach of FNs was praised in comparison to other professionals. Family Nurses were more likely to work towards the mothers having competence, for example when assistance was needed with the baby *“The midwives in the hospital were like, ‘I’ll do it’ and took him off me and did it for me, where as [FN] will tell you how to do it, instead of undermining you.”* The fact that the Family Nurses were known and familiar was also valued, as described by this mother who had been embarrassed when she burst into tears in front of the midwife, *“Its better that [FN] comes because the midwives from the hospital they just send any old random person. So it’s nice to know the person who is coming.”*

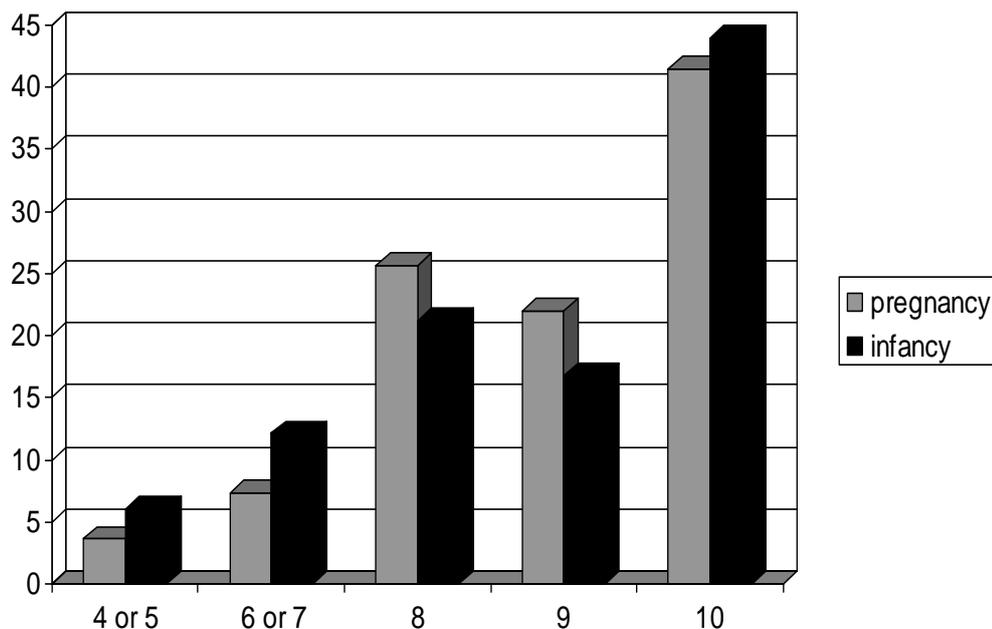
As the relationships with the Family Nurses developed (most clients had been receiving visits for at least two months when they were first interviewed) they were often described as *“more like a friend”, “there for us as people, rather than doing her work”, “she is really friendly, she made us feel comfortable round her rather than on edge.”* Their capacity to hold back was also valued *“She does not force her point of view on me”, “She doesn’t tell me what to do”,* and to admit lack of knowledge, *“If she ever does not know [about a question asked] she says ‘I will find out the answer for you’ and on the next visit she has the answer.”*

Several clients reported that they had been able to discuss issues related to their family with the Family Nurse, sharing confidences that they would not have done with other professionals, such as this mother who had feared her own baby would be taken away because she had been taken into care in her own childhood. *“I talk to the nurse about my mum’s drinking and how she smokes a lot of cannabis, I have been able to talk to her about that. I feel like I can trust her. I can’t really talk to the midwife about my mum and I can do this with the nurse.”*

Although, after their babies were born, they understood that the Family Nurses would also deliver the CHPP, there was a perception that they would not be as judgemental as health visitors, but would instead work out a way for the mother to cope. The strength-based focus of the programme led to mothers feeling that they more able to admit problems. *“I feel more honest with [FN] than I would with a health visitor, if you think you are not doing it right, if you mention it to the Health Visitor she might think, ‘she can’t look after her’, but with [FN] it is, ‘Don’t worry, we will sort it out, or go through this and find ways to get around it’.”*

At the end of their interviews respondents were asked to rate their Family Nurse on a scale from one to 10 with the two end points defined as: 1 = not much of a support and 10 = fantastic, I don’t know how I would cope without her, she is so understanding and helpful. The majority gave very positive ratings, with an average of 8.8 with more than 40% (see Figure 5.1). This was replicated when they were seen several months later, after their baby has been born, when the mean rating was almost unchanged at 8.7. The overall distribution of ratings is very similar at the two time points indicating that the FNs presumably maintained the behaviours that gave them initial acceptance (see Figure 5.1).

Figure 5.1: Client ratings of Family Nurses on a 10-point scale (percentages)



Understanding the extent of FNP

The programme is designed so that it extends for more than two years, from the second and third trimesters of pregnancy until the child is 24 months old. It is also recommended that an average visit should last for at least one hour, much longer than the time usually spent by a home visitor such as a midwife or health visitor. Keeping attrition to a minimum is accentuated in the programme guidelines; the documented differences that the support provides are less likely if the programme is terminated prematurely. Thus it is useful to know whether these young women understand the full implications of what they have agreed to. It might be nice to see a friendly Family Nurse in your home who treats you more appropriately than other medical practitioners, particularly if one is unemployed or not in education so perhaps a bit bored at home [as some of the respondents indicated], but another to realise that she will be visiting

you in your home for another 2 years after the birth, and spending at least an hour each time she visits.

However, when asked about what the programme entailed the majority were able to give a fairly detailed account. For example this young girl was able to give the precise programme details: *“She said she’d be coming round weekly for a month, and then it was fortnightly until the baby is born - then she’ll come every week for a month and then fortnightly again until the baby is two.”* Others were not all that precise but understood that the visits would continue until their child’s second birthday. One noted that the regularity was what enabled her to gain from the programme *“She is so easy to talk to. She has taught me a lot. The midwives are nice but I feel more comfortable with the nurse. I think it is because I see her on a weekly basis.”* The clients were asked about how long their FN usually stayed and their replies reflected the figures reported in Chapter 3, with most saying *“about an hour”* or *“an hour and a half.”* For example, *“The shortest visit has been half an hour and they go up to about an hour. The time she stayed is just right. We have the visits every two weeks.”* Generally there was approval for the length of time spent *“I think it’s great, we need it”*. Some noted that it did not seem a long time because there was always so much to do and to talk about, *“The time seems to go quick, about an hour to an hour and a half, mostly an hour and a half. It doesn’t seem like it is that long, when she is leaving, I’ll look and say ‘where has the time gone?’”*

Are the materials acceptable?

There are several differences between the FNP programme and the other kinds of home visiting that are usually offered in England. In addition to the number of visits and their length, each has a structured curriculum and the FNs have very clear expectations of what they hope to cover at each visit. The detailed documentation helps practitioners to deliver the programme with fidelity, but there is a possibility that the materials will not be acceptable to families in England since they have been developed in the USA. The clients were asked during the interview conducted while they were still pregnant if they could recall the materials that Family Nurses had used in recent visits, and also to indicate which they liked or did not like.

The activities and materials are numerous, but virtually all were recalled by at least some of the clients, including smoking and diet diaries, sheets about exercise, dental care, safe sex, contraception, labour and danger signs. They recalled that breastfeeding was covered, how to talk to their baby in the womb, how to prioritise the things they needed to get for the baby, how to position a sleeping baby, and how their daily activities would change once the baby was born. A number of the ‘facilitators’ used in the programme invite families to explore their own circumstances, histories and feelings with the Family Nurse. Some of these were noted and valued, such as constructing their baby’s family tree. One mother remarked that this had helped her to find out more about her partner’s family as they constructed it together. The FNs gave their clients folders to keep all the handouts and worksheets, and this was valued by many: *“My folder has a load of stuff, I have been reading it, the information is right helpful because I was worrying at first and it has calmed me down.”*

A number of positive comments were made about the fact that information was discussed, not just handed out - as some had experienced when receiving information from midwives. This 18 year old was pleased that there was time spent on discussing the information: *“At first I thought she was just going to give us leaflets with information on, I didn’t realise she was going to go through everything and help us with different things we weren’t sure about, I wasn’t expecting her to be doing stuff like that.”* Others were pleased about the ‘homework’ that they were given because it kept them busy: *“I*

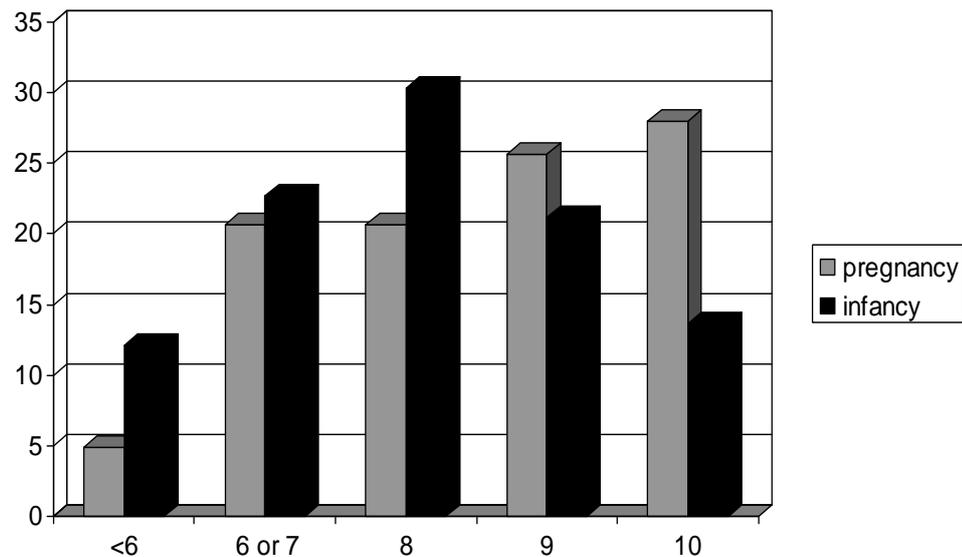
don't mind doing them because it keeps me occupied", "I like them, it gives me time to sit down and do something, half an hour to myself", "It gives me something to do as I am always in the house", "Every week she leaves stuff for me to read, to keep, so it's nice to look back on them and go through them." However others were not so enthusiastic about the sheets that the FNs hoped they would complete or read: *"I don't like the worksheets as I am not good at them, but I have been doing them anyway, I feel a bit obliged", "I hate the paper things, some of them you have to fill out for the whole week and I can't remember the whole week", "Spending time writing things down is a waste of time as you know you are never going to look at it again."*

While the worksheets are valuable the Family Nurses do not expect that all clients will complete them and the most important information exchange takes place during visits. Learning accompanied by models of foetal development (or the 'rubber babies' as one father described them) and pictorial material. It often helped to alleviate anxieties related to childbirth. Dolls were also mentioned in relation to discussion of breastfeeding: *"Some of it was on breast feeding and she brought a doll. She wanted to see if I remembered what position to hold it in and things like that. We went through positioning and the most comfortable ways to hold the baby. So it's been quite good because if you didn't have a doll to practice with it would be difficult. So I'd like to give it [breastfeeding] a go."* The activities that led them to think in different ways were also valued *"You have to think of your special qualities, which is quite hard!"*

Not surprisingly some of the clients expressed the view that they were being told things they already knew. Many had younger siblings, and some had done child care courses at school or college. One remarked *"I would not say I have learned anything, I have lots of children in my family"* and another said *"I never gained anything, not being rude, I already knew the stuff she was talking about. I thought I might benefit after the baby is born."* These and others who made similar comments were continuing, despite their view of the materials though some expressed frustration *"It's getting more and more boring, it's like a story book you have read again and again and she [FN] can't put it down."* Others noted that they would prefer to talk than to do paperwork, *"I won't read the materials, they have just sat in my folder."*

The mixed views about the materials were reflected in the ratings that were made, again on a 10 point scale where the end points were: 1 = not useful, knew most if it or poorly presented and 10 = fantastic, really understandable and have taught me a lot about my pregnancy and how to cope. They were asked to rate the materials during their pregnancy and again in early infancy (see Figure 5.2). While the average ratings of the materials are close to those of the FNs, at each time point the FN rating was higher than the rating of the materials (time 1, 8.8 vs. 8.3, $t=2.87$, $p<0.01$; time 2, 8.7 vs. 7.8, $t=4.54$, $p<0.001$). The comments made showed that the materials would not be so useful without the FN: *"You can't ask a book a question."* The materials were more likely to receive moderately high ratings of 8 or 9 rather than 10, especially in infancy. Thus it appears that, as the programme progressed, views about the materials were getting slightly less positive. The average rating was lower in infancy (pregnancy 8.3; early infancy 7.8).

Figure 5.2: Client ratings of FNP materials on a 10-point scale (percentages)



Overall, however it seems that the majority of clients enjoy the materials that the Family Nurses provided, valuing the information: *“I liked learning about the growth of the foetus and brain development and how the baby learns in the womb”* and appreciated the new ways that they were being encouraged to think about themselves and their families, that they were being challenged *“The one about what I wanted for my baby was hard because I didn’t know, but I did it in the end”*. They also recognise that *“It is not always about foetal development [covered in a college course], it has been about my feelings.”*

Why stop FNP?

As described in Chapter 3, there was in some sites a substantial amount of attrition. To reduce this in the future it is important to understand why clients drop out. It was possible to speak to a small number (20) of the clients who had stopped receiving the support. They had received on average 3.4 visits during pregnancy (range 1 to 16). The main reason for leaving was that they were well supported by their own mothers or their family or that they had seen their family members recently experiencing satisfactory health support (i.e. their mother or sister recently having had a baby and been well supported by the Health Visitor) so did not think that the FNP support added anything for them. Some clients stated that they were already experienced with babies, i.e. changing nappies, bathing through experience with nieces or nephews so did not need to learn more. Some felt that the information they had received was acceptable but that it was more for younger girls: *“I thought it was for younger people, I am 18 but I am quite mature for my age. My Mum is dead supportive anyway and I have family so I felt I did not need help”* and a couple complained about the paperwork. Two also mentioned that they had not at first understood that the visits would go on until their baby was two years old, and felt that was too long. Some also mentioned having difficulty fitting in the visits, one of whom had long-standing support from a range of other agencies, *“It was hard trying to juggle my day to day life, like all the other people who I have to go and see, I have lots of people who come and see me because of my circumstances.”* Others mentioned that they found it a problem to have home visits because of family problems or having to stay in. One had left due to moving out of the area and would have liked to continue if the service had been available elsewhere.

Most mentioned that they liked the Family Nurse and that it had nothing to do with her, *"She was really nice, I really liked her"*, it was the extent of involvement that they did not want. However two did decide to leave after a change of FN which may be particularly unsettling since the programme focuses heavily on forming a close relationship with the client. They found it was not easy to form a relationship with the second Family Nurse, one indicating that she was disappointed that the new FN was not familiar with her details and circumstances.

Other difficulties appeared to be associated with a high level of anxiety in families about being scrutinised. One family indicated that they thought the questions being asked by the FN when she completed some of the data forms indicated that she believed they were doing something wrong. This perception may have been exacerbated by the fact that it was necessary to communicate with them using an interpreter, so the questions may have been phrased awkwardly in the other language.

2. Acceptable to fathers / partners?

The Family Nurses encouraged clients to have their partners present at some or all of their visits, and this took place on about half the visits (described in detail in Chapter 10). Some fathers (30) were interviewed during pregnancy about the process of accepting the programme and their views on what it could offer, for their partners and for themselves. In general they were pleased to be involved, although many did not expect that they would be part of the programme. As one remarked, *"I liked that she wasn't just involving [client], she was involving me as well."* This 23 year old, with an 18 year old girlfriend was pleasantly surprised by the programme: *"I did not expect to be involved I thought it would be more for my girlfriend's benefit but when I turned up she said she would help me as well. I have learned about being a parent and that has helped a lot. I don't mind doing the worksheets; I find them really useful."* Some clearly relished the close involvement, possibly different to previous experiences as described by this young man, who had children from a previous relationship: *"Sometimes we all get carried away and we're chatting for ages. [FN] gets loads of questionnaires each time. Like try to remember how you feel, or something like, she'll give one to her [client] and one to me and see if we get the same sort of answers. Last time it was how many babies would you like to have."*

However it often took a few sessions before fathers became engaged with the activities; this young man who lived with his partner and other family members became more interested when he felt that the programme was touching on issues that were his responsibility: *"I was a bit wary at the beginning, and when she went through one or two things I thought 'well, its not for me really, its just for [client]'* but then after a couple of sessions I started to get a bit more involved. When she started saying stuff like about the finance and what the baby needs, how to look after the baby properly, I thought 'right, I haven't really got much of a clue so maybe I'll stick it out.'" Another also noted that it took him a while to become interested *"It's been better than what I thought it might be. I wasn't very sure at first..."* FNP Family Nurses helped fathers to learn more about the medical side of the pregnancy to alleviate anxieties. This young man had indicated that he was worried about the birth process and described how *"the Family Nurse brought a little baby to show us how the baby is actually born. I've never seen a birth before and it was quite interesting."*

Initially some of the fathers thought the FN's presence would be intrusive and possibly judgemental, as this young man (a teenager himself), noted: *"When I first heard about it I thought it would have been all about [client] being a teenage mother, not giving information but trying to check up, prying into our pregnancy, but it hasn't been like that."* Another young man recalled that the first thing the FN had said to him was *"Am I*

proud that I'm going to be a Dad, am I getting ready for everything" and although he had trouble expressing his thoughts about the programme in great detail he concluded by saying *"I would say, 'Come to the visits it is a good thing to do'."*

If partners were older, and had other children, they sometimes thought that they did not need to be present for the visits but it became apparent that the FNP experience was more detailed than their previous interactions with health professionals and that they had things to learn *"First off I thought 'this is going to be boring' and I did think I knew everything, but when she did come there is so much more that I have found out and so much more that I can still find out from her."* Another older father, who had several teenage children, noted that the Family Nurse *"has updated me on certain information and refreshed me on others, and she is going to be helping me with stopping smoking"* and she also spent time dealing with some of his personal difficulties. Nevertheless, he usually stayed in a separate room so that the FN could concentrate on his girlfriend and her needs.

A number of other fathers reported that they were more comfortable taking a 'back-seat' during the visits, as this 19 year old, who lives with his girlfriend and her family, describes: *"When she visits I am not always in the same room. Because I feel like if I am needed to be spoken to obviously my girlfriend will come and get me. Sometimes I am in there sometimes I am out of the way. [In the future] I'll probably just go along with everything. Like when I go and leave my girlfriend and the nurse to it. If I am needed I will be there."* Others had work responsibilities so could not always arrange to be present, as described by this 24-year old, with a 17-year-old girlfriend. He indicated his strong commitment to being involved by saying *"At the end of the day I am going to be the father of a child. I want to take part in everything that comes to me"* but when asked if he attended the visits: *"No, it has been mixed. If I am at a job close by, and [client] wants me to be there, I will be there, but some of the times I can't get away."*

Overall then, most of the fathers who were interviewed expressed pleasure both at their girlfriend or wife having been offered FNP and in the fact that the Family Nurses were very keen to involve them in the visits and in the completion of worksheets and in studying materials. Some thought that the most appropriate strategy was to be at home, on call if necessary, but not present for the whole visit although a minority have been present at every visit (see Chapter 10 for more details of their involvement in visits).

3. Acceptable to extended family?

In some cases the client's mother was interviewed rather than her partner. Mothers were usually positive about the idea of FNP. *"I think it is a good idea. It has boosted her confidence, people getting involved with her, so she doesn't feel as if she is on her own."* This mother had not sat in on the Family Nurse visits, although she had been encouraged to do so but was joining her daughter in attempting to stop smoking. Other mothers also expressed praise for the FNP programme: *"I thought it was really good. The fact that somebody was actually coming round to see [daughter] and explaining and going through everything with her, which I probably wouldn't be able to."* Grandmothers-to-be generally encouraged their daughters to listen to the Family Nurse if the information was different from their own experience. This mother was not concerned that the advice being given was contrary to her own parenting: *"I never breastfed, she [daughter] is determined to. That was through [FN], because she was telling her how good it is for the baby."* Family Nurses were seen as professionals, providing up to date information though it seemed that they did not generally challenge the previous generation directly. This mother recounted a discussion rather than a

lecture; *“We debate things, we have all got the baby’s best interests at heart, rather than her [FN] always saying she is right Weaning, of course now it’s done at 4 or 5 months and I just sort of laughed.”*

Other mothers also stayed away from the actual visits, though they might go through the materials at a later point in time: *“Yeah they’re good. We sit there sometimes and look at them.”* Some were working so could not be present at visits and others did not have fluent English. However they generally talked to their daughter after the visits and reported that they had heard good things about the Family Nurses. The overall opinion is reflected in this mother’s remarks; she concluded that the programme was having a beneficial impact: *“It has given her more confidence. It’s made a big difference to your pregnancy. I think it’s a really good idea. It’s a good thing for any age, not just for the young ones, any first time mums.”*

The one dissenting voice was a mother who was still coming to terms with her daughter’s pregnancy [her daughter had learning difficulties] and felt that *“Girls should not be encouraged to keep their babies, there is too much support, we don’t need her, there is nothing she can do for [daughter].”*

Thus, overall most of the mothers who were interviewed were not taking a very active role in the FNP visits, but were aware of the topics being covered and made themselves available to discuss the materials with their daughters. However, it appeared that they were positive about the idea that the FNP support might make their daughters independent and able to cope with their new parental responsibilities.

4. Acceptable to Family Nurses and supervisors?

All the Family Nurses (FNs) and supervisors who participated in the ten pilot areas were interviewed at two stages during the year (N=57). Two Family Nurses left the FNP (pregnancy and choice) and the Family Nurses who replaced them were interviewed at the second time point.

All had wide and long experience before joining FNP, as described in Chapter 2. While most had been working as health visitors in the recent past, many had general nursing, midwifery and other specialist positions as part of their history. Fewer than half those surveyed at this stage had any experience of midwifery, labour and delivery. Many FNs had worked in health visiting teams based in or linked to Sure Start local programmes (SSLPs), and in some instances had been colleagues in such teams. (Some SSLPs have now become Children’s Centres). One Children’s Centre Manager, interviewed for this study, noted that she had ‘lost’ all the health visitors working from her Centre to the FNP.

A not untypical respondent described training as a general nurse, specialising in obstetrics, moving into occupational health, training as a health visitor and health visiting since 1984 in several areas of the UK. Ultimately, after a spell attached to a Sure Start local programme she became the coordinator of a team of health visitors, and was doing that when she applied to be a Family Nurse.

Early experiences

In the first months of the programme the emphasis for the Family Nurses was on recruitment to the programme. Sites had experienced difficulties in setting up recruitment systems based on clear identification of suitable clients, which would enable Family Nurses to introduce the programme to them effectively. Family Nurses were anxious to fill their case loads by the deadline they had been given and became

actively and directly involved in the recruitment process, liaising with midwives, attending clinics and talking to other agencies working with young people in order to speed recruitment. Being proactive in this way was new for the FNs and demonstrated how each felt very conscious that the success of FNP was her responsibility. This was both because they believed in FNP and what it was trying to do, and also because they felt that they had had the benefit of extra training and investment.

