Family Nurse Partnership National Annual Review: England

Name of Country	Date Report Completed	12 Month Reporting Period
England		1.04.2023 – 31.03.2024

Part One – Programme Overview

Size of Programme: sites	Size of Programme: staff	Commentary
Number of sites: 51	**Number of Nurses (FN):** 290 (excluding maternity leave and sickness): 18 maternity leave 3 extended sick leave 1 vacancy	
Number of commissioned places: information not available.	**Number of Supervisors (SV):65**	Includes job shares
	Number of Quality Support Officers (QSO):52	Full complement

National implementation leadership team capacity and function		Commentary
The national implementation team includes 1 deputy director, 1 head of clinical delivery, 2 quality and implementation leads, 3 senior clinical leads, 1 data analyst (vacant), 5 practice development leads (supervisors working in sites who work for the national team for between 15 – 25 days a year).		The team sits within the Office of the Chief Public Health Nurse in the Department of Health and Social Care. The remit of the team covers the 0-19 public health nursing workforce and delivery of the Healthy Child Programme, the national prevention and early intervention public health framework. The oversight of the FNP programme in England sits within this remit.

Local and national funding arrangements		Commentary
The national body for delivery of training and oversight of the FNP programme in England is the 0-19 Clinical Programmes Unit, Department of Health and Social Care. The funding for the financial year 2024 / 2025 has been agreed. Funding for local teams is via the national public health grant allocated annually to local authorities. The allocation for 2024/25 has not yet been announced. Local authorities choose whether to commission an FNP team as part of their 0-19 public health offer.		Sites (via commissioners and teams) are provided with tailored support to encourage continued investment in the service. Over the last year, one new site was commissioned. This was a site that had previously been decommissioned. There have also been some initial conversations with 2 areas about commissioning a new team. Two local authority areas have increased their team sizes, 1 area has commissioned a second team and we are in early discussions about a possible second team. 2 sites have been decommissioned.

Current policy / government support for FNP		Commentary
The Healthy Child Programme is the national prevention and early intervention public health framework. This sets out the universal offer for all families including those who require additional support. FNP continues to be part of the targeted offer that local areas can chose to commission to meet the needs of their population.		There are cross government programmes of work focussed on addressing the needs of babies, children and young people with the current electoral cycle offering opportunities to review and work collaboratively to ensure that all babies have the best start in life and children and young people are supported to meet their full potential.

Organisation responsible for FNP education	Clinical education staff	Commentary
Newly established 0 – 19 Clinical Programmes Unit (CPU), formed from the merging of the FNP National Unit and the Children and Young People's Team in the Chief Public Health Office of the Department of Health and Social Care	3 WTE senior clinical leads 3 sessional educators 5 practice development leads	The learning programme (Appendix 3) is delivered by 3 senior clinical leads who sit in the 0-19 Clinical Programmes Unit. They are supported by 5 practice development leads who work on the supervisor and mentorship programme and 3 sessional educators who support delivery of motivational interviewing and PIPE as part of the core learning programme.

Part One – Implementation

Clients		Commentary
Total number of active clients: 6097		
Attrition: 823		
Inactive: 23 (0.4%)	Attrition with inactives or 'drop out' – clients not being contactable, not being at home etc is very low at 0.4%	Inactives or 'drop out' is very low over the whole programme. While nurses report clients are increasingly challenging to engage due to increasing vulnerability levels, once they are recruited, they tend to continue, appreciating the specific support FNP brings them. This is evidenced by the low attrition figures and client feedback at annual reviews and advisory boards.
Leavers 835 (14%)	Attrition from leavers for a variety of reasons is as follows: Clients no longer have parental responsibility - 136 or 16.3% Transfer to area with no FNP or outside England – 252 or 30.1% (reduced from 31%) Service capacity - (transferred to health visiting service) 91 or 3.5%, an increase from 2.9%	Clients who no longer have parental responsibility has increased. Compared to the average over the last 3 years of 13.2%. This reflects national trends with increasing levels of vulnerability and pressure on resources in the system. There are significant numbers of clients who leave the programme due to moves out of the local authority where FNP is commissioned. FNP is commissioned by local authorities and is not present in all local authorities. Early transfers to the health visiting service (universal public health nursing service) occur when capacity within the FNP team is insufficient to meet commissioned capacity in the teams or when teams are unable to meet local requirements due to sickness absence or staff turnover.

