Meeting:	Date:	Agenda Item No:
CHILDREN'S TRUST BOARD	14 March 2013	7

TITLE OF PAPER: Family Nurse Partnership Programme (FNP)

APPENDIX: Family Nurse Partnership Programme Annual Report 2012/13

FNP Annual Report 2012/13

Barnet

Annual Review date: 12th December 2012

"There is a magic window during pregnancy… it's a time when the desire to be a good mother and raise a healthy, happy child creates motivation to overcome incredible obstacles including poverty, instability or abuse with the help of a well-trained nurse."

David Olds, PhD, Founder, Nurse-Family Partnership

1 – Vision for FNP in Barnet

Please describe current vision and ambitions for FNP (e.g. how would you like it to grow, become integrated, influence other services etc)
FNP is an important part of our early intervention and prevention strategy. Our Children's Trust board and Health and Wellbeing Board both emphasis the importance of a good early start. We would like to see FNP become mainstream and this will be considered as part of our planning over the forthcoming year. FNP is one the main priorities within our refreshed Children's and Young peoples Plan FNP has become very well integrated in the last year and the team has worked hard to become an established and recognised service across Barnet. Referrals are now coming into the service regularly from all agencies and the services remit is understood within the multi-agency team. FNP has influenced other services e.g. troubled families family focus and is seen as an evidenced based approach to support young families

2 – Strategy

Please describe the local strategy for FNP taking into account the following key points:

- Sustainability, funding and expansion plans
- Ownership / Funding / Organisational contracts / FNP Sub-licence
- Strategic Partnerships (e.g. Children's Trust, Health & Wellbeing Board, LCSB, Local Authority Elected Members)
- FNP fit with local strategies, plans, policies (e.g. JSNA, Early Years, 0-19s, Children's Plan, Family Support, Teenage Pregnancy, Social Care)
- Describe any plans for regional working (strategic or operational)

Analysis and Narrative
Sustainability- The FNP Board reports into the Executive management group who oversees progress and planning to ensure the outcomes are aligned and integrated into other workstreams

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales

3 – FNP Advisory Board

Please describe the FNP Advisory Board taking into account the following key points:

- (Core Model Element) Ongoing FNP Advisory Board, chaired by the commissioner, which meets at least quarterly to lead, support and develop the programme, ensures delivery to the model and is working to achieve sustainability.
- How does the Advisory Board promote Programme quality?
- How does the Advisory Board engage FNP with the broader strategic agenda for children, young people and family support?
- Advisory Board Chair / frequency / terms of reference / membership & attendance
- Accountability
- Client involvement and participation

Analysis and Narrative
1. The FNP advisory board meets monthly, and has oversight of FNP progresses based upon reporting format, this faciliatates the opportunity to investigate report findings and identify concerns and agree action plans. 2. There is also robust multi-agency representation, who are tasked with the dissemination of information and key issues from the services which may have implications or identify gaps and the relevance they has on individual services and action planning, these are also then cascaded into partner agencies. 3. The FAB has consistently had user representation, and has a number of interested clients. **Sustainability- VS- The FNP Board reports into the Executive management group who oversees progress and planning to ensure the outcomes are aligned and integrated into other workstreams** H:\annual review\FNP Advisory Board TOR Final July 2011.doc H:\advisory\advisory board report June 2012..docxH:\advisory\activity report as at 19 September 2012.doc H:\advisory\minutes 24 october 2012.doc H:\advisory\FAB_minutes_July_12.doc

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
1. Increase and maintain user engagement 2. Strengthen the framework for FNP user participations and involvement	Have 3 teenage parents, a Grandmother and Father interested	Recruitment of interested volunteers through user days and children's centres.	Supervisor/provider lead/ user rep
3. Increase attendance of senior midwifery management of partner agencies, and a commitment of at least 2 meetings a year.	Ensure a high level of strategic ownership from partner agencies	Provider invitation to key SMT	Commissioner/ provider lead: Jan 13.