At this stage FNs were reporting that:

- They were able to recruit mothers with characteristics which had made them 'hard-to-reach' for previous services (including SSLPs);
- Most young women were willing to receive the service and it did not appear to carry a stigma of being targeted at disadvantage, though FNs were aware of having to take care in presenting the service, since some clients had queried its purpose;
- They were under pressure when trying to fit in the intensive training programme and to get their required numbers of visits done;
- They were concerned about managing a full caseload of 25 if their clients continued to be as needy as those who were being referred;
- The actual delivery of the programme materials, though daunting to start with, was working better as they became more practised at doing it;
- Monitoring data were taking a lot of time to collect (and some had been worried that it would put clients off the programme, but this was not happening);
- Although they had to be flexible about the programme requirements according to the needs of the clients, they were delivering visits of the required length and were covering all domains in most visits;
- The need to keep separate NHS records in some sites was proving onerous;
- Relationships within the FNP team were central to a positive experience of FNP;
- They understood the role and importance of group supervision in the programme but were concerned that there would not be enough time for it when caseloads were full;
- One-to-one supervision was valued for the support it gave and for helping to maintain the fidelity of the programme;
- They were concerned about salary levels for FNPs, which varied from site to site;
- The infra-structure for the programme - offices and equipment - was not in place in some areas;
- There could be dilemmas for the FN relationship with a client when safeguarding concerns arose.

Later experiences

A second round of interviews with FNs was carried out in November and December 2007. They had been in post since 1st April 2007 so most were referring to 8-9 months experience of providing the programme. At this stage the majority had recruited their stipulated caseload (25 clients for a full-time FN) although attrition meant that only a small proportion was still working with that number (see Chapter 3).

At their initial training in Durham FNs were asked to complete a short questionnaire asking them about the considerations they had had when applying for the post (see Table 5.1, Time 1). This exercise was repeated at the second interview, with FNs asked to rate the reasons they were doing the work (See Table 5.1, Time 2). The order and weight of their responses had not changed substantially.

The FNs, previously health visitors and midwives, were already used to working in teams. It is interesting that while they felt that the job bore out their initial hopes for it, in some areas it has surpassed these, notably on the matter of ‘implementing theories’. It is likely that the rise in this figure is due to the attention that has been paid to the theoretical basis of the Family Nurse partnership in their training.

Table 5.1: Family Nurses’ reasons for taking/doing the job

Reasons (could select any number)	Time 1 %	Time 2 %
Opportunity for working in a new way	89	91
More time for intensive work one-to-one with families	84	90
Training and acquisition of new skills	84	90
Targets the most needy families	82	88
At the cutting edge of developments in health care	82	88
Work is well-resourced	57	72
Uses skills that were previously under-used	55	74
Chance to implement theories to which I subscribe	48	79
More opportunity to work in a team	0	70

A similar exercise was carried out at two points in time to investigate what they predicted would be their influence on maternal and child outcomes (see Table 5.2, Time 1) and what they perceived this influence to be after some months in the job (Time 2).

Table 5.2: Family Nurses’ perceptions of their likely influence on child and parental outcomes; average ratings on a scale from 1 to 10

Possible outcomes of FNP	Time 1 (Mean)	Time 2 (Mean)
Infant development	8.1	7.7
Breastfeeding	7.7	6.7
Fewer infant injuries	7.4	7.3
Maternal self sufficiency	7.3	6.8
Child readiness for school	7.3	6.6
Maternal health in pregnancy	7.3	7.9
Infant prenatal development	7.1	7.7
Wider spacing of subsequent pregnancies	6.9	7.0
Maternal use of cigarettes	6.4	6.5
Maternal employment	6.0	5.7

Although there are few differences in these predictions, it is noticeable that where the Family Nurses had had the most input with the pregnant clients - on maternal health and infant prenatal development - their expectations for effect have risen. FNs also noted that there were other areas of influence, on outcomes for fathers as well as for mothers and babies. For mothers these included higher self-esteem, improved communication with services and with family members, better awareness of postnatal depression, uptake of contraception and use of Children's Centre services. Factors affecting fathers included improved relationships between couples, the use of services and increased understanding of pregnancy and the child. An additional child outcome was better communication between mother and child.

Referral and recruitment

The business of actually getting clients became less central to the FNs as time went on and they accumulated full caseloads. In the first few months however it made a big impact on their time and energy, since all felt that it was essential to maintain good relations with local midwives to ensure referrals. They had met all relevant local staff in local clinics and hospitals, had kept up contacts, made presentations about FNP, explained systems to midwives and clerks in maternity units. Where midwives and FNs were based together - in a Children's Centre in one example - this whole process was easier. It also helped when paperwork about a referral was properly completed, because this gave FNs an opportunity to judge if a potential client did fit the programme criteria and also gave accurate contact information. The burden of actually getting the referred mother-to-be onto the programme fell to the FNs, and they described approaching the first visit in different ways, emphasising the commitment needed from clients but often playing down the time involved.

In some sites FNs continued to be frustrated with midwives because:

- They were not referring anyone;
- They were referring the wrong people;
- They were not providing enough information to enable the FN to process the referral;
- Delays in referral could mean a mother was ineligible for FNP.

The difficulties and delays in recruitment were also attributed to others, including the PCT, teen pregnancy services and social services, who were described as being - like midwives and health visitors - "*threatened by the programme,*" In some PCTs very strict guidelines about data protection prevented the FNs from having access to midwifery data. In one site discussions between the Acute Trust and the PCT meant that six weeks of potential referrals were lost. Technical issues in databases also affected referrals, and initial confusion over the exact criteria for referral resulted in confusion and delay. But there was a general feeling that many of the difficulties surrounding recruitment had been worse at the beginning of the programme and that they have been reduced because of presentations and communication by the local FNP team.

Coping with attrition

Since FNs had a personal responsibility for recruitment, it is clear that if clients on their caseload left the programme, it would have an impact on them. In addition, the importance of fidelity to the programme had been explained to the FNs in their training and they were aware, as the vanguard in an experimental approach that a lot depended on them to show that the programme could work. Keeping clients was an essential part of the demonstration.

The majority of responding FNs had experienced the departure of at least one client. For many this occurred immediately after the initial recruitment visit, when clients, having thought about the programme, decided it was not for them. Most FNs were not upset when this happened, and felt that perhaps another young person might benefit from the programme. But where an FN had invested significant time with a mother, and a relationship had been developed, they felt responsible for the departure. *"It was awful. I was devastated." "I was gob smacked...I really felt as though I had been dumped, kicked in the teeth."* This extreme response was much more pronounced with the first leaver, and as time went on FNs were inclined to blame themselves less. Many were reflective about how to deliver the programme differently to different kinds of client - and sometimes they were relieved that a client had left who was difficult or with whom they had not formed a bond.

When asked why they thought clients had left the programme FN discussed two sets of factors: those that were outside their influence and those which had to do with their own practice, reflecting the detail that was given in the relevant forms (see Chapter 3) and the views expressed by clients.

Family influences.

Parents or a partner may persuade a client that she does not need the programme. In one case a parent had had social services contact in the past and did not trust professionals coming into the house. Contact with social services was often quoted as a reason to refuse the FNP service, especially if the FN had referred the family. Some families feel the programme has a social stigma because it is aimed at teenagers. One FN described how a young father identified this in the leaflet used to explain the programme, saying *"He felt the leaflet painted a picture of young girls with social difficulties unsupported, and his family was not like that."* These losses can be difficult for FNs, who may have established a good relationship with the client, and who may have doubts about the quality of the support being offered by the family.

Life events

Some clients were transient, especially if they were homeless or leading chaotic lives. Others travelled home to another country to have the baby, or left the UK altogether. Some do not want to leave the programme when they move, but it is impractical for the FN to continue to visit. Many clients keep in touch with FNs by text and phone calling.

Medical reasons

Terminations and miscarriages represent a small number of programme leavers and most FNs continue to support the client for a period afterwards.

Inability to commit to programme schedule

This could be because of demanding factors like work. Some clients constantly cancelled appointments and were unable to sustain a programme of regular visits. They may have a history of sporadic contact with services and only use them when there is a pressing need. With this in mind FNs do not talk much to these clients about the two-year commitment of the programme in case it puts them off.

FNs reported a constant anxiety about drop-out and 'losing' clients. They identified people on their caseload who were 'rocky', and talked about the way they balanced the delivery of the programme with the need to keep clients involved. *"At times you put the materials on the back burner because you are aware there are pressing issues which the client wants to talk about. You want to keep them in the programme, so the actual programme contents have to wait."*

How do FNs retain clients?

FNs were asked what they did to keep clients on the programme. They described five ingredients which helped: meeting emotional need, flexibility, giving information, being Family Nurses and the fact that mothers wanted the best for their babies.

Meeting emotional needs

Almost all the Family Nurses spoke of the importance of the therapeutic relationship they had with their clients. Weekly and fortnightly visits at home had enabled trust, respect and rapport to build up, and the strength of this relationship has meant that clients could at times surprise the FNs with their reliability. *"The relationship is absolutely key, if you are genuine and open and interested in them."* Many noted that they were the sole source of positive attention for many clients, the only person to listen to their ideas and concerns. Some said that the clients were not inhibited and were able to ask questions in the context of this strong relationship.

Flexibility

Many FNs felt that the programme was deliverable because they were able to change appointments, meeting places and elements of programme content, including topics to be discussed and the approach to them. Working practices were flexible, focussing on the needs of the client, who could contact them any time, even texting at night and weekends. Family Nurses often consulted with clients about elements of the programme to be covered in visits, and dealt with these in different ways according to the client's preferences, abilities and the issues that were concerning them at the time.

Information

Family Nurses were able to give information to clients in more detail than that offered by existing services. This was a factor of the extra time they had to spend with clients, but it was also partly due to the close relationship between them. They were, for example, asked to interpret information from scans, or growth charts once the baby was born. This suggests that some young mothers feel unable to ask questions of staff in mainstream services. Many FNs helped clients with information about housing and the benefits they were entitled to, rather than signposting them to other services and several said that this had helped them to engage with the clients concerned, because these were their chief concerns at the time.

Being Family Nurses

Respondents said that the fact that they were health professionals, but with a different name and a caring approach, was making them more acceptable to young clients, who could be prejudiced against workers from mainstream services, particularly social workers.

Clients wanting the best for their baby

Family Nurses are contacting young women at a time when many are susceptible to taking advice and receiving support in order to ensure that they are healthy during their pregnancy and their child has a good start. FNs reported that some young women seemed determined to defy stereotyping and prove to their families and the community more widely that they could do something well. *“They want to prove people wrong, that they are going to be a good teenage mum.”*

Training

In the first round of interviews, FNs spoke at length about the intensive training they had received at the outset and in the early months of the programme. On the whole this had been highly valued. In the later interviews, in the light of experience in delivering the programme, they have been able to identify areas in which they need more training. There were concerns among non-midwife trained former health visitors about a lack of knowledge of midwifery practice. There were specific requests for training about the journey from conception to birth to include information about when bloods and the foetal heart timeline are taken. Another gap in training was mental health, where FNs felt that they needed more guidance in supporting mothers who might not need to be referred to a CPN or psychiatrist but needed to be advised. Several FNs also felt they had inadequate knowledge of the benefit entitlements for people in this age group. Mention was also made of the need for help in dealing with family dynamics at the same time as trying to deliver the programme; of family planning; and of drug awareness.

Fidelity

Family Nurses have a delicate and difficult balance to strike between responding to the client's needs and delivering the programme as it is prescribed. The issues to which they referred most regularly were making a response to the immediate needs of a client, and being flexible. Many FNs told tales of visits where much of the prescribed work had to be abandoned due to an incident of domestic violence, an argument or crisis in the family, a relationship breakdown or a housing problem. Many clients have difficult lives and many troubles, and FNs have to deliver the programme in this context. It can be extremely difficult to do this, and most FNs have several clients who are likely to encounter crises regularly. They have found that clients cannot engage with the programme materials when they are preoccupied about an issue. Family Nurses offer support during crises and use the programme flexibly in order to do so. They believe this is essential to keep clients engaged.

This raises questions about the fidelity of the programme to the original model. FNs themselves are aware of this. *“I am not covering the domains I am supposed to be covering.”* For some the solution was not to have expectations that all the work would be completed every week, and to see any engagement by a client with the programme as a success. This may have implications for fidelity in terms of covering the expected proportions of each content domain, described in Chapter 3.

A number of FNs talked about the pressure they were under to make the programme work. They felt its ultimate success or failure rested with them, and noted that this was not a pressure they were familiar with, since as health visitors or midwives they were simply a tiny part of the huge NHS operation. The work was also highly pressured in itself, with many FNs reporting that they found it difficult to complete paperwork, visits, driving, supervision, case conferences, and visits to agencies, and to have any leave. Staff used cancellations by clients as an opportunity to catch up on unfinished

paperwork and many found it difficult to reschedule clients when they cancelled. If clients did not cancel or failed to respond to calls, many FNs could not have done the job. The FNs covering larger geographic areas found it particularly difficult to meet the fidelity of the programme with the amount of time they were spending on travelling.

The FNs were also aware of needing to manage the tension between advocating for the client and child protection. FNs have had to contact social services about a client or attend case conferences about a family. In these instances the FNs talk about how they balance the strength-based approach of the programme with an assessment of risks, and the need to share information about families. As well as causing a minority of clients to leave the programme, this creates enormous pressure for a Family Nurse.

Job satisfaction

Many of the FNs talked about the pleasures of observing progress in their clients - with healthy eating, control of smoking (though some felt they were having little impact on this), improvement in relationships with partners or within the family. Some reported helping to stabilise clients' lives by advocating for them, and there were instances where a client's relationship with social services or other agencies have improved.

Successful pre-natal outcomes were reported: increased attendance at ante-natal clinics, and young women realising that reducing stress during pregnancy is important for the health of their babies. In general FNs believed that fathers were benefiting from the programme, being better prepared for labour and parenthood. The main post-natal successes reported were in breast-feeding and a reduction in the expected number of premature babies. The latter is particularly significant as it improves the baby's chances of developing well in the first year. One Family Nurse said, *"The main success, that goes against the statistics, is that most of them have gone full term."* And another: *"I am definitely convinced I am getting good birth weights."*

Following a structured programme

The FNP contrasts with the previous experience of FNs. It is a structured programme, with prescribed activities and learning that have to be carried out in full to ensure fidelity. FN noted that their previous work was far less structured, required no intense relationship with clients, and was a good deal less stressful. On the whole they liked the structure. Each visit includes a review of the previous week, a reflection on how clients are feeling, open discussion and the specific topic for the visit. Structure stimulated discussion, gave momentum to the work, gave clients something to look towards each week. *"Structure makes you dare to do the programme with them."* However, there were some reservations expressed. Some themes were reported to be repetitive; it could be difficult to adapt the structure to a client; and content was considered time-consuming and not of interest to some clients.

FNs described a growing ability to use the materials in the programme flexibly. They had found that there were facilitators to appeal to different tastes, reading ability and age. They were able to highlight successful facilitators, but had some criticisms, particularly of the language used in some instances. But the general conclusion was that there was enough variety in the facilitators to enable flexible use to suit client need. *"You start to realise what works for you and what works for the clients. That is why you need a lot of choice of topics, as you know some materials are not going to work for you."*

The descriptions of their growing familiarity with the programme and its materials indicated that Family Nurses' understanding of the programme increased with their experience of practically applying it.

5. Acceptable to other service providers and local stakeholders?

Young parents have become a target for many services, all anxious to show that they are taking seriously the need to reach the most vulnerable families. Young parents are easier to identify as 'vulnerable' than many others where the 'need' - mental illness, drug use - requires an element of disclosure.

Among the services that have made a particular effort to reach young parents by developing work specifically for them are:

- Midwifery service and midwives;
- Health visiting service: groups for young parents (often in Children's Centres);
- Teenage pregnancy coordinators
- Connexions: information and advice for all young people from 13-19;
- Youth and community services: personal development opportunities;
- Housing services: support workers for vulnerable families;
- Parenting programmes: special groups for young parents;

In addition two services are likely to work with young families as part of their general service to families:

- Safeguarding teams; and
- Children's Centres

Frontline practitioners in these services encounter Family Nurses in their day-to-day work. In addition, at a management level, personnel in the ten pilot sites responsible for commissioning services and for workforce development in the PCTs, and for the Children's Centre strategy in the local authority, also have an interest in FNP, as do managers of the other front-line services listed above. The level of interest and the parties involved varied among pilot sites, but interviews with a sample of stakeholders were conducted in each.

Understanding of the FNP

Management staff in health and local authority services had heard of the FNP, and most had attended meetings introducing the concept, including presentations by the leader of the central team. Staff at this level were particularly aware that the scheme had achieved outcomes in American evaluations, and some were able to specify these. They did not have a detailed understanding of the ingredients of the scheme, other than that it was intensive home visiting which continued through the antenatal period until a child reached the age of two years. Several noted that there had been little time for them to consider the strategic implications of the scheme before it had actually started.

Practitioners working directly with families were most likely to know about FNP because they had had contact with an individual Family Nurse. Almost all of the FNs had previously worked in the PCT, and a proportion had been associated with Sure Start Local Programmes and other efforts to support disadvantaged families. This made them the commonest conduit through which workers in other services learnt about FNP. FNs told people about their new role or they were visiting a client who was

previously in contact with one of these relevant services, particularly Connexions, so that information about what the FNP could do was transferred in the context of an individual case (and did not give a full picture of the project's aims and methods.) Sometimes teams gave presentations to groups about their work, but this rarely occurred in Children's Centres.

All sites had instituted a 'steering' group, usually of managers, but in some areas with mixed list of invitees, which included frontline workers too. These groups monitored the implementation of the local project, identified risks and addressed them; promoted long-term sustainability and considered any adjustments that might be needed to ensure the best use of resources. These groups generally met every two or three months. The early meetings had a high level of attendance, which had reduced as time went on, with health representatives likely to be the most consistent contributors. In some areas a 'reference' group for local practitioners working with families has been established in addition. A local health visitor said *"By having these meetings it has helped us look at the long-term implications, how that role will fit into our new strategy for health visiting, into child health promotion and into everything that is happening within the PCT and the local authority. It has also helped us iron out some problems and barriers we have had such as referrals."*

The roles of the Project Manager and the Project Lead were important in spreading knowledge and understanding of the FNP. In several areas these personnel were thoroughly embedded in local multi-agency services for families, knew everybody and used established networks to explain the FNP as well as giving formal presentations about it. However, familiarity with FNs and managers could mean that other stakeholders interpreted the new scheme in the light of these relationships: as a type of enhanced health visiting, for example. None of the non-health stakeholders interviewed were able to clearly differentiate the FNP from other health services for families, except to say that it was being offered to teenage parents.

Response to the FNP - within the Health Sector

Health visitors and midwives understood most about the FNP. Health visitors expressed welcome for it, and a belief that more intensive work with the neediest families was the direction in which their services needed to go. Where they had initial reservations these had been about the recruitment strategy, or possible implications for their own work, such as:

- The service was being offered to some young women who were considered not to need it, *"Stable young women with lots of support"*;
- The service was not being offered to some women whom midwives considered would benefit from it, because of the age and other criteria of the scheme; *"The programme hasn't got some of our most vulnerable in"*;
- That existing services aimed at young parents - groups, for example - would be undermined by FNP and membership would reduce; (in the event, the opposite has occurred, and FNs have encouraged their clients to use such services);
- Those women who refused or dropped out of FNP would continue to be the responsibility of the mainstream services and they would be the hardest people to engage, with no extra resources to do it.

However, there was some evidence that staff who had started out with worries about the implications of this new way of working were becoming less anxious about it as time went on - in fact several said *"My attitude to it has changed."* Operational managers in PCTs, while clearly welcoming the service (they had generally been centrally involved in the application process) had been worried in the beginning about the workforce implications of the pilot. These immediate concerns were alleviated when the posts of locally recruited FNs were filled, but managers expressed continued uncertainty about how the programme could roll out over the longer term. *"How do you recruit to pilot sites without depleting the universal workforce?"*

Some respondents had done some thinking about the implications of the FNP for future development, seeing health visiting as developing two distinctive strands and wondering if 'progressive universalism' would require a third way to meet less acute but apparent need. It was suggested that the 'assets-based' approach could be a valuable addition to the training of other staff teams and that there were things to be learned from the supervision offered to FNs. One respondent felt that the FNP would need to be 'watered down' to a less intensive service if it was to be offered more widely. There was a need for further guidance from government about how to incorporate the intervention into long-term planning.

Response to the FNP - outside the Health Sector

Beyond the health sector, where understanding of FNP was limited even among staff who were attending steering and other groups, there was a more subdued welcome for it. The idea that families were being offered intensive support was welcomed, but staff from frontline agencies were afraid of overlap with their own work. Some also hoped that the FNP programme would relieve some of their own involvement with some of the young women, but they wanted more feedback. They wanted FNs to attend more multi-agency meetings, to take referrals from them and to give them more information about clients. Several individual examples were given of cases where many agencies were involved besides the FN, and where there had been confusion about responsibilities. It was felt that some young women were tired of the amount of intervention they were receiving, though in the cases cited it was the mothers of the young women who were expressing this.

Specific concerns expressed by workers in non-health agencies were:

- *"If too many people are going in working with these young people, it's not what they want."* (Housing adviser);
- There was insufficient feedback from the FNP about the people it works with and how they are doing;
- Some parents see the programme as compulsory but don't really want to be on it; How does a strengths-based model work when there are safeguarding concerns. (One social worker noted that she did not share this concern because she believed that the intensive work with families until the child is two would mean *"they will have made positive changes in their lives"*);
- What would happen to the FNP families when they had further children?

6. Conclusions

Clients and their families were positive about the FNP. While it took a while for them to understand the full extent of the FNP support and what the aims were, they liked it in comparison to other services they had received and were struck in particular by the different way that they were perceived by the FNP staff, not judged and demeaned but supported and strengthened. Some were not quite sure when they accepted, thinking that they would give it a try and most then found that it was better than they had expected. This was particularly true of some of the young men who were interviewed. They had not expected health professionals to involve them in such positive ways and this helped some to feel more involved as fathers-to-be. When grandmothers-to-be were involved they tended to take a back seat, letting the Family Nurse give 'up-to-date' information even when it sometimes differed from their own beliefs or practice. They were generally happy that there was someone else who would also support their daughters.

Most FNs reported enjoying the job and the challenges it offered. They are mainly very loyal to the programme and have a sense of achievement. They feel satisfaction that their clients are well prepared for labour and have support from them when their babies are born. Many say it is the best job they have ever had. But a theme that became more apparent in their second interviews was the strain of seeing 25 clients and the number of visits required to them. FNs did not think this was sustainable in the long term. *"I don't want to work 50 hours a week."* (See also Chapter 7).

