The Family Nurse Partnership Programme

Information leaflet

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Document Purpose	For Information
Gateway Reference	17581
Title	The Family Nurse Partnership Programme: Information Leaflet
Author	Family Nurse Partnership National Unit
Publication Date	**July 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Foundation Trust CEs , Directors of Nursing, Local Authority CEs, PCT Cluster Chairs, NHS Trust Board Chairs, Allied Health Professionals, GPs, Directors of Children's SSs, Other interested parties, including media
Circulation List	
Description	The Information Leaflet will provide a detailed overview of the Family Nurse Partnership programme in England. It also includes additional information for commissioners.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

First published [December 2010]
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

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Information leaflet

Prepared by Family Nurse Partnership National Unit

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General Information

What is FNP?

FNP has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency.

FNP is a voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two.

A strong and rigorous US evidence base, developed over 30 years, has shown FNP benefits the most needy young families in the short, medium and long term across a wide range of outcomes helping improve social mobility and break the cycle of inter-generational disadvantage and poverty.

The Government made a commitment in October 2010 to double the number of places on FNP, to 13,000 places by 2015. There are now around 9,000 places in 74 teams in 80 local areas.

How does FNP work?

FNP uses in-depth methods to work with young parents, on attachment, relationships and psychological preparation for parenthood. Family Nurses build trusting and supportive relationships with families, guide first-time young parents and use behaviour change methods so that they adopt healthier lifestyles for themselves and their babies, provide good care for their babies and toddlers, and plan their futures.

The programme offers a schedule of structured home visits which can be weekly, fortnightly or monthly and which last between one and one and a half hours. Nurses are guided in their work through detailed visit-by-visit guidelines that reflect the challenges parents are likely to confront during pregnancy and the first two years of the child's life. Within this framework nurses use their professional judgement to address those areas where needs are greatest.[1] The FNP model draws from three distinct strands of theory: human ecology, self-efficacy and attachment. These theoretical strands, woven together within a professional nursing framework, produce a unique preventive programme of great depth, breadth and vitality. FNP has a specific way of working with the most vulnerable families, taking advantage of an expectant mother's intrinsic motivation to do the best for her child and working to develop and expand the strengths within a family to promote change.

Who is eligible for FNP?

Enrolment and participation is voluntary.

The criteria for women to be offered the FNP are:

[1] http://www.nursefamilypartnership.org/assets/PDF/Communities/Implementation_Logic_Model, http://www.nursefamilypartnership.org/assets/PDF/Communities/TOC-Logic-Model

- All first time mothers age 19 and under at conception
- Living in the agreed catchment area
- Eligible if previous pregnancies ended in miscarriage, termination, still-birth, multiple births included.
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.

Women are excluded from the programme if they plan to have their child adopted or they have had a previous live birth.

What happens when the child reaches the age of two?

From the outset parents know that FNP ends when their child is two years old. Throughout this time the Family Nurse works with parents to help them to become confident and independent and to make best use of local services, in particular Children's Centres. FNP includes materials and activities on actively planning for the future and ending relationships well and preparation begins well before the end of the programme.

All families will be transferred to health visiting services so the remainder of the Healthy Child Programme can be completed.

Why does FNP have to be delivered by those from a nursing or midwifery background?

The US evidence for FNP shows significantly improved outcomes for vulnerable young families when FNP is delivered by high quality experienced nurses, and delivery by nurses is therefore a licensing requirement. There are a number of reasons for this – for example we know that nurses are trusted by the public, respected as a caring profession and have academic preparation in the social, life and caring sciences. They also have unique knowledge that appeals to a first-time mother who will have many questions and concerns about her health and the baby's health. Finally, the FNP programme itself is high intensity and demands a high level of professional expertise.

The US Denver trial compared outcomes between nurse-visited and paraprofessional-visited groups, and found the nurses' outcomes for clients were generally twice as strong as those of the paraprofessionals.

In England, Family Nurses mainly have a health visitor, midwifery or community health background giving them the expertise needed to deliver this complex clinical programme. The evaluation of the first ten FNP sites in England conducted by Birkbeck, University of London, found that FNP nurses are highly valued by their clients and welcomed into their homes.

Why is FNP a licensed programme?

If evidence-based programmes are diluted or compromised when implemented, research shows that they are unlikely to replicate the benefits. For this reason the University of Colorado, who developed FNP, licensed it to ensure that it is delivered in accordance with the original programme model and so we can be confident that children and families are likely to benefit.

The license sets out core model elements covering clinical delivery, staff competencies and organisational standards to ensure it is delivered well.

The license is held in England by the DH. The DH FNP National Unit supports sites to deliver the programme and monitors fidelity to the licensing conditions.

What does it mean to deliver a licensed programme?

As a licensed programme, FNP specifies what should be delivered, to whom and what outcomes can be expected once the nurses have learned how to deliver it well. It ensures that commissioners are provided with data on delivery and programme impacts.