4 – Provider Organisation

Please describe how the organisation is delivering its responsibilities to ensure that good leadership, management support and systems are in place to support family nurses and supervisors to deliver, develop and continually improve programme delivery (including Core Model Elements)

- **Please attach your Local Safeguarding Model for FNP**

Key Points:

- Logistics (e.g. accommodation, IT, mobile working)
- Clinical governance
- Team appointments and contracts
- Supervision of the Supervisor, appraisals and personal development reviews
- Service user / client feedback

Analysis and Narrative
FNP safeguarding model is as follows: Provider lead/ manager meets with team supervisor monthly for a 1:1, to support and guide supervisor where necessary Safeguarding nurse provides safeguarding support to FNP supervisor and also quarterly to the team. Team have a dedicated base, IT, Laptops and desk phones along with mobiles, the equipment enables team to work at base or be mobile. The team work within CLCH clinical governance framework, which in turn means they adhere to the CLCH clinical supervison policy/ procedures The team attend local professional forums and wider Children Families Health & Wellbeing meetings and development forums (Band 7 away days) The team undertake the relevant programme in relation to FNP training and also local mandatory training requirements. The team where recruited by October 2011, on fixed term contracts (to July 2014) The team have all had annual appraisal and PDP set. The team also participate in CLCH patient reported experience measures, patient stories and as such continually receive feedback, however this is written into the wider HV outcome measures.

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
1. Separate the PREM from generic HV reporting	To ensure feedback to FNP is FNP specific	Work with IG an CG to extrapolate data feedback.	Supervisor/provider lead and CG Team Jan 2013.

5a – FNP Team

- Describe how FNP has been working in your area over the last 12 months. What is working well and where are the challenges and opportunities?

Key points:

- Description of last 12 months (e.g. expansion, current team size – both actual and budgeted, vacancies, sickness)
- Caseload size and intensity (e.g. need for use of interpreters)
- Eligibility criteria and client recruitment pathways
- Supervisor use of monthly clinical supervision from the Named Nurse
- Provision and use of psychological consultancy

Analysis and Narrative
Set up and Team FNP commenced in Barnet in November 2011. The team where recruited and commenced in post November 2012, (1 supervisor, 4 nurses and 1 administrator) following pregnancy training in October 11, and attendance at Trust induction the team could commenced recruiting. As limited lead up time to recruitment beginning, limited processes in place the first few months where spent engaging local services, setting up referral pathways and sharing of information. The team have now settled, and reflect the expectation that they hit the ground running following initial training, with little equipment and resources in place. Processes and systems are now in place and are embedded throughout the first year. The team establishment is full, and no vacancies exist. Sickness rate is minimal, we believe the ethos of flexible working has kept this low. **Client Recruitment** Client Recruitment was initially slow and it was difficult to embed a referral pathway with the local maternity unit, although we had a robust process with our other 2 maternity units, no referral process is the same and we have had to be resilient and adaptable to gain the trust of the varying maternity units. There has been constant work with all maternity units and the Family Nurses now attend monthly social concerns meetings in both local providers and also teach at mandatory midwifery training in each unit, promoting a bottom up approach to referrals. Recently it has been agreed the nurses visit each of the maternity unit clinics weekly to identify and collect any referrals from the booking notes, each nurse has a delegated role and maternity unit. We have also changed the referral form from opt in to opt out (Sept 12), we am optimistic that this will enable all referrals to be sent to FNP team and this way we can give the clients the relevant information to enable them to make an informed choice to join the programme. Our key referrers on inception were social care and we have developed strong links with the Local authority and this is evident in our partnership multi-agency training and conference days. We are fortunate to have multi-agency support across all professions, from health, social care, troubled families- family focus workers/teams and the voluntary sector. The area of partnership working we would like to see improved are among General Practices, involvement and schools, the team is continually pushing to improve this. This has included letters; cold calling and more recently ensuring safeguarding and SC incorporate FNP within the GP training sessions. Attending CLCH GP stakeholder event. Schools in particular have been more difficult to engage, some schools have been very supportive and we have good links, whilst many others do not want the team to come into the schools (felt this may be the topic material).