The workload was starting to become a big issue towards the end of 2007 when caseloads were close to the maximum (reflected in web-based discussion between Family Nurses and their reflections to the research team, but a number of others were raised, often specific to sites in the study. In some areas there were negative comments on the quality of supervision, or of management and leadership. There were many comments about the burden of paperwork, and there have been basic resource problems around IT and phone availability which have proved a hindrance in some areas. Often a single logistical problem can prove hard to bear when staff are working at full stretch:

"I like the FNP role but the benefits are only just outweighing the negatives: when they started saying we couldn't come back to our base and hot desking, I started to think about looking for another job."

The response of stakeholders indicates that more careful preparation of the wider workforce which has contact with families is needed. Although stakeholders are able to identify the FNP through the clients it works with, the timescale and intensity of the work, they do not have insight into the purposes and nature of the project, or the theories in which it is located. As a result most see the FNP as simply another agent to be incorporated in a multi-agency approach, whereas it may work best as a specialist tool with very specific points of interface with other family services.

This preparation needs to include:

- Clear exposition of the nature of the project which differentiates it from other work with families;
- Clear description of who the FNP will be working with (changing recruitment procedures caused confusion and some resentment in associated services);
- Clear delineation of specific points of interface with other family services.

Once a local FNP project is operational it is important that there is:

- Local feedback to stakeholders about the progress of recruitment and turnover in the project; (currently there is too heavy a demand on individual Family Nurses to do this - the dissemination of written updates to stakeholders could be more appropriate);
- Exploration of how this intervention can be part of the range of support for families, with explanatory models of the ways in which this could be effected. The amount of progress that has been made so far in local sites on integration suggests that managers will need more help to conceptualise how to integrate FNP;
- A local point of contact for agencies that have concerns about the precise responsibilities of FNP (for example, where there are safeguarding issues).

Many of the concerns expressed by all stakeholders about FNP would be met by clear messages of what it does, and where it fits into the local picture.

Chapter 6 - Management and existing structures

“The Family Nurse Partnership programme provides an effective model of support for first-time mothers with complex needs. In a system that ‘thinks family’, the key components and principles of these whole family interventions would underpin support for a wider range of families at risk.” (Social Exclusion Task Force, 2008, p. 8)

1. Roles and responsibilities

The ten FNP pilot sites, which were awarded central government funding under the umbrella of the Health Led Parenting Programme, were advised on the local management structure needed for the project.

- The Project Lead was to sponsor the project across the local authority and the PCT, to keep it on the strategic agenda.
- The Project Manager - a part-time post, three days a week were recommended - was to be responsible for the recruitment and support of the supervisor, delivering the project as agreed, and the budget. This job also involved making sure that FNP was locally embedded in the wider local services, health, Children’s Centres, general practice, safeguarding and maternity services, engaging stakeholders and ensuring its long-term sustainability. The role was intended to work as a defence for the team of Family Nurses, allowing them to get on with visiting families and protecting them from organisational or wider professional distractions.
- The supervisor, a central part of the model, was to manage the work of the Family Nurses, maintaining the integrity and quality of the programme, overseeing recruitment and engagement, building local relationships and facilitating continual learning and service improvement. Supervisors would deliver the programme to a small caseload of families.

The overarching management of all 10 sites was conducted by the central team, located jointly within the DCSF and DH. The team consisted of the Project Director, the Implementation Lead, the Central Project Manager, an External Relations Officer and a Clinical Psychologist.

- They organised and delivered all the training for the 10 sites, including 2 residential weeks, in April and May, a number of master classes on specific topics, and training to gain certification in the use of additional materials required for the work.
- They liaised with the National Service Office in Denver, monitored fidelity, established a website as a means of communication and sharing of the FNP materials and made visits to sites, both to solve local difficulties and to provide additional support for the teams.
- They held regular meetings with Project Leads, Project Managers and supervisors.
- In the latter part of the year a number of reflective practice ‘learn and change’ groups were organised to allow the FNP staff to discuss their experiences in this initial phase of implementation and agree changes required.
- The central team also managed the evaluation, with additional input from the DCSF research group.

2. Project leadership and management

Nine of the ten pilot projects had leaders who were senior managers in the PCT. In one case the lead role was shared between the PCT and the local authority, and the joint leader here was a Social Care Manager. Role titles varied, but the focus of all leads was commissioning or providing children's services. The majority of these managers had a background in community nursing, usually health visiting. Project Leads noted that the FNP provided an opportunity to build on existing good practice, particularly joint working, that it focused on the greatest need, that it was evidence-based, and that it offered a way to reconsider the approach of health visitors. *"We have all these highly qualified health visitors out there on the patch, but we don't know what they are doing... we know what these home visitors [FNs] are doing and we know that the outcomes will be related to what they are doing... we need to learn from that."*

Project Leads chaired the meetings of local boards, steering groups and stakeholder meetings. Their goal was to achieve support for the FNP from senior officers in the PCT, local authority and relevant agencies, which could mean dealing with the reservations of some, particularly senior health visiting and midwifery staff.

Project Leads supported the Project Managers. The closeness of their working varied among the ten sites, often related to whether they were working from the same offices. Interviews with personnel in these two roles suggested that the tasks outlined for each post were being shared in different ways between them. So, for example, in one area the Project Manager was representing the FNP programme at meetings, which would be attended by Project Leads in other areas. Project Leads were spending time, in varying degrees of partnership with the Project Manager, on basic issues like the bases from which FNPs were working, and the provision of IT systems for them. They could also become involved in issues like referral and recruitment, oiling the wheels by talking to midwifery managers.

An observation made by some Leads, and reinforced by Project Managers, was that the FNP training and delivery system had excluded project management. The training experiences and supervision in the programme were intense for the FN team, and members had bonded very closely. Project management staff commented on how changed FNPs had become: *"I was quite surprised to see how different they were in some ways - almost like an elite, detached from the PCT."*

Project Leads felt they needed more guidance from the FNP central team on how the FN experiment could influence the development of the health visiting workforce in the future. The most common suggestion was that elements of FNP training could be incorporated into health visitor training (a suggestion that was also made by midwifery managers in relation to midwives, and Children's Centre managers in relation to their staff teams). This indicated misconceptions about the holistic nature of the FNP approach. Leads also wanted information about the future directions of FNP in order to be able to engage local interests in it. Some noted that FNP represented a very small element in local planning for children and families and that it could be overlooked in the context of authority-wide planning.

Project Managers fell into two groups:

- Those with a background in health visiting and who had been (and sometimes remained) in close contact with their profession;
- Those whose background was project management, generally in the NHS, though sometimes in integrated settings, like Sure Start Local Programmes.

Most had another role either in the NHS or children's services, and all found this gave them an additional opportunity to talk about FNP and link it with other local services.

Although some Managers felt they should have been included in the FN training courses, others considered that it was not necessary to have an intimate understanding of the detailed workings of FNP to project manage. *"I would not need to know the in-depth programme but I would need an overview of it."* This respondent saw her role as taking the onus of the team to enable them to concentrate on visiting clients. *"So I try to be 'Miss Fix-it', to facilitate things, smooth the wheels, open those doors, do as much as I can to take the responsibility for the logistics and the general management off [the supervisor]."* In another area the Project Manager noted that when she attends meetings to talk about the FNP *"The key people who make the decisions and buy the service, they're asking you these fundamental questions - 'So what's different about it then?'"* Project Managers felt they could have been better equipped from the outset to answer these questions.

Project Manager and supervisor posts stand alongside each other. This caused difficulties in some sites - difficulties that were addressed usually by the setting up of a regular meeting between them. In the FNP context the project is a very specific entity, and while Project Managers were aware of the requirements of the model, they did not understand all of the detail, and could underestimate the importance of parts of it. It was common, for example, for FN group supervision time, an essential ingredient of the fidelity of the programme, to be lost to discussions of nuts and bolts matters.

Project Managers have dealt with the accommodation and communication needs of teams, including arranging interpretation, and have sometimes been frustrated that they have not been able to provide what FNs need due to local hold-ups. They have worked with the supervisors, who had the major responsibility to maintain the quality of the data collected by Family Nurses in each site, and have managed the project budget. They have also been responsible for disseminating information about FNP. All managers emphasised that it was important for FNP to keep its links with other agencies. *"It could become very separated from other services."* Some felt that over-stretched services might withdraw from supporting the families with which FNP were working, though there was no evidence that this was happening. But this did raise an important strategic issue for FNP: how far can it operate as just another service in a multi-agency context? Although the Project Managers were trying to protect them, FNs were spending a lot of time liaising with other agencies. If what these agencies report is correct, the FNs were their main source of information about the FNP. Liaison of that kind, and attendance at the many multi-agency meetings that relate to disadvantage, makes considerable extra demands on FNs.

3. PCTs and Acute Trusts

Most of the health services relevant to a pregnant client are within primary care, but maternity care sits within the acute (hospital) trusts. This has meant that midwives have, prior to the move to Children's Centres, often been somewhat isolated from other health colleagues including health visitors. They face a particular challenge in conceptualising maternity services as part of a multi-agency framework of support for vulnerable clients. Equally, midwifery procedures can seem opaque to those working in the primary sector.

Some of the midwifery services in the ten sites studied had developed specialist services for teenagers, including dedicated clinics, specialist midwives, separate antenatal and postnatal classes or groups, multi agency referral routes and pathways, or the employment of a specialist midwife with strategic responsibility for improving services for teenagers. Extra services might be targeted at all teenagers or at the most vulnerable. The role of 'Teenage Pregnancy Midwife' could encompass any of these different approaches. In areas with no specialist services for teenagers, young pregnant women were receiving standard care and formed a small part of the individual caseloads of a large number of community midwives. Besides the statutory involvement of this service with the FNP target group, the matter of recruitment has meant that collaboration with the midwifery service has been essential for the operation of the FNP teams.

Midwifery management had been directly involved in the application to take part in FNP in a minority of sites. In most there had been superficial involvement, usually a request from those preparing the bid for data on the number of young women delivering babies. Once the bid was successful, midwifery managers were not always kept informed about the progress of the scheme, or invited to steering group meetings. *"Then I didn't hear anything for the longest while....I seem to have been missed out of the loop"* (Midwifery Manager). Where midwifery managers were involved in the steering group, it had offered a constructive two-way process that had helped to address issues around referrals and to improve communication between local midwives and Family Nurses.

The midwifery managers' view of the FNP

Maternity services in four sites noted that midwives had not been targeted for recruitment as Family Nurses, or had been invited to apply as an afterthought. These were also sites where those preparing the bid had failed to involve midwifery management in the strategic thinking, and the resulting job descriptions were felt to be unappealing to midwives. *"Well, no midwives had been recruited - I think they forget that we are the acute trust and it had gone out on the PCT email, so we were oblivious to it until it was up and running...It just sort of appeared from nowhere without any midwifery input"* (Teenage Pregnancy Midwife).

In a couple of sites the FNP was seen by some as a threat to existing specialist roles such as teenage pregnancy midwives, whose funding was precarious, or as superfluous in areas with strong pre-existing support services for teenagers (where professionals were not aware of the difference between the FNP and those services). Occasionally defensive attitudes could become directly obstructive at management level, as when a modern matron intervened in communications between FNPs and the midwifery service: *"She has been the gatekeeper and has prevented the team from meeting up with the teenage pregnancy midwife or the community midwives or indeed going inside the hospital"* (Family Nurse).

Midwifery managers saw the FNP as involving some extra work for midwives, but the amount depended on the referral system - some FNP sites had devised referral mechanisms that had no impact on midwives at all. However, at more than half the sites maternity professionals acknowledged the limitations of what midwifery could achieve on its own to improve outcomes for young mothers and babies and saw the FNP as complementary to the service they offered. It could save midwifery time by supporting vulnerable clients. One manager suggested that if FNP were to be rolled out, referral to it would need to be embedded in the care pathway for young pregnant women, to become an integral part of the care package.

Midwifery service and the FNP

FNP relies on maternity services as the primary (but not exclusive) route for receiving contact details of pregnant young women who might be eligible for the programme.

Maternity referral from midwifery systems

The short time scales on which sites and the evaluation team had established processes for consent and referral initially impacted on the operation of referral systems in all research sites. The 'standard' referral system to the FNP teams was for the midwives to identify eligible clients when they first booked for maternity care (or retrospectively) and to pass their names on to Family Nurses. There was a feeling among FNP teams in a majority of sites that many midwives were not referring eligible clients, and some evidence that this was so. Midwives reported that they had been confused by the referral criteria, which had changed (more than once in some areas). Some were referring selectively; others were confused about the purpose of FNP and the difference between Family Nurses and other outreach workers. Issues of clarity tended to arise in those sites where there was poor partnership between FNP and midwifery services because managers had not been effectively included in the design and implementation of the programme.

The referral system from midwife to FN was more likely to work smoothly if:

- Midwives understood and actively promoted the FNP to clients;
- The maternity service made specialist provision for teenagers, enabling eligible young women to be readily identified, rather than trying to engage dozens of community midwives in the process of referral (This did not identify older eligible women).
- The FNs or Programme Manager had done systematic outreach to midwives to explain and promote FNP;
- The midwife had an existing working relationship with the FN;
- There was liaison between midwives and FNs about individual clients;
- Midwives saw the FNP as beneficial, both to clients and their own service, by reducing their workload, promoting attendance at ante-natal classes and reinforcing health messages;
- The system added as little weight as possible to the workload of midwives - using the standard inter-agency referral form, with which midwives were already familiar, for example.

In individual sites mechanisms had been developed with the midwifery service to maximise the transfer of information about eligible clients. Examples included:

- Normal referral forms sent to a single location for the FNs to access;
- FNs attended the dating scan clinics, where reception staff would identify young women in the age group so that FNs could approach them directly;
- An antenatal scan adviser passed to FNs the names of all young women who booked for a scan;
- Midwives allowing FNs to look at booking folders or databases to check if any eligible women had been missed;
- Giving midwives laminated bookmarks with FN contact details.

Good communication between FNs and midwives was important, and this included feedback about clients in the programme. A particular criticism in some sites was that FNs had not let the midwives know which clients had been accepted on FNP.

Communication was generally better when there was a Teenage Pregnancy Midwife in the area, and if there was some alignment between the pilot site and the acute trust providing the maternity services.

Concerns were expressed among maternity professionals about maintaining the boundaries between midwifery and the FNP. Even midwives who had a positive attitude to the new programme were concerned that FNs were asked inappropriate health questions when they did not have midwifery training, were duplicating midwives' work around health promotion and (inadvertently) giving clients an impression there was no need to attend antenatal classes. However, other respondents felt that overlapping information given by midwives and FNs was mutually reinforcing.

4. Links with Children's Centres

Children's Centres are now one of the ways that services are made available to families with babies and young children, adding to services provided through GPs and health centres. They are widespread, with one promised for every community by 2010. The services offered vary according to the level of disadvantage in the community, but the full range includes early learning and day care, help with parenting, health and welfare services for child and parents, outreach, family support and activities, and guidance on training and back-to-work opportunities.

One potential benefit of FNP would be to increase the use of other services available in the community by the young clients. Teenage parents are known to be less inclined to access them than other families. And the prominence of Children's Centres in family policy made it clear that there was likely to be a strong interface between them and the FNP in pilot areas. This was emphasised by the requirement that application for site status be made jointly by PCTs and local authorities. In reality the management of the project has tended to be by PCTs, except in one area, where there was a joint responsibility, with one of the joint leaders being a social care manager from the local authority. However, the Sure Start Children's Centre model was not new and most (though not all) Project Leads and Managers had experience of the multi-agency one-stop development through Sure Start Local programmes as well as Children's Centres. In addition, health visitors and midwives had been working out of these settings for some time, so the idea of integrating FNP with them made sense and was hardly a surprise.

In all sites there was some evidence of joint planning, with the Project Leads from PCTs reporting close relationships with local authority Children's Services Managers. Although invited to the FNP boards and steering groups, the majority of local authority managers did not attend, and in interviews, two noted that the FNP, though interesting, was a small project and not a priority for them. This meant that Children's Centres were not receiving clear instructions from management about FNP and how it could fit into their agenda. This was borne out in one area by the refusal of two Children's Centres to take part in the evaluation of FNP since they had not received specific instructions from the local authority to do so.

Children's Centres as bases for FNs

In four sites Family Nurses had been based in Children's Centres, but in two areas this arrangement had been interrupted. In the two sites where FNs continued to work out of centres, individual FNs were sited in different centres in the areas with the largest geographical spread. In another site the whole team had been based in one Children's Centre and the FNP Project Manager was also the Children's Centre manager. In this example the team was moved out of the Children's Centre for a significant part of the

first year because it was not possible for PCT IT systems to be installed for them. This problem also occurred in the other areas using Children's Centres as bases.

Many of the FNs had had a previous long and close working relationship with Children's Centre staff as part of multi-agency teams, and attempted to maintain these established links. However some FNs expressed dissatisfactions when their team offices located in Children's Centres, mainly because of the IT problems but also because of noise, interruptions and the unfamiliarity of other professionals in the building with the FNP work. Even those FNs who had previously worked in SSLPs or Children's Centres preferred to be based with the FNP team where possible. FNs reported that some processes integral to the FNP model were commented upon by colleagues. Group supervisions drew the remark *"they're sitting again"*. And Children's Centre colleagues might try to refer a client who could not be recruited by the FNs either because they did not fit the criteria (teenage mothers who had already given birth, for example) or because FN caseloads were full. An FN based in a Children's Centre noted in passing that the health 'enclave' was a refuge for her.

Children's Centre managers

The main sources of information about the relationship between FNP and centres were interviews with eighteen Children's Centre managers. They showed a range of understanding of FNP and some misconceptions. Most had a general knowledge, could identify the client group and knew that the work was intensive and continued until the child was two. Few knew about the philosophy or content of the programme.

One Children's Centre manager described what she understood about the FNP approach: *"A packaged version of what we do, in a round about way... We were heading in the direction of the FNP work anyway, but somebody, years ahead of us, had actually got it together in a package"*, one manager mentioned Professor Olds; and another mentioned that the programme came from America and had good outcomes, but did not know what these were. Where managers had some information, this had come to them directly from FNs themselves, and this was most likely to happen if that had a previous relationship with the FN concerned.

Where managers had previously had links with staff who were now part of FNP, some informal contact was taking place. But, Children's Centre managers were not attending FNP steering group meetings. Sometimes they are aware that their own managers are invited to such groups, but had not had any feedback from them. Most were not going because they have not been invited. *"I think that if they are going to get on board I should be more involved and made more aware of what is happening,"* said one.

Children's Centres themselves hold many multidisciplinary meetings. All managers interviewed said that FNs were not present at these, or at service planning meetings. *"I go to a CAF steering group and in the last meeting we said we really should get someone from the FNP to attend."* A manager who has an FN based in her centre noted that though they share an office she does not really know what the FN is doing, but said that she always looks busy!

Linking families to Children's Centres

All managers saw the main benefit of FNP for the centre as being the introduction of new parents to Children's Centre services. *"We all know each other so don't have formal links. They look at our activity sheet and see what's going on and link the young parents in."* In most instances the service used is a teenage parents group. Several centre managers felt that FNs are a good way to publicise activities and provide handholding support for clients to use them. All say they have good links with health visitors and see this as a way of linking to FNP. (One manager persisted in referring to FNs as 'health visitors' throughout the interview). Frequently Centre managers were conceptualising the FNP as an outreach service for the Centre: *"The Family Nurses could come into the Children's Centre and do some groups. They could do smoking cessation, breast-feeding and do drop-ins. We want to have a good partnership and reach these targets."*

One respondent, an outreach worker for a Children's Centre, showed a much deeper knowledge of FNP. She said of FNs *"Their role is different from health visitors. It is much more personal and they certainly have much more contact. They are able to see how the parents and children are working together through all the ups and downs of life rather than just when they decide to come to the clinic on a good day."* This interviewee reported having seen an impact from the presence of the FNP: *"I know through the Children's Centres that these parents are actually accessing some of the services ... from our own statistics that we take, suddenly we have very young mums who are attending parent toddler groups. We know there is no stigma there and we know from our registration that they are attending."* FNs themselves report that they do introduce clients to groups at centres, usually but not always for young mothers, and often accompany them there. A manager noted that nearly 50% of the teenage parents at a special small group had been introduced by the FN.

When asked how they would like to develop the links with the FNs, and integrate the service, some managers recognised that there were clients who do not want to attend groups and saw FNP as a way of engaging these 'hard-to-reach' families. Most felt that the special relationship the FNs had with clients was the key to getting them into centres. Managers felt they could offer FNs space for meetings but nothing else was suggested. It was noticeable that no respondent mentioned safeguarding as a reason for linking with the new service - even where there were family support teams and social workers based in the centre. This oversight may have occurred because few of the FNP mothers had delivered their children at the point when the interviews were carried out. No respondent mentioned any specific service planning that was including FNP.

The majority of Children's Centre managers said that they were sure that the Centre was reaching 'hard-to-reach' families. When asked how they were achieving this, the most common answer was through publicity. No manager was able to cite monitoring or other evidence to show exactly how far reach extended. One manager said that the centre had a café and was welcoming and friendly. Where there were family support teams it was not clear that they were doing very much home visiting. Most centres were offering family support in groups held at the centre or satellite venues. *"We have a fixed timetable and we want to get the more hard to reach engaging with that, and when they do we will put in more professional input. The FNP nurse has not been involved in discussions about this."*

5. The central team and wider service structure

The FNP pilots are a central government initiative, emanating originally from the Social Exclusion Unit (SEU), which conducted a review of the programmes to combat exclusion in 2006, and re-visited the evidence about effective interventions. Apart from the often-cited evidence of outcomes for children that had accrued around the Nurse Family Partnership in the United States, SEU officials noted particular aspects of the programme that made it attractive for testing in the UK context:

- Built on the lessons of Sure Start local programmes, that more effort had to be made to reach the most needy families;
- Provided a way of bringing Children's Centres and health services together in collaborative working; (another lesson from Sure Start - that services for families are more likely to work if health services are involved in them);
- Used home visiting, an effective method of reaching people;
- Evidence that it could make some difference to the intergenerational transmission of disadvantage which was a feature of socially excluded families;
- Provided an opportunity for DCSF to work in partnership with the DH;
- Gave commissioners of services encouragement to consider the longer-term effects of what they were planning;
- Promoted the idea of maintaining fidelity to an evidence-based programme;
- Contributed to the examination of the future role of health visitors;
- Changed relationship between the family and the professional worker;
- Exemplified 'progressive universalism' - varying the level of service according to the level of need;
- Could engender trust in services among needy families;
- Because the health visiting service was universal it offered the prospect that the FNP could be sustained and spread more widely, if it was found to be feasible to implement it in England.

Partnership between DCSF and DH

The funding for the first pilot stage of FNP came from the DCSF. Directors from the Department of Health and DCSF shared responsibility for the development, with the DCSF nominally heading in the first year, the DH taking the lead subsequently. However, the Directors concerned noted that they had much wider collaborative arrangement around the Every Child Matters and Child Health Promotion agendas. They also explained that the condition of funding pilot sites that local authorities and PCTs should work in partnership was not new. Every Child Matters had required them to come together to analyse the needs of the local population, to align budgets to commission jointly. The application process for FNP gave the departments an opportunity to see how far partnership was working in a practical way.