Nurses are guided by visit by visit guidelines and use their professional skill and expertise to tailor these to each individual client and their baby. The structure, methods and materials the programme provide mean they can be clear and confident about what they have to do and when, freeing them up to concentrate on how to deliver FNP well.

What evidence is there that FNP makes a difference?

30 years of high quality US research into FNP has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes including:

- improvements in antenatal health
- reductions in children's injuries, neglect and abuse
- improved parenting practices and behaviour
- fewer subsequent pregnancies and greater intervals between births
- improved early language development, school readiness and
- academic achievement
- increased maternal employment and reduced welfare use
- increases in fathers' involvement

NFP (Nurse Family Partnership in the US) is consistently rated by rigorous evidence reviews as the best evidence-based preventive early childhood programme. In a review by the Lancet, FNP (MacMillan 2009) was cited as the strongest of one of only two programmes shown to prevent child maltreatment.

What about research in this country?

We are committed to strengthening the evidence base for FNP in an English context. A three year formative evaluation of the first 10 sites in this country has been carried out by Birkbeck, University of London and a large scale randomised control trial, involving 18 of the sites, is underway. Issue -specific research to support the effective implementation of the programme is also underway. This includes looking at the costs associated with running the programme locally and understanding the FNP workforce in order to be able to support the growth of the programme.

The independent randomised control trial is being led by the South East Wales Trials Unit at Cardiff University in collaboration with Universities of York, Bristol and Glamorgan. The study, known as 'Building Blocks', will assess whether FNP benefits women, children and families

over and above usual services as well as its cost effectiveness in the UK and is due to report initial findings when the children are aged 2 in early 2014.
http://medicine.cf.ac.uk/primary-care-public-health/research/early-years/current-projects/building-blocks/

What does the formative evaluation in England tell us?

The formative evaluation of the first 10 pilot sites completed in 2010 suggests that the programme can be delivered well in England, families like it and think it is making a difference and also that the potential for impacts is promising. More specifically:

- There are early signs that clients now have aspirations for the future and cope better with pregnancy, labour and parenthood
- Clients are reducing smoking during pregnancy
- Breast feeding initiation is higher than national rate for same age group (FNP = 63% UK under 20s=53%)
- Mothers also had significantly improved mastery, a form of self esteem linked to positive behaviour change, at the end of the programme compared to the start.
- Clients were returning to education and employment, making regular use of effective birth control methods and spacing subsequent pregnancies.
- FNP children also appear to be developing in line with the population in general which is very promising as this group usually fare much worse.
- Graduates of the programme are very positive about their parenting capability reporting high levels of warm parenting, low levels of harsh discipline and levels of parenting stress similar to that in the normal population.

The published reports from the evaluation are available at:
Barnes, J et al (2008) Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, London DCSF.
www.education.gov.uk/research/data/uploadfiles/DCSF-RW051%20v2.pdf
Barnes, J et al (2009) Nurse-Family Partnership Programme: Implementation in England – Second Year in 10 Pilot Sites: the infancy period. London DCSF.
www.education.gov.uk/research/data/uploadfiles/DCSF-RR166.pdf
Barnes J (2011) The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123238

Additional information for commissioners

The NHS Operating Framework

The 2012/13 Operating Framework for the NHS in England emphasises that PCT clusters are expected to maintain existing delivery, and continue expansion of the Family Nurse Partnership programme in line with the commitment to double capacity to 13,000 places by April 2015, to improve outcomes for the most vulnerable teenage mothers and their children. The reference to FNP is on page 14 of the Operating Framework: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

FNP is an early intervention programme that should be jointly led by the NHS and Local Authority as part of their joint strategy for children. FNP is a licensed programme with fidelity measures to ensure replication of the original research conditions. The fidelity requirements cover aspects of clinical delivery, staff competencies and organisational standards.

How much FNP costs: Early evaluation evidence in 2008 suggested that the average local cost for a place on the FNP is approximately £3,000 a year. A study is currently underway to update and understand these costs further. The minimum size for a FNP team is four FTE nurses and a part time supervisor. In smaller areas it is possible to start with a smaller team or to share the supervisor across 2 neighbouring areas.

Where FNP can be commissioned from: FNP can be commissioned from a range of providers including the local provider of community maternal and child health services. In smaller areas, an existing neighbouring FNP site may be well placed to take on and supervise more nurses to cover the population. There may also be providers who are social enterprises or from the charitable sector. The FNP DH National Unit can advise about different arrangements.