	Site decommissioned – 91 or 10.9%, an increase from 9.6% Infants removed from birth 2 or 0.2%, an increase from 0.4% Client requests no further programme 295 or 35.3% (down from last 3 years of 38.8%) Infant death, stillbirth or termination – 30 or 3.6% up from 2.3% over last 3 years	Attrition of clients also occurs when sites are decommissioned. There has been a slight increase in numbers of infants removed at birth, suggestive of the increase in vulnerability of clients more generally. Most common reason for this are having sufficient family support, in work, and/or not being able to commit to the intensity of the programme.

Nursing workforce		Commentary
Average caseload size - (we are not able to obtain this data from our data system, however, see commentary)	Nurses are taken from a variety of backgrounds including, midwifery, specialist public health nursing (0 – 5 and 5-19), mental health, children's nursing and adult nursing.	The caseload size is nationally agreed as no more than 25 per WTE nurse. The actual caseload size is agreed locally via the advisory board and anecdotally varies between 18 and 23 clients.
Vacancies Nurse vacancies – not able to obtain this data from our data system. Supervisor vacancies – none		
Team capacity (see appendix 2 for further details)		There have been challenges in team capacity in 28 sites. This is either due to staff turnover or sickness and is the responsibility of the local provider organisation to manage.

FNP Education		Commentary
The FNP education programme for new nurses and supervisors is provided by the 0 – 19 Clinical Programmes Unit and consists of: • Foundations – a 5-day residential training • Advanced motivational interviewing – 2-day residential training • PIPE & infancy - 3-day residential training • DANCE is delivered virtually over 5 weeks by the UCD DANCE team. • Toddler – 2-day virtual training. • New Mums Star – 1-day virtual training The Supervisor Learning Programme is 2 residential introductory days and 2 residential days for supervision and safeguarding, plus 6 virtual learning days spread over a 10-month period. All supervisors are supported through the learning programme by a practice development lead who provides individualised mentorship which includes observations of team learning and supervision sessions. Development days are offered annually for family nurses and quality support officers. Supervisor development days happen bi-annually. One session focusses on hearing from practice and the other session offers an agenda based on the needs of the supervisor community.		The FNP education programme is offered by blended means; face to face, virtually and via the training platform Moodle. There is an expectation that all family nurses and supervisors complete the modules on Moodle which consist of pre-course learning and consolidation following training. These modules are designed to complement and enhance learning completed individually, with supervisors and with the team.

Quality Support Officers development days		Following requests from the Turas Data User Group for an opportunity for QSO's to come together for a development day, 2 sessions were held in March with 50 QSO's attending across the two days. The sessions included time for QSO's to discuss the variances in their roles, share good practice, and make connections. Turas skills practice and presentations on the importance of the role of the QSO to support quality assurance and quality improvement and good implementation were also part of the day. QSOs were encouraged to develop regional networks with other QSOs to share skills and knowledge. Annual development days will now be planned to build on this.

Turas Information System		**Commentary**
Turas is the information system that family nurses use to collect client data following each visit. It is managed by NHS Scotland and was commissioned in 2020 by Public Health England to provide an improved information system as the previous system was no longer fit for purpose.		Over the past year, the national data analyst post has been vacant due to spending control measures within the DHSC. This has affected our ability to gain maximum benefit from the Turas information system However, recent controls have now been relaxed and the post will be recruited to. This post is expected to be filled shortly.