Analysis and Narrative
Caseload size Since October 2011 we have received 130 referrals, of which 62 where eligible and enrolled on the programme and 13 where in the process of being recruited. 57 clients where not eligible. This is inline, if not slightly higher than was expected. Each nurse caseload is approximately 14, and the supervisor has 4 clients, if all those awaiting recruitment are indeed recruited, caseload numbers will be almost 17. The advantages of this steady recruitment have enabled the team to deliver the programme dosages and become confident in their work. However the slow numbers has meant we have not recruited the 100 clients expected, although this was always an anticipated risk in view of the low pregnancy numbers in Barnet at the beginning of the programme. It is anticipated that if we continue to recruit at 5- 10 a month, then 100 clients is achievable by end of March 13. This has implications on budgeting into 2014/15. A comparison with the Public helath projected pregnancies for 2013 has shown a gentle increase is expected (this is an estimated figure). We have found that caseload size and its dependency can vary throughout the programme, as vulnerabilities can become more complex or child protection concerns develop. The use of interpreters has increased in recent months, and presently each nurse has 1 non English speaking client, we have liaised with interpreting services to negotiate the use of the same interpreter once they have met a client, to improve consistency and also reduce amount of time nurses spend explaining the programme, the nurses have had to identify ways to work with the programme and ensure the message and content is delivered, as some elements can be lost in translation. The supervisor has monthly supervision with the named nurse, which has proved beneficial and helpful as the client load has increased. There are excellent working relationships with the safeguarding team, and the named nurse is available for the team when the supervisor is away. **Safeguarding clients'** 4 children have a CP plan, 1 Child is in need, we are also completing CAFs regularly due to the nature of the client's ages and vulnerabilities. **Psychology for the FNP team:** This commenced in March 12. The supervisor has found her individual sessions most beneficial. The team sessions have been more mixed and the needs of the nurses are very different, there has been discussion regarding the need to link theory of psychology to practice to the pregnant teenager and developing newborn. H:\psychology\INTERNAL_AGREEMENT1 PSYCHOLOGY final april12.doc

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
1. Referral pathway with maternity units.	Increase referrals, all clients meeting referral criteria are referred and opt out once spoken to with nurses.	Continue building relations and maintain presence in social concerns meetings and training. Increase Senior management at FAB.	Supervisor/ provider lead and commissioner. Jan 13.
2. Review of psychology services	To have both psychologist and team enjoying psychology sessions. Team to feel they are able to link	Evaluate contract Seek FNP national unit advice	Supervisor / provider lead Jan 13.

	theory and practice		
3. GP and schools engagement	Continue communications, and reminders re: referral criteria	Engage CCG	Commissioner

5b – FNP Team

- Describe how the FNP team is delivering against the core model elements (see appendix).

Key points:

- Progress with the FNP learning programme and competencies (including local learning required)
- Progress with team-based learning packs (including skills practice)
- Supervision one-on-one with each family nurse weekly, one home visit with each family nurse every 4 months and regular team meetings
- Using the FNP Information System to accurately input data and use of reports to assess, manage and enhance programme quality programme and inform reflective supervision
- Dedicated administrative support to ensure that data is entered completely and accurately on a timely basis and providing general administrative support to the team

Analysis and Narrative
Core model elements are prescribed in five areas of the programme: 1. Client enrolment and engagement: 2. Family nurse recruitment, training and working practices 3. Supervisor recruitment, training and working practices 4. Administrative support 5. Implementing agencies All team members have completed all relevant FNP training, and local mandatory requirements. All team members completed TNA at the commencement of programme and are working towards the FNP competencies; this was reviewed with each nurse at their annual appraisal. Team based learning, we meet weekly, these meetings include, and operational meeting, case review / presentations / skills practice- we are presently undertaking DANCE integration along with PIPE practice, following Dance and toddler training. We regularly have outside speakers, and this was more so earlier in the year. Each nurse attends 2 weekly and monthly social concerns meetings at our local maternity units. There were initially some team dynamic issues and it was with consistent encouragement and guidance that team members now feel comfortable with this practice. The supervisor meets weekly with each nurse individually to review caseload and each client is discussed with key issues summary, and joint visits are and have been undertaken regularly. The nurses originally found these uncomfortable, however they are normal aspect of practice now, we are also considering joint visits whilst implementing DANCE to aid scoring of key domains. The supervisor produces monthly reports for FAB, based upon fidelity measure, to enable FAB to monitor success criteria and identify

Analysis and Narrative
concerns in a timely manner and identify actions required. More recently the supervisor has had to revisit Open Exeter Data entry with nurses, to interpret their own data and recognise how achievement for fidelity is monitored as a team and not just individually. Admin support is active in data entry and pulling of reports, and the postholder is about to take the lead as FAB administrator, she has the underlying knowledge of programme to enable minutes and reports to be succinct and accurate.

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
1 Better team understanding of Data reports and FAB board	All key professionals to understand the relevance of data and be able to interpret	Discuss with FNP national unit, to attend a FAB and discuss data	Supervisor / provider lead and FNP NU

6 – Clinical Quality – Enrolment and Attrition

- Please fill in progress for enrolment and attrition in the table below and describe any over or underperforming areas and plans for improvement.