What information to expect on how well FNP is doing: Routine data is collected on:

- Enrolment rates and demographic characteristics of those taking up the programme
- Proportion of the programme received by clients in pregnancy, infancy and toddlerhood
- Retention of clients in the programme
- Indicative short term outcomes such as smoking during pregnancy, breastfeeding, birth weight, hospital admissions, child health and development, maternal mental health, subsequent pregnancies, participation in education and employment, referrals to other services

Fit with other services: FNP sits at the intensive end of the prevention pathway for more vulnerable children and families. It needs to be embedded within the local Healthy Child Programme and safeguarding arrangements as part of health visitor, Sure Start Children's Centres, GP and maternity services.

Workforce: Family Nurses come from a range of nursing and midwifery backgrounds which include health visitors, midwives and school nurses. Current internal data suggests around

65% are registered as health visitors only, 10% as midwives, 15% having dual health visitors and midwifery registration and the remainder from other nursing backgrounds.

Conditions for successful implementation

FNP is a demanding and complex programme to deliver, and the organisational context (both commissioner and provider) has a direct impact on retention of families, turnover of nurses and the quality of the programme. Understanding and commitment to the programme, the local FNP team and their clients is important in achieving the benefits for children. For this reason local organisations will be asked to prepare and demonstrate organisational readiness i.e. motivation, leadership, partner and community support
and capacity to fund and deliver, before starting the programme. The FNP National Unit provides support and advice to commissioners and providers on organisational and system readiness, setting up and managing the FNP.
There are different provider models in use, and experienced FNP commissioners and providers are on hand to support organisations and leaders who are new to FNP.

How to know whether FNP is successful locally

- A range of data is collected and reported on via the client based FNP Information System which shows how well the programme is being delivered according to the programme's fidelity goals. If good progress against the fidelity goals is being made then it is more likely improved outcomes for families will be achieved.
- Data will show you:
    - How many clients were offered the programme, how many were enrolled, at what stage in their pregnancy and whether the fidelity goal of 60% enrolment by 16 weeks in pregnancy was achieved.
    - How many clients completed the programme and how many left before the end of the programme.
    - The proportion of the programme delivered to clients in pregnancy, infancy and toddlerhood and how this compares to the programme's fidelity goals.

Information on indicative short term outcomes is also provided including:

- Smoking and breast feeding rates, birth weight, hospital admission,
- Infant health and development,
- Mother's mental health, subsequent pregnancies, participation in education and employment, referrals to other services.

Clients will tell you about their experiences of the programme and you will observe the positive way that babies and young mothers and fathers interact and play together.

Practice and evidence from the US and the UK demonstrate that FNP is most successful when organisations have a shared commitment to the ethos and values of FNP and can mirror them in the organisational support to the FNP team.

Organisational attributes that will suggest successful implementation include the provision of good work conditions for the team; a belief in the organisation's ability to implement the model; enabling the new team to unlearn some behaviours, learn new ways of working and make mistakes; reducing unnecessary demands; not expecting instant successes and solutions; celebrating success; and listening to staff and clients.

What a commissioner needs to do

A commissioner needs to:

- Facilitate a discussion with local stakeholders about the benefits of FNP and find a provider committed to improving children and young people's health and well being.

- Identify funding for the programme until all children are two years old - in effect funding for three years.

- Include the development of FNP as part of the children's health delivery plan for 2012/13 to 2015.

Relationship to health visitor expansion

FNP expansion sits alongside that of health visitors in the NHS Operating Framework and FNP complements and supports the work of health visitors, providing the intensive end of prevention for families who need more help to care well for their children and themselves.

Registered health visitors working as Family Nurses can continue to be counted as health visitors. We are working with a number of FNP sites to integrate FNP within universal services by sharing the learning and testing new practice and service models for the Healthy Child Programme.

Why do we need FNP when we already have a model of intensive health visiting?

FNP provides a well researched intensive programme backed up by a specific learning programme for nurses and supervisors, materials, guidelines and data so commissioners and practitioners can be confident that their resources and skills will produce better outcomes for disadvantaged children.

Parents can be told confidently about the potential benefits for their children and themselves if they participate in FNP.

How does FNP fit with other children's services?

As an evidence-based early intervention programme, FNP sits at the intensive end of the prevention pathway for more vulnerable children and families. It therefore needs to be embedded within the universal maternal and child health services, especially the Healthy Child Programme and health visitors. FNP needs to be embedded within local safeguarding arrangements and have close liaison with GPs and maternity services.

At a local level, FNP teams work closely with a range of children's services including Social Care, Sure Start Children's Centres and voluntary sector organisations.

Role of the FNP National Unit

The National Unit is currently based in DH and has been leading delivery of FNP since 2006. We are responsible for the license in England; we train the nurses and supervisors, provide the

programme materials, undertake research and development and give advice and support on organisational and clinical delivery. We have also developed a number of tools and materials that share the learning from FNP with universal services (the Healthy Child Programme and health visiting). We are working with colleagues as they expand FNP in their region and will help new sites prepare for FNP, set up and implement the programme so that they meet the licensing requirements.

For further information and queries contact:
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