The Deputy Chief Nurse responsible for primary care, community nursing, public health, children and social care took lead responsibility for the development, since it was part of her brief. Although involved in all the early meetings between the departments and the Social Exclusion Unit, her central role dated from October 2006, seconded from the Department of Health to the DCSF for three days a week. Subsequently she has become Director of the FNP, reducing her other responsibilities. She headed a small unit based at the DCSF, which was comprised of a Central Project Manager and the External Liaison Officer. At an early stage two consultants were recruited to the team, a midwifery adviser and a health visitor trainer / adviser / academic, the Implementation Lead. Later a clinical psychologist joined them.

This very small central team was responsible for learning from the team in the USA about the NFP and negotiating its use in England, planning the implementation, recruiting the pilot sites, purveying the ingredients of the programme to the workers, training them to carry it out and supporting them while they are doing so. In describing how this was done, those in the team responsible for implementation noted how innovative and different the process was from anything in which they had previously been involved. Those involved in administration and finance described systems that were common to all statutory programmes.

A distinguishing feature of the relationship, however, is the amount of contact between members of the central team and the frontline staff delivering the programmes. Apart from regular visits to the ten sites and reviews of progress, the whole team has been involved in the many events about the FNP that have taken place during the year. This has resulted in those involved at grass roots level feeling that they are part of an innovative and exciting development, which is receiving attention at the highest policy-making levels. This feeling - that being involved in the FNP makes staff a pioneering and 'special' group - has been emphasised by the leadership, and has provided energy for the experiment. Respondents in local sites have suggested that this has sometimes helped them to transcend what are clearly very challenging aspects of the implementation of the programme.

The tasks of the central team

The Project Director, the Implementation Lead and the initial Midwifery Adviser all visited the NFP headquarters in Denver, Colorado, met Professor Olds and his senior staff and received training in the approach and its application. The American team have since visited England as part of the licence agreement, and have been involved in the training of Family Nurses. But the responsibility for ensuring that the English version of the intervention is implemented according to the model rests with the central team, and particularly with the Project Director and the Implementation Lead. The latter described how unique the programme was in comparison with any other work being carried out by health professionals in the UK. She saw as one of the functions of her role articulating what is different about the programme and why it is different. And she noted that the more she knew about the programme the more confidence she felt in it. Among the unique qualities she identified were:

- The centrality of the relationship between Family Nurse and client;
- The high levels of new skills Family Nurses had developed to help them manage that relationship;
- The holistic nature of the programme, all parts of it being essential. Elements cannot be applied in isolation;
- The importance of the regularity of the home visits, and the regularity of the pattern within the visits, as a therapeutic tool for people with deregulated lives;
- The modelling of behaviour throughout the programme, by Family Nurses to clients, by supervisors to Family Nurses - and by the central team to the ten pilot teams. *"You don't have to have the answers, in the same way as the FN doesn't have to have the answers for the family - but what you do need to be able to do is to contain their anxiety and to give them a space in which they reflect in a strength-based way, in a productive way."*

As the custodians of the fidelity of the scheme, the Project Director and Implementation Lead have had to discuss with the Denver team the extent to which modifications can be made to suit the English context. Apart from some changes made to written materials, the central team have tended to reinforce the importance of fidelity to the scheme and to discourage any variations. As the year has gone on it has

become clear that there is some room for variation in the application of the programme, but the central team felt that this could get out of hand if there was too much variation from the prescribed approach. However, FNs are encouraged to mix and match materials, to swap the order of visits round if such changes seem to suit a family better, to respond to the circumstances they find when they visit.

Both the Project Director and Implementation Lead noted the challenge to longstanding professional attitudes, which they see as inherent in FNP. Describing her response to her first exposure to the home visiting nurses in the US, the Project Director noted that they emphasised the positive and took great enjoyment in their work. The strength-based approach to families offered an opportunity to see clients not as presenting with problems, but as people who could have positive and satisfying engagement with their babies. This 'hearts and minds' element means that FNP has been constantly 'sold' to local managers and stakeholders, and the commitment of the teams of Family Nurses has to be continually upheld. The onus for this has fallen largely on the Project Director and Implementation Lead.

The Central Project Manager has dealt with the 10 site Project Managers, focussing mainly on the financing of the local projects, with responsibility for informing Ministers of the programme progress, ensuring that the evaluation was delivered as specified and that data were collected by sites. The External Liaison manager communicates with sites about matters like training arrangements, and manages the website. One of the significant differences about FNP has been the level of openness about difficulties encountered by FNs, supervisors and managers, which they share with one another, between sites and with the central team.

6. Conclusions

Midwifery

To maintain partnership working between Midwifery and the FNP:

- Midwifery managers should always be involved in the planning of FNP services and should be kept informed of service development by their management equivalent in the PCT. They should be part of the strategic board guiding the programme;
- Any referral system between midwifery and the FNP should be designed to minimise additional work for midwives;
- Where midwives are involved in referring women to the FNP, they need to understand the programme, its specific remit, its distinctive approach and its goals;
- Where midwives are involved in referring young women to the FNP, a referral should be written into the antenatal care pathway;
- FNs need to inform the midwifery service as to whether individual clients are participating in the programme;
- Clear guidance is needed from the Department of Health to maternity services in those areas where the FNP is operating to clarify issues of consent and confidentiality for referrals.

Children's Centres

- The responses of Children's Centre managers to the FNP showed a low level of understanding of the precise nature of the programme;
- Without some more detailed knowledge of the programme content, the theories on which it is based and the techniques in which FNs have been trained, it is difficult to see how managers will be able to plan the integration of the FNP with their own services;
- What knowledge managers do have of FNP services comes from individual FNs - they have not been informed through their own management system;
- Family Nurses have been responsible for getting young clients to use Children's Centre Services;
- Children's Centres are keen to integrate the FNP into their services but need guidance on how to do this.

The unique elements of the FNP approach and the importance of fidelity to it suggest that there will continue to be a need for a central support unit that is independent of the main delivery mechanisms - PCTs and local authorities - for the service. There is a danger that it could be diluted or modified if there is no dedicated structure to maintain its integrity.

Chapter 7 - Cost issues

1. How much time are the FNP staff working per week?

Fifty-six of the 57 FNP staff kept a diary (although two, who were changing jobs, kept it for only a week each). One Family Nurse was on annual leave for the entire diary period. The most striking information to come from the diaries is that all the other 54 who returned diaries worked more than their normal hours. After taking account of annual leave and time off in lieu taken during the period, the FNP staff worked an average of 6 hours 45 minutes a week more than their normal hours (see Table 7.1; note that the figures in the table indicate hours for the two-week diary period). The overall average number of overtime hours worked in two weeks was 13 hours, 29 minutes. Full-time Family Nurses (three-quarters of those returning diaries) worked 7 hours and 10 minutes more per week than their standard hours and part-time FNs worked 5 hours and 25 minutes more pre week. Only one managed to take sufficient time off in lieu to bring her actual hours worked to below her standard hours (and she is included in the average figure, bringing it down, at least marginally). On average, both full-time and part-time FNs worked 20 per cent more hours than their standard working week. Calculated as a proportion of standard hours, taking into account whether or not the FNs were full or part-time, this ranged across the sites from 13.8% of standard hours to 32.9% of standard hours. Overall, fewer than 10% of the respondents had worked 6 or less hours of overtime in the two-week period and the majority (76%) had worked more than 9 hours of overtime.

As the diary period does not cover the whole year, it cannot be stated categorically that the working patterns observed were representative. However, absence rates were low during the diary period. Less than 9 per cent of the standard hours available were accounted for by annual leave and sick leave. The average over the year would normally be around 15 per cent of available hours. Thus the pressure to cover for colleagues' work will have been somewhat lower over the diary period than the average over the year.

Family Nurses have a set pattern of visits to deliver, which is the underlying basis of the FNP programme. In addition, they provide the Child Health Promotion Programme to the families once the clients have had their babies, and they liaise with other agencies. The overall resource level available for England was based on the caseload pattern of nurses in the United States. The pattern and content of visits is the same in both countries.

However, given that English Family Nurses are clearly finding that to deliver the programme they need on average to go beyond their standard working hours (and bearing in mind that they were not operating on completely full caseloads at the time of the diary exercise) there are several possible reasons underlying the observed pattern. The first is that the standard working hours of English FNs are shorter than those of American nurses. In the UK the average employee (in all occupations) works 1648 hours a year, while in the USA they work 1809 hours (OECD, 2007). Holiday entitlements also differ; they are commonly two to three weeks in the USA and six weeks for NHS nurses. This difference, with no difference in normal weekly hours, would mean that US nurse home visitors have around 7 per cent more standard hours during the year than English Family Nurses. Secondly English Family Nurses, related to their being embedded within the NHS, are doing other work apart from FNP activities. For example, one of the issues raised during the course of the evaluation is that they often have to complete several sets of notes. In only two of the ten sites do Family Nurses complete only a single set of FNP notes. In most sites they complete

two sets of notes, and in two sites they complete three: one set of FNP notes, one set of PCT notes and one set of health visitor notes. This is one example where it was straightforward to ascertain the additional burden imposed by the delivery of the FNP programme in England within the institutional context of a universal National Health Service. It is likely that there are other issues related to the English institutional framework that lead to a higher overall workload for a given caseload of clients. They also are required to attend some activities to maintain their professional status.

Finally, the Family Nurses and supervisors were the first to test the FNP in this country, and are likely to have spent time in familiarising themselves with the materials, discussing them within teams and reading around the topics of the training events than would be the case in the USA where most practitioners have been providing this service for some time. All these activities were essential to becoming fully trained, but will not carry on in the long-term.

2. How do Family Nurses spend their time?

Family Nurses spend around 30 per cent of their working time in direct contact with clients, either on visits, attending clinics or by telephone or text. Attendance at clinics, as reported in their interviews, was generally when they accompanied a client, or introduced her to other services. Some were also attending scan clinics as a means of recruiting clients. They spend a similar proportion of their time on tasks associated with contacts (unsuccessful visits, preparation, travel and notes). They spend 20 per cent of their time on activities that are specific to the FNP programme (team meetings, training, supervision, promotion of the programme and work associated with programme data requirements). The remaining 20 per cent is accounted for by administration, liaison with other organisations and professionals and other work, including time that was not allocated to other headings in the diaries. Figure 7.1 shows the overall allocation of time into the four broad areas. Figure 7.2 shows a more detailed breakdown within each of these four categories.

Client contact

The diaries identified 898 visits over the two-week period, involving 613 individual clients, although 137 visits did not provide a client indicator, so the number of clients with whom contact was made will have been larger in reality. The administrative visits database for the same period identified 675 clients who were visited, although this was based on the returns of only 54 Family Nurses, compared with 56 for the diaries. The average length of a visit was just over an hour and a quarter, both in the diaries and in the administrative records.

Family Nurses had 129 unsuccessful visit attempts, including those where the client cancelled by text message at the last minute. These took an average of 27 minutes. They also had 316 contacts with clients either by telephone or by text message. The number of different clients identified was 100, but 192 contacts had no identified clients, so again, the number of clients involved will be underestimated.

Figure 7.1: Allocation of time by groups of activity

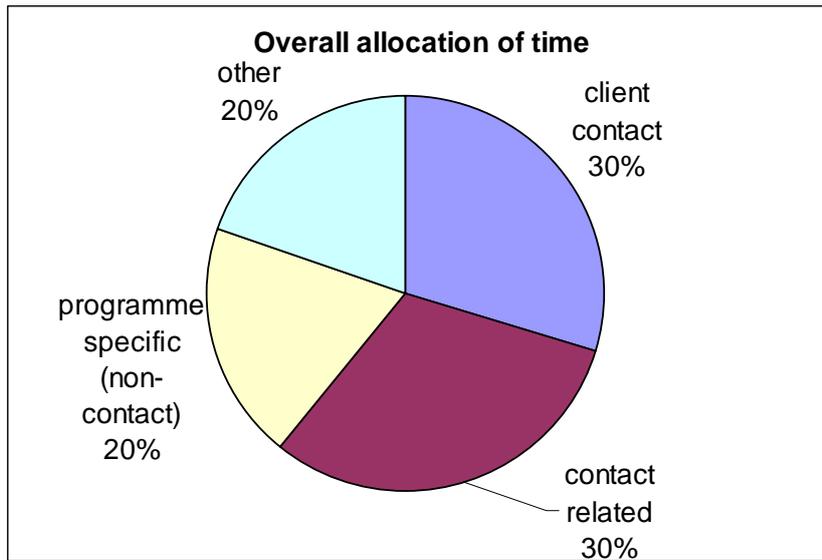
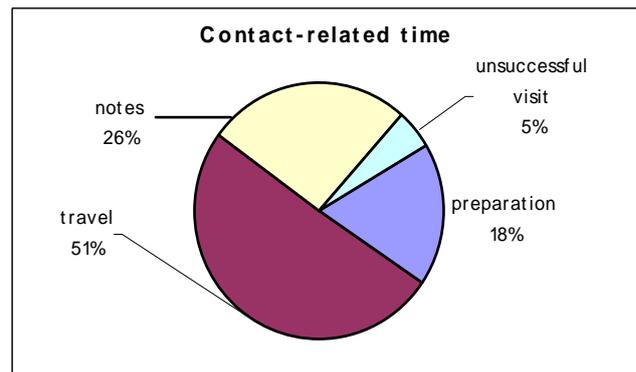
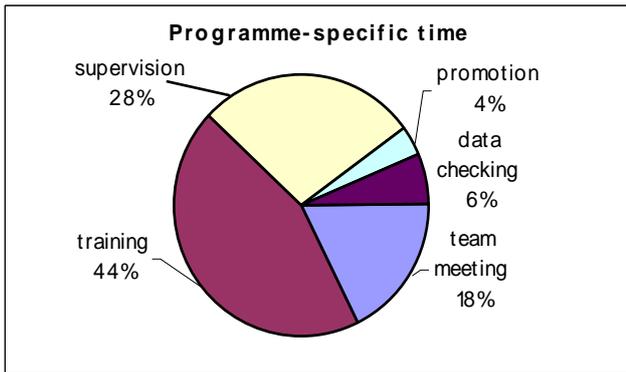
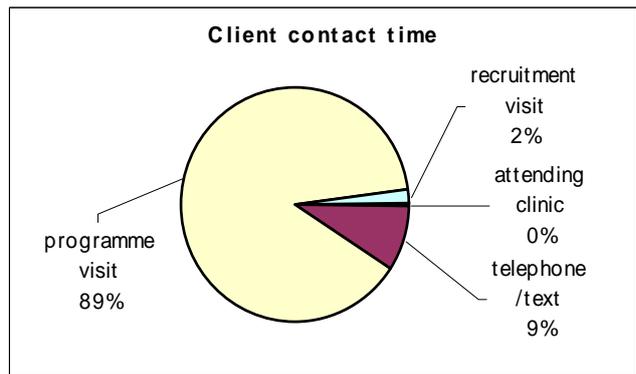
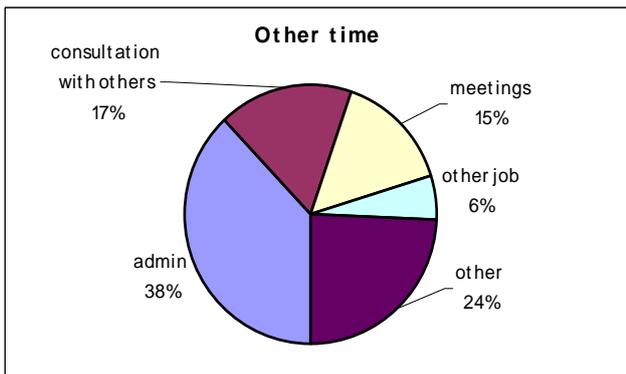


Figure 7.2: Allocation of time within activity groups



Contact-related time

The main element in contact-related time, accounting for half the total, or 15 per cent of all time, is travel. The average journey time for all journeys was 25 minutes. According to the administrative returns, the average distance travelled for a visit-related journey was 6.2 miles.

Preparation for visits (18 per cent of contact-related time and 6 per cent of all working time) and notes (26 per cent of contact-related time and 8 per cent of all time) were the other two main elements of contact-related time. Since total contact-related time and contact time were about the same, it is clear that each hour spent on visits generates another hour of work in terms of travel, preparation and notes.

Programme-specific time

Some elements of what Family Nurses do are specific to the protocols of the FNP programme. These elements account for 20% of Family Nurses' time. The most important element in this group is training (44% of programme-specific time, 9% of all working time). Other elements include individual and group supervision (28% of programme-specific time, 6% of all time), and team meetings (18% of programme-specific time, 3% of all time). Data checking and programme promotion, although relatively small elements in themselves actually accounted for one full-time equivalent Family Nurse over the two-week period (81 hours 45 minutes).

Other time

Family Nurses spent 3% of their working time in consultation with others (case conferences, and discussions with GPs, social workers, Connexions and other agencies). They spent 8% of their working time on administrative tasks and 4% on unclassified activities.

Interpreters

During the diary period there were 1045 visits either completed or attempted. Interpreters were present on 25 occasions (2.5% of the total). However, in one site interpreters were present during 17 per cent of visits, and the availability of interpreters was a constraint on the ability of Family Nurses to manage their time effectively. Several diaries contain comments to the effect that scheduled visits had to be cancelled at short notice because of the non-availability of interpreters.

3. Variation between sites

Table 7.1 shows the average time spent per Family Nurse on key activities by site. It also shows the average overtime hours worked. In some sites they spent more time on all activities other than administration than do Family Nurses in other sites, but the time spent on visits is linked with overtime. Family Nurses in site 6 spent more time on most activities than those in the other nine sites, except for notes and did the second highest number of overtime hours. Those in site 2 had the highest levels of overtime working and also the highest amount of time on visits, and their mean number of visits, at 7.5 (Table 3.7) was the second highest. The site with the lowest amount of overtime spent the third lowest time on average making visits in the two weeks and had one of the lowest average number of visits made at 5.4. Nevertheless, site 3 had the highest mean number of visits at 8.1 but only a moderate mean amount of overtime (see Table 3.7).

FNP sites vary significantly in their geographical size and transport connections, so one may have expected that travel activities would account for the greatest range in time spent by FNs. However, while travel times do vary, these are not the greatest cause of variation. There is significant variation in the time spent on training, but this is to be expected over a relatively short period, as this is a lumpy activity, often in half days or full days, so if a whole team has a training session this will show up as a large block of time. There are some other unexpected features. In site 1, notes took twice as much time as they did in the other nine sites. Staff in site 7 spent a comparatively large amount of time in team meetings and on administration. Time spent on supervision in site 7 was nearly three times that spent in sites 1 and 8.

4. Conclusions

Family Nurses across all sites are not managing to deliver the programme within their normal working hours. At the time of the diaries they were working 20% more than their standard hours. This has implications for the extension of the programme to other areas, because the more it moves into the mainstream, the less likely is it to be able to rely on the continuing willingness of FNs to work additional hours, whether or not they are paid for them. Moreover, this was happening at a time when many Family Nurses did not yet have a full caseload. The standard schedule, apart from the first month following enrolment and the first month following the infant's birth, is visits every two weeks, which with a full caseload would imply around 1,000 visits a week across all sites. Although just over 1,000 visits were attempted, only 898 were achieved. But these visits involved only in the region of 700 clients.

Comments made in the diaries suggest that FNs who work part-time find it particularly difficult to keep their non-working days free of work commitments. This also has implications for rollout, given that the majority of health visitors in England work part time, and this is the pool from which most Family Nurses are drawn.

At present the babies born to the clients of the Family Nurses are only a few weeks or months old, so that the lifetime outcomes for the clients and their children are unknown. This means that it is not yet possible to compare the benefits of the programme with the costs. The next phase of the evaluation will explore overall programme costs and workforce implications.

Table 7.1: Average time (hours:minutes) per Family Nurse on main activities over two-week diary period by site

							Site				
	1	2	3	4	5	6	7	8	9	10	Average (range) across all sites
Activity											
Home visits	17:54	25:27	23:26	18:10	16:21	24:26	21:03	20:10	23:45	18:51	20:57 (16:21 – 25:27)
Travel	12:38	14:36	13:50	8:09	10:38	15:07	13:06	13:20	11:15	12:00	12:25 (8:09 – 15:07)
Preparation	6:50	5:57	4:05	3:51	3:57	6:00	2:30	3:30	5:30	4:39	4:29 (2:30 – 6:50)
Notes	14:43	6:39	6:01	6:45	5:24	5:41	5:33	5:30	7:18	5:51	6:45 (5:24 – 14:43)
Admin	8:28	7:42	5:18	4:45	3:03	6:33	8:39	5:52	6:30	6:00	6:10 (3:03 – 8:39)
Team meetings	2:33	3:36	3:24	2:00	2:30	5:55	8:41	1:24	2:24	2:26	3:19 (1:24 – 8:41)
Supervision	2:56	4:37	5:11	6:05	3:30	4:33	8:18	2:57	3:56	4:22	4:43 (2:56 – 8:18)
Training	8:03	5:30	9:10	18:45	7:48	9:00	2:22	9:15	15:52	13:03	9:47 (2:22 – 18:45)
Consultation	2:20	3:18	2:52	2:27	1:33	2:18	1:30	1:55	1:22	3:42	2:23 (1:30 – 3:42)
Overtime hours	16:08	23:42	13:14	8:08	8:16	19:56	11:18	13:22	12:07	12:36	13:29 (8:08 – 23:42)
Site total											
Standard hours	330:00	360:00	585:00	427:30	360:00	300:00	375:00	435:00	375:00	367:30	
Actual hours worked	378:25	460:15	651:10	470:10	327:10	334:45	424:00	447:45	404:45	408:00	
Actual hours leave/TOIL	32:15	18:15	39:45	19:00	82:30	45:00	07:30	67:30	30:00	22:30	
Overtime hours	80:40	118:30	105:55	61:40	49:40	79:45	56:30	80:15	59:45	63:00	
Overtime hours as % of standard hours	24.4%	32.9%	18.1%	14.4%	13.8%	26.6%	15.1%	18.4%	15.9%	17.1%	

Source: Family Nurse Diaries

Chapter 8 - Nature of the work and best practice

All those directly involved in the FNP in the pilot sites point out that, while the intervention may appear on superficial examination to be a more intensive version of existing UK early years health services, the actual experience is of a very new way of doing things. Many of the FNs themselves were attracted to the work because it was new: *"...in my old job, although I still really enjoyed it and it was what I wanted to do, I had still been looking out for other things, you know, something new to get my teeth into."* They also wanted an opportunity to target the most needy parents, a wish that had arisen from their previous experience. The implication is that FNs did not feel they were properly able to target need in their roles as health visitors and midwives. *"This project was a blueprint for what I wanted to do; it was as though somebody had read my mind."* Since their original motivation, the FNs have acquired a much closer understanding of the programme. On the whole they remain committed to its approach.