New Mum / Parent Star		**Commentary**
The New Mum Star is a collaborative assessment undertaken by the family nurse and client to identify areas of strength and areas for development. Based on this the family nurse and client agree priorities and programme materials are selected accordingly. The expectation is that a New Mum Star is completed in each phase of the programme.		Between 1.4.23 and 31.2.24, 65.13% of New Mum Stars have been completed. This is a decrease since quarter 3 of 22 /23, the most likely cause being the introduction of 10 new supervisors over the last year and the impact of teams with reduced capacity due to staff turnover, sickness absence, maternity leave.

65.13% of clients have had a new mum star completed in the period 1.4.23 – 31.3.24		In terms of delivery to clients, data shows that the default when NMS are not completed is the standard programme. However, the plan for this year will be to continue with quality improvement measures which will be greatly assisted by the appointment of the data analyst which will allow more in-depth analysis of individual sites as we recognise that there is some marked site variation affecting the figures.

		Commentary
Core Model Elements (Appendix 1)		Aggregated data from monitoring CMEs at Annual Reviews in reporting period (also see appendix 2) 17 core model elements in FNP programme in England

Core Model Element 1 – Client eligibility criteria, recruitment and retention on programme

Element:	Compliance			Commentary and any action identified to work towards full compliance
1.1 Eligibility Criteria **Voluntary enrolment** **1st time mother** **Local vulnerability criteria**	**100%**	**85 – 99%**	**< 85%**	
	☑			
1.2 Fidelity Goal: 75% of clients offered are enrolled on programme.	**75% +**	**65 % +**	**< 64%**	This indicator is collected locally and is not monitored centrally as data is only entered on Turas once the client is recruited. However, it is reported annually via the annual review process.
		☑		

1.3 Fidelity Goal: 100% enrolled before 28 weeks	**100%**	**98% +**	**< 98%**	Late enrolments are predominantly vulnerable clients that may transfer into an area or when local processes do not identify clients for the service in time.
		☑		
1.4 Fidelity Goal: 60% enrolled before 16 weeks.	60% +	50% +	< 49%	80% of sites are non-compliant with this indicator. This is for a variety of reasons; staff turnover within the teams, increased vulnerability of clients and longer time needed to engage or clients who are late notifications, but vulnerability is prioritised. This next year work will continue to gather information to understand the issue better before deciding the best approach to this.
			☑	
1.5 Fidelity Goal: Attrition less than 40% for programme	**< 40%**	**40 – 50%**		Attrition is 13% Of this 13%: 31% transfer out to an area where there is no FNP service. 16% have their parental rights removed. 35% no longer want the programme. 11% of clients leave the programme as a result of decommissioning of the service
	☑			

Core Model Element 2 - Family nurse recruitment, education and working practices

Element	Compliance		Commentary and action to work towards full compliance
2.6 Family Nurse Caseloads	**25 or less**	**> 25**	100% of caseloads are 25 clients or less.
	☑		
2.7 Supervisor Caseload	**Minimum 1 client**	**No clients**	98% of Supervisors carry a small caseload of on average between 1 – 2 clients
	☑		

2.8 Nurse education	**FNP foundations**	**In post but awaiting course**		All nurses recruited to posts fulfil basic education requirements of NMC registered nurse or midwife. 50 nurses trained during this period.
				

Core Model Element 3 – Supervisor recruitment, education and working practices

Element	Compliance			Commentary and action to work towards full compliance
3.1 Supervisor Education	**Completed SV training**	**In training**	**Awaiting training**	All Supervisors fulfil basic requirements of NMC registered nurses or midwives with master's level education or equivalent experience. All new supervisors receive national FNP training for managerial post and nurse training if they are not already a family nurse. Yearly development days (2 per year) are mandatory for updating and collaboration
	12	**10**	**1**	
3.2 Weekly Supervision	**Weekly**	**Less than weekly**		100% of sites had weekly supervision
				
3.3 Tripartite Meeting [1]	**Tripartite Meeting with SV and NN**	**Group**	**Not in place**	Variances to this CME occur when the local capacity for a tripartite meeting with a named nurse for each Family Nurse is not available. This is more so with large teams. This CME is specific to FNP in England

[1] The tripartite meeting is a three-way meeting between the Supervisor, the named nurse and the family nurse. It is part of the safeguarding model in England and Is designed to provide an opportunity for the named nurse to add her/his expertise in safeguarding to the FNP team, as well as offering an objective point of reference for analysis of cases, sharing of research findings, local knowledge and access to local services.