Key points:

- Sites enrol at least 60% of clients enrolled in the Programme by the 16th week of pregnancy and 100% no later than the 28th week;
- Each client enrolled is visited by the same family nurse throughout her pregnancy and the first two years of her child's life
- Percentage of clients offered the programme who are enrolled (please detail % uptake data and include analysis for previous 12 months)

Analysis and Narrative
Clients recruited before 16 weeks is at 51.6%, (53.1% end Nov 12), this is not at 60% yet, there has been a steady increase in achieving 60%. When the team initially commenced recruiting clients, very few where under 16 weeks pregnant at referral, the team has worked very hard to embed the referral pathway with maternity units and build relationships, which have contributed to the continuous improvement. The recent changes to the referral form to be a opt out rather than opt in, is expected to improve this further. Attrition: Of those recruited, 2 clients left in pregnancy, they moved out of borough. This is an ongoing concern as many clients are temporarily housed out of borough and it is anticipated this could become more difficult with the future changes to housing benefits. Programme attrition in pregnancy is 10% (team within this criteria)

Enrolment and Attrition (also refer to dashboard)		
Data for last 12 months	Performance	Fidelity Goal
Recruitment by 16 weeks	51.6%	60%
% enrolled who are offered FNP	87%	75%
Attrition (Programme Completers)		40%
Attrition (pregnancy)	6.7%	10%
Attrition (infancy)		20%
Attrition (toddlerhood)		10%

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
1. To recruit more clients by 16 weeks	Enrolment criteria, achieve 60% clients enrolled by 16 weeks.	Continue engaging maternity services, and revisit GP's and schools.	Supervisor
2. Continue to work with housing	Increase number of clients kept in local borough	Continue liaison with contacts in housing	Supervisor/team

7 – Clinical Quality – Visit Dosage

Please fill in progress for visit dosage and average length of visit in the tables below and describe any over or underperforming areas and plans for improvement (include reference to fidelity goals)

Visit Dosage (also refer to dashboard)		
Data for last 12 months	Performance (Stage Completers)	
Pregnancy	63.3%	% receiving ≥80% of expected visits
Infancy	68%	% receiving ≥65% of expected visits
Toddlerhood		% receiving ≥60% of expected visits

The team continue to deliver the programme and visit schedule, our client group have some excellent attendees, however those who have been more difficult to maintain the visit schedule with have been the older clients 18-19 years old. A number of clients have been housed outside the borough, as far afield as Hackney and we have also had 3 in mother and baby units, where visits where not encouraged in the first few weeks.

The clients who have not always been available, have had numerous reasons, or have been too busy, however of those who have been poor engagers in pregnancy they have come back onboard in infancy and once delivered.
Of those clients whom have proven the most difficult to engage, the team have discussed these clients at team meetings and this has given the nurses the opportunity to be inventive, some clients have agreed to a monthly visit, or joint visits ante natal, this has proven more successful than pushing the weekly visits and still maintains contact rather than risk the client disengaging completely.

63.3% is above the programme average for the same time scale.
81.1 minutes is within the expected time spent on visits.

Average length of visit (also refer to dashboard)		
Data for last 12 months	Performance	Fidelity Goal
Pregnancy	81.1mins	≥60 mins
Infancy		≥60 mins
Toddlerhood		≥60 mins

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Continue to implement the visit schedule and identify different ways to maintain engagement	Increase visit dosage achievements	Continue working with clients, consider options with poor engagers, and individual plans fro clients	All team and supervisor

8 – Clinical Quality – Programme Content

- Please fill in progress for programme content in the tables below and describe any over or underperforming areas and plans for improvement.

Key points:

- (Core Model Element) Follow the FNP Home Visit Guidelines and adapted programme guidelines, which specify the desired structure and content of each visit;
- (Core Model Elements) Apportion home visit time among content domains within the ranges specified.

Analysis and Narrative
The team have found that with their clients in the initial visits there is much more pressing matters namely housing and benefits, and these areas have taken up significantly more time than was anticipated, it is also recognised that without dealing with the issues concerning clients they will not be receptive to any of the other programme content. (Environmental health) The team identified that we had not been scoring maternal health correctly, and we have planned to review this, and ensure team members have programme content scoring guides when entering data onto open Exeter, and thinking through % allocations.