1. Benefits of the FNP for practitioners

- **Reaching real need.** All FNs describe the depth of knowledge they have been able to gather from some clients. This has partly been because of the intensive contact, but it is also made possible by the programme materials, which help FNs to explore clients' lives with them. FNs describe the relationship that results as something they have not encountered before in their professional lives. Although there is some discussion about the exact criteria that will help the programme reach the clients who need it most, FN responses show that they feel this is happening already.
- **Using skills.** Most FNs believed that FNP drew on their existing health visitor/midwife skills as well as adding a whole new set. *"Although the way of working is new, you pull on the experience you have as a health visitor...I've worked in deprived areas, where there was a lot of child protection and chaotic families and that is a huge thing. If you had never done any of that, you would be overwhelmed."*
- **Working with a structured programme.** FNP may have sounded prescriptive and alien at the outset, but FNs report that they have grown to like the structure. *"It's massively different. I quite like structure anyway, personality-wise. If I'm given something to do, I just get on and do it. At the beginning you tended to think too much about what you were going to do because there might be seventeen bits of paper for one visit. Now I've got used to it, you just bring it all into the conversation, mentally tick-box as you go along and you know you've covered everything. I have adapted to it alright, I think."* FNs noted that the structure of the materials was helping them to structure their own thinking about the visits and what had happened in the visit, advancing their own understanding. *"Health visiting is so loose compared to this. A health visitor might say 'I supported the client' but not be specific. We are now able to analyse what we have done."*
- **Standing shoulder to shoulder with the client.** FNs see themselves as aligned with clients, whose strengths they are emphasising. They are aware of the change in their own position when they compare themselves to other practitioners - in case conferences, for example. They like making a partnership with the client where they can.

- **Small signs of progress.** Frequent visiting allows FNs some quick feedback on the effects of visits: one described how a first visit on brain development in babies had encouraged a client to immediately buy some books for her unborn baby. *“She must have had ten books in this carrier bag and asked me which book I thought the baby would enjoy most - which was lovely.”*
- **Close relationship within the FNP team.** FNs have relied on their colleagues to help them with the intensity of the work. The experience of being in a small exclusive group is also inclusive for the members. *“They care - they actually care about the clients and the work is important to them, and you feel the same.”*
- **High quality training.** FNs are appreciative of the quality and amount of training they have received and the status of those who have delivered it.
- **The scope of the work** The FNP approach offers practitioners the chance to work with the whole family - especially with fathers and extended family. FNs feel that they are being given an opportunity to tackle root causes of family dysfunction.

2. Barriers to effective working

Many of the things that FNs consider affect their capacity to do a good job have been alluded to elsewhere in this report.

- **Size of caseload.** In several areas FNs are reporting that it is not possible for them to deliver the complete programme, with full fidelity to 25 families.
- **Last minute cancellation of visits.** Young mothers agree to the FNP programme, but there is no sanction that obliges them to take part. Often they give the FN very short notice that they cannot receive a visit. And it is then difficult to re-schedule into a full timetable.
- **Insufficient planning time.** Absorbing the new stages of the programme and also to prepare materials for their visits and know which are the best to use once they are with a client. This problem should lessen as FNs get more familiar with the programme.
- **Clients’ loss of interest after the birth.** FNs note that this is the time when it can become harder to retain clients. *“They are not so keen to have you there in the early days after the bay is born. They have lots of visitors, they don’t need you.”*
- **Fatigue.** FNs report that three visits per day is the maximum for effective working but generally they have to do more to ensure fidelity.
- **Presence of numbers of people during a visit.** It can be difficult for the FN to capture the client’s attention when there are other people in the room for the duration of the visit.
- **Clients who cannot read or write.** FNs deliver the programme to mothers with literacy difficulties but report that they do not feel it is as effective as it could be.
- **Problems with supervision.** Although not commonly mentioned, difficulties that were identified with supervision were insufficient confidence in the supervisor and insufficient time for the job from part-time supervisors.
- **Having to keep separate data** for the PCT alongside the data required by FNP and the evaluation of FNP.
- **‘Slipping back into the health visitor role after pregnancy’.** FNs note this tendency when they fear that a client is losing interest in the programme. Several had found that the way to deal with this was to use the PIPE materials.
- **Insufficient knowledge** about some matters that arise on their caseloads. Substance misuse, domestic violence and mental health problems were mentioned.

- **Travelling long distances.** Although this was particularly acute in one of the sites with a big rural hinterland, FNs in other areas brought up this matter: *“I did four visits yesterday and it’s a nightmare. I’ve got one in X (area), and one in Y (area) and one in Z and I’ve got them all the way up the river and back.” If you get held up it’s very stressful.”*
- **Getting expenses from the PCT.** This had been a particularly acute problem in the early months of the programme.
- **Insufficient quantities of equipment.** In larger teams FNs report that they have to share equipment and it often not available when they need it.
- **Not being informed when client has been discharged from maternity unit.** Most clients make contact when the baby is born, but sometimes FNs do not know that the mother has come home.

3. Best practice in delivering the FNP

In order to understand better how FN works in practice, a small group of cases were selected for scrutiny. One was taken from each site. Interviews were conducted with the client and family members, with the Family Nurse, her supervisor and with other professionals involved with the clients where relevant. Most were chosen because they represented particular features in the client or family, features that were replicated in many of the FN caseloads. Short descriptions of the client and her situation are given below. They illustrate some of the extremely complex situations in which FNs are working.

Case studies

1. Strongly engaged father

Both client and partner are working with the Family Nurse, despite the fact that the pregnancy was unplanned. Initially the client wanted to have a termination but the father did not want this. He has attended all the FN visits and completes all the facilitators. When first approached the client felt she did not need FNP as her mother is supportive and she has some experience of young children. But she felt the programme would benefit her partner as he was inexperienced with children - so it was for his benefit they decided to be involved.

2. Client under 16 years

This client is 14, and has been in care after running away from home when her family pressured her to have a termination. Her mother lives alone and is dependent on alcohol. In addition to the Family Nurse this client sees a social worker, a youth worker and a support worker for runaways. The client was in a relationship when she became pregnant and now lives with her boyfriend and his mother. She goes to school and is studying for GCSEs. The FN finds this client easy to work with and finds her poised and mature.

3. Client who is transient or homeless

This teenager was classed as homeless before becoming involved with FNP. She says that her pregnancy is the result of a rape and that the father could be one of several men. There is a big age gap between the client and her current partner, about whom there have been concerns expressed by the social services department and the FN. At the first interview with the researcher the client was seven months pregnant and had just moved into a mother and baby unit (where she had a key

worker from social services) with the intention that she would stay there until the child was two. However, due to a disclosure made to the FN, the baby was placed with foster parents. The client has supervised access to the child for three hours a day and remains engaged with the FNP

4. Client who is isolated / asylum seeker

The client is an asylum seeker. She came to England unaccompanied when she was 15, and was taken into the care system. She now has a partner who is the father of the baby, but she lives alone in local authority housing. The FN feels that the client is well engaged with FNP even though there are language difficulties. The client is learning English through an ESOL course.

5. Client who had previously been in care

This client has been in foster care, moving frequently from one family to another, for most of her adolescence. Her partner, who is the father of the child, was also in care for much of his childhood. His parents were drug users, and he has also used drugs but is not currently doing so. Until recently this client had a social worker, but since she has been using FNP, social services have decided she does not need to be monitored. A particular concern is that most of the mothers in this client's family have experienced postnatal depression. The FN found this client difficult to engage and hostile to authority at the outset, but this attitude has changed. Both the client and her partner are involved with FNP.

6. Client with a premature baby

This 17-year-old client had brief contact with the FN before her baby was born 10 weeks prematurely. The mother is unqualified, spent no time at school after the age of 13, and has a history of sexual abuse in childhood. Since she became pregnant she has had three partners, one the father of her child. None are now engaged with FNP. After the baby was born they spent four weeks together in a Special Care Unit, and since discharge this client has been moving between her sister's house, her mother's house and hostel accommodation. The FN is concerned about attachment and post-natal depression, and the mother's history of eating disorders.

7. Client with identified learning disabilities

The client went to a special school and has an IQ of below 70. She was taken into care at 8 because of abuse, and then lived with a foster family until she was sixteen. She moved away to live with a boyfriend, but returned to her hometown when the relationship finished. When the FN first contacted this client she was living in a bed-sit in an area known for drug use and prostitution. She had no bed, linen or furniture, and the accommodation was damp and verminous. The client had frequent urinary tract infections and slept on a wet mattress on the floor. The FN contacted social services and the mother now lives with her baby in a foster placement. The FN found her difficult to engage initially, being very quiet and making little eye contact. However, she has become much more communicative, and contacts the FN by phone between visits.

8. Client who is well supported, partner and extended family

This client lives at home with her parents and partner (the father of her child). She has a close relationship with her own family and the family of her partner. She had been with him for 18 months when she became pregnant. She was in fulltime work prior to the pregnancy and plans to take a year off before returning. Her mother will look after the baby until he/she goes to nursery. The FN describes her as a model client, who was recruited to the programme at 16 weeks gestation, has never cancelled a visit, and is one of the few where the FN has been able to carry out the prescribed visits consecutively.

9. Non-English-speaking client

This client and her husband live in a small bed-sit which is due to be demolished, therefore housing is an issue and takes up time on the FN's visits. The client does not speak English - though her husband does - and the FN visits with an interpreter. Her husband does not appear to trust the FN and recently has only allowed her to visit when he is present. He answers the FN's questions and the client's answers tend to be brief and in agreement with her husband. The interpreter has observed that in earlier visits, when the husband was not present, the client was more confident and had longer conversations with the FN. The mother-in-law is also present for FN visits and interrupts frequently. The FN suggested that the client could visit the Children's Centre with her baby and perhaps start to learn English, but the husband would not allow it. The client has subsequently asked the FN not to visit any more.

10. Client who is well supported, partner

The client lives with a partner. They had had a short relationship (two months) before she became pregnant. The client's family was upset about the pregnancy and she was estranged from her father for some months. However, since the baby was born this has been repaired and she has support from him, other family members and friends. The FN found this client very easy to recruit and she rarely misses appointments and is very involved in the programme.

A detailed examination of the Family Nurse involvement in these ten cases revealed evidence about what constitutes best practice in delivering the programme.

Engaging the clients

- Clients who are well engaged describe their FNs as friendly, understanding and as being good listeners.
- Initial access to the client is secured because the FN is seen as approachable and different from other professionals; clients feel she is non-judgmental, non-threatening and has time to spend with them.
- Once the client is engaged, the FN builds trust and mutual respect between them. This is done by, for example, reinforcing confidentiality at every visit so that clients are able to disclose things to the FN that they might not tell anyone else. *"We know she is not going to tell anybody and we feel comfortable talking to her."*
- In order to get clients to keep appointments FNs have been flexible, altering their approach to visits to suit clients and maximise participation. They have been persistent. (One FN carried out a visit by taking a client to a GP appointment she had forgotten about and doing the visit afterwards in the car!) Where clients have moved frequently, FNs have visited in all the different homes. FNs make themselves available by phone and text.

- FNs have also been flexible about the frequency and length of visits to accommodate clients who need more intensive input. FNs offer a break in visits to clients who are finding them too much.
- FNs have accompanied clients to appointments with other agencies.
- Collaboration with other agencies on a client's behalf.

Box 8.1: Best practice in collaboration

Client wanted to return to school, but crèche available for sixth form pupils only. FN contacted the school to discuss access for the client's child.

FN kick-started a housing process which had stalled due to client's non-engagement with services.

Social worker acknowledged that one client has three hours of access a day with her child because the FN is involved with her.

Where successful communication between FN and other agencies revealed discrepancies in asylum-seeking client's information about her age and history, all professionals involved agreed that her well-being was more important than accuracy about her past and that her version of events and her age should be accepted.

FN consulted with locality psychologist to gain understanding of a client's complex background.

Engaging with families and others

Stresses in the lives of clients can affect their ability to participate in FNP. FNs try to reduce them so that clients are better able to absorb the content of the programme, and this involves them in work with partners, family, foster carers and staff from other agencies. This means being non-judgemental in order to gain the confidence of family members and friends, building relationships with and between them as a basis for stabilizing issues between family and client. Many FNs report successes in this sphere, and have found that family members and others who have been persuaded to join in with the programme have often been extremely helpful. For example, where a client with learning disabilities was re-housed with a foster family, the FN liaised with the foster mother to agree her role vis-à-vis the baby and the client.

Spending time

Feedback from clients indicated that the time FNs spend with them is important. *"I felt good after the Family Nurse left because there was somebody coming round, caring for me and that gives me a good feeling."* Other professionals have larger caseloads and cannot spend as much time with the client, and they do not visit so frequently. *"She knows a lot of personal stuff that the midwife doesn't. The midwife doesn't have time for that sort of thing."* Clients noted this extra time means that they gain more and deeper information from the FN.

Programme materials

Clients respond differently to the FNP programme materials, according to their literacy and education levels. FNs need to keep the interest of clients who find the materials basic, as well as those who are daunted by them. The approaches taken are to elicit knowledge from the client and then to add to it; discovering together; lecturing and providing information. In the case of clients with learning disabilities, FNs have often tailored the materials and methods of delivery to the individual.

Box 8.2: Best practice in adapting programme materials to an individual

The client has learning disabilities. The FN's approach is to bring up subjects three or four times over a long period, so that the client becomes used to hearing about them, and has time to process the information, come to her own conclusions and make informed decisions. Although the baby was only 3 months at the time of the case study, the FN was already talking about weaning, so that the client would have plenty of time to prepare and be used to the idea.

The FN selects the programme materials to be used. She does not choose items like the 'Healthy Eating Quiz' which she often used with other clients, because it is a test of logic, and this client does not understand or enjoy this type of experience and becomes disengaged.

The client reported that she was pleased that the FN had found for her a book about babies aged 0-1 in large print. The FN commented that *"being gentle and encouraging gives her ownership, lets her feel empowered, and she is tuned in to this baby...I don't do the programme in its whole format, I miss out bits for her."*

However, not all clients enjoyed being 'taught' by the FN. *"It's more like dictation, feels you are being told what to do"* said one. The client's mother, who was also present at the interview, put it more strongly: *"New mums don't have time to fill in all this bloody paper...if it had been me I would have said 'Sod off!'"*

4. Best practice in the FNP as identified by clients

The FNP aims to enrich the lives of clients in all areas that involved their well-being or that of their children. The materials cover both practical and emotional aspects of pregnancy, birth, parenting and relationship experiences.

- Clients express a preference for help which they see as practical, and which can be quickly proven to be effective: *"I think the information she has given us in communicating with the baby is really useful. Telling us to communicate while I was pregnant...I do think it has made a difference as my baby calms down when he hears our voices."*
- Most clients appreciate the professional background of the FN and want to take advantage of her health expertise.
- Housing issues cause concern for many clients and FNs have spent a great deal of time helping clients by writing letters to housing association, contacting the council, finding foster homes and getting clients into sheltered accommodation. Despite the time taken up by crises, including housing crises, the FN continues to deliver the programme as far as she can.

- FNs had managed to make relationships and engage with clients with whom other professionals/practitioners had not managed to engage. Clients drew a distinction between their relationship with the FN and that with other figures. *“We have a different relationship than with them...I am not judged, she doesn't make me feel bad.”*
- FNs have been able to maintain a relationship even where a Child Safeguarding procedure has been put in place at the instigation of the FN.
- FNs have emphasised the strengths of a client even in contexts where other local professionals have been negative. There was some evidence that this could lead to a review of their estimate of the client's capabilities by these agencies.
- FNs have encouraged clients to re-engage with agencies which they had previously stopped using or refused to use.
- Where clients have no English or English as a second language, FNs have tried to develop ways of communicating. In some cases the communication with a client has been good enough for them to be able to act as the client's advocate with other agencies.
- FNs have been able to engage with fathers by talking to them specifically. Some fathers have expressed surprise at this: *“I didn't expect to be involved: I thought it would be more for my girlfriend's benefit.”* Client's report changed attitudes towards the baby in fathers.
- FNs have been flexible about when they can work with families in order to keep fathers involved, and where the father has assumed the prime caring responsibility, FNs have carried out the entire FNP visit with the father.

Box 8.3: Observed effects of best practice

In two of the cases studied in the small sample described above major changes in the client were observed by professional workers from agencies other than health.

One of the clients had been in poor health before joining the programme, but the focus on healthy eating during pregnancy has made a physical difference and her weight increased from 6 to 9 stone. *“The nurse taught me to eat small but often.”* A social worker reported that this client had used techniques learned from the programme to negotiate pain relief during labour (Smart Choices). *“We can actually see that she knows rather than just being able to follow instructions...she is using her own initiative...we could close the case knowing that she has that support, rather than just being left to herself.”*

A second client was originally a heavy smoker (40 a day) and now does not smoke at all. This client's learning disability worker said: *“Everyone has commented on the change in this client, but I am not sure anyone would be able to say it was due to the impact of a specific worker...(she) still has some major difficulties with her learning disability, but the change has been incredible to see...she used to be incredibly lethargic...but now she is up and doing what she needs to be doing...I have to say I know one can get cynical in this job and I was expecting the worst, but it has been remarkable and the client should be very proud of herself.”*

5. Some limits of best practice

The examples cited in this chapter have largely been taken from the application of FNP approach in complex situations, on the principle that the difficulty quotient in these cases is higher, and the programme harder to implement, so if it is implemented, this is a good sign. However, there are situations that prevent implementation:

- Where clients simply lose enthusiasm for the programme (after the baby is born is a key time for this to happen);
- Where other agencies do not keep the FN informed about matters like changes in care plans;
- Where the demands of the extended family members mean that the FN finds herself engaging with them rather than with the client;
- Where clients feel that FNP is being offered to them because it is assumed they will not be good parents;
- Where language and cultural issues prove insurmountable;
- Where fathers or other family members are not supportive of the client's involvement in the programme. Some partners who were not the father of the child could behave intrusively during the visit, speaking for the mother or contradicting the FN.

Box 8.4: Interpretation and best practice

In one pilot site, where the majority population is from a minority ethnic culture, a permanent interpreter was not appointed to the FNP for eight months. In the interim agency interpreters were used to accompany FNs on visits. These staff members were not interviewed by the FNP team, and they had no training in the FNP materials. In the case study carried out in this site, one agency interpreter offended the client by making inappropriate and negative comments about her furniture; another spent some of the visit time telling the client about her planned foreign holidays.

The FN reported difficulties in using some of the materials with this client, and suspected this had been the result of inadequate interpreting and the client failing to understand the materials.

Cultural manners could get in the way of effective communication. Where an FN felt that her non-English-speaking client had benefited from some work they had done on routines, the client told the researcher that she did not find the questionnaire about routines helpful. The client's husband told the researcher that his wife did not want the FN to continue visiting but his cultural politeness prevented him from telling a visitor to his home that she was no longer welcome. This raises a serious question about whether a programme that relies so centrally on a therapeutic relationship between Family Nurse and client can be delivered in these circumstances.

6. Conclusions

This kind of work is new and it is about getting to the most needy first-time mothers. It does, nevertheless, draw on the previous skills of the Family Nurses. In addition, the FN's personality and relationship to the client is central to making and keeping the link with the programme. The evidence from these case studies indicates that while the skills of the FNs and their best practice in approaching each client can result in effective engagement and work with clients, progress can be strongly influenced by factors related to the client, both current and historic. It is a particular challenge to retain clients with complex issues on the programme. The following points about good practice can be extrapolated:

- Because the goal is to deliver a service to the most vulnerable, elements of best practice are focussed on enabling this. For example, spending time exploring clients' lives with them (which might be seen as over-stepping boundaries in other professions) are best practice in the FNP;
- Despite the new qualities of the approach, FNs generally consider that their previous experience is useful to it (and some think it indispensable);
- Family Nurses like the elements of new practice like the structure and prescription of the programme, even if they were dubious about them at the outset;
- The personality of FNs is an aspect of best practice: they use themselves as an element in the programme. This makes it particularly draining;
- Almost all FNs note that the main barrier to doing the job to the standard they want is that there is too much to do in the time available.
- There have been some practical irritations which have affected best practice, including the nature of the bases from which FNs work, inadequate back-up, equipment and poor communication from other agencies;
- The nature of an FN's practice is visible in FNP in ways that it was not in their previous roles. If they do not retain clients, or deliver fidelity, they know that they have not done this, and feel personally responsible. It is also evident to the team, management and central team;
- FNs often have to balance the capacity of the clients to cope with the programme with the programme delivery - so that best practice may actually be delivering less of the prescribed material, or giving clients a break, - if clients can be retained on the programme;
- As well as their practice being far more exposed than in other roles, FNs can also receive immediate feedback, which shows them that the practice is effective, or, sometimes, feedback after a long period, which they had not expected.

Chapter 9 - Sites, teams and supervision

The ten pilot areas for FNP vary in their size, demography, and administrative structure. As described in Annex 1, the two with the largest areas cover rural as well as urban populations. All the other sites are covering entire towns or cities or in London covering boroughs. These sites present some contrasts - between small urban communities and large cities for instance - or between populations with substantial numbers of families from black and minority ethnic groups and those with virtually none. Nevertheless there are major similarities. All the sites offer areas of social exclusion and disadvantage, often in city centres or peripheral estates. The nature of deprivation varies. Families may live in large estates, or be scattered in small rural locations with little access to transport or to other amenities. Although the variables are not exhaustive, they have given an opportunity to gauge how far differing community life and geography may affect the working of Family Nurses.

Most obviously it has an impact on where the team can be based. The most common model is for them to be sited together as a team, usually in an NHS building or in a Children's Centre. In the larger areas FNs have been based in separate offices, often in Children's Centres, but come together weekly as a team. In one site the journey to a client's home rarely takes more than 15 minutes, and a few families live within walking distance of the FN base.

The imperatives of geography make it likely that there will be no perfect recipe for providing bases for FNs. The evidence from those who are working in the larger areas is that they are spending a great deal of time travelling (especially to meet with their colleagues) and that this can result in an accumulation of unpaid overtime. But team meetings are an essential element of the fidelity of the programme. In addition each full-time Family Nurse needs to meet with the supervisor weekly for individual supervision, or fortnightly if part-time although his or her guidelines gave some leeway for this to be telephone contact if distances were too great.

1. FNP teams

In six teams all the FNs had been health visitors and of those six teams four were also led by a health visitor, and two by a midwife. In four teams the FNs included at least one midwife, led in three cases a by a supervisor with a health visitor background and one who was a teenage pregnancy coordinator. A simple description of the most recent employment of the teams does not show the full extent of the midwifery knowledge among FNs. Many of those who were working as health visitors before they joined FNP are also qualified midwives. Their previous experiences may have added value for the FN role. For example, in one site three of the FNs had previously worked together as a health team in a Children's Centre - so they knew one another very well before FNP began. In another they had all been based in separate GP practices and their paths had sometimes crossed. In most of the smaller conurbations there were previous links between at least some members of the team. Only in one team did none of the FNs know one another at all. There was anecdotal evidence that the position of any newcomer to a group where there were pre-existing relationships could be uncomfortable at the outset, but the central support systems for FNP have been able to pick these situations up.