				67 %of sites had tripartite meetings 30% sites had group meetings. 2.3% had neither
3.4 Accompanied Home Visits	**Compliant**	**Partially compliant**	**Non-compliant**	68% of sites are non-compliant with Supervisors doing 3 visits per nurse per year. This is planned QI for this year.
				
3.5 Team Learning & Team Meetings	**12 - 14 hrs plus per month**	**< 12 hrs per month**		94% of teams are compliant with this core model element. 6% of teams are non-compliant, as reported on their annual review self-assessment. This indicator is included in their improvement plan for the following year.
				

Core Model Element 4 – Local organisational infrastructure and resource and administrative support

Element			Commentary and action to work towards full compliance
4.1 FNP Advisory Boards established and functioning	**In place and meets regularly**	**Not in place**	
			100% of sites have an Advisory Board.
4.2 Provider Organisation is CQC registered to provide universal public health services to vulnerable families	**CQC compliant provider**	**Non CQC compliant provider**	
			

4.3 Quality Support Officer	**In post**	**Not in place**	
	☑		100% of teams have a quality support officer in post
4.4 Psychology consultancy	**In place**	**Not in place**	
	☑		100% of teams have a psychology consultation offer in place

Overall Compliance with RAG rated key Core Model Elements		
Compliant	Getting There	Non-compliant
13/17*	3/17*	1/17*
		Overall compliance with core model elements = **94%**

Part Three – Programme Impact

Data		Commentary
Client characteristics	**Reporting period: 1.04.2023 – 31.03.2024** In comparison to the data from 2022/23 it is interesting to note that this year's data shows an increase in clients who were under 18 and 16 at enrolment. This reflects national data that is beginning to suggest an increase in teenage pregnancies. Slight increases in reliance on state benefits, requiring mental health services and experience of long-standing illness also reflect the national trends. 36% clients are under 18 at enrolment, of those 17% are 16 and under 43% are in education, employment or training at enrolment (EET) 37% are reliant on state benefits for all income 32% had received mental health services in the past 24% had a long- standing illness of which 68% said this was life limiting 30% disclosed current IPV or within last 12 months 83% clients are white British 38% had lived away from home under- age of 18 57% had an academic or vocational qualification 47% had at least one social care intervention in the past 25% suffered anxiety or depression at intake 35% smoked at intake	**Indicators showing increased vulnerability since 2022 / 2023 are as below. All others are either the same or an improvement since then.** 26.4% were under 18 at enrolment, 12% under 16 47.6% were EET 35.1% reliant on state benefits for all income 31.1% had received mental health services in the past 19.7% had a long-standing illness of which 67.7% said this was life limiting 29.2% disclosed current IPV or within the last 12 months

Maternal outcomes	**Reporting period: 1.04.2023 – 31.03.2024** 9% increase in clients with low mastery scores by 24 months 23% clients under 18 had a subsequent pregnancy by 24 months 40% clients quit smoking during pregnancy 41% clients are in education or employment at 24 months 62% clients leave the programme with firm plans to return to education or employment	**Reporting period: 1.04.2022 – 31.03.2023** **Comparative outcomes below are where there has been a subsequent decrease since 2022/23. All other outcomes are either the same or and improvement.** 15.7% increase in clients with low mastery scores - suggesting increase in self-efficacy.
Child outcomes	**Reporting period: 1.04.2023 – 31.03.2024** 92% babies immunised at 12 months 95% at 24 months 54% babies received breastmilk at birth 17.1% had at least one social care intervention 9.2% had a child in need plan	**Reporting period: 1.04.2022 – 31.03.2023** **Comparative outcomes below are where there has been a subsequent decrease since 2022/23. All other outcomes are either the same or and improvement.** 91.7% immunised at 12 months, 96% of babies immunised at 24 months 57.7% received breast milk at birth 12.8% had at least one social care intervention 6.8% had a child in need plan