Programme content (also refer to dashboard)		
Last 12 months	Performance	Goal
Pregnancy		
Personal health	28.7	35-40%
Environmental health	17.4	5-7%
Life course development	14.2	10-15%
Maternal role	24.2	23-25%
Infancy		
Personal health		14-20%
Environmental health		7-10%
Life course development		10-15%
Maternal role		45-50%
Family & friends		10-15%
Toddlerhood		
Personal health		10-15%
Environmental health		7-10%
Life course development		18-20%
Maternal role		40-45%
Family & friends		10-15%

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Realistic allocation of programme content.	Monitor within team meetings, and ensure staff fully understands allocations of % going into infancy.	Monitor at team meetings and review with individuals at supervision.	Supervisor.

9 – Outcomes and short-term maternal and child health and development indicators:

Please use this space to highlight key points around improvements in maternal and child health and development and other programme outcomes.

- This should include consideration of the programme's short-term child and maternal health indicators (e.g. child development, smoking cessation, subsequent pregnancies, breastfeeding, immunisations, A&E attendances, hospital admissions, EET) and other information on potential impact such as safeguarding or child protection examples.
- You should also include data completeness in the FNP IS in this section.

Analysis and Narrative
Smoking data: of all those clients smoking at recruitment, there has been a 75% reduction in the numbers of cigarettes smoked at recruitment to 36 weeks. The family nurses now also carry CO2 monitors(in joint working with local smoking cessation services) which enables pro-active work with the clients to demonstrate CO2 levels and will hopefully help in referral to stop smoking. There has been a reduction in number of clients using drugs and alcohol from recruitment to 36 weeks. Breastfeeding initiation is at 78.6 %, this is above the programme average (across UK), and 35.7% are still breastfeeding at 6 weeks. The data is limited for those still breastfeeding at 6 months, in part due to the small numbers at this stage. Immunizations at 6 months: 100% of babies reaching 6 months have received their immunisations. 0% A&E attendances for ingestion or injury. 75% clients reaching 6 months are taking contraception. 41.7% clients enrolled where in employment or education 25% in EET at 6 months of infancy- of those entering education 50% clients are accessing course (NVQ) in children's centres. We are also holding a workshop in conjunction with Home start Barnet and Tended on "Healthy relationships" in the new year. Ages and stages questionnaires: There is no data available, these can only be entered at 6 months, those completed have not been entered by end November- data incompleteness.

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
ASQ data scores	Ensure FN's entering this data as soon as are able to at 6 months	Discussion in team meeting and with individual nurses.	Supervisor, Dec 12.

10 – Achievements, celebration and relevant information:

Please explore any issues that may not have been covered above as well as any areas for discussion that you would like to highlight to the board.

- This is an opportunity to celebrate successes, what has been working well and any aspects of work that you are particularly proud of.
- This may include work on sharing the learning, or any awards as well as how programme graduation and transition is managed locally.

Analysis and Narrative
We have an established multi-agency advisory board that has continued to meet monthly, with regular user input and proactively recruiting more. At programme set up, supervisor spoke at the EIP launch, which created good local contacts and networks with youth and Early years. Presentation at Children's trust board with local MP lead, with positive feedback. Stand at Social care speak out day. Team have a presence at midwifery training sessions locally. We are one of a few teams that can offer FNP to all pregnant teenagers in the borough. The team has settled in well, the referral pathways are in place; however do need constant review and communication with maternity units. We are on target to meet the required 100 clients, in a slightly longer time scale than was anticipated, but is inline with local data and public health figures. The team delivered 2 celebration days with our clients in May 12, these were attended by approximately 9 clients and partners and were very successful, and themes included- memory boxes, art work ad belly casts which the clients then decorated to tell the story of their journey so far. We also did meals on a budget, which again was very popular. The days are being repeated in November 12, with a Christmas theme and now more babies we will be able to do Christmas baubles, calendars' and weaning foods. The celebration days where held in youth centres and children's centres. In July 12, we held a stakeholder event, and this went well, it was chaired by our Director of Children, Families Health and Wellbeing division, and the DOH lead attended. We felt very honoured as 2 of our clients spoke of their journeys to that point and we also had testimonial from other clients, this was most powerful to all in attendance. We have also developed a video of FNP Barnet (to be shown), and recently where invited to take part in a TV programme looking into teenage pregnancy and services available- one of our clients was interviewed and her nurse- we have been contacted by ITV who are interested in doing further filming. We are also proud of our relationships with Local Authority, each nurse has links to key children's centres/GP's and schools in a defined geographical locality and this has certainly aided relationships with our children's centres and signposting clients. We are presently working with Homestart Barnet (voluntary organisation), who have agreed to do a drama//peer led workshop for our clients regarding healthy relationships. A major concern presently is the difficulty keeping clients in the borough, and with the chain to benefits and housing next year this problem will further increase. Long term this will affect attrition as we are being forced to lose clients as they move across a local authority boundary.