Where teams are based

Family Nurses care about their base - and would generally prefer to be together. In one site there is a central office but no adequate shared office space for the whole team. The FNs are expected to 'hot desk' in Children's Centres round the area, but have been resisting this, saying that they need to be together and support one another. *"I need to know I can come back here and talk to the other nurses about what I've done, or ask them any questions I am not sure about."*

The main reasons why teams have had to shift from one base to another has been either problems with the provision of IT - PCTs have found it difficult to set up adequate systems in non-PCT premises - or the size of the base. Situations where the whole team including the administrator are located in one building and everyone has their own desk and computer are optimal. The preference of FNP teams for NHS buildings is not compatible with the intention that the FNP will provide a bridge between PCT and local authority provision for families.

Allocation of clients

The majority of sites have tried to develop some kind of geographic division of the area so that FNs recruit their clients from a limited catchment area and so that their visiting schedule is rationalised as far as possible. In practice this system has often had to be adjusted. In the large cities FNs have tried to keep to allocated areas, but this sometimes proved difficult when assigning clients. In the smaller urban settings clients have generally been allocated case by case, depending on the state of individual FN caseloads. In one site only allocation was based on keeping caseloads as equal as possible but with some attempt to match clients to specific skills in the team. So, for example a client expecting twins was placed with an FN with a midwifery background, a client with learning needs with an FN who is experienced in working with people with learning needs.

Leaving the FNP team

Interviews and web postings by FNs indicate that many consider leaving the work at times, either because of the amount they have to do, because they felt emotionally drained, or because of tensions within teams. Several noted that one of the reasons they had held on when times were difficult was the thought of the other members of the team.

Relationship within FNP teams

FNP training has endeavoured to consolidate the relationship between the members of FNP teams from each site. Comments from external interviewees (including Project Leads, Project Managers and other stakeholders) are that FN teams, including supervisors, are tight-knit and present as a kind of 'elite' or secret society

There is a wide range of reasons why some groups cohere more than others, but the role and behaviour of the supervisor can be a significant factor. The supervisor and Project Manager may make an alliance which separates them from other team members, FNs may have applied for the supervisor's job in the first place, FNs may feel they are better qualified than the supervisor and do not have respect for her as a result.

Teams were rated by researchers on a scale from 1 to 7 based on information from a variety of sources besides FN interviews: supervisors, Project Managers and Leads, notes of regular visits by the central team psychologist and observations by researchers of teams working together and of supervision. Half the sites were judged to be functioning well (rated 6 or 7), two were functioning adequately (rating of 4) and two were thought to be having some difficulties in functioning well as a group (rating of 3). However, there were indications that difficulties within teams could be resolved over time and that team functioning was susceptible to improvement.

2. Supervision in the FNP

Each team of FNs has a supervisor who is responsible for managing the work of the Family Nurses, maintaining the quality and integrity of the programme, overseeing the recruitment and engagement of families and facilitating continual learning and service improvement. They hold a small caseload of families (minimum of 2 clients for a half-time supervisor) to whom they deliver the programme. *"It is being a jack-of-all-trades - you have got to know about the programme, the facilitators - the pregnancy, the infancy the toddler stage - you need to know how all the facilitators work, how your team work as a group and as individuals, and how it is really important that each member of the team is really happy and knows what they are doing...It has been - almost like a Family Nurse - non-judgmental"* (supervisor).

Regular supervision is an intrinsic part of the FNP model and is of two types: group supervision, properly occurring every fortnight, when members of the team present a case for discussion with their peers; one-to-one supervision involving a meeting with each Family Nurse, and the supervisor making an accompanied visit with each FN to a client every four to six months.

There is a necessary variation between this pilot project and US practice. In the USA supervisors will be experienced nurse home visitors. In England there was no pool of experience from which to draw and the supervisors therefore embarked on this programme from the same starting point as all the FNs. Because they have a smaller caseload, they have also become less experienced than the FNs as the piloting have continued. Several have noted how the FNs are more familiar with using facilitators and more adept at using them because they have had more practice. In future the trained FNs and supervisors from this pilot offer a useful resource as supervisors in an extended programme.

Role of supervisors

Supervisors said that the main elements of their role involved leadership, communicating information to the team and supporting the team, the main responsibilities being the one-to-one and group supervision, and supervised visits described above, and ensuring the fidelity of the programme. They networked with the central team, the PCT and local authority. They felt they were responsible for keeping the team together and focussed, which meant being really familiar with the pregnancy and infancy guidelines and data collection. Many said it was essential that they had their own clients so that they could understand the FNs' experiences and be familiar with the materials.

The nature and quantity of support they were offering to the team varied with the site. Some supervisors said this meant finding out what each individual FN needed, others that the best form of support was for them to be emotionally stable themselves. Some concentrated on persuading the Family Nurses of the value of supervision and its central role in the FNP approach. They talked about helping staff to manage their time and giving them a chance to offload. Some supervisors noted the need to have empathy with the FNs, non-judgmental, non-confrontational and approachable. These qualities seemed to mirror what was required to foster the relationship between FN and client.

Supervisors said that they were hard-pressed to carry out all the elements of their role, particularly promotion of the programme in the locality, and liaison with the central team and the evaluation team. Some felt the client visiting aspect suffered as a result. But several noted that this provided an important balance to the job and doubted that they could supervise the team without the understanding it gave them. And some felt it offered some respite, too: *"I am so pleased there is a nurse visiting part to the post because it's an absolute relief to get out of the office sometimes."*

Most supervisors felt that non-visiting part of the job was a full-time post and yet considered there was still insufficient time to do everything properly. *"I feel frustrated in that for the last six months I don't feel like I have done a good job for anybody."* Other frustrations were about operational matters, including paperwork and equipment not being in place, which had affected the working of the team.

Group supervision

Observations of the group supervisions which are a central element in the FNP approach indicate that, when working well, these require the supervisor to be on a par with other members of the team and not 'superior' in experience or knowledge. The main function is to convene the meeting and to ensure that individuals are able to present a case, discuss this case with their peers and receive their advice, suggestions and insights on how to handle it. This process was observed in some sites, and could lead to engagement by FNs with one another and strategies for moving forward with clients.

However, there was a difficulty in ensuring that the requisite time was available for this process. The group meeting was often divided into two parts, operational matters and the supervision, and the first was inclined to poach time from the second, with the supervision sometimes relegated to a few snatched minutes at the end of the meeting. In some areas Project Managers who had attended the operational part of the meeting stayed for the supervision, in others local arrangements for visits - from safeguarding officers, for example - meant that the meeting became a multi-disciplinary sharing of information. Again, the group supervision time was reduced. Although nobody actually said so, the implication was that this element of the programme was expendable, and could be compensated for by informal interaction between FNs. This may explain why in the one site where FNs have no communal base, the group supervision observed was of the prescribed variety, since the team only came together for scheduled group meetings. Other teams have more informal contact and tend to substitute this for formal group supervision.

As well as providing FN with help on specific cases, it appears that the group supervision process offers team members a level of insight, mutual support and understanding, which is essential to the FNP process. The case studies that are discussed are often harrowing and very difficult, but FNs note that their colleagues help them to find a way forward. There was evidence that this also gave team

members a stake in one another's caseload, since FNs often referred to clients over time so their colleagues knew their history. They were also able to report back on the efficacy of the specific work they were doing, thus learning from one another. When the psychologist from the central team attended group supervisions they concentrated on the standard process, though some time was spent on teams catching up on their general progress. Without a focus - like the psychologist - teams could spend quite a lot of their group time complaining about difficulties, without using the case study method to move things on.

Demarcation between supervisors and Project Managers

The Project Manager role is not part of the USA NFP model; it has been necessary in England in order to establish the local sites and to enable them to be accommodated into the existing NHS / local authority service model. From the outset there were difficulties of definition here. These could affect the jobs people applied for. Early on the central team clarified the job descriptions for each post, but there remained considerable variability in each site. In the main the Project Manager has dealt with the budget and done some dissemination about the programme locally, the supervisor has supported the team and done some promotion too.

The relationship between supervisor and manager could be very good or problematic. Some supervisors felt there was a contradiction in being supervised by the Project Manager. They did not want to admit to anxieties about performance because it would mean admitting to a weakness when they were responsible for the efficiency of the whole team. They were far more comfortable with the support they received from the central team psychologist, but even here there were concerns about confidentiality. How far were weaknesses being shared with the central team?

The shared responsibility for promotion could lead to difficulties. These mirror a wider dilemma for FNP. It is a very specific holistic model of work, which can often only be conveyed by the narrative of those involved in it from day-to-day. Supervisors (and FNs themselves) who have the day-to-day experience are able to communicate the essentials to other people; it can be harder for Project Managers to do so.

Monitoring fidelity

Supervisors are the local custodians of fidelity - of applying the model accurately and improving performance. Most noted that their early training had enabled them to do this, but that it was their experience of implementing the programme that had really helped. This was mainly because they became more familiar with the ingredients of the programme - the techniques and programme materials. The feedback from regular programme monitoring had been a useful way of gaining insight into what was happening in client visits in terms of the domains covered. Joint visits were helpful in understanding what FNs were doing, identifying where they were concentrating on one area rather than another.

Supervisors' understanding of FNs

Supervisors all talked about the need to allow staff an opportunity to offload, because of the challenges of the clients, the difficulties of the clients' lives, and the pressures of being part of a demonstration project which is receiving a great deal of attention and for the success of which they feel personal responsibility. To give this support they have to be non-judgmental, flexible about the needs of different FNs, non-confrontational and approachable. To achieve this, supervisors needed to know more about FNs' home lives than would normally be required in a professional situation.

They needed to provide a safe place for FNs (and themselves) to speak openly about worries, fears and weaknesses in regard to the work. This process was more revealing than most FNs were used to and not all had found it possible to behave in this way. There were signs that they were becoming more used to it as the project proceeded, and that supervisors were becoming more used to facilitating the process.

How pivotal is the supervisor in the team process?

Over the past year the research team has amassed a considerable amount of material about the workings of the teams in the ten pilot sites. While supervision is clearly an important element in team functioning, it stands alongside the relationship between team members in terms of its importance. However good the supervision, it does not compensate for difficulties between team members. On the other hand, a team where the FN relationship is well founded and supportive can cope, even when supervision is removed for a period. Ideally an FN team has both. The following description is of a site that does:

The supervisor does a joint visit every three months and the client is picked randomly. The supervisor is looking for fidelity to the programme, content of visit and what is covered, how the nurse relates to the client and other family members. The supervisor also sees her role as supporting staff rather than managing them, as she feels confident in them.

The supervisor is warm and friendly and encourages the nurses to offload about their visits. She will advocate for them to the manager and PCT of their behalf. She covers their work if they are away.

The team in this example is described as:

Generally very cohesive and strong, at the group supervision they really support each other. They have tended to justify their colleague's actions if she expressed doubt about her behaviour - for example 'You have very difficult cases' or 'I think you handled it better than I could'. There is no bad feeling or animosity between nurses about client allocations or workloads.

In this second example there are tensions between team members and with the supervisor:

The nurses are very different characters and have commented on this in their interviews. They have different personalities and ways of working. Together they seem to get along well and support each other personally and professionally. They have some issues with the way they are managed. Their comments suggest they do not find supervision helpful or valuable.

But it is important to acknowledge that team dynamics can alter over time. Towards the end of the first year several teams reported that differences between FNs and supervisors were now reduced. The conclusion must be that team relationships and the role of the supervisors are inextricably entwined, and both need to operate well to ensure optimal functioning of teams and take time.

Importance of administrators in team functioning

The FNP process requires the generation of considerable amounts of data by all members of the team. Given the pressure that FNs are under to complete all other elements of the programme in line with fidelity, the data requirement was seen as onerous in the first months of the project, but less so as time went on, particularly as feedback from the evaluation team enabled supervisors and teams to judge their progress.

The role of the part-time FNP administrators was extremely important here, and contributed to the smooth functioning of teams. There is again a conspicuous contrast. In one site the administrator is conscious of getting things done correctly and shows many signs of personal investment in FNP. She takes the lead in making sure Family Nurses hand her their data forms when they get back to the office. In another there has been a litany of problems around administration, with many changes of personnel and other human resource problems. The unsatisfactory situation has communicated itself to FNs who do not always return to the office at the end of the day's visits and have left forms at home or forgotten about them.

The administrator is and will continue to be an important member of the FNP team. The pilot experience indicates that the post needs to be full-time if administrators are also providing back-up support for FNs (copying materials, for example).

3. Conclusions

The organisation of FNs into dedicated teams is central to programme operations, with support from within the team and between team members acting as a consideration when FNs are finding the work difficult. The way FN teams work is more intimate and mutually dependent than FNs had experienced in team-working in previous roles, where, for example, one of the prime functions of the team is to allow practitioners to cover for one another. However, most team members found it easier to relate to people who shared their own background.

FN training has reinforced relationships within teams, partly because FNs have had to travel together to undertake training, and trainers have treated them as a group and also because they underwent 'bonding' exercises (though many disliked these at the time). FNs who are not based with other members of their team feel isolated and can often lose some sense of the FN identity - for example by bonding with another professional who is seen more regularly.

Teams did not necessarily cohere from the outset, but relationships have improved over time, and are aided by the supervision process. It is therefore extremely important that group supervision is protected and experienced regularly. Supervisors help to make teams work, but where their role is undermined, by management or for other reasons, it is nevertheless possible for FN teams to function and provide support to one another. Ideally the team coheres and the supervisor helps this to happen. Supervisors, like FNs, feel extremely overloaded and that they do not have enough time to complete all elements of the job - but value the fact that they are visiting families and thus getting an insight into the day-to-day experience of team members.

In the future it should be possible to ensure that a supervisor who has experience as an FN leads FN teams. Support for supervisors from the central team psychologist and especially from the Implementation Lead has been helpful to them. They liked the direct link to the central team, and the opportunity to help one another. If FNP develops in a wide number of sites, a system to allow links between supervisors, perhaps on a regional basis, would be helpful.

Supervisors have had a more extended local promotional role than might have been expected from their job descriptions. This may be because their insights into FNP, based on their own visiting experience, have made them able to communicate what the programme is about in ways that are not open to Project Managers. Although most have enjoyed this part of the work, it can add considerably to their workload. Thus this will need to be account in any rollout of the programme.

Overall the team functioning can have a great deal of impact, helping FNs to cope with issues such as clients leaving, helping to resolve work-load difficulties, and allowing the strong emotional element of the work to be managed.

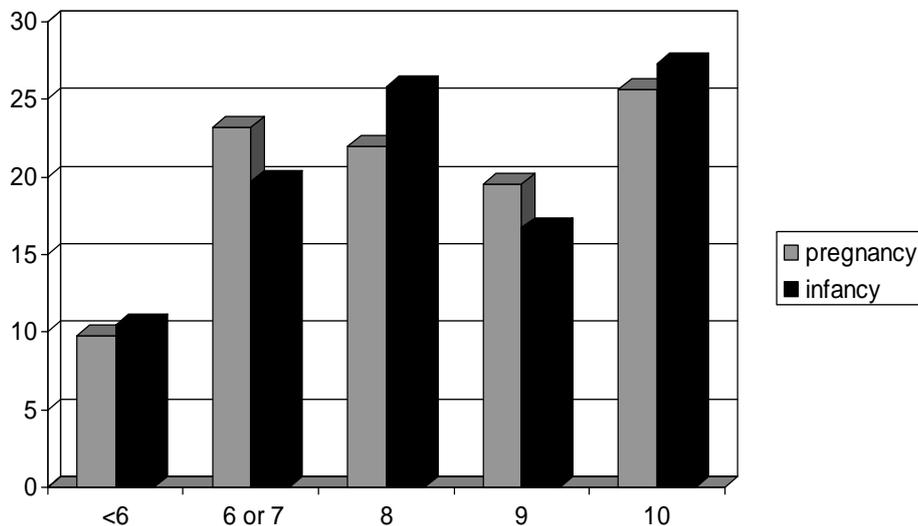
Chapter 10 - Potential impacts of NFP

This evaluation was not designed to answer whether the FNP leads to greater changes in the young women who receive the programme compared with those not receiving support in this manner. To answer that question a randomised trial is required so that comparisons can be made between families receiving the support and those who are not. However there are a number of sources of information about whether any changes are taking places in the lives of the clients, and about their overall well-being in relation to areas that are health priorities for England. These are the reports of the clients themselves, the forms that the Family Nurses use to collect the same information at intake and at later stages, and the forms describing parenting behaviour such as breastfeeding and the health and well being of the infants, where their behaviour or status can be compared to national statistics or to government targets.

1. Client ratings

After their semi-structured interviews, completed during pregnancy and then again in early infancy, clients were asked to indicate on a scale from 1 to 10 whether they thought that the support had made a difference to them. The end points were defined as: 1= no difference at all, I have not learned anything new and have lots of other support anyway; 10 = made all the difference in the world, before being offered FNP I was not sure how I would cope. Overall they indicated during pregnancy and in the first month or so after their baby was born that they thought the support had made a substantial difference, with a quarter giving the highest rating (see Figure 10.1). The average rating in pregnancy was 8.0, and the average in infancy was 8.1.

Figure 10.1: Client ratings of the difference that FNP support has made to them, on a 10-point scale (percentages)



2. Substance use changes during pregnancy

Health Habits forms are completed by Family Nurses at intake, and again at 36 weeks gestation and these allow for an examination of change in the rate of smoking, alcohol consumption and illicit drug use.

Smoking

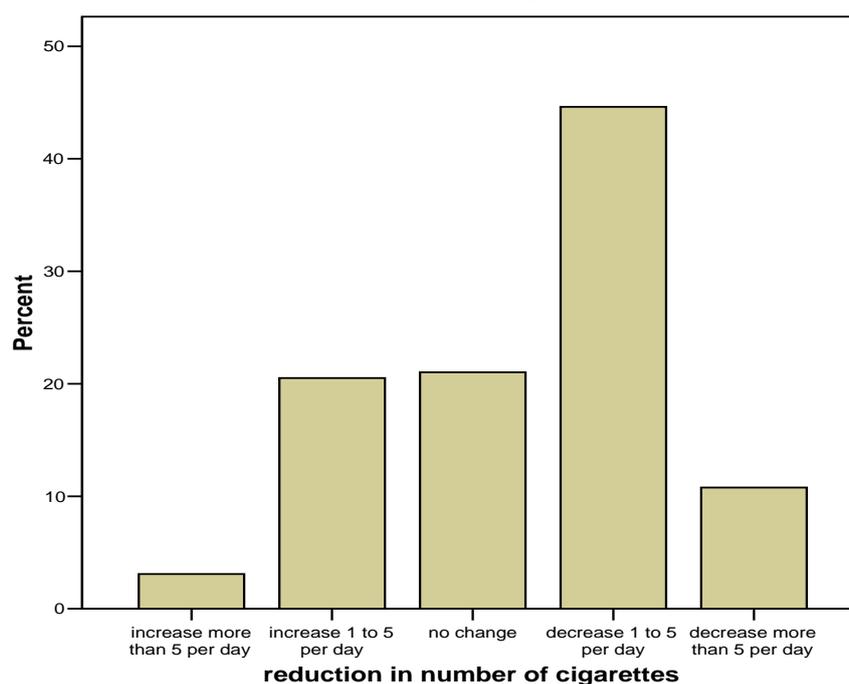
As described in Chapter 4, out of 911 clients with intake 'Health Habits' forms completed, 40% had smoked in the previous 48 hours with a further 5% indicating that they had smoked at some time in the pregnancy. The mean number of cigarettes smoked at intake was 2.5 per day, with a range from 0-30. Just under a quarter (24%) reported a rate of smoking of 5 or more per day. At 36 weeks the same form was re-applied and data were available for 515 clients, when the rate of smokers was lower at 34%. The mean number of cigarettes smoked at 36 weeks was 2.2 per day (range 0-40). Almost all those describing themselves as nonsmokers at intake were also not smoking at 36 weeks (96%). Data were available at both time points for 475 clients and the rates of smokers for that sub-sample were comparable to the whole group, with 41% at intake and 34% at 36 weeks. This represents a relative reduction of 17% in the proportion of clients smoking from intake to near the end of pregnancy.

For the 475 clients with information at both times, the average number of cigarettes smoked per day was significantly lower at 36 months than at intake, though the change is small (average reduction 0.5 cigarettes per day, $t = 3.12$, $p < 0.002$). Excluding those who were not smoking at intake, the average reduction for the remainder ($N = 195$) was 1.3 cigarettes per day ($t = 3.66$, $p < 0.0001$). Of these, the largest proportion (21%) did not change their smoking intake but where reduction occurred it was generally up to 5 fewer cigarettes per day (87, 45%) with smaller numbers reporting larger reductions (6-10 fewer cigarettes 15, 8%; 12-23 fewer cigarettes 6, 3%) (see Figure 10.2). Some reported more smoking at 36 weeks, with 40 (21%) indicating between 1 and 5 more per day and a small number (6, 3%) with larger increases (between 7 and 37 more).

Looking at those who smoked at least 5 per day at intake, only 115 had data at both time points. Their average reduction in smoking was 2.4 cigarettes (range 1.4 to 3.3; a significant reduction, $t = 4.77$, $p < 0.0001$).

Numbers with information at both time points are small when broken down by site, but there were significant differences between sites, the most effective having an average reduction of 1.7 (2.9 when including only those who smoked at intake) while in one site there was an average increase in reported smoking of 1.6 (2.7 including only smokers). This may have been influenced by some clients being more open about their behaviour once they got to know their Family Nurses.

Figure 10.2: Extent of change in smoking between intake and 36 weeks gestation for clients who reported any smoking at intake (N=195)



Alcohol consumption

The current UK NICE guidelines indicate that pregnant women should not consume more than 1-2 units per week (Carvel, 2008). Questions about alcohol consumption at intake cover the number of days in the previous two weeks that they have taken any alcohol and the number of units consumed per day on those days when alcohol was consumed. The majority (787/913, 86%) did not report any alcohol consumption at intake, with an average number of days in the previous two weeks when alcohol was consumed of 0.2 (range 0 to 6). The average number of units consumed was 0.3 (range 0 to 20; 789 report 0). The average for those who reported any alcohol consumption was 2.3 units per day (range 1 to 20).

At 36 weeks data were available at both time points for 478 clients. The average number of days when alcohol was consumed and the average number of units consumed per day were both significantly lower than at intake, though the differences are small (mean number of days 0.1, range 0 to 4; mean units 0.2, range 0 to 6; 92 % reporting no alcohol in the previous 14 days). Data were available at both time points for only 68 of those who had reported any alcohol consumption at intake. At 36 weeks their consumption was significantly lower than it had been at intake at 0.4 units (range 0 to 5, $t = 5.28$, $p < 0.0001$) with the majority (54, 79%) reporting no alcohol consumption in the previous 14 days.

Other drugs

Similar questions asked about the use of marijuana, cocaine and other drugs such as heroin or amphetamines in the previous two weeks. Reported use of other drugs was low. Only 2.5% reported any use of marijuana at intake (23/910) and 1.9% reported any use at 36 weeks (10/514). The mean number of days on which marijuana was used was 0.2 at intake and 0.1 at 36 weeks but the difference was not significant. Out of 475 with data at both time points, 10 clients indicated using the drug on fewer days, and 12 reported consuming less when they did use marijuana. However three

indicated an increase in the number of days and 6 indicated an increase in the number of joints smoked when it was used. There are no follow-up data for the three clients who reported using cocaine or other 'street' drugs at intake.