	6.3% has a child protection plan 65.03% ASQ scores within normal range of development 40% of clients who smoked at enrolment gave up at 32 weeks pregnancy 90% born full term Less than 1% were hospitalised for injury or ingestion	5.3% has a child protection plan 66% ASQ scores were within normal range of development
Working with fathers and communities of practice	20.6% of visits are with the father present. FNP sites are supporting a father's worker to deliver an intensive service to young fathers, either the partners of FNP clients or who are referred to them via other agencies, e.g., care leavers via social care. This is in addition to the FNP offer for fathers and / or when the parents are no longer a couple. This has led to an increasing awareness of father inclusive practice in other services in local areas, where the FNP and fathers' service has acted as a catalyst for more equitable practice and acknowledgement of the role fathers play in parenting. Other FNP sites are developing father supportive services, working with FNP teams in a variety of different ways. A national community of practice has been established to share practice about working with young vulnerable fathers and to develop expertise in this area.	This is an increase from 19.5% in 22/23.

Safeguarding data audit	During this reporting period we undertook a piece of work in response to an anomaly between data reported and practice feedback. Analysis of national programme data indicated that the number of clients and infants on safeguarding plans had reduced contrary to reporting from sites that safeguarding within FNP caseloads was increasing. With the recent changes made to the way data is collected and recorded within Turas our first step was to try and understand what might be happening and to ascertain the level of accuracy in the recording of data in the information system. Sites were asked to carry out an audit of their caseloads comparing data and clinical records. Analysis of the audit returns indicated there is or has been an issue with data recording. This work has generated some immediate quality improvement ideas that have been actioned.	

Client feedback: All client feedback has permission from clients to be shared			**Commentary**
Stockport Annual review	FNP Annual Review (youtube.com)	Video from Stockport Annual review.	
Video		FNP Annual Review - Child's Journey (youtube.com)	Stockport FNP client, told via the child's voice – one of the concepts nurses are taught about and who then communicate this to their clients. (Appendix 4).

Part Four – Programme Improvement and evaluation

Quality improvement goals set out in 2023/24 annual review		Commentary
Accompanied home visits		Accompanied home visits: the data has continued to be monitored on a quarterly basis and after some initial improvement appears to have stalled. Site annual reviews have continued to provide a forum to highlight the importance of accompanied visits and are reported upon as part of the site self-assessment process. A QI project is a priority for 2024/25 once the data analyst is appointed.
Implementation of the workforce packages to offer wider shared learning		Implementation of workforce packages (previously known as Knowledge and Skills Exchange / KSE packages). This project was successfully delivered during the reporting period. The current packages were refreshed and updated. The packages cover attachment, Motivational Interviewing, and the adolescent brain. Two new learning packages have been developed, trauma informed care and clinical supervision. A new service development toolkit has been developed to assist sites to develop alternative pathways for vulnerable clients who are not eligible for FNP. These have been well received by local areas and continue to expand the reach of FNP.
Extending eligibility criteria.		Extending eligibility criteria: this work has focused on service development that utilises the expertise of the FNP team to develop or enhance services for vulnerable families. The development of work with fathers has continued to grow (see impact for further detail) as well as enhanced pathways for families who don't meet the criteria for or can't access FNP.

Part Five – Action Plans

Indicator	Actions	Commentary
Accompanied Home Visits (AHV)	A quality improvement plan for this indicator that focusses on continuing the increase in supervisors achieving these and evaluating the benefits of this practice for the service will be done over the next year.	The accompanied home visits are an important part of the clinical governance of the programme, quality assurance and an element of the safeguarding model. There are also possible benefits for the 0 – 19 public health nursing service that this practice can demonstrate and so this will be a key area of improvement for the next year.
Review of FNP delivery	Options appraisal of FNP programme Review of learning programme materials, guidance and quality assurance framework	A piece of work has been commissioned and is being led by a public health registrar to assess the potential options available for development of the Family Nurse Partnership Programme, considering the political, financial, social, and technical context, with the goal of identifying the most effective and feasible strategies that will meet the needs of the target population. From this evidence-based recommendations for maximising its benefits to the target population will be developed. A task and finish group is reviewing our processes for quality assuring the learning materials and guidance as well as reviewing our ways of working. This is to ensure quality support for programme delivery and to support integration of the work into the broader 0-19 public health nursing remit of the Clinical programmes Unit.