Analysis and Narrative
Feedback stakeholder days and client days H:\annual review\Annual_evaluation_results[1].doc **The key areas for action this next year are:** Continuing to recruit, clients- for this to be successful we require senior maternity input on the FAB Maintain accurate and timely data, address concerns early. Working with housing where we can to keep clients in borough or in surrounding areas. Better engagement of schools and GPs Work with our local Pilot CCG.

Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Continuing to recruit, clients- for this to be successful we require senior maternity input on the FAB	Embedded and robust referral pathway with maternity services	Senior maternity management representation on FAB,	Supervisor/ provider lead and commissioner
Maintain accurate and timely data, address concerns early.	Integral role of the post	Work with all nurses and identify where gaps may be.	supervisor
Working with housing where we can to keep clients in borough or in surrounding areas.	Reduce number of clients leaving the borough, and improved understanding of the FNP role with these clients	Liaise with housing and identify actions to help	supervisor
Better engagement of schools and GPs	Early signposting into FNP from GP's and schools, and improve recruitment by 16 weeks	Continue to liaise with GP's and schools and identify how else this can be achieved. Consider a GP event	Supervisor/ provider lead and commissioner.
Work with our local Pilot CCG.	CCG promote FNP service, so integral aspect of funding considerations for the future. Improved feedback to GP's and promotion of service.	Identify timescale to present to CCG boards.	Commissioner

Post Meeting – Summary and Improvement Plan (for completion by the Service Development Lead)

Analysis and Narrative (to be completed by SDL following Annual Review)
We were delighted to be at Barnet's first Annual Review (AR) and to meet so many wonderful young parents and their babies who actively participated and contributed to the AR meeting. The evidence is strong to support how seriously client engagement is taken by the FNP team in helping to lead and embed the programme in Barnet. Clients spoke very positively about the programme and how it has supported their and their babies' lives – " it has been a life saver", "helped me to think more about the future rather than panicking about the now", "it helps when you feel you are being listened to", " FNP gave me the right help". It was lovely to have one grandmother attend the meeting who is also a member of the Advisory Board and to hear from her how much she feels the programme supports her so as she can support her daughter and grandchild. One of the real strengths on the programme is its evident connectivity with universal and appropriate targeted support services. All parents spoke of their involvement with children's centres, with the nurses each allocated children's centres, supporting families to use and building links to develop good working relationships and understanding of the programme. Both the Commissioning and Provider lead spoke of the importance of having FNP and of its connectivity across the system of children's services. This could be further strengthened by their participation in the AR and regular attendance at board meetings. It has been a positive start to the programme with 63 clients recruited aiming to have a 100 by the end of March. The maternity referral pathway has been a challenge, but through tenacious relationship building is now improving. Having senior strategic representation from maternity services on the board is recommended and would be welcomed by the team. The team is in place and working well together, their commitment and passion was evident from the quality of their input at the AR meeting and hearing the clients speak so positively of their work with them. The team are getting to grips with Data and report feeling confident with Open Exeter, it was acknowledged that further improvements in inputting could be achieved, but good progress for this early stage of the programme. Client mobility was (as with other London Boroughs) a significant concern. The team do well aiming to "stick with" clients if they move out of Borough, continuing to work with them where possible. The team aims to keep clients "on" if the move out temporarily. Dosage levels have scope for improvement and it was evident that a great degree of thoughtfulness is being given to it, ensuring that the nurses are confident and practiced in all elements of the programme. As with other sites, a reduction in time spent on the environmental domain with an increase on maternal role is recommended. Linked to this is having strategic discussions with Housing aiming to reduce mobility where possible through earlier permanent housing in the borough. The high breastfeeding initiation (78.6%) is very good, as was the 100% immunisation take up at 6 months. It has been a good first year, with strong good outcomes achieved in getting the programme established and running well, with a presence in the Borough and some excellent client engagement. A very positive platform has been built, upon which the team, clients and stakeholders can continue to strengthen and grow.