3. Maternal nutrition

In relation to PSA Delivery Agreement 12, indicator 3 is to improve levels of obesity in children under 11 years (HM Treasury, 2007b). One of the aims of the FNP support is to help mothers to eat more sensibly themselves during pregnancy, and to instil views on healthy eating that will then translate into a healthier diet for their children. During interviews conducted in pregnancy, many clients recalled the materials and activities that were designed to help them to have a healthier diet, particularly that they should eat more fruit and vegetables, consume less sugar and fat and drink more water. They were asked to keep diaries recording everything that they ate. Some recalled that, on seeing what their daily intake was, they had started drinking more water or milk, others that they were not eating enough, "*She told me what to eat and she told me to eat little bits at a time, that's helped me a lot*" (in Chapter 4 the range of BMI values shows that some of the young women were seriously underweight prior to becoming pregnant). Many noted in interviews that they had tried to eat more healthily after going through their diary, mainly after the diaries had revealed that they were not eating the recommended five fruits and vegetables a day. "*Writing the food down, to show what I'm eating, I didn't eat fruit. My mum gives me it, but I don't like it. I signed the form 'I agree to eat 5 fruit and vegetables'. It's a commitment, but it is hard.*"

Ongoing monitoring of their weight and BMI once they have given birth, and that of their children, would be required to determine whether this recall of healthy eating materials did translate into more effective weight management.

4. Breastfeeding

In 2005 in the UK, 76 per cent of mothers (all ages) began breastfeeding but only 64 per cent were still breastfeeding at one week and few than half (48%) when their infants were six weeks old (Shribman & Billingham, 2008). The rate of breastfeeding is lower for mothers in low SES occupations (65%), for those who left school at age 16 or younger (49%) and for mothers under the age of 20 (52%). One third (34%) of mothers under 20 were reported to still be breastfeeding when their infant was one week old and only 14% when they were 6 weeks of age (Bolling et al., 2007).

Given the significant long-term health benefits, the UK Government would like to see levels of breastfeeding prevalence at six to eight weeks as high as possible (HM Treasury, 2007b; PSA Delivery Agreement 12). Information about breastfeeding is available from several sources.

Client interviews

In their first interviews many mothers recalled that the Family Nurse had provided them with materials and information about the benefits of breastfeeding, and about how to actually proceed, with diagrams and photographs. There was also a doll that could be used, though a number of the respondents expressed dislike for the realistic tongue movements, suggesting that the doll might not be encouraging for all.

Remarks showed that Family Nurses have been informative but not dogmatic. One mother noted, *“When she first mentioned breastfeeding I said I didn’t want to. She said ‘I’m not going to force you, just give you the information.’”* Some mothers-to-be had fixed plans during pregnancy but most were keeping their options open until the birth and the programme helped some to understand the benefits more clearly; *“Now I know what breast feeding is and how it helps, before I thought it was nothing. It’s good for the baby and I want the best for my child.”*

In their second interviews mothers were asked about infant feeding. A number mentioned that, although they had hoped to try, they had not breastfed because they had a Caesarean section and others indicated that they had tried for a few days but that it was too painful. These remarks indicate a potential role for hospital nurses and for midwives to be particularly supportive of breastfeeding when mothers have delivered by Caesarean section. Many of the clients texted their Family Nurse to tell them about the birth, but visits could not always be scheduled within the first few days of the birth meaning that some would have given up on breastfeeding before the first FNP visit after the birth. However some did describe ways that the Family Nurses, or the materials that they had provided, were able to support breastfeeding as indicated by these three mothers: *“I was struggling to get him to latch on, and that book didn’t do much for me, so in the end I just looked in my folder and I read that bit and it worked a treat!”*; *“When he was breastfeeding she was showing me a good position to do it as he wasn’t latching on at first that was really helpful”*; *“I think I would have still breastfed if I had not had had my nurse but I might have given up, I hated it at first, it was really hard and I was in pain, but my nurse encouraged me to carry on and it’s been fine since then.”*

Family Nurses also helped mothers to maintain their confidence even if breastfeeding had not succeeded. This 19 year old has tried hard to breastfeed in the hospital but without much constructive guidance and without success. Subsequently her Family Nurse helped her to come to terms with it. *“The hospital made me feel like I had to breastfeed, they said I had to give it a go until I was bleeding at the end, they pushed me that far. The nurse said ‘Well you have given it a go it’s not a bad thing to bottle feed’.”*

Family Nurse audit

Family Nurses were asked to complete an audit for each of their clients to indicate whether breastfeeding was planned and whether the client’s family had expressed a view about breastfeeding. If the infant was born they also indicated whether breastfeeding had been attempted, continued up to 2 weeks as the exclusive feeding method, continued up to 2 weeks in conjunction with bottles, and continued beyond 2 weeks. Forms were completed for 962 clients and the FNs reported that the majority (646, 67%) planned to breastfeed. If this translated into action then the rate would be close to, but still lower than, the rate for England and Wales in 2005, reported to be 77% but much higher than the rate for mothers under the age of 20 (53%) (DH, 2008). Family views were not known for all but where it was known, the majority of families were also said to be in favour (529/743, 71%).

Of the 962 clients for whom FN forms were completed, 541 has given birth and it was reported that more than two thirds (374, 69%) had initiated breastfeeding, which is an impressively high rate. However many gave up soon after birth and a smaller proportion (219, 41%) were breastfeeding at 2 weeks. The majority of these (189) were said by the Family Nurses to be continuing with breastfeeding after 2 weeks.

FNP forms

At the birth of an infant an Infant Birth Form is completed by the Family Nurse with the mother. In addition to information about the baby's weight and health they are asked whether breastfeeding has been tried. At 6 weeks an extension of the Infant Birth form explores whether breastfeeding is still taking place and, if not, when it was stopped. Infant Birth Forms were available for 494 infants but 11 did not have information about breastfeeding. Of the remainder, 65% (313/483) mothers reported trying breastfeeding, similar to the rate based on the FN audit.

Only 200 6-week 'infant status' forms were available. Mothers were asked at that point if they had ever breastfed and 60% (120) said yes, comparable to the rate based on the FN audit and again higher than the rate for this age group in the most recent Infant Feeding Survey. Thirty-four (17%) had not continued past one week after the birth, another 45 (23%) has stopped between 1 and 5 weeks after the birth but 21% (41/200) were still breastfeeding at 6 weeks, again higher than the rate of 14% reported for mothers under 20 in the Infant Feeding Survey. This information looks promising but will be more reliable when data are available for all the infants rather than this small proportion.

5. Bottle feeding and weaning

Many clients were uncertain about how old their child should be when they start weaning, causing particular anxiety amongst parents who considered their child to be a "hungry baby", not sleeping well or appearing dissatisfied after feeding. Early weaning or inappropriate thickening of bottle feed can lead to inappropriate weight gain in infants. A number of the clients mentioned that FNs had advised them to use 'hungry baby' milk, particularly at night, presumably to prevent them thinking that early weaning might be a better solution. Weaning was an area where advice from friends and relatives could conflict with that of the FN, with older relatives advocating weaning at around 4 months. Clients tended to take the advice given by the FN, which tended to be fairly firm (to wait until they are 6 months) over that given by others; *"Me and Mum thought we could wean him at 3 months and she [FN] said I couldn't, it is 6 months"*. Family Nurses had also explained that current research indicates that babies weaned before six months are more likely to suffer from obesity late in life and they were respected as authorities on the latest evidence.

6. Father / partner involvement

Many studies have shown that children do better academically and emotionally if their father is involved in their life, and families also gain financially if fathers, including non-resident ones, contribute financially. There is no detailed information about father involvement with their children, but there is information about their involvement with the FNP support.

Comments in Chapter 4 suggested that many fathers were interested in the FNP programme, looked at materials with their partners and were supportive of the concept of FNP, but in their interviews they did not give a great deal of detail about how it might have changed their own behaviour. For some the information provided by the FN had alleviated some of their anxieties about the birth process.

Unfortunately for one young man, his girlfriend eventually had a Caesarean section: *"I went through all the information about labour alongside my girlfriend and found that useful as this was all new to me so I felt prepared for labour."* Nevertheless, he also

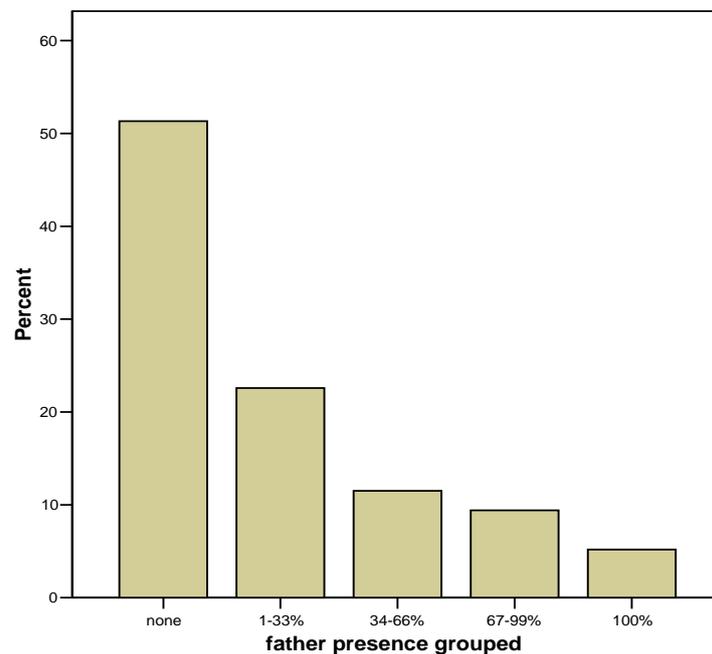
noted, *"It has helped me cope with being a father"* and was enjoying learning how to communicate with his infant.

Some reported that they were trying to give up smoking, although this had not been successful as yet. Nevertheless they were changing their smoking habits: *"I don't smoke in the house anymore. I've cut down to a couple but I don't think I'll stop"; "I'm smoking less now because I either have to go outside or to my room with the window open and something under the gap of the door."* Others noted that the FNs' materials had helped them to think about what was important for the baby, that material items were less important than paying attention to the baby *"Not buying so much stuff like toys - more picking up the baby and talking to him"* and one noted *"she gives you your confidence back."* When couples were both present at visits, or looked through the worksheets and materials subsequently, some were able to discuss and potentially resolve their thoughts about parenting, as this couple describe: *"(Father) Sometimes she gives us a bit of homework. Before he was born, we would have a debate about what we thought was right. (Mother) Yeah, stuff like, how you can bring up a child. He would have his opinion, I would have mine and then we will compromise."*

The Home Visit Encounter form documents whether or not the father or partner was present, and also how involved he was in the materials and activities. Forms were available for 1138 clients, who received during pregnancy 6.6 visits on average (range 1 to 21). Fathers were present for on average 1.6 visits (range 0 to 13). There was some father presence for 49% of the clients and taking only those, the average number of visits for fathers was 3.3. On average fathers were present for 23% of visits, but values ranged from 0% to 100%. Fathers were present for more than one third of visits for a quarter of the clients and for all the visits for 5% (see Figure 10.3).

At each visit fathers (and clients) are rated by the Family Nurses on their involvement, their conflict or disagreement with the materials being used, and on their understanding of the materials using five point scales (1 =low, 5 = high). Their average involvement was 3.9, understanding 4.1 and conflict 1.2 (N=554). The equivalent ratings for the clients were 4.7, 4.5 and 1.2, significantly higher for involvement and understanding but with no difference in the level of conflict with the materials. Comparing clients when there was some presence of their partner at visits with those where there was none (N=584), there was a small but significant difference; when fathers were present the client average involvement rating was higher (4.7 vs. 4.6, $t = 2.65$, $p < 0.01$). Understanding and conflict did not differ with father presence.

Figure 10.3: Percentage of visits during pregnancy where father/partner was present, grouped (N=1138)



To give a general overview of father involvement, FNs were asked to report, for each of their clients, on the use that fathers made of FNP materials. In a number of cases fathers were unavailable for visits, either through work commitments or for other reasons, such as being incarcerated, or living at some distance. They were asked to indicate if clients asked for materials so that fathers could be involved with some of the activities, and whether these were returned. They also reported on the extent to which fathers expressed an interest in FNP via the clients. Forms were returned from 944 clients; it was reported that in one quarter of cases (240, 25%) request had been made during about a third of visits for FNs to leave materials for the father/partner with nearly another one third asking for materials for their partner most of the time (291, 31%). Thus the clients are interested in involving their partners and fairly successfully. Family Nurses indicated that for a quarter of clients, most of the visits included reviewing homework completed by the partner (231, 24%), and for almost the same proportion of clients fathers had completed homework about one third of the time (206, 22%). More than half the clients indicated that their partner was interested in the materials, this happening on most visits for just over a quarter (245, 26%) and on about a third of visits for just over another quarter (252, 27%).

7. Confidence in parenting

One major theoretical underpinning of the NFP model is self-efficacy, providing parents with ways to solve problems for themselves and to become more able to make decisions about their lives. While some fathers may have been helped to be more confident, the mothers were able to describe this in more detail how the FNP visits had helped them to be more confident about becoming a mother. The amount of information and preparation enabled some to relax and be less stressed as the birth approached, which is likely to have a beneficial impact on the developing foetus. One noted, *“If it wasn’t for [FN] coming around and feeding me all this information I’d be clueless and think ‘what on earth is happening to me?’”* Preparation for the birth

involved both reducing anxiety and giving them sufficient information so that they know what questions to ask during labour and the delivery. As one father commented *“Other people, like the family, have just told us how it going to be painful and how scary it is, but not how to handle it.”* Some of the mothers of the pregnant women also made similar comments about how their daughters had felt less scared after receiving FNP support. This confidence continued after the baby was born as their behaviour could be interpreted and then the appropriate action taken; *“I now know all the baby’s noises for when he’s got wind or is constipated, he makes this funny face.”* The potential for FNP was nicely summarised by one mother of a 3 month old *“She gives you that bit of extra support, confidence that you are doing things right with your child. She makes you feel better.”*

Much of that confidence described above came from having someone trusted who could be asked about seemingly trivial issues pertaining to their infant’s health and well being, but instead of being given stock answer useful strategies were provided. In addition time was available, as opposed to, for instance, a GP visit; *“Well your GP, they rush you in and they rush you out, she [FN] doesn’t, she will spend time with you.”* For example a number of the mothers described how their FN had given advice about infant constipation, suggesting various strategies including drinks of cooled boiled water and gentle massage of their stomach. The latter appeared to have been particularly successful.

Family Nurses were consulted about a wide range of other infant care issues such as skin conditions, stomach upsets, mouth thrush and coughs and many noted that it was good to have someone that they could text or telephone rather than relying on services that might not respond so promptly or supportively. They were also pleased that the FNs weighed their infants at home, so that they could avoid crowded sessions at child health clinics. The regular updates on infant weight were reassuring for them. Advice on infant safety had been received, such as how to place the baby in the cot with its feet at the bottom, and not wearing a hat while sleeping, to avoid overheating.

Crying can lead to stress and some of the mothers reported that their Family Nurse had given good advice so that they were better able to cope when their baby would not stop crying. *“The best thing the nurse has done for me is she said that if my baby is crying and I can’t cope to put her down and leave her. Because if I put her down I can go away and calm down and it won’t hurt her if she cries.”* Another reported the success of infant massage. She had the leaflets from the FN in her folder and when here baby screamed and would not stop she tried the massage and *“He really likes it!”*

8. Mother-child relationship

One of the other theoretical underpinnings of the NFP programme is attachment theory. After advice on feeding, the most often mentioned aspect of the FNP programme was learning about ‘baby cues’ - ways that infants ‘say’ what they need. The ability to ‘read’ and understand their children was very highly valued by clients, and that knowledge was empowering for them and likely to strengthen bonding. The clients were able to see the theory/ information given to them by their FN in pregnancy put effectively into practice with their babies. *“I think we have bonded more, because of the activities we do. I take time out with her and try those things. I wouldn’t have thought to do that (pulling faces at the baby) if I didn’t have a Family Nurse.”*

Many of the remarks made by mothers once their babies were born showed that the preparation for communicating with their infant, and the expectation that their baby would in turn be able to communicate with them was both a revelation and also allowed them to enjoy their relationship with the baby, seeing him or her as a real person. *“It is amazing the way you can tell by her facial expression, whether she wants attention or feeding. I’d no idea about that.”* Many were amused that infants copied facial movements such as this mother; *“She told me to make funny faces to the baby and she [the baby] did it back to me, it’s nice to see that she’s communicating”* and this father *“I don’t know if it was just a coincidence, but I remembered the part about how babies would copy if you put your tongue out, he really did it.”*

Understanding why babies behave the way they do (for instance crying) without making negative connotations of their behaviour is important in preventing abuse parenting. A number of mothers expressed both surprise and pleasure that the information provided by the FN about infant behaviour was accurate: *“[FN] says there must be a reason that your baby is crying, so I look for that. I’m perfect at it now.”* *“She tells me how to read signs from the baby when he’s deep sleeping, how he moves his hand when he has got wind. I look at the leaflet, and I look at him, and it is actually true.”* This is likely not only to improve parenting but also in the long term to increase the likelihood that clients will remain involved with the support as their babies grow and develop.

9. Conclusions

The way in which the comprehensive and structured Family Nurse Partnership support extends traditional advice provided to new parents and might make a real difference to family life is nicely summarised by this 18 year old: *“It’s quite good because people think you have a baby and you just have to learn how to bath him and put him to bed, change him and feed him. But it is not, it is more than that, you need to know what the cries are for, it isn’t always just for the bottle. And it is good to know ways that you can bond with them. So it is quite helpful, more than what people might think it is.”*

Most of the new mothers, when asked about their infants, replied with remarks such as *“I love him to bits”, “He is fantastic” “She’s wonderful, she’s everything to me.”* One cannot know what their feelings would have been like without the FNP but it is encouraging that in the early stages of their child’s life they are generally very positive both about their new role as a parent and about their child. The picture was not rosy for all, many had ongoing difficulties with housing and relationships; some had mental health problems. However the FNs were able to work with them on these aspects of their lives while encouraging them as parents.

At intake more than 50% of clients had before they became pregnant been either under or over-weight according to their BMI. Many recalled in interviews that Family Nurses had given them a lot of information about eating appropriately, with the use of diaries and information sheets, and this was said to have helped them to think about eating more fresh fruit and vegetables, and fewer fattening foods, which should contribute both to maternal and then infant health.

Mothers reported smoking less by the end of pregnancy, and also drinking less alcohol - though few had reported any alcohol consumption at all when questioned by FNs at intake. It will be important in a randomised trial to collect objective evidence of substance use during pregnancy since this is covered extensively in the FNP materials.

Many clients recalled that their Family Nurse had given them a great deal of support to enable them to think about breastfeeding. Two thirds of clients were said by their Family Nurse to be planning to breastfeed, higher than the rate nationally for mothers of this age group, and of those who had given birth two thirds had attempted to breastfeed with 41% still breastfeeding at 2 weeks. By six weeks the rate of breastfeeding, at 21% was still higher than that for a nationally representative sample of mothers under 20 years of age (14%).

Many studies have shown that children do better academically and emotionally if their father is involved in their life, and families also gain financially if fathers, including non-resident ones, contribute financially. This study provides evidence about the involvement of fathers in the FNP programme, which should lead to closer involvement in their children's lives.

A randomised control trial is necessary to tell whether they and their infants are faring better than they would without FNP but many of these young women appear to believe that it is helping them.

Chapter 11 - Discussion and implications

1. Prevention of cycles of disadvantage and social exclusion

The impetus for introducing NFP to England had at its heart a focus on reducing social exclusion for the generation of children being born to these young families. There is considerable evidence that young motherhood is intergenerational. Teenage mothers are more likely to have mothers who had a child in her teens (Kiernan, 1997) and this is true even after controlling for family, school and individual factors (Manlove, 1997). Other factors associated with a higher likelihood of young parenthood include living in poverty, emotional problems during adolescence and low educational attainment (Kiernan, 1997). For example, evidence from the British National Child Development Study (Hobcraft & Kiernan, 2001) is that, of first time mothers under the age of 20, 8% had not experienced poverty during childhood compared with 31% of those judged to be poor.

There is also evidence that those who become teenage mothers have poorer outcomes later in adult life. Hobcraft and Kiernan (2001), looking at a range of outcomes at age 33 for women experiencing their first birth at different ages, found that those who became mothers in their teens had the highest proportions with negative outcomes compared to older first-time mothers. Outcomes more likely for those who gave birth for the first time before the age of 20 included: living in social housing (45%) receiving benefits (43%), having no qualifications (37%), a low household income (44%) poor health (24%, mental health problems (24%) and a low satisfaction with life (33%). The rates were higher for the under 20s than for all other age groups. For all the adult outcomes, although childhood factors such as poverty were predictors, taking these into account there was still a strong significant association between age at the first birth and poor outcomes. This study also found that, after the age of 22, there was unlikely to be a negative impact on adult outcomes.

Explanations of the adverse consequences of early motherhood often make associations with low educational attainment, which limits later employment options available to women. Additionally, young mothers, particularly teen mothers, are often single parents, which create difficulties balancing childcare and paid employment. Where partners and husbands do exist, they also tend to have low educational attainment and therefore limited employment opportunities (Robson & Berthoud, 2003).

The FNP programme has the potential to mitigate against these adverse outcomes. Research from the USA, summarized in Chapter 1, has shown that in all three trials of the programme there was wider spacing between the first and subsequent births, less reliance on welfare, more take-up of education and more paid employment. There was also more paid employment of partners. Although recruited for the most part with a simple age criterion, the English client group reflects the earlier UK findings in that they are disproportionately from households with low income, they have few educational qualifications, and many vulnerabilities including mental health problems. Thus it is possible to offer a service that is not presented as stigmatizing with a simple age criterion, but that reached some of the most disadvantaged first-time mothers, likely to become even more disadvantaged in later life.

Selection based on additional risks for mothers giving birth aged 20 to 23 was less successful and indeed the earlier UK research (Hobcraft & Kiernan, 2001) suggests that, if any over 20s were to be selected, then 22 would be a better cut-off. After that, adult outcomes in later life seem to be substantially similar to mothers giving birth for the first time at older ages. Refusal of FNP was greater for the 23 and 24 year olds, and only small numbers were identified. Thus future sites may want either to recruit only under 20s - the simplest option since it requires less of the other services in terms of information sharing - or to offer routinely to under 20s and selectively from 20 to 22 years.

This study was not designed to identify outcomes. However, the kinds of effects that the young women described are likely to be important in reducing the likelihood of them experiencing the adverse outcomes identified in previous research. Many were encouraged to think about going back to education, they were being linked up with child care provided in Children's Centres or in their schools so that this could be achieved and they were being helped to work more effectively with their child's father, even if the couple were not in an ongoing relationship. This closer involvement of the young fathers in their babies' lives is likely not only to enhance child development but also increase the likelihood that the fathers will contribute financially to their upkeep, helping to keep their mothers out of extreme poverty.