Part Six – Record of Meeting for Global Collaborative Guidance Group

Part Seven – Appendices

Appendix 1

Annual Review calendar, dashboard, and Quality Assurance Framework

Appendix 2

Learning Programme Implementation Framework

Appendix 3

Client feedback - Megan's speech

Appendix 4

Licensing Core Model Elements

The FNP programme has developed over many years to become the highly respected evidence-based programme that is now being offered to disadvantaged families in seven different countries. As the programme has developed and expanded, its various components have needed to be described and delineated, so that the many thousands of FNP nurses, supervisors and implementing bodies who have become involved, are able to faithfully reproduce the programme model that has been rigorously tested. The key features of the programme that need to be reproduced have been identified as Core Model Elements ("**CMEs**") and each country or organisation provided with a licence for FNP agrees to adhere to these as they implement the programme within their own context. The CMEs have been adapted for the UK setting because of the formative evaluation; experiences within UK FNP sites since 2007; learning from the Building Blocks RCT (2016) and the current programme adaptation project. They have been approved as the UK licensing conditions by Professor David Olds at the University of Colorado Denver.

Applying the CMEs in practice provides a high level of confidence that the outcomes achieved by families who enrol in the FNP programme will be comparable to those achieved by families in the initial three randomised controlled trials and outcomes from ongoing research on the programme.

Fidelity is the extent to which there is adherence to the CMEs alongside provider /nurse uptake, application of new research findings, and carefully developed adaptations and quality improvement innovations. Fidelity helps protect the integrity, quality, and effectiveness of the FNP programme while being relevant to the local context. Sub-licensees are responsible for ensuring that providers/sites/FNP nurses and supervisors implement and develop the local programme with fidelity to the FNP model.

Core Model Elements are prescribed in 4 areas of the programme:

1. Client eligibility and enrolment.
2. Family nurse recruitment, education and working practices.
3. Supervisor recruitment, education and working practices.
4. Local organisational infrastructure and resource and administrative support.

Element 1. Client Eligibility and Enrolment:

1.1 Client participates voluntarily in the Family Nurse Partnership programme.

***Definition**:* FNP clients participate voluntarily in the program. In all situations, clients must be enabled to understand that they are participating in the program voluntarily and that they may withdraw from the program at any time. Written materials, including pamphlets setting out the voluntary nature of the program and/or signed consent should be used to support this.

1.2 Eligible clients include first-time mother's only, and sites use the eligibility criteria set out by the Family Nurse Partnership National Unit.

Definition: First-time mother is either a nulliparous woman (i.e., has experienced no previous live births) or has never parented a child before. Women who have experienced a neonatal death, have had a child removed from their care immediately after birth, or had their first baby adopted immediately after birth would therefore be eligible for inclusion in the programme.

1.3 Sites enrol clients early in pregnancy and no later than the 28th week of pregnancy unless pregnancy concealed or in exceptional circumstances because of a client moving into the area and not being known to local health services until after 20 weeks gestation.

***Definition**:* A client is considered to be enrolled when they receive their first FNP visit, and any necessary consent forms have been signed. Prior to this, FNP nurses may undertake pre-enrolment visits to assess a woman's eligibility, explain the program to the prospective client and invite them to participate. The 28th week of pregnancy is defined as no more than 28 weeks and 6 days of gestation. A concealed pregnancy is defined where the mother is not booked for antenatal care after 20 weeks (*Wessel et al* 2002). Where a female, through fear, ignorance, or denial, does not accept or is unaware of the pregnancy in an appropriate way" (*Sadler* 2002).