FNP Improvement Plan for Barnet			
Area for Improvement	Outcome (Where do we want to get to?)	Actions (How will we get there?)	Owner(s) and Timescales
Stronger maternity referral pathway	Improved and sustained early referrals	Senior maternity representation on Advisory Board	Commissioning/Provider leads with FNP SV – immediate & review
Supporting client engagement(nurses confident in using programme tools) Client mobility	Clients stay on programme	SV reflect & review through SV with FN's Senior Housing representation on Advisory Board	SV with FN's – ongoing Commissioning/Provider lead with FNP SV – within 3 months
Strengthened vision for FNP	Sustain FNP in children and family system of services	Connect with Health & Well Being Board	FNP Advisory Board – immediate & over coming year
Improve dosage	Strong programme outcomes – Highly skilled and high quality team	Team deliver the programme; skills practice; continued good supervision	FNP SV and FN's – on-going

Appendix – Core Model Elements and Fidelity Goals

The FNP Licensing Core Model Elements

Core model elements are prescribed in five areas of the programme:

1. Client enrolment and engagement
2. Family nurse recruitment, training and working practices
3. Supervisor recruitment, training and working practices
4. Administrative support
5. Implementing agencies

When the Programme is implemented in accordance with these Model Elements, the Parties can reasonably have a high level of confidence that results will be comparable to those measured in research. Conversely, if implementation does not incorporate these Model Elements, results may be different from research results.

Clients:

1.1 Enrolment and participation in the FNP is voluntary;

1.2 Eligible clients include first-time mothers only;

1.3 Eligible clients include high-risk mothers only (e.g. low resource mothers, teens), and criteria is agreed with the FNP NU.

1.4 Sites enrol at least 60% of clients enrolled in the Programme by the 16th week of pregnancy and 100% no later than the 28th week; and

1.5 Each client enrolled is visited by the same family nurse throughout her pregnancy and the first two years of her child's life.

Family Nurse

Each family nurse will:

2.1 Be registered with the Nursing and Midwifery Council (NMC), be educated to a degree level and meet the person specification for a family nurse.

2.2 Follow the FNP learning programme and attend all FNP specific essential training.

2.3 Follow the FNP Home Visit Guidelines 1) original visit schedule, which specifies the frequency and timing of home visits; and 2) the adapted programme guidelines, which specify the desired structure and content of each visit, and programme assessments and interventions to be used;

2.4 Apportion home visit time among content domains within the ranges specified.

2.5 Actively participate in FNP supervision as specified.

2.6 Be trained in specified approaches for establishing therapeutic relationship and motivating clients for positive behaviour changes;

2.7 Carry a caseload of no more than 25 families per full-time employee;

2.8 Work at least three days per week (20 hours per week) on the programme. Collect data about activity, visit content, mothers, and children according to the schedule and procedures specified by the international partner's data management team and approved by Dr. Olds.

2.9 Will work exclusively in this programme unless agreed with the FNP National Unit.

Supervisor

Each programme supervisor will:

3.1 Be registered with the NMC, at least equivalent in education and training to family nurses, preferably to masters level, and meet the person specification requirements.

3.2 Follow the FNP learning programme and attend all FNP essential training, as well as supervisor training and learning sets.

3.3 Carry a supervisory load of no more than eight individual family nurses (per full-time programme supervisor).

3.4 Carry a small clinical caseload (2/3 families).

3.5 Work at least three days per week (20 hours per week) on the programme.

3.6 Use programme reports to assess and manage areas where systems, organisational, or operational changes are needed in order to enhance the overall quality of programme operations and to inform reflective supervision with each nurse;

3.7 Meet one-on-one with each family nurse at least weekly to provide clinical supervision, preferably in person but by telephone where travel constraints limit nurse or Programme Supervisor mobility.

3.8 Conduct at least four team meetings per month: two to discuss programme implementation and two case based meetings to identify client challenges and solutions;

3.9 Develop opportunities for learning within the team and invite experts from other disciplines to participate in case based team meetings whenever cases require such consultation;

3.10 Make a minimum of one home visit every 4 months with each nurse;

Administrative Support

Each Site will employ a person (at least 0.5 full-time equivalents per 100 mothers enrolled) to provide support to the family nurses and programme supervisor, including

4.1 Ensuring that data about family nurse activity, visit content, mothers, and children are entered into the local database completely and accurately on a timely basis; and

4.2 Providing general administrative support

Implementing agencies:

Each Family Nurse Partnership implementing agency will:

5.1 Be located in and operated by organisations known in the community for being a successful commissioner and provider of prevention services to low-income families.