The young mothers who were interviewed and some fathers reported that they felt more confident about being a parent. Most were interested in the materials and had understood and acted on guidance concerned with enhancing their child's development. If their interest in the materials designed to highlight learning opportunities for their babies continues then their children should be on the way to make a better start in school.

The health outcomes that might reduce later health problems for the mothers or their infants look as promising. Smoking reduction was moderate. There was a high level of interest in breastfeeding infants, which translated into a higher rate of actual breastfeeding during the early weeks compared to mothers of that age group in the Infant feeding survey (Bolling et al., 2007).

Social exclusion can be defined as more than suffering from a number of disadvantages. The concept of social exclusion has its origins in Europe rather than the USA, but describes a similar phenomenon to the Underclass - i.e. a group of people who are not only materially deprived, but who have lost contact with 'mainstream' society. However, the term is much more fluid than the underclass thesis and it describes much more diffuse phenomena. Individuals and groups can be socially excluded in different ways, to different degrees and for different periods of time (Barnes et al., 2006). Social exclusion focuses on relational issues: inadequate social participation, lack of social integration, discrimination and prejudice and lack of power (Room, 1995). A crucial dynamic in the understanding of exclusion is a focus on the excluders as well as the excluded. It is obvious for many remarks made by these young women, and their partners, that they feel and are excluded, judged or demeaned by many professionals that they come into contact with. The FNP programme could provide a way for this psychological aspect of their exclusion to be reduced. The FNs behaved in ways that were contrary to this, they accepted, supported and strengthened their clients. This can allow these young people to approach the rest of their lives with a sense or potential to be achieved rather than failure to be accepted. It can also provide them with a model of professional behaviour that they should expect of other groups. Some reported being able to deal more competently with the labour and delivery context and this should also apply to other contexts as their child grows, such as childcare settings or schools. It has been

suggested that one of the most important outcomes of the Head Start initiative in the USA or the Perry Preschool Project (Schweinhart et al., 1993) was not that they 'boosted child IQ' since this often faded over time, but the programmes gave the families an expectation that formal services could be helpful for their children, and that is what made the difference in the long term. The FNP has the potential to achieve this for young vulnerable parents and their children in England.

2. Fitting the FNP into the English context of services for children and families.

Fitting in with the multi-agency approach to service delivery

The experience in the ten pilot sites has shown that the FNP is best viewed as a discrete intervention: focussed, complete in itself and not so much a partner in a multi-agency approach as a prelude to it. When respondents referred to newly trained FNs as an 'elite group' in a concerned way, there may be no cause for concern. This is likely to be the most fruitful way to conceptualise this intervention.

When Family Nurses are subject to the demands of multi-agency working, like being situated in Children's Centres, having to attend many meetings with other practitioners and so on, they become overstretched and unable to complete the core task - fidelity to the programme. Supervisors note that they feel overstretched by the need to promote the programme (even though they often enjoy doing so). Perhaps the key word here should not be promotion but protection - to work effectively the FNP needs to be guarded from many of the demands of working in a society with far more public services available for families than that for which it was first designed.

This is not to minimise the importance of the multi-agency approach to supporting families. However, that approach is weak at the very place where the FNP appears to be effective - reaching vulnerable families. Although Children's Centre managers claim to be successful in their reach, the claims are rather unconvincing. It is known from the early findings of the impact of Sure Start local programmes that the most vulnerable can sometimes miss out (Belsky et al., 2006), though the most recent research indicates that this situation did not continue once the programmes became established (NESS, 2008). A useful way for managers to view the FNP would be to say 'This is doing something we find challenging - reaching some hard-to-reach potential user of our services'. Then the thinking can focus on the way multi-agency services can build on the bridgehead that has been created. This will not mean that the FNP should operate in a vacuum, divorced from other support services. There is every reason to suppose that helping clients participate in other services, introducing them to Children's Centres, even helping Children's Centres to set up services for them will work well, both for the clients and for the Children's Centres.

Even the acceptability of the FNP to clients can be compromised by its confusion with services delivered by other agencies. Clients are suspicious of its links with social services, and when they leave the intervention early it can be because they have not distinguished the role of the FN from that of a social worker. Clients also describe what they are being offered in the language of familiar services - as 'support' rather than as a learning programme, which might result in their regarding and rearing their children in ways that will be exciting and satisfying to them and perhaps beneficial for the children. Yet many clients do describe the experiences they have when the programme is being implemented in just those terms: the most common example is the effect that talking to the baby in the womb has on their relationship to it. This is about learning and development, rather than support.

Changed alignment of professionals

FNs describe themselves as being in a changed alignment with their clients. They have reached this position as a result of the FNP training, the new skills they have developed like motivational interviewing, and by the experience of using the programme, the contents of which have succeeded in re-orienting them. This new position can be precarious, and it is interesting that FNs under pressure - from clients who are proving uncooperative for example - find themselves reverting to their old professional position. Several FNs had the insight to know that this is what they are doing and that it was not the way forward. But they are exposed by the FNP approach in ways that do not occur in the midwifery or health visiting from which they have come, and it is not surprising that they cling to these familiar rocks. But it is revealing that they recognise that in doing so the therapeutic relationship with the client can be lost. The Family Nurses all know that what they are doing here differs fundamentally from what they used to do.

It is too early to say whether this re-alignment is helping to make the intervention uniquely acceptable to hard-to-reach clients. It is part of the complex mixture of ingredients in the FNP approach, which also includes the way the practitioners have been trained and supported, the materials and methods of the programme and the way they are supervised and work in a team. If the recipe is unpicked the impact cannot be predicted. Some agencies have suggested that they would like to be able to implement aspects of FNP (use the materials, for example), but this is not viable (and would also not be permitted under the licence).

However, the one aspect of the FNP approach, which may have transferable implications, is the positioning of the Family Nurse in a relationship, which is shoulder-to-shoulder with the client. It is distressing to hear how many clients report being treated disdainfully by services because they are young parents. There were particularly worrying accounts of experiences in maternity units. But Family Nurses are considered non-judgemental, and liked because of it. How they have been trained to respond in this equal way, making partnerships with the people with whom they work may well provide lessons for the development of practitioners from other agencies.

Dealing with scrutiny and workload

In their previous professional experiences the Family Nurses had not encountered the kind of detailed record keeping, and the specific objectives, that are part and parcel of the FNP. While they enjoyed learning the new techniques, and for the most part enjoyed receiving all the useful materials, it was at times difficult to be told that they had not recruited the young women early enough in their pregnancies; that were not doing enough visits; or not completing forms accurately or completely. While on the one hand they know that this was integral to the programme, on the other had it seemed intrusive and this aspect of the supervision seemed at times judgemental rather than supportive; they felt that they were not being treated as professionals.

In the future it may be useful to help them think in more detail about why there is so much emphasis on the extent of exposure to the programme, to 'dosage', by using a medical analogy. In their experiences as nurses they would have expected to trust information about when to start using a drug, how much should be given, and how long to keep on providing the drug so that the expected benefit could be attained. In the case of the FNP they themselves, with the FNP curriculum, are the 'drug'. Research has demonstrated that it needs to be initiated by a certain point in

pregnancy, given for a minimum amount of time, and continued for a specific period. The promised benefits, based on randomised trials conducted in the USA, may not happen if the dosage is different. This needs to be set out early on in their training so that it does not subsequently look as though they are being subject to critical examination because they are failing, but the ongoing collection of statistics is necessary if they themselves and their supervisors are to know whether the programme is being delivered accurately.

Many of the FNs reported that there were just not enough days or enough hours in the day to provide sufficient home-visits and to take part in all the additional activities inherent in the FNP. It is possible that the caseload indicated by the USA team cannot be managed in England, with different working hours and holidays. However it is possible that some separation from employment in the statutory sector - discussed below, may be one way to enable the staff to have more time for delivery if the programme.

Central support for the FNP

The discrete and focused nature of the FNP as an intervention has been reflected in the way it has been set up and supported. This occurred very rapidly: within eighteen months of the idea being postulated by the Social Exclusion Unit there is evidence from a year's experience of implementation in ten areas of England. This has shown that:

- FN teams can be established.
- Existing staff (midwives and health visitors) can be converted into FNs.
- On the whole they like the result.
- Clients who are first time parents can be recruited in sufficient numbers.
- On the whole, they like the result.

The mechanism by which this has been affected, a central team relating directly to the 10 sites, has been a way of ensuring the 'discrete' nature of the programme. The apparatus that has locked it into local planning and delivery, leadership and management based in the PCT, appears to have been effective. The fact that these 'outside the team' staff have been operating with some rather inexact conceptualising about the intervention has been a drawback, which is particularly acute in the local authority. Here staff are a long way from understanding how the FNP works.

If the premise that the FNP works best as a discrete, focussed intervention is accepted, then the need to support it with a dedicated team that ensures the integrity of the approach and underpins the need for fidelity to it will be essential. There is a tendency, as social programmes are rolled out from their early testing, to give the development and support role to regional and local agencies, which are already dealing with training and support for family services. The FNP does not lend itself to this approach. It may benefit, in the long-term, from being supported by a central unit, which is positioned outside the statutory sector, which acts as a contractor to those wishing to implement the intervention. The example of Home-Start UK, a central unit that enshrines Home-Start expertise and trains staff in local organisations, disseminating information and acting as a uniting focus for the approach, might provide a model for the future. Similarly, in the USA the National Service Office for the NFP provides training for new sites, receives and processes data forms and monitors activities. If the service is to be offered throughout England in the context of progressive universalism it is likely that this kind of organisation will need to be established.

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ANNEX 1 - Descriptions of the 10 pilot sites

The ten sites are described briefly here, indicating their location, team size and recruitment strategy. Note that the order in which sites are described here is not the same as the ordering in tables, giving anonymised site information.

County Durham and Darlington (North East)

This application was made from five merged PCTs in County Durham and Darlington PCT, and two Local Authorities. County Durham PCT took on the commissioning role and Darlington PCT the provider arm. The FNP team cover approximately 900 square miles with a total population of about 600,000. Apart from the cities of Durham and Darlington the area is mostly rural. The population of County Durham is approximately 479,000 with 30% of households with children said to be receiving some state benefits. Four of the seven district councils are ranked high on the Government's Needs Index. Darlington, ranked as the 91st most deprived local authority out of 354, consists of an urban area and 20 small to medium sized rural settlements. The population is 98,600 with the majority living in the urban centre. There is high unemployment across the area, especially amongst the young. The small town of Consett in the North Western corner of the patch is an ex-steel producing community, and close by is Stanley where there is a small ex-mining community. There are also numerous ex-mining communities running from the North Eastern corner of the patch to the South Eastern corner. In the rural areas the farming communities can be socially isolated, being sometimes up to 15 miles from the nearest Children's Centre. Lack of transport is also a problem and people here can feel lonely and isolated. Throughout County Durham there are 43 Children's Centres with a further six located in Darlington. The teen conception rate in 2004 was 47.8 per 1,000 under 18s, higher than the national rate. Due to the large population recruitment was confined to first-time mothers under the age of 20.

The County Durham team has seven Family Nurses, five of whom are full-time and two who work a 30-hour week. There is a full-time supervisor and the Project Manager is from the County Durham PCT. Six of the Family Nurses are based in Children's Centres and the seventh is based in a Healthy Living Centre. The supervisor is based at the NHS administration building, along with the Project Manager and the administrator. All the meetings / supervisions take place at this NHS building.

Manchester (North West)

Manchester is the sixth largest city on England with a population of 441,200. More than one quarter of the population are aged 0 to 19, 35% of these are from BME groups, almost half the children in Manchester schools receive free school meals and over half are born to a single parent. The Indices of Deprivation (2004) rank it second out of all local authorities and almost half the 33 wards were in the top 100 most deprived wards in the country. Manchester PCT is one of the largest in the North West having recently merged from three (North, Centre and South). In 2004 there were 557 conceptions to women under the age of 18, representing a rate of 65.2 per 1,000. While the rate fell in the early 1990s it remained relatively stable from 1998 onwards. Due to the large population recruitment was planned only for first-time mothers under the age of 20. There were 11 Sure Start Local Programmes in Manchester and now there are 29 Children's Centres.

The Manchester team has three full time Family Nurses and three at four days per week. The supervisor is full-time and the administrator part-time. The FNP team is based in office above a community centre and the Project Manager is based in a health centre.

Barnsley (Yorkshire & the Humber)

Barnsley Metropolitan Borough is one of the four districts in South Yorkshire, 15 miles north of Sheffield and 20 miles from Leeds. The borough stretches from the Pennines in the west to the Dearne Valley in the east and covers 127 square miles. In 2005 the total population was 222,100. The majority (80%) of the borough's residents live within the area that includes the town centre. Barnsley's demographic profile is unusual in that it is one of the most deprived local authorities in England - ranked 28th out of 354 with 23% of the population living in wards that are amongst the 10% most deprived - but it has the lowest ethnic minority population in the South Yorkshire region. In 2004 the under-18 conception rate was reported as being 50.8 per 1000, higher than the rates for Yorkshire and the Humber (47.3) and for England (41.5). In Barnsley the bid was jointly made by the Local Authority, the PCT and Barnsley NHS Trust. There were five Sure Start Local Programmes in Barnsley, transforming into Children's Centres. At the time of application there were in all 16 operational Children's Centres with a further four planned for early 2008. It was determined, on the basis of births for previous years that both under 20s and 20 to 23 year olds would be recruited.

Barnsley has four full time Family Nurses, a part-time supervisor and a part-time administrator. The Barnsley team (supervisor, administrator and the Family Nurses) were all based in a room above a community centre, with a cafe downstairs with the Project Manager based a local authority building.

Derby City (East Midlands)

Derby City has a diverse population of 234,600, with a growing number of asylum seekers and others who do not speak English. At the time of the 2001 census 12.6% of the population was from a BME background, with the largest ethnic groups being those with Pakistani or Indian backgrounds. The Index of Multiple Deprivation ranked Derby 69th out of 354 local authorities. At the time of application it was estimated that 1,000 first time births occurred per year, but with no details about what proportion were to young mothers. Derby City PCT made the application. It was reported that there was one integrated health team (which included midwifery services) for the four original Sure Start local Programmes and the seven newly developed Children's Centres. It was determined that both under 20s and 20 to 23 year olds would be recruited.

The Derby team is composed of four full-time Family Nurses, a full-time supervisor and a part-time administrator. The Project Manager is also from the Derby City PCT. The Derby team (Project Manager, supervisor, Family Nurses, and administrator) were originally based together in a Children's Centre (there are 14 in the city) but then moved into a PCT office building in the centre of a town. They have since moved to an alternative family centre where the team continue to share an office with the supervisor.

Walsall (West Midlands)

The Metropolitan Borough of Walsall is located in the heart of central England. The town of Walsall, eight miles north of Birmingham on the south Staffordshire border. The borough of Walsall had in 2001 a population of 253,499 but slightly more than that are registered with local GPs. There is a high rate of unemployment in the area and a large proportion of the population are unskilled or semi-skilled. The Index of multiple deprivation places it in the top 20%. It was originally proposed to target only the wards to the west of the M6 motorway, where there is more deprivation and two wards to the south with high ethnic diversity but subsequently clients have been recruited from the whole borough. Walsall had five Sure Start Local Programmes and now has 15 Children' Centres.

The team has four full time Family Nurses, a part-time supervisor and two part-time administrators. The team and the Project Manager were located in offices above a Children's Centre, but then all but the Project Manager moved to a PCT building for four months, due to IT problems. Currently they have all returned to the open plan office above the Children's Centre. All team meetings are held in that building.

South East Essex (East of England)

South East Essex PCT and Southend Borough Council jointly made this bid, with recruitment taking place throughout the PCT (which in addition to Southend includes Castle Point and Rochford). In a densely populated area on the Thames estuary, the total PCT population is 341,250 with more than half living in Southend, which falls within the top third of local authorities for deprivation and includes 5 of the top 20% most deprived wards in England. One quarter of the children in the Southend area live in poverty. In 2004 the rate of births to women under the age of 18, although dropping since 1998, was 47 per 1,000 births, higher than the rate for England and substantially higher than the rate for the East region. Compared to the rest of the region, a greater proportion of families live in medium or high-rise housing. Due to the small population it was determined that both under 20s and 20 to 23 year olds would be offered the FNP. Southend had one Sure Start Local Programme and currently there are 10 Children's Centres in the Southend area.

The team has four full time Family Nurses and a part-time supervisor. The administrator currently works full-time. The whole team is based in a building run by South East Essex NHS PCT. It also houses a variety of clinics as well as permanent office space for local health visitors, speech therapy team and the chiropody team. The Project Manager and Lead work from another NHS PCT building in the town.

Slough (South East)

This application came from the newly formed Berkshire East PCT, covering the areas of Bracknell Forest, Slough and the Royal Borough of Windsor and Maidenhead. However the area chosen for the intervention was limited to Slough Local Authority. A mainly urban and relatively small locality just west of London and close to Heathrow, Slough has a population of approximately 120,000. The population is young and diverse with one of the highest BME populations outside of London. One in five of the residents come from outside the United Kingdom and there are both established minority ethnic populations and high levels of new immigrants, many of whom are transient. Deprivation is moderate with all wards in the top 50%. There was one Sure Start Local Programme and now five Children's Centres have opened.

Due to the small population it was determined that both under 20s and 20 to 23 year olds would be recruited.

The Slough team is composed of one full time Family Nurse, one at 4 days a week and three at three days a week. The supervisor works four days a week and the administrator is part-time with another NHS job in the same building for the remainder of the week. The Project Manager is also the Associate Strategic Development Manager for the PCT and was herself a health visitor. The team is situated in an NHS hospital; the Project Lead and Manager are situated in the same NHS hospital. Some FNs see clients at Children's Centres if they are unable to visit the home. Team meetings are held in the same office.

Somerset (South West)

This proposal came jointly from Somerset PCT and Somerset County Council but the work of the FNP team is concentrated in four towns - Bridgewater, Taunton, Yeovil and Frome. Three of these are in the 20% most deprived Lower Super Output Areas and the fourth (Frome) is in the 30% most deprived. They have a combined population of 218,050, representing 42% of the total population of the county (520,600). There are few BME residents. The areas surrounding the selecting locations are predominantly rural and sparsely populated. The under-18 conception rate for the county in 2004 was 32.0 per 1,000 births, lower than the national rate. There are currently 24 Children's Centres in Somerset, with nine of those in the areas where FNP clients were recruited. Due to the relatively low teen birth rate and the size of the population it was decided to recruit both under 20s and 20 to 23 year olds to FNP.

The site has four Family Nurses, a full-time supervisor and a part-time administrator. Two FNs are full-time, one works just over four days (32 hours) per week and the other works three days a week. All four FNs are located separately, three based in Children's Centres and the fourth based in a local maternity unit; the Project Manager works from home. Each base is separated from the others by at least 10 miles, the furthest distance between locations being 45 miles. The administrator is in the same Children's Centre as one of the Family Nurses, in a building including offices, separate from the Children's Centre activities. Team meetings are held at different sites around the county, sometimes in this office building, which has one barely-large-enough-meeting space, sometimes in other Children's Centres, mostly in buildings, which the local authority/PCT has scattered around the county for this purpose. The latter can be in the towns where FNs work, or in the countryside.

Southwark (London)

The Inner London borough of Southwark has a population of 267,600. It is ranked the 17th most deprived borough; placing it within the 5% most deprived districts in England. A relatively large proportion of the population is young; the borough has high levels of population mobility, vulnerable children and young people in need, asylum seeking children and teenage conception. Indeed in 2004 Southwark had the highest under-18 conception rate in the country, at 85.2 per 1,000. The population is diverse and multiracial with substantial populations of Black-African and Black-Caribbean background. Due to the high teen conception rate it was decided to recruit only those first-time mothers under the age of 20 although this was subsequently amended so that 20 to 23 year olds could be recruited. The borough had 7 Sure Start Local Programmes and now there are 16 Children's Centres.

The FNP team has five Family Nurses, three full-time and two at four days a week and a full-time supervisor; the administrator is part time. The team are based in PCT administrative offices, in an open plan area. Team meetings are held in the building and the Project Manager is also based in the same building.

Tower Hamlets (London)

The Inner London borough of Tower Hamlets has a population of 196,106 and is the fifth most densely populated borough in England and Wales. Much of the housing is high-rise. It is the second most deprived borough in the country with a relatively young population (80% are estimated to be under 50 years old) and a high birth rate. However, in 2004 there were 174 conceptions to girls aged under 18, with a teen birth rate of 43.2 per 1,000, close to the rate for England. Almost half of such births in 2001 were to women of Bangladeshi background. It was originally decided only to recruit under 20 year olds but this was amended during the year and 20-23 year olds were also recruited. Tower Hamlets had seven of the original Sure Start Local programmes and now has 20 Children's Centres.

The team consists of four full time Family Nurses, a full time supervisor, a part time administrator and a full-time time interpreter who also assists with the administrative work. The whole FNP team including FNs, administrator, supervisor, Project Manager and interpreter, is based in the same office, located centrally in the catchment area, in an NHS building that houses PCT teams from three London boroughs and a private company on a separate floor.

ANNEX 2 - Details of the research interviews by site

Site	FNP staff					Stakeholders										Clients				
	FN 1	FN 2	PL 1	PM 1	AD	MWM	MW teen	Teen preg.	HV lead	Conn.	HV	MW	Social Work	CC	Other	CL1	CL1 Rel.	CL2	CL2 Rel.	D/L
1	5	5	1	1	1	1	1	1	1	1	0	0	0	0	0	10	4	9	1	2
2	5	5	1	1	1	1	0	0	2	1	0	0	0	1	2	9	3	6	0	3
3	8	8	1	1	1	2	1	0	1	1	1	1	1	2	0	16	6	14	0	2
4	7	7	1	1	1	2	1	0	1	0	0	0	0	2	2	11	2	10	2	2
5	6	6	1	1	1	1	1	0	0	0	1	0	1	3	0	10	5	9	1	2
6	5	2	2	1	1	0	2	0	0	0	0	0	0	0	0	9	4	5	1	1
7	5	5	1	1	1	1	0	0	0	0	0	0	0	0	0	10	5	10	3	2
8	5	6	1	1	1	2	0	0	0	0	0	0	0	0	0	10	4	7	1	2
9	6	5	1	1	1	1	0	0	0	0	0	2	0	2	3	10	2	7	2	2
10	5	5	1	1	1	0	0	0	0	0	0	0	0	1	3	11	3	5	1	2
All	57	54	11	10	10	11	6	1	5	3	2	3	2	11	10	106	38	82	12	20

Key:

- AD** FNP administrator
- CC** Children's Centre manager
- Conn.** Connexions
- CL** Client
- D/L** Declined FNP or left programme
- FN** Family Nurse or supervisor
- HV** Health Visitor
- MW** Midwife
- MWM** Midwifery Manager
- PL** FNP Project Lead
- PM** FNP Project Manager
- Rel.** Partner or other relative

Ref: DCSF-RW051

ISBN: 978 1 84775 165 2

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Published by the Department for
Children, Schools and Families