1.4 Each client enrolled is visited as far as possible by the same family nurse throughout her pregnancy and the first two years of her child's life or until graduated from programme if earlier.

Definition: The process of developing and maintaining relationships is central to nursing professional practice. A specific type of relationship, the therapeutic relationship, is developed between the assigned FNP nurse and the client through the one-to-one home visits that occur over the duration of the programme. The overarching core competency for a FNP nurse is: **The ability to support and maintain a therapeutic relationship with each client and use FNP programme methods to enable necessary changes in understanding, capabilities, and behaviours; ensuring the mother can nurture, develop, and protect her child and herself from harm.**

1.5 The client is visited at home throughout her pregnancy and in the first two years of life or until graduation if earlier according to the current FNP programme personalised schedule agreed between the client and nurse.

Definition: The client (partner, and/or family when appropriate) is visited throughout her pregnancy and the first two years of her child's life or until graduation if earlier. A schedule of visits with proposed content has been developed for the programme. An alternate programme schedule and content is defined as any personalised planned visit schedule and content aligned with FNP Guidelines. The process of purposefully adapting and personalising programme delivery to meet specific client and child needs over the course of the programme is supported by the New Mum Star (NMS) framework.

Element 2. Family Nurse Recruitment, Education and Working Practices:

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.

Definition*:* It is expected that provider organisations will assure themselves that this process results in the employment of FNP nurses with a valid NMC registration, degree level education and the desired skills, knowledge and abilities required to successfully deliver the FNP programme. In addition to these academic qualifications, nurses must have personal qualities, values, and beliefs, which will ensure that there is a good fit with the spirit of FNP.

2.2 Complete all elements of the FNP core and ongoing clinical learning and implementation programme and deliver the intervention with fidelity to the Family Nurse Partnership model.

Definition: The FNP Learning, and implementation programme is designed, delivered and quality assured by the FNP National Unit. This ensures that nurses and supervisors receive the education and coaching that they need to become competent to deliver the programme and builds on their professional education and experience. The system, content, and methods of education and coaching need to prepare registered nurses and supervisors in the unique practice skills inherent in relationship-based, strengths-focused intervention and be relevant to local context. Nurses and supervisors must be supported to access ongoing learning opportunities provided by the FNP National Unit.

2.3 FNP nurses, using professional knowledge, judgment, and skill, utilise the programme materials personalising them to the strengths and risks of each family and apportioning time appropriately across the areas identified on the New Mum Star framework.

Definition: The FNP Guidance provides the flexibility needed to meet the clients' needs and desires as well as programme goals. The format offers FNP nurses a guide to explore the content topics most relevant to clients. The NMS framework is part of the assessment process which guides personalisation of programme delivery.

2.4 Actively participate in FNP supervision as specified.

***Definition**:* The process of supervision, as carried out through a safe, honest, and trusting relationship and is as important an intervention as the direct work undertaken with the client (*Gibbs* 2002).

The objectives are:

1. Competent, accountable performance (Managerial Function)
2. Continuing professional development (Educational/Development Function)
3. Personal support (Supportive Function)
4. Linking the individual to the organisation (Mediation Function)

The current model specifies weekly 1:1 supervision with FNP Supervisor for each nurse and weekly (or equivalent) team learning sessions.

2.5 FNP nurses and supervisors apply the theoretical framework that underpins the programme (self-efficacy, human ecology, and attachment theories) to guide their clinical work and achievement of the three FNP goals.

Definition: They also introduce content that supports clients in developing the knowledge, skills, and self-efficacy to achieve the three FNP programme goals of:

1. Improved pregnancy outcomes through the practice of good health-related behaviours
2. Improved child health and development
3. Improved economic self-sufficiency

2.6 Carry a caseload of no more than 25 families per full-time employee.

Definition: Each WTE FNP nurse has a maximum of 25 clients at any one time on her caseload. This must be pro rata for part time FNP nurses.

2.7 FNP teams and Provider organisations collect and utilise data to guide programme implementation, inform continuous quality improvement, demonstrate programme fidelity, assess indicative client outcomes, and guide clinical practice and supervision.