5.2 Convene a long-term FNP Advisory Board, chaired by the commissioner, that meets at least quarterly to promote a community support system to the program and to promote programme quality and sustainability.

5.3 Ensure adequate support and structure shall be in place to support family nurses and supervisors to implement the programme and to assure that data is accurately entered into the database in a timely manner.

UK Requirements

Psychological support:

Each FNP team will be supported by an appropriately qualified and skilled psychologist/child psychotherapist who will offer monthly consultancy as set out in the FNP Management Manual.

Safeguarding:

The FNP Advisory Board will ensure that safeguarding supervision and systems are in place in accordance with the FNP Management Manual.

Governance:

The FNP should be incorporated into local clinical governance arrangements.

Responsibilities for the sub license and local replication

- The commissioner is responsible for commissioning the programme in its entirety and for ensuring that the provider can meet the licensing requirements i.e. to provide sufficient funding with long term commitment, to understand and use the outcomes measures that the programme is known to affect, to use the core model elements, fidelity measures and FNP data sensitively for contract monitoring and quality assurance.
- The provider is responsible for meeting the licensing requirements, demonstrating excellence through the provision of data to the FNP National Unit and continually improving the quality of the programme.
- The FNP National Unit is responsible to the University of Colorado for ensuring the FNP licensing conditions are being met in England.
- The FNP National Unit will provide quality benchmarking information to commissioners and providers. If the FNP National Unit is concerned about the quality of a local programme, we will raise this with the provider and alert the commissioner of our concerns.
- The local FNP Advisory Board is the joint forum with responsibility for ensuring excellence in programme delivery, programme sustainability and support to FNP by community partners and champions.

The FNP Fidelity Goals

Fidelity goals relate to client recruitment, retention, visit dosage and coverage of content. These goals provide sites and the FNP National Unit with a benchmark against which fidelity can be assessed. Achieving these goals, or being close to them, will maximise a site's likelihood of delivering the same results as those found in the research trials. However, it is recognised that nurses' achievement of some of these fidelity goals, notably those on visit dosage, is demanding and they need to be seen as 'stretch goals' especially during the learning phase of programme delivery. It should also be recognised that the achievement of the recruitment and enrolment goals is highly related to the site's establishment of a successful recruitment pathway.

Sites are able to download regular reports detailing their collective and individual nurse achievements against these goals from the FNP Information System and will use these to learn about and reflect on their progress.

The fidelity goals cover 4 main areas:

1. Recruitment,
2. Retention of clients (measured by attrition rates)
3. Amount of programme received ('dosage'- measured by visits)
4. Programme content received (measured by FNP domain spread).

The specific fidelity goals for each area are set out below;

A. Recruitment and Enrolment

The programme attains enrolment goals of;

- At least 60% enrolled *before* 16 weeks of pregnancy and 100% no later than the 28 weeks.
- 100% clients enrolled are first-time mothers, within the specified site age bracket
- 75% of eligible clients who are offered the programme are enrolled
- Each nurse enrols 25 families (or pro rata adjusted) within 12 months of recruitment commencing.

B. Attrition

Clients leave the programme at no more than these rates:

- Cumulative programme attrition is 40% or less through to the child's second birthday
- 10% or less during the pregnancy phase.
- 20% or less during infancy phase
- 10% or less during toddler hood

C. Dosage

Clients receive:

- 80% or more of expected visits during pregnancy
- 65% or more of expected visits during infancy
- 60% or more of expected visits during toddler hood
- On average, length of home visits with participants is ▪▪60 minutes.

D. Programme Content

It is expected that the content of home visits reflects variation in developmental needs of participants across the programme phases:

Average Time Devoted to Content Domains during Pregnancy

Personal Health	35-40%
Environmental Health	05-07%
Life Course Development	10-15%
Maternal Role	23-25%
Family and Friends	10-15%

Average Time Devoted to Content Domains during Infancy

Personal Health	14-20%
Environmental Health	07-10%
Life Course Development	10-15%
Maternal Role	45-50%
Family and Friends	10-15%

Average Time Devoted to Content Domains during Toddlerhood

Personal Health	10-15%
Environmental Health	07-10%
Life Course Development	18-20%
Maternal Role	40-45%
Family and Friends	10-15%