Definition: Information is recorded on the national FNP information system (Turas). Data collected is analysed and reports are generated for individual clients, nurses, teams, and local and national systems in a timely way, in line with FNP Governance arrangements. In addition, this data may be used by research teams (Contingent upon adherence to required permissions for release of data), alongside other data, to inform their evaluation of the implementation of FNP.

2.9 The role of Family Nurses and Supervisors' primary focus must be on the delivery of the FNP programme and provide sufficient weekly hours to support safe and consistent service delivery.

Definition: Effective local delivery of the FNP programme requires each family nurse to have the capacity to deliver the programme to clients and participate in supervision, team learning and wider learning. This also ensures consistent application of FNP skills and approach. Supervisors are required to have the capacity to lead and manage the

team and provide strategic leadership within the local system. Ensuring this facilitates opportunities for the FNP team to impact on wider system workforce and service developments. The requirement is:

1 WTE Supervisor maximum of 8 WTE Family Nurses. 1 WTE Family Nurse minimum 3 days per week.

Element 3. Supervisor recruitment, education and working practices:

3.1 Each FNP team has an assigned FNP supervisor who leads and manages the team and provides nurses with regular reflective supervision and is registered with the NMC, at least equivalent in education and training to family nurses, preferably to master's level, and meet the person specification requirements.

Definition: Each supervisor can carry a supervisory load of no more than eight whole time equivalent family nurses (per full-time programme supervisor).

It is expected that provider organisations will assure themselves that this process results in the employment of FNP supervisors with a valid NMC registration, degree level education and the desired skills, knowledge and abilities required to successfully deliver and lead the delivery of the local FNP programme. In addition to these academic qualifications, nurses must have personal qualities, values, and beliefs, which will ensure that she is a good fit with the spirit of FNP.

3.2 Complete both the clinical and supervisory elements of the FNP learning programme.

Definition*:* Supervisors who have not previously practiced as a family nurse must complete the core family nurse learning programme.

3.3 Carry a small clinical caseload.

Definition: The supervisor must deliver the programme to a defined group of clients with FNP National Unit guidelines.

3.4 Facilitate the learning, professional development, and effective practice of each nurse in the team.

Definition:

- Provide one to one individual clinical supervision within FNP National Unit Guidelines. For each nurse on a weekly basis (pro rata for part time nurses) preferably in person but by telephone, where travel constraints limit nurse or supervisor mobility.
- Facilitate the equivalent of four half day team meetings per month: two to discuss programme implementation/ skills practice and two case-based meetings to identify client challenges and solutions. (One of which is facilitated by the psychological consultant).
- Develop an individualised learning plan for each nurse and leading the team-based learning activities, as specified in the FNP learning programme.
- Make a minimum of one home visit every 4 months with each nurse for field supervision purposes.

- Use programme reports to assess and guide programme implementation, inform supervision, support quality improvement, and demonstrate programme fidelity.

Element 4. Local organisational infrastructure and resource and administrative support:

4.1 High quality FNP implementation is developed and sustained through national and local organised support. This is an indicator for effective outcomes for clients.

Definition:

- Each Sub-licensee Organisation will have an effective Care Quality Commission (CQC) registration and expertise in the provision of universal services to vulnerable families.
- Local strategic leads will convene a long-term FNP Advisory Board or equivalent chaired by a senior commissioner, which meets regularly to facilitate programme sustainability through effective quality assurance and improvement in the local system; scrutinise and monitor local governance arrangements; oversee quality improvement plans and ensure the client's voice informs service development.
- This includes the completion of an annual review and accompanying report to be shared with the FNP National Unit. This will be aligned to FNP National guidance.
- Each site will employ a dedicated administrator in line with the national job description to provide essential administrative services to enable effective delivery of the programme.
- Each FNP team will access psychological consultancy monthly with an additional requirement for the supervisor to receive monthly one to one session as per guidance.
- Ensuring that the necessary infrastructure and resources for the team, including office equipment, printed guideline materials and other resources, mobile devices etc., are